In The Matter Of:

Public Employees' Benefits Program Board
Videoconferenced Open Meeting

November 17, 2016

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PUBLIC EMPLOYEES' BENEFITS PROGRAM BOARD

TRANSCRIPT OF PROCEEDINGS

VIDEOCONFERENCED OPEN MEETING

THURSDAY, NOVEMBER 17, 2016

CARSON CITY AND LAS VEGAS, NEVADA

The Board:	PATRICK CATES, Chairman LEAH LAMBORN, Member DON BAILEY, Member CHRISTINE ZACK, Member JAMES WELLS, Member TOM VERDUCCI, Member CHRIS COCHRAN, Member ROSALIE GARCIA, Member ANA ANDREWS, Member
For the Board:	DENNIS BELCOURT, Deputy Attorney General
For Staff:	DAMON HAYCOCK Executive Officer CELESTENA GLOVER Chief Financial Officer NANCY SPINELLI Quality Control Officer KARI PEDROZA Executive Assistant CHRIS DeSOCIO Chief Information Officer
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A G E N D A

THURSDAY, NOVEMBER 17, 2016, 9:00 A.M.

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CHAIRMAN CATES: Good morning, Everyone. So this is the time and place for the Public Employees Benefits Program board meeting, November 17th, at 9 a.m. Let's go ahead and start the agenda with roll call.

MS. PEDROZA: Don Bailey.

MEMBER BAILEY: Here.

MS. PEDROZA: Ana Andrews.

MEMBER ANDREWS: Here.

MS. PEDROZA: Chris Cochran.

MEMBER COCHRAN: Here.

MS. PEDROZA: Rosalie Garcia.

MEMBER GARCIA: Here.

MS. PEDROZA: Leah Lamborn.

MEMBER LAMBORN: Here.

MS. PEDROZA: Tom Verducci.

MEMBER VERDUCCI: Here.

MS. PEDROZA: Jim Wells.

MEMBER WELLS: Here.

MS. PEDROZA: Christine Zack.

MEMBER ZACK: Here.

MS. PEDROZA: And Patrick Cates.

CHAIRMAN CATES: Present.

MS. PEDROZA: And we have a quorum.

CHAIRMAN CATES: Thank you.

Next agenda item is public comment. Before we start that, let me just make a quick comment on the agenda. I stated at the last meeting, I'll state it again because I know this is probably a little different for people. But public comment, I will observe the three-minute rule for public comment, out of respect for all of the participants. I would encourage and welcome any written testimony if anybody does not feel that three minutes is adequate for public comment.

A couple of items -- So this is for general public comment. Agenda Item Number 9, which is discussion and possible action regarding proposed plan design changes for fiscal year 2018, we are going to take public comment at the beginning of that agenda item, so if you want to comment on that, I would suggest that you hold your comments until we get to that item.

Also, Agenda Item Number 6, the audited financial statements, I understand from the executive director that our auditors are not quite complete with that agenda item, so we will pull that from the agenda.

And with that, we'll go ahead and take public comments. Do we have any public comments in Reno? I mean Carson City. I said Carson City. I used to work for the Wildlife Commission and we had meetings in Reno all the time.

I apologize.

Go ahead and state your name for the record.

MR. HARRIS: Good morning. My name is Jack Harris for the record. I'm the state president of the Retired Public Employees of Nevada.

My name is Jack Harris and I'm the state president of the Retired Public Employees of Nevada. First, I've been attending these meetings since 2005. And over the years I know we've had some changes to the forum. But I missed two meetings in a row and I see a lot of new faces. And it is Mr. Wells and Mr. Haycock and others that, you know, have been here before. Know that we have been actively involved in working or representing our members in the PEBP, particularly the extreme.

Before I come to that, I do want to make a comment that over that period of time, there's always been an RPEN member representative here at the meeting except for the one in September. And that's when you made the change or promoted or appointed the new quality control officer, Nancy Spinelli. We didn't have an opportunity to give our input at that time. But I do want to as a member for RPEN and our association we want to commend the board on your selection. It is an excellent selection. And Nancy over the last year and during the interim has done a great job working with us to try to, you know, reach out and do education to our

members on RPEN and the exchange.

Also that I want to just bring to the attention of the board that starting about four years ago we sat down with Towers Watson at that time, it's been a period between Extend Health Towers Watson, One Exchange Towers Watson, Willis Towers Watson, so we've gone through that trying to keep it straight. But during the period of time we've sat down and we've gone through and made a lot of progress in the program, particularly in education, the enrollment process, the reimbursement process, we sat down at the beginning, we sat down again and went through line by line by line on their presentations. So it wasn't one size fits all. But it was really reflective of what was available in Clark County, what's available in Washoe County, Carson City, and then statewide. So those, we've made great progress on that part.

And we did sit down and did have a rather extended meeting last night with John Seegrist and the Towers Watson, their staff representatives up here, you know, discussing our concerns and our continued concern about the customer service aspect of it and how we can go about maybe improving. You know, right now it seems to be kind of like the stock market. It goes up and it goes down on the participation. How we can improve the communication not only between Towers Watson and RPEN and also PEBP getting the message out that these sessions are available and we need to

be utilizing it.

With that, I'd like to thank you again. And good luck.

CHAIRMAN CATES: Thank you.

MS. BOWEN: Good morning. My name and words for the record, my name is Peggy Lear Bowen, P-e-g-g-y space L-e-a-r space Bowen, B-o-w-e-n. And I'm here to compliment and just say thank you, thank you, thank you for the efforts of this body to be as open and accessible as possible and with the beautiful new changes on the public comment section on your meeting notice. It is done exactly and precisely correctly with information available to all.

As Mr. Harris indicated, RPEN could not be present at the September meeting because their conference was in Elko, Nevada. I took time from the conference to go upstairs and try and get in on that meeting. It took almost an hour and a half to finally make things function so that we could reach through computer the visual access of it. And when you started having difficulties I think it was with item eight or nine -- I forget the number at this point -- that there was a major vote that pertained to us and things like that going on. I called in here. And I don't know how you were notified. But I do know at that moment in time when I was finally able to get back on to the computer for the computer communication to take place, that at that point a

major item pertaining to number eight or nine was now not going to be voted on. It was going to be put off to another meeting so that we could -- And I know you're not supposed to make assumptions. But I'm hoping and praying that you did that so that we would be able to be present and participate in a discussion item that had great impact on the retired people of -- state workers and such in Nevada. And I want to compliment you on everything that you are doing communication-wise for this board to be more open and transparent.

A cautionary note that on this agenda as brought up, there are items that are on this agenda that the legislature in the last session acted upon and gave direction to and they've now been brought up on this agenda as -- to be rediscussed by this body for possible putting in to place what the legislature already took action on. And I know that we want this board to continue. You are our voice to the legislature, to the governor, and to every other situation. And we need you to maintain your credibility and your vibrance and your strength as a board and reestablish trust as a board with this entity so that we have a voice that we can come to on a monthly basis or whatever. It's that important.

So to look at things that the legislature has already, even though it wasn't a big bipartisan vote, it was

a bipartisan vote when the houses were represented by one party.

CHAIRMAN CATES: Three minutes.

MS. BOWEN: Thank you very much. Please use caution at taking on the legislature and thank you for all you do.

CHAIRMAN CATES: Thank you very much.

Anymore public comment?

MR. ERVIN: Good morning. My name is Kent Ervin K-e-n-t E-r-v-i-n. I'm an active participant in the program. I'm a professor. But today I'm speaking on behalf of the Nevada Faculty Alliance which represents NSHE faculty statewide. My comments are for the record.

We're generally concerned about the plan changes proposed that represent benefit cuts. I'll save my specific comments regarding some technical aspects of those for Agenda Item 9. But we're concerned generally that the current proposals that are presented today don't reflect the overall potential impacts of a flat state subsidy or a five percent reduction along with medical cost trends.

As board members you should insist on a report showing the full cost of maintaining the current plan design including the enhancements. Then we can start from there to address budget realities. But the participants and the legislators deserve to see the actual state of affairs rather

than this piecemeal add here, take back there, where we don't see the overall view of what's going with the budget and have those hidden until too late in the process to make informed decisions and let the legislators make the informed decisions.

So thank you. I'll have more comments about Agenda Item 9. But I look forward with working with all of you on behalf of the Nevada Faculty Alliance and NSHE participants. Thank you.

CHAIRMAN CATES: Thank you very much.

Any more public comment here in Carson?

MR. YOUNG: Yes. Hi. I'm Tyler Young representing AFSCME, the American Federation of State --

CHAIRMAN CATES: I'm sorry. Is it Tyler or Ty?

MR. YOUNG: Tyler Young. And we're Local 4041. Unfortunately I cannot stay until action item nine, so I just wanted to state that on behalf of public employees we're really concerned about wanting to make sure we maintain current benefits and cost of the current levels. Because right now we don't know if we're going to get a COLA this year. And last session the COLA was very small and was offset by PERS and benefit increases. So the only way the state employees are going to have any chance of getting ahead is if the board stands together and tries to negotiate better benefits and better rates with the insurance companies.

CHAIRMAN CATES: Thank you.

Any more public comment here in Carson?

Do we have any public comment in the overflow room upstairs?

Do we have any -- I'm sorry. Go ahead. Was that a no? I think that was a no.

How about in Las Vegas? Do we have any public comment in Las Vegas?

MR. UNGER: Yes. I'm Professor Douglas Unger, D-o-u-g-l-a-s U-n-g-e-r, at large representative of the executive committee of the UNLV Faculty Senate. And unfortunately my duties will not allow me to be here for the specific comments preceding Agenda Item 9.

Good morning and thank you all and the board for your service to the State of Nevada employees. We understand how hard you're working on our behalf and I would like to express how much your efforts truly are appreciated. Please know that we understand the difficult position the board is in today in needing to consider possible reductions in various health care and other benefits because of constraints and limits imposed on by our state budgeting process. We trust you're doing all of can to maintain our benefits at or near existing levels for the next contract year to the absolute best of your abilities to do so.

This said, we're disappointed such reductions may

be deemed necessary. With all due respect and with deference to the good judgment of the board. We do celebrate and applaud the good news in the proposed discussion of Agenda Item 9 today though about the possible implementation of a new preventive drug list for the CDHP plan. This drug list really should alleviate some of the higher prescription costs shouldered now by state employees and we hope this new benefit will be improved. Thanks to all who have participated in putting together and proposing this list.

Conversely, however, I hope the board does not approve the possible reductions to life insurance benefits from the $25,000 for active and $12,500 for retirees in Agenda Item 9.4. The reason I ask that you do not approve this life insurance reduction is a compassionate one. According to a Pew Research survey, more than a quarter of senior citizens over the age of 65 nationwide have not made adequate plans for their death. And among people under 50, about two-thirds have no plans at all and are severely under-insured. I suspect that State of Nevada employees aren't much different from national averages. And I am especially concerned for our younger fellow state employees who may not have considered adequate insurance in case, God forbid, the worst happens to one of them.

Even if offered an opportunity to buy up insurance to this level, we see no study or survey or other

research that indicates how many state employees, especially younger ones, would choose to take advantage of this benefit or living paycheck to paycheck would just let it go. Keeping the life insurance benefit at $25,000 very may well help a shocked young widow or widower with children pay for a funeral and keep a house payment going at least long enough to make solid follow-up plans. And keeping the benefit at this level will at least soften a bit the aftermath for a family suffering the death of a state employee or the employee's spouse who might be inadequately prepared, as are so many people in America.

The current level seems about right to us. Not too much, surely, but not too little either and thus does what a genuine benefit should do.

Thanks to the board for seriously considering the compassionate justification for maintaining this life insurance benefit. And thank you all again in advance for your good judgment in making your decisions and for your public service to state employees, including to our faculty and staff at UNLV.

CHAIRMAN CATES: Thank you, sir.

Any more public comment in Las Vegas?

MS. WHITTEN: Sonja Whitten. I am a state employee with the Division of Welfare and Supportive Services and I'm also a member of AFSCME Local 4041. And I am here

out of concern for the proposed changes to our health care as well as the reduced life insurance rates and all of the detrimental changes that would harm State of Nevada employees who have given so much during the state's recovery during the recession.

I would hope that the board would look at other ways to maintain our benefits. As most employees that I've spoken with state to me that the catastrophic health insurance that we call the PPO is not really affordable to them and they pray that nothing ever happens that they actually have to use it. And the health insurance offered through the HMO, the wait times to get appointments and follow-ups have become very lengthy.

So paying more and getting less just does not seem appropriate or wise, and so I would ask that the board would look at other ways to fully fund our health insurance and provide adequate health insurance for state employees.

CHAIRMAN CATES: Excuse me. Can you spell your name for the record for the reporting secretary?

MS. WHITTEN: No problem. Sonja, S-o-n-j-a, Whitten, W-h-i-t-t-e-n.

CHAIRMAN CATES: Thank you very much.

Any other public comment down in Las Vegas? Seeing none, we'll close that agenda item.

And we will move on to Agenda Item Number 3,

consent agenda. So we have three items on this agenda. 3.1, approval of the action minutes from the September 22nd board meeting. 3.2, acceptance of Health Claim Auditors quarterly audit findings for HealthSCOPE benefits. And 3.3, acceptance of PEBP vendor reports. This is a consent agenda item. Do any of the members wish to have discussion on any of these items? Seeing none, I would take a motion to approve.

MEMBER WELLS: So moved.

CHAIRMAN CATES: Second?

MEMBER COCHRAN: I'll second.

CHAIRMAN CATES: Okay. We have a motion to approve and a second. All those in favor say aye.

(The vote was unanimously in favor of the motion)

CHAIRMAN CATES: All opposed say nay. The motion carries unanimously.

MEMBER GARCIA: Abstain.

MEMBER ANDREWS: Abstain.

CHAIRMAN CATES: Okay. Very good. Thank you.

Okay. So we'll move on to the next agenda item, Number 4, Health Claim Auditors annual audit of Towers Watson Exchange Solution PayFlex Systems, Inc. for the PEBP plan fiscal year 2015 for possible action. 4.1, report from Health Claim Auditors. Good morning.

MS. CARR: Good morning, Mr. Chair, members of the board. For the record, my name is Robert Carr and I

represent Health Claim Auditors.

This past September we had -- I performed an audit of the PEBP retiree health reimbursement arrangement or HRA claims administered by Towers Watson One Exchange for PEBP's fiscal year 2016. The audit was conducted at PayFlex, which is One Exchange subcontractor that's located in Omaha, Nebraska. The audit was conducted with a valid selection of 400 claims with numerous claims audited on a bias basis that were selected from member's historical files and some of those files that were requested by PEBP staff. The selected -- The bias selected claims are not included within the statistical performance calculations that I displayed to you today.

Results of the categories within the performance agreements reflect that One Exchange met the agreement guarantees of accuracies, reimbursement, turnaround times, and reporting, but unperformed with the customer service 30-second response time for network calls which ranged from 26 seconds in quarter one to 192 seconds in quarter three for an average of 110 seconds for the plan year. It is our recommendation that PEBP collect a penalty for this under performance that we calculate at $6,995.55.

One Exchange, which was originally contracted with PEBP as Extend Health, has been your administrator for HRA claims for the PEBP retirees since July of 2011. During

this time our audits have observed numerous improvements in the administration of your plan and currently report that the adjudication processes for member reimbursements are performing much better than in the past. However, research of the customer services levels and PEBP member complaints have detected a few important issues that I wish to present to you.

Inasmuch as many of the complaints were not found to be supported by documented evidence, the review of individual files, and statistics support these complaints, we did observe that once One Exchange and/or PayFlex were engaged with a problem, they provided timely follow-ups with return calls and e-mail response to your members.

It is our opinion that One Exchange insurance carrier vendors are of concern and are a major source of PEBP participant errors and frustrations. Errors were detected due to poor communication and inaccurate information being transmitted from these carriers to your participants and also to One Exchange itself that failed to communicate disenrollments for months at a time but continued to collect premiums until One Exchange received a termination notice.

As a result, we have inquired with One Exchange to see if we have any recourse within their contracts with their carriers that will allow them to collect overpayments for reimbursement of PEBP fundings rather than create the

overpayments to the participants in the case of retrospective terminations when the carrier is the cause of the error or at fault.

The specific complaints that were requested by PEBP staff for focus audits, it's our opinion that five of the six were legitimate issues. Of the five to contain errors, four of those were pertinent to insurance carrier causing retrospective terminations, incorrect termination, or incorrect third party billing amounts, while one of the issues was caused by multiple and inconsistent funding from the PEBP data feed to One Exchange.

Review of reports for customer service guarantees displayed the percentage of first call resolutions entered by the One Exchange customer service reps at over 96 percent. However, the voice of the customer survey only reflected a 68 percent of first call resolutions.

Reports received for the participant customer satisfaction surveys supplied for the first three quarters of the Plan Year 2016, displayed a decreased in perceived service levels of overall customer service satisfaction, customer service rep care and concern, and customer service rep availability to find a solution category as compared to the levels that were observed at the beginning of your Plan Year 2016.

At the time of this audit, overpayments had

increased by $105,000 from last year to $704,321.30, which represented 1,144 claims.

Currently of the 1,144 claims, only 401 or 35 percent of the overpaid claims representing $213,000 are two years of age or less.

We have inquired with One Exchange if they can supply the current overpayment report with specific reason codes to better reporting to PEBP to help expose the true cause of these overpayments. One Exchange did agree to deliver this report, but they did also state that they believe that the majority of overpayments were coming from delayed death notices that come from PEBP.

This audit also observed multiple problems created from the PEBP information feed to One Exchange. Cases were observed where the funding was initially authorized but not reflected in the subsequent data feeds, which caused One Exchange to take back funding from participants, which also created additional overpayments.

And our last audit issue to present to you today concerns the response of a One Exchange representative to a board member's inquiry during your September 2015 board of directors meeting, in which it was stated that Towers Watson would have a commission earnings of approximately 3.7 million dollars for that year. In response to the PEBP's executive officer's request to validate these numbers within the course

of our regular audit, we did obtain the data from One Exchange that reflected the commissions earned for the period of PEBP's plan year 2016 to be approximately $3,971,000.

With this, Mr. Chairman, this would conclude my presentation.

CHAIRMAN CATES: Thank you, sir.

We're moving on to 4.2, Towers Watson Exchange Solutions/PayFlex Systems response to audit report. Does Towers Watson wish to come forward and respond?

MR. SEEGRIST: I was just stuck in the corner.

CHAIRMAN CATES: Good morning. Welcome.

MR. SEEGRIST: Thank you. May name is John Seegrist. I'm vice president of the fund administration for Willis Towers Watson. We appreciate the chance to be able to address this with you. We've had a good chance to be able to work with Bob as we have over the last several years with Health Claim Auditors and continue to look for areas of improvement where we can go forward with that where we're not contesting any of the findings in the audit. The audit was done very fairly and revealed everything that we wanted to be able to do as identified areas in there that we continue to work. I think the main areas that were identified in there was our carrier relations and trying to find more timely notification, participation involvement of the plans that impacts their qualification of a continuing nature that has a

downstream impact of overpayments on there. That was really kind of the main thing that we really were planning on trying to address.

With other areas of the customer service, we're making some significant changes this next year in improving our communication moving forward trying to provide additional information on denied claims to the participants to be able to make sure that everything that we provide them as clear as possible to resolving issues they may have in a more timely basis. And so we look forward to a lot of changes that we'll see coming over the next year. And that's all the comment that I have.

CHAIRMAN CATES: Very good. Thank you. Okay.

Okay. So let's move on to 4.3, accept audit report findings and assess penalties if applicable in accordance with the performance guarantees included in the contract pursuant to the recommendation of Health Claim Auditors. I would open it to the board for any comments, questions.

MEMBER COCHRAN: Mr. Chair, Chris Cochran for the record. I do -- I would like some explanation on the overpayments process. I would like to know how many years are we talking about exactly. It appears that this is a trend over four years, this $700,000 -- it's five years. $700,000 in overpayment. All right. So can somebody lay

this out for me how this happens and then what happens to resolve the issue on overpayment.

MR. SEEGRIST: I would be happy to be able to talk to you about that. The majority of these are related more to delayed death notifications. I'll give you an example. If we have a retiree, John Doe, that comes along and he passes away at the end of June on there, we will keep the account open. So what we try to do to be able to make sure we have better participation experience for the reimbursements is most things are automated. So if John Doe has a plan with Hometown Health with this policy, Hometown Health will draft his premium out of his account, they will send One Exchange a file fee, and we will submit that for reimbursement and redirect deposit it back in to John Doe's account. And we do that to make sure it's simple. So what may happen if he passes away at the end of June and we don't get a notification, the carrier will take that money out of his account and send us a receipt that they received the money and then we'll direct deposit it back in to his account. So if we don't find out until August that the person has died, we go back and we retroactively cancel everything back, which makes that reimbursement that he received for his premium ineligible and putting him in to overpayment since was on auto.

Since the individual policies are owned by the

retirees, so John Doe owns that, when the carrier recognizes that he has passed away, they'll refund those premiums that they have taken out of his account for July, but they return them to John Doe, not to One Exchange or to PEBP, because that's who owns the policy.

And so we go ahead and we make attempts to be able to start to collect those overpayments. We send notices to the last known address. Since this involves death, if there's a surviving spouse, we have a little higher rate to be able to recover. If there isn't a surviving spouse recovering those from the state, we have a very small percentage that will voluntarily be able to do that. No efforts are made other than demands for recovery of those funds from the participants. So that's the majority of what we see as it relates to that delay death notification.

The other way to be able to stop that also is the same kind of thing. PEBP owns the eligibility requirement. That's how we receive funds. So when we recognize someone is dead, that someone has passed away, that comes on file to us from PEBP. So as soon as -- whether the carrier recognizes it or not, as soon as we get the notice from PEBP that someone has passed away, we will shut off all payments and close that account. And so it's the same thing. So whether we get the notification, the carrier finds out sooner or PEBP finds out sooner, that will be shut down as quick as

possible. But there's just that delay in there. And that is not uncommon at the end of life for those delays to happen.

MEMBER COCHRAN: So it's similar to, say, social security when someone dies and they haven't yet received the death notification and they continue to pay social security payments to the beneficiary and then they come back and they get -- they go to get the money back?

MR. SEEGRIST: Social security is a little more heavy-handed in getting it back than we are. But it's exactly the same situation. Social Security runs into the same thing.

MEMBER COCHRAN: Right. I just needed it for my clarification in terms of understanding what we were talking about exactly with overpayments.

MR. SEEGRIST: That's really what it was. There are other steps you can take to try to recover that from the state. And usually the amounts that go in to overpayment for the individual they're within a couple hundred dollars is usually what we see for participants. So it's usually not cost-effective to be able to sue them and definitely not a good PR statement to go after the widows or the people that have passed away.

MEMBER COCHRAN: Okay. And then for Mr. Carr, I wanted to question on the complaints. The large percentage of incoming calls from PEBP participants estimated about 20

percent of the calls. This is a new report.

MS. CARR: Yes.

MEMBER COCHRAN: Do we know, are those individuals, separate individuals, or are these potentially -- are the complaints coming from -- may more than one complaint be coming from the same individual?

MS. CARR: It's both. But our estimate of the 20 percent is individuals. One of the advantages we had was to conduct the internal PEBP audit just before we did theirs. So we were able to actually -- I actually brought an extra auditor in to actually listen to those calls. And they would record the member's name and we were to follow up with them when we went to the job site. So I'd estimate 20 percent were different individuals.

MEMBER COCHRAN: Okay. And then on the 68 percent there's a difference between what Towers Watson is reporting in its resolution to the complaints versus what you're determining?

MS. CARR: No. It's what your members are determining. And that's the reason we reported that because typically you'll find coalition between the two. It may vary by five or six percent. But when you see a 96 percent versus a 68 percent or whatever the numbers were, it is such a wide number that the perceived value from your members obviously seems to be a little different than the customer service reps

perceived value of solution.

MEMBER COCHRAN: So do we know what the exact figure is yet? Were you able to discern that?

MS. CARR: Well, those are actually exact figures because they were done from data that's collected from PayFlex and One Exchange. The difference is that when a call comes in with a complaint or a concern from your members, the customer service reps decide whether that was resolved or not. Then what happens immediately, they get to do a participant survey and the participants' obviously interpretation of whether it was resolved or not is different than CSR's. So that was the difference -- So 68 percent of the members said, yeah, it was resolved the first call. The other 32 percent no. Where John is looking at his reports and assuming that, you know, only three percent required a second or a follow through from the first call resolution. That's such a big disparity. So basically what it is, they're true numbers, it's just the interpretation of One Exchange's interpretation first call resolution versus your members.

MEMBER COCHRAN: And then coming back to the overpayments issue again. When that money -- How do we know when that money has been collected or -- You know, we get these reports. I think we had a similar situation with a previous vendor several years ago, a few years ago, where we

had a significant number of overpayments. And I saw a comment in there about if it's not done within a certain number of years you write it off as bad, I guess, bad debt or bad collections or whatever.

MS. CARR: And our recommendation is still the same. It is we know when it's taken off because obviously the report it's actually a very positive entry. So when it comes off, when we resolve this specific claim in collection, it comes off the report. So we monitor that. So we monitor what goes on and what goes off. And that's the key that this year we had an increase of $105,000. That means we're taking in more than what we're collecting. And maybe it's because of what John is proposing is the aggressiveness of the collections or what have you. So we do monitor what comes on and comes off.

MEMBER COCHRAN: And when that money comes back to PEBP, who does that money go back to?

MR. SEEGRIST: What it does is it comes in to us and in to One Exchange and it is given as a credit against the claims that reflect the claims dollars.

MEMBER COCHRAN: Okay. I guess I'll wait and save any other questions to ask.

MS. CARR: To follow up, Dr. Cochran, one of the other things that we requested this time that is unusual is now we're asking to dig down in to those overpayment reports

because John, and thoroughly he believes that, you know, it's the death, and it may be. We haven't been able to validate that. So we're going to the next step and being able to validate why those overpayments are there. Are they truly what John is saying? Which I believe, you know, has got a big number. But what else is causing those overpayments? When you talk about two years, it's a statistical industry standard that if you've got an overpayment that's aged two years or greater, it's either you collect it or not. We do not -- Even though you write them off, we do not let the vendors wash them.

MEMBER COCHRAN: But the estate has probably been settled by that point, so it's unlikely --

MS. CARR: In that particular case. But for any overpayment, two years, very unlikely. And that's the reason that's the magic number. And when it becomes a big as number as it is now, that 65 percent of your overpayments are now aged over two years, that 65 percent of that $700,000 becomes less of a chance you're going to collect.

MEMBER COCHRAN: Well, and that's one of my concerns. I mean, obviously when we're looking at potentially changing our benefits, you know, a hundred thousand dollars here, a hundred thousand dollars there, and after a while it adds up. And it could be funds that we use for, you know, augmenting the benefits that we currently

provide. And I don't know -- You're never going to get a zero number. This is always going to be a problem. And I accept that.

MS. CARR: But we would like to see it at least static where we're collecting as much as we're writing off.

MEMBER COCHRAN: Okay. All right. Thank you very much.

CHAIRMAN CATES: Any other comments from the members?

MEMBER ZACK: Christine Zack for the record. So at this point we're just sending letters, that's it. And I understand why you're not pursuing collection --

CHAIRMAN CATES: Can you push your button.

MEMBER ZACK: I'm sorry. I understand why we're not pursuing collections and that these are small amounts of money. But wouldn't it also be cost-effective to simply file a notice within the estate?

MR. SEEGRIST: There's a lot of different things we could do. Right now this is what the contract requires us to do. There is a little more that we do on these. It doesn't work in the case where the person has passed away. But we do try to offset claims as well. So there's a small percentage of the overpayment that comes from these several policies being canceled and losing qualification. So in that kind of situation on there, there may be future claims that

come in and will offset the overpayment against those. And some of those we recover. Also, there may also be later claims that are manually submitted that where if you're $200 of overpayment and another claim shows up later that is still eligible from a current period where they're still alive or still qualified for a hundred dollars on those, we'll offset and use that to recover it. And the offset recovers some of those. The problem is that at the end of life there's no other claims to offset against it on those. And so the only things we go to an effort on those is just the demand letters that we send out to try to recover those funds.

But you're exactly right, there's a lot of different things that could be done to be able to try to recover those overpayments. But right now that's the only thing in our contract right now is just the demand letters for recovery.

MEMBER ZACK: Okay. So there's no notice of claim being filed on the estate?

MR. SEEGRIST: No.

MEMBER ZACK: Okay. Thank you.

MR. SEEGRIST: That's just not required.

CHAIRMAN CATES: Any other members? Go ahead.

MEMBER VERDUCCI: Tom Verducci for the record. I just want to ask how are those meetings going that you're having in Carson City one week per month? Is that helping on

the flow of reimbursement paperwork, enrollment? Are we seeing any progress there?

MR. SEEGRIST: Yeah, we have. We're getting a really positive response from those meetings. And, as you know, we were doing group meetings for a while. And the one that started in September we have somebody here one week a month that comes in and schedules one-on-one appointments. Before when we did it, we would do it for a couple days and have a big group and set up appointments. And now it's a consistent week when people can come in. It's real positive responses. People like that. Even though this level of customer service is provided on the phone, we find that some just want face to face to be able to do that. And even some of the issues they come in for still require a phone call to be able to resolve them and to be able to do that. But we get very positive responses on that.

We're not quite filling up all of the time spots we have. To be able to do that, it was one of the dates that we had met with RPEN about trying to get that out. There's still some people that don't know we're holding those meetings. We're going to try a few more efforts to let people know that we're here and having these meetings. And we think that we can probably reach a few more people and try to encourage that a little bit more. We haven't had a lot of walk-ins to be able to do that. We're running one to two a

week, so not many people that walk in. For the most part people are scheduling appointments, which is the better experience for them. So then they know someone is available to meet with them.

We're looking at that. We're happy to be able to add on more times to be available for participants as need be. Right now we're not filling up the time slots that we have. If we start getting more requests, we're happy to add more days in there to be able to meet those requirements.

We're also looking at, we have done some of the other meetings in Las Vegas. The last few ones that we had done there we were not filling up. We just weren't having that much demand. We're going to be holding a couple more meetings down there soon to be able to do that. So even though there's a larger population there, we don't get as many people coming in, so there isn't much of a demand. But we are going to schedule a few more meetings. And it's going to be more of the older style where we hold a group meeting and then we have appointments to meet after the group meetings.

MEMBER VERDUCCI: And just as a follow-up, do most retirees need help with their reimbursement paperwork or do a lot of them do it on their own?

MR. SEEGRIST: Most of them do it on their own. Yeah, and by far, the largest majority do it on their own.

It really has more of kind of a learning curve to be able to do that. And it's kind of different. It depends on what they're submitting in there. So about 85, 87, I think, is where we're running right now on the claims come through where we file it for them on auto reimbursement so the retirees don't have to do anything.

And then there's another section out there that submit claims for Part B reimbursement and that's when they were trying to communicate with the ones that have social security. That's a real easy thing to be able to submit.

Where we see a lot of the challenges on members that are submitting reimbursement for out-of-pocket expenses, and some of those are a little bit more of a challenge to be able to document on those, the IRS requires five specific items in a document that we have to be able to see, we need to know who the provider is on all of our updated service, who they are, what they pay, and so they have to be there. And that sometimes is kind of a struggle for them to be able to do that. Once they get it, they seem to get it.

And so that's really the kind of concern for us is this ten percent that kind of struggle with that data on there.

Over the last year in the spring of this year we did a bunch of in a number of different cities that kind of have higher concentrations of retirees some focus groups

trying to find out a little bit more about this population and why they're doing that. And what we found on those is the retirees that will come in and read the documentation on our forms we find their claims go through fine. Every claim form has on the back side of it has step-by-step instructions to do that. But the problem is we find it's a lot to read and comprehension is kind of hard.

So we're in the process of in 2017 -- And this is part of the communication and things I was talking about -- we're changing the way that our documents are looking and we're putting in to a couple different sections that are highlighted with some more visual cues. Also, the top one talks about what you need to do and then a section on what you need to know. So we're trying to focus on the population that will not read all of these instructions with more bullet points. And so if all they're going to read is the bullet points we want them really clear in one spot. They're all in the instructions right now, but the steps you need to do are mixed in to the instructions. So if you don't read them you don't get them. And so the focus group we have, we think that will help. And then the visual cues we're putting in there we find a group that they don't read anything but they do recognize pictures. No disrespect there, but they just don't. And so we do it -- In the visual cues that we're putting in there, we're linking also to the ones on the

website and also in our guide. So, as an example, direct deposit has an image of a little bank on the screen. Anyway, we're putting more visual cues to try to encourage how they get things.

The other thing that we found also is that every time we have to deny a claim or send out an address to determination on our explanation of payment right now we have technically correct codes on there that say, well, this is why your claim was denied, you're missing payments on there, and we just tell them what that is. What we're finding on there is that that requires for most of that small population, they ask, they need to call and say, hey, what does this really mean, what do I need to do.

So what we designed on these new statements is they're going to be quite a bit longer. So we put the technical explanation, this is why your claim was denied. And then we have the word action and we have action steps under that on each one of these that will go through and say you're missing a payment, you need to do this, this, this. And so we're hoping to do that.

Also at the bottom of those we're adding an 800 number with a little code on there so they can call in and listen to a pre-recorded message that gives more detail about that specific, why that was claimed, so that gives more detail. And that also links to a message on the website and

they can go on the website and listen to it. If that is still not, they can still -- they're always welcome to talk to a person as well.

But our goal is here that the communications we have we want them to be self-contained and more of a learning curve for them to be able to help them resolve this on their own.

One of the things that we're starting to do over this next year is that we've noticed that there is a number of retirees that in this ten percent of those if you have one denied you're more likely to have five or ten denied in there. And so we want -- we're going to start doing some more data mining of where we identify participants that are having a higher number of denied claims and we're going to start doing more outreach to them because obviously we're missing something. If they continue to have the same type of claim denied over and over, we're not communicating correctly. So we're taking that as our responsibility. And it may be just a challenge with the retiree, but that's our responsibility to try to develop something to where we can communicate to them so they don't have these claims denied over and over.

So we're also doing a similar data mining thing with phone calls on there. So we're tracking the number of customer service calls that we get in a 30-day period.

So one of the things to your questions when we talk about the difference between what was reported on the voice of the customer where the retiree says, no, it wasn't one call to resolve it and the CSR thinks I did a good job, I resolved that on there, is that time given. Sometimes they just get frustrated and hang up and say, oh, yeah, I've got it and then they just call back. But we found a number of times and there's nothing the rep can do because the person said they were done. So we want to address and we think we can catch it because they keep calling back.

The other thing on there is sometimes it requires more follow-up there. So even though the representative told them exactly what they need to do, the participant, it's not resolved. Because all the participant got was an explanation of how to do it. They didn't actually -- They haven't done it yet out there. And so sometimes they just don't remember.

One of the things we put in our guides the year before last was a section of just note paper on our guide and we asked them to write things down. We find that sometimes even though we tell them the steps they call back and ask the same questions. And so that's one of the things we're trying to do is encourage them to write them down. We also hope by putting these steps in, we would tell them on the phone, write on their statement, they won't forget then, that it will be a reminder of what they need to do each time. So I

know that was an awful long answer to your question.

MEMBER VERDUCCI: That was good. And I think whatever can be done to make things more simple for the aging population will be good. I just know from personal experience, my dad is 99 years old, and if he had to fill out paperwork, you know, he would have a very difficult time preparing it. So anything that makes things more simple I think will help that process.

MR. SEEGRIST: You're making an excellent point. That's part of the reason we encourage so much of the automation of the premiums on there because we have a number of people that still like to send paper checks, which is fine, and if you're 70, that's fine to be able to do that. But if you're 94 or 95, that's a different story. And what we don't want on there is people's policies to cancel because they forget to pay their premiums or they forget to ask for reimbursement. And that's kind of what we find out in that older end of retirees that we work with. And so we're also doing some more outreach to really encourage that automation. You're making exactly the point that we're concerned about.

MEMBER VERDUCCI: Thank you very much.

MR. SEEGRIST: Sure. Not a problem.

CHAIRMAN CATES: Any other members?

MEMBER VERDUCCI: You know, if there's no other discussion, I'm ready to make a motion.

CHAIRMAN CATES: Before you make a motion, let me just point one thing out. We have a typo on this agenda item. It refers to the PEBP plan year 2015. And we are considering the plan year 2016. I've consulted with Deputy Attorney General Belcourt. I don't believe that is a material defect in the agenda. It's pretty clear what we're considering. The back-up is clearly marked and I think the substance of it is pretty clear. So I'm comfortable that we can take action on it. I would just ask that any motion reflect that it is for Plan Year 2016.

MEMBER VERDUCCI: Okay.

CHAIRMAN CATES: Go ahead.

MEMBER VERDUCCI: Thank you, Mr. Chairman. Tom Verducci for the record. I would like to make a motion for the Plan Year 2016 to accept the auditor's findings and assess any appropriate performance guarantees.

CHAIRMAN CATES: Do I have a second?

MEMBER ANDREWS: I second. Ana Andrews for the record.

CHAIRMAN CATES: Okay. We have a first -- a motion and a second. Is there any discussion on the motion? Seeing none, all of those in favor of the motion say aye.

(The vote was unanimously in favor of the motion)

CHAIRMAN CATES: All opposed say nay. Motion carries unanimously. Thank you.

MR. SEEGRIST: Thank you.

CHAIRMAN CATES: Okay. We'll close that agenda item and move on to Agenda Item Number 5, Health Claim Auditors, Inc. annual audit report of Catamaran for PEBP Plan Year 2016. We have the same typo. It says 2015. But it's Plan Year 2016 for possible action.

Move on to 5.1, report from Health Claim Auditors.

MS. CARR: Thank you again, Mr. Chair, members of the board. Again, my name is Robert Carr and I represent Health Claim Auditors, Inc. This last September and October, Health Claim Auditors performed a prescription drug audit of Catamaran, formerly known as Catalyst RX and currently known as OptumRx, for PEBP's benefit plan of prescription drug claims.

The prescription claims audited this year were processed by Catamaran from the 1st of July 2015 to the 30th of June 2016 or PEBP's Plan Year 2016, of which we reviewed a hundred percent of the drug claims that were processed within this time.

Discounts provided to PEBP within your contract are based on a measurement of average wholesale price or AWP for those of you that know the acronyms. Unfortunately, the detailed claim report received for your claims for name brand drug claims was delivered in a 2009 pre-class actions lawsuit

accounting format which is not in compliance with your current contract. So I won't take up your valuable time by explaining to you the difference.

However, I have provided you a detail of this issue that's in Exhibit A of the report that's titled the national class action lawsuit of AWP pricing. And that's located on page 30 of the report.

The results displayed in the report though are reflective of conversions to the contract calculation language in order to analyze compliance of your contract in the agreements.

The audit revealed that Catamaran was found to underperform in the measurement of discounts for retail generic drug claims and the application of dispensing fees for retail name brand drug claims but achieved over performances for the rest of the guaranteed financial categories.

The agreement that you have allows for the aggregate combination of discounting and dispensing fee guarantees. So we find at this time that no funds are due to PEBP within these categories. PEBP is to receive a hundred percent of manufacturer rebates with a guarantee for each name brand drug as dispensed. Our calculation for the PEBP Plan Year 2016 reflects a total of 525,196 to be the minimum guaranteed payment. At the time of this report, the third

and fourth quarter rebates had not been received, but we calculate and recognize that there was a shortfall at that time of rebates that were collected thus far.

Historical reviews of numerous prior plan years reflect that the rebate collection for the fourth quarter is always the largest and Catamaran has always and typically met the annual minimum guarantee. So we expect the same this plan year. But at the time of this report we calculate that PEBP should expect an additional $271,583 to satisfy your agreement.

Our audit calculates that PEBP overpaid the contract administrative fees for Plan Year 2016 due to a reduction negotiated by your PEBP staff that took effect in September of last year. We estimate the total amount due PEBP at this time and within this category is $8,912.82.

We also reported that Catamaran met all customer service levels with the exception of 95 percent of the mail order claims that are to be shipped within two days. Unfortunately, 91 percent of mail order claims were shipped during PEBP's second quarter of which we estimate a penalty for this category to be $28,510.

Per your contract, Catamaran must transfer a full electronic file of claim accumulators in claims each business day to your third party administrator. This is to administer your deductibles and your auto payments and what have you so

that they coordinate with the medical payment.

97 percent of files must be transferred each business day and a hundred percent of files must be transferred within 48 hours. And the third party administrator will calculate that -- Well, long story short. We reviewed the data files from both Catamaran and your third party administrator and determined that Catamaran only achieved a 96.5 measurement for the plan year.

Even though Catamaran and HCA disagree on this number and with our findings, we both did agree that the $5,000 penalty for the under performance of this category in PEBP's second quarter was appropriate. So we recommend that you collect that penalty also.

In conclusion, with this report, HCA finds Catamaran is in compliance with all the other guaranteed metric measurements and benchmarks. We recommend that PEBP collect the amount of $42,423.22 for under performances and make arrangements for collection of at least an additional $271,583, which is the minimum owed for the manufacturer rebates.

With this, Mr. Chairman, this would conclude my report.

CHAIRMAN CATES: Thank you. Thank you.

Damon, go ahead.

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

spoken with Catamaran and we have agreed that although there is a finding of $42,423.22 to be assessed against the final administrative fee payment, that because there are outstanding rebates that we will not make that final payment until all rebates have been collected in full and reconciled to the contract. And so as the board decides today to assess fees, recognize that we will withhold the entirety of the final payment until we receive all of the payments that are due to PEBP.

MS. ROSS: If I may.

CHAIRMAN CATES: Well, let's move on to 5.2, Catamaran response to the audit.

MS. ROSS: Hello. My name is Shannon Ross. I'm the associate director for Catamaran, now Optum. And I was PEBP's account manager during the time of the plan year.

So I just wanted to state that PEBP is in compliance with the contract. PEBP's contract actually allows that all administrative fees be held until such time as the board approves the audit finding. And because the rebates are still pending in accordance with industry norm that we have them be paid in arrears, we've agreed that we'll just have the rebate payment be made and then PEBP will make payment for the administrative fees in compliance with PEBP's contract. So I just wanted to clarify that is a provision in the contract today.

CHAIRMAN CATES: Okay. Thank you.

MS. ROSS: And we don't contest anything that HCA found. We have always been a great partner to HCA and we appreciate that. I'm happy to answer any questions that you have.

CHAIRMAN CATES: Very good. Thank you.

Any comments or questions from the board?

MEMBER GARCIA: Mr. Chair, I just wanted to follow up. Thank you. I wanted to -- Rosalie Garcia for the record. I wanted to follow up with the under performance for our mail order. How are you addressing that?

MS. ROSS: Well, so PEBP is now, as of July 1st, is no longer a client. So the issue for your members would no longer be pertinent for us as your vendor. As other clients would feel, we have actually added additional mail order locations across the country. There's now a new facility in Vegas, so Nevada residents would be able to have expedited moving forward. But PEBP could encounter that from another vendor moving forward.

MEMBER GARCIA: Thank you very much.

Damon, do you see any issues with our new vendor with regard to service to our employees or our base?

MR. HAYCOCK: Thank you, Ms. Garcia. For the record Damon Haycock. As transitioning new vendors always has some hiccups, right, we're going from one system to

another, one group of individuals that people are used to talking to for, as Mr. Carr stated in this audit, it was Catalyst and then it was Catamaran and then it was Optum, but it was the same group of folks.

So for the most part we believe that the transition has been successful. There has been, as exists in any transition, some difficulties and some of our members have had some issues with filling their prescriptions or didn't understand certain processes that are now in place. We believe though that we've been able to go back collectively with our partners now at Express Scripts to personally address them and I have personally got on the phone and tried to solve problems for participants to ensure that they get all the information that they need down to what I like to call the gnat's eyelash of pricing to understand exactly why certain costs are the way that they are.

I personally believe that the biggest complaint that we've had is not necessarily an Optum issue or an Express Scripts issue but it's a national issue on the increased cost of generic drugs. And there has been numerous reports that have stated that these generic drugs have seen massive increases over the last year. And it's very customary and very understandable for a participant to call us and say, well, my drug went up. It's because you changed vendors.

But when we do the research and find out that the average wholesale price for that drug has gone up considerably over the last two or three opportunities, it's a little bit easier to understand that. Regardless if it was our vendor now or our vendor before, that cost is still going to go up.

MEMBER GARCIA: I don't want us to digress too much from -- I'm really most concerned at this point regarding the vendor providing the service to our members. I don't -- I just want us to be on top of it and not let it get out too far away from us.

MR. HAYCOCK: For the record Damon Haycock. Thank you. And, yes, let me return it back to your initial point. That's one of the reasons why we're very excited that we have been able to fill the position of quality control officer in house to be here every day. And so she is also a part of that process. We feel that the service levels as always can improve. But at this point we feel satisfied with our new vendor.

MEMBER ANDREWS: Ana Andrews for the record. And my question is to Damon. When will the first audit of the Express Scripts take place and when will it be reported?

MR. HAYCOCK: For the record Damon Haycock. I believe that Mr. Carr has the exact schedule but that these audits are performed on an annual basis. And so once the

plan year is over there will be a scheduled time period where Mr. Carr will go out and visit them and perform the exact same audit that he just performed, or similar to Optum as he will for Express Scripts. I assume you will see some time around this time next year the first audit of Express Scripts.

MEMBER ANDREWS: Thank you.

CHAIRMAN CATES: Any other questions or comments from the board?

MEMBER WELLS: Jim Wells for the record. A couple questions for Mr. Carr. You talked about the fact that you got the calculation, the claim calculations, in the old format. So the examples that you had on page 31 of the audit show the full amount of a thousand dollars minus 16.43 percent. Did those claims end up costing the plan or participants any additional money?

MS. CARR: No, sir.

MEMBER WELLS: They did not?

MS. CARR: No. The only difference was the reporting of those numbers. You still pay X amount of dollars. It was just a calculation from where that began.

MEMBER WELLS: So the actual claim paid was consistent with the contract. The reporting of the claims was different.

MS. CARR: That is correct.

MEMBER WELLS: Second question. On page six, the results that you had originally provided for penalties, you now agree with Catamaran's response?

MS. CARR: Actually they didn't change. Those -- You will find that I will never change any of the vendors' responses. That was actually included within a response from Catamaran. The $15,000 for the transfer was never 15,000. It was always 5,000. The administration fees were off by $5,000 because the original report we received, including certain paper claim fees and what have you, they're not part of that. So what happened is we were supplied a second report from Catamaran, which we are now all in agreement with. But that was Catamaran's response. That's the reason I didn't change it.

MEMBER WELLS: Just as your HCA amount findings were 57,000.

MS. CARR: Yes, sir. And that's what they assumed we were poking at them with.

MS. ROSS: Yeah. It was our tangle.

MEMBER WELLS: And then lastly, the six months in arrears, it looks like we are now two quarters, so the six months for the March quarter should have been received by now. At what point does Catamaran think it will get the rebate check?

MS. ROSS: It's actually from the State

Department of Treasury. We've been working -- The State Department of Treasury actually misallocated to another State of Nevada client. So we're working with the state to allocate those funds directly to PEBP and not the other agency. So the payment was made and that's why our records reflect it was made. We're working with the state to allocate it correctly to PEBP.

MEMBER WELLS: Okay. Thank you.

CHAIRMAN CATES: Any other questions or comments from the board? Seeing none, anybody like to make a motion?

MEMBER BAILEY: For the record, Mr. Chair, Don Bailey. I'd like to make a motion to accept the audit report conducted on Catamaran and submitted by Health Claim Auditors.

CHAIRMAN CATES: Do we have a second?

MEMBER COCHRAN: I'll second.

MEMBER BAILEY: Including the assessment of the penalties. That should make it clear enough.

CHAIRMAN CATES: You're good. Do we have a second to that motion?

MEMBER COCHRAN: I'll second. Chris Cochran.

CHAIRMAN CATES: We have a motion and a second. Any discussion on the motion? Seeing none, all those in favor of the motion say aye.

(The vote was unanimously in favor of the motion)

CHAIRMAN CATES: All opposed say nay. Seeing none, motion carries unanimously.

So we are now going to move -- Agenda Item 6 I pulled at the beginning of the meeting, so we're going to move on to Agenda Item Number 7, presentation of fiscal year 2016, other post-employment benefits valuation performed in conformance with the GASB requirements.

MR. NIMMER: Thank you, Mr. Chairman, members of the board. For the record my name is Tim Nimmer. I serve as Aon's chief actuary. And joining me today is Stephanie Messier. We would like to review the GASB 45 OPEB valuation results. GASB stands for the Governmental Accounting Standards Board. Number 45 valuation. So this is -- these are for retiree health care type benefits. And I will review briefly what those benefits are, some of the major items for disclosure, and then answer any questions you might have.

Moving to slide two, the retiree health care post-employment benefits are, for example, your medical benefits, prescription drugs, dental, vision, life insurance. We are valuing all of those benefits that you would receive in retirement in understanding what that liability looks like today. We valued them under two methods. One would be a little explicit, which are the direct contributions. So for a dollar paid to a retiree in retirement, we value that as a direct contribution or an explicit benefit.

Implicit benefits are those in which are a bit more difficult to calculate. That is when you comingle the funds. So if you have an active and a retiree, so someone who is 22, someone who is 64, you have them receiving the same rate, then there's an implicit subsidy for that younger person paying a portion of their premium to offset the higher cost of that retiree. So we value under both of those scenarios.

Moving to the disclosures on slide -- Is that five? Moving to the disclosures, the way we value these benefits, if you will think about a hypothetical employee that is age 40 today, and they started working for the state when they were 22. So what we are trying to do is understand how much has that individual accrued in terms of benefits at age 40 and then how much do we expect to pay them in the future. And we track them throughout their lifetime. So we follow them throughout their lifetime, whether they retire, become disabled, all the way through death. Okay. They can terminate the plan and we take that in to consideration as well.

So with that hypothetical employee in mind, the present value of benefits, which if you look on the top right-hand corner, the 2.1 billion dollars, that would be for that employee's present value of all the benefits and everything that employee has accrued to age 40 plus

everything they will also accrue until retirement. So past and future, the present value of all of those benefits.

The second number, which is the actuarial accrued liability, the 1.5 billion number, is what that individual has earned to date. So we look at the employees in that scenario, the 18 years that employee has worked, he or she has accumulated a benefit throughout that period of service. We need to value that. And for this plan if you aggregate all of that for every employee it's about 1.5 billion dollars.

The actuarial value of plan assets would be how much money do we have in our account today. And under the actuarial accrued liability would be taking the second line minus the first, meaning what is your actuarial accrued liability, minus how much money you have in your bank today and the resulting number is the unfunded amount. I will get in to the annual OPEB cost here momentarily.

Moving to slide six. As I mentioned, the present value of benefits is 2.1 billion dollars. This is for both the employees' and the retirees' lifetimes, so this would include all the benefits that are communicated to members effective on July 1, 2015. For a quick review, some of the major highlights were the deductible move from $1900 to $1500. The co-insurance moved from 75 percent to 80 percent. And, as noted earlier, the life insurance differences were

retiree moved from $5,000 to 12 and a half thousand. Actives 10,000 to 25,000. And another major component was the dental benefits moved from a $1,000 annual max to a $1500 annual max. And when we look at the total liability, about 62 percent of this liability is for the active employees, meaning the future retirees.

Slide seven, the actuarial accrued liability. Again, this is for how much of a benefit have you accrued to date. So our 40-year-old example, the 18 years of their service. That was the 1.5 billion dollars. The normal cost at the bottom of the page would be how much will that employee earn during that year, that fiscal year. So just a one-year increment. When you aggregate that for the state it becomes 59 million dollars. Another disclosure needed to make for the public record.

Slide eight, we discuss in broad terms the gain and the loss to the liabilities based on the prior valuation which was presented to the board approximately one year ago. So for this please keep in mind a loss would increase the liability, meaning it would increase how much the plan owes. A gain would be a decrease in liability. A little different than normal gain/loss for a balance sheet.

So the passage of time, the first portion, that would be the expected increase and liability from interest and things of that nature. It was about a four percent loss.

So over a years point of time we would expect those costs to increase about four percent.

The demographic changes, the actives, the active population decreased approximately 20 percent. The inactive population increased slightly. Now, the age and gender mix of those individuals, the composition changed, so it made it a little bit more expensive. But overall it was about a one percent loss.

The new claims in premiums would be a gain, meaning the beneficial plan experience over the past year improved the overall results. And the new employer subsidy, so the state subsidy went down slightly from the prior valuation. The non-state participants are getting the same subsidy as the state now, which was an increase. However, the majority of the liability is driven by the state retirees. So overall this was roughly in balance.

And a new trend assumption. We changed the trends. It is an actuarial assumption, meaning how long it gets us to an ultimate rate. It's an actuarial term for -- an underwriting term that has a negligible effect on this valuation.

On slide nine the change in actuarial accrued liability on the demographics, as I mentioned earlier, there was a 20 percent reduction in head count on the current actives, which translated to approximately 20 percent gain.

It's a very direct relationship there.

On the current retirees, the relationship isn't quite as direct in terms of 20 percent to 20 percent. We had a two percent increase in head count. However, I would like to inform the board the dependant composition increased significantly more. So the dependants increased about eight percent overall, which is contributing to the additional liability.

Also those new retirees are on average younger, which means we will pay their benefits for a longer period of time, hence the increase in liability.

The annual OPEB cost, think about that, and income statements, it's the overall expense to the plan, includes an overall cost. It was reduced primarily because of the overall plan experience and the numbers I mentioned earlier.

That concludes my presentation of the Governmental Accounting Standards Board disclosure 45. And, Mr. Chairman, I'm happy to answer any questions at this time.

CHAIRMAN CATES: Thank you. Do we have any questions from the board?

MEMBER WELLS: Jim Wells for the record. The future retirees that turn active, that 20 percent reduction, is that reflective of the population that's hired after January of 2012? Is that what's driving that number?

MR. NIMMER: Yes.

CHAIRMAN CATES: Any other questions? Comments? Seeing none, we'll close that.

All right. We're going to take a ten-minute break. So we'll reconvene at 10:30 on the dot. Thank you.

(Recess was taken)

CHAIRMAN CATES: I would like to call the meeting back to order. Let's see, where are we at? Number eight, Agenda Item Number 8, state of PEBP report for Plan Year 2016. Damon.

MR. HAYCOCK: Thank you, Mr. Chairman. Damon Haycock for the record. As a departure from previous years, we are presenting this report in November versus in January. I wanted to make sure that we were capturing the time frame to report on. I believe my predecessor may have reported on a calendar year basis. I ran in to a little bit of difficulty separating calendar year from plan year the last time I did this. And so I wanted to make sure that it was a hundred percent transparent. And I felt we could get this report out to the participants earlier and the stakeholders. It's also kind of an opportunity to tee up what happened last year to discuss what may happen next year.

And so in front of you, you should have the packet on the specific report. Similar to prior years, we have replaced the mission and value statement. These are the

updated missions and value statements that were approved by the board based on the advisory committee's recommendation last spring.

As an overview, of course, we continue to provide a consumer-driven health plan alongside health maintenance organization or HMO plans per our active employees, non-Medicare retirees, while covering Medicare retirees through the individual marketing exchange. No different from previous years.

We, however, on the consumer-driven health plan experienced much better than projected cost in Plan Year 2016. Some of these factors include, we had, although an increased population of 6.6 percent with our participants and a total of 7.8 percent with our covered lives, we believe that they did not utilize the plan at the same rate as the existing population and therefore due to that mix the costs were not proportional to the increased population.

Some of the highlights on cost savings. The plan paid 10.8 percent less on average for each high cost claim. Those are those claims where individuals go and receive care that costs greater than a hundred thousand dollars. So 10.8 percent less is a huge, huge decrease, based on this past plan year versus Plan Year 15.

We attribute that to very aggressive negotiations. Often our high cost claims are out-of-state

services. And our third party administrator HealthSCOPE Benefits does an excellent job in putting the participants and Nevadans first in making sure that we have the best pricing for the services that are required.

We also experienced a decrease of 7.4 percent inpatient hospital costs. So every time someone gets admitted to the hospital, the paid per admission was down ten percent and every day they were there it was also down 11.5 percent. So, again, we've seen some significant cost savings on the inpatient side.

Our in-network medical providers were utilized more. They increased back in Plan Year 15 at 94.3 percent all the way up to 96 percent in this last plan year. And so the level set how important this is, the average in-network discounts are services are just under 62 percent of billed charges. So every time someone sees an in-network provider, it saves them money, it saves PEBP money, and it saves Nevada money.

Also in Plan Year 16 we saved an additional 5.2 million dollars, 3.4 million in out-of-network negotiations, $490,000 in subrogation. And that's the recovery from other insurance who should pay first. $570,000 in out-of-state transplant services and $827,000 in ambulatory services.

Additionally, our in-network dental providers were utilized more as well. Our in-network providers

increased from just under 92 percent in Plan Year 15 to almost 94 percent in Plan Year 16. And the average in-network discount is just under 23 percent, which attributed to about 9.6 million dollars in discounts.

Our average utilization for the year was also lower than projected for pharmacy. The total members that utilized the pharmacy benefits increased almost three percent from last year to this last plan year -- Excuse me -- Plan Year 15 to Plan Year 16. However, the total cost per member per month decreased 2.9 percent from Plan Year 15 to '16.

So as we will talk about trend later in this process, not today but in January, that says that last year's trend for pharmacy utilization is almost down three percent, which is very unheard of across the nation.

Total cost per member per month decreased, right, and generic drug utilization increased from 81.9 percent in Plan Year 15 to 83.7 percent in Plan Year 16.

So in a nutshell, PEBP's consumer-driven health plan experienced a great year. I would go out on a limb and say an exceptional year with cost containment strategies and substantial in-network discount services. Our contractors, our third party administrators, negotiated aggressively and subrogated as much as they could to transfer cost appropriately to other insurance.

So that, I want to include in this specific state

of PEBP report because it's going to explain why we have the excess reserves that we have for the next agenda item.

Our overall enrollment in PEBP increased two percent. That's across all plans. The consumer-driven health plan, the HMO plan. And we have a graph that shows how it is split.

Some of the accomplishments that we had last year. Again, the board's duties, policies, and procedures and their strategic plan was approved. A recommendation was made by a very hard-working PEBP advisory committee, a multi-year effort, to revise those documents and to make them what they are today. And I've included them as an attachment to this report. So when other stakeholders looks to how did PEBP do last year, they'll be able to see that accomplishment. And I want to thank those members of that committee.

We also had some, as many of you know, some PEBP board roster changes for outgoing members and for new appointments between May and July of this year. We did adopt a regulation last year at the June 17th, 2016, adoption hearing. And, in a nutshell, that was to align the waiting period with what we were doing in practice already at the time. We had an older waiting period that allowed for a lengthier time before people could receive benefits. And we did that housekeeping regulation to align it with current

policy.

As a reminder, you are eligible to participate in PEBP on the first day of the month if you are newly hired or reappointed with PEBP on the first day of the month and you are allowed to receive benefits on the first day of the month following if you are hired any day after the first day of the month. So it's a very reduced waiting period.

As far as contracting, we had a lot of efforts and a lot of activities that occurred during these contracts. Our pharmacy benefits manager contract was renegotiated to remove some duplicative services with the pharmacy benefits manager consulting, which saved approximately $90,000 last plan year.

As you heard earlier today with the audit, the pharmacy benefits manager, Catamaran/Optum finished their final year of service with PEBP and we developed a request for a proposal and selected Express Scripts to replace Catamaran and Optum for Plan Year 17.

We developed an RFP for actuary consulting services and of course award that to the incumbent Aon Consulting, as was previously reported.

We did the same with our financial auditor. We developed an RFP and awarded to the company of Casey Neilon.

Our website overhaul occurred, many of you already know. Back in November of 2015, we awarded a new

contract for that website redesign to KPS3, a local marketing and development team, out of Reno, Nevada. And more information, of course, is lower in this report.

As customer service occurred through last plan year, we received just over 40,000 phone calls. The average time to answer those was about 29 seconds. And the abandon call rate was 2.66 percent, which does exceed industry standards in the performance guarantees included in our vendor contracts of 30 seconds and three percent respectively.

PEBP also has received 1,477 total walk-ins during the same time period. In Plan Year 2015 we -- PEBP had received just over 1,000 e-mails, but in Plan Year 2016 it more than doubled to 2,119 e-mails. This is an indicator that more information is being requested electronically and less -- I won't even say less over the phone. But in addition to those phone calls and other mediums of communication.

As mentioned earlier, we did a website redesign in April of 2016. We did relaunch an overhaul website and development in coordination with that contractor, KPS3. The new look and feel, as well as improved functionality, has produced high remarks from PEBP's participants, stakeholders, and some of the board members. We appreciate it. We believe it is a successful overhaul.

We continued in 2016 to provide in-person education outreach. We feel this is quintessential for the success of being able to provide outreach and education to our participants. As you heard earlier from Towers Watson, there are folks that really want to be talked to face-to-face. PEBP, along with its vendors, provided statewide educational sessions regarding the Medicare exchange and HRA administration for retirees as well as HSA/HRA administration for employees. We were also requested to and provided new hire orientations to various agencies across the state.

For our fiscal year performance indicators, we have exceeded many of our Plan Year 16 indicators to include our expense ratios, our generic drug utilization, our in-network medical and dental utilization.

PEBP, however, did not meet its goal of 114.7 percent claims loss ratio, which was designed to spend down excess reserves. As exceeding these other goals and saving this kind of money counteracted the ability to spend down those reserves. So as an unintended consequence, we were able to keep more money in the plan, even though we anticipated spending more money down to try to bleed down those excess reserves.

Depending on who you talk to, I think it's a good thing. It means that we were very astute and efficient with

how we managed our plan. But it also gives us an opportunity for our next agenda item to talk about what to do with those and now that we have additional how many more benefits can we potentially save.

There is a chart here that discusses the performance measures and goals versus actuals. Below that is our program finances. We are roughly a billion dollar biennial budget, right. 487.3 million dollars was our revenues and our expenses for Fiscal Year 2016. Both of the charts describe exactly where those funds were allocated. You will see, and I deeply apologize, on page six that it should say 2016 financial overview. Today is typo day at PEBP.

But I just want to continue and say that we maintain financial solvency with our fully funded reserves are incurred but not reported, are incurred but not paid for each of the last 13 plan years and a fully funded catastrophic reserve for each of the last 11 plan years.

As of June 30th, 2016, we believe there were 24.9 million dollars in the program above those required reserve levels on a budgetary basis. This is cash as opposed to accrual. We will discuss this more when we talk about Agenda Item Number 9.

We have derived our revenue in Fiscal Year 16 from three primary sources. This hasn't changed. We

received state subsidies. We receive other contributions and funds carried forward from previous years.

Program revenues can only be spent on program expenses. In 2016 the expenses of the program were the same ones honestly that we've had each year: Self-funding administrative claims, health savings accounts, health reimbursement arrangement contributions, fully insured premiums, and agency operations. The balance, which is about 29 percent, was reserved and carried forward in to this current fiscal year, 2017.

Let's talk a little bit about reserve utilization. The conservative financial policies advocated by our consultants and adopted by this board, the adoption of plan design changes when necessary to balance increasing medical costs and the responsible funding of benefit enhancements ensure that this plan is run in a fiscally prudent manner. As part of our annual rate setting process, the board does determine how to utilize any reserves accumulated in excess of those actuarially required to maintain our solvency.

So as a recap, in November 2014, the board did approve plan benefit design for the previous plan year, Plan Year 2016. The rates were approved in March of 2015 and include the continuation of the enhancements that you have today. Those are a decrease to the consumer-driven health

plan deductible from $1900 and $3800, that's individual and family, to 1500 and $3,000 respectively, and increased co-insurance rates from 75 percent to 80 percent. One annual vision screening exam not subject to any deductible or co-insurance. An increased dental annual maximum benefit from 1,000 to $1500. That increased basic group life insurance benefit from 10,000 to 25,000 for employees and from 5,000 to 12-point-5,000 for retirees. Additional HSA and HRA contributions, and, of course, Medicare Part B premium credits for retirees that were enrolled in our consumer-driven health plan or HMO.

The board also at that time carried forward to provide similar long-time benefits in Plan Year 2017, which is exactly where we're at today. All of those benefits have been the same for the past three years.

So what future challenges do PEBP see -- does PEBP have? Of course we have the 2018-2019 biennial budget development. And I think you've heard me say this so many times that you're probably tired of it. But we were requested to build flat and five percent budgets, like all other state agencies. And there are some inherent difficulties when we know that costs traditionally in this industry increase.

We have a defined employer contribution. That is that subsidy bill that is approved on a biennial basis. So

whatever gets approved at the legislature in this upcoming session will be the money we have to live on and we'll have to make decisions in the off year and hopefully we had the right decisions going in to the session.

We will need to experience another great year this year to mitigate increased costs as the budget is finalized during the session. We'll talk a little bit more about that on the next agenda item on why certain recommendations are and how we're addressing those future changes.

And as you've heard multiple times, we have a projected reduction of excess reserves. Last time I did this report, I said there was a projected elimination or a complete spend-down. I can't say that this time, because obviously when we had a stellar year last year, we saved money. But we projected excess reserve levels will not be able to continue to fund the enhancements as they were originally designed.

I think it's important to note -- I was going to wait until the next agenda item, but I think it applies here to this future challenge, that we shouldn't forget that the enhanced benefits were supposed to be temporary. They were designed to expend excess reserves and sunset. And so our next item where we discuss what to do with what we have left, this is something that we initially planned on not having

funding for, for the next biennium. So I hope it's looked at not necessarily as negative but as a positive that we were efficient enough and lucky enough to continue to have these reserves available.

With that, I will take any questions, Mr. Chairman, on this state of PEBP report.

CHAIRMAN CATES: Go ahead, Tom.

MEMBER VERDUCCI: Tom Verducci for the record. I wanted to ask you how these cost savings can convert in to lower premiums and perhaps how they can enhance the benefits or leave them about the same.

MR. HAYCOCK: Thank you, Mr. Verducci. Damon Haycock for the record. To not to get in to a really long, drawn-out discussion on premiums, I'll try to summarize it. The premiums are built off of a 24-month look back. And so every good month you have reduces premiums and every bad month you have increases them from a very conceptual high level standpoint. And so rates will be developed in March. And I honestly don't have enough data to talk about rates today. Those rates will be predicated on this plan year, partial plan year of Plan Year 17 and partial of the plan year before. So this good experience that we had should be reflected in our trend recommendation moving forward and our rate development process, which then, of course, filters down in to who pays what and how much.

As far as how does this affect keeping benefits, that I think is probably best have discussed in the next agenda item. But the more money we have for excess reserves today, the more benefits we hope we can keep moving forward.

MEMBER VERDUCCI: Thank you.

CHAIRMAN CATES: Go ahead.

MEMBER ZACK: Thank you, Mr. Chair. Christine Zack for the record. I saw under the 2015 overview you mentioned the CDHP and alongside the HMO plans. But then the detail is only on the CDHP, not on the HMO performance. What can you tell us about the HMO performance in 2016?

MR. HAYCOCK: Thank you for that question, Ms. Zack. And the reason why, just to give a caveat, the reason why you see the bulk of the information on our consumer-driven health plan is because PEBP manages its own self-insured program and has access to all of its data. When you have fully-insured products, you can only get so much.

However, the experience of the HMO plans, I have to say that only time will tell what happens this next plan year because we're in the process of negotiating the HMO vendors from the HMO RFP. I feel like I can say that without breaking any confidentiality.

However, they were able to have very minimal increases to rates when we extended their contract. I think that was presented previously prior to you being on the

board. And so we need to make sure that we work with them to determine if their experience and the rates that were presented to us confidentially are appropriate. So long story short, it's a little too early to tell. But we're definitely getting that information.

MEMBER ZACK: Thank you.

CHAIRMAN CATES: Other comments, questions from the board?

Okay. Seeing none, we'll close that item. Thank you, Damon.

MR. HAYCOCK: Thank you.

CHAIRMAN CATES: Okay. Let's move on to the big one. Okay. Agenda Item Number 9, discussion and possible action regarding proposed plan design changes for Plan Year 2018.

Before I open this up to public comments, I just want to share my thoughts a little bit with this. We received a lot of concerned comments from members about this agenda item. You know, as Damon went through in his last agenda item, we are spending down reserves for enhanced benefits. The state's fiscal position is not as robust as we would like. That's why there's a call for five percent budget reductions. I think all the members would want to maintain current benefits or enhanced benefits without increases in premiums. However, we as a board need to do our

diligence in considering possible scenarios to keep this plan solvent by making benefit plan changes. It remains to be seen whether those changes will be needed, but I think we need a fair and open discussion about that and to hear comments from all of the plan members.

So I know there's a lot of concern about this. These are items for discussion. I don't think we in good conscious can just say we want to keep everything the same and not cost anymore and wait for the legislature to increase subsidies. It is incumbent upon us to do our due diligence on these things and I would hope that everybody will keep that in mind as we tackle this agenda item.

And so with that, I will open it up to public comment here in Carson City. Please come forward and state your name for the record. And, again, we'll be keeping it to three minutes. I'll let you know when you've hit three minutes and ask you to wrap it up.

MS. LOCKARD: Thank you, Mr. Chairman. My name is Marlene Lockard and I am representing the Retired Public Employees of Nevada, RPEN. And I appreciate your comments, Mr. Chairman. This is always difficult. And, for the record, I would like to state that RPEN fully recognizes that these enhanced benefits were one-shot enhancements and that we could be in this very position at any time. And so we appreciate the past years of these enhanced benefits. And

we, as an organization in working with PEBP, feel fairly confident that we will be able to continue these enhancements.

From the inception of the initial cuts and changes to benefits in 2011 to public employees and retirees and the changeover in the new plan, we have recognized excess reserves from the beginning. And I don't have it with me today. But I have a running total of year by year of the accumulation of excess reserves. And, of course, it's those excess reserves that has created the opportunity for the enhancements to begin with.

And so we applaud that right now today we have an excess reserve balance. Some of you that have been here -- And I know there's many new members. I have been a broken record on excess reserves. And not too many meetings ago I was told that there are no excess reserves to mitigate the cost for 2017. So I applaud PEBP for what they've been doing and am delighted to see this amount and would hope that no final decisions are made until the smoke clears and we see exactly where the excess reserves fall out prior to making a final decision.

With respect to some of the specific changes that are indicated in Item 9, RPEN has concerns with a number of suggestions, one being the elimination of the Towers Watson -- I always get mixed up on what they're called now.

Is it Towers Watson Exchange?

CHAIRMAN CATES: Yes. You're at three minutes.

MS. LOCKARD: Oh. We would really like to have an opportunity to poll our members. While we feel strongly that the PEBP benefit should follow the retiree, we feel that eliminating the automatic reimbursement, you heard the discussion earlier under the audit discussion of how difficult it is for some of our seniors for their reimbursement. And we need to know what the impact would be of our members on that particular item. So I appreciate the time a lot. Thank you.

CHAIRMAN CATES: Thank you very much.

MS. MALONEY: Good morning. Priscilla Maloney representing the AFSCME retirees. I always love going after Marlene because I ride her very large coattails and keep under that three-minute rule because all of the excellent work that she and RPEN do.

So basically our position is first of all we do -- I just could echo so much of what Marlene has already told you. But our board also wants to go through these things item by item, be able to discuss them with our membership. We didn't have the opportunity to do that in preparation for this meeting.

The other thing that I would like to throw out for our board is, again, those concerns about Towers Watson

remain. I won't go through them right now because they're well-documented and archived in the minutes from prior AFSCME statements and prior meetings.

But also the larger 50,000-foot view issue here is while we are mindful of the reasons that were articulated I believe it was in the September PEBP board meeting of why the survey did not ask the employees and members of PEBP, both the actives and the retirees, about whether or not they would like an option where PEBP asks the legislature for money, more money, to keep things static at where they are. We understand the policy reasons articulated. But as the Nevada Appeal reported in November after the economic forum met, we already have some indication that the commerce tax is bringing in more revenue than anticipated. Those numbers will not be trued up until December 6 when the economic forum makes their final recommendation for the budget.

So, again, from the 50,000 foot level we would certainly like at least to have an opportunity for the dialogue to continue about whether a flat or reduced budget is really truly necessary for all state agencies at this point. That is at least a consideration that is of great concern to my board.

So we do appreciate that we're glad that they -- that the PEBP staff were able to do the hard work and find some excess reserves that they didn't think they had and make

these suggestions creatively to help smooth what, as I understand, and my members do understand, was never intended to be permanent enhancements. We would like more opportunity to talk to our members now about this.

And so our position at this point is that we oppose any plan design changes or rate increases based on the information we have as of today, based on a snapshot of today. Again, we'll see what the economic forum says on December 6th.

CHAIRMAN CATES: Thank you.

MS. MALONEY: Thank you.

MS. BOWEN: Good morning. My name and my words for the record, Peggy, P-e-g-g-y, Lear, L-e-a-r, Bowen, B-o-w-e-n, are concerning this issue and how we're -- the process we're using today. What was beneficial in the past to us as the members of the audience and constituents of your board was that the presenters for each of these items and what they were recommending and why, those presentations took place and then a public comment session was allowed before a vote was taken. And that gives us a process to know what's going to be presented and not shooting in the dark and hoping we hit a mark that might come up later. And if you could possibly consider that even today. And I know that you're not supposed to act on public comment today, but I think you can act on process today. Because it was not listed here on

the agenda about the public comment session and what you were going to do that you can enhance what you might want to do to allow a public comment session after everything has been heard so we can speak with knowledge, at least as today's presentation goes. Thank you very much.

CHAIRMAN CATES: Thank you.

MR. ERVIN: Good morning. My name is Kent Ervin, K-e-n-t E-r-v-i-n. I'm speaking today for the Nevada Faculty Alliance which represents NSHE faculty statewide -- Do I need to start over?

MR. HAYCOCK: Please.

MR. ERVIN: Good morning. My name is Kent Ervin, E-r-v-i-n, speaking for the Nevada Faculty Alliance which represents faculty statewide. My comments are for the record.

We are concerned that the proposed plan changes represent in effect a reduction in benefits and net compensation in the face of stagnant salaries. While we appreciate the so-called excess reserves being used to maintain some of the so-called enhancements, the net effect is a reduction of benefits from what's currently available. Excess reserves are simply savings by PEBP due to progressive past cuts in benefits and cost projections that have turned out to be higher than our actual experience.

The 2015-2017 plan design, including those

enhancements, should serve as a base model moving forward because that's what the state employees have experienced in practice. Changing plan design from year to year is confusing for participants and likely contributes to the extremely off street of actual aerial cost predictions over the past five years.

The successes that are reported in cost containment should at some point be put back in to the base plan features regarding specific proposed cuts.

The worst for the participants is the increase in deductibles from 1500 to 1600 or higher as well as -- which are well above the HSA minimums for HDH plans and a possible decrease of the 80/20 co-insurance break.

These aggressive costs hit hardest those participants who have the highest health needs and are already the out of pocket and have low incomes. The out-of-pocket maximums are already unaffordable for our classified employees, for many of our classified employees. The 80/20 should be retained and the deductible should go down towards the IRS minimum, not up.

On the HSA/HRA contributions, decreasing those has the same net effect as increasing the deductible, so it's also highly regressive. The reduction or elimination of the HSA contributions for dependants seems unfair because the rates and premiums are set based on four tier groups and the

deductibles are based on those tier groups but then the HSA is on a per-dependent basis, which creates odd changes in the effective premiums for those groups. The HSA contributions would be better set as a constant percentage of the deductibles for all tier groups.

On the two options for supplemental HSA contributions, we show problems. Treating HSA matches differently from HRA is unfair to those ineligible for the HRAs and then tying HSA contributions to revive wellness programs flies in the face of pretty firm legislative guidance not to fund a wellness program and a legislative pushback on the PEBP program overall.

The idea of taking back HRA balances over 5K is penalizing those who have saved carefully for their future needs, the ones who have done that the best, which is what the proposal is strongly encouraging for the HSA participants.

Furthermore, it will fail to realize savings because once this idea becomes known, those participants are going to spend down their balances.

CHAIRMAN CATES: We're at three minutes.

MR. ERVIN: Okay. Professor Unger talked about the life insurance.

Finally, I would just like to reiterate that we need fair cost proposals for both the base grant and keeping

all of the enhancements in order to know how to really move forward and let the legislators and participants know the true situation. And so thank you very much.

CHAIRMAN CATES: Thank you.

MS. FERRARI: Karen Ferrari and I'm a retired member. I would just like to reiterate what everyone else said. I appreciate everything that has been done to keep costs down and to have a larger reserve.

There were a few items on here that to me, reiterating what Ms. Bowman had mentioned, I think not hearing the discussion it makes a little bit difficult for us to understand what the implication may be for us as retired members, especially where it said that we may be required to participate in HRA administration fees. I would have no idea what that might entail, what the cost of that might be. And I think there are several issues on here that are similar to that. So perhaps if there is an opportunity at another point for us to be able to give some feedback on what it may be. I mean, we know what the one-time benefits from the dental and the life insurance, those are pretty obvious for most of us. But I think there are a few things, as far as the rollover, if we have been being prudent in trying not to use a lot of our money in case of a catastrophe down the line, that might be something. Again, I don't know what the fiscal impact of that is. But it might be something that will help us

understand how that will affect us in the future. Thank you.

CHAIRMAN CATES: Thank you.

Any more public comment here in Carson City?

How about in our overflow room?

UNIDENTIFIED SPEAKER: No, sir.

CHAIRMAN CATES: Do we have public comment down in Las Vegas?

MR. FRANKLIN-SEWELL: Yes, there's public comment in Las Vegas.

CHAIRMAN CATES: Okay.

MR. FRANKLIN-SEWELL: Can you all hear me?

CHAIRMAN CATES: Yes, we can hear you.

MR. FRANKLIN-SEWELL: Chairman Cates and members of the board, for the record, my name is Shaun Franklin-Sewell, S-h-a-u-n F-r-a-n-k-l-i-n dash S-e-w-e-l-l. And I'm here as the chair of the recently formed UNLV Employee Benefits Advisory Committee. Committees members represent multiple campus employee groups including academic and administrative faculty, classified staff, and the president's advisory counsel.

The committee met on Tuesday and spent almost two hours reviewing Agenda Item Number 9. During our meeting, members expressed some dismay at the incremental addition of $100 to the individual deductible amount. We fear the addition could be the beginning of a series of reductions to

benefits and hope it is not.

Other members of the company wondered if it was possible to allow for a modest increase in premiums in order to keep some enhanced benefits.

The committee was most pleased with the following items in the plan benefit design analysis, including maintaining the general benefit maximum at $1500 per plan year, the potential implementation of a preferred drug list, avoiding adding a duplicative second opinion requirement, and avoiding adding a hardware benefit, especially if adding that benefit would have added to plan cost.

The committee understood that some items presented by staff could be seen as reduction benefits but are actually being proposed in order to better fund the health care of all CDHP participants. These items include a $25 co-pay for annual vision exams, implementing and HRA annual rollover cap of $5,000, requiring Medicare Exchange retirees to pay life insurance premiums and HRA administration fees, instituting reference-based pricing, and adding a hearing aid vendor with an established network. Although we did wonder if we could avoid the cap while still adding the concierge vendor.

The addition of $100 to the individual deductible amount was not the committee's only item of concern. Other items included the elimination of the enhanced life insurance

benefit. We wondered if the enhancement could instead be reduced by half to 12,500 for individuals and 7,500 for retirees and the reduction in the enhanced benefit for dependants to zero dollars. We wondered if enhanced HRA/HSA funding for dependants could also be tied to matching contributions and/or completion of wellness and preventive screenings.

Thank you for the opportunity to present this public comment as a general summary.

Many of the committee's members continue to be pleased with Executive Director Damon Haycock's communication with constituents and believe the board and staff continue to try to meet the goal of providing the best health care benefits at the least possible cost to the state and employees.

CHAIRMAN CATES: Thank you.

MR. WASDEN: My name is Dr. Jason Wasden. That's W-a-s-d-e-n. I'm a member of the UNLV Employee Benefits Advisory Committee. And I would just like to support everything that Shaun just said. And we do appreciate Damon coming to speak with us.

CHAIRMAN CATES: Okay. Who's next?

MS. SUMNER: Right here. My name is Raven Sumner, S-u-m-n-e-r. I am also a member of the UNLV Employee Benefits Advisory Committee as well as a member of the

Academic Faculty Committee. And I'd like to say that we do support what Shaun had just stated. And thank you very much for your time.

CHAIRMAN CATES: Thank you.

Any other public comment?

MS. WHITTEN: Sonja Whitten, S-o-n-j-a W-h-i-t-t-e-n. I am a state employee. And, again, I would like to just reiterate and agree with the items previously stated by AFSCME retirees as well as the RPEN, retired public employees, and the gentleman, Kent Ervin, who I believe is with the faculty and staff up in Reno. These proposed changes would be very detrimental to state employees. And I'm hopeful that the board will find a way to not look at these as enhancements but as ways to provide state employees affordable health care, because preventive care is our best option. And if employees can't afford to go and utilize the insurance that they're paying for, it really is of no benefit to the state employees. And it does cost the state more in the long term.

CHAIRMAN CATES: Okay. Thank you.

Do we have any other public comment in Las Vegas? Okay. Seeing none, we'll close public comment.

Before we proceed with this item, I would just like to take a five-minute break. I want to consult with the AG, deputy attorney general. So we'll take a five-minute

break and we'll reconvene at 11:20.

(Recess was taken)

CHAIRMAN CATES: I was just consulting with the deputy attorney general regarding public comment on this item and some concerns were expressed about when we take public comment. I think I'd like to handle this item as we took the public comment already. We'll go through the items. If anybody hears anything that gives them additional concern, you'll have an opportunity at the end of the agenda during the regular public comment where you can make additional comments.

So with that, I'll turn it over to Damon.

MR. HAYCOCK: Thank you, Mr. Chairman. Again, Damon Haycock for the record. I have had the luxury to discuss this report once it's been posted with members from AFSCME, members from RPEN. And in going through this I realize that I probably built this out of order. And so I'd like to direct every one's attention -- I'm going to start with the excess reserve discussion and then I'm going to go to over overall recommendation. But I want to level set what PEBP is truly recommending today to happen at this exact point in time.

Obviously the introduction to this report discusses the things that we were asked to do, right. We were asked at our September 22nd board meeting to provide the

board opportunities for additional plan year benefit design analysis and we have developed analysis on this laundry list of 14 items that we knew we needed to go back and research.

Additionally, we researched and analyzed previously unreported opportunities as we brainstormed and talked with our consultants and talked with our vendors and did some more research and found that there may be additional cost containment strategies or an ability to improve participant experiences within this consumer-driven health plan.

And to make sure that there's no shadow of doubt, today we're talking about the consumer-driven health plan plan benefit design. This is not a discussion on the health maintenance organization plans. We are still in negotiations with those vendors.

So as far as excess reserves, I've been asked multiple times, and I'm going to give some credit to Ms. Lockard from RPEN who said I want to see a transparent accounting of excess reserves. I don't know another way to make it more transparent than dollars and cents coming in and going out on this table here on page two.

So when we close our fiscal year we have an amount of cash that is sitting in our account. And it's not just excess cash that we can go do things with. That cash is generally earmarked for certain activities to occur in the

next fiscal year. So you'll see that we started with about 140 million dollars of cash. However, we earmark funds from that cash to make sure that we can fund our reserves. If we don't do that then we have to raise rates and ask everybody to give us more money to then fund reserves every year.

And so we carried forward these funds to ensure that we have enough operating capital in our approved reserve levels to keep the plan solvent. So you'll see that we have 36 million dollars of budgeted reserves. And these are legislatively-approved budgets. We have almost 29 million dollars of incurred but not reported reserves. We have 25, just over 25 million dollars in catastrophic reserves.

And then if you remember from the report on September 22nd or any of the approvals for reserve expenditures through rate setting or prior year plan benefit design discussions, there is an amount that the board has been approved to fund regarding the plan design. 28.75 million was the projection for Plan Year 17. So when we start at Plan Year 17 out the gate we have to reduce that 140 million dollars.

Now, one of the things that we did, because we recognize that no one likes to be told, and I don't ever like telling people, hey, I want to cut your benefits because we don't have money. Are we truly as efficient as we can be? Can we get a little bit more aggressive with some of these

reserves? Because reserves generally are carried forward year to year. And it's actual cash. And so it's cash that's not necessarily going back to the plan to help reduce costs or reduce rates.

And so we looked back at these reserves. And the first reserve we looked at was the health reimbursement arrangement reserve. The idea -- And I think you've heard the CFO speak multiple times on it and I'm sure the previous CFO's before her -- we wanted to make sure that this reserve was funded in case there was a run on the Medicare. Everybody went out and tried to draw it down. We don't anticipate this ever happening.

We did a five-year look back and we noticed that on average about 64 of it is being distributed. The largest amount was 72 percent in one year. Now, because we're looking at getting a little bit more aggressive across the board, I'm looking at trying to create some excess reserves by reducing this reserve back to about 85 percent funded. And so that gives us a little buffer in there to ensure that if there is something that comes up, as you heard from public comment earlier today, that individuals have potentially been saving their HRA for something catastrophic. If that catastrophic issue occurs, we want to make sure we have the funding available.

Additionally, we need to increase our incurred

but not reported reserve level for 2018. And why do we need to do that? We have increased population. If you heard in my state of PEBP report that we had 6.6 increased participants, those folks are going to utilize the plan and all of our folks are going to utilize the plan and we need to make sure that we have enough money to pay that lag of claims that comes in at the end of the year. And so this reserve is designed to pay out that lag of claims because of our one-year timely filing process.

That has been provided to us every year by our consultants. And our latest figures show that we need to have about 35.3 million dollars walking in to Plan Year 18. And so if you look at the 28.8 and you look at 35.3, the difference is 6.5 million dollars, and so we need to earmark those funds.

Then we went back and looked at, you know, when did we use catastrophic reserves? Have we used that to balance the budget? Did we use that to balance the plan? That was designed to help offset those unexpected issues. And it turns out that we haven't utilized them since the inception of the consumer-driven health plan.

But for a brief history lesson, I believe it was 2000 and 2001, PEBP had to go back and ask for a significant amount of funding to bail out the program. And so these catastrophic reserves were designed to hopefully prevent

that. And they're designed at a 95 percent competence level.

And so talking with our actuaries and making sure that we weren't getting too aggressive, we believe that a 20 million dollar level is an appropriate level walking in to Plan Year 2018. So that can return 5.1 million dollars back to the plan to start this conversation.

So when you add everything in and take away everything that's earmarked, you come up to just under 25 million dollars. This, of course, is significantly different than the last time we talked to you about excess reserves. So I want to clear the air before I continue. It isn't just that we saved money, which I think we're very proud of and we need to continue to do this. We're also getting a little more aggressive with our reserves as well. And so that 25 million dollars is a culmination of these two paradigms of saving money and also do we need to keep this much cash moving forward every year. Now that we have five years of experience, we feel a little bit more comfortable to play and manipulate the reserves a bit.

So before I get in to all of the specific plan benefit design and analysis recommendations, for those of you that have the packet, if you don't, I will definitely go through this, I'm going to go to just about the end of the report, which talks about our overall recommendation. It's on page 12. So I'll wait a few seconds while people get

there.

But I think one of the things that we've heard consistently from our public comment today and I've heard from folks is we don't know what we don't know. And today if a plan benefit design is approved, we don't know if we're going to have another great year in Plan Year 17 or if we're going to have a worse year in Plan Year 17. We do not know if there will be new legislative mandates that will come out through the legislative session and we don't know what the net effect will be, based on the recent elections, although I think it's way too early to start that conversation. We don't know what we don't know.

And so if we make a decision today, if the board makes a decision today, of course, we will implement that decision to the best of our ability at PEBP. However, I think there's a high probability that we will be revisiting this decision in January when trend comes out and then in March when rates come out, as well as -- At least by March we'll have a couple of months of the legislative session under our belt and we'll be able to understand a little bit more about potential liabilities or reductions or increases that the legislature will provide.

And so my overall recommendation is really three things. It's three basic tenants. It's constants. And that is that we approve the use of excess reserves to

incrementally keep as many of the enhanced benefits as possible while ensuring those benefits can be funded over the entire biennium. That's the first recommendation.

And why? We have 25 million dollars. And if you do the math and see that we have reserved 28.75 million dollars for this year's plan benefits, chances are we may be able to fund one year of the exact same plan we have today.

But then what happens in 2019? Do we have to just completely rip the plan apart and go back to the base here? No one wants to do that as far as I know. And we don't want to drive off that cliff. And so the idea of the recommendations are to try to extend those reserves over the entire biennium and then we'll adjust as we receive more or spend more in the off year.

So the first is to approve an incremental change and to make sure that those can have the highest probability of succeeding in to the next plan year.

The second is that any new benefits that are approved either save costs or have a significant impact on participants' ability to receive that high quality health care at affordable prices. We're looking at potentially cutting benefits. And it's difficult to say at that same time but we want to add these benefits. A lot of people, as you heard earlier, say we like what we have, we've had it for the last three years, why are you cutting them. And so it's

a financial reason. And I won't get off on that tangent yet. But if we're going to add something, it needs to have an impact. It needs to go along with the mission and values of this board.

And then, finally, to require all participants to pay their minimum share of benefits solely affecting their group. You heard public comment today about having retirees pay for their HRA administration. I'll walk through that process a little bit more and you'll see that in its entirety right now we're talking about less than six dollars a month, okay, for paying for their HRA administration and for their life insurance. And so we're talking six dollars a month. I'm not saying that that's material or immaterial because I don't know everybody's lifestyle. But I want to level set that discussion.

My proposed timeline to this overall recommendation is that we return here to the board with Aon's analysis and report on Plan Year 2017 trend in January as we do every January. And at that time we'll provide another update to these excess reserves. Maybe they've gone up. Maybe they've gone down. Maybe they've stayed static. And possible adjustments to our recommendation. So when we go through each one of these, we'll talk a little bit about why we're recommending them, and then we may be able to, again, adjust those recommendations and say this is what we think

now that we have found more money or we have less money and why.

And, finally, we'll know what the governor's recommended budget will be by the next meeting in January. And so the steps moving forward through the session will be clear and we'll be able to know exactly what we have as a starting point for money and we'll be able to continue to discuss the recommendations and build a plan accordingly.

We will then return to the board in March of 2017 to set the final rates for the Plan Year 2018. And we should, again, have an even better idea of what mandates have come out from the legislature and updated experience. And so we'll be able to tie that rate to the most appropriate and educated experience level. And I think there may even be additions or subtractions to the recommended plan benefit design.

I've talked with staff about this before and then I'll go in to this real quickly. But this appears to be a departure from how things have been done in the past. And I think things have been done in the past -- And I'm going to speak and hopefully not out of turn. When you have a lot of excess reserves you can come up with a plan benefit design in November and you can pretty much own it by March. But when you're running out of money and every dollar counts and every decision counts, there are some cost-saving activities that

we implemented this year that we don't know the ramifications of. There may be more money on the table. And the last thing that I would ever recommend to this board is to approve a cut to a benefit and then say, oops, it looks like we had more money. I don't ever want to put anyone in that position.

So my overall recommendation, before I go in to the specifics, is that if we're going to approve a plan benefit design today that we approve the concepts that we are going to try to save as many of these benefits as possible in an incremental fashion and that we are going to only include those new benefits that really add the most value and/or save money. And, finally, that we ask people to ensure that they are always paying for their part of health insurance because health insurance is really a social contract between the payor and the employer and the insurance plan and we all pay our fair share.

So with that I'm going to move back to the beginning. Hopefully that level sets some of these specific discussion topics.

The first thing that we were asked to look at was deductible changes in hundred-dollar increments. That came right out of the September 22nd board meeting. And we utilized our consultants at Aon to perform an analysis. And what you'll see is the annual cost that PEBP has to pay for

each one of these levels, all right.

And so if you were to look at the bottom of the table you see a $1900 deductible/$3800 deductible and 75/25 co-insurance. That's the base plan. So you'll see at the bottom that the annual cost of the plan is nothing. That's the base plan. That's getting rid of all of this enhanced benefit.

Each different tier, each different level at different co-insurance margins are attributable to a different cost to the plan. And so once you take a look at those on the right side you'll see basically what's the price tag to have those benefits at what level.

We anticipate about 3.8 million dollars to keep things the way they are today. But what PEBP is recommending based on how we were able to balance all of the budgetary requirements with this 24.9 million dollars of excess reserves is that we only do a small $100 incremental change to that deductible but we leave the 80 percent 20 percent co-insurance alone. That's designed to help folks pay for their insurance once they've met this high deductible and we feel that that's pretty standard across the industry. That, of course, has a price tag of just over three million dollars.

Then we talk about the PEBP maximum dental. This is actually applied to all plans. Because both the HMO's and

our Medicare Exchange folks are eligible to participate in our dental plan. So we have a significantly higher population in dental as we do just in the consumer-driven health plan.

This right here, we have some analysis about how much we paid and how much the member paid, and we do it in year-after-year basis and we tried to put some trend to what we think will happen in 2018. But we're not recommending any change to this. When we looked at the utilization report from Plan Year 2016 we saw there was significant utilization of our dental plan over a thousand dollars. And so that tells me that people are using this benefit. And to take that away may be an extreme -- I don't want to say extreme. But may be a burden to their ability to seek the dental care that they need.

So PEBP, again -- And I should have said this at the beginning. If we have to make a decision today based on the dollars we have today, this is PEBP's recommendation. So this is why we're going step by step. So that cost we think will be about four million dollars.

Next is the life insurance. This was a very tough one. I know it's a contentious topic. I know people want their life insurance and I don't want to ever recommend taking away life insurance. We looked at what that would look like in thousand-dollar increments as was requested by

the board. You'll see what we have a projected employee participant count and also retiree because they have a different rate. And in basic thousand-dollar increments on the employee side, for every thousand dollars you want to provide in life insurance, the difference to the plan is about $177,000.

So we are actually recommending taking this back down. Not because we don't believe in life insurance or we don't want to help people maintain a healthy solvency after they unfortunately pass away and their families have to try to deal with things. The reason why we're recommending that this be moved back down is that we have been provided an opportunity from our current vendor to allow those folks to buy it back up. And that may not sound like it's a great deal, you know, oh, wow, I get to buy it back up. But normally when you lose life insurance benefits you have what they call convertibility or conversion. And you're allowed to convert your losses over to an individual plan. Now, that individual plan has different requirements than the group plan has. You don't get necessarily the group benefit that is applied when you have more people participate in life insurance.

And so our life insurance vendor, the standard, has offered us the opportunity to allow folks who get negatively affected by this to be able to buy it back up to

the level that we take. That level specifically, without evidence of insurability. What does that mean? That means that you don't have to go and get underwriting. You won't be told to go see your doctor and go get a physical to see if you qualify. PEBP is taking, potentially, potentially, recommending that we remove this benefit or reduce it. And whatever is reduced, there's an opportunity to get it again, to get it back again, and to pay for it. So everybody can make an individual decision of what works for them and their families on life insurance.

That's why we're recommending this. It's really unfortunately a financial matter and not a we don't believe in life insurance matter, but we wanted to look at what can increase access to high quality health care at affordable price and this is one of the ones that we felt we had to reduce.

The annual vision exam. We were asked to look at what a co-pay would do. So we recommend -- We were looking at the numbers. You'll see on page five that the analysis in there shows what actually occurred in Plan Year 15 and '16 and we trended it forward to '17 and '18 what we believe was paid or will be paid this year and next year. And then, of course, how much a co-pay would offset that.

So I want to draw your attention to Plan Year 18. You'll see that we anticipate paying about 1.2 million

dollars in annual vision exams. But if there's a co-pay, we get to recover about 300,000 of it back again. So that still means that we're going to utilize excess reserves to offset the cost of annual vision exams at almost a million dollars. So we're not removing a benefit. We're not eliminating a benefit. We're just asking folks to pay a little bit on their co-pay to help offset the cost of this benefit. And to show us a comparison, the HMO plans require some form of payment as far as seeing the annual visit and going through that process. Again, it's not something we necessarily think is the greatest thing, but we have a budget that we need to meet.

I want to talk about the HSA/HRA funding. This one you have definitely heard a lot of public comment on and it's got some interesting dynamics to it. And we'll discuss this one probably a little bit more than we will all the others combined. We had to develop our budget. You heard Chairman Cates say a lot of folks are being asked to five percent cut. What does that mean to us? It means less money from the state. That's exactly what it means. It's no different.

Well, our base plan initially in 2012 had a $700 HSA and HRA contribution for the individual participant and $200 for each dependant, max three. All right. That was the base. And over the last three years we've been able to

increase that by an additional $400 per individual participant and $100 per dependant, max three. So if you had a family of four on the plan, you got $2,000 in HSA funding on July 1st deposited and you had a $2,000 increase to your HRA balance if you weren't on the HSA plan.

We had, again, a difficult time trying to meet budgetary requirements, so we were looking at where can we make some reductions that weren't as nasty as some others where we're actually cutting out complete benefits.

So on the base side we were looking at just to meet budget to keep that initial $700 but to reduce that hundred dollar HSA/HRA contribution for dependants. And it's not that we don't like dependants. Please don't go home and say we don't like dependants, because that's not it. If you look nationally, everyone is trying to balance the high cost of health care. And we actually are one of not too many that offer subsidized health care for dependants and subsidized health care for retirees, so that has a cost.

However, we wanted to try to continue to utilize excess reserves to provide HRA/HSA funding and we wanted to take an opportunity to really impact future health care for this plan.

You heard today in public comment that there is some potential options that are presented here in this agenda item that go directly against what the legislature has asked.

Now, I would at that point, if we need to talk about that, and I'm willing to, I would like to defer that to Mr. Wells because Mr. Wells is intimately knowledgeable about that process as the former executive officer. But it is my understanding that the issue with the wellness program wasn't that wellness wasn't important to the legislature but that providing a premium incentive to only a subset of people and not another set of people appeared to show an inequality or inefficiency. And I could be wrong. And I'll defer to Mr. Wells here when I'm done. But I had heard that that was part of the problem. I can't imagine anyone saying that it's a bad idea to get preventive care.

And so how do we get people to get preventive care? All right. So what I brought with me today is the utilization report that was part of the consent agenda on the September 22nd board meeting so that it's out there for the public to look at to validate what I'm saying. But I want to talk a little bit about a couple statistics as to why we're going to recommend that we tie some of these things to other components, all right.

Preventive service compliance. If you go back and look at the report -- If you don't have it, I can get it to you -- on page 26, preventive office visits. That's that annual exam that people are -- should go see their doctor at least once a year to make sure nothing is wrong and if they

find something wrong they can address it. Out of all the folks that are 19 years old plus, males, females, regardless, 35.3 percent of our planned participants actually did it. 35.3 percent go to the doctor once a year to see are they okay.

What happens if we put off health care? What happens if we don't know that we are pre-diabetic or we are on our way to hypertension or we have high blood pressure? What happens to us physically? What happens to us mentally? What happens to our family and what happens to our cost? Our cost and our plan cost and our state taxpayer cost?

Not seeing the doctor causes problem. I didn't create that statistic. I didn't come up with that line. And what I think is imperative for the long-term solvency of our health plan is that we incentivize the ability for people to do what we think they need to do. And they don't have to. This isn't a mandatory you have to go to the doctor. We would never tell anyone that they have to. But incentivize because it makes good health care sense.

So with that, I'll return back to the report. But there are two options that we would like to potentially tie this enhanced HSA/HRA funding to. Not the base amount but the enhanced amount. One option is to do a match. If you think about it today, there are many private sector organizations that have a matching process for retirement,

all right. You put in X percent of your pay. The employer puts in X percent of your pay. And it goes in to 401K or other type of retirement account. And it's basically a teamwork approach to retirement.

This match allows folks to put some of their money, their tax-free, tax-deferred money, in to an HSA account so that they can plan for future health care expenses.

Today, and we ran the numbers -- Well, I should not say today. But in all of last plan year, 65 percent of our participants did not put a penny in to their HSA. They only accepted the employer contribution and never took advantage of tax-deferred health care dollars.

So in order for folks to afford health care moving forward, it may be beneficial, it may be prudent to put some of those tax dollars now -- Not those tax dollars, but those pre-tax dollars now to avoid those after-tax dollars later.

Additionally, option two is to, again, tie it to wellness. Now, the original wellness program that was at PEBP had a list of things to do, take a health assessment questionnaire, get your BMI checked, end up getting a FitBit. There was a series of things that had to occur.

I think it's imperative that we crawl, walk, and then run. And at the crawl phase, we just basically figure

out what can everybody do, what can everybody do that doesn't affect you based on age, based on gender, none of that? What are the basic preventive care services that make sense? Going to your doctor once a year. Getting your annual labs. Going to the dentist once a year and just getting your teeth cleaned once. We're not saying go four times a year. Just go one time a year. And the beauty of all of this is it doesn't cost you anything. All of these services are free to the participant. The plan already pays a hundred percent. And by tying the additional HSA funding and HRA funding to it, everybody is treated equally. Everybody has an opportunity. And if you plan it right, you can probably get all of this done in one day, and it doesn't cost you anything.

And so this is a paradigm shift on making HSA and HRA funding something that you have to kind of earn. We want to give you a base amount, but we want to promote better health care. So that's kind of the contention HSA/HRA discussion in a nutshell.

But we recommend the base amount -- If we had to today, if the decision had to be made today that the base amount be 700 and 100, individual and dependant, and that we provide a $300 enhanced benefit to the participant directly for either wellness, matching, or both.

Then let's talk about a vision hardware benefit.

This is one of the ones that was brought up at the last meeting. What would it look like if a hundred dollar vision hardware benefit was provided in Plan Year 2018? So we went and looked back at previous years 2015 and 2016 vision claims and you'll see the table here where we trended it forward and then we have three different utilization levels because we don't know if everyone that goes to see the eye doctor is going to require a pair of glasses that year.

So we have a 33 percent, you know, a third of the people will need it or two-thirds need it or all hundred percent need it, so you can kind of see a floor and a ceiling and see what those costs would potentially be. Worst case scenario, I believe, would be about 1.1 million dollars and a hundred percent utilization. But it's anywhere from 380,000 to 760,000 if you're at the 33 to 66 percentile range.

PEBP is not recommending that we move forward with this hardware benefit. Again, not because we don't like glasses. I've been wearing them since I was nine, so I know how it feels. But because today there are other competitive opportunities out there where people can receive hardware that don't meet this hundred dollar requirement. And not all of us know that. And I can't sit here and lobby or discuss or market someone else's program. But I haven't paid a hundred dollars for glasses in a decade and I have such bad vision that I can't read the HP on her computer right there

without them.

So, again, there are other opportunities and we think that because of budgetary needs that this isn't the time. However, if there's more money in the future, I don't see why PEBP can't assist in this recommendation.

Then HRA rollover balances. We talked about this at the last board meeting on September 22nd. The idea isn't to punish people for saving money. That's not what it is at all. It's been our experience that folks generally that have high balances -- This isn't everybody. I'm sure someone is going to come to the table and say, Damon, I have a high balance and I don't do this. But we believe that there are folks that don't even use their HRA at all. And it's not because they're saving it. It's because they either don't know to how use it, they don't know they have it. We've talked to these participants and they have accumulated these balances without even knowing they have them.

Carrying forward a reserve of cash to make sure that folks have access to this when they're not using these dollars is difficult. It's difficult and it's carrying forward cash that can be better used to enhance or continue to build enhancements to our plan.

We're not saying take away all of their money. We were asked I think it was by Ms. Lamborn to look at thousand-dollars increments. We already had pulled the

information in $500 increments, so we just showed them to you. I apologize if it's too much information. But you can see how many accounts and what that looks like if it was returned.

So the easiest way to read this table is if you look at the far right number, so we'll take the second one down, one penny to $500. If you capped it at $500, the amount returning to PEBP would be almost ten million. No one is recommending we cap at it $500. But just to understand how this table was written. So at the $5,000 range we're talking about 650, $7,000. And, again, we're trying to piecemeal how to get this 25 million dollars to extend over two plan years.

So we recommend capping it at 5,000, because at least with $5,000 you can still satisfy any deductible you have, whether you're individual at 15, 16, 18, 1900, whatever we come with, or you have a family where you're at the 3,000, 3200, 34, 3800, whatever we end up settling on, you can still satisfy that deductible and then you can satisfy some of the cost sharing as well.

So the whole point, I believe, and I could be wrong, that the HRA and HSA were established back in 2012 to provide first dollar coverage for health care. We're putting a high deductible health plan in, but we want to give folks an opportunity to have money available so they don't have to

come up with that high deductible before they see their doctor the first time. So I think that still meets that intent, that vision of how it was created.

Then Medicare Exchange retirees paying life insurance and HRA administration fees. This isn't a punishment. It's an equity thing. Today HMO participants and CDHP participants have an administrative load that is built on top of their base rate. So there's a base rate that is developed that says this is how many claims you're going to have and this is what we think your experience is going to be, and so this is how much we need to charge people to be on each of these plans. And then PEBP says, yeah, we have all of these administrative costs. And there's not that many but we have them.

We need to make sure that we can keep the lights on in here and pay our court reporter and those types of things. But we need to make sure we have an administrative load. And we build in to that administrative load on the consumer-driven health plan and the HMO plan the cost for retirees on the Medicare Exchange to pay for their specific life insurance premiums and their specific HRA administration.

So as you heard from Towers Watson earlier today, they talked about some of the HRA and customer service things, Towers Watson has a third party administrator that

manages that HRA, just like we do with HealthSCOPE. Well, the retirees on the Medicare exchange aren't paying that part of it. Everybody else is.

And so we're not saying we want to punish retirees on the Medicare exchange. If you were to add both of those two current dollar amounts every month together, it's $2.83 for $5,000 of life insurance and it's $2.75 a month for HRA administration. So for less than six dollars or less than what is a Happy Meal now at McDonald's, we can actually take that out of the administrative load and apply it to the people that are actually using those services.

And so as far as an answer equity thing, that's something that we're recommending. And what it also does is it reduces our admin load, right. People are paying for their services. So if you look at it, it doesn't sound like a lot. Less than six dollars. But that's $393,000 worth of payments if you take all 11,000 plus Medicare Exchange recipients.

And then CDHP limits an in-network for hearing aids. We have had some issues with providers charging a little bit more than we think is appropriate. Sometimes a lot bit more. And we don't have anything in our master plan document that limits that.

So, initially, we looked at, well, we want to look at that, we don't want to expose the plan to high cost

mark-ups. And thanks to working with our excellent third party administrator, they found a network that actually will help people get the hearing aids that they need. And we can design the benefits within there. We can design it where it has a $1500 per ear minimum. Excuse me. Maximum. But at least when someone needs a hearing aid, they call the number, they call HealthSCOPE. There will be a potential menu item that goes to this concierge company. And they can talk to someone and say, I need a hearing aid and I was prescribed this and what should I do? And they'll help them and walk them through that process. And that cost is nothing to them. Nothing at all.

But what it does do is it saves the plan money because it doesn't allow providers to just write for -- prescriptions for hearing aids and mark them up. And so it's a process to help folks and it's a process to save the plan money. We recommend implementing this.

Now, the Medicare Exchange participation to receive the HRA. You heard from RPEN earlier today that they wanted to poll their members and they talked to me about this before and I think that's an excellent idea.

What I do want to say is that not tying the HRA to the Medicare Exchange does not mean you lose your automatic reimbursement. That's not what it means at all. You can stay with Towers Watson for the rest of your life and

you can have automatic reimbursement and they will gladly manage that for you. That's not the problem. That's not the process.

The issues are in some of these overpayments, and you heard some of the discussion earlier today, is that folks will hop off the plan knowingly or unknowingly and often it's unknowingly from the calls that I've had to deal with and the issues that we've had to work at PEBP, and then all of a sudden the carrier doesn't inform Towers Watson. Sometimes they don't inform them for years. And we had one individual that I think wasn't -- didn't know that they were off the plan for three years. And so the carrier finally told Towers Watson and Towers Watson said, hey, you're not on my exchange, it looks like we've been automatically reimbursing your premiums for three years. The participant says, well, I want to get back on. No problem, but you owe all of that back HRA. How fair does that seem? I don't know. If they did it on purpose then they made a decision. But if they didn't, and I can go through scenarios where it makes sense how people inadvertently hop off. If you untie it and you give this person the choice and the ability to work with a local broker agent and get a different plan that is on Towers Watson, but most importantly, you give the opportunity for the people to still remain on Towers Watson and get their automatic reimbursement. So all it's doing is it's adding

choice.

And this is something that I remember former board members requesting, so I'm not going to open up old discussions. But why does the HRA have to be tied to the vendor? Why can't it be tied to the person like the HSA? This is a step in that direction to make that occur.

But we at PEBP strongly agree that we want our participants to know about this and we want to know how they think and how they feel. So we're very interested to see what AFSCME and RPEN come back with as far as polling their members.

So we recommend if we had to make a decision today that you untie it from the exchange. And Towers Watson doesn't have an issue with this at all. We already walked it through with their leadership.

Second opinion doctors. I'm going to kind of gloss over this one. If you have an issue and you have a treatment that you need to have and you're concerned that maybe you shouldn't have it, normally you can go to your utilization management vendor, the case manager, because these are complicated issues. It's not like I -- should I get my finger in a splint because I broke it. These are some major issues here. Should I get this shoulder surgery or should I get this other type of treatment? And we feel that second opinion doctors should be or could be an addition to

our already existing utilization management process and program. We don't want to get in the way of that.

PEBP doesn't recommend that we pursue direct relationships with second opinion doctor vendors because then we will be kind of pitting them against our utilization management vendor and that flies in the face of partnership.

And so we believe that if you as a board agree or want this type of process and procedure and benefit that we can reach directly out to our current vendor and negotiate and talk to them about our desires to include.

Reference-based pricing. I think I've said this before. We had I think it was an $85,000 hip replacement we had to pay out in rural Nevada when that same hip could have been replaced in northern Nevada or southern Nevada at less than $20,000, something around there. So there's some drastic pricing differences here on what facilities will charge. And honestly it's because they can. They're in the network so they can.

And we want to be good stewards of taxpayer dollars, good fiduciaries of the health plan fund, and good performance of high quality health care at affordable prices for our participants.

And so there is a presentation that's attached to this report that HealthSCOPE put together. It's a really good presentation. I can walk through it if people have

questions. However, this is not something that PEBP has created out of thin air. Our neighbors to our left in California, they actually implement this and saved I think it was millions of dollars. Do we feel we're going to save millions of dollars? No, we don't have that many. But it's still a good business practice that we don't allow our providers to just take health care costs when they're drastically different for the exact same procedure.

And so we believe that if we take a small chunk out of reference-based pricing and do it for hips and knees that it's a good step in the right direction for controlling now and long term cost for the plan.

The CDHP near site clinic update. All I can tell you is that the feasibility study is still being -- is still in process. We anticipate getting a result in December. And we will bring back those results to the board. We will not take any action, of course, until the board gets to see that, hear that, and then provide us with direction.

What I can say is attached to this report is a series of pricing that Aon has provided. Aon was requested by the board on this September 22nd meeting could we see -- I think the words were can we see what other entities look like and what those costs would be a for start-up and operations, which you'll see in that attachment to this report is a plethora of different clients that they have shared with us

or at least costs where you'll see the different participation levels. And why is it different participation levels? Because if we were looking at three feasibility studies, Reno, Carson City, and Las Vegas, we have different levels of population there. So you can see kind of where these pricing models could turn out. But, honestly, we want to make sure that we do a Nevada-specific, three-region feasibility study to give exact numbers, or at least better numbers than what the national book of business looks like.

We recommend no action be taken, because even if the feasibility study makes sense and this is a slam dunk, we need the runway to put it together and that wouldn't occur until Plan Year 19, so we would bring it back to the board for approval for that plan year.

And then we have a CDHP preventive drug benefit. One of the issues that I heard for the 15 months I've been here at PEBP and I would assume my staff for many years beyond is that one of the issues that folks complained about significantly is that why do I have to satisfy a high deductible before I get my first drug I need to maintain my health. Why?

Now, of course, the answer has always been, well, we give you $1100 or $1500 or $2,000 so you don't. But regardless of the HSA/HRA funding, there is an opportunity for PEBP to provide a new benefit to participants to allow

them to bypass the high deductible and go right in to cost sharing for a certain subset of drugs. We worked with our vendor Express Scripts. We have attached to this report a preventive drug list. It's a sample list. It is no where near what would actually occur. And the reason is they have diabetes care drugs on here and we already have a diabetes care program that does something similar. So we would have to tweak the list of it. But you get an idea. It covers stuff like hypertension and asthma and those types of things.

And we believe that if -- if we are going to take benefits away from our participants because we have a financial issue, that this is money well spent, that providing this at least softens the blow of potentially higher deductibles. And if we end up going with lower co-insurance, at least they can get their medicine that they need for some of these maintenance drugs on day one without having to satisfy an increased deductible. And so we think this is a good idea and we recommend it strongly.

So, again, and I've said this many times, but I want to be abundantly clear because I think I'll be quoted later, we are recommending an overall recommendation of the concepts of how this plan benefit design can be created. We have specific recommendations within if the board wants to make a final recommendation today and we can discuss those.

But, honestly, I personally believe that today we

still need a little bit more information to make that final decision. And I would like the ability to come back to the board and revise recommendations based on up-to-date information in January and a final information in March.

And with that, Mr. Chairman, I'll take any questions?

CHAIRMAN CATES: Okay. Thank you, Damon. That's an awful lot to consider. So questions, comments from the members?

MEMBER COCHRAN: Mr. Chair, just a couple of things. Particularly when I think some of the major issues we're going to be looking at is enhancements to the HRA and HSA and I think that's going to be one of the big issues on the list of deductibles. Damon, you mentioned in there that there are 65 percent of the members don't contribute any money in to the HSA. Do we know whether or not --

UNIDENTIFIED SPEAKER: We can't hear Dr. Cochran's comments in Las Vegas.

MEMBER COCHRAN: My apologies. I forgot to turn on the microphone. So I'm asking Mr. Haycock about the issue pertaining to the HSA's and HRA's and the contributions to those funds by members. And, as you recall, Mr. Haycock mentioned that there were about 65 percent of our members who don't contribute to that. Do we know whether or not there's any relationship between that lack of contribution and the

number of people who actually use their plans within an annual year? So for example, I'm assuming we have many members in our CDHP who may not even use their plans in a given year. Am I correct in that assumption?

MR. HAYCOCK: For the record Damon Haycock. I think that's a fair assumption, Dr. Cochran. You have to define what many is, of course.

MEMBER COCHRAN: Yeah, yeah. And it would be good to know, actually.

MR. HAYCOCK: And I would be more than willing to come back with that analysis and say this is how many people are actually using the plan. I don't have it in front of me today, so I apologize. I don't think I want to put HealthSCOPE on the spot because I don't think they have it at this exact moment. We can definitely get that number.

MEMBER COCHRAN: I think it's important just from the perspective of understanding, you know, as we go forward whatever decisions we make in trying to let people know what our plans are going to do and what options they have. Do they even know these things are available? How do they get that information? Do they know they can do these things? Because that's one of my concerns.

Because for some people when they hear about health insurance, especially depending on your age, it's just going in one ear and out the other. You know, so there's

nothing we can do for those folks except for down the road when those individuals end up needing to use their health care plans and they find out the high cost of how it's affecting them, then they start coming to us and asking us what we can do to enhance our plans. That's just human nature, so I'm not going to take anything away from that.

There are a couple of things that I would like us to consider. Number one is this idea of matching HSA funds to me creates a two-tiered system. So for those people who have the resources to be able to do it and put more money in to their HSA and PEBP will match that will not be available for all members. And so from that perspective, just the way I would look at it, is I would likely be opposed to that type of thing. If you can't provide that benefit to all of our members because they can't afford it, then I would just as soon we not do it. I'm not saying it's a bad idea. But my other concern is that people won't use it. They don't know it. They're not going to care about it. And then one day they'll come back and talk to us about it.

The other pertains -- And we probably didn't request this information when we asked you to put together the summary. And it would be something that I would be interested in knowing. Because I do agree and I was on this board when we enhanced the benefits. And my perspective at the time was this is an enhanced benefit because we have

these big reserves and we can do this. And I as a board member never had the idea that we can go forward -- that this was necessarily going to be a long-term thing. This is something that we were going to do because we had these reserves.

So I'm not opposed to enhancing our benefits. I would just much rather that we say this is what the plan costs and we're going to put this money in there and it's not going to be based necessarily on reserves. It's based on we're going to do this and this is what we're going to budget for the plan.

But the other thing that I would like us to consider is what if we didn't enhance the benefits but we lowered the deductible. I think the max deductible for an HSA -- to qualify for an HSA is $1250. Am I correct on that?

MR. HAYCOCK: Dr. Cochran, this is Damon Haycock for the record. For next year it's $1400. We're getting real close to the --

MEMBER COCHRAN: Okay, okay. So the minimum is 1400 now. Okay. So, you know, I was just looking at considering it that way because if we could lower it to 1200 and we still have the $700 HSA, that would make it much more palatable. So, you know, I think that if the minimum is 1400 I would look to see what we would reduce our enhancements by, by going to the minimal deductible. I'm assuming those are

IRS purposes for doing that. So I would like us to be considering that option.

And let me just -- Because I think, you know, when I got on this board it was -- it's been a big issue. The whole issue of the high deductible plan has been the thing that has impacted people the most. It's like it's going to cost me a lot of money especially if I've got family members and I'm going to be paying out a lot of money before I ever realize any of this and I can't afford to do this. And so are people putting off services.

Also, if we're going to tie any kind of enhancement to the preventive services, again, it is very imperative upon PEBP to make sure that all of the employees who are in the CDHP know about those services, know how to get them, give them enough time frame for that to happen. Because we haven't been successful in getting people to do the preventive stuff.

And so, you know, tying it to that, it's going to be incumbent upon us to make sure that we can tell -- we can say how do we inform every single member that this is what you're going to need to do so that when they come back to us we've got at least -- we can say, you know, we're trying to do what we can for our members and we're trying to make sure that we inform you. But, you know, are we doing everything in our power to make sure that they know what these benefits

are.

And on the hearing aid issue, I am a little worried about using a specific vendor that we set a cap on that and then that vendor turns around and tries to up-sell to participants, you know, like, well, we have this invisible hearing aid. In other words, you either get a megaphone that you stick in your ear for $1500 or, you know -- or you can -- for $500 more, which your plan will cover, we will sell you this hearing aid. So I do worry a little bit about that and I think I might rather see us say we're going to cap this. You go out and this is what you've got to spend and go out and get the hearing aid that works best for you rather than using a specific vendor.

And I would do that in any of the products that we do that, you know. I mean, there are certain advantages to using vendors. But I do worry about what is a minimum product that we get. So I'm sure there are other members of the board who have comments and I've really gone through this thing with a fine tooth come and I would be happy to submit anything else or work with you guys going forward. Thanks.

CHAIRMAN CATES: Go ahead.

MEMBER ZACK: Thank you, Mr. Chair. Christine Zack for the record. Damon, I know that we're not taking any action on the clinics today. However, since you're coming back in two months with the recommendations and that this was

something I really pushed for during the last board meeting, I wanted to make sure we're also still considering partnering with existing operators in the community that would bear more of the cost of creating and building these clinics. Because I've looked at the pricing in the Aon study and I think that there might be an opportunity through partnerships with current operators to offset a significant amount of those costs.

MR. HAYCOCK: For the record Damon Haycock. There is nothing off the table at this point, Ms. Zack. And those were the marching orders to Aon to do a complete feasibility study to look at what opportunities already exist within the locations and what could we leverage and what could we maximize.

What I will say is when it comes time to present this feasibility study, there will be a full-on discussion about what PEBP recommends and why. And it won't just be because of the feasibility study we think X. A full-on description of why these health clinics work, why we feel -- if our recommendation is to move forward and where the real cost savings are. Because the real cost savings that have been proven nationally -- And I'll just give a teaser and then we'll get back to it -- isn't in saving money and developing one. It's in the referral process. That's where all of your money is saved. And so your concern that we have

to mitigate if we partner with the local partnership is that are we providing them another funnel in to the regular health care system and are we maximizing our savings that way.

And, so, again, I don't want to get too much in to the weeds on this today, but we'll come back with a comprehensive report, not just a feasibility study, to discuss these issues.

MEMBER ZACK: So then it will look at both options?

MR. HAYCOCK: Yes.

MEMBER ZACK: All right. Perfect. Thank you.

MEMBER BAILEY: Mr. Chair.

CHAIRMAN CATES: Go ahead.

MEMBER BAILEY: For the record Don Bailey. I too agree with Dr. Cochran. I was there when we submitted these enhancements. They were not a lifetime applied operation. In fact, in discussions with the audience and members we discussed actually these permanent enhancements would not be permanent. That they would some time be reduced or some of them may go away.

But I would like to see the board take more time with the staff and study. There are a lot of recommendations here. Some of them go up. Some of them go down. I think it's going to take us more time to digest this and then move it in to 2017.

CHAIRMAN CATES: Go ahead, Ana.

MEMBER ANDREWS: Ana Andrews for the record. I agree with Don. And one of the things I wanted to add is based on the comments provided by the audience here, in Vegas, and the statements that Damon made, this is, we barely have about four months of experience for Plan Year 17. So we're making a lot of assumptions with these recommendations. And I agree that we should probably come back in January and then even in March.

The biggest unknown for me that is a concern is what is the economic forum going to come back with. What is our budget going to look like? And what is the legislature ultimately going to do? And I believe that the first two months of the legislative session, February and March, will be an indication as to what it is that they want to do. And, I also agree, we need to really look at these options up close.

And while I was not on the board when the enhancements and the CDHP was set, I do recall getting the materials and reading the minutes. And I also remember that these enhancements were not to be permanent. So that is my recommendation to my fellow board members today. Thank you.

CHAIRMAN CATES: Tom.

MEMBER VERDUCCI: Tom Verducci for the record. I just want to point out that I think it's very important that

we do focus on the HSA contributions. I do see that this is the direction the country is going in in terms of employees making a contribution. Whatever we can do with the -- to provide an incentive for that I think would be helpful. But also where employees could choose from HSA or HRA, I would really like to lean them towards the HSA because it's portable. And a lot of the HRA funds are forfeitable. So if it's possible to even mandate or encourage them to first make the contributions in to the HSA I would be very supportive for that.

Also I believe there was a survey taken a few years ago from retirees and they were asking for hardware. In fact, I think the response was close to 90 percent. And if we're asking retirees to read through contracts from Towers Watson and they don't have glasses to properly read them, it becomes more difficult. And I think that when you have 90 percent of people asking for a benefit that might be doable, it's something that if it can't be decided upon today, which I don't think it would be, that it could spill in to what the final budget outcome would be.

As far as the cap on the $5,000, if these are largely forfeitable funds that aren't going to be used, I see it coming back in to the plan.

You know, we've been asked to do a five percent budget cut by the governor. And we're making changes in a

plan. The most important thing that I think that we need to be looking at are are we doing anything catastrophic? Are we affecting people's future lives or are we doing small adjustments within our budgetary constraints? And I don't want to be in a position of, you know, eliminating life insurance benefits if it comes to reducing them. You know, I heard from UNLV perhaps 50 percent reduction might be appropriate or if we provide them the ability of being able to pay the lost benefit that was coming that could be a solution. But I would really hate to see -- put a retiree in a position where they're getting older, they pass away, and their family is left with reduced benefits. I think we've got to take care of whatever we can to take care of the retiree.

CHAIRMAN CATES: Go ahead.

MEMBER GARCIA: Thank you. A couple of things. Thank you. A couple of things. With regard to hardware, I'm just going to join that bandwagon. Often times when we think of members only, you know, having hardware we're thinking the member. But from personal experience, I have five members on the plan who all need hardware. And I know I'm not the only one like that. So it does get to be cost-prohibitive. You have to start divvying it out a little bit and deciding who needs the hardware more. And on top of that it always gets broken. And people -- My children are used to some good duct

tape when necessary. So I will go old school on them. But just keep that in mind.

I have a question for Damon and that is with regards to the HSA/HRA. And it might not need to be answered now, but I think that eventually -- I just wanted to make sure or ask the question, you know, what are the restraints with the HSA/HRA if a member retires, terminates, or goes to an HMO? I just -- You know, I think that's something we really need to consider when we're thinking about changing that particular section of our plan.

And I did want to ask, just to be certain, and I know that, you know, you guys are awesome with us. But I want to make certain that every voice within the PEBP family is heard and confirm whether or not there are any other programs that PEBP staff would suggest that the board review for enhancement or actuation or any of the following? I know you acted on the questions presented. But I always want to leave it open for, you know, grass roots suggestions. And that's what I had. Thank you.

CHAIRMAN CATES: Go ahead.

MEMBER LAMBORN: Thank you, Chairman. Leah Lamborn for the record. I do like the idea, of course, of not making decisions today and trying to do things incrementally and trying to see where we're at with the budget and the economic forum. But what I ask is when we

come back that we can see what the target is. So, for example, five percent of the base expenditures is 25 million dollars would be a target that we're trying to reach in savings or possibly increasing premiums with the reserve, that cuts it down to 12 and a half million a year. So something like that in that type of a format where we know the target that we're trying to reach so we can make better decisions on savings and then what we need to -- what we can't reach in savings, of course, need to be premium increases unfortunately. So thank you.

CHAIRMAN CATES: Any other comments?

MR. WELLS: All right. I'll say a couple things. Jim Wells for the record. I want to hit on a couple of little things. Some members have already hit on them. Others might be a little new. There's been a couple of people who have said that these plan design changes that were implemented three years ago were not intended to ever be permanent and that's the way we should be looking at this.

Going back from 1500 to 1900, from 1100 to 700 on the HSA contributions is a pretty steep hit for everybody and I think at this point we have an opportunity to phase this out.

For those of you who have mentioned that we should wait for the economic forum to rescue us, I can tell you from having the most experience of anybody sitting in

this room that that is not going to happen. So to just sit here and wait and not make decisions today I think is a mistake. I think that we need to start making plans to get this plan in to line with what -- I'm going to make decisions for this plan if I don't have direction from this board. I've got a budget that has to be submitted. We've got about six weeks left to wrap it up. I was hoping to get some decisions today on where we are -- on where the board wants to go so we can start looking at whether or not just from my perspective whether or not the premiums for the participants are going to be much higher or whether or not there's -- there's not going to be state money. I'm telling you that right now. So I think that we need to look at starting to make these. I think the HSA and the HRA I think that's an easy decision to defer to a later date because you can predicate that on how much money we have in March. I think waiting until January to make plan design changes and trying to reprise them in short order, I'm not very supportive of that.

I'm also not supportive of making this a base plan. I think that we need to be starting a phase back to what the base plan is. I think that that's the direction that the board needs to look.

As for the additional HSA and HRA being tied to either preventive or matching, there are -- there are

struggles with doing either one. So there is some mention about whether or not the legislature would approve a wellness program. And while they were not anti-wellness, they were certainly anti-requirement. And so it is -- And to say that we didn't communicate with every single individual, I can't tell you how many communications went out regarding the wellness program. I can't make someone read something and neither can Damon. So when we send this stuff out, it's a chunk of people are going to read it and a chunk of people are going to throw it away and complain that they didn't know what was going on. That's just a fact of life with this plan and I think that that's a reality that we need to be cognizant of.

The preventive plan, one of the complaints that you're going to probably get is how does the preventive, what do I do on the HMO side. I don't get any additional benefit on the HMO side if I do these preventive services, whereas now we're tying it to the CDHP. Specifically for the HSA because you still have a problem that you can't really give additional HRA funds if you have the match. So you can do that with the preventive side, but on the match side you can't match HRA funds. So there are some limitations in tying those two pieces to either preventive visits or matching. So, again, it's a difficult place for us to be. But I think that we need to start working back towards the

plan.

I have some concerns about adding the preventive drug list. We've talked already today about adding the benefit that you in the future have to take away. We're looking at doing it with life insurance. We don't know how much that's going to cost. We don't have a lot of experience with it. And, frankly, I'm a little bit concerned about that.

I think that removal of the requirement to have Medicare retirees go through the exchange is trading one set of complaints for another. I think that you are seeing a very small percentage of the people who have problems. And while they are very legitimate problems and things need to be done to fix them, I don't think you upset the apple cart when you think you fixed the wheel. So those are my comments on this side.

MEMBER GARCIA: Mr. Chair, Rosalie Garcia. With all due respect, Jim, for the benefit of those in attendance that may not be aware of your state employment, would you please introduce your position relative to the directors -- the board -- that the board takes. Because you made a statement stating that you're going -- you are going to move forward. But I don't think necessarily everybody understands how that's a standalone statement.

MEMBER WELLS: I have to put in a dollar amount

for the state share in the budget.

MEMBER GARCIA: I'm sorry. Again, your position.

MEMBER WELLS: My position on?

MEMBER GARCIA: When you say you have to put a dollar. I mean, we're all board members.

MEMBER WELLS: What is my title?

MEMBER GARCIA: Yes, sir.

MEMBER WELLS: Oh. So, I'm the budget director for the state.

MEMBER GARCIA: Thank you. Not everybody knows that.

MEMBER WELLS: And so given where we are, I mean, we are going to have to put -- Everybody is familiar with the bill. Maybe not everybody is familiar. The legislature passes a bill that puts a dollar amount per employee per month and that dollar amount is what comes out of the budget document, the documents that are submitted through the -- through this process.

When the agency request budget was submitted, there was a dollar amount in there. That number is supposed to be reflective of the flat budget with a five percent reduction. It wasn't. And it was a fairly significant increase to what the state would have to pay.

So we have been working -- And I have been working with Damon on some of these to see how close we're

getting to what the numbers could be, given where we are with the reserves are today. You're never going to know what the reserves are in FY 17 before you set the rates for FY 17. So at some point you're going to have to leap off a bridge and have faith that those reserves are going to be there.

Right now we are -- I think this is getting us pretty close to where we need to be in '18 anyway.

MEMBER GARCIA: Thank you.

CHAIRMAN CATES: Okay. Well, I'm not sure what the path forward is. A lot of members expressed the desire to defer any decisions. I agree with Director Wells that we can't kick the can down the road. I would like to see if we could get a consensus and get some votes for any of these recommendations. Some of them we may need to defer. But it would be extremely helpful if we made some decisions.

MR. HAYCOCK: Thank you, Mr. Chairman. Damon Haycock for the record. I want to address something that Ms. Lamborn said. What's our target? Right now we believe we have 25 million dollars. And the recommendation that PEBP has placed forward today on those specific items is spending 13.2 of that. So just about a little over half. I'm sorry, I realized after I wrote the report that that's probably a pretty important figure that should have been in here. So my sincere apologies to the board.

But the idea, again, is to try to create a

benefit that can sustain at least over a two-year period and hopefully with continued cost savings that we would be able to keep that 13.2 and make it 26.4 and make up the additional million plus that needs to happen for those reserves.

It's way too early to talk about rates, which unfortunately becomes the bone for everybody to pick at. We can all talk about benefits and say, well, this is what the benefit would be and this is what the subsidy would be, but how much is the participant paying. And it's a difficult discussion to have. We can throw numbers out any day of the year. But generally they're wrong until we finally establish rates. And then at the end of that plan year, we go back and see if we can get them right to begin with. So rates is kind of a moving target.

But I don't believe, and I'm going to go out on a limb here, that if a decision is made today, that's great, I think we can move forward, I think it can just be built into that, I get all of that. I don't believe that we would have to rerun analysis in January on this stuff. I think we would have to rerun analysis on any new stuff. But the only analysis we have to rerun isn't on how much this plan benefit cost versus this plan benefit cost. The analysis is how much excess reserves do we have. And regardless if there's a economic forum that provides more money or less money or the same, all we have to do is figure out the experience of our

year and say, you know what, we think 25 is more like 27 and Mr. Verducci and Ms. Garcia advocated for hardware benefit and now we have the money to add that in. And that's kind of the way I was seeing that process go. Not specifically that benefit but as an example.

But in reality -- And I will speak to Jim's point -- there's only so much at the trough, correct. You can only go back to the trough so much to get the money that you want. So I have a suspicion that whatever gets approved today is going to have to alter a little bit. Maybe not a lot. But a little bit. And if we can accept that then it might make the decision process easier. I don't know if that helped.

CHAIRMAN CATES: The only other thing I would add at this point in time in looking at these recommendations, I could not be in favor of enhancing benefits, not with the situation that we're faced. I agree we need to look at incrementally looking back to the baseline benefits. Some of these proposals I could get behind more than others. But I don't think any of the enhancements are properly approved at this time in my opinion.

Does anybody else have any other comments? Want to take a stab at a recommendation? We're all over the board, so I'm not quite sure how we're going to get a conclusion on this. Does anybody want to move to consider

each recommendation individually?

MEMBER WELLS: Mr. Chairman, I would prefer that we do each one.

CHAIRMAN CATES: Okay. Let's go ahead and do that.

UNIDENTIFIED SPEAKER: I would ask that the board members speak up. And I know they have had a hard time hearing. Please.

CHAIRMAN CATES: Yes. Please make sure everybody speaks up so everyone can hear.

Okay. So CDHP deductible and co-insurance levels. The PEBP's board recommendation is to incremental reductions in this enhanced benefit will result in $1600, $3200 deductible while keeping the co-insurance levels at 80/20. Does anybody want to make a motion to approve this recommendation?

MEMBER ANDREWS: So moved. Ana Andrews for the record.

CHAIRMAN CATES: Do I have a second?

MEMBER ZACK: I'll second. Christine Zack for the record.

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

MEMBER WELLS: Can you just repeat the motion? I missed it.

CHAIRMAN CATES: So the motion is to accept PEBP's recommendation for CDHC(sic) deductibles and co-insurance, which is a $1600 individual deductible, $3200 family deductibles, with co-insurance at 80/20. Any other discussion on the motion?

MEMBER COCHRAN: Mr. Chair, I have a request for information on this. When we're talking about these incremental changes, so we're saying we want to go up to $1600 deductible from the current $1500 deductible, does that mean the next year we go up to a $1700 deductible or are we capping it at the $1600 deductible? And can we consider remaining at the $1500 deductible for the sake of developing the budget?

MR. HAYCOCK: For the record Damon Haycock, Dr. Cochran, the recommendation and I believe the motion is strictly for Plan Year 18. I don't think anyone is requesting a decision be made for Plan Year 19 at this time. And I believe the motion, and the board can correct me, is for that specific hundred-dollar increment. I would imagine that the vote would have to be taken -- I would turn over to Mr. Belcourt. And if the motion is pulled then the discussion on the $1500 deductible could occur just out of protocol.

MEMBER COCHRAN: Okay. Just to be clear because we are talking about plan benefit year '18. We've heard

conversation among board members that we want to work our way back to what we originally had in 2012. So when we talk about increasing this a hundred dollars incrementally, we're talking about getting back to the 2012 plan year by approximately 2022, you know. So, I mean, that's, you know -- And it may not even happen, right. Because things could change in the budget. So I think it needs to be clear that we're not necessarily saying we're getting rid of the -- we're going back to the way things were in 20 2012 and it could change. But I just, you know, so when I hear incremental changes, it implies to me that we are going to creep back up to that original amount in some -- And that the board is committed to do that. But maybe I'm misreading.

MR. HAYCOCK: For the record Damon Haycock. I may be misusing the term incremental or I may have misunderstood. So I will -- What I meant by incremental is that small chunks, you know, that we were going to evaluate it in little chunks and that people can decide which chunk they wanted to keep and which chunk they wanted to get rid of. At no time was PEBP's recommendation to develop a five-year policy.

And so my estimation, my assumption, if you'll let me, is that this time next year we would come back and talk about '19 plan benefit design based on hopefully some more information that we receive in January on the budget to

kind of outline where we think we're going. But just like every year, this board will choose the plan benefit design for the next plan year traditionally at the November board meeting. So I don't think this is a set in stone for anything but Plan Year 18. And, again, I will come back in January with updates to numbers regardless.

MEMBER WELLS: Mr. Chairman, it's Jim Wells. I kind of want to be a little bit clear here that the base plan is still the base plan. We are buying up -- buying down, whatever you want to call it, the deductible. Instead of buying up or down to $1500 next year, we're buying down to 1600. And instead of 3,000, we're buying down to 3200. And we are still maintaining the 80 percent co-insurance rate. And these are still relatively one chunk in my opinion and my vote for the affirmative satisfies this, that is my understanding.

CHAIRMAN CATES: Any other discussion on the motion? Go ahead.

MEMBER LAMBORN: So then I just want to be clear. Then so with the changes, the 1600 and the 3200, I'm computing a savings of 700 and -- approximately 750,000, is that?

MR. HAYCOCK: For the record Damon Haycock. Yes. I looked at it as a, you know, you go to the restaurant and you buy off your menu and this is how much you're paying and

you know you only have 25 million dollars in your pocket, right, for kind of a silly type of an example. It's not -- It's the inverse. This is everything -- I think Jim said it very eloquently. This is everything that's being bought up with excess money. This isn't everything that's being saved because technically the base plan is the base plan. So where do you find -- How much do you want to buy your purchasing powers for the excess reserves that we believe that we have today? So say we're going to save $75,000, if you'll let me, I would like to say we're spending three million dollars for this benefit that is above and beyond the base benefit that was designed in the plan in 2012.

MEMBER LAMBORN: So if I may. Again, Leah Lamborn for the record. Back to that whole target then, if we're trying to have 25 million dollars a year or 12 and a half million a year and we have to spend the reserves, then the difference of the base of going to $1600 or $3200 deductible, there is a difference of $750,000 that we would save on the base year expenditures. Are we trying to keep track here of where we are?

MR. HAYCOCK: For the record Damon Haycock. Yes, we're definitely keeping track. And I have an actual sheet that has all of the recommendations and the sticker price and what the total is? Again, I'm not expecting the board to accept all of PEBP's recommendations as stated in this. If

you did, it's 13.2 million dollars, which is a little bit more than half of what we believe is excess reserves.

But I didn't want to speak on behalf of the board and make that policy, which is why I wanted to know if you guys are looking at, if we want to take the reserves we have today and spend them over two years, then you have roughly 12 and a half or 13 million, depending on how aggressive you want to be, to buy each of these items.

MEMBER WELLS: Jim Wells for the record. When PEBP submitted its agency budget request with the flat and minus five percent, they were required to go back and put in the base plan to get down to those kind of numbers. So when we're talking about today what's in the base budget, we're really talking about the zero that's the 1900, the 3800 and 75/25 co-insurance. So that's what was submitted in the budget. We're using down excess reserves to pay 3.06 million to buy down to 1600, 3200, and keep the 80/20.

MR. HAYCOCK: Sorry.

CHAIRMAN CATES: Thank you. That's very helpful.

Go ahead.

MEMBER VERDUCCI: Tom Verducci for the record. You know, as I see this here, the recommendation would be to increase the deductible from 1500 to 1600. My question is the sentence that says final excess reserve calculations may adjust this recommendation up or down, up or down. Could you

expand on that?

MR. HAYCOCK: Yes. For the record Damon Haycock. Thank you. My initial intent was to read through this report start to back and then say at the final recommendation, which was let me come back in January with better numbers and then that may adjust this up or down. So if there's more money maybe our recommendation is we don't buy down the -- we don't change the deductible, that we can keep it at its current 1500 and 3,000 or maybe if there's less money that we will come back and say we actually want to do a $200 reduction. It was just trying to share all the different opportunities.

But I believe -- And Ms. Andrews can correct me. That was not her motion. Her motion was strictly to approve that PEBP recommendation at the rate that was stated and that the bringing-it-back type of scenario wasn't part of the discussion.

MEMBER VERDUCCI: Thank you.

CHAIRMAN CATES: Okay. Any other comments on the motion? Hearing none, those in favor of the motion say aye.

(Members Cates, Verducci, Andrews, Bailey, Zack, Lamborn, and Wells voted aye)

CHAIRMAN CATES: Those opposed?

MEMBER GARCIA: No.

MEMBER COCHRAN: No.

CHAIRMAN CATES: That's two no's. Okay. Motion

carries.

Okay. Next recommendation, PEBP maximum dental benefit. Recommendation of PEBP is to keep the enhanced benefit of $1500 as appropriate due to high utilization. Anybody have any discussion on this item or want to make a motion? Go ahead, Tom.

MEMBER VERDUCCI: You know, I don't see this being disadvantageous to the participants. I would like to make a motion that we accept PEBP's recommendation.

CHAIRMAN CATES: Okay. Do I have a second?

MEMBER GARCIA: Second.

CHAIRMAN CATES: Okay. So we have a motion and a second. Any discussion on the motion? Seeing none, those in favor of the motion say aye.

(The vote was unanimously in favor of the motion)

CHAIRMAN CATES: Those opposed? The motion carries unanimous.

Okay. Next item, PEBP life insurance. The recommendation is PEBP believes eliminating the enhanced benefit for both employees and retirees is appropriate with the standards option or buyout.

MR. HAYCOCK: So for the record Damon Haycock. Again, that's not eliminating life insurance. It's reducing it to the 2012 levels of $10,000 benefit for employees and $5,000 benefit for retirees. So it is not an elimination of

the entire benefit, just those enhanced benefits provided for the last, I believe, three years.

CHAIRMAN CATES: Any discussion or motion?

MEMBER COCHRAN: So just to be clear, we won't have any enhancement? I'm trying to calculate how much of our reserves we're spending based on what was presented. So that would be a zero balance if we did that, there's not going to be any additional cost on this?

MR. HAYCOCK: Correct, Dr. Cochran. That is correct.

CHAIRMAN CATES: So I have a question. So the budget that was submitted, did it include the enhanced benefit or?

MR. HAYCOCK: That's a good question. For the record Damon Haycock. I want to reiterate and try to make this hopefully very transparent. Not a single enhanced benefit was put in to the budget that was submitted to meet that five percent cut and not to blow the rate out of the water. We dropped the benefits, as was the original plan by the board three years ago to have these things sunset.

CHAIRMAN CATES: Okay. Thank you. Any other comments? Tom.

MEMBER VERDUCCI: I just have a question for Damon. If we had the benefit reduced to $10,000 but the retiree wanted to keep the same coverage and make a voluntary

contribution to maintain their life insurance benefits, would that be possible in this scenario?

MR. HAYCOCK: That is affirmative, Mr. Verducci. We have set up with the standards so they will be able to purchase back up to the amount that we are taking from them without any evidence of insurability.

MEMBER VERDUCCI: What type of communication would go out? I'm afraid if someone had a reduced life insurance benefit and we didn't take any action on making their own contribution, if it was just a reduction, and they weren't aware that that was happening, how would they be aware that they have the option of picking up the additional contributions?

MR. HAYCOCK: Damon Haycock for the record. Mr. Verducci, PEBP will send out communications. The standard has a requirement to send out communications on conversion rights and any other options that are available. We will double-team this process and any decisions made by this board that are different from what we have today, which obviously a couple have been made. Excuse me, one has been made so far. We plan to have a robust communication campaign between, starting tomorrow through rate setting all the way in to the next plan year, we will pepper the participants with this information.

CHAIRMAN CATES: Mr. Wells.

MEMBER WELLS: Mr. Chairman, Jim Wells for the record. I actually think that this is one of them that's easy to defer because of the way it's set up. It is a rate that you can plug in to the rates at a very late date and come up with a decision. This one and the HSA/HRA contributions are the easiest to do later. So if that helps, we don't necessarily need to make -- I don't think we need to make this decision today.

CHAIRMAN CATES: Very good. Any other comments?

MEMBER BAILEY: I do.

CHAIRMAN CATES: Go ahead.

MEMBER BAILEY: For the record Don Bailey. I concur with Mr. Wells on that. I think we should pull it.

CHAIRMAN CATES: Okay. Any other comments? I'm not seeing anybody want to make a motion, so I think we're deferring this.

Okay. Very good. We'll move on. CDHP annual vision exam. The PEBP recommendation is to implement a $25 co-pay for annual vision exams is appropriate to reduce local plan cost for the enhanced benefit to a projected $938,000. Any discussion?

MEMBER BAILEY: I have a question. For the record Don Bailey. Damon, what's the impact on the employees?

MR. HAYCOCK: For the record Damon Haycock. The

employees then would go and have their annual vision exam and be required to pay $25 at the desk. It's just a straight co-pay that they would have to pay. And that would offset the cost of the claim going back to our third party administrator. And the plan would pay the difference up to the maximum allowable.

MEMBER BAILEY: Okay. And at this time they're paying nothing?

MR. HAYCOCK: Correct.

MEMBER BAILEY: Thank you.

MEMBER COCHRAN: Mr. Chair, Chris Cochran for the record. Just a question. Prior to the enhanced benefit was it a free exam every two years?

MR. HAYCOCK: For the record Damon Haycock. It was every year. Oh, you're talking about the enhancement?

MEMBER COCHRAN: Yeah, the enhancement.

MR. HAYCOCK: I'm sorry.

MEMBER COCHRAN: Weren't you allowed to get -- or did we always pay for an exam but you could only get one every two years? I was under the impression that you had to wait two years.

MEMBER WELLS: This is Jim Wells for the record. Prior to 2011 you could get one exam a year and one set of glasses every other year subject to the, I think there was a hundred dollar maximum back then. When the plan went in to

effect in 2012, there was no exam, period. It was part of your deductible and co-insurance. This was an enhanced benefit to put it in without a co-payment.

MEMBER COCHRAN: Okay. So I was confusing the hardware with the exam. Okay. All right. No other questions.

CHAIRMAN CATES: Any other questions or comments on this item? Go ahead, Tom.

MEMBER VERDUCCI: Tom Verducci for the record. I do not see $25 being real significant. However, it would be nice to be able to explain to a participant, yes, you can go in and have your $25 vision exam and then as a result you would have a pair of glasses if you're told you need to have glasses. And I just think it would be more well-received from the retiree group. I don't see $25 being a huge amount that's going to make or break anybody. But I would like to see a positive outcome tied to it, go have your vision and then go get your glasses.

MEMBER GARCIA: Rosalie Garcia. I could be wrong, but I almost am sure many years ago we would go in, pay the $25 deductible, get the vision, and then every two years get hardware if needed.

MEMBER COCHRAN: Up to a certain amount. Because my hardware plan never covered my glasses.

MEMBER GARCIA: Right. With the hundred dollars.

Up to the hundred dollars. I think that plan really works very well overall in satisfying people with children in getting the necessary annual exam and also knowing that they could also see after they get the exam, if needed.

CHAIRMAN CATES: Patrick Cates for the record. I guess the only difficulty with that, if I'm reading this right, is you save approximately $300,000 by having the $25 co-pay, but to provide hardware, it's a million bucks in additional cost. So you're kind of going the wrong way.

MR. HAYCOCK: So for the record Damon Haycock. It depends if -- depends how probable you see a hundred percent utilization, right. There are folks that may have gone last year and received glasses that don't want them this year. What it does -- And, again, I'm going to change the terminology because of how it's being calculated, you're not really saving 300. You're only spending 937 in enhanced benefits. So you're chewing away at that 25 million dollar figure by spending $940,000 on this enhanced benefit and tying a $25 co-pay so you can avoid 300 more thousand dollars paying for it. I know it's vernacular. But if -- And once you get to the vision hardware, I think that discussion may have a vote and it will go that direction. But hopefully that answers your question.

CHAIRMAN CATES: Thank you. Any other comments? Any motions on this item?

MEMBER WELLS: Mr. Chairman, one comment and then a motion. The HMO plans already have a co-payment for their vision exams. I think in being consistent, and I think vision exams are important, especially for those who need them. So I would make a motion that we would enhance the benefits by adding the vision exam annually with a $25 co-pay.

CHAIRMAN CATES: Thank you. Do we have a second?

MEMBER ZACK: Christine Zack for the record. I second the motion.

CHAIRMAN CATES: Very good. We have a motion and a second. Discussion?

MEMBER GARCIA: Yes. With the HMO plan for vision care, do they -- do they have a hardware benefit?

MR. HAYCOCK: For the record Damon Haycock. There are two separate benefits depending on which HMO you're in. There is an HMO hardware benefit similar to what we were offering or discussing today at a dollar amount. And then there's a percentage co-insurance amount for the northern Nevada HMO.

MEMBER GARCIA: Okay. So for the south Nevada HMO what is that benefit? So for vision services what would an employee or a member get?

MR. HAYCOCK: Let me verify with staff. But I think it's right around a hundred dollars or 125. I have to

look at the summary plan document and do it real quick.

MS. SPINELLI: This is Nancy Spinelli. I believe it's a hundred dollar flat co-payment in lieu of contact lenses or hardware.

MEMBER GARCIA: But it is a $25 deductible, as Mr. Wells says?

MS. SPINELLI: Co-payment. And then for vision exam I believe is a $10 co-payment for southern Nevada.

MEMBER GARCIA: Okay. So it's not apples to apples?

MR. HAYCOCK: Correct.

MEMBER GARCIA: It's definitely one and then the other. But if we are comparing the two programs, the HMO could walk in and get a vision exam with a $10 co-payment and a $25 co-payment for hardware up to a hundred dollars or just the hundred dollars?

MS. SPINELLI: Again, Nancy Spinelli. They could purchase a pair of glasses for a hundred dollar flat co-payment. That's what the plans say, up to that amount.

MEMBER GARCIA: Okay. And what is currently on the recommendation is that we're not even discussing the hardware program part right now. It's just flat the $25 co-pay for the exam. And I think that it may be best if we put the two together because it's both vision exam. I don't understand why we are not considering both under vision

services.

MEMBER COCHRAN: Chris Cochran for the record. I get your point and I wouldn't disagree with you except I think that the proposal is to eliminate the hardware plan. So I would prefer that we take that up separately. If we're on board with the $25 co-pay, I would much rather us take that action now and let's look at the hardware issue as a separate issue. Okay.

CHAIRMAN CATES: Any other comments?

MEMBER BAILEY: Mr. Chair, for the record Don Bailey. These numbers we're throwing around and we're approving some of them, are they going to be addressed later on, Damon?

MR. HAYCOCK: For the record Damon Haycock. What my plan to do, if it pleases the board, is to come back in January even after these decisions are made and share where we're at on excess reserves. It's my understanding, and I haven't gone through this many times with you guys yet, but that when you approve rates in March is really when you approve the finality of everything. There's a plan benefit design so that we can develop the rates and we apply the trend. But if the legislature comes back and says we want to give you half the money we're giving you, it's a bad example. It's not like you're going to be stuck with your health plan design today. I can't imagine that we'd say, oh, well, we'll

just hopefully live and die on our reserves.

So I think there's always an opportunity to pivot. But in January I will definitely come back and bring excess reserve calculations. And if it pleases the board, I will bring back suggestions to adjust some of the previous decisions for an open discussion.

MEMBER BAILEY: Well, I think the board is going to need that, because the legislators, they're not going to be favoring that budget anyway. We know that. So I think what we got to do is be realistic here and bring some of this back. Because, okay, so in between time now we're talking November. So in the meantime you're ready to take on all the questions you're going to get from the members.

MR. HAYCOCK: For the record Damon Haycock. Not to be difficult, but I don't have a choice. Whatever is said and done today I will be taking calls. And we will be working with our membership and we will transparently share what has occurred today. We will draft up a newsletter and send it out and try to explain to the best of our ability what decisions were made and why to soften any blows that people may feel that they are receiving and to accurately and appropriately and transparently share what we do at PEBP. That will no doubt have phone calls ringing.

MEMBER BAILEY: Okay. At the end of this meeting or not the end of this meeting but we're having public

comment; correct?

CHAIRMAN CATES: Correct.

MEMBER BAILEY: Okay. Thank you.

CHAIRMAN CATES: Any other discussion on the motion? Seeing none, I'll call for a vote. All of those in favor of the motion say aye.

(All members except for Member Garcia and Member Verducci voted aye)

CHAIRMAN CATES: Opposed?

MEMBER GARCIA: No.

MEMBER VERDUCCI: No.

CHAIRMAN CATES: Okay. Motion carries.

Okay. So at this point in time our reporting secretary needs a break. We've been here since 9:00 o'clock. It's now 1:00 o'clock. I'm relentless. I'm willing to take a short break and just slog through this, but we've only got through about one-third of these recommendations, and we may need some more time. Does the board want to take a full lunch break and then come back or do we want to take a short break and get back to business? Short break. Okay. Let's take a -- 15 minutes. Let's come back at 1:15.

(Recess was taken)

CHAIRMAN CATES: Okay. Calling the meeting back to order. So we are now on 9.6, CDHP HSA/HRA funding. And PEBP's recommendation --

MEMBER WELLS: Mr. Chairman, this is another one that I would recommend we defer until later. This is the easiest of the ones.

CHAIRMAN CATES: What's the pleasure of the committee? Do we want to have any discussion on this?

MEMBER ZACK: Christine Zack for the record. I agree with Mr. Wells, let's defer it.

CHAIRMAN CATES: If nobody objects we'll skip over this one and move on.

Okay. 9.7, CDHP vision hardware benefit. PEBP's recommendation, PEBP believes the hardware benefit of a hundred dollars is cost prohibitive at this time. Do we want to have any discussion on this item?

MEMBER VERDUCCI: Tom Verducci for the record. Is it possible to defer this one until we see if it's in the governor's budget in January? Bad question?

CHAIRMAN CATES: We could defer all of them on that basis. I don't know how far that would get us. You know, I'm wondering -- Ms. Garcia is not here. Maybe we should skip this one because that was important to her. We could just skip it and move on until she gets back.

Okay. So let's move on to HRA annual rollover caps.

MR. HAYCOCK: For the record Damon Haycock. I just wanted to make a clarification. It was made at the

September 22nd board meeting and I didn't carry it forward in this report, but the anticipation isn't that we necessarily do this on July 1 of 2017. Because we want to provide the opportunity for -- at least the recommendation was contingent upon the opportunity that participants are aware of it and it doesn't sneak up and bite them on July 1 and that we would assess that at the end of the plan year.

Here's where the funding gets a little difficult to follow. There's been discussion that what happens if everyone who has over $5,000 just goes and tries to use their benefit. What that does is it reduces the total amount of liability and then we take 85 percent of that if we follow my reserve analysis and then our reserve can be reduced accordingly. So whether they spend the money or don't spend the money, the money is returning to the plan either in a lowered reserve liability or an actual balance being reduced. And so I don't know if that helps the discussion, but I wanted to make those two clarifications.

CHAIRMAN CATES: Okay. Thank you, Damon. So PEBP recommendation is to cap the annual HRA rollover amount at $5,000. Discussion? Go ahead.

MEMBER ZACK: No. I'm ready for a motion.

CHAIRMAN CATES: Oh, okay. How about a motion then.

MEMBER ZACK: Thank you. Christine Zack for the

record. I move to -- Let me make sure I get the wording correct -- to cap the amount at the $5,000 as recommended by PEBP.

CHAIRMAN CATES: Do I have a second?

MEMBER BAILEY: I second the motion.

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

MEMBER GARCIA: Yes, Mr. Chair. Rosalie Garcia. I had a couple of questions. My first is how would this affect current members' HRA contributions or would it?

MR. HAYCOCK: For the record Damon Haycock. It doesn't change current contributions. The current contributions have been deferred, right, to the next meeting. But as it stands today, if you had the $5,000 cap today, we would still provide contributions until the cap -- I see what you're saying. How does that affect that. So yes, we would keep a maximum amount in there at $5,000. And once it crested the $5,000 it would cap it. And the next year if none of those funds were used then there would be no additional balance to put in to them, that it would just streamline and be capped at $5,000. So it does affect it. Thank you.

MEMBER GARCIA: I just want to not hold harmless. But I want to make sure that members who might currently have a balance of $6,000 would be -- would they be able to always

keep that balance or would it go away?

MR. HAYCOCK: Operationally, Ms. Garcia -- Damon Haycock for the record. Operationally, PEBP foresees that if this plan benefit design change is approved, on July 1, whatever is in their HRA account on July 1 of next year they would have. And at the very end of the year, the last day of the year, we would take a snapshot and see who had more than $5,000 and we would reduce their available balance to $5,000. So it's not something we would implement the first day but give everybody a chance to understand what's happening with their HRA to appropriately communicate it and to apply the rollover cap at the end of the plan year, not at the beginning.

MEMBER GARCIA: Okay. Forgive me for not knowing this. But had there ever been a time when our members had been told put a lot of money in your HRA, you can keep it forever?

MR. HAYCOCK: For the record Damon Haycock. I can say for the last 15 months that hasn't occurred. I don't know about my time before. And I'll defer to Mr. Wells. Oh, Tena, go ahead.

MS. GLOVER: This is Celestena Glover for the record. So, if I understand your question, you're asking about the money that the participants are putting in to their HRA accounts. Participants cannot contribute to the HRA.

The money that's in there is the money that the plan puts in for them. Participants can contribute to their health savings account. Two different accounts. Does that help?

MEMBER GARCIA: Okay. All right. That does. Thank you. So we are only speaking about the HRA, capping the HRA?

CHAIRMAN CATES: Right.

MEMBER GARCIA: Okay. Thank you very much.

CHAIRMAN CATES: Any other discussion on the motion?

MEMBER VERDUCCI: Tom Verducci for the record. Is it customary to cap HRA contributions? Is it being done elsewhere in the country in terms of other programs?

MR. HAYCOCK: For the record Damon Haycock. Good question, Mr. Verducci. When we asked our partners how they deal with their other books of business, many of their other clients don't even have HRAs. And the ones that do often cap them. Because they are a liability that must be carried forward every year and paid for. And so I don't know if we're behind the curve in this process or we're on the curve in this process. But this isn't a new idea for PEBP. Excuse me. It's not a new idea for the nation. It's a new idea for PEBP.

MEMBER WELLS: This is Jim Wells for the record. It's actually not a new idea. There was always a discussion

of having an HRA cap when the plan was put in place and there were annual votes for the first couple years. But because we really hadn't put enough money in, we never had gotten to the point where the cap, a realistic cap anyway, had been met from the contribution. And since employees and retirees can't contribute to their own, it's only state contributions that are getting in there. Now that we are far enough along, the conversation is back to having a cap. But we have had this conversation before.

CHAIRMAN CATES: Any other comments on the motion?

MEMBER COCHRAN: Just to be clear -- This is Chris Cochran for the record -- the cap is $5,000 and we are saying that it can't be capped at a higher amount than the $5,000? I think that's what Tom was asking.

MEMBER VERDUCCI: Tom Verducci for the record. I believe the question that I heard there is can it be a higher amount than 5,000? Could it be 6,000? And this is a comment, this 750 balance that these are affected here, and I would be curious, are there balances out there that be ten, 12,000? I mean, what's going to be the actual impact on one person? Are we looking at any balances that are substantially higher than $5,000 or just giving a nominal amount?

MR. HAYCOCK: For the record, Damon Haycock. I

want to be very careful in how I answer this question, Mr. Verducci, because I don't want to misstate. What you see in front of you is the average account balance, not the maximum account balance. And so if all of them had that exact same account balance, it would be a $876 loss. And that, depending on who you talk to, is never nominal, right. But we have balances that are significantly higher and we have balances that are closer to the $5,000 and the penny. And so it will affect some individuals in that 750 number of accounts, some individuals dramatically and some individuals very little at all. And we can come back with a line by line, 750 line item number and say this is how many people lose it per dollar. But, again, it's -- we took an average to not take up 50 pages of a report, but we can definitely do that if you guys would like. But we recommend 5,000 just because it does cover -- it covers deductibles at any discussion we've had today. And that's really what we believe would be the most important that people had first dollar coverage for health care if they were on the HRA.

MEMBER VERDUCCI: Thank you very much.

CHAIRMAN CATES: Any other comments on the motion? I'll just add my comment. To me this seems like a no-brainer. I don't want to see people lose money in their account. But it's a benefit they're not using. So it seems like there would be minimal harm done, so I'm in favor of the

motion.

Any other comments?

MEMBER VERDUCCI: I would tend to agree with the chair and I do support this motion.

CHAIRMAN CATES: Well, let's call for a vote then. All in favor of the motion say aye.

(The vote was unanimously in favor of the motion)

CHAIRMAN CATES: Opposed? The motion carries unanimous.

Okay. Let's step back to 9.7, vision hardware benefit. CDHP vision hardware benefit. So the item for consideration was a hundred dollar vision hardware benefit. PEBP's recommendation is that it believes a hardware benefit of $100 is cost-prohibitive at this time. So any discussions on the recommendation? Any motions on the recommendation?

MEMBER BAILEY: This is for Damon. How did you come about with these figures?

MR. HAYCOCK: For the record Damon Haycock. These figures, I was provided participant count for vision claims from our third party administrator HealthSCOPE Benefits for the years 2015 and 2016 as well as the plan cost. So I was provided a download of those. I took those and I took the percent increase from one year to the next and I applied probably very simple math and just trended it forward and said if we're going up by X amount per year and

our population continues to grow, is it safe to say that it's probable that more folks will then need to see the eye doctor and then how many percentage of those folks would potentially need glasses. And that's why I gave three different analysis. A third of those folks, two-thirds of those folks, or every person that walks in to an eye doctor walks out with a pair of glasses. So there's some options here.

Personally, I don't believe you'll get a hundred percent utilization. I don't think this is a 1.15 million dollar benefit. I think you're either at the one-third to two-third. I honestly think you're closer to the one-third only because you can't go without glasses. Nobody is going to walk around without being able to see. So I can't imagine there's going to be a massive pent-up demand for glasses. Although, maybe you'll have folks say, wow, the plan is getting cut, let's all go get our glasses before they cut it again. So I don't know. It's a gamble. But those are the numbers and that's how I came up with that.

MEMBER BAILEY: Okay. Thank you.

CHAIRMAN CATES: Any other comments or questions?

MEMBER COCHRAN: Mr. Chair, this is Chris Cochran. So just for clarification, we won't be paying any hardware benefits?

CHAIRMAN CATES: That's correct.

MR. HAYCOCK: For the record Damon Haycock. You

guys can pass a motion to approve the no hardware benefit, you can pass a motion that says we like the hardware benefit and we want to fund it at a hundred dollars. It's truly up to the board's discretion.

MEMBER COCHRAN: So but currently because we call it an enhancement, right, so, you know, prior to the enhancement we didn't pay a hardware benefit.

MR. HAYCOCK: So for the record Damon Haycock. As part of the enhancement there is no hardware benefit today. All the enhanced benefits that were provided they do not include a hardware benefit.

MEMBER COCHRAN: Okay.

MEMBER VERDUCCI: Tom Verducci for the record. One of the reasons I do support the hardware is we are cutting benefits. I would really like to be able to say that we did something that did enhance the benefits. I understand there's budgetary constraints. And I just want to be on record saying that.

MEMBER WELLS: Mr. Chairman, Jim Wells for the record. And I'm going to kind of go the other direction. I think at a time when we are having to make reductions, adding a benefit like this, one, is not something that I would support. I would support the recommendation that has been made by staff.

CHAIRMAN CATES: Any other comments?

UNIDENTIFIED SPEAKER: What did he say?

CHAIRMAN CATES: That he supports the recommendation of staff not to approve the hundred dollar benefit for hardware. Patrick Cates for the record. I would tend to agree with Director Wells. It would be wonderful to provide a hardware benefit. But at the time that we are looking at reducing the other enhanced benefits, it doesn't seem like the appropriate time to add something in.

MEMBER GARCIA: Rosalie Garcia. I just want to go on record as saying I believe that a hardware benefit would be really good for our members. But given today's discussions, I understand the constraints. I wish that we could continue on. But I just want to let you guys know that I do support the hardware benefit.

CHAIRMAN CATES: Thank you.

MEMBER ZACK: Christine Zack for the record. Sort of similar to what Rosalie just said. If this was an existing benefit, an existing enhanced benefit, I would not vote to take it away. But because it's not already there, I can't in good conscience based on the current budgetary constraints vote to further enhance benefits. So I would agree with PEBP's recommendation.

CHAIRMAN CATES: Thank you. Any more comments or a motion?

MEMBER COCHRAN: Mr. Chair, I'll make a motion

that we follow staff's recommendation and not enhance the benefits for hardware.

CHAIRMAN CATES: Okay. Second?

MEMBER LAMBORN: Leah Lamborn. I second that.

CHAIRMAN CATES: Any discussion on the motion? Seeing none, I'll call for a vote. All in favor of the motion say aye.

(All members except Member Verducci voted aye)

CHAIRMAN CATES: Any opposed?

MEMBER VERDUCCI: Opposed.

CHAIRMAN CATES: One opposed. Motion carries.

Okay. So we are now down to 9.9. 9.9, Medicare Exchange retirees pay life insurance and HRA administration fees. So PEBP's recommendation, PEBP believes every participant should pay their share for the program PEBP offers and therefore retirees on the exchange should pay for life insurance, premiums, and their specific HRA admin fees. Any discussion? Or a motion?

MEMBER COCHRAN: Mr. Chair, this is Chris Cochran. I do have a question to ask. We're taking this as the life insurance benefit and HRA fees together; correct? Just for the record, on the life insurance benefit, are we currently paying the $5,000 life insurance benefit for our members?

MR. HAYCOCK: For the record Damon Haycock. We

are currently paying a $25,000 benefit for our members that are employees and a $12,500 benefit for our retirees. We have a base plan amount that we build in at the 10,000 and 5,000 amount respectively and we have been utilizing excess reserves to offset the additional premiums for those additional enhanced life insurance benefits.

If you're asking -- I don't know if you are, Dr. Cochran. I thought about making this clarification. If you guys decide to -- If you guys, I apologize. If the board decides to approve a continued enhanced life insurance benefit, that is coming out of excess reserves. That isn't going to be an additional charge for premium cost to the retirees. They pay their base amount. So I don't foresee that $2.83 per month increasing. But if it appears that it will increase, which I don't foresee it, we will bring it back to the board for final approval.

MEMBER ZACK: Christine Zack for the record. Damon, a question. Here for this section you have analyzed the total plan savings per year for both the life insurance cost and the HRA administration fee. But what I'm not seeing is what the plan cost is or what the return to reserves is. I'm not sure if I'm not analyzing this correctly.

MR. HAYCOCK: So for the record Damon Haycock. Unfortunately, and I will endeavor to do better next time, there's pluses and minuses in this report and a lot of these

are what are we going to buy. That's the plus, or the minus, depending on how you want to look at it. But what this does is it will return $797,000 to the plan to go back in to the bucket for excess reserves to offset the cost for these other plan benefit design decisions. And once you all decide exactly what you want, we can quickly give you a running total.

MEMBER ZACK: Understood. And I'm keeping a running tally. I just wanted to make sure I understood so that we could analyze it in the same way that we did in capping the HRA account balances at 5,000, because it's a return to the reserves.

MR. HAYCOCK: Correct.

MEMBER ZACK: Okay. Thank you.

CHAIRMAN CATES: Any other comments? Anybody want to make a motion? Crickets.

MEMBER LAMBORN: Leah Lamborn for the record. I make a motion to take PEBP's staff recommendation to pay for their program needs -- I'm sorry. For them to pay for the Medicare Exchange -- Let me start over. One more time. So I make a motion to accept PEBP's recommendation for Medicare Exchange retirees to pay for their life insurance and to also pay the HRA admins.

CHAIRMAN CATES: Thank you. Do I have a second?

MEMBER ANDREWS: Ana Andrews. Second.

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

(The vote was unanimously in favor of the motion)

CHAIRMAN CATES: Opposed? Motion carries unanimously.

Okay. So the next item is 9.10 on the agenda. Next item is CDHP limits and new network for hearing aids.

MR. HAYCOCK: Can I clarify?

CHAIRMAN CATES: Sure, Damon, go ahead.

MR. HAYCOCK: For the record Damon Haycock. Thank you, Mr. Chairman. I want to offer up kind of a tweak to our recommendation. After listening to the testimony here today from both board members and others, I want to -- I think what we can do to get the intent of what we're trying to accomplish here is to do -- to develop language in our master plan document to put some limits on the ability for these folks to receive higher -- not higher cost, but way too expensive hearing aids that shouldn't be that costly without necessarily having to implement a network or to put a cap. We can come back when we approve the master plan document for next year and propose that language there. The $36,000 is a rough estimate. It's not enough to make a major decision.

But what we really wanted to do is to slowly shift the environment that providers that support the state's

health plan do not get to mark up exorbitantly the costs to our participants. And we want to ensure that we send the message that that will no longer be tolerated. And that's what the intent is of this plan benefit design.

But I think we can get it down the road with a master plan document update, which we will bring back at the same time that we do every year. The costs are, again, we have no idea because we don't know how many people are going to need hearing aids. And as you see there, out of the 62 that had it in Plan Year 15 and the 73 that got them in '16, only 29 of those folks actually had costs over $1500. So it's not necessarily a major cost saving action as it is a paradigm shift for our provider network.

CHAIRMAN CATES: Any comments?

MEMBER WELLS: Mr. Chairman, this is Jim Wells. I would concur with Mr. Haycock on these particular benefits.

CHAIRMAN CATES: Any other comments?

MEMBER BAILEY: Jim, would you repeat that.

MEMBER WELLS: This is Jim Wells again. I would agree with not going forward with the recommendation that's in the packet today and looking at putting the stipulations or restrictions in the plan document instead.

MEMBER BAILEY: I agree with that. I need a hearing aid, obviously.

CHAIRMAN CATES: Any other comments on this item?

If everybody just wants to move on, I don't think we need a motion. Everybody agreeable to that? We'll just move on.

Okay. Next item we are now on 9.11, Medicare Exchange participation to receive HRA. PEBP's recommendation, PEBP sees no drawback to allowing Medicare retirees the ability to continue to receive their HRA monthly allotments whether they participate in the exchange or not. The trade-off, however, is if a retiree leaves the exchange, Towers Watson will no longer be able to allocate on their behalf with carriers nor administer auto reimbursement for planned premiums if they will no longer know if the retiree is on a specific plan.

MEMBER WELLS: Mr. Chairman, this is Jim Wells. This is one I'm not going to support. I think that there was some comments this morning when we went through the audit about getting some information on the reasons for the overpayments. And that seemed to be the primary driver behind this. And, frankly, I think that there are -- until we know what's the cause of those overpayments, I don't know that we necessarily can say this is going to automatically fix them. And I think that it could be just trading one set of complaints for another. I would prefer to defer this to a later date when we can get the information on why those overpayments are occurring and some recommendation from either Towers Watson or staff on what we can do to mitigate

them.

CHAIRMAN CATES: Any other comments?

MEMBER ANDREWS: I have a question. Ana Andrews. I just have a question. What was the reasoning or the logic behind making state retirees go in to this program? What was the reasoning way back when? Is that too far back?

MEMBER WELLS: This is Jim Wells for the record. A couple part -- A couple things. One, it allowed us to have an advocate on their behalf. And so right now they can call Towers Watson and Towers Watson will help them walk through the process. This is a very competitive marketplace and there are a lot of unscrupulous people out there who will take advantage of retirees. So one of the ideas was that we would put them to people who were agnostic as to the plans that they were selecting. And, keep in mind, we were also trying to transition 10,000 plus people at one time. So it was a way for us to do all of this at once to create a plan that was objective as far as the selection that the retirees make so that these people at Extend Health were there -- At the time it was Extend Health -- were there to basically listen to what the participants' issues were, medical issues, what kind of pharmaceuticals they were on, where they lived. I can't remember. There was three or four different criteria that they would kind of walk through to help them pick the plan that worked best for them. That was the idea behind it.

And then in the meantime, the other side of that is that the auto reimbursement was a huge -- And there's 85 percent-ish of the people whose claims that are processed through auto reimbursement. Leaving Towers Watson will cause you to not be able to have auto reimbursement. And then you get in to -- And they mentioned it this morning. When you're doing manual claims that's the hardest thing to fix. I just believe that we're trading one set of complaints for another.

MR. HAYCOCK: For the record Damon Haycock. I don't disagree with Mr. Wells' statements. I think that's a definite issue that will have to be dealt with if this goes through. There's a piece of the process that I think people aren't necessarily factoring in. And I don't know if I didn't eloquently state it well enough. There are folks that don't want to be on Towers Watson plans because there's a plan they do want that isn't offered by Towers Watson. And I don't know if forcing folks to be on an exchange and on those plans and saying we're promoting choice is so much more important than allowing those folks to make that rational decision. Do I give up my auto reimbursement to get on a plan that meets my health care needs? And if I can make that decision and I'm aware of that decision -- And that's a discussion we can go back and forth on how aware those folks are -- it allows these folks to pick the health care that they want. And since we provide basically a defined

contribution, we provide an HRA allotment based on years of service, who are we to say where you have to go when they should be able to choose where they want to go.

And as far as advocates are concerned, I believe that if an individual were to sit down with a Nevada-based broker and say I would like to look at my options and that broker was honest through their licensure and says here are your options and they choose that option that in today's marketplace when folks have issues they go back to their broker and they ask that broker to be their advocate. Am I saying all of those brokers are good at this? No. But what I will say is that the opportunity does exist.

But, again, I don't disagree with you, Mr. Wells. I do think that we'll get phone calls from folks saying I didn't know about the auto reimbursement. So I just wanted to offer a couple different objective standpoints on this issue.

CHAIRMAN CATES: Thank you.

Any other comments?

MEMBER BAILEY: For the record Don Bailey. So are we going to strike this and pull it off the agenda? Is that what I'm hearing?

MEMBER GARCIA: Mr. Chair.

CHAIRMAN CATES: Well, we're having a discussion right now. Nobody has made a motion. So if we don't do a

motion, we just move on.

MEMBER GARCIA: Mr. Chair, Rosalie Garcia. I also -- I like -- I would want our retirees to be able to have their options and participate in the HRA. I believe at this time we don't really fully understand or have the necessary mechanisms in place for PEBP to be prudent with the process. Am I wrong?

MR. HAYCOCK: For the record Damon Haycock. It depends on what that process is. I know that's not a direct answer to a very direct question. Can we manage this process if a retiree contacts us and says, I lost my auto reimbursement, what do I need. You know, where are you at, are you on the exchange. Yes, I am. Then we work through it with our HRA folks at Towers Watson and we figure out what happened. If they're not on the exchange, we tell them, well, you're not on the exchange and we look to help them in any other process that we can. But we really lose even more of a mechanism in to the process, right. If you enroll in your own individual medicare gap or supplement plan or advantage plan, then only they can help you at that point. We don't have a window. But let's not forget that we don't have a window in to Towers Watson system either. So we have to rely upon their ability to solve problems and we advocate on their behalf.

But we -- I hope that answers your question,

Rosalie. Could we handle the issues? I think, as Mr. Wells said, we would have less issues with people wanting to leave Towers Watson and go on to another plan. Obviously they would be able to do that. But we would have those folks that, as he said earlier, didn't read the notices, didn't come to the meetings, didn't read the newsletter, didn't read all of, my term, of peppering of communication and this snuck up on them. And so, yes, there's always that opportunity.

But what I want to -- I want to return an idea back to the board that I think one of the vision statements -- And I can't quote it right now. I can look back in my report because I attached it -- is personal responsibility. We want to promote personal responsibility for your health care. And if we micromanage or control everybody's health care does that meet that vision? Does that also meet the vision that says access to high quality health care that we want people to take control of their environment. And, really, it's a policy decision that you all will make and PEBP will support either way and implement accordingly.

We think there's an opportunity, but there's no cost saving. This isn't a cost-saving measure for PEBP. This is an opportunity to change policy and allow the retiree to keep their HRA funding as long as they enroll in an approved health care plan and not just an exchange plan.

CHAIRMAN CATES: Any other comments?

MEMBER GARCIA: Rosalie Garcia. I move to adopt PEBP's recommendation with regard to allowing Medicare retirees the ability to continue to receive their HRA monthly allotments whether they participate in the exchange or not.

CHAIRMAN CATES: Is there a second?

MEMBER COCHRAN: I'll second. Chris Cochran.

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

MEMBER WELLS: Yeah. Mr. Chairman, Jim Wells. I will be voting no on this. I think this is a mistake. I think this is going to create a whole 'nother set of problems that we are not anticipating that I think it would very clear this morning that there's not a clear -- not a list of known reasons why people's overpayments are being collected and that's the primary reason behind this recommendation was to try to minimize the overpayments in the HRA funding issues that our participants have. I don't think this is going to fix them. I think this is going to exacerbate them. And I'll be voting -- I'll be voting no on this.

We can talk about choice. And that is probably the one thing where I would concur, this will give more choice. However, if we want to have choice, why don't we just give people their money and let them pick whatever plan they want to be on. We don't do that. We provide plans for

our participants that they enroll. So if you want to have choice for everyone, then let's have choice for everyone. But to just say this is the only reason that we're doing it is choice is not something I agree with and I'll be voting no.

MEMBER VERDUCCI: I also agree. Tom Verducci for the record. I agree with Mr. Wells. And I don't see any cost savings that's involved. And I think we don't fully understand what the implications that it could have to retirees and it could subject them to salesmanship and giving up benefits. And I also will be voting no on this item.

MEMBER GARCIA: I would believe in the ability for PEBP staff and leadership to be able to follow this process and take care of any necessary or leading issues that their recommendation may have -- can identify.

So my assumption in PEBP's recommendation is that we're allowing this process to occur based and knowing that the leadership will follow through on any kind of necessary closing of doughnut holes to be able to ensure that PEBP and the members remain whole, that it does not turn in to a problem.

CHAIRMAN CATES: Any other comments on the motion?

MEMBER ANDREWS: Ana Andrews for the record. I believe Mr. Wells made a statement earlier that has me

thinking. Initially I was going to support this motion, but I think I'm also going to vote no. And the reason is he mentioned that we probably should defer this until the overpayment issue with Towers Watson is resolved. My recollection is that we've been having complaints and issues with Towers Watson for quite a few months or years. And the amount of overpayments is of concern to me. While I understand that after two years your chances of recovering the money is not that good, at this point I don't think I can support this motion.

MEMBER COCHRAN: May I ask a question? And I'll ask this of Mr. Wells since he has experience with this and in your opposition to this. The concern that we're going to exacerbate other payments to other providers out there who are unable to collect that from them, do you anticipate the same problems with the other -- with the other participants in this?

MEMBER WELLS: This is Jim Wells for the record. Without seeing the detail behind what's creating the overpayments, yes, I would tend to agree that overpayments are going to continue irregardless of whether they are allowed to leave the exchange or required to stay within it.

The other part of this for me is that if you have a group -- And who knows how many thousands of people or hundreds of people or tens of people will go out there and

pick their own broker. Today if we have a problem with a retiree issue, staff can call Towers Watson and work through those issues. They're not going to be able to call every broker down the street. That's going to be out of their realm of control. These people will literally be out there on their own. And the only thing they'll be entitled to is the HRA reimbursements, which depending if what the audits say and what Mr. Seegrist followed up with is correct, I just don't see the overpayment problems getting better. I just don't.

MEMBER LAMBORN: I would just like to add too that the $700,000 overpayment amount is for six and a half years. If you look at the amount per year, it's reducing significantly. So it appears that progress is being made in the way of reducing those overpayment amounts and may be switching at this time and may have the reverse impact.

MEMBER ANDREWS: Ana Andrews for the record. I just have a question. So let's say that we vote yes and we say you have your choice. And one of those retirees goes off and gets a plan that did not work out for them and they lose their money, whatever the case may be, they're going to contact PEBP. How is PEBP going to handle it? Are we going to tell you, oh, well, you made your choice and now it's your problem and not ours?

MR. HAYCOCK: For the record Damon Haycock. That

occurs today. We get phone calls from people. We get letters. We get requests. We have issues where folks inadvertently or purposefully move off the exchange. And we have statutes and regulations that we must abide by, one of them being that if we reinstate coverage we have to reinstate coverage during that open enrollment period and we can reinstate all program coverage with the exception of life insurance. So we have folks right now that are very frustrated that they have left the exchange for whatever reason, they knew it or they didn't, and then they have lost access to their HRA funding. And then when we finally can reinstate them back, they lose access to that critical retiree life insurance. That's a statute. That's not a PEBP regulation. That's a statute.

And so I'm not -- Honestly I'm okay if you want to wait to see what overpayments look like. It's not going to make or break the discussion today because it's not a cost-saving measure. This was designed as a plan policy choice. And, yes, we wanted to show that there are significant overpayments. But let's not also forget what you didn't see in the audit. And what you didn't see and hear today is that there are folks that have been inadvertently dropped from Towers Watson because an agent of record number got changed. And so it's not just death benefit notifications or we have carriers not notifying. There is

mess-ups across the board.

And so I'm all right with waiting until another board meeting because we have time. This isn't going to affect Jim Wells' governor's recommended budgets. It's not going to affect our ability to create rates. I don't have a problem with pushing this if you want to wait and see what those numbers look like.

MEMBER COCHRAN: Jim -- I mean, Damon, can I ask you a question. Is there -- I guess one thing -- Who ever wants to answer this. Is there a potential for an unscrupulous vendor to come to a person knowing that they've got an HRA paying for their insurance to come to them and all of a sudden they're making payments and taking their HRA payments and they're not providing them with the product they are supposed to provide?

MR. HAYCOCK: For the record Damon Haycock. That's an excellent question, Dr. Cochran. Yes, there's always that chance. But there's that chance today except without the HRA, right.

MEMBER COCHRAN: The reason I mentioned that is because we always hear about targeting, you know, programs that target, you know, the elderly to try to, you know, and sometimes we shake our heads at those issues and say how could you have fallen for that. But at the same time, they are there and people are taken advantage of.

MR. HAYCOCK: I think that may -- To your credit and to your statement, that is a possibility. But I want to apply that to today. Today that can happen. They're not going to get that HRA fund, but they may get their commissions for enrolling someone in a health plan that doesn't work, and then that participant loses their HRA.

So, again, the ability for fraud, waste, and abuse always exists. That's why we have groups like the Nevada Division of Insurance and the governor's office for consumer health assistance. And we have these programs. And I'm not saying that they're going to catch everybody. But they're there to help.

I agree that there are these issues, but I don't think these issues are non-existent today. I think they exist today anyway. It's just what happens when these issues occur today? Do we rip their HRA from them or do we allow them to keep it? But you're still going to get the same problems.

MS. RICH: For the record Laura Rich, operations officer. I just wanted to, you know, kind of answer your question as well. That's already happening today. We have -- During open enrollment we have these brokers that go to our members and say, oh, here's, for example, an AARP plan and it's two bucks cheaper than what you're paying now. What they don't understand is it may be two bucks cheaper but now

they're not getting their HRA funding. So they switch to that plan thinking, oh, I'm getting a much better deal, yet they now turn around and lose their funding. And they find that out, you know, a month, two, three months later, depending on when that occurs, and then they're calling PEBP and coming back and saying, oh, my goodness, what did I do? I didn't know I did this. And so we can reinstate them depending on the situation. But they've now lost their life insurance. So, I mean, that's already happening.

MEMBER WELLS: Again, for the record, Jim Wells. Which is why we send out communication saying never to accept a phone call to change your plan. You make the outbound phone call to change your plan. So we have made these communications to retirees for years now saying if you need to change your plan, you call, you don't accept a call or you don't change your plan when someone calls you. And so, again, this goes back to one of my arguments is this group of people aren't sophisticated in certain areas and I just don't believe that this will be a benefit to them.

I would like to defer it and wait and see what the overpayment report comes back and looks like and have another discussion about this. But under its current circumstances I won't support this.

CHAIRMAN CATES: Okay. Any other comments on the motion? Seeing none, I'll call for a vote. All those in

favor of the motion say aye.

MEMBER GARCIA: Aye.

MEMBER COCHRAN: Aye.

CHAIRMAN CATES: Opposed?

(The remaining members voted no)

CHAIRMAN CATES: So we had two ayes and everyone else opposed. Okay. The motion fails.

Let's move on to 9.12, possible new optional second opinion provider benefit on the CDHP. PEBP's recommendation, PEBP believes utilizing second opinion doctors is a best practice suited to utilization management and will work with the current utilization management vendor to explore the advantages and disadvantages of their use. Therefore, PEBP recommends no direct contract relationship be developed outside of utilization management. Discussion?

MEMBER COCHRAN: Just for clarification, Mr. Chair. Chris Cochran. So we really don't have to take any action on this; correct?

MR. HAYCOCK: Correct.

CHAIRMAN CATES: Correct.

MEMBER COCHRAN: Okay. Thank you.

CHAIRMAN CATES: Any other comments? Any motion? It looks like we're moving on. Okay.

9.13, possible reference-based pricing requirements for musculoskeletal services and outpatient

colonoscopies on CDHP. PEBP's recommendation, PEBP believes it is important to implement reference-based pricing on hip and knees today with the ability to increase the types of services reference priced in the future as costs begin to increase. So PEBP's recommendation is to have reference-based pricing on the knees and hips. Discussion? Motion? Anything?

MEMBER COCHRAN: Chris Cochran for the record. The reference-based pricing, I mean, I understand the reason for doing that. But shouldn't that be part of the negotiations with the providers that are going to provide those things so that they know what they're going to be getting and so that our members -- I mean, I would think that, you know, we don't want our members -- our members aren't necessarily going to go out of network to have this work done if they know that they're not going to -- if they know they're going to have to pay a considerable portion out of pocket. Or they are. I mean, they're going to go to a specific provider saying this guy is the best there is. I'm going to go to the Andrews Clinic in Florida and have this done. I realize I'm going to be paying a lot more out of pocket. But I'm just trying to understand, you know, a real need for this if these are contracted vendors.

MR. HAYCOCK: For the record Damon Haycock. Thank you, Dr. Cochran. Unfortunately not all contracted

vendors have the exact same services at the exact same prices. And you may have been or may not have been following the news in, say, Elko, Nevada. Their commissioners are very upset with their local hospital for extremely high prices to their location. And I know that they are a network provider that we pay more for hips and knees. And so this is -- this actually helps the negotiations. Because when we go to back to the master plan document and say we have a not-to-exceed price on this service of X, then there is no negotiations. We don't have to talk an $85,000 hip down to $25,000 or whatever that number is. We point to the master plan document. They're an in-network provider. And, therefore, if they are going to offer this service, they're offering it in accordance with our master plan document. And if they're not, then they don't have to be an in-network provider.

But, again, it's that's environment change that doesn't allow -- or it allows our plan to not be at the mercy of the providers who dictate pricing to PEBP. But we have purchasing power. We have 69,000 covered lives in our program and we need to utilize those lives to ensure we get the best prices possible. And I'll get off my soap box.

But we've been negotiating directly with providers for the last six months to try to get some of these exorbitant costs down. This would greatly enhance our ability to successfully do that.

MEMBER COCHRAN: And just one last question. How would we establish the reference-based pricing? Who would be responsible for doing that?

MR. HAYCOCK: For the record Damon Haycock. What we would do is we would bring this back again as a master plan document change for the board to approve. We would bring the analysis. There's a report in there already that's attached to this that you guys can review. We can pull additional numbers for updated experience. And we can present a recommendation for an MPD limit, just like we have limits already on certain services and products in our master plan document, bring it back to the board in the Spring and you guys approve the master plan document and you move forward with it. We will have to talk with our networks to make sure that our networks can implement this, because it may impact their contracts. But if we stay strong in our belief that we will not triple pay for a process that we shouldn't, then I'm confident our networks will back us.

MEMBER WELLS: Thanks, Mr. Chairman. Jim Wells for the record. I'm looking at the CalPERS case study that's in the back. And when they did this, they did it through kind of what they call value-based plan design, where they selected hospitals throughout the geographic region of the State of California and then came up with a price. And then basically if you went outside of that network of 41

hospitals -- And 41 hospitals in California is probably a drop in the bucket. I don't know if there's 41 hospitals in Nevada.

MR. HAYCOCK: There isn't.

MEMBER WELLS: But you're looking at it up to scale. But they actually have a $3,000 penalty plus you pay the difference in the actual cost versus the amount that they're going to limit to you.

And there's some great statistics that came out, and I've seen these before, that people will migrate to these hospitals where it's cheaper. And the hospitals where it's more actually decrease their price.

I really like the idea. I just want to make sure we have a good implementation plan behind how we do it, making sure that we can address the geographic. Does it make sense for us to have somebody from Wells have to go to Reno and then it actually costs more because they are having to stay in Reno longer. I just would want to see a little bit more about how the plan would kind of roll out.

MR. HAYCOCK: For the record Damon Haycock. That's exactly what we can do. We can produce a plan, if you want to call it the what-if scenario. What if someone lives out in Esmeralda County or what if the costs are actually cheaper if you take travel and per diem out, then you would go with that cheaper cost. So you would look at it almost

like bundle pricing. So the total amount of cost, what is the next best alternative, right. What I fear about the CalPERS study is that they created a network within a network and so they basically narrowed that network down. And one of the benefits of the consumer-driven health plan as a PPO is that you're allowed to make that choice to go to the providers that you want to go to. Sometimes you'll pay more. Sometimes you'll pay less.

But if we can put some of these caps in. Again, we're not trying to take profits away from providers. But what we're trying to do is to make it a little bit more fair. And that way if it turns out that someone -- And I don't want to pick on specific -- someone in a rural hospital has a 60 or $70,000 procedure and we can pay that person -- we can literally put that person in a limousine and drive them to Reno or Vegas and put them up for the night or the week and give them gambling money, which we won't do, but we could do that and it's still cheaper to do some of these procedures that it just seems to me like a slam dunk.

But when it's on the cusp, then that's part of the implementation that we have to discuss. And I have no problem putting something together with staff and our consultants and our partners as to how that would roll out for an inclusion in to the master plan document. Ultimate approval by the board, of course.

CHAIRMAN CATES: Any other comments? Tom.

MEMBER VERDUCCI: Tom Verducci for the record. So let's say we put a cap in place and a participant had the procedure done. Are they running a risk where they're going to have a huge out-of-pocket cost or would there be an agreement with the insurance company providers where they understand that, you know, there is a limit as opposed to subjecting the participants to have excessive costs out of pocket?

MR. HAYCOCK: So for the record Damon Haycock. I think the easiest way to ensure that participants are not blind-sided by balanced billing is that as part of the implementation plan you put a pre-authorization process in place and they contact our utilization management vendor and say I have been diagnosed with X and I need Y and I need this knee replaced or I need this hip replaced.

And then -- I'm going to go off on a tangent for a moment to see how the other -- If there was a second opinion doctor then they would go through that process and see is it really necessary or do we save money that way. But bounce back to the prior authorization, our utilization management vendor today solicits through our network of providers if there's a medically appropriate high quality health care facility to have these services done.

And so we would work with that vendor to ensure

that they through their PA process funnel folks to the lower cost reference-based price process -- facilities. And if a facility within the network still has a contract with our network that says, no, I'm allowed to charge whatever I want and you have to take a percentage off billed or something like that, then the participant will be told by the utilization management vendor or PEBP that if you choose to have it done here, you are choosing to not have it done here and this is the cost difference and this is your choice. Similarly to what Dr. Cochran said, if you want to go to another out-of-network place, you are making that decision and you are paying more in going to that place.

So I think we can put some controls in place here, not only in our master plan document, but within our utilization management process, because this isn't a cheap service. That's when you just say, oh, wow, I got to go get a hip, I'm going to go down to the hospital and see if they can do it. It's something that gets managed by PEBP. It's a very intrusive procedure, a lot of rehabilitation, and it affects people's lives. So we want to make sure that we control the process to the best of our ability and I think we can put those controls in place through our pre-authorization process.

MEMBER GARCIA: Rosalie Garcia. Is there -- Are there any other reference-based pricing examples that we

currently have?

MR. HAYCOCK: Damon Haycock for the record. I believe, and I could be off on this percentage, but the State of Montana just referenced-based their entire plan. They said we are going to do a Medicare Plus and that's all we're paying and that's what we're doing. And they just rolled that out, I think, in the last few months, I believe. So anyway, they just announced that they're going to be doing reference-based pricing. It's just a manner in which to control costs.

Another great example of reference-based pricing is Medicare. Medicare says we're paying the Medicare allowable rate and that's what we're paying. And so referenced-based pricing is not new and we want to benefit from that. That's our recommendation is that we benefit from that. And we start small. We start with some of the low-hanging fruit, the hips and knees that are drastically different in prices.

If you see the study that Jim was mentioning in HealthSCOPE's analysis, you'll see that bar chart just kind of stay here and then run way out there. There's some folks that are charged an extreme amount of money for the same procedure. And then there's also the quality of care. I'm not saying that people in rural hospitals don't have high quality. And I think that they receive accolades for their

quality. But you have, how many times does someone do a procedure in that environment versus how many times do they do that procedure in the urban environment. And I'm not saying that more procedures are better than less procedures. But there is a perception of quality that you have more experience in how you are doing your operations.

So there's all of those things to consider. And I think we can maintain high quality health care and make it more affordable to ensure that these costs are not affordable year after year by PEBP.

MEMBER GARCIA: Thank you.

CHAIRMAN CATES: Any other questions? Anybody want to make a motion?

MEMBER VERDUCCI: I'd like to make a motion that we accept staff recommendation.

CHAIRMAN CATES: Okay. Do we have a second?

MEMBER BAILEY: I'll second that motion. Don Bailey.

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

MEMBER WELLS: Mr. Chairman, Jim Wells. If we could have staff kind of bring back the implementation details of what they plan on putting in the master plan document kind of in advance of just a master plan document update so we can kind of get a look at it and kind of vet

that before it actually has to go in to the master plan document, I would appreciate that. We don't have a lot of time to finalize the master plan document changes if they are needed, especially if there's something in there that we want to change.

CHAIRMAN CATES: Thank you. Any other comments on the motion? Seeing none, I'll call for a vote. All in fever of the motion say aye.

(The vote was unanimously in favor of the motion)

CHAIRMAN CATES: Opposed? Motion carries unanimously.

We're skipping 9.14. That's going to be brought back to a later meeting.

So we're moving on to 9.15, possible new preventive drug benefit on the CDHP. PEBP's recommendation, PEBP believes increasing deductibles and lowering HSA/HRA contributions and life insurance amounts will be a bitter pill to swallow for our participants. If PEBP can implement this preferred drug list, crucial and necessary medications can be made more affordable. Implementing the preventive drug list allows the plan to begin helping participants manage their health care needs earlier in the plan year while lowering the overall cost with non-compliance. PEBP recommends implementing this list. Go ahead.

MR. HAYCOCK: For the record Damon Haycock. One

clarification, Mr. Chairman and members of the board. The attached list is not the final list. We want to reserve the right to go through and ensure that we're not -- We haven't done a cost analysis on this list. So I want to make sure that we're not putting out there thousands and thousands and thousands of dollars of drugs that isn't going to be cost-effective to the plan. We want to go drug by drug, line by line, and we want to put some controls in place. If there are a generic equivalent available for a brand name drug, that the generic equivalent is the only drug that's available on this list, so we don't have people going out and spending higher cost dollars and getting this initial cost sharing on these higher cost brands.

And so we want to make sure that this isn't a free-for-all on pharmacy drugs but that we can work with our vendor, Express Scripts, to manipulate this list to make it the most appropriate for PEBP. And we will bring that back for your approval prior to implementation.

MEMBER ZACK: Christine Zack for the record. This is the one new enhanced benefit that I do support, because I think that ultimately it will result in a cost savings to PEBP. Damon said earlier personal responsibility. I believe strongly in that. I think, for example, if you're taking an asthma drug, Singulair, that will now be on the list, you could prevent a costly asthma attack that forces

you in to an ER late in the evening. So those things actually in the long run will result in a net savings to PEBP, so I support the recommendation.

CHAIRMAN CATES: Thank you. Any other comments?

MEMBER ANDREWS: One question. Damon, does this include specialty medication?

CHAIRMAN CATES: For the record Damon Haycock. No, it does not. This is -- This is not an all-encompassing list, unfortunately. It is designed strictly on what still meets the requirement to allow a consumer-driven health plan to still offer a health savings account. So there's some IRS requirements that are tied to it as well. But, no, it does not include specialty drugs.

MEMBER BAILEY: For the record Don Bailey. My question, Damon, is do we have any indication of who's going with the high end -- high end drugs other than the generics? I mean, we saw a report and the report is in here, generics are going down and you're using them more and more and more other than the high end drugs.

MR. HAYCOCK: For the record Damon Haycock. I think, if I understand correctly, Vice Chair Bailey, that there are certain drugs -- and I'll pick on one that I know about here in this list. Asthma is a great example from Ms. Zack. There's a drug that's called Advair. It's a disc. People take it as a maintenance drug potentially every day.

And it's very expensive because it's not the drug inside that is still on patent. It's the darn disc, the delivery device, that is. And so that thing can be quite costly. But if you don't take that drug every day, you gamble with the opportunity to have a flare-up and you don't maintain or manage your asthma and you can be required to go in for a breathing treatment or go in to the ER. I've seen people do this. And it's the same story with, you know, people that I've talked to that have said I'm splitting pills now or I'm no longer going to take these because the costs have increased.

So it's not just a cost savings to the participant on the brand side. It's also on the generic side as well. Because, ultimately, for these drugs we want people to take them to avoid higher cost episodes. So I agree, I didn't put a whole lot of savings in here because I don't think you're going to realize those savings this year. And I think expecting a return on investment on avoided ER and urgent care on the first year of a new program I think is a little bit aggressive. But this is providing a benefit that people have been asking for. And not to everybody but to some folks to help us with that -- not that paradigm shift but just the notion that we want people to take care of themselves today to prevent high cost catastrophic health care in the future. And it goes along with that idea of

preventive services and the preventive drug list. And the cost of prevention is much cheaper than the cost of actually treatment. And I think that can be quantified if you would like.

MEMBER BAILEY: Okay. Well, I'm just concerned about the expenses of drugs overall with the pharmaceuticals. They don't cooperate very well. And maybe the list is the way to go get them more in to generics and maybe that generic number will drop at the next audit even more.

MR. HAYCOCK: For the record Damon Haycock. I want to make sure I understand the generic number dropping. So the cost is increasing for generics. We are actually being -- We are happy that people are using more generics because they're cheaper than actual brand name drugs. But, yes, we would love the cost to be reduced. Personally I don't think you're going to see generic costs go down. That's just my personal opinion. That's where we're seeing massive increases. I think August this year was the one percent increase across the board on the generic drugs, the single highest increase in years.

But what this really does is it provides people the opportunity to receive those drugs earlier in the plan year with plan assistance. Today if you have a $300 a month required maintenance drug, you have to pay that until you satisfy your deductible. And, yes, we give HRA and HSA funds

to go offset that. But they have to pay those deductibles until we finally start helping to pay for the plan. It doesn't make sense to me why we don't want to incentivize people to take their maintenance drugs to avoid high cost claims in the future.

MEMBER BAILEY: Who are we going to count on to guide them?

MR. HAYCOCK: For the record Damon Haycock. This is a program that we would implement with our current pharmacy and benefits manager, Express Scripts. We would likely have done since their implementation pepper out information, talk to the folks, ensure that our call centers collectively know that this program exists, implement this program with other clients throughout their book of business. And we would then ensure that the master plan document was updated and that our third party administrator would be able to accumulate any accumulators that exist. And so that way it would run very similar to if someone had already satisfied their deductible.

We do this today in another version on the diabetes care management. The cost of insulin is extremely expensive and those that participate on that reduced management program get it for $25. So we're able to manage that program today very simply and I think that we could manage this as well.

MEMBER BAILEY: Okay. Well, we don't want to overload the staff.

MR. HAYCOCK: For the record Damon Haycock. I don't think it's the staff that's going to be doing the grunt work. I think honestly it's our vendor ESF.

MEMBER VERDUCCI: Tom Verducci for the record. My question is would there be any circumstance where we would be changing the available medication and pharmaceutical drugs that would be available to the participant if we force them to go from a preferred drug to a generic?

MR. HAYCOCK: For the record Damon Haycock. This is an add-on. It's not a replacement. And so this is an opportunity for folks that meet these conditions and these circumstances who have these prescriptions at these levels to participate and take advantage of day one cautionary. It does not stop anybody from receiving a dispense-as-written drug and going through the normal channels that's we have today where you satisfy your deductible and then you get co-insurance assistance until you meet your out-of-pocket maximum and then the plan pays a hundred percent. So we're not disadvantaging anybody who is on the plan today. It's designed to advantage those people that actually can be affected by this program.

CHAIRMAN CATES: Any other questions? Comments? Go ahead.

MEMBER GARCIA: Rosalie Garcia. First I do want to recognize that the play on words for bitter pills did not go unnoticed. Thank you very much. That was very nice. And I would like to move that the board adopt PEBP's recommendation, PEBP staff recommendation, to implement a new preventive drug program on the CDHP as presented.

CHAIRMAN CATES: Do we have a second?

MEMBER ZACK: Christine Zack for the record. I'll second it.

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

MEMBER WELLS: Mr. Chairman, Jim Wells. I want to make sure that this includes the restriction that Mr. Haycock talked about on brands when generics are available that only the generic version of that medication is covered under the preventive benefit.

MEMBER GARCIA: Yes. Rosalie Garcia. Yes, I believe that was part of the description; correct?

MR. HAYCOCK: For the record Damon Haycock. I think what Mr. Wells is asking is to amend the motion to include it. And therefore there's no, right, there's no chance to misunderstand it.

MEMBER GARCIA: So included.

MEMBER ZACK: Christine Zack for the record. I second the amended motion.

CHAIRMAN CATES: Any discussion on the amended motion? Seeing none, I'll call for a vote. All in favor of the motion say aye.

(The vote was unanimously in favor of the motion)

CHAIRMAN CATES: Opposed? Motion carries unanimously.

Close Agenda Item 9 and move on to Agenda Item Number 10, executive officer's report.

(The court reporter interrupts)

MR. HAYCOCK: So for the record Damon Haycock. And as I promised our court reporter, I will try not to make this long for her poor fingers. This is my executive officer report to the board participants and the participants and other stakeholders. It's continuing on the format where we talk about various sections of PEBP just to keep everyone up to date.

Operationally, I wanted to share some of our first quarter call center statistics. They're quite important. Our abandonment rate is 1.21 percent. Our average speed to answer is 13 seconds. So although you saw all last year we were butting up against that industry standard, we're actually improving and we wanted to show that today in this section.

On page two under communications, we wanted to share it where in-person education outreach has occurred in

the first five months of this plan year. And how many participants that we reached out to and spoken to directly. So these are important.

The July meetings, the August meetings, the October and November, we want to share how dedicated we are to providing that in-person assistance, that light touch when it comes to trying to explain something as difficult as health insurance benefits to our participants and how to maximize their use. This is something that my quality control officer, Nancy Spinelli, has reinvigorated last year and that continues to operate and we have no desire to look back.

Under finance on their contract update, the HMO evaluation committee selected the winning vendors in the first week of November. When I wrote this report, the letter of intent had not gone out. I can tell you, and this is all that I can say, is that the HMO letter of intents have gone out to two vendors, Hometown Health in the north and Health Plan of Nevada in the south. And that we are under confidential negotiations and will be potentially bringing back the negotiated contract to this board hopefully at the January board meeting for a February board of examiners approval.

We also developed an amendment to the eligibility enrollment vendor contract to implement more stringent

performance guarantees on data accuracy and timeliness of data transfers. We are very proud of this. And we appreciate the partnership with our current vendor. It was retroactive to September 1st. And I think it's -- I don't know if it's been approved by the board of examiners or it's still sitting there, but it should be approved very soon by the clerk of the board.

Under finance, budget, and development update, I wish I could tell you more, but we've been working diligently with the governor's finance office to revise the biennial budget figures based on new experience and information in an effort to cooperatively develop PEBP's portion of the governor's recommended budget. We anticipate the ability to share that result with you at the January board meeting after the governor has announced the State of the State.

So, in conclusion, we remain dedicated to providing those high levels of customer service that we maintain to offer in-person education and outreach appropriately and effectively managing our vendors and working without partners to develop the highest quality of health care at affordable prices.

You'll see attached to this, we have a proposed PEBP board meeting calendar. We wanted you all to take a look at this and hopefully as kind of homework see if this will jive with your current schedules. We know you have

other things to do besides work on the PEBP board. We may update this. We understand that there's a potential conflict with PERS meetings and that folks like to be at both. So give us a little bit of time and we'll see if we can send something out next week. My assistant is going through and doing the research and hopefully we can get it adjusted. But figure these weeks are the weeks that we definitely want to have these meetings.

You'll notice that there is some teleconference ones on the legislature. Those in years past, I believe, have either been held or canceled based upon current situations. So they may not be held. But we wanted to try to reserve some time to do those telephonically so we can provide you with updates on the bills that are being presented to the committees and see if there's a position you would like me to take on your behalf. And with that, I'll take any questions.

CHAIRMAN CATES: Any questions? No. We will move on. Let's take a five-minute break. Let's resume at a quarter till.

(Recess was taken)

CHAIRMAN CATES: Okay. Let's call the meeting to order. We are now on Agenda Number 11, discussion and possible action regarding Towers Watson One Exchange service improvement plan. Go ahead.

MR. GARCIA: Chris Garcia for the record with Towers Watson One Exchange. We wanted to provide an update on our service improvement plan as well as what we did at the last board meeting. The information in this update is as of November 4th.

Since our last board meeting, we had three major items that have occurred that we wanted to provide an update on. The first item is regarding our retiree meeting that occurred prior to Medicare annual enrollment starting. We held three different meetings in early October. One in Las Vegas, one in Carson City, and one in Reno. There were two different types of meetings held on each day. One was for participants who are aging in to Medicare and one for participants who are already Medicare eligible. That focused on making changes for Medicare open enrollment as well as focusing on the HRA.

We did provide some details in the service improvement plan on the estimated number of attendees at each meeting. So in Las Vegas, and you see a breakdown by the agent versus open enrollment HRA meetings. Las Vegas had 35 in the agent meeting, 30 estimated in the open enrollment HRA meeting. Carson City was 17 in the agent meeting, 22 in the open enrollment HRA meeting. And with Reno, 32 in the agent meeting and 25 in the open enrollment HRA meeting. That was a total of 161 estimated attendees for all three locations in

preparation for open enrollment.

The next item we wanted to talk about was the HRA on-site assistance. So we have been live for two months going in to the beginning of November with the HRA team specialist being available here at the PEBP offices for one week per month. She's actually here today. And this is her week that she's here now. We were able to get some details from her for the months of September and October for the week that she was here. And we had that information below. So you'll see the total number of people that she met with in person seems low but she was actually also able to assist with phone calls as well as e-mail inquiries that the PEBP member service team received.

So for the month of September when she was here, from September 12th through September 16th, she had nine appointments. There were zero walk-ins for that period of time. And then for the month of October, the week she was here, October 10th through October 14th, 14 appointments and one walk-in.

We have a list of the weeks for the remainder of 2016 as well as the first quarter of 2017. They are listed in the service improvement plan. We will also be doing -- continuing this program and continuing her one week per month in to future 2017. We just haven't finalized those dates. Once we have those available, we will share them with the

board.

I'll pause. Are there any questions regarding the first two items before we get in to the annual enrollment period?

MEMBER VERDUCCI: Chris, Tom Verducci for the record. Do you see these meetings being enough? Would you say too much, less, or how do you feel in terms of your current presence there? Should we have additional days or are you showing up where we have zero walk-ins and you're there too much?

MR. GARCIA: Thank you for the question. And that's the HRA specialist who is here, she actually had quite a number of walk-ins this week that she's been here so far, so I think as the program becomes more aware to the retirees up here in northern Nevada, I think we'll see her appointments get fuller and then she'll have more walk-ins. We are also talking about doing additional meetings in Las Vegas. So when we met with RPEN last night, we talked about going back and doing the meetings in Las Vegas where we would do a larger HRA focus meeting in the morning with appointments in the afternoon. So we would like to continue that as well. So I think right now the week -- the one week per month is a great place to start. And, as John Seegrist had mentioned earlier when he was up here speaking during the claim audit, that we are open to looking at additional time

if it was necessary.

MEMBER VERDUCCI: Thank you.

MR. GARCIA: So the last item is probably our biggest focus right now. We are in the middle of our annual enrollment period for Medicare. It started on October 15th and it runs through December 7th. So during this time participants can take the following action. So if they are currently in a Medicare Advantage plan they can switch to another Medicare Advantage plan during annual enrollment without any underwriting considerations or they can change between the Medicare Advantage plan or go from a Medigap plan to a Medicare Advantage plan.

When you get to the Medicare supplement or Medicare -- Medigap plans, excuse me, the participants did likely face underwriting in the event that they want to change between Medigap plans or go from a Medicare Advantage plan to the -- Excuse me. Medicare Advantage plan to a Medicare -- Medigap plan. In most cases if a participant enrolled in a Medigap plan they tend to stay within that plan.

And then the last change that they can make is for Part D plans. And this is the one that we see the most activity on during the open enrollment season. Participants can change their Part D plans during open enrollment without any underwriting consideration. This type of change is the

most common one that we'll see.

And so we did pull -- On the next page you'll see some data. It's only for the first little over two weeks of the open enrollment season. But it gives us an idea of how many people actually switched from one plan to another based off of their original plan and the new plan that they've elected for 2017. And as you can see, people changed, say, from Medicare supplement plan to another Medicare supplement plan is relatively small, only 12 so far. Or say from a Medicare Advantage plan to another Medicare Advantage plan only 32. But when you look at the prescription drug to another prescription drug plan, it's 144. And that's really only for the first part of the open enrollment season.

We're going to continue to provide you with these data points as we progress through the open enrollment season and we'll give you a final listing of this information once open enrollment closes.

And we know that in the past a big item for us has been the call wait times that were experienced during last open enrollment. We know that people were calling in and experiencing 30-minute, 40-minute wait times. So we've been focused as a business on improving that overall delivery during the open enrollment season. So we did look at call stats specific from October 15th through November 3rd. And we did a comparison to the same period of time last year. So

as you can see in the chart below, for the same period of time, we've seen the decrease in the average wait time by over seven minutes, almost eight minutes. And then we've seen an average wait time -- Excuse me. We've seen an average wait time -- Excuse me. Call abandonment rate decreased by 7.15 percent. Because when you look at last year, we had over 337 calls abandoned just from the period of time from October 15th through November 3rd. And for this year we've only seen 12 abandoned calls.

I think we've made a lot of improvements with our open enrollment season with the staffing that we have in place to handle the call volumes that we expect to receive. And hopefully this information verifies that with you.

Are there any questions regarding open enrollment and the call stats or any other information regarding the enrollment changes for 2017 so far?

MEMBER COCHRAN: Yes, I do have a question. The Medicare Part D plans, do you know what the main reasons why people are changing?

MR. GARCIA: It's very common to change. It's typically a retiree or participant, if they're taking new prescriptions that they've incurred in the middle of the year that they didn't plan on taking when they first enrolled, say, for 2016. Now they're looking for something, a new plan that might offer a better benefit for them for that new type

of prescription that they're taking. That's the most common reason that somebody will change in one prescription plan to another.

MEMBER COCHRAN: All right. Thank you.

MR. GARCIA: You're welcome.

CHAIRMAN CATES: Proceed.

MR. GARCIA: All right. Thank you very much.

CHAIRMAN CATES: Thank you.

Okay. We're now to Agenda Item Number 12, public comment. Do we have any public comment here in Carson City?

MS. LOCKARD: Thank you, Mr. Chair. My name is Marlene Lockard and I'm representing RPEN. I just wanted to as we moved through the agenda items in Section 9 and the decisions that were made on each of those items -- And Mr. Wells just left. But his comment that the base budget is pre-enhancements, I just wanted to put in perspective. Over -- In 2011, the massive changes that were made to the health plan for state employees and health retirees -- retirees were a result of the economic situation in the state at that time. We have come back, not totally, from 2011.

But if we are going -- I would argue that the excess reserves from 2011 to the current time have paid for the enhancements since the original cuts in 2011. So I think an argument can be made that we shouldn't refer to these as enhancements. We should begin to reset as those enhancements

as the new base. Now, I understand the current situation with the state budget, and Mr. Wells is doing his job, obviously, as the budget director for the state. But for state employees and retirees to go back to the recession 2011 base I don't think is appropriate. State employees suffered the most in this state because they were the low-hanging fruit. They didn't have collective bargaining agreements, et cetera.

So I think there's much discussion going forward on what our baseline for benefits actually should be, given the five-year experience of double digit excess reserves. Were the cuts in 2011 too much? And I think that's something this board should consider.

And I appreciate that we have time to make adjustments in January and before final decisions in March. But if we're -- The enhancements are roughly, I'm told by Mr. Haycock, valued at around 30 million dollars, if we're going to roll back PEBP's budget to the base of pre-enhancements, that is a savings to the State of Nevada budget of 30 million dollars. And, again, my point that state employees have already really taken a hit for a number of years.

So I just think it's -- I don't know how to a generalize that. And I'm sorry Mr. Wells had to leave. So I just -- I just think it's a discussion that we should

consider.

And, you know, you approved the Medicare retirees absorbing the costs for their costs for life insurance and for the administration costs. And I think I'll get push back from my membership. But I think it's appropriate. I think Medicare retirees can step up and pay those costs. We shouldn't have to have the other folks carry us there. But at the same time, to put all the enhancements back to day one and then the previous sessions PEBP has been a help to the state budget overall in saving money that goes back to the general fund to defer some of the shortfall in other areas of state government.

And I used to have a hat on like that, so I know how it works, and I know from the budget office perspective. But looking at this population of state employees and retirees, I'm not sure that 30 million dollars back to the general fund is a big chunk taken away from the health care for our employees. Thank you.

CHAIRMAN CATES: Thank you.

Any other public comment? Come on up.

MS. GRAF: Do I tell you my name?

CHAIRMAN CATES: Yes.

MS. GRAF: My name is Susan Graf, G-r-a-f. Susan like normal. Well, I am a real retiree. There seemed -- I don't know if you had ever seen one from your discussion. So

I am a real retiree and I have a question. You have been, like, really smart, Mr. Haycock. But, I was kind of offended by that I've never paid a hundred dollars for a pair of glasses comment, because my glasses cost $300. But I'm blessed. I have a daughter who is married to a doctor and she said there's this thing called Zenni where you can get your glasses for much cheaper. I'm just lucky. What about all of those retirees who aren't lucky enough to have a smart daughter-in-law?

So how come you can't tell us things like that and say, well, we know that you don't have a lot of money and here are some additional resources. I understand that there's a line between information and between endorsing things. But, still, it just seems like I am not only a retiree, I'm a medical disability retiree, I had a stroke. So all of that clear communication that the man who left was talking about, I don't see it as clear at all. And those letters are very hard to read. And so I might be dumb. That was, like, what I wanted to say.

CHAIRMAN CATES: Thank you very much.

Any other public comment?

Do you have any public comment down in Las Vegas?

UNIDENTIFIED SPEAKER: We do not.

CHAIRMAN CATES: Okay. Do you have public comment?

UNIDENTIFIED SPEAKER: No. I'm waving to my friends.

CHAIRMAN CATES: Order. Order. Okay. Seeing no more public comment, we'll close that item and move to Item Number 13 to adjourn. We don't have to take a vote on that. We're adjourned. Thank you.

(Hearing concluded at 3:09 p.m.)

STATE OF NEVADA)
)ss.
CARSON CITY)

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

That on Thursday, the 17th day of November, 2016, I was present at The Richard Bryan Building, 901 S. Stewart Street, Carson City, Nevada, for the purpose of reporting in verbatim stenotype notes the within-entitled public meeting;

That the foregoing transcript, consisting of pages 1 through 219, inclusive, includes a full, true and correct transcription of my stenotype notes of said public meeting.

Dated at Reno, Nevada, this 8th day of December, 2016.

_____
CHRISTY Y. JOYCE, CCR
Nevada CCR #625

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