

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

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*November 17, 2016*

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1 PUBLIC EMPLOYEES' BENEFITS PROGRAM BOARD

2 TRANSCRIPT OF PROCEEDINGS

3 VIDEOCONFERENCED OPEN MEETING

4 THURSDAY, NOVEMBER 17, 2016

5 CARSON CITY AND LAS VEGAS, NEVADA

6  
7 The Board: PATRICK CATES, Chairman  
LEAH LAMBORN, Member  
8 DON BAILEY, Member  
CHRISTINE ZACK, Member  
9 JAMES WELLS, Member  
TOM VERDUCCI, Member  
10 CHRIS COCHRAN, Member  
ROSALIE GARCIA, Member  
11 ANA ANDREWS, Member

12  
13 For the Board: DENNIS BELCOURT, Deputy  
Attorney General

14  
15 For Staff: DAMON HAYCOCK  
Executive Officer  
16 CELESTENA GLOVER  
Chief Financial Officer  
17 NANCY SPINELLI  
Quality Control Officer  
18 KARI PEDROZA  
Executive Assistant  
19 CHRIS DeSOCIO  
Chief Information Officer

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

---oOo---

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.  
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1                   CHAIRMAN CATES: Thank you.

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

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

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

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

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1 I apologize.

2 Go ahead and state your name for the record.

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

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

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

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

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

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1 be utilizing it.

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

4 CHAIRMAN CATES: Thank you.

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

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

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

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

24 So to look at things that the legislature has  
25 already, even though it wasn't a big bipartisan vote, it was  
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1 a bipartisan vote when the houses were represented by one  
2 party.

3 CHAIRMAN CATES: Three minutes.

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

7 CHAIRMAN CATES: Thank you very much.

8 Anymore public comment?

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

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

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

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

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

10 CHAIRMAN CATES: Thank you very much.

11 Any more public comment here in Carson?

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

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

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

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

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

24           Even if offered an opportunity to buy up  
25 insurance to this level, we see no study or survey or other  
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1 research that indicates how many state employees, especially  
2 younger ones, would choose to take advantage of this benefit  
3 or living paycheck to paycheck would just let it go. Keeping  
4 the life insurance benefit at \$25,000 very may well help a  
5 shocked young widow or widower with children pay for a  
6 funeral and keep a house payment going at least long enough  
7 to make solid follow-up plans. And keeping the benefit at  
8 this level will at least soften a bit the aftermath for a  
9 family suffering the death of a state employee or the  
10 employee's spouse who might be inadequately prepared, as are  
11 so many people in America.

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

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

21           CHAIRMAN CATES: Thank you, sir.

22           Any more public comment in Las Vegas?

23           MS. WHITTEN: Sonja Whitten. I am a state  
24 employee with the Division of Welfare and Supportive Services  
25 and I'm also a member of AFSCME Local 4041. And I am here  
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1 out of concern for the proposed changes to our health care as  
2 well as the reduced life insurance rates and all of the  
3 detrimental changes that would harm State of Nevada employees  
4 who have given so much during the state's recovery during the  
5 recession.

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

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

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

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

22 CHAIRMAN CATES: Thank you very much.

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

25 And we will move on to Agenda Item Number 3,  
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1 consent agenda. So we have three items on this agenda. 3.1,  
2 approval of the action minutes from the September 22nd board  
3 meeting. 3.2, acceptance of Health Claim Auditors quarterly  
4 audit findings for HealthSCOPE benefits. And 3.3, acceptance  
5 of PEBP vendor reports. This is a consent agenda item. Do  
6 any of the members wish to have discussion on any of these  
7 items? Seeing none, I would take a motion to approve.

8 MEMBER WELLS: So moved.

9 CHAIRMAN CATES: Second?

10 MEMBER COCHRAN: I'll second.

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

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

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

16 MEMBER GARCIA: Abstain.

17 MEMBER ANDREWS: Abstain.

18 CHAIRMAN CATES: Okay. Very good. Thank you.

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

24 MS. CARR: Good morning, Mr. Chair, members of  
25 the board. For the record, my name is Robert Carr and I  
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1 represent Health Claim Auditors.

2           This past September we had -- I performed an  
3 audit of the PEBP retiree health reimbursement arrangement or  
4 HRA claims administered by Towers Watson One Exchange for  
5 PEBP's fiscal year 2016. The audit was conducted at PayFlex,  
6 which is One Exchange subcontractor that's located in Omaha,  
7 Nebraska. The audit was conducted with a valid selection of  
8 400 claims with numerous claims audited on a bias basis that  
9 were selected from member's historical files and some of  
10 those files that were requested by PEBP staff. The  
11 selected -- The bias selected claims are not included within  
12 the statistical performance calculations that I displayed to  
13 you today.

14           Results of the categories within the performance  
15 agreements reflect that One Exchange met the agreement  
16 guarantees of accuracies, reimbursement, turnaround times,  
17 and reporting, but unperformed with the customer service  
18 30-second response time for network calls which ranged from  
19 26 seconds in quarter one to 192 seconds in quarter three for  
20 an average of 110 seconds for the plan year. It is our  
21 recommendation that PEBP collect a penalty for this under  
22 performance that we calculate at \$6,995.55.

23           One Exchange, which was originally contracted  
24 with PEBP as Extend Health, has been your administrator for  
25 HRA claims for the PEBP retirees since July of 2011. During  
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1 this time our audits have observed numerous improvements in  
2 the administration of your plan and currently report that the  
3 adjudication processes for member reimbursements are  
4 performing much better than in the past. However, research  
5 of the customer services levels and PEBP member complaints  
6 have detected a few important issues that I wish to present  
7 to you.

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

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

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

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

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

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

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

25           At the time of this audit, overpayments had  
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1 increased by \$105,000 from last year to \$704,321.30, which  
2 represented 1,144 claims.

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

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

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

19 And our last audit issue to present to you today  
20 concerns the response of a One Exchange representative to a  
21 board member's inquiry during your September 2015 board of  
22 directors meeting, in which it was stated that Towers Watson  
23 would have a commission earnings of approximately 3.7 million  
24 dollars for that year. In response to the PEBP's executive  
25 officer's request to validate these numbers within the course  
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1 of our regular audit, we did obtain the data from One  
2 Exchange that reflected the commissions earned for the period  
3 of PEBP's plan year 2016 to be approximately \$3,971,000.

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

6 CHAIRMAN CATES: Thank you, sir.

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

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

11 CHAIRMAN CATES: Good morning. Welcome.

12 MR. SEEGRIST: Thank you. My name is John  
13 Seegrism. I'm vice president of the fund administration for  
14 Willis Towers Watson. We appreciate the chance to be able to  
15 address this with you. We've had a good chance to be able to  
16 work with Bob as we have over the last several years with  
17 Health Claim Auditors and continue to look for areas of  
18 improvement where we can go forward with that where we're not  
19 contesting any of the findings in the audit. The audit was  
20 done very fairly and revealed everything that we wanted to be  
21 able to do as identified areas in there that we continue to  
22 work. I think the main areas that were identified in there  
23 was our carrier relations and trying to find more timely  
24 notification, participation involvement of the plans that  
25 impacts their qualification of a continuing nature that has a  
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1 downstream impact of overpayments on there. That was really  
2 kind of the main thing that we really were planning on trying  
3 to address.

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

13 CHAIRMAN CATES: Very good. Thank you. Okay.

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

20 MEMBER COCHRAN: Mr. Chair, Chris Cochran for the  
21 record. I do -- I would like some explanation on the  
22 overpayments process. I would like to know how many years  
23 are we talking about exactly. It appears that this is a  
24 trend over four years, this \$700,000 -- it's five years.  
25 \$700,000 in overpayment. All right. So can somebody lay

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

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

25 Since the individual policies are owned by the  
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1 retirees, so John Doe owns that, when the carrier recognizes  
2 that he has passed away, they'll refund those premiums that  
3 they have taken out of his account for July, but they return  
4 them to John Doe, not to One Exchange or to PEBP, because  
5 that's who owns the policy.

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

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

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

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

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

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

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

23 MEMBER COCHRAN: Okay. And then for Mr. Carr, I  
24 wanted to question on the complaints. The large percentage  
25 of incoming calls from PEBP participants estimated about 20  
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1 percent of the calls. This is a new report.

2 MS. CARR: Yes.

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

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

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

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

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

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

21 MEMBER COCHRAN: And then coming back to the  
22 overpayments issue again. When that money -- How do we know  
23 when that money has been collected or -- You know, we get  
24 these reports. I think we had a similar situation with a  
25 previous vendor several years ago, a few years ago, where we  
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1 had a significant number of overpayments. And I saw a  
2 comment in there about if it's not done within a certain  
3 number of years you write it off as bad, I guess, bad debt or  
4 bad collections or whatever.

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

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

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

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

23 MS. CARR: To follow up, Dr. Cochran, one of the  
24 other things that we requested this time that is unusual is  
25 now we're asking to dig down in to those overpayment reports  
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1 because John, and thoroughly he believes that, you know, it's  
2 the death, and it may be. We haven't been able to validate  
3 that. So we're going to the next step and being able to  
4 validate why those overpayments are there. Are they truly  
5 what John is saying? Which I believe, you know, has got a  
6 big number. But what else is causing those overpayments?  
7 When you talk about two years, it's a statistical industry  
8 standard that if you've got an overpayment that's aged two  
9 years or greater, it's either you collect it or not. We do  
10 not -- Even though you write them off, we do not let the  
11 vendors wash them.

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

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

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

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

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

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

8 CHAIRMAN CATES: Any other comments from the  
9 members?

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

13 CHAIRMAN CATES: Can you push your button.

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

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

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

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

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

19 MR. SEEGRIST: No.

20 MEMBER ZACK: Okay. Thank you.

21 MR. SEEGRIST: That's just not required.

22 CHAIRMAN CATES: Any other members? Go ahead.

23 MEMBER VERDUCCI: Tom Verducci for the record. I  
24 just want to ask how are those meetings going that you're  
25 having in Carson City one week per month? Is that helping on  
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1 the flow of reimbursement paperwork, enrollment? Are we  
2 seeing any progress there?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21           Also at the bottom of those we're adding an 800  
22 number with a little code on there so they can call in and  
23 listen to a pre-recorded message that gives more detail about  
24 that specific, why that was claimed, so that gives more  
25 detail. And that also links to a message on the website and  
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1 they can go on the website and listen to it. If that is  
2 still not, they can still -- they're always welcome to talk  
3 to a person as well.

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

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

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

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

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

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

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1 know that was an awful long answer to your question.

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

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

21 MEMBER VERDUCCI: Thank you very much.

22 MR. SEEGRIST: Sure. Not a problem.

23 CHAIRMAN CATES: Any other members?

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

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

11           MEMBER VERDUCCI: Okay.

12           CHAIRMAN CATES: Go ahead.

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

17           CHAIRMAN CATES: Do I have a second?

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

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

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

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

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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

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

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

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

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

18           The agreement that you have allows for the  
19 aggregate combination of discounting and dispensing fee  
20 guarantees. So we find at this time that no funds are due to  
21 PEBP within these categories. PEBP is to receive a hundred  
22 percent of manufacturer rebates with a guarantee for each  
23 name brand drug as dispensed. Our calculation for the PEBP  
24 Plan Year 2016 reflects a total of 525,196 to be the minimum  
25 guaranteed payment. At the time of this report, the third  
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1 and fourth quarter rebates had not been received, but we  
2 calculate and recognize that there was a shortfall at that  
3 time of rebates that were collected thus far.

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

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

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

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

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1 that they coordinate with the medical payment.

2 97 percent of files must be transferred each  
3 business day and a hundred percent of files must be  
4 transferred within 48 hours. And the third party  
5 administrator will calculate that -- Well, long story short.  
6 We reviewed the data files from both Catamaran and your third  
7 party administrator and determined that Catamaran only  
8 achieved a 96.5 measurement for the plan year.

9 Even though Catamaran and HCA disagree on this  
10 number and with our findings, we both did agree that the  
11 \$5,000 penalty for the under performance of this category in  
12 PEBP's second quarter was appropriate. So we recommend that  
13 you collect that penalty also.

14 In conclusion, with this report, HCA finds  
15 Catamaran is in compliance with all the other guaranteed  
16 metric measurements and benchmarks. We recommend that PEBP  
17 collect the amount of \$42,423.22 for under performances and  
18 make arrangements for collection of at least an additional  
19 \$271,583, which is the minimum owed for the manufacturer  
20 rebates.

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

23 CHAIRMAN CATES: Thank you. Thank you.

24 Damon, go ahead.

25 MR. HAYCOCK: For the record Damon Haycock. I've  
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1 spoken with Catamaran and we have agreed that although there  
2 is a finding of \$42,423.22 to be assessed against the final  
3 administrative fee payment, that because there are  
4 outstanding rebates that we will not make that final payment  
5 until all rebates have been collected in full and reconciled  
6 to the contract. And so as the board decides today to assess  
7 fees, recognize that we will withhold the entirety of the  
8 final payment until we receive all of the payments that are  
9 due to PEBP.

10 MS. ROSS: If I may.

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

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

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

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1           CHAIRMAN CATES: Okay. Thank you.

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

6           CHAIRMAN CATES: Very good. Thank you.

7           Any comments or questions from the board?

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

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

20           MEMBER GARCIA: Thank you very much.

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

23           MR. HAYCOCK: Thank you, Ms. Garcia. For the  
24 record Damon Haycock. As transitioning new vendors always  
25 has some hiccups, right, we're going from one system to  
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1 another, one group of individuals that people are used to  
2 talking to for, as Mr. Carr stated in this audit, it was  
3 Catalyst and then it was Catamaran and then it was Optum, but  
4 it was the same group of folks.

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

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

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

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

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

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

23           MR. HAYCOCK: For the record Damon Haycock. I  
24 believe that Mr. Carr has the exact schedule but that these  
25 audits are performed on an annual basis. And so once the  
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1 plan year is over there will be a scheduled time period where  
2 Mr. Carr will go out and visit them and perform the exact  
3 same audit that he just performed, or similar to Optum as he  
4 will for Express Scripts. I assume you will see some time  
5 around this time next year the first audit of Express  
6 Scripts.

7 MEMBER ANDREWS: Thank you.

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

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

17 MS. CARR: No, sir.

18 MEMBER WELLS: They did not?

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

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

25 MS. CARR: That is correct.  
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1           MEMBER WELLS: Second question. On page six, the  
2 results that you had originally provided for penalties, you  
3 now agree with Catamaran's response?

4           MS. CARR: Actually they didn't change. Those --  
5 You will find that I will never change any of the vendors'  
6 responses. That was actually included within a response from  
7 Catamaran. The \$15,000 for the transfer was never 15,000.  
8 It was always 5,000. The administration fees were off by  
9 \$5,000 because the original report we received, including  
10 certain paper claim fees and what have you, they're not part  
11 of that. So what happened is we were supplied a second  
12 report from Catamaran, which we are now all in agreement  
13 with. But that was Catamaran's response. That's the reason  
14 I didn't change it.

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

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

19           MS. ROSS: Yeah. It was our tangle.

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

25           MS. ROSS: It's actually from the State  
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1 Department of Treasury. We've been working -- The State  
2 Department of Treasury actually misallocated to another State  
3 of Nevada client. So we're working with the state to  
4 allocate those funds directly to PEBP and not the other  
5 agency. So the payment was made and that's why our records  
6 reflect it was made. We're working with the state to  
7 allocate it correctly to PEBP.

8 MEMBER WELLS: Okay. Thank you.

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

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

15 CHAIRMAN CATES: Do we have a second?

16 MEMBER COCHRAN: I'll second.

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

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

21 MEMBER COCHRAN: I'll second. Chris Cochran.

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

25 (The vote was unanimously in favor of the motion)  
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1                   CHAIRMAN CATES: All opposed say nay. Seeing  
2 none, motion carries unanimously.

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

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

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

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

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

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

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

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

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

18 Moving to slide six. As I mentioned, the present  
19 value of benefits is 2.1 billion dollars. This is for both  
20 the employees' and the retirees' lifetimes, so this would  
21 include all the benefits that are communicated to members  
22 effective on July 1, 2015. For a quick review, some of the  
23 major highlights were the deductible move from \$1900 to  
24 \$1500. The co-insurance moved from 75 percent to 80 percent.  
25 And, as noted earlier, the life insurance differences were  
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1 retiree moved from \$5,000 to 12 and a half thousand. Actives  
2 10,000 to 25,000. And another major component was the dental  
3 benefits moved from a \$1,000 annual max to a \$1500 annual  
4 max. And when we look at the total liability, about 62  
5 percent of this liability is for the active employees,  
6 meaning the future retirees.

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

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

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

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

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

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

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

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

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1 It's a very direct relationship there.

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

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

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

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

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

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

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1 MR. NIMMER: Yes.

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

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

6 (Recess was taken)

7 CHAIRMAN CATES: I would like to call the meeting  
8 back to order. Let's see, where are we at? Number eight,  
9 Agenda Item Number 8, state of PEBP report for Plan Year  
10 2016. Damon.

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

23 And so in front of you, you should have the  
24 packet on the specific report. Similar to prior years, we  
25 have replaced the mission and value statement. These are the  
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1 updated missions and value statements that were approved by  
2 the board based on the advisory committee's recommendation  
3 last spring.

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

10 We, however, on the consumer-driven health plan  
11 experienced much better than projected cost in Plan Year  
12 2016. Some of these factors include, we had, although an  
13 increased population of 6.6 percent with our participants and  
14 a total of 7.8 percent with our covered lives, we believe  
15 that they did not utilize the plan at the same rate as the  
16 existing population and therefore due to that mix the costs  
17 were not proportional to the increased population.

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

24 We attribute that to very aggressive  
25 negotiations. Often our high cost claims are out-of-state  
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1 services. And our third party administrator HealthSCOPE  
2 Benefits does an excellent job in putting the participants  
3 and Nevadans first in making sure that we have the best  
4 pricing for the services that are required.

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

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

19 Also in Plan Year 16 we saved an additional 5.2  
20 million dollars, 3.4 million in out-of-network negotiations,  
21 \$490,000 in subrogation. And that's the recovery from other  
22 insurance who should pay first. \$570,000 in out-of-state  
23 transplant services and \$827,000 in ambulatory services.

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

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

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

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

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

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

25 So that, I want to include in this specific state  
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1 of PEBP report because it's going to explain why we have the  
2 excess reserves that we have for the next agenda item.

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

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

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

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1 policy.

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

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

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

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

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

24 Our website overhaul occurred, many of you  
25 already know. Back in November of 2015, we awarded a new  
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1 contract for that website redesign to KPS3, a local marketing  
2 and development team, out of Reno, Nevada. And more  
3 information, of course, is lower in this report.

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

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

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

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

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

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

24                   Depending on who you talk to, I think it's a good  
25 thing. It means that we were very astute and efficient with  
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1 how we managed our plan. But it also gives us an opportunity  
2 for our next agenda item to talk about what to do with those  
3 and now that we have additional how many more benefits can we  
4 potentially save.

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

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

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

24           We have derived our revenue in Fiscal Year 16  
25 from three primary sources. This hasn't changed. We  
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1 received state subsidies. We receive other contributions and  
2 funds carried forward from previous years.

3 Program revenues can only be spent on program  
4 expenses. In 2016 the expenses of the program were the same  
5 ones honestly that we've had each year: Self-funding  
6 administrative claims, health savings accounts, health  
7 reimbursement arrangement contributions, fully insured  
8 premiums, and agency operations. The balance, which is about  
9 29 percent, was reserved and carried forward in to this  
10 current fiscal year, 2017.

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

21 So as a recap, in November 2014, the board did  
22 approve plan benefit design for the previous plan year, Plan  
23 Year 2016. The rates were approved in March of 2015 and  
24 include the continuation of the enhancements that you have  
25 today. Those are a decrease to the consumer-driven health  
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1 plan deductible from \$1900 and \$3800, that's individual and  
2 family, to 1500 and \$3,000 respectively, and increased  
3 co-insurance rates from 75 percent to 80 percent. One annual  
4 vision screening exam not subject to any deductible or  
5 co-insurance. An increased dental annual maximum benefit  
6 from 1,000 to \$1500. That increased basic group life  
7 insurance benefit from 10,000 to 25,000 for employees and  
8 from 5,000 to 12-point-5,000 for retirees. Additional HSA  
9 and HRA contributions, and, of course, Medicare Part B  
10 premium credits for retirees that were enrolled in our  
11 consumer-driven health plan or HMO.

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

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

24 We have a defined employer contribution. That is  
25 that subsidy bill that is approved on a biennial basis. So  
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1 whatever gets approved at the legislature in this upcoming  
2 session will be the money we have to live on and we'll have  
3 to make decisions in the off year and hopefully we had the  
4 right decisions going in to the session.

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

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

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

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

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

7 CHAIRMAN CATES: Go ahead, Tom.

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

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

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

5           MEMBER VERDUCCI: Thank you.

6           CHAIRMAN CATES: Go ahead.

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

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

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

23          However, they were able to have very minimal  
24          increases to rates when we extended their contract. I think  
25          that was presented previously prior to you being on the  
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1 board. And so we need to make sure that we work with them to  
2 determine if their experience and the rates that were  
3 presented to us confidentially are appropriate. So long  
4 story short, it's a little too early to tell. But we're  
5 definitely getting that information.

6 MEMBER ZACK: Thank you.

7 CHAIRMAN CATES: Other comments, questions from  
8 the board?

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

11 MR. HAYCOCK: Thank you.

12 CHAIRMAN CATES: Okay. Let's move on to the big  
13 one. Okay. Agenda Item Number 9, discussion and possible  
14 action regarding proposed plan design changes for Plan Year  
15 2018.

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

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

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

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

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

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

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

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

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

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1 Is it Towers Watson Exchange?

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

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

12 CHAIRMAN CATES: Thank you very much.

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

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

24 The other thing that I would like to throw out  
25 for our board is, again, those concerns about Towers Watson  
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1 remain. I won't go through them right now because they're  
2 well-documented and archived in the minutes from prior AFSCME  
3 statements and prior meetings.

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

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

23 So we do appreciate that we're glad that they --  
24 that the PEBP staff were able to do the hard work and find  
25 some excess reserves that they didn't think they had and make  
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1 these suggestions creatively to help smooth what, as I  
2 understand, and my members do understand, was never intended  
3 to be permanent enhancements. We would like more opportunity  
4 to talk to our members now about this.

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

10 CHAIRMAN CATES: Thank you.

11 MS. MALONEY: Thank you.

12 MS. BOWEN: Good morning. My name and my words  
13 for the record, Peggy, P-e-g-g-y, Lear, L-e-a-r, Bowen,  
14 B-o-w-e-n, are concerning this issue and how we're -- the  
15 process we're using today. What was beneficial in the past  
16 to us as the members of the audience and constituents of your  
17 board was that the presenters for each of these items and  
18 what they were recommending and why, those presentations took  
19 place and then a public comment session was allowed before a  
20 vote was taken. And that gives us a process to know what's  
21 going to be presented and not shooting in the dark and hoping  
22 we hit a mark that might come up later. And if you could  
23 possibly consider that even today. And I know that you're  
24 not supposed to act on public comment today, but I think you  
25 can act on process today. Because it was not listed here on  
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1 the agenda about the public comment session and what you were  
2 going to do that you can enhance what you might want to do to  
3 allow a public comment session after everything has been  
4 heard so we can speak with knowledge, at least as today's  
5 presentation goes. Thank you very much.

6 CHAIRMAN CATES: Thank you.

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

11 MR. HAYCOCK: Please.

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

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

25 The 2015-2017 plan design, including those  
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1 enhancements, should serve as a base model moving forward  
2 because that's what the state employees have experienced in  
3 practice. Changing plan design from year to year is  
4 confusing for participants and likely contributes to the  
5 extremely off street of actual aerial cost predictions over  
6 the past five years.

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

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

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

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

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

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

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

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

21 CHAIRMAN CATES: We're at three minutes.

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

24 Finally, I would just like to reiterate that we  
25 need fair cost proposals for both the base grant and keeping  
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1 all of the enhancements in order to know how to really move  
2 forward and let the legislators and participants know the  
3 true situation. And so thank you very much.

4 CHAIRMAN CATES: Thank you.

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

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

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

2 CHAIRMAN CATES: Thank you.

3 Any more public comment here in Carson City?

4 How about in our overflow room?

5 UNIDENTIFIED SPEAKER: No, sir.

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

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

10 CHAIRMAN CATES: Okay.

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

12 CHAIRMAN CATES: Yes, we can hear you.

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

21 The committee met on Tuesday and spent almost two  
22 hours reviewing Agenda Item Number 9. During our meeting,  
23 members expressed some dismay at the incremental addition of  
24 \$100 to the individual deductible amount. We fear the  
25 addition could be the beginning of a series of reductions to

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1 benefits and hope it is not.

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

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

12 The committee understood that some items  
13 presented by staff could be seen as reduction benefits but  
14 are actually being proposed in order to better fund the  
15 health care of all CDHP participants. These items include a  
16 \$25 co-pay for annual vision exams, implementing and HRA  
17 annual rollover cap of \$5,000, requiring Medicare Exchange  
18 retirees to pay life insurance premiums and HRA  
19 administration fees, instituting reference-based pricing, and  
20 adding a hearing aid vendor with an established network.  
21 Although we did wonder if we could avoid the cap while still  
22 adding the concierge vendor.

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

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

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

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

16 CHAIRMAN CATES: Thank you.

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

22 CHAIRMAN CATES: Okay. Who's next?

23 MS. SUMNER: Right here. My name is Raven  
24 Sumner, S-u-m-n-e-r. I am also a member of the UNLV Employee  
25 Benefits Advisory Committee as well as a member of the  
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1 Academic Faculty Committee. And I'd like to say that we do  
2 support what Shaun had just stated. And thank you very much  
3 for your time.

4 CHAIRMAN CATES: Thank you.

5 Any other public comment?

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

20 CHAIRMAN CATES: Okay. Thank you.

21 Do we have any other public comment in Las Vegas?

22 Okay. Seeing none, we'll close public comment.

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

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1 break and we'll reconvene at 11:20.

2 (Recess was taken)

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

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

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

23 Obviously the introduction to this report  
24 discusses the things that we were asked to do, right. We  
25 were asked at our September 22nd board meeting to provide the  
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1 board opportunities for additional plan year benefit design  
2 analysis and we have developed analysis on this laundry list  
3 of 14 items that we knew we needed to go back and research.

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

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

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

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

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1 next fiscal year. So you'll see that we started with about  
2 140 million dollars of cash. However, we earmark funds from  
3 that cash to make sure that we can fund our reserves. If we  
4 don't do that then we have to raise rates and ask everybody  
5 to give us more money to then fund reserves every year.

6 And so we carried forward these funds to ensure  
7 that we have enough operating capital in our approved reserve  
8 levels to keep the plan solvent. So you'll see that we have  
9 36 million dollars of budgeted reserves. And these are  
10 legislatively-approved budgets. We have almost 29 million  
11 dollars of incurred but not reported reserves. We have 25,  
12 just over 25 million dollars in catastrophic reserves.

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

21 Now, one of the things that we did, because we  
22 recognize that no one likes to be told, and I don't ever like  
23 telling people, hey, I want to cut your benefits because we  
24 don't have money. Are we truly as efficient as we can be?

25 Can we get a little bit more aggressive with some of these  
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1 reserves? Because reserves generally are carried forward  
2 year to year. And it's actual cash. And so it's cash that's  
3 not necessarily going back to the plan to help reduce costs  
4 or reduce rates.

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

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

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

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

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

22 But for a brief history lesson, I believe it was  
23 2000 and 2001, PEBP had to go back and ask for a significant  
24 amount of funding to bail out the program. And so these  
25 catastrophic reserves were designed to hopefully prevent  
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1 that. And they're designed at a 95 percent competence level.

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

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

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

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1 there.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24 Then we talk about the PEBP maximum dental. This  
25 is actually applied to all plans. Because both the HMO's and  
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1 our Medicare Exchange folks are eligible to participate in  
2 our dental plan. So we have a significantly higher  
3 population in dental as we do just in the consumer-driven  
4 health plan.

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

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

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

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

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

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

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

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

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

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

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

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

22 Well, our base plan initially in 2012 had a \$700  
23 HSA and HRA contribution for the individual participant and  
24 \$200 for each dependant, max three. All right. That was the  
25 base. And over the last three years we've been able to

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

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

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

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

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

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

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

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

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1 find something wrong they can address it. Out of all the  
2 folks that are 19 years old plus, males, females, regardless,  
3 35.3 percent of our planned participants actually did it.  
4 35.3 percent go to the doctor once a year to see are they  
5 okay.

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

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

20           So with that, I'll return back to the report.  
21 But there are two options that we would like to potentially  
22 tie this enhanced HSA/HRA funding to. Not the base amount  
23 but the enhanced amount. One option is to do a match. If  
24 you think about it today, there are many private sector  
25 organizations that have a matching process for retirement,  
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1 all right. You put in X percent of your pay. The employer  
2 puts in X percent of your pay. And it goes in to 401K or  
3 other type of retirement account. And it's basically a  
4 teamwork approach to retirement.

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

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

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

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

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

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

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

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

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

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

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

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1 without them.

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

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

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

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

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

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

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

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

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

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

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

23 So as you heard from Towers Watson earlier today,  
24 they talked about some of the HRA and customer service  
25 things, Towers Watson has a third party administrator that  
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1 manages that HRA, just like we do with HealthSCOPE. Well,  
2 the retirees on the Medicare exchange aren't paying that part  
3 of it. Everybody else is.

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

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

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

24 So, initially, we looked at, well, we want to  
25 look at that, we don't want to expose the plan to high cost  
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1 mark-ups. And thanks to working with our excellent third  
2 party administrator, they found a network that actually will  
3 help people get the hearing aids that they need. And we can  
4 design the benefits within there. We can design it where it  
5 has a \$1500 per ear minimum. Excuse me. Maximum. But at  
6 least when someone needs a hearing aid, they call the number,  
7 they call HealthSCOPE. There will be a potential menu item  
8 that goes to this concierge company. And they can talk to  
9 someone and say, I need a hearing aid and I was prescribed  
10 this and what should I do? And they'll help them and walk  
11 them through that process. And that cost is nothing to them.  
12 Nothing at all.

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

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

22 What I do want to say is that not tying the HRA  
23 to the Medicare Exchange does not mean you lose your  
24 automatic reimbursement. That's not what it means at all.  
25 You can stay with Towers Watson for the rest of your life and  
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1 you can have automatic reimbursement and they will gladly  
2 manage that for you. That's not the problem. That's not the  
3 process.

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

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1 choice.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 Now, of course, the answer has always been, well,  
23 we give you \$1100 or \$1500 or \$2,000 so you don't. But  
24 regardless of the HSA/HRA funding, there is an opportunity  
25 for PEBP to provide a new benefit to participants to allow  
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1 still need a little bit more information to make that final  
2 decision. And I would like the ability to come back to the  
3 board and revise recommendations based on up-to-date  
4 information in January and a final information in March.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19 MEMBER COCHRAN: Okay, okay. So the minimum is  
20 1400 now. Okay. So, you know, I was just looking at  
21 considering it that way because if we could lower it to 1200  
22 and we still have the \$700 HSA, that would make it much more  
23 palatable. So, you know, I think that if the minimum is 1400  
24 I would look to see what we would reduce our enhancements by,  
25 by going to the minimal deductible. I'm assuming those are  
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1 IRS purposes for doing that. So I would like us to be  
2 considering that option.

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

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

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

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1 are.

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

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

21           CHAIRMAN CATES: Go ahead.

22           MEMBER ZACK: Thank you, Mr. Chair. Christine  
23 Zack for the record. Damon, I know that we're not taking any  
24 action on the clinics today. However, since you're coming  
25 back in two months with the recommendations and that this was  
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1 something I really pushed for during the last board meeting,  
2 I wanted to make sure we're also still considering partnering  
3 with existing operators in the community that would bear more  
4 of the cost of creating and building these clinics. Because  
5 I've looked at the pricing in the Aon study and I think that  
6 there might be an opportunity through partnerships with  
7 current operators to offset a significant amount of those  
8 costs.

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

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

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

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

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

10 MR. HAYCOCK: Yes.

11 MEMBER ZACK: All right. Perfect. Thank you.

12 MEMBER BAILEY: Mr. Chair.

13 CHAIRMAN CATES: Go ahead.

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

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

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1                   CHAIRMAN CATES: Go ahead, Ana.

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

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

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

23                   CHAIRMAN CATES: Tom.

24                   MEMBER VERDUCCI: Tom Verducci for the record. I  
25 just want to point out that I think it's very important that  
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1 we do focus on the HSA contributions. I do see that this is  
2 the direction the country is going in in terms of employees  
3 making a contribution. Whatever we can do with the -- to  
4 provide an incentive for that I think would be helpful. But  
5 also where employees could choose from HSA or HRA, I would  
6 really like to lean them towards the HSA because it's  
7 portable. And a lot of the HRA funds are forfeitable. So if  
8 it's possible to even mandate or encourage them to first make  
9 the contributions in to the HSA I would be very supportive  
10 for that.

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

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

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

15 CHAIRMAN CATES: Go ahead.

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

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

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

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

20 CHAIRMAN CATES: Go ahead.

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

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

11 CHAIRMAN CATES: Any other comments?

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

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

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

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

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

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

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

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

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

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

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

25 MEMBER WELLS: I have to put in a dollar amount  
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1 for the state share in the budget.

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

3 MEMBER WELLS: My position on?

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

6 MEMBER WELLS: What is my title?

7 MEMBER GARCIA: Yes, sir.

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

10 MEMBER GARCIA: Thank you. Not everybody knows  
11 that.

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

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

24 So we have been working -- And I have been  
25 working with Damon on some of these to see how close we're  
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1 getting to what the numbers could be, given where we are with  
2 the reserves are today. You're never going to know what the  
3 reserves are in FY 17 before you set the rates for FY 17. So  
4 at some point you're going to have to leap off a bridge and  
5 have faith that those reserves are going to be there.

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

8 MEMBER GARCIA: Thank you.

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

16 MR. HAYCOCK: Thank you, Mr. Chairman. Damon  
17 Haycock for the record. I want to address something that  
18 Ms. Lamborn said. What's our target? Right now we believe  
19 we have 25 million dollars. And the recommendation that PEBP  
20 has placed forward today on those specific items is spending  
21 13.2 of that. So just about a little over half. I'm sorry,  
22 I realized after I wrote the report that that's probably a  
23 pretty important figure that should have been in here. So my  
24 sincere apologies to the board.

25 But the idea, again, is to try to create a  
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1 benefit that can sustain at least over a two-year period and  
2 hopefully with continued cost savings that we would be able  
3 to keep that 13.2 and make it 26.4 and make up the additional  
4 million plus that needs to happen for those reserves.

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

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

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

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

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

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

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

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

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

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

11 Okay. So CDHP deductible and co-insurance  
12 levels. The PEBP's board recommendation is to incremental  
13 reductions in this enhanced benefit will result in \$1600,  
14 \$3200 deductible while keeping the co-insurance levels at  
15 80/20. Does anybody want to make a motion to approve this  
16 recommendation?

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

19 CHAIRMAN CATES: Do I have a second?

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

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

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

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

6                   MEMBER COCHRAN: Mr. Chair, I have a request for  
7 information on this. When we're talking about these  
8 incremental changes, so we're saying we want to go up to  
9 \$1600 deductible from the current \$1500 deductible, does that  
10 mean the next year we go up to a \$1700 deductible or are we  
11 capping it at the \$1600 deductible? And can we consider  
12 remaining at the \$1500 deductible for the sake of developing  
13 the budget?

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

24                   MEMBER COCHRAN: Okay. Just to be clear because  
25 we are talking about plan benefit year '18. We've heard  
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1 conversation among board members that we want to work our way  
2 back to what we originally had in 2012. So when we talk  
3 about increasing this a hundred dollars incrementally, we're  
4 talking about getting back to the 2012 plan year by  
5 approximately 2022, you know. So, I mean, that's, you  
6 know -- And it may not even happen, right. Because things  
7 could change in the budget. So I think it needs to be clear  
8 that we're not necessarily saying we're getting rid of the --  
9 we're going back to the way things were in 20 2012 and it  
10 could change. But I just, you know, so when I hear  
11 incremental changes, it implies to me that we are going to  
12 creep back up to that original amount in some -- And that the  
13 board is committed to do that. But maybe I'm misreading.

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

22 And so my estimation, my assumption, if you'll  
23 let me, is that this time next year we would come back and  
24 talk about '19 plan benefit design based on hopefully some  
25 more information that we receive in January on the budget to  
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1 kind of outline where we think we're going. But just like  
2 every year, this board will choose the plan benefit design  
3 for the next plan year traditionally at the November board  
4 meeting. So I don't think this is a set in stone for  
5 anything but Plan Year 18. And, again, I will come back in  
6 January with updates to numbers regardless.

7 MEMBER WELLS: Mr. Chairman, it's Jim Wells. I  
8 kind of want to be a little bit clear here that the base plan  
9 is still the base plan. We are buying up -- buying down,  
10 whatever you want to call it, the deductible. Instead of  
11 buying up or down to \$1500 next year, we're buying down to  
12 1600. And instead of 3,000, we're buying down to 3200. And  
13 we are still maintaining the 80 percent co-insurance rate.  
14 And these are still relatively one chunk in my opinion and my  
15 vote for the affirmative satisfies this, that is my  
16 understanding.

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

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

23 MR. HAYCOCK: For the record Damon Haycock. Yes.  
24 I looked at it as a, you know, you go to the restaurant and  
25 you buy off your menu and this is how much you're paying and  
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1 you know you only have 25 million dollars in your pocket,  
2 right, for kind of a silly type of an example. It's not --  
3 It's the inverse. This is everything -- I think Jim said it  
4 very eloquently. This is everything that's being bought up  
5 with excess money. This isn't everything that's being saved  
6 because technically the base plan is the base plan. So where  
7 do you find -- How much do you want to buy your purchasing  
8 powers for the excess reserves that we believe that we have  
9 today? So say we're going to save \$75,000, if you'll let me,  
10 I would like to say we're spending three million dollars for  
11 this benefit that is above and beyond the base benefit that  
12 was designed in the plan in 2012.

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

21 MR. HAYCOCK: For the record Damon Haycock. Yes,  
22 we're definitely keeping track. And I have an actual sheet  
23 that has all of the recommendations and the sticker price and  
24 what the total is? Again, I'm not expecting the board to  
25 accept all of PEBP's recommendations as stated in this. If  
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1 you did, it's 13.2 million dollars, which is a little bit  
2 more than half of what we believe is excess reserves.

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

9 MEMBER WELLS: Jim Wells for the record. When  
10 PEBP submitted its agency budget request with the flat and  
11 minus five percent, they were required to go back and put in  
12 the base plan to get down to those kind of numbers. So when  
13 we're talking about today what's in the base budget, we're  
14 really talking about the zero that's the 1900, the 3800 and  
15 75/25 co-insurance. So that's what was submitted in the  
16 budget. We're using down excess reserves to pay 3.06 million  
17 to buy down to 1600, 3200, and keep the 80/20.

18 MR. HAYCOCK: Sorry.

19 CHAIRMAN CATES: Thank you. That's very helpful.  
20 Go ahead.

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

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1 expand on that?

2 MR. HAYCOCK: Yes. For the record Damon Haycock.  
3 Thank you. My initial intent was to read through this report  
4 start to back and then say at the final recommendation, which  
5 was let me come back in January with better numbers and then  
6 that may adjust this up or down. So if there's more money  
7 maybe our recommendation is we don't buy down the -- we don't  
8 change the deductible, that we can keep it at its current  
9 1500 and 3,000 or maybe if there's less money that we will  
10 come back and say we actually want to do a \$200 reduction.  
11 It was just trying to share all the different opportunities.

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

17 MEMBER VERDUCCI: Thank you.

18 CHAIRMAN CATES: Okay. Any other comments on the  
19 motion? Hearing none, those in favor of the motion say aye.  
20 (Members Cates, Verducci, Andrews, Bailey, Zack, Lamborn, and

21 Wells voted aye)

22 CHAIRMAN CATES: Those opposed?

23 MEMBER GARCIA: No.

24 MEMBER COCHRAN: No.

25 CHAIRMAN CATES: That's two no's. Okay. Motion  
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1 carries.

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

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

10 CHAIRMAN CATES: Okay. Do I have a second?

11 MEMBER GARCIA: Second.

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

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

16 CHAIRMAN CATES: Those opposed? The motion  
17 carries unanimous.

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

22 MR. HAYCOCK: So for the record Damon Haycock.  
23 Again, that's not eliminating life insurance. It's reducing  
24 it to the 2012 levels of \$10,000 benefit for employees and  
25 \$5,000 benefit for retirees. So it is not an elimination of  
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1 the entire benefit, just those enhanced benefits provided for  
2 the last, I believe, three years.

3 CHAIRMAN CATES: Any discussion or motion?

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

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

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

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

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

23 MEMBER VERDUCCI: I just have a question for  
24 Damon. If we had the benefit reduced to \$10,000 but the  
25 retiree wanted to keep the same coverage and make a voluntary  
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1 contribution to maintain their life insurance benefits, would  
2 that be possible in this scenario?

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

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

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

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

9                   CHAIRMAN CATES: Very good. Any other comments?

10                  MEMBER BAILEY: I do.

11                  CHAIRMAN CATES: Go ahead.

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

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

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

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

25                  MR. HAYCOCK: For the record Damon Haycock. The  
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1 employees then would go and have their annual vision exam and  
2 be required to pay \$25 at the desk. It's just a straight  
3 co-pay that they would have to pay. And that would offset  
4 the cost of the claim going back to our third party  
5 administrator. And the plan would pay the difference up to  
6 the maximum allowable.

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

9 MR. HAYCOCK: Correct.

10 MEMBER BAILEY: Thank you.

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

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

16 MEMBER COCHRAN: Yeah, the enhancement.

17 MR. HAYCOCK: I'm sorry.

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

22 MEMBER WELLS: This is Jim Wells for the record.  
23 Prior to 2011 you could get one exam a year and one set of  
24 glasses every other year subject to the, I think there was a  
25 hundred dollar maximum back then. When the plan went in to  
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1 effect in 2012, there was no exam, period. It was part of  
2 your deductible and co-insurance. This was an enhanced  
3 benefit to put it in without a co-payment.

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

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

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

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

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

25 MEMBER GARCIA: Right. With the hundred dollars.  
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1 Up to the hundred dollars. I think that plan really works  
2 very well overall in satisfying people with children in  
3 getting the necessary annual exam and also knowing that they  
4 could also see after they get the exam, if needed.

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

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

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

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

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

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

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

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

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

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

24                  MR. HAYCOCK: Let me verify with staff. But I  
25 think it's right around a hundred dollars or 125. I have to  
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1 look at the summary plan document and do it real quick.

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

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

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

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

11 MR. HAYCOCK: Correct.

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

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

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

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1 services.

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

9 CHAIRMAN CATES: Any other comments?

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

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

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

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

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

24 MEMBER BAILEY: Okay. At the end of this meeting  
25 or not the end of this meeting but we're having public  
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1 comment; correct?

2 CHAIRMAN CATES: Correct.

3 MEMBER BAILEY: Okay. Thank you.

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

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

9 CHAIRMAN CATES: Opposed?

10 MEMBER GARCIA: No.

11 MEMBER VERDUCCI: No.

12 CHAIRMAN CATES: Okay. Motion carries.

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

22 (Recess was taken)

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

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

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

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

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

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

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

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

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

24                   MR. HAYCOCK: For the record Damon Haycock. I  
25 just wanted to make a clarification. It was made at the  
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1 September 22nd board meeting and I didn't carry it forward in  
2 this report, but the anticipation isn't that we necessarily  
3 do this on July 1 of 2017. Because we want to provide the  
4 opportunity for -- at least the recommendation was contingent  
5 upon the opportunity that participants are aware of it and it  
6 doesn't sneak up and bite them on July 1 and that we would  
7 assess that at the end of the plan year.

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

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

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

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

25 MEMBER ZACK: Thank you. Christine Zack for the  
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1 record. I move to -- Let me make sure I get the wording  
2 correct -- to cap the amount at the \$5,000 as recommended by  
3 PEBP.

4 CHAIRMAN CATES: Do I have a second?

5 MEMBER BAILEY: I second the motion.

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

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

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

23 MEMBER GARCIA: I just want to not hold harmless.  
24 But I want to make sure that members who might currently have  
25 a balance of \$6,000 would be -- would they be able to always  
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1 keep that balance or would it go away?

2 MR. HAYCOCK: Operationally, Ms. Garcia -- Damon  
3 Haycock for the record. Operationally, PEBP foresees that if  
4 this plan benefit design change is approved, on July 1,  
5 whatever is in their HRA account on July 1 of next year they  
6 would have. And at the very end of the year, the last day of  
7 the year, we would take a snapshot and see who had more than  
8 \$5,000 and we would reduce their available balance to \$5,000.  
9 So it's not something we would implement the first day but  
10 give everybody a chance to understand what's happening with  
11 their HRA to appropriately communicate it and to apply the  
12 rollover cap at the end of the plan year, not at the  
13 beginning.

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

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

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

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

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

7 CHAIRMAN CATES: Right.

8 MEMBER GARCIA: Okay. Thank you very much.

9 CHAIRMAN CATES: Any other discussion on the  
10 motion?

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

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

24 MEMBER WELLS: This is Jim Wells for the record.  
25 It's actually not a new idea. There was always a discussion  
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1 of having an HRA cap when the plan was put in place and there  
2 were annual votes for the first couple years. But because we  
3 really hadn't put enough money in, we never had gotten to the  
4 point where the cap, a realistic cap anyway, had been met  
5 from the contribution. And since employees and retirees  
6 can't contribute to their own, it's only state contributions  
7 that are getting in there. Now that we are far enough along,  
8 the conversation is back to having a cap. But we have had  
9 this conversation before.

10 CHAIRMAN CATES: Any other comments on the  
11 motion?

12 MEMBER COCHRAN: Just to be clear -- This is  
13 Chris Cochran for the record -- the cap is \$5,000 and we are  
14 saying that it can't be capped at a higher amount than the  
15 \$5,000? I think that's what Tom was asking.

16 MEMBER VERDUCCI: Tom Verducci for the record. I  
17 believe the question that I heard there is can it be a higher  
18 amount than 5,000? Could it be 6,000? And this is a  
19 comment, this 750 balance that these are affected here, and I  
20 would be curious, are there balances out there that be ten,  
21 12,000? I mean, what's going to be the actual impact on one  
22 person? Are we looking at any balances that are  
23 substantially higher than \$5,000 or just giving a nominal  
24 amount?

25 MR. HAYCOCK: For the record, Damon Haycock. I  
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1 want to be very careful in how I answer this  
2 question, Mr. Verducci, because I don't want to misstate.  
3 What you see in front of you is the average account balance,  
4 not the maximum account balance. And so if all of them had  
5 that exact same account balance, it would be a \$876 loss.  
6 And that, depending on who you talk to, is never nominal,  
7 right. But we have balances that are significantly higher  
8 and we have balances that are closer to the \$5,000 and the  
9 penny. And so it will affect some individuals in that 750  
10 number of accounts, some individuals dramatically and some  
11 individuals very little at all. And we can come back with a  
12 line by line, 750 line item number and say this is how many  
13 people lose it per dollar. But, again, it's -- we took an  
14 average to not take up 50 pages of a report, but we can  
15 definitely do that if you guys would like. But we recommend  
16 5,000 just because it does cover -- it covers deductibles at  
17 any discussion we've had today. And that's really what we  
18 believe would be the most important that people had first  
19 dollar coverage for health care if they were on the HRA.

20 MEMBER VERDUCCI: Thank you very much.

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

2 Any other comments?

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

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

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

8 CHAIRMAN CATES: Opposed? The motion carries  
9 unanimous.

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

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

18 MR. HAYCOCK: For the record Damon Haycock.  
19 These figures, I was provided participant count for vision  
20 claims from our third party administrator HealthSCOPE  
21 Benefits for the years 2015 and 2016 as well as the plan  
22 cost. So I was provided a download of those. I took those  
23 and I took the percent increase from one year to the next and  
24 I applied probably very simple math and just trended it  
25 forward and said if we're going up by X amount per year and  
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1 our population continues to grow, is it safe to say that it's  
2 probable that more folks will then need to see the eye doctor  
3 and then how many percentage of those folks would potentially  
4 need glasses. And that's why I gave three different  
5 analysis. A third of those folks, two-thirds of those folks,  
6 or every person that walks in to an eye doctor walks out with  
7 a pair of glasses. So there's some options here.

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

19           MEMBER BAILEY: Okay. Thank you.

20           CHAIRMAN CATES: Any other comments or questions?

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

24           CHAIRMAN CATES: That's correct.

25           MR. HAYCOCK: For the record Damon Haycock. You  
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1 guys can pass a motion to approve the no hardware benefit,  
2 you can pass a motion that says we like the hardware benefit  
3 and we want to fund it at a hundred dollars. It's truly up  
4 to the board's discretion.

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

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

12 MEMBER COCHRAN: Okay.

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

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

25 CHAIRMAN CATES: Any other comments?  
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1 UNIDENTIFIED SPEAKER: What did he say?

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

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

15 CHAIRMAN CATES: Thank you.

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

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

25 MEMBER COCHRAN: Mr. Chair, I'll make a motion  
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1 that we follow staff's recommendation and not enhance the  
2 benefits for hardware.

3 CHAIRMAN CATES: Okay. Second?

4 MEMBER LAMBORN: Leah Lamborn. I second that.

5 CHAIRMAN CATES: Any discussion on the motion?

6 Seeing none, I'll call for a vote. All in favor of the  
7 motion say aye.

8 (All members except Member Verducci voted aye)

9 CHAIRMAN CATES: Any opposed?

10 MEMBER VERDUCCI: Opposed.

11 CHAIRMAN CATES: One opposed. Motion carries.

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

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

25 MR. HAYCOCK: For the record Damon Haycock. We  
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1 are currently paying a \$25,000 benefit for our members that  
2 are employees and a \$12,500 benefit for our retirees. We  
3 have a base plan amount that we build in at the 10,000 and  
4 5,000 amount respectively and we have been utilizing excess  
5 reserves to offset the additional premiums for those  
6 additional enhanced life insurance benefits.

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

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

23 MR. HAYCOCK: So for the record Damon Haycock.  
24 Unfortunately, and I will endeavor to do better next time,  
25 there's pluses and minuses in this report and a lot of these  
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1 are what are we going to buy. That's the plus, or the minus,  
2 depending on how you want to look at it. But what this does  
3 is it will return \$797,000 to the plan to go back in to the  
4 bucket for excess reserves to offset the cost for these other  
5 plan benefit design decisions. And once you all decide  
6 exactly what you want, we can quickly give you a running  
7 total.

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

13 MR. HAYCOCK: Correct.

14 MEMBER ZACK: Okay. Thank you.

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

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

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

25 MEMBER ANDREWS: Ana Andrews. Second.  
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1           CHAIRMAN CATES: Okay. We have a motion and a  
2 second. Any discussion on the motion? Seeing none, I'll  
3 call for a vote. All in favor of the motion say aye.

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

5           CHAIRMAN CATES: Opposed? Motion carries  
6 unanimously.

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

9           MR. HAYCOCK: Can I clarify?

10          CHAIRMAN CATES: Sure, Damon, go ahead.

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

24           But what we really wanted to do is to slowly  
25 shift the environment that providers that support the state's  
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1 health plan do not get to mark up exorbitantly the costs to  
2 our participants. And we want to ensure that we send the  
3 message that that will no longer be tolerated. And that's  
4 what the intent is of this plan benefit design.

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

14 CHAIRMAN CATES: Any comments?

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

17 CHAIRMAN CATES: Any other comments?

18 MEMBER BAILEY: Jim, would you repeat that.

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

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

25 CHAIRMAN CATES: Any other comments on this item?  
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1 If everybody just wants to move on, I don't think we need a  
2 motion. Everybody agreeable to that? We'll just move on.

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

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

2 CHAIRMAN CATES: Any other comments?

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

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

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

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

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

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

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

18 CHAIRMAN CATES: Thank you.

19 Any other comments?

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

23 MEMBER GARCIA: Mr. Chair.

24 CHAIRMAN CATES: Well, we're having a discussion  
25 right now. Nobody has made a motion. So if we don't do a  
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1 motion, we just move on.

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

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

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

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

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

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1                   CHAIRMAN CATES: Any other comments?

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

6                   CHAIRMAN CATES: Is there a second?

7                   MEMBER COCHRAN: I'll second. Chris Cochran.

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

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

21                  We can talk about choice. And that is probably  
22 the one thing where I would concur, this will give more  
23 choice. However, if we want to have choice, why don't we  
24 just give people their money and let them pick whatever plan  
25 they want to be on. We don't do that. We provide plans for  
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1 our participants that they enroll. So if you want to have  
2 choice for everyone, then let's have choice for everyone.  
3 But to just say this is the only reason that we're doing it  
4 is choice is not something I agree with and I'll be voting  
5 no.

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

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

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

22 CHAIRMAN CATES: Any other comments on the  
23 motion?

24 MEMBER ANDREWS: Ana Andrews for the record. I  
25 believe Mr. Wells made a statement earlier that has me  
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1 thinking. Initially I was going to support this motion, but  
2 I think I'm also going to vote no. And the reason is he  
3 mentioned that we probably should defer this until the  
4 overpayment issue with Towers Watson is resolved. My  
5 recollection is that we've been having complaints and issues  
6 with Towers Watson for quite a few months or years. And the  
7 amount of overpayments is of concern to me. While I  
8 understand that after two years your chances of recovering  
9 the money is not that good, at this point I don't think I can  
10 support this motion.

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

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

23 The other part of this for me is that if you have  
24 a group -- And who knows how many thousands of people or  
25 hundreds of people or tens of people will go out there and  
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1 pick their own broker. Today if we have a problem with a  
2 retiree issue, staff can call Towers Watson and work through  
3 those issues. They're not going to be able to call every  
4 broker down the street. That's going to be out of their  
5 realm of control. These people will literally be out there  
6 on their own. And the only thing they'll be entitled to is  
7 the HRA reimbursements, which depending if what the audits  
8 say and what Mr. Seegrist followed up with is correct, I just  
9 don't see the overpayment problems getting better. I just  
10 don't.

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

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

25 MR. HAYCOCK: For the record Damon Haycock. That  
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1 mess-ups across the board.

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

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

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

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

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

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

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

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

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

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

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

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

2 MEMBER GARCIA: Aye.

3 MEMBER COCHRAN: Aye.

4 CHAIRMAN CATES: Opposed?

5 (The remaining members voted no)

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

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

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

19 MR. HAYCOCK: Correct.

20 CHAIRMAN CATES: Correct.

21 MEMBER COCHRAN: Okay. Thank you.

22 CHAIRMAN CATES: Any other comments? Any motion?

23 It looks like we're moving on. Okay.

24 9.13, possible reference-based pricing  
25 requirements for musculoskeletal services and outpatient  
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1 colonoscopies on CDHP. PEBP's recommendation, PEBP believes  
2 it is important to implement reference-based pricing on hip  
3 and knees today with the ability to increase the types of  
4 services reference priced in the future as costs begin to  
5 increase. So PEBP's recommendation is to have  
6 reference-based pricing on the knees and hips. Discussion?  
7 Motion? Anything?

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

24 MR. HAYCOCK: For the record Damon Haycock.  
25 Thank you, Dr. Cochran. Unfortunately not all contracted  
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1 vendors have the exact same services at the exact same  
2 prices. And you may have been or may not have been following  
3 the news in, say, Elko, Nevada. Their commissioners are very  
4 upset with their local hospital for extremely high prices to  
5 their location. And I know that they are a network provider  
6 that we pay more for hips and knees. And so this is -- this  
7 actually helps the negotiations. Because when we go to back  
8 to the master plan document and say we have a not-to-exceed  
9 price on this service of X, then there is no negotiations.  
10 We don't have to talk an \$85,000 hip down to \$25,000 or  
11 whatever that number is. We point to the master plan  
12 document. They're an in-network provider. And, therefore,  
13 if they are going to offer this service, they're offering it  
14 in accordance with our master plan document. And if they're  
15 not, then they don't have to be an in-network provider.

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

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

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

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

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

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

4 MR. HAYCOCK: There isn't.

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

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

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

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

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

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

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

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1                   CHAIRMAN CATES: Any other comments? Tom.

2                   MEMBER VERDUCCI: Tom Verducci for the record.

3                   So let's say we put a cap in place and a participant had the  
4                   procedure done. Are they running a risk where they're going  
5                   to have a huge out-of-pocket cost or would there be an  
6                   agreement with the insurance company providers where they  
7                   understand that, you know, there is a limit as opposed to  
8                   subjecting the participants to have excessive costs out of  
9                   pocket?

10                  MR. HAYCOCK: So for the record Damon Haycock. I  
11                  think the easiest way to ensure that participants are not  
12                  blind-sided by balanced billing is that as part of the  
13                  implementation plan you put a pre-authorization process in  
14                  place and they contact our utilization management vendor and  
15                  say I have been diagnosed with X and I need Y and I need this  
16                  knee replaced or I need this hip replaced.

17                  And then -- I'm going to go off on a tangent for  
18                  a moment to see how the other -- If there was a second  
19                  opinion doctor then they would go through that process and  
20                  see is it really necessary or do we save money that way. But  
21                  bounce back to the prior authorization, our utilization  
22                  management vendor today solicits through our network of  
23                  providers if there's a medically appropriate high quality  
24                  health care facility to have these services done.

25                  And so we would work with that vendor to ensure  
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1 that they through their PA process funnel folks to the lower  
2 cost reference-based price process -- facilities. And if a  
3 facility within the network still has a contract with our  
4 network that says, no, I'm allowed to charge whatever I want  
5 and you have to take a percentage off billed or something  
6 like that, then the participant will be told by the  
7 utilization management vendor or PEBP that if you choose to  
8 have it done here, you are choosing to not have it done here  
9 and this is the cost difference and this is your choice.  
10 Similarly to what Dr. Cochran said, if you want to go to  
11 another out-of-network place, you are making that decision  
12 and you are paying more in going to that place.

13 So I think we can put some controls in place  
14 here, not only in our master plan document, but within our  
15 utilization management process, because this isn't a cheap  
16 service. That's when you just say, oh, wow, I got to go get  
17 a hip, I'm going to go down to the hospital and see if they  
18 can do it. It's something that gets managed by PEBP. It's a  
19 very intrusive procedure, a lot of rehabilitation, and it  
20 affects people's lives. So we want to make sure that we  
21 control the process to the best of our ability and I think we  
22 can put those controls in place through our pre-authorization  
23 process.

24 MEMBER GARCIA: Rosalie Garcia. Is there -- Are  
25 there any other reference-based pricing examples that we  
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1 currently have?

2 MR. HAYCOCK: Damon Haycock for the record. I  
3 believe, and I could be off on this percentage, but the State  
4 of Montana just referenced-based their entire plan. They  
5 said we are going to do a Medicare Plus and that's all we're  
6 paying and that's what we're doing. And they just rolled  
7 that out, I think, in the last few months, I believe. So  
8 anyway, they just announced that they're going to be doing  
9 reference-based pricing. It's just a manner in which to  
10 control costs.

11 Another great example of reference-based pricing  
12 is Medicare. Medicare says we're paying the Medicare  
13 allowable rate and that's what we're paying. And so  
14 referenced-based pricing is not new and we want to benefit  
15 from that. That's our recommendation is that we benefit from  
16 that. And we start small. We start with some of the  
17 low-hanging fruit, the hips and knees that are drastically  
18 different in prices.

19 If you see the study that Jim was mentioning in  
20 HealthSCOPE's analysis, you'll see that bar chart just kind  
21 of stay here and then run way out there. There's some folks  
22 that are charged an extreme amount of money for the same  
23 procedure. And then there's also the quality of care. I'm  
24 not saying that people in rural hospitals don't have high  
25 quality. And I think that they receive accolades for their

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1 quality. But you have, how many times does someone do a  
2 procedure in that environment versus how many times do they  
3 do that procedure in the urban environment. And I'm not  
4 saying that more procedures are better than less procedures.  
5 But there is a perception of quality that you have more  
6 experience in how you are doing your operations.

7 So there's all of those things to consider. And  
8 I think we can maintain high quality health care and make it  
9 more affordable to ensure that these costs are not affordable  
10 year after year by PEBP.

11 MEMBER GARCIA: Thank you.

12 CHAIRMAN CATES: Any other questions? Anybody  
13 want to make a motion?

14 MEMBER VERDUCCI: I'd like to make a motion that  
15 we accept staff recommendation.

16 CHAIRMAN CATES: Okay. Do we have a second?

17 MEMBER BAILEY: I'll second that motion. Don  
18 Bailey.

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

21 MEMBER WELLS: Mr. Chairman, Jim Wells. If we  
22 could have staff kind of bring back the implementation  
23 details of what they plan on putting in the master plan  
24 document kind of in advance of just a master plan document  
25 update so we can kind of get a look at it and kind of vet

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1 that before it actually has to go in to the master plan  
2 document, I would appreciate that. We don't have a lot of  
3 time to finalize the master plan document changes if they are  
4 needed, especially if there's something in there that we want  
5 to change.

6 CHAIRMAN CATES: Thank you. Any other comments  
7 on the motion? Seeing none, I'll call for a vote. All in  
8 favor of the motion say aye.

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

10 CHAIRMAN CATES: Opposed? Motion carries  
11 unanimously.

12 We're skipping 9.14. That's going to be brought  
13 back to a later meeting.

14 So we're moving on to 9.15, possible new  
15 preventive drug benefit on the CDHP. PEBP's recommendation,  
16 PEBP believes increasing deductibles and lowering HSA/HRA  
17 contributions and life insurance amounts will be a bitter  
18 pill to swallow for our participants. If PEBP can implement  
19 this preferred drug list, crucial and necessary medications  
20 can be made more affordable. Implementing the preventive  
21 drug list allows the plan to begin helping participants  
22 manage their health care needs earlier in the plan year while  
23 lowering the overall cost with non-compliance. PEBP  
24 recommends implementing this list. Go ahead.

25 MR. HAYCOCK: For the record Damon Haycock. One  
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1 clarification, Mr. Chairman and members of the board. The  
2 attached list is not the final list. We want to reserve the  
3 right to go through and ensure that we're not -- We haven't  
4 done a cost analysis on this list. So I want to make sure  
5 that we're not putting out there thousands and thousands and  
6 thousands of dollars of drugs that isn't going to be  
7 cost-effective to the plan. We want to go drug by drug, line  
8 by line, and we want to put some controls in place. If there  
9 are a generic equivalent available for a brand name drug,  
10 that the generic equivalent is the only drug that's available  
11 on this list, so we don't have people going out and spending  
12 higher cost dollars and getting this initial cost sharing on  
13 these higher cost brands.

14 And so we want to make sure that this isn't a  
15 free-for-all on pharmacy drugs but that we can work with our  
16 vendor, Express Scripts, to manipulate this list to make it  
17 the most appropriate for PEBP. And we will bring that back  
18 for your approval prior to implementation.

19 MEMBER ZACK: Christine Zack for the record.  
20 This is the one new enhanced benefit that I do support,  
21 because I think that ultimately it will result in a cost  
22 savings to PEBP. Damon said earlier personal responsibility.  
23 I believe strongly in that. I think, for example, if you're  
24 taking an asthma drug, Singulair, that will now be on the  
25 list, you could prevent a costly asthma attack that forces

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1 you in to an ER late in the evening. So those things  
2 actually in the long run will result in a net savings to  
3 PEBP, so I support the recommendation.

4 CHAIRMAN CATES: Thank you. Any other comments?

5 MEMBER ANDREWS: One question. Damon, does this  
6 include specialty medication?

7 CHAIRMAN CATES: For the record Damon Haycock.  
8 No, it does not. This is -- This is not an all-encompassing  
9 list, unfortunately. It is designed strictly on what still  
10 meets the requirement to allow a consumer-driven health plan  
11 to still offer a health savings account. So there's some IRS  
12 requirements that are tied to it as well. But, no, it does  
13 not include specialty drugs.

14 MEMBER BAILEY: For the record Don Bailey. My  
15 question, Damon, is do we have any indication of who's going  
16 with the high end -- high end drugs other than the generics?  
17 I mean, we saw a report and the report is in here, generics  
18 are going down and you're using them more and more and more  
19 other than the high end drugs.

20 MR. HAYCOCK: For the record Damon Haycock. I  
21 think, if I understand correctly, Vice Chair Bailey, that  
22 there are certain drugs -- and I'll pick on one that I know  
23 about here in this list. Asthma is a great example from  
24 Ms. Zack. There's a drug that's called Advair. It's a disc.  
25 People take it as a maintenance drug potentially every day.

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1 And it's very expensive because it's not the drug inside that  
2 is still on patent. It's the darn disc, the delivery device,  
3 that is. And so that thing can be quite costly. But if you  
4 don't take that drug every day, you gamble with the  
5 opportunity to have a flare-up and you don't maintain or  
6 manage your asthma and you can be required to go in for a  
7 breathing treatment or go in to the ER. I've seen people do  
8 this. And it's the same story with, you know, people that  
9 I've talked to that have said I'm splitting pills now or I'm  
10 no longer going to take these because the costs have  
11 increased.

12 So it's not just a cost savings to the  
13 participant on the brand side. It's also on the generic side  
14 as well. Because, ultimately, for these drugs we want people  
15 to take them to avoid higher cost episodes. So I agree, I  
16 didn't put a whole lot of savings in here because I don't  
17 think you're going to realize those savings this year. And I  
18 think expecting a return on investment on avoided ER and  
19 urgent care on the first year of a new program I think is a  
20 little bit aggressive. But this is providing a benefit that  
21 people have been asking for. And not to everybody but to  
22 some folks to help us with that -- not that paradigm shift  
23 but just the notion that we want people to take care of  
24 themselves today to prevent high cost catastrophic health  
25 care in the future. And it goes along with that idea of

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1 preventive services and the preventive drug list. And the  
2 cost of prevention is much cheaper than the cost of actually  
3 treatment. And I think that can be quantified if you would  
4 like.

5 MEMBER BAILEY: Okay. Well, I'm just concerned  
6 about the expenses of drugs overall with the pharmaceuticals.  
7 They don't cooperate very well. And maybe the list is the  
8 way to go get them more in to generics and maybe that generic  
9 number will drop at the next audit even more.

10 MR. HAYCOCK: For the record Damon Haycock. I  
11 want to make sure I understand the generic number dropping.  
12 So the cost is increasing for generics. We are actually  
13 being -- We are happy that people are using more generics  
14 because they're cheaper than actual brand name drugs. But,  
15 yes, we would love the cost to be reduced. Personally I  
16 don't think you're going to see generic costs go down.  
17 That's just my personal opinion. That's where we're seeing  
18 massive increases. I think August this year was the one  
19 percent increase across the board on the generic drugs, the  
20 single highest increase in years.

21 But what this really does is it provides people  
22 the opportunity to receive those drugs earlier in the plan  
23 year with plan assistance. Today if you have a \$300 a month  
24 required maintenance drug, you have to pay that until you  
25 satisfy your deductible. And, yes, we give HRA and HSA funds

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1 to go offset that. But they have to pay those deductibles  
2 until we finally start helping to pay for the plan. It  
3 doesn't make sense to me why we don't want to incentivize  
4 people to take their maintenance drugs to avoid high cost  
5 claims in the future.

6 MEMBER BAILEY: Who are we going to count on to  
7 guide them?

8 MR. HAYCOCK: For the record Damon Haycock. This  
9 is a program that we would implement with our current  
10 pharmacy and benefits manager, Express Scripts. We would  
11 likely have done since their implementation pepper out  
12 information, talk to the folks, ensure that our call centers  
13 collectively know that this program exists, implement this  
14 program with other clients throughout their book of business.  
15 And we would then ensure that the master plan document was  
16 updated and that our third party administrator would be able  
17 to accumulate any accumulators that exist. And so that way  
18 it would run very similar to if someone had already satisfied  
19 their deductible.

20 We do this today in another version on the  
21 diabetes care management. The cost of insulin is extremely  
22 expensive and those that participate on that reduced  
23 management program get it for \$25. So we're able to manage  
24 that program today very simply and I think that we could  
25 manage this as well.

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1                   MEMBER BAILEY: Okay. Well, we don't want to  
2                   overload the staff.

3                   MR. HAYCOCK: For the record Damon Haycock. I  
4                   don't think it's the staff that's going to be doing the grunt  
5                   work. I think honestly it's our vendor ESF.

6                   MEMBER VERDUCCI: Tom Verducci for the record.  
7                   My question is would there be any circumstance where we would  
8                   be changing the available medication and pharmaceutical drugs  
9                   that would be available to the participant if we force them  
10                  to go from a preferred drug to a generic?

11                  MR. HAYCOCK: For the record Damon Haycock. This  
12                  is an add-on. It's not a replacement. And so this is an  
13                  opportunity for folks that meet these conditions and these  
14                  circumstances who have these prescriptions at these levels to  
15                  participate and take advantage of day one cautionary. It  
16                  does not stop anybody from receiving a dispense-as-written  
17                  drug and going through the normal channels that's we have  
18                  today where you satisfy your deductible and then you get  
19                  co-insurance assistance until you meet your out-of-pocket  
20                  maximum and then the plan pays a hundred percent. So we're  
21                  not disadvantaging anybody who is on the plan today. It's  
22                  designed to advantage those people that actually can be  
23                  affected by this program.

24                  CHAIRMAN CATES: Any other questions? Comments?  
25                  Go ahead.

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1           MEMBER GARCIA: Rosalie Garcia. First I do want  
2 to recognize that the play on words for bitter pills did not  
3 go unnoticed. Thank you very much. That was very nice. And  
4 I would like to move that the board adopt PEBP's  
5 recommendation, PEBP staff recommendation, to implement a new  
6 preventive drug program on the CDHP as presented.

7           CHAIRMAN CATES: Do we have a second?

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

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

12          MEMBER WELLS: Mr. Chairman, Jim Wells. I want  
13 to make sure that this includes the restriction that  
14 Mr. Haycock talked about on brands when generics are  
15 available that only the generic version of that medication is  
16 covered under the preventive benefit.

17          MEMBER GARCIA: Yes. Rosalie Garcia. Yes, I  
18 believe that was part of the description; correct?

19          MR. HAYCOCK: For the record Damon Haycock. I  
20 think what Mr. Wells is asking is to amend the motion to  
21 include it. And therefore there's no, right, there's no  
22 chance to misunderstand it.

23          MEMBER GARCIA: So included.

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

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

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

5                   CHAIRMAN CATES: Opposed? Motion carries  
6 unanimously.

7                   Close Agenda Item 9 and move on to Agenda Item  
8 Number 10, executive officer's report.

9                   (The court reporter interrupts)

10                  MR. HAYCOCK: So for the record Damon Haycock.  
11 And as I promised our court reporter, I will try not to make  
12 this long for her poor fingers. This is my executive officer  
13 report to the board participants and the participants and  
14 other stakeholders. It's continuing on the format where we  
15 talk about various sections of PEBP just to keep everyone up  
16 to date.

17                  Operationally, I wanted to share some of our  
18 first quarter call center statistics. They're quite  
19 important. Our abandonment rate is 1.21 percent. Our  
20 average speed to answer is 13 seconds. So although you saw  
21 all last year we were butting up against that industry  
22 standard, we're actually improving and we wanted to show that  
23 today in this section.

24                  On page two under communications, we wanted to  
25 share it where in-person education outreach has occurred in  
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1 the first five months of this plan year. And how many  
2 participants that we reached out to and spoken to directly.  
3 So these are important.

4 The July meetings, the August meetings, the  
5 October and November, we want to share how dedicated we are  
6 to providing that in-person assistance, that light touch when  
7 it comes to trying to explain something as difficult as  
8 health insurance benefits to our participants and how to  
9 maximize their use. This is something that my quality  
10 control officer, Nancy Spinelli, has reinvigorated last year  
11 and that continues to operate and we have no desire to look  
12 back.

13 Under finance on their contract update, the HMO  
14 evaluation committee selected the winning vendors in the  
15 first week of November. When I wrote this report, the letter  
16 of intent had not gone out. I can tell you, and this is all  
17 that I can say, is that the HMO letter of intents have gone  
18 out to two vendors, Hometown Health in the north and Health  
19 Plan of Nevada in the south. And that we are under  
20 confidential negotiations and will be potentially bringing  
21 back the negotiated contract to this board hopefully at the  
22 January board meeting for a February board of examiners  
23 approval.

24 We also developed an amendment to the eligibility  
25 enrollment vendor contract to implement more stringent

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1 performance guarantees on data accuracy and timeliness of  
2 data transfers. We are very proud of this. And we  
3 appreciate the partnership with our current vendor. It was  
4 retroactive to September 1st. And I think it's -- I don't  
5 know if it's been approved by the board of examiners or it's  
6 still sitting there, but it should be approved very soon by  
7 the clerk of the board.

8 Under finance, budget, and development update, I  
9 wish I could tell you more, but we've been working diligently  
10 with the governor's finance office to revise the biennial  
11 budget figures based on new experience and information in an  
12 effort to cooperatively develop PEBP's portion of the  
13 governor's recommended budget. We anticipate the ability to  
14 share that result with you at the January board meeting after  
15 the governor has announced the State of the State.

16 So, in conclusion, we remain dedicated to  
17 providing those high levels of customer service that we  
18 maintain to offer in-person education and outreach  
19 appropriately and effectively managing our vendors and  
20 working without partners to develop the highest quality of  
21 health care at affordable prices.

22 You'll see attached to this, we have a proposed  
23 PEBP board meeting calendar. We wanted you all to take a  
24 look at this and hopefully as kind of homework see if this  
25 will jive with your current schedules. We know you have

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1 other things to do besides work on the PEBP board. We may  
2 update this. We understand that there's a potential conflict  
3 with PERS meetings and that folks like to be at both. So  
4 give us a little bit of time and we'll see if we can send  
5 something out next week. My assistant is going through and  
6 doing the research and hopefully we can get it adjusted. But  
7 figure these weeks are the weeks that we definitely want to  
8 have these meetings.

9           You'll notice that there is some teleconference  
10 ones on the legislature. Those in years past, I believe,  
11 have either been held or canceled based upon current  
12 situations. So they may not be held. But we wanted to try  
13 to reserve some time to do those telephonically so we can  
14 provide you with updates on the bills that are being  
15 presented to the committees and see if there's a position you  
16 would like me to take on your behalf. And with that, I'll  
17 take any questions.

18           CHAIRMAN CATES: Any questions? No. We will  
19 move on. Let's take a five-minute break. Let's resume at a  
20 quarter till.

21                           (Recess was taken)

22           CHAIRMAN CATES: Okay. Let's call the meeting to  
23 order. We are now on Agenda Number 11, discussion and  
24 possible action regarding Towers Watson One Exchange service  
25 improvement plan. Go ahead.

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1 MR. GARCIA: Chris Garcia for the record with  
2 Towers Watson One Exchange. We wanted to provide an update  
3 on our service improvement plan as well as what we did at the  
4 last board meeting. The information in this update is as of  
5 November 4th.

6 Since our last board meeting, we had three major  
7 items that have occurred that we wanted to provide an update  
8 on. The first item is regarding our retiree meeting that  
9 occurred prior to Medicare annual enrollment starting. We  
10 held three different meetings in early October. One in Las  
11 Vegas, one in Carson City, and one in Reno. There were two  
12 different types of meetings held on each day. One was for  
13 participants who are aging in to Medicare and one for  
14 participants who are already Medicare eligible. That focused  
15 on making changes for Medicare open enrollment as well as  
16 focusing on the HRA.

17 We did provide some details in the service  
18 improvement plan on the estimated number of attendees at each  
19 meeting. So in Las Vegas, and you see a breakdown by the  
20 agent versus open enrollment HRA meetings. Las Vegas had 35  
21 in the agent meeting, 30 estimated in the open enrollment HRA  
22 meeting. Carson City was 17 in the agent meeting, 22 in the  
23 open enrollment HRA meeting. And with Reno, 32 in the agent  
24 meeting and 25 in the open enrollment HRA meeting. That was  
25 a total of 161 estimated attendees for all three locations in  
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1 preparation for open enrollment.

2           The next item we wanted to talk about was the HRA  
3 on-site assistance. So we have been live for two months  
4 going in to the beginning of November with the HRA team  
5 specialist being available here at the PEBP offices for one  
6 week per month. She's actually here today. And this is her  
7 week that she's here now. We were able to get some details  
8 from her for the months of September and October for the week  
9 that she was here. And we had that information below. So  
10 you'll see the total number of people that she met with in  
11 person seems low but she was actually also able to assist  
12 with phone calls as well as e-mail inquiries that the PEBP  
13 member service team received.

14           So for the month of September when she was here,  
15 from September 12th through September 16th, she had nine  
16 appointments. There were zero walk-ins for that period of  
17 time. And then for the month of October, the week she was  
18 here, October 10th through October 14th, 14 appointments and  
19 one walk-in.

20           We have a list of the weeks for the remainder of  
21 2016 as well as the first quarter of 2017. They are listed  
22 in the service improvement plan. We will also be doing --  
23 continuing this program and continuing her one week per month  
24 in to future 2017. We just haven't finalized those dates.

25 Once we have those available, we will share them with the  
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1 board.

2 I'll pause. Are there any questions regarding  
3 the first two items before we get in to the annual enrollment  
4 period?

5 MEMBER VERDUCCI: Chris, Tom Verducci for the  
6 record. Do you see these meetings being enough? Would you  
7 say too much, less, or how do you feel in terms of your  
8 current presence there? Should we have additional days or  
9 are you showing up where we have zero walk-ins and you're  
10 there too much?

11 MR. GARCIA: Thank you for the question. And  
12 that's the HRA specialist who is here, she actually had quite  
13 a number of walk-ins this week that she's been here so far,  
14 so I think as the program becomes more aware to the retirees  
15 up here in northern Nevada, I think we'll see her  
16 appointments get fuller and then she'll have more walk-ins.  
17 We are also talking about doing additional meetings in Las  
18 Vegas. So when we met with RPEN last night, we talked about  
19 going back and doing the meetings in Las Vegas where we would  
20 do a larger HRA focus meeting in the morning with  
21 appointments in the afternoon. So we would like to continue  
22 that as well. So I think right now the week -- the one week  
23 per month is a great place to start. And, as John Seegrist  
24 had mentioned earlier when he was up here speaking during the  
25 claim audit, that we are open to looking at additional time

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1 if it was necessary.

2 MEMBER VERDUCCI: Thank you.

3 MR. GARCIA: So the last item is probably our  
4 biggest focus right now. We are in the middle of our annual  
5 enrollment period for Medicare. It started on October 15th  
6 and it runs through December 7th. So during this time  
7 participants can take the following action. So if they are  
8 currently in a Medicare Advantage plan they can switch to  
9 another Medicare Advantage plan during annual enrollment  
10 without any underwriting considerations or they can change  
11 between the Medicare Advantage plan or go from a Medigap plan  
12 to a Medicare Advantage plan.

13 When you get to the Medicare supplement or  
14 Medicare -- Medigap plans, excuse me, the participants did  
15 likely face underwriting in the event that they want to  
16 change between Medigap plans or go from a Medicare Advantage  
17 plan to the -- Excuse me. Medicare Advantage plan to a  
18 Medicare -- Medigap plan. In most cases if a participant  
19 enrolled in a Medigap plan they tend to stay within that  
20 plan.

21 And then the last change that they can make is  
22 for Part D plans. And this is the one that we see the most  
23 activity on during the open enrollment season. Participants  
24 can change their Part D plans during open enrollment without  
25 any underwriting consideration. This type of change is the

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1 most common one that we'll see.

2           And so we did pull -- On the next page you'll see  
3 some data. It's only for the first little over two weeks of  
4 the open enrollment season. But it gives us an idea of how  
5 many people actually switched from one plan to another based  
6 off of their original plan and the new plan that they've  
7 elected for 2017. And as you can see, people changed, say,  
8 from Medicare supplement plan to another Medicare supplement  
9 plan is relatively small, only 12 so far. Or say from a  
10 Medicare Advantage plan to another Medicare Advantage plan  
11 only 32. But when you look at the prescription drug to  
12 another prescription drug plan, it's 144. And that's really  
13 only for the first part of the open enrollment season.

14           We're going to continue to provide you with these  
15 data points as we progress through the open enrollment season  
16 and we'll give you a final listing of this information once  
17 open enrollment closes.

18           And we know that in the past a big item for us  
19 has been the call wait times that were experienced during  
20 last open enrollment. We know that people were calling in  
21 and experiencing 30-minute, 40-minute wait times. So we've  
22 been focused as a business on improving that overall delivery  
23 during the open enrollment season. So we did look at call  
24 stats specific from October 15th through November 3rd. And  
25 we did a comparison to the same period of time last year. So

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1 as you can see in the chart below, for the same period of  
2 time, we've seen the decrease in the average wait time by  
3 over seven minutes, almost eight minutes. And then we've  
4 seen an average wait time -- Excuse me. We've seen an  
5 average wait time -- Excuse me. Call abandonment rate  
6 decreased by 7.15 percent. Because when you look at last  
7 year, we had over 337 calls abandoned just from the period of  
8 time from October 15th through November 3rd. And for this  
9 year we've only seen 12 abandoned calls.

10 I think we've made a lot of improvements with our  
11 open enrollment season with the staffing that we have in  
12 place to handle the call volumes that we expect to receive.  
13 And hopefully this information verifies that with you.

14 Are there any questions regarding open enrollment  
15 and the call stats or any other information regarding the  
16 enrollment changes for 2017 so far?

17 MEMBER COCHRAN: Yes, I do have a question. The  
18 Medicare Part D plans, do you know what the main reasons why  
19 people are changing?

20 MR. GARCIA: It's very common to change. It's  
21 typically a retiree or participant, if they're taking new  
22 prescriptions that they've incurred in the middle of the year  
23 that they didn't plan on taking when they first enrolled,  
24 say, for 2016. Now they're looking for something, a new plan  
25 that might offer a better benefit for them for that new type

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1 of prescription that they're taking. That's the most common  
2 reason that somebody will change in one prescription plan to  
3 another.

4 MEMBER COCHRAN: All right. Thank you.

5 MR. GARCIA: You're welcome.

6 CHAIRMAN CATES: Proceed.

7 MR. GARCIA: All right. Thank you very much.

8 CHAIRMAN CATES: Thank you.

9 Okay. We're now to Agenda Item Number 12, public  
10 comment. Do we have any public comment here in Carson City?

11 MS. LOCKARD: Thank you, Mr. Chair. My name is  
12 Marlene Lockard and I'm representing RPEN. I just wanted to  
13 as we moved through the agenda items in Section 9 and the  
14 decisions that were made on each of those items -- And  
15 Mr. Wells just left. But his comment that the base budget is  
16 pre-enhancements, I just wanted to put in perspective.  
17 Over -- In 2011, the massive changes that were made to the  
18 health plan for state employees and health retirees --  
19 retirees were a result of the economic situation in the state  
20 at that time. We have come back, not totally, from 2011.

21 But if we are going -- I would argue that the  
22 excess reserves from 2011 to the current time have paid for  
23 the enhancements since the original cuts in 2011. So I think  
24 an argument can be made that we shouldn't refer to these as  
25 enhancements. We should begin to reset as those enhancements  
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1 as the new base. Now, I understand the current situation  
2 with the state budget, and Mr. Wells is doing his job,  
3 obviously, as the budget director for the state. But for  
4 state employees and retirees to go back to the recession 2011  
5 base I don't think is appropriate. State employees suffered  
6 the most in this state because they were the low-hanging  
7 fruit. They didn't have collective bargaining agreements, et  
8 cetera.

9 So I think there's much discussion going forward  
10 on what our baseline for benefits actually should be, given  
11 the five-year experience of double digit excess reserves.  
12 Were the cuts in 2011 too much? And I think that's something  
13 this board should consider.

14 And I appreciate that we have time to make  
15 adjustments in January and before final decisions in March.  
16 But if we're -- The enhancements are roughly, I'm told by  
17 Mr. Haycock, valued at around 30 million dollars, if we're  
18 going to roll back PEBP's budget to the base of  
19 pre-enhancements, that is a savings to the State of Nevada  
20 budget of 30 million dollars. And, again, my point that  
21 state employees have already really taken a hit for a number  
22 of years.

23 So I just think it's -- I don't know how to a  
24 generalize that. And I'm sorry Mr. Wells had to leave. So I  
25 just -- I just think it's a discussion that we should

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1 consider.

2 And, you know, you approved the Medicare retirees  
3 absorbing the costs for their costs for life insurance and  
4 for the administration costs. And I think I'll get push back  
5 from my membership. But I think it's appropriate. I think  
6 Medicare retirees can step up and pay those costs. We  
7 shouldn't have to have the other folks carry us there. But  
8 at the same time, to put all the enhancements back to day one  
9 and then the previous sessions PEBP has been a help to the  
10 state budget overall in saving money that goes back to the  
11 general fund to defer some of the shortfall in other areas of  
12 state government.

13 And I used to have a hat on like that, so I know  
14 how it works, and I know from the budget office perspective.  
15 But looking at this population of state employees and  
16 retirees, I'm not sure that 30 million dollars back to the  
17 general fund is a big chunk taken away from the health care  
18 for our employees. Thank you.

19 CHAIRMAN CATES: Thank you.

20 Any other public comment? Come on up.

21 MS. GRAF: Do I tell you my name?

22 CHAIRMAN CATES: Yes.

23 MS. GRAF: My name is Susan Graf, G-r-a-f. Susan  
24 like normal. Well, I am a real retiree. There seemed -- I  
25 don't know if you had ever seen one from your discussion. So  
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1 I am a real retiree and I have a question. You have been,  
2 like, really smart, Mr. Haycock. But, I was kind of offended  
3 by that I've never paid a hundred dollars for a pair of  
4 glasses comment, because my glasses cost \$300. But I'm  
5 blessed. I have a daughter who is married to a doctor and  
6 she said there's this thing called Zenni where you can get  
7 your glasses for much cheaper. I'm just lucky. What about  
8 all of those retirees who aren't lucky enough to have a smart  
9 daughter-in-law?

10 So how come you can't tell us things like that  
11 and say, well, we know that you don't have a lot of money and  
12 here are some additional resources. I understand that  
13 there's a line between information and between endorsing  
14 things. But, still, it just seems like I am not only a  
15 retiree, I'm a medical disability retiree, I had a stroke.  
16 So all of that clear communication that the man who left was  
17 talking about, I don't see it as clear at all. And those  
18 letters are very hard to read. And so I might be dumb. That  
19 was, like, what I wanted to say.

20 CHAIRMAN CATES: Thank you very much.

21 Any other public comment?

22 Do you have any public comment down in Las Vegas?

23 UNIDENTIFIED SPEAKER: We do not.

24 CHAIRMAN CATES: Okay. Do you have public  
25 comment?

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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.)

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

3

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

7 That on Thursday, the 17th day of November, 2016, I  
8 was present at The Richard Bryan Building, 901 S. Stewart  
9 Street, Carson City, Nevada, for the purpose of reporting in  
10 verbatim stenotype notes the within-entitled public meeting;

11 That the foregoing transcript, consisting of pages  
12 1 through 219, inclusive, includes a full, true and correct  
13 transcription of my stenotype notes of said public meeting.

14

15 Dated at Reno, Nevada, this 8th day of December,  
16 2016.

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\_\_\_\_\_  
CHRISTY Y. JOYCE, CCR  
Nevada CCR #625

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	<b>42:21</b>	<b>\$85,000 (2)</b> 114:12;189:10	<b>Abstain (2)</b> 15:16,17	<b>accumulation (1)</b> 73:9
<b>\$</b>	<b>\$3,000 (2)</b> 67:2;191:6	<b>\$876 (1)</b> 163:5	<b>abundantly (1)</b> 117:20	<b>accumulators (2)</b> 42:23;202:17
<b>\$1,000 (1)</b> 54:3	<b>\$3,971,000 (1)</b> 20:3	<b>\$90,000 (1)</b> 62:12	<b>abuse (1)</b> 185:8	<b>accuracies (1)</b> 16:16
<b>\$10 (2)</b> 153:8,14	<b>\$300 (3)</b> 105:23;201:23; 218:4	<b>\$938,000 (1)</b> 148:20	<b>academic (2)</b> 81:18;84:1	<b>accuracy (1)</b> 207:1
<b>\$10,000 (2)</b> 145:24;146:24	<b>\$300,000 (1)</b> 151:7	<b>\$940,000 (1)</b> 151:18	<b>accept (12)</b> 21:14;29:3;39:15; 50:12;137:11;139:1; 142:25;145:9; 170:21;186:11,15; 196:15	<b>accurately (1)</b> 155:21
<b>\$100 (5)</b> 81:24;82:23;96:17; 101:2;164:14	<b>\$3200 (3)</b> 138:14;139:3; 142:17	<b>A</b>		<b>achieved (2)</b> 41:15;43:8
<b>\$105,000 (2)</b> 19:1;27:11	<b>\$36,000 (1)</b> 171:22	<b>AARP (1)</b> 185:23	<b>acceptance (2)</b> 15:3,4	<b>acronyms (1)</b> 40:23
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<b>\$12,500 (2)</b> 12:12;169:2	<b>\$393,000 (1)</b> 110:16	<b>abandoned (2)</b> 214:7,9	<b>access (7)</b> 7:18;70:16;99:14; 107:19;178:16; 183:11,12	<b>act (2)</b> 76:24,25
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