In The Matter Of:

Public Employees Benefits Program Board

Legislative Update Meeting

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PUBLIC EMPLOYEES' BENEFITS PROGRAM BOARD

TRANSCRIPT OF PROCEEDINGS

LEGISLATIVE UPDATE MEETING

THURSDAY, MARCH 9, 2017

CARSON CITY AND LAS VEGAS, NEVADA

The Board:	PATRICK CATES, Chairman ANA ANDREWS, Member DON BAILEY, Member LEAH LAMBORN, Member TOM VERDUCCI, Member CHRISTINE ZACK, Member ROSALIE GARCIA, Member CHRIS COCHRAN, Member
For the Board:	DENNIS BELCOURT, Deputy Attorney General
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THURSDAY, MARCH 9, 2017, 2:00 P.M.

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CHAIRMAN CATES: Okay. Good afternoon. Let's call the meeting of the Public Employees Benefits Program Board to order. March 9th, 2:00 p.m. We do have members calling in today on the line. I would ask the members to keep their phones on mute when they're not speaking and remember to put them back on mute when they do speak. And do always identify yourself so our reporter knows who's speaking.

With that, we'll go to Agenda Item Number 1, roll call.

MS. LANDRY: Don Bailey.

MEMBER BAILEY: Here.

MS. LANDRY: Ana Andrews.

MEMBER ANDREWS: Here.

MS. LANDRY: Chris Cochran.

Rosalie Garcia.

MEMBER GARCIA: Here.

MS. LANDRY: Leah Lamborn.

MEMBER LAMBORN: Here.

MS. LANDRY: Tom Verducci.

MEMBER VERDUCCI: Here.

MS. LANDRY: Jim Wells.

Christine Zack.

MEMBER ZACK: Here.

MS. LANDRY: Patrick Cates.

CHAIRMAN CATES: Here.

MS. LANDRY: We have a quorum.

CHAIRMAN CATES: Thank you. Now we'll move to Agenda Item Number 2, public comment. We have basically only one agenda item. But we'll take general public comment now. We'll also take public comment when we're discussing the bills and again at the end. Does anybody have public comment for Agenda Item Number 2?

Seeing none, we'll close Agenda Item Number 2 and go to Agenda Item Number 3, discussion and possible action regarding 2017 legislative bills that may impact the Public Employees Benefits Program, including the following: Assembly bills, senate bills, and bill draft requests.

MR. HAYCOCK: Thank you, Chairman. Damon Haycock for the record. Every board member should have received also a copy of written public testimony. There was some public testimony submitted by a couple of folks from UNLV. We also have some testimony that was submitted by Hometown Health discussing Senate Bill 233. We have representatives from Hometown Health that are going to help kind of walk through that here in a little bit after we introduce some of these bills. But if you don't have these, we will need to know soon. They are up on the website and were posted yesterday.

So, moving right along, it's on the actual legislative session bill tracking sheet you should have in front of you, we're going to start with Assembly Bill 249. And I'm going to take Assembly Bill 249 and Senate Bill 233 in tandem because they both primarily are asking for the same thing, just one is an assembly bill and the other is a senate bill. There is very similar language in each of these proposed bills. The only difference I'll outline is on Senate Bill 233.

But primarily these bills allow for a revision to how plans must provide contraceptives to Nevadans enrolled in health insurance. Most plans today offer either 30 days or 90 days of issuance of drugs. There's a multitude of reasons why it's important to limit drug prescriptions to 30 to 90 days that I'll let some of the folks from Hometown Health talk about as part of their comment on SB 233. But this still allows the people who receive contraceptives to get them on a 12-month supply and it also includes as part of contraceptives male sterilization to be covered at a hundred percent by the plan. The Affordable Care Act as passed requires that female sterilization as well as -- I think there's 18 different contraceptives that are approved by the Affordable Care Act to be paid for at a hundred percent by health plans as part of the preventive insurance benefits. Male sterilization is not one of them currently approved at a

hundred percent. Most plans, to my knowledge, allow that process to be part of the co-pay, co-insurance or deductible parts of health plans. And so the male sterilization being recommended in these two bills is to be covered at a hundred percent on the first day of the plan.

You'll see under the potential impact to PEBP, that's basically what I've just shared with you, that they're going to eliminate co-insurance requirements, also for multi-source contraceptives. Currently PEBP has a generic mandatory requirement unless a special circumstance exists. If there is a brand name drug that is prescribed, regardless if it's contraceptives or not, and there's a generic equivalent, PEBP requires that the participant try the generic equivalent first. Often it's called step therapy. And if there's an issue with that generic, if there's a reaction per se, then their doctor can send in and they can get an exception and have that brand name drug.

And it's a cost control process to ensure that we offer similar drugs with similar results without having to pay too much for them.

These two bills eliminate the requirements for co-insurance, so no co-pays, no co-insurance. The interesting part about the bill as written today is that it says you cannot charge a higher deductible nor can you charge co-insurance or co-pays. It doesn't mean you can't charge

your original deductible that you charge for all of your other prescriptions. And so our interpretation and bouncing it off of legal and our various partners is that our high deductible health plan, our consumer-driven health plan still applies to that male sterilization part. And then once that deductible is met then the co-insurance gets waived and the rest of the costs get picked up by the plan.

Consequently, the cost of male sterilization is less than our current high deductible. So we don't feel that there's currently a fiscal impact on that male sterilization to the consumer driven health plan, but there will definitely be one to our health maintenance organization that will have to go right in to a hundred percent payments and waive that co-pay.

So we will be required, again, to eliminate co-pays for contraceptives and male sterilization and that we cannot impose any other restrictions or delays on the access of an insured to any such benefits, including without limitation to a program of step therapy or prior authorization. And there's some clinical concerns about that as well. That's AB 249.

And on Senate Bill 233 it's basically the same language, but then they also had a section on hormone replacement therapy. And that by eliminating step therapy and prior authorization, which PEBP has in place currently

through our pre-certification requirement would be PEBP's and our consumer driven health plan's impacts.

And today we have up here from Hometown Health who just came up to the table Richard Rosen, Dr. Rosen, and John Kim, their Pharm D, to discuss their public comment and kind of walk through some of the concerns both with 12-month contraceptives and eliminating step therapy and preauthorization for hormone replacement.

And I'll turn it over to you gentlemen. If you'll hit the button and announce yourselves for the record.

MR. ROSEN: Thank you. My name is Richard Rosen, R-i-c-h-a-r-d R-o-s-e-n, M.D., medical director at Hometown Health.

MR. KIM: My name is James Kim, J-a-m-e-s K-i-m, Pharm D, manager of pharmacies at Hometown Health.

MR. ROSEN: We have a prepared statement, which apparently has been transmitted to you by our organization already. So I was planning on reading this document, but I do not have to read it since you have seen it.

Basically our concerns are primarily what impact it has on the patient as opposed to the cost issues. There's also sound medical and clinical reasoning behind why there are step therapies and why there are prior authorization requirements for these drugs. These drugs are not restricted in the sense that they have access now to them.

But giving a patient, for example, a 12-month prescription without a trial does not make a lot of clinical sense. Many times patients are intolerant of a drug. They have to have titration of dosages in order to find the ideal dose of a drug. No one can predict how any individual will tolerate a given medication. And in particular with drugs affecting hormones, affecting women's health, they often take months before those side effects present. And it's standard of care in the OB/GYN field to always advise patients that they will not get the maximum effect from the drug immediately and that they should take it for months before they will know if they tolerate it or have a side effect.

By giving a patient a 12-month supply as a "trial" doesn't make much clinical sense because it's not uncommon at all for them to switch medications. So it's possible that they're going to take the medicine for two months, stop it, take another one, might take it for three months and find something wrong and take a third one. It just doesn't make a lot of clinical sense to be giving them 12 months at a time.

The reason that the prior authorization exists for this class of drug is not to deny care and not to deny or withhold treatment. We don't currently do that. They have access to hundreds of products, many of which are generic. If the product that they choose in cooperation with their

OB/GYN is not -- happens to be a generic equivalent for it, they can get the brand drug if it has clinically. And we are in constant communication with the provider. Both myself and our pharmacy department is in contact with the clinicians whenever there's a question about whether something is valid, clinically makes sense or not.

So we just don't see it being sound that on the very first prescription for a product you give 12 months at once because of clinical indication, not so much because of cost. Most of the medications are generic now in this class. There are hundreds of them. It's really for patient safety and what makes sense from a clinical standpoint.

We also have some concerns about the lack of clarification on male hormones in this bill because it's not the same as with women's hormones. In women's health care there is no specific advantage to a woman manipulating the quantity, strength, or whatever of any given hormonal therapy because they don't get any additional benefit. In the male market, that's quite not the case. They are often used out of indication for other indications that have no clinical value, such as anabolic steroids in athletes using them to build muscle, anti-aging properties have been purported and they have not been found to be of any value. So we really are concerned about the lack of clarification in this bill where it doesn't clarify who's getting what kind of hormones.

In fact, it's open to any hormone therapy, thyroid, other endocrine therapy, it could be growth hormone, it could be anything. So we would certainly want to see more clarification that the intent of the bill if it is for women and women's health that it be clarified what hormones are being recommended.

We also have had some concern about our lack of ability to drive someone to a recently-developed generic because it takes time throughout a given year of many drugs to go generic. And patients have access to those generics. And so we don't want that to change. We use our -- We use our methods of adjudication based on clinical reasons and what providers are thinking clinically, not so much about the cost. It's really -- Hormone therapy is accessible now.

Do you have any other comment about --

MR. KIM: So as far as the utilization management on the oral contraceptives --

CHAIRMAN CATES: Could you state your name for the record, sir.

MR. KIM: Oh, my name is James Kim for the record. It doesn't really increase access. Because as of now our plan lets any, basically any oral contraceptive available to any patient depending on trial and failure of a generic. So access doesn't really increase without the limitation of utilization but inhibits payor to contain costs

of very expensive brand name medications.

MR. HAYCOCK: Thank you, Gentlemen. If you'll please stay there in case the board has any questions. You can go ahead and hit the button off right now and then turn it on if they have questions.

I want to real quick also discuss a little bit about how PEBP responds to these bills. Generally we try to get these meetings as quickly as we can when we know bills are coming down the pipe so we can get a position from the board. Unfortunately last I think it was either Thursday or Friday we got notice that these two bills were going to be heard on Monday of this week. And through open meeting law, I can't poll the board and ask you guys through e-mail can you tell me how you want me to respond. And so we monitored but we did not go up and provide specific testimony.

I assume these are going to be heard again. My understanding from watching the bills as they were being presented by the sponsors in both the house and the senate that there was some friendly amendments that were going to be proposed by various groups. And that this should be the last time that these are heard. We will be able to provide any position that the board has.

But before I ask for a position or ask for any questions, I want to talk a little bit about the fiscal impact to PEBP. Like I said, on the first one, on AB 249,

because the deductible is still applied to male sterilization, then we're talking about what is just the amount of money that men have been paying for their co-pays and co-insurance. And on our consumer driven health plan it's somewhere between 1500 and 2,000 a year for all of them. So we didn't think it was really material to present that as a fiscal note.

However, on Senate Bill 233, the cost of waiving everything for hormone replacement therapy is something that my chief financial officer presented in a fiscal report, and I'll let her kind of walk you through the highlights now.

MS. GLOVER: This is Celestena Glover, Chief Financial Officer for the Public Employees Benefits Program. So we reached out to Express Scripts to get an idea on the hormone replacement therapy especially with no step therapy or preauthorization. We wanted to know how much the plan had paid and how much the participants had paid. ESI came back to us with co-pays in the amount of $226,000 for the first six months of the plan year. I just basically said, okay, we've got six months left. At this point the plan starts picking up more, the participants less. So I trended it up to 30 percent to get us the annual cost. That's about $293,000 a year in co-pays that if that was going on right now the plan would be picking up those costs.

Using the seven percent for pharmacy inflation

that we built in to the budget, I built seven percent for each fiscal years for the next four years. We're looking at 314,000 in the first year, up to close to 400,000 by the time we get to the fourth year of a fiscal impact. That doesn't include any additional costs that we might see if contraceptives go to a 12 month and they aren't using generics and so we end up with a higher cost brand. It doesn't include the sterilization. That is just the step therapy or the hormone therapy that we're seeing right now.

So we did submit that on Tuesday and it has not hit the bills yet. But that will be one of the fiscal notes that you'll see coming up.

MR. HAYCOCK: So with that -- This is Damon Haycock again for the record. If there's any questions for members of the board on this bill either to PEBP and its staff or to the gentlemen that showed up from Hometown Health, we would entertain them at this time, Mr. Chairman.

CHAIRMAN CATES: Are there any questions from the committee?

MEMBER COCHRAN: Mr. Chair.

CHAIRMAN CATES: Go ahead.

MEMBER COCHRAN: This is Chris Cochran. Just a question for staff -- And I may have zoned out a little bit on Tena's response -- but are we -- when we respond to something like this, are we telling them that this is what

financial -- what potential financial impact this is going to have on PEBP and if this passes what will need to be done in order to allow PEBP to meet this requirement?

MR. HAYCOCK: For the record Damon Haycock. Chris, I'll answer that one. On any bill that the Legislative Council Bureau feels that may affect us, they send over a fiscal note request, and they ask us what is the financial impact to our organization. At that time we often add some narrative to not only the fiscal impact but also the operational impact. But generally they want to know what the cost will be to the organization in the next biennium, I think out four years. So a total of four years of fiscal impact.

We, again, then can testify on behalf of the board if we are provided a position to discuss not only the fiscal impact to the agency but also operational or as the gentlemen from Hometown Health said, the clinical aspects that the patient has to potentially deal with if this gets passed. Does that help?

MEMBER COCHRAN: It does help. And let me just ask a follow-up question. And this is for everyone who's testified so far or for you, Damon. As written this bill affects all insurance plans being offered in Nevada. So it's not just us. It's not just Hometown Health. It's going to be anybody who's offering a health insurance plan in the

State of Nevada; correct?

MR. HAYCOCK: Damon Haycock for the record. That is correct, Chris. This is a potential mandate for Nevada.

MEMBER COCHRAN: Okay. So we can anticipate similar feedback from all insurance groups providing health care in Nevada would be my guess. I mean, so in terms of, you know, we're trying to prepare our response as it affects us. And I think that's a good thing to do. I just want to make sure that we are, you know, that -- It would be interesting to know is what the -- And maybe the folks from Hometown Health can help on this question. Are we hearing -- What are we hearing within the industry itself regarding this particular provision?

And then, finally, Patrick, just to let you know, I got on the call late, so I am in attendance.

CHAIRMAN CATES: Thank you.

MR. HAYCOCK: For the record, Damon Haycock. I'm going to start off and then I'm going to pitch it over to Hometown Health. There was obviously for most bills in the legislature they call up anyone who is for and anyone who is against and anyone who is neutral. And there were groups that testified on all fronts on both of these bills during both of these hearings, Chris. I think it's Nevada Association of State Health Plans, NASHP, they came up to represent the health plans of the state as their association

and they said they had some concerns with the bill, similarly to what you heard from Hometown Health. Not to that granular level. But also concerns that health plans offered on a year basis. And so if you provide a years worth of services -- So in this instance you give a years worth of contraceptives and three months go by and the person loses their medicine, is the plan responsible to issue any more or is it going to be on the participant because you've already given them a 12-month supply? And so they started making some of those comments and said they were going to be working with the sponsors to try to clarify some information.

So, yes, they are being represented. I don't know -- I didn't hear any specific health plans go up to the hearings. But I'll let Hometown Health kind of segue from here.

MR. ROSEN: Richard Rosen again for the record, representing Hometown Health. In response to something you just said, not only could they possibly lose their medicine one month in to the 12 months, but they also change plans and leave the plan. We use all 12 months of their participation in the plan to cover the cost of their treatments. So if they are on a treatment and leave the plan, you know, if they have one month or three months of medicine, it's different than 12 months of medicine.

But, in addition, we didn't look entirely at

cost. We know that this will cost more money. But we looked at initially this bill as how does it help a patient who is a member of our plan and look at from the standpoint of the patient. Is there any benefit over what the existing situation is for a patient. We really don't see it. We don't see this as being beneficial to the patient. It only opens the door for excessive prescription providing and excessive cost. It's not like they don't have the access now.

So this really doesn't add anything for them. It just puts a burden on us of providing medicine without sound medicine oversight. We use utilization management and oversight for making sure that the appropriate care is given to a patient for appropriate conditions and it's been vetted through societies, the government, and all national medical societies. So we really are looking for what's best for the patient. And we don't see this as adding any added-on service for the patient but causing a great increase in cost if patients are given 12 months of prescriptions at one time.

MR. HAYCOCK: So for the record, Damon Haycock. I want to add something and dovetail off of what Mr. Rosen said. To be fair, there is certain health plans that have the ability to -- I shouldn't say health plans. Employers currently have the ability to take a religious exemption to providing contraceptives. That religious exemption does

exist in Nevada, but it is my knowledge and the testimony that I heard on these bills that no employer in Nevada has taken that religious exemption. But there's a concern that that exists and that was part of what one of the sponsors of the bill had said they felt it would be unfair to the Nevadan needs or who wants to control birth through contraceptives.

And then, secondly, a lot of folks wanted to have the convenience of not having to go to the pharmacy every 90 days or every 30 days.

I don't know if that's enough to legislate. But that's for the legislature to decide, not for me to decide.

But as Hometown Health they said, you know, they have a plan developed very similarly to ours. And we feel the same way here at PEBP as far as staff is concerned that this doesn't increase access and it doesn't increase care. We have the same concerns about taking away any of those things like step therapy and preauthorization, which is also utilized to ensure that someone doesn't have two drugs that counteract each other or cause some form of bad reaction. And the person may not always know that they're prescribed something from one doctor and they go to another doctor and get prescribed something else and those records aren't always available. And so that preauthorization process can actually save people a lot of misery when they find out that they're going to take a drug that may be negative compared to the

drug that they have already. And so that's our concern.

But as far as the idea of providing, you know, contraceptives to women and even male sterilization, we don't have any issue with that on our plan or any concern about it at this point.

If they revise the bill to eliminate the requirement of a deductible, we will then have to come up with more cost associated for our plan.

CHAIRMAN CATES: Any other questions from the members? I have some questions. Damon, who are the sponsors of these bills?

MR. HAYCOCK: For the record Damon Haycock. I know the assembly bill was sponsored by Assemblywoman Benitez-Thompson. And the sponsor for the senate bill, I can see her face in my head, and I can't remember. I will get that to you here before the meeting is over.

CHAIRMAN CATES: Okay. And did I understand you correctly that they had hearings on both of these bills on Monday?

MR. HAYCOCK: For the record Damon Haycock. That is correct. Monday morning, late morning, they held the one on the assembly bill and late afternoon they held the one on the senate bill. It's just ironic because the fiscal notes weren't due until Wednesday.

MS. GLOVER: This is Celestena Glover for the

record. And assuming they haven't changed the schedule, I believe there's a work session on AB 249 today.

CHAIRMAN CATES: Should we adjourn the meeting and go crash their work session?

Can I ask you, Mr. Rosen, did Hometown Health testify on both of those bills and did you testify in opposition?

MR. ROSEN: I believe not. We were not aware of the bills until I think it was the day before yesterday late and we -- this was done very rapidly in response.

CHAIRMAN CATES: Okay. Thank you. Any other questions from the board.

MEMBER ANDREWS: Mr. Chair.

CHAIRMAN CATES: Yes.

MEMBER ANDREWS: Ana Andrews for the record. I have a couple. The first one is -- I watched one of the hearings. I could not watch the other one. And I didn't hear anybody discuss that maybe they could change the language. And I'm asking Damon if he does know or anybody at PEBP that they would reduce the 12 months and just go with the three months and renegotiate? That's the first question.

The second is not a question. It's a point that I wanted to make because it's happened to me on two bills that I'm following here. Is PEBP actively looking at -- I have my PLT and it sends me e-mails. And on a couple of my

bills I have gotten a notice that the bill was heard after the fact, after it's taken place. And in that instance what you have to do is open the bill and go to the recording of the video so you can listen and watch the whole thing.

And I'm just saying this so everybody is aware there's been quite a few that you hear that oh, it was heard and it was yesterday.

MR. HAYCOCK: So for the record, Damon Haycock. Thank you, Ana. That is correct. Many people here at PEBP have personalized bill tracking or legislative tracking. I think my wife can attest to how annoyed she is that all I do is look at that thing in the evenings and start following bills.

You are correct. Most of the time when a bill is heard or it's spoken about, it's actually happened to PEBP, we had a budget meeting and we're not the sponsors of Senate Bill 80. But they asked us a question and we made a response. So then we saw at the end of the day that there was an update to Senate Bill 80 that was, you know, talked about or heard jurisdiction because we weren't in the right committee.

And so sometimes you hear things after the fact when the legislator decides to ask a question about a bill or an agency comes forwards with a bill or makes a comment about a bill and then all of a sudden it becomes tracked in the

personalized legislative tracking. But, yes, we do watch those and we do watch the recordings when we miss them. But so far I don't think we've missed any.

MS. GLOVER: This is Celestena Glover for the record. And I try to get on every day and at least see what's happening. I track primarily the meetings that I know our bills are probably going to pop up in. So human services, government affairs. I do make a point of going back. And even if I attended the meeting, going back and listening to the recordings because you miss stuff, questions they've asked, you don't write the notes. So, if anything, if we need to do a follow-up we can.

MEMBER ANDREWS: Thank you.

CHAIRMAN CATES: Any other questions from the members?

Well, it sounds like there's a lot concerns all around on both of these bills. If PEBP is putting a fiscal note on these bills, you can bet Medicaid and others will be putting some more fiscal notes on them. We just heard from one of the major health care providers in the state that has problems with these bills.

Is there an appetite on the part of the board to take a position on these bills or to throw out any direction to Damon on how to address them with the legislature? As I see it, we can take a position of simply either support,

neutral, or opposed and then leave it up to Damon as to how to articulate that to the legislature. So I would entertain a motion or further discussion on that.

MEMBER LAMBORN: This is Leah Lamborn. I'd like to make the motion that the PEBP board opposes both AB 249 and SB 233.

CHAIRMAN CATES: Okay. We have a motion. Do we have a second?

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

CHAIRMAN CATES: Thank you, Tom. So we have a motion and a second. The motion is for the PEBP board to take a position of oppose on AB 249 and SB 233. Is there any discussion on the motion?

MEMBER COCHRAN: Mr. Chair, this is Chris Cochran.

CHAIRMAN CATES: Go ahead.

MEMBER COCHRAN: You know, there are portions of the bill that I support and portions that I don't support. I will have to tell you I'm not at this point -- I mean, I would like to know more about where this bill is further along. As written, I would say, well, I can't support everything in there, but there are some things that I probably could support in that bill.

So I, you know -- And knowing that bills get

amended down the road, I'm not -- I would much rather wait that we submit our position on this until -- unless there's not going to be any more public hearings on this. And I'm assuming that the legislature is going to be holding additional hearings. Am I wrong about that?

MR. HAYCOCK: For the record, Damon Haycock. Chris, they definitely can. Once they get in to working sessions, it gets a little bit more difficult. But perhaps I can propose a different perspective. We can always -- The board has the ability to always take a neutral stance and then I can come and voice the concerns that were provided at this hearing, or excuse me, at this meeting and our willingness to work with the planned sponsors to ensure that we clean up some of the language to protect the members of our plan and really the Nevadans from issues arising out of the language of the bill. So we can take a neutral plus -- a neutral plus type of scenario and I can go in and I can vocalize your wishes.

MEMBER COCHRAN: Well, and I'm saying that only because, you know, maybe there are provisions in which on the purchase of the contraceptives that there not be deductibles for that. I guess that's the intent of this particular bill; correct? And our concern on it is if we don't have deductibles then we're paying extra for these bills -- I mean, we're paying extras -- it's going to cost us more to

implement the results of, you know, whatever -- if this bill passes.

So that would be my take is that, yes, it's going to cost us more money. So the question then reverts back to the state, if this is going to cost us more money how do you expect us to pay for it. So if we're strictly doing it on fiscal that it's going to cost us more money, you know, technically I might be opposed to it. But if it's something that's going to improve benefits for our members, then there are things that we probably could support on that.

MEMBER LAMBORN: So this is Leah Lamborn. I have a question. Couldn't we change our positions after the bill is amended at some point? And, again, I don't see that this would be a fiscal impact really to the state. I think that this would flow down really to our members with higher costs to them and premiums eventually. Am I correct?

MR. HAYCOCK: So for the record, Damon Haycock. Yes, you're absolutely correct, Leah. We can present a position. And then as amendments come in and we have the opportunity to testify again we can amend that position. Part of the process this year -- And I'm pretty sure it was done by my predecessor in years past -- is we will continue to bring you the same bills and give you updates until they either die on the vine or the session ends. So we will be able to have you revise your position. And even if you have

a very solid position one meeting, once we provide more information on the next one, I will of course ask the chairman to ask or to either reaffirm the position or change it. So we can definitely oppose it today if that's the will of the board based on two factors: One, the potential cost to the members, which will equal rate increases, and two, the concern of patient safety on avoiding things like step therapy and preauthorization and not necessarily driving them back to the doctor to report issues when they have a 12-month supply of any medicine. And I can vocalize that almost word for word to the legislature if that's the intent of the board.

MEMBER BAILEY: For the record, Don Bailey. I would support staying neutral on this bill, these two bills. There's some things in the bills that are probably really good for our members. But I think there's some things in here that are not good for our members. And the financial impact is going to be huge. And so I think if we stay neutral -- Because we also know they're going to amend this bill and they're going to amend them probably big time. Someone has introduced these bills and they're important to that individual or that company. But I think we just need to stay neutral. And then we can go in favor of or against. That way we got an open door and it's not closed on us. We tell them no right now and that's the way our legislators are

going to look at it.

MEMBER GARCIA: This is Rosalie Garcia.

CHAIRMAN CATES: Go ahead.

MEMBER GARCIA: I kind of take a different stance with regard to bills that are proposed. I would want us to give a voice exactly for that reason so that the legislators would know that we have concerns regarding it. So in that light I would want to support a no.

CHAIRMAN CATES: You would support the motion?

MEMBER GARCIA: Exactly, right. Thank you.

CHAIRMAN CATES: Okay. Thank you. Are there any other comments from the members on the motion? Any discussion? Go ahead.

MEMBER ANDREWS: This is just a statement. You were asking who was the sponsor. It's Frierson on one of them. And Julia Ratti on the other one. On the AB 249, 27 legislators are sponsors and co-sponsors. On SB 233 there is 11.

CHAIRMAN CATES: Right.

MEMBER COCHRAN: Mr. Chair, this is Chris Cochran again.

CHAIRMAN CATES: Go ahead.

MEMBER COCHRAN: Yeah. This is kind of getting back and kind of relates to what Don mentioned and then is kind of also in response to what Rosalie mentioned. As I

said before, there are certain segments of this bill that I like and there are certain segments of the bill that I would -- that I don't like. But to say we do not support the bill if this is the way PEBP was going to go on this, then we're essentially rejecting everything that's in the bill. And I would much rather than give a position as to whether support -- whether to endorse or not -- or not to endorse the bill would say, you know, if we want to get specific, these are areas that we can support. You know, so that's the way I look at it. Because otherwise we're -- I just have a problem with saying, well, we don't support the bill. There are certain things in this bill that I personally support. And, you know, it's the 12-month thing. That's an issue and I wouldn't necessarily support that. But there are also matters related to patient compliance and the ability to, you know -- I mean, we have patients who have a three-month supply, the same types of things of whether it's in our plan or any other plan that a person in the State of Nevada may have where they change employers, well, they've got three months worth of supplies of prescriptions, doesn't cost inflate your cost, recognizing that that same issue supplies, that, you know, they may not be with us for that entire time.

The 12-month thing is something that I would personally have a problem with. But there are other components of this bill that I would support. So, you know,

just know that when I vote, if we do bring this to a vote, we have a motion, that I will be voting against the motion to vote against this bill.

CHAIRMAN CATES: Okay. Thank you. Any other comments or discussion?

MEMBER LAMBORN: So this is Leah Lamborn again. So, again, could we not testify that we oppose the bill as written but we would be happy to reconsider that position pending any amendments that may take place? I was always trained to know you have to do your fiscal note or your position based on the way the bill is currently written.

CHAIRMAN CATES: For the record, this is Patrick. I would tend to agree with that. If the bill has provisions that we think are untenable, I personally think it's okay to oppose that bill and then change our position if it gets amended. However, I certainly also understand other committee members' perspectives that if there are good things in the bill, we may not want to necessarily oppose it outright. It is being sponsored by the leadership of both houses. It has wide sponsorship. So it's obviously important to a lot of people. I think either tactic is valid. We can just say we oppose it until such time as we see new language and then change our position. Or we can be neutral and let Damon express all the concerns that we've discussed. I think either one would be equally effective. I

can go either way on this. How's that for splitting it down the middle?

MEMBER LAMBORN: This is Leah Lamborn again. I don't know if I would agree that they would be equal. But I do think that an opposition letting them know that we would be willing to change our position, we are very concerned about certain portions of the bill. And I do agree there are certain things in here that are good. But there's a lot -- I just have a lot of problems with no prior authorization, no step therapy, the 12 months. There's a lot of things in here I'm concerned about.

CHAIRMAN CATES: I think I'm inclined to support your motion. It could go either way, but I would be inclined to support that. So we have a motion and a second. Is there any other discussion? Seeing none, I'll call for a vote. All those in favor of the motion say aye.

MEMBER ANDREWS: Aye.

(Several ayes stated at once)

CHAIRMAN CATES: Maybe the ones on the phone should identify themselves.

MEMBER GARCIA: Member Garcia. Aye.

MEMBER LAMBORN: Leah Lamborn. Aye.

MEMBER VERDUCCI: Tom Verducci. Aye.

CHAIRMAN CATES: And all those opposed?

MEMBER ZACK: Me. Christine Zack. Aye as well.

CHAIRMAN CATES: Oh, sorry. Okay. So we've got all the ayes?

All those opposed say nay.

MEMBER BAILEY: Nay.

MEMBER COCHRAN: No, nay.

CHAIRMAN CATES: Okay. It looks like the motion carries.

MR. HAYCOCK: For the record, Damon Haycock. Before I move to the next bill, this is for Vice Chair Bailey and Chris Cochran. I'll make sure and share the discussion we had here today when we share our opposition that we're not opposed to the entirely of the bill but there is some language in here that give ours agency and our board concern and we would be more than willing to work with the planned sponsors to help revise and amend it to ensure that we protect the safety of our patients and keep the solvency of our health plan. Hopefully that's fair. I'm not just going to walk up to the table and say, yeah, PEBP board opposes and then walk off. So please don't think that your voices won't be shared.

I'm going to move on to the next one and I'm going to quickly punt it to Chair Cates, which is Senate Bill 80. He's already given an overview back in January. Just today we learned here at PEBP that there is a new BDR number attached to what looks to be a rewrite of this. It's BDR

18-979.

MEMBER ANDREWS: What is it?

MR. HAYCOCK: BDR 18-979. If you go out, you will not see those texts yet. It's not out there. And so I really don't have a lot. I could talk about it specifically. I did not see that version of the bill. And so we're here to kind of talk a little bit about Senate Bill 80 as it was originally put forth. I know Chair Cats testified I think it was this morning a little bit on this bill. But I tried to summarize it real quickly that we again transition to the Department of Administration, the PEBP board would transition from governing to advisory, that the agency and executive officer would be replaced with the administrator, who would report directly to the department director of administration. It also pulls the quality control officer out from being appointed by the board and has it appointed by the administrator and that there would be some purchasing language taken out, the exemption for the PEBP board to basically trump purchasing in NRS 333.

At this point I'm going to turn it over to Chairman Cates, as he is the sponsor of the bill, to provide any additional updates.

CHAIRMAN CATES: Sure. Thank you, Damon. As Damon said, there is a BDR number posted on the legislative website but no language. I just became aware of that

yesterday. I gave testimony this morning at the deferred comp budget hearing. The legislature had a lot of questions about SB 80. Basically I'll paraphrase what I told them this morning. The new BDR language differs from SB 80 in the following two substantive ways: One, it does not seek to combine the two programs in to one division as SB 80 does. It keeps them both separate, both reporting to the director of administration. It also changes the composition of the PEBP board by removing the local government representative and replacing it with a second NSHE representative. Those are really the major differences.

When we submitted the language you see in SB 80 that was very early on last summer, early spring or early fall, I believe. Excuse me. And it was a bit of a place holder. We were already working on revised language. And when that language is released by LCB legal, you typically get it in advance of them posting it, and you have an opportunity to make any language changes. LCB legal did not meet their deadline before we were able to see the language and we had been working with them since as to how we can get that amended language in. And their solution was to put the new language in a fiscal bill, which is the BDR 18-979.

So it's been a little difficult for me to speak to our intent when the bill that is out there published doesn't quite reflect the governor's office intent. So I've

tried to do my best to describe those differences.

As I went through this morning and as I talked about at our last meeting, essentially what is driving this are really a few things. It's part of a broader effort of the part of the executive branch to bring some oversight and consolidation to boards and commissions generally. There are other proposals out there, for instance, bringing the OHB commission under conservation of natural resources, reform of behavioral health boards, licensing boards, and bringing them under health and human services.

We had a whole host of proposals that we looked at for the governor's office related to the boards and commissions, only some of which made it out the other end in terms of legislation. So I just want to keep it in that broader context.

The intent is that we more closely tie together all of the components that are employee benefit packages, employee benefits packages that also include our commitment to retirees. We need to more closely coordinate what benefits this program is offering with the benefits we can offer through human resources in terms of pay raises and other issues of recruitment. There are a lot of states that organize it this way. In fact, public employee health programs having a governing board, there's a minority of states that have that structure. I think that's important to

keep in mind.

And really we have seen concerns over the years and with this board in particular about how they handle administrative rules, how they conduct procurements, the issues that the board went through last year with the HMO RFP. As somebody that is responsible for state purchasing, I frankly was appalled at how the board conducted those RFP's, setting aside their own rules and making what I would characterize as an arbitrary opinion over the objections of the executive officer and the state purchasing administrator. I don't think that's very good business for the state. And the only reason that that didn't go forward was because we simply ran out of time and had to extend the current contracts, which that did not cost employees or retirees any money. But had the board's wishes been fulfilled, there would have been rate increases.

There are other examples of that kind of stuff going on on other boards. And I don't want to disparage any individuals. I think it's the nature of when you have an appointed board of people who come from diverse backgrounds who may or may not understand the state processes and the collective reasoning does not always conform very well with administrative law and things of that nature.

I am philosophically opposed to having employees reporting to public bodies where they have to be evaluated by

those public bodies or they have to have disciplinary action reviewed by those public bodies. I think that's a very difficult structure. I think in certain circumstances it makes sense to have those structures. For instance, the head of LCB reports to the legislature. I mean, they're the supreme legislative body. They're elected. This board is appointed. So I think the oversight role is more difficult. If you're a county manager or a city manager or something like that, that's fine. That makes sense. Again, those governing bodies are elected by the people. We're all appointed and we come from diverse backgrounds and have a variety amount of time and knowledge to be able to be dedicated to this program. So I think the active running of a program by an appointed body like this I think is inherently problematic.

Let's see, what have I missed? Fundamentally those are really the issues that we're trying to get at with this. And, again, we're very grateful for everyone's service on this board currently and all past members. But we think it would be a lot better structure to have it under a department where it can be supported by a department where the employees of that organization are reporting through the structure of the department and not through a board.

And it in no way diminishes the ability of members to participate. It in no way diminishes the ability

of these boards to voice their opinions and provide input to the programs. And as I told the legislature this morning, if the state decided to take a course of action that was different than what the board had recommended, I think that would be a discussion that would have to be had by the legislature. That would have to be justified. We would have to say why we did that. And I don't see that as a problem. I think it's a better way to organize it. I think it would be fair for our members and it would still allow the public, the retirees, and employees to have a full voice in this program.

And if we had actual language out yet, I would go so far as to try to ask for a vote on this, but I don't want to you vote on a bill that we don't want to go forward. So I'm not going to ask for that today. But I would ask that people really think about that. I know there's been a lot of people at the legislature and at this meeting, public comment testifying against it. And I know they're concerned about loss of control.

And I would go back to what I said last time. Fiduciary responsibility of this program ultimately rests with the governor and the Nevada legislature. And that fiduciary responsibility is only delegated to this board. And I think it's important to recognize where it truly rests. And that's it. Thank you.

MR. HAYCOCK: For the record, Damon Haycock. I'm not quite sure how to follow that, Chairman Cates, but I think I'll move on to Senate Bill 139.

Senate Bill 139 basically makes various changes to provisions relating to patient-centered medical homes. It requires an advisory, the advisory counsel on the state program for wellness and the protection of chronic disease to establish an advisory group comprised of interested persons and government entities to study the delivery of health care through patient-centered medical homes. This group with the commissioner of insurance and the director of the Department of Health and Human Services will be tasked to adopt regulations that prescribe standards concerning payments to, and incentives, for patients that are in medical homes.

So in a nutshell, really, it is creating a body that is going to vote on past regulations on how patient-centered medical homes should be incentivized and then all health plans within the state are simply going to have to implement.

So if it were passed, we would have to build incentives in to reimbursing patients their medical homes in Nevada without knowing what those incentives will be until approved by an advisory group that may or may not include PEBP's input on those incentives. And so depending on the cost, the impact can be minimal to massive. Again, once I'm

done with the quick overview, I'll turn it over to Tena who wrote a fiscal note on there. But we reached out to our third party administrator, who has seen these incentives in their book of business across the nation, and they said traditionally or potentially they are a dollar per head type of incentive. And it can be anywhere from five dollars up to $50. And depending on how many of these homes you have in Nevada or in the state that you implement, there can be a sizable incentive that you're going to have to pay for with no additional funding.

And so I'll let Tena walk through kind of the ideology behind the fiscal note we put on there. But, of course, any required incentives will need to be passed on to the participants in the form of rate increases, right. We don't have, you know, additional profits that we can cut and then absorb additional unfunded mandates. So this truly is, again, an unfunded mandate. That is what would happen to the consumer driven health plan.

HMO's will also need to incur these incentives and will have to increase their rates accordingly. And they gave us information to include, I believe, at least a narrative on their concerns about having to increase rates if again there is these incentives.

When you legislate or -- Let me back up. When you regulate an incentive or a payment model to a provider,

you take away the negotiating power of the negotiator to get the lowest cost. And so when it says I'm supposed to get X, Y, Z and I meet the minimum requirements, I get X, Y, and Z. And I don't have the opportunity to say, well, you know, we're the State of Nevada and we would like a special deal. There's only a couple of us going there, can we work out some way to help out the Nevada taxpayer who is going to subsidize my folks going there. We lose all negotiating power. Our networks lose all negotiating power. And it becomes, again, a requirement that must be paid for.

And, as many of us know, not all providers charge the same and we will often steer or influence our membership to go to a high quality, lower cost provider to save everybody money. And we won't be able to do that with mandated incentives.

And with that I'm going to turn it over to Tena to give a quick overview on the fiscal note that was put there.

MS. GLOVER: Again, Celestena Glover for the record. So when Damon and I reviewed this bill, BDR at the time, we looked at essentially our worst case -- best case/worst case scenario using a five dollar per head per month. And this was per member. So not primary participants but all participants in the plan at five dollars a month, $60 a year, times 55,000 members, we're looking at about 3.3

million dollars. If you take that out to, in our case, worst case scenario at $50 a head, so ten times the amount, 600 per participant, so just multiply that 3.3 million dollars.

So what we did is attach a spreadsheet with the best case to the worst case. We didn't actually -- Anybody who knows how they rank, they put dollar amounts in there, we did not do that. We put an attachment so we could show them what our calculations are. So it really depends on what the advisory committee ends up doing.

MR. HAYCOCK: For the record, Damon Haycock. I want to add one thing. We also, in our analysis, we didn't assume all 55,000 belly buttons were going to participate. So we broke it down I think in to 10,000 member categories because there's also the other half of this, which is do you have enough patient-centered medical homes in the state, senior membership? And so it may be minimal, it may be massive. This may prompt other patient-centered medical homes to spring up because they know they're going to get guaranteed funding. But we kind of gave just a snapshot analysis of what it may look like. I haven't seen this bill. This bill was provided in notice of eligibility for exemption on February 28th. I have not seen to date any hearing or work session assigned to this bill yet.

So we are monitoring it. We are watching it. I do look at my personalized legislative tracker every night to

see when it is going to pop up. But as of this moment there hasn't been any testimony that I know of on this bill, but we would like to once, of course, the board has discussed it if there's a position you would like us to take, we definitely want to be able to take it.

CHAIRMAN CATES: Thank you, Damon.

Any discussion, comments on the bill?

MEMBER LAMBORN: This is Leah Lamborn. So I would like to know what this -- Thank you -- what the incentive pays for? I'm reading through the bill and of course it's not very clear. I don't see that these medical homes are -- What is the incentive payment for? I don't see that they're required to have any outcomes, which again would probably be developed hopefully by the advisory board. And maybe I'm just missing it. So I don't know if anybody has the answer to that question or if it's even a question. Do we know what we're paying for?

MR. HAYCOCK: For the record, Damon Haycock. Excellent question, Ms. Lamborn. I -- When I read the bill, and I had the same kind of concerns that you did, is it wasn't quite specific enough, which would be part of our questions through testimony, is that is there an assumption that if you just become qualified as a patient-centered medical home and you go through the qualification process similar to a certification that is through NCQA or those

types of things that you're supposed to meet a certain level of standards when you are qualified or certified as a patient-centered medical home. And really that patient-centered medical home -- And I'm probably going to butcher it and I'll get e-mails later. But the idea is that it's almost like a village raising a child. So it's people all taking care of the patient and ensuring that the patient-centered medical home, the initial primary care physician, is also coordinating care with all of the other supplemental care facilities and they're all part of the same type of group. And so the idea is that being able to devote more time and to ensure more coordination you would get better outcomes. And I think that's kind of it in a nutshell. Hopefully I didn't butcher it too bad.

But the incentive is just it's a participation incentive is the way that I looked at. So if you're going to participate in this program -- It's similar to our diabetes care management program where if you participate in our diabetes care management program we offer you incentives through co-pays for your insulin or insulin replacement and your diabetic supplies. We can design it where there's no outcomes. You just pay to play, you get in and you get it because we want you to take it. Or you can design it where it has certain requirements that you must lower, you know, certain outcomes or have certain outcomes like A1C or those

things.

So that's the long answer to say you're right. I don't think it's been completely defined. But my understanding is that the patient-centered medical home isn't something you just slap on the side of your building as a provider. You actually have to go through a certification or qualification process.

MEMBER COCHRAN: This is Chris Cochran, Mr. Chair.

CHAIRMAN CATES: Go ahead, Chris.

MEMBER COCHRAN: So patient-centered medical homes are something that I actually know a little bit about. And Damon is correct, it's a quality-based system. It's in some respects very similar to what managed care was trying to do, what HMO tried to do by coordinating patient care. But its primary benefit is for people who have chronic illnesses, chronic diseases, in order to make sure that their care is more comprehensive, that we reduce the number of -- we reduce admissions in to, for instance, for hospitalization. And ultimately based on better quality reduces the overall cost of care for an individual.

So the incentive is -- The burden of the incentive is on the provider. It's not on the patient per se. And so any kind of reimbursement would be going for those providers to meet certain standards within -- that are

set forth to be a patient-centered medical home and to qualify.

You know, so it's really an attempt to improve the overall quality of care given to individuals. It's not trying to add necessarily more services to say, well, now, you know, you're going to pay more because we're required to have patient-centered medical homes.

I think you're going to see a lot more patients -- Like you said, Damon, I think you're going to see a lot more patient-centered medical homes crop up around the state because Medicare is going with these organizations. And now Medicaid is looking at patient-centered medical homes as a way to try to control cost and improved quality.

So, I mean, if I were PEBP, I wouldn't take a position on this one way or another at this point because the intent of patient-centered medical homes is just by its very name, patient-centered. So to improve the quality of care to patients. I.

Don't know if that is a good enough explanation. But it's not something that is intended to be a financial burden on PEBP if we have patient-centered medical homes.

MEMBER LAMBORN: Mr. Chair, this is Leah Lamborn, if I may.

CHAIRMAN CATES: Go ahead.

MEMBER LAMBORN: Thank you. So I guess I kind of

asked that a little fishplate because I do know what the intent of medical homes having Medicaid background. It just didn't seem -- No criteria of outcomes or what a medical home -- these medical homes are to receive as incentive payment is required to do. And, again, I think you've already touched on it. This is what managed care already does. I do realize it's the coordination of care. But I'm just not seeing that language in there. It's just left so open that, again, it doesn't reassure me that we're going to get a service for this medical home. But, again, I think that would be the task of the board. And I would hope that they would put something in requirement outcomes on that.

And I agree with you, Mr. Cochran. I think we should remain neutral on the bill at this time.

CHAIRMAN CATES: So I have a question, Damon. Has there been a hearing on this bill?

MR. HAYCOCK: So for the record, Damon Haycock. No, there hasn't, Chairman Cates. And just as a point of clarification, and I'll speak personally and I won't speak for the agency. I actually like patient-centered medical homes. I just don't like being told I can't negotiate with them and that I have to pay them a specific rate that is established by someone that may not take my plan's needs in its consideration. And so having a group of folks decide that they can afford to pay a certain incentive without

ensuring that all plans can afford to pay that incentive without massively harming the participants and their monthly premiums I think is unfair. And so I like the idea of having patient-centered medical homes. I think they're a good product. It's similar to direct primary care where it's trying to put the patient first instead of the assembly line version of primary care that many folks suffer from today.

But I also feel that you should not tie the hands of the health plan to negotiate the most appropriate competitive price model when anyone gets the same amount regardless if they have better outcomes or not.

CHAIRMAN CATES: Thank you.

Any other discussion on the bill? Anybody like to make a motion on the bill? Seeing and hearing none -- I'm sorry. Go ahead.

MEMBER ANDREWS: Ana Andrews for the record. I would make a motion that we just let it be until we find what it is exactly that they want to do.

One of the things that I read in the bill is that they want to create an advisory counsel to do a study. So Leah had asked earlier what are we paying for. Well, I guess for the study. I'm not clear on it, to be honest with you. But I don't think that -- In my particular case I'm not ready to say oppose -- not even neutral. I mean, let's just see what happens with it.

CHAIRMAN CATES: I agree. I would tend to agree with that. Any other comments? Anybody have a desire to make a motion on this? Hearing none, I think we'll just move on.

MR. HAYCOCK: For the record, Damon Haycock. Just to clarify, the board is taking no position on this bill, we'll continue to monitor it, and as we get more information as hearings start coming down, we'll be able to present more information back to the board at future dates and we'll ask for a position at that time.

So I'm going to talk about a BDR right now and generally it can be kind of premature. It's BDR 40-809. The reason why we've been able to see it -- I don't even know if there's a link out to the language on there now. No, not yet. We got it. We got a copy of it because we were asked to put a fiscal note. And normally we wait before we brought it before the board. But if there's any bill that we want to talk about today it's this one. And the concern really, and I'm just going to break it into its most simplistic function, it puts a maximum cap on out-of-pocket costs for every member of a health plan for their pharmacy drugs at $500.

So the consumer driven health plan if it were to adhere to a $500 out-of-pocket maximum for anything, it basically kills your health savings accounts, because you have to have a high deductible health plan to qualify for a

health savings account per the Internal Revenue Service. And in order to have a high deductible health plan that is HSA eligible, you cannot carve out special deductibles for special processes with the exception of preventive services and certain chronic disease programs. That's how we're allowed to carve out a benefit for our disease -- Excuse me -- our diabetes care management program because it does qualify as part of a high deductible health savings account eligible plan.

But in carving out pharmacy, and we talked about this -- I know I did when I first got to PEBP and asked staff and asked legal, and they said, you can't do this, you can't carve out pharmacy and still have an HSA.

So it really leaves two scenario. And before we even talk bought the financial impact, and I'm sure Tena is biting at the bit to share with you because it's pretty sizable, but if you have a $500 out-of-pocket max for pharmacy, you either have to get rid of your HSA on the consumer driven health plan and only offer an HRA or health reimbursement arrangement and then you're allowed to carve out the $500 out-of-pocket max, which means you're going to have a $500 deductible or less. You can't have a higher deductible than an out-of-pocket max. And so you'll have -- You'll be running both of those benefits separately.

Or you change your entire plan from a high

deductible health plan with an HSA option to a low deductible health plan or a no deductible health plan with no HSA and you basically reset the plan back to 2010 as an option. I mean, you can do any kind of manipulation within there. But you could lower the deductible down to $1100, anything underneath the threshold so it's a low deductible plan, and then carve out again a pharmacy benefit at $500.

And really the cost controls and the plan design that this board and the State has gotten behind for the last I think six years now would change dramatically. And that's just on the design part of it. There's a lot of folks that would receive significant relief on their pharmacy benefits. Let's not lie, right. There are people that satisfy their pharmacy -- Excuse me. They satisfy their current family out-of-pocket maximum on our consumer driven health plan in the first month on their drugs, on their pharmacy drugs. So they satisfy $7800 worth of pharmacy benefits in their first month. This would give them significant relief.

But it also means someone else has to pay for it. Someone has to pick up the remainder of that pharmacy benefit. And, yes, it would be the plan. But the plan doesn't create money. We collect it through premiums. And so you're talking about a massive increase to premiums to cover those folks that have these pharmacy benefits that we currently say have cost controls a higher out-of-pocket max

and a higher deductible.

And it doesn't just affect the consumer driven health plan. It will also affect the HMO plans.

Currently, moving forward, we're looking at a specialty benefit starting July 1 of 40 percent co-insurance on specialty. That goes away if this thing comes alive. It's a $500 max. So they're going to hit that almost immediately for many of the drugs that are coming out today.

So to give kind of an impactful, financial overview, I will once again turn it over to Tena.

MS. GLOVER: Celestena Glover for the record. So taking the information in this BDR that we were able to see because of the fiscal note request, I requested information from HealthSCOPE and ESI. We looked at Catamarran's data from last year. And I did some calculations and made some assumptions. So the way we approached it was to assume that the deductible essentially goes out the window, the max would be $500 because of the pharmacy. Got some information from the HMO.

So what it boiled down to is about a 29 million dollar, 28 million dollar, hit in the first year. Trended up on the medical side by four percent and the RX side by seven percent. When all was said and done we were at 30 million in the second year and future biennium at about 73 million dollars. Back that in to the cost, you're talking rates

increasing significantly for participants because that money has to come from somewhere. So that would affect our overall rates by about $230 per primary participant on the CDHP.

CHAIRMAN CATES: All right. Wow.

MR. HAYCOCK: So for the record, Damon Haycock. We're not really excited about this BDR at PEBP, our staff are not. Again, we recognize that this appears to be -- And I'm going to go out on a limb here, and hopefully, again, I don't get the e-mails tomorrow. I'm not against providing a benefit to participants. And the high cost of pharmacy is killing this nation when it comes to medical costs. We know that. And it is -- I don't want to say it's out of control. But it is very difficult to continue to pay for these high-cost drugs, especially when they come out for one indication and then they get approved for another. And they are extremely expensive and people can't afford them and plans can't afford them.

But instead of addressing the cost at the manufacturer's part, we're going to address the final cost at the purchaser's part, which doesn't reduce the cost to health care. It doesn't reduce the cost to pharmacy. It just shifts all of it back to the plan, which, in turn, shifts it right back to all of the participants and it becomes even more expensive for folks in their monthly rates.

And it's one of those things that is difficult to

try to sell. The intent of this bill -- My understanding of the intent is we're trying to provide relief to Nevadans who have high cost pharmacy. I get that. But I don't know if going after the health plan by making the health plan somehow find a way to pay for it instead of going after the manufacturer or a group who purchases a drug and then jacks it up 3,000 percent. To me that's where the real catalyst of the problem needs to be investigated.

And I know they're looking at these things at a federal level under the new administration and they're looking at things, you know, trying to work not only with manufacturers but with pharmacy benefits managers to reduce the cost of pharmacy benefits across our nation. But you ask any health plan administrator across the nation what are their biggest costs and they're going to say specialty pharmacy drugs. And this doesn't reduce the cost of these drugs. It just hides the cost in an out-of-pocket max that then gets reverted back to everybody's premium. And with that, we'll take questions.

CHAIRMAN CATES: Comments or questions from the members?

MEMBER COCHRAN: This is Chris Cochran again, Mr. Chair.

CHAIRMAN CATES: Go ahead.

MEMBER COCHRAN: Sorry to chime in on everything,

but. Actually, Damon, what you say is absolutely correct. This is one that, you know, based on the way that this -- the way it sounds, do we have a copy of this in our -- I guess we do; right? It's in the legislative update.

MR. HAYCOCK: For the record, Damon Haycock. Chris, we have a brief overview. We have a copy of the BDR. And I forgot you guys couldn't see it. So after this meeting we'll send it out to everybody.

MEMBER COCHRAN: So -- Yeah, you're right. All this is doing is shifting the cost to the insured, which is ultimately going to shift the cost to the individuals. And as long as there's no control on the price of pharmaceuticals, this will just continue to go up. You know, there's no incentive, there's no incentive on the part of pharmaceutical companies to come up with a way to lower their costs for those folks who actually need these drugs rather than necessarily just advertise them and say, you know, you could have Hepatitis C, go out and get screened for it even if you're not showing symptoms so that your doctor can prescribe you a $90,000 a month prescription. These things are going to -- There are going to be ways that if plans start doing this that the cost for health plans across the country are going to be astronomical.

And, quite honestly, my gut tells me this plan doesn't have much of a chance -- I mean, this proposal

doesn't have much of a chance. But if there is a proposal that I would -- that I can support, it's this one right now for the very reasons that Damon has cited.

CHAIRMAN CATES: All right. Thank you.

MS. GLOVER: So this is Celestena Glover for the record. One of the things that we did get feedback on, which leads to what Damon and Chris both said, what this will also do, which is not part of our cost assumptions, are there will be no incentive once that $500 cost is met to use generics. They will be more likely to be incentivized to go ahead and get brand names if there is no reason not to if the plan is picking it up. So, ultimately, in your first year of rates you might not see it there, but you will definitely see it in future years and that could be even worse than we're seeing.

CHAIRMAN CATES: Thank you.

Any other comments from the members?

MEMBER VERDUCCI: Mr. Chairman, Tom Verducci.

CHAIRMAN CATES: Go ahead, Tom.

MEMBER VERDUCCI: Yes. I would have a real hard time supporting this bill because I just think it would be detrimental to our HSA plans. You know, we need to have the HSA plan in place. And with the massive cost increase I just don't see how we can really get behind it and support it. I like what it's trying to do in terms of giving a cap on the deductible and the pharmacy benefits, but I just don't think

that it's within our budget parameters at this point to eliminate the HSA plan in our program. I just think it's too valuable. And in the future we're going to really be relying on the HSA going forward.

CHAIRMAN CATES: Thank you, Tom. I would echo those sentiments. I was thinking the same thing exactly. The HSA is a key part of making our high deductible plan palatable for our members. And it would be a shame to lose that and just have rate increases forced on everyone.

Any other comments? I don't know if anybody wants to make a motion. We don't have the language. It's just a BDR. But we certainly could make a motion to oppose it if that's the desire or maybe neutral with instructions to Damon to express those concerns to the sponsor. Whatever the pleasure of the committee is, I'll entertain any motion you'd like to make, or none at all.

MEMBER VERDUCCI: Mr. Chairman, Tom Verducci. I would like to make a motion that we oppose BDR 40-809.

MEMBER COCHRAN: I'll second that motion. This is Chris Cochran.

CHAIRMAN CATES: Thank you, Chris. Great. We have a motion and a second to oppose BDR 40-809. Any discussion on the motion? Seeing and hearing none -- I'm sorry. Go ahead.

MEMBER COCHRAN: I'm sorry. I'm sorry. Just one

quick question. Of course I make that second not having actually read the bill. But I just want to make sure there are no surprises in there that I -- But, you know, as discussed I can't support this bill. So anyway, you know, that would be my own caveat, but I still make the second -- I'll still stand with my second.

CHAIRMAN CATES: Very good. Thank you. We can always change it if the language comes out different than what we perceive it to be.

Very good. Any other comments or questions before we take a vote? Seeing, hearing none, all of those in favor of the motion say aye.

(The vote was unanimously in favor of the motion)

CHAIRMAN CATES: Anybody opposed say nay. I don't think there's anyone left. Hearing none, the motion carries unanimously.

MR. HAYCOCK: Thank you, Mr. Chairman. For the record, Damon Haycock. This concludes the bills that we have -- that we have known of as of this time to share with the board for any impact to PEBP and positions. Just to summarize that the board has approved that PEBP testify and oppose Assembly Bill 249 and Senate Bill 233 for the direct language that is in there that has some patient safety concerns and also costs to the plan. And if there is ever a bill number attached to BDR 40-809 to oppose it for all the

reasons we just discussed.

Just as a point of clarification, after the board meeting, we will send out our copy of the BDR that was presented to us for our fiscal note. I still have it on my desktop. I think Kari does too. And then if you have any other concerns or questions if you want to singularly reach out to me and share your concerns. But regardless, I have to go with what the board has decided today.

And with that, I will turn it back to you, Mr. Chairman.

CHAIRMAN CATES: Thank you, Damon. This is an action item. I said I was going to take public comment on it. We have already voted, so I didn't think that through very well. But is there anybody that would like to make public comment on this agenda item? And we'll also have general public comment afterwards, but if you want to speak about the bills.

MS. LAIRD: Senate Bill 80. But I also have another comment. Should I wait until the end?

CHAIRMAN CATES: Okay. Yeah. We're almost to the end.

MS. LAIRD: Okay. Good.

CHAIRMAN CATES: Okay. So we'll close Agenda Item Number 3 and move to Agenda Item Number 4, public comment.

MS. LAIRD: For the record, my name is Terri Laird, and I'm the executive director of RPEN, the Retired Public Employees of Nevada. It's Terri, T-e-r-r-i, Laird, L-a-i-r-d.

Just a brief comment on Senate Bill 80. For all the reasons mentioned in Professor Unger's written comments, we also are against Senate Bill 80 as it sits now. And based on the Chair's comments today, I assume that we will still be opposed to it, again, for all the reasons that Professor Unger has mentioned in his comments.

We have already testified on the record a couple of times before in the legislature when this bill has been mentioned.

Primarily, we, you know, we like the way the board sits today. We like being able to speak freely and come to you like we are. And we're concerned that there could be issues with transparency if this bill were to move forward.

The other thing I would also just like to mention, it doesn't relate to any of the bills today, am I allowed to say that?

CHAIRMAN CATES: Yeah.

MS. LAIRD: The only other thing I just wanted to mention is that we have also at Damon's last budget presentation our lead lobbyist, who is Marlene Lockard, I

also work as a lobbyist along with her. But she did testify. Damon presented the seven options. We're still very concerned about the orphan issues, the out-of-state retirees, the escalating health insurance that the small group is facing because they are such a dwindling pool, small pool.

Among the seven options that Damon presented, we are on the record as being in favor of option four. And I just wanted to put that on the record before the board. And that, as you know -- I don't know, Damon, if you wanted to address that.

But option four was putting it back -- putting a lot of financial responsibility for that group on the local government. So that's -- Again, we're just real concerned with this. We have quite a few members of our organization that are impacted by that, that escalating cost. I know one of our members was, like, 800 percent increase she faced for the last year, the last biennium I should say. So it's just a real critical issue that we're very interested in getting a resolution to. So I be would be happy to answer any questions that I could.

CHAIRMAN CATES: Do we have any questions, any of the members? I think we're good. Thank you.

Any other public comment?

MS. LAIRD: I have nothing else to say.

CHAIRMAN CATES: We got time to fill. You sure

you don't have anything else?

MS. LAIRD: I'm good. Thank you.

CHAIRMAN CATES: All right. With that, I'll close Agenda Item Number 4 and move to Agenda Item Number 5. This meeting is adjourned.

(Hearing concluded at 3:30)

STATE OF NEVADA)
)ss.
CARSON CITY)

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

That on Thursday, the 9th day of March, 2017, I was present at PEBP offices, 901 S. Stewart Street, Carson City, Nevada, for the purpose of reporting in verbatim stenotype notes the within-entitled meeting;

That the foregoing transcript, consisting of pages 1 through 62, inclusive, includes a full, true and correct transcription of my stenotype notes of said public meeting.

Dated at Reno, Nevada, this 22nd day of March, 2017.

_____
CHRISTY Y. JOYCE, CCR
Nevada CCR #625

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