

In The Matter Of:
Public Employees Benefits Program
Teleconferenced Open Meeting

March 23, 2017

Capitol Reporters
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STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
TELECONFERENCED OPEN MEETING
THURSDAY, MARCH 23, 2017
CARSON CITY, NEVADA

THE BOARD: PATRICK CATES - Chair
 DON BAILEY, SR. - Vice Chair
 ANA M. ANDREWS - Member
 JIM WELLS - Member
 LEAH LAMBORN - Member
 TOM VERDUCCI - Member
 ROSALIE GARCIA - Member
 KRISTINE ZACK - Member
 DR. CHRISTOPHER R. COCHRAN - Member

For the Board: DENNIS BELCOURT
 Deputy Attorney General

Executive Staff: DAMON HAYCOCK
 Executive Officer

 LAURA RICH
 Operations Officer

 CELESTENA GLOVER
 Chief Financial Officer

 KARI PEDROZA
 Executive Assistant

 NANCY SPINELLI
 Public Information Officer

REPORTED BY: CAPITOL REPORTERS
 NICOLE J. HANSEN, NV CCR #446

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1 CARSON CITY, NEVADA; THURSDAY, MARCH 23, 2017; 9:30 A.M.
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4 CHAIR CATES: This is the time and the place
5 as publicly noticed for the Public Employees' Benefit
6 Program meeting.

7 Agenda Item No. 1, roll call.

8 MS. PEDROZA: Anna Andrews?

9 MEMBER ANDREWS: Here.

10 MS. PEDROZA: Don Bailey?

11 VICE CHAIR BAILEY: Here.

12 MS. PEDROZA: Chris Cochran?

13 MEMBER COCHRAN: Here.

14 MS. PEDROZA: Rosalie Garcia?

15 MEMBER GARCIA: Here.

16 MS. PEDROZA: Leah Lamborn?

17 MEMBER LAMBORN: Here.

18 MS. PEDROZA: Tom Verducci?

19 MEMBER VERDUCCI: Here.

20 MS. PEDROZA: Kristine Zack?

21 MEMBER ZACK: Here.

22 MS. PEDROZA: Jim Wells is excused for this
23 portion.

24 And Chair Cates?

25 CHAIR CATES: Here.

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1 MS. PEDROZA: You have a quorum.

2 CHAIR CATES: Thank you.

3 Okay. We'll go on to Agenda Item No. 2:
4 Public comment.

5 I just want to point out that we did receive
6 some e-mailed comment, and that has been provided on the
7 table over there and on the web site as an attachment for
8 the agenda. So I'll go ahead and open up public comment.
9 We will be limiting comment to three minutes. If you
10 want to make additional comments, we'd welcome them in
11 writing.

12 Do we have any public comments here in Carson
13 City?

14 MR. RANFT: Good morning, Chairman and
15 respective committee. My name is Kevin Ranft with AFSCME
16 Local 4041 representing the AFSCME local state employees.
17 And this morning, we come with a lot of, you know,
18 concerns, but at the same time, appreciation. We respect
19 everyone on the Board.

20 With that being said, there's challenges to
21 always meet, but there's a lot of concerns on the state
22 employees' side as well. We understand you guys try your
23 hardest. But with that being said, state employees, for
24 many, many years, have had the budget balance on their
25 back, and enough is enough. You know, at what point do
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1 we say, "What are we going to do for our state
2 employees?" Is it burdened on this board? Is it
3 burdened on the state government? Is it burdened on the
4 legislators? Who is it burdened on to stop having this
5 budget balanced on the state employees' back?

6 We're here today to say, "Okay. Let's
7 potentially raise some rates for the health insurance
8 premiums," but who is going to pay for that? We know the
9 health care costs are going on up. Who is going to pay
10 for that? When state employees have not seen a raise in
11 eight years and the raise they did see last session was a
12 1 and 2 percent that was offset, that is not helping the
13 employees out one bit or their families.

14 So I come here with a little bit of emotion
15 and irritation, but respectfully, I respect each and
16 every one of you. You guys have a hard job, and you're
17 doing a damn good job. But with that being said,
18 somebody has got to pay for it.

19 We have a subsidy that's being set right now
20 in the legislature subsidy, and we're doing projections
21 based off of these rates today that from the gov. rec.
22 Well, that's great. But we want these legislators to
23 stand up and say, "We are going to respect our state
24 employees. We are going to set the rates higher for
25 these subsidies than the governor," and then we're at a

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1 higher number, but the rates are already set. So the
2 state employees are paying more than they should be.

3 It's kind of a broken process. We should be
4 talking about setting rates in maybe the middle of June,
5 not right now. Maybe that will even impact some of the
6 plan design. The system is a little bit broken because
7 it's based off of projections. Again, there's a little
8 bit of extra money. It sounds like in the economic
9 forum, there may be some more funds available.

10 So we know we have health care costs going
11 up. Somebody has to pay for it, but not on the state
12 employees' backs. We would also like to see some
13 comparisons. You know, there's other states around
14 there. What are they doing, how are they doing it,
15 what's the best practice, and I respect that Damon
16 Haycock has looked into that. But let's see it. Let's
17 see it.

18 With that being said, I'd like to hold my
19 public comments for Action No. 5 and others as they are
20 discussed, and I thank you all for your time.

21 CHAIR CATES: Thank you, sir.

22 MS. LOCKARD: Good morning, Mr. Chairman and
23 members of the Board. My name is Marlene Lockard, and
24 I'm representing the Retired Public Employees of Nevada.
25 I'm here today to say thank you. We are very pleased

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1 about the adjustments that are proposed on this agenda
2 accommodating some of our comments for years, and we are
3 very pleased. There are still a number of issues, but we
4 are pleased about the recent changes and the rollback to
5 some benefits that were cut from 2011, and we wanted to
6 acknowledge that. Thank you.

7 CHAIR CATES: Thank you.

8 MS. MALONEY: Good morning to the Board,
9 because I always look at this green light and wonder if
10 it's really on. Oh, it wasn't. See, it looks like it's
11 on, but it's not.

12 So good morning to the Board and Chair Cates.
13 Priscilla Maloney representing the AFSCME retirees. I
14 want to echo basically what both Mr. Ranft and
15 Ms. Lockard said. We're thrilled with the proposed
16 adjustments to where we are at in plan design changes in
17 Item No. 5 on the agenda and really want to give a shout
18 out to Mr. Haycock. He has been by far -- at least I've
19 been with AFSCME one way -- in one capacity or another,
20 both with the actives and the retirees since 2011, and of
21 all of the folks we've worked with, as far as our staff
22 leader goes, Mr. Damon Haycock has been absolutely the
23 most willing and eager to reach out, to communicate, and
24 to talk things over. So we're thrilled with the changes,
25 as is Ms. Lockard's group.

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1 But again, the ongoing -- and some of this, I
2 think, is my own ignorance and the general public's
3 ignorance, and I don't mean any disrespect to the general
4 public, but it's like today we are having a national
5 conversation about plan design, plan costs, and we are
6 looking at a vote on some historic legislation or a
7 failure of that vote in D.C. that's going to affect not
8 just this insurance plan but every public and private
9 ERISA qualified or not ERISA qualified plan across the
10 country.

11 And one of the things that's been said to me
12 repeatedly by people in the insurance industry -- we're
13 fortunate enough on the retiree board to have Roger
14 Bremner as our vice president. He is not only a former
15 assemblyman, six terms, he's here in the audience today,
16 but he was also a broker for over 30 years within the
17 insurance industry.

18 Most people do not understand the
19 complexities in 2017 of health care insurance and health
20 care benefit delivery, and so we're having this national
21 conversation today. So we recognize the struggle to get
22 rates set in a timely, appropriate, and legal manner. I
23 don't even know what the legal requirements are. As
24 Mr. Ranft suggested, is it possible that we could set
25 them later in the budget cycle during our -- and I see a

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1 no from staff, but no -- but that's the kind of
2 information and dialogue we need to be having. And I
3 appreciate how willing the PEBP staff has been to do that
4 and to help us understand the complexities.

5 I think for years, perhaps, perhaps in this
6 country, health insurance provided by the employer bumped
7 along with people just being glad it was there, not
8 really understanding. And as right now, I'm in a COBRA
9 plan through my spouse who got laid off, and believe me,
10 when you get the bill for the real cost of your premium
11 and your plan design -- and as a cancer survivor, I can
12 tell you the plan design saved my life because we had
13 everything we needed from our employer-sponsored health
14 care plan. But when that COBRA runs out in June, I'm
15 going to be left to see what they're doing on the Hill
16 today and because I am not yet Medicare age. So there's
17 a huge amount of complexities. I'm trying to learn more
18 every day. We appreciate all of that. But again, just
19 hopefully, we can keep working together through the
20 budget process. And I know I've used up my time,
21 hopefully not in the existential sense.

22 CHAIR CATES: I appreciate your comments.

23 MS. MALONEY: Okay. There you go. Thank
24 you.

25 MR. ERVIN: Kent Ervin representing the
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1 Nevada Faculty Alliance, the statewide association of
2 NSHE faculty at all eight institutions.

3 Chairman Cates, Members of the Board, are you
4 planning to have public comment in relation to the
5 individual agenda items?

6 CHAIR CATES: On action items, yes.

7 MR. ERVIN: Okay. In that case, me, too, for
8 what's been said, and I'll get back to you on individual
9 agenda items.

10 CHAIR CATES: Okay. Thank you.

11 Any other public comment in Carson City?

12 Do we have any public comment in Las Vegas?

13 MEMBER COCHRAN: Yes.

14 CHAIR CATES: Go ahead.

15 MR. WASDEN: My name is Dr. Jason LaMarr
16 Wasden; J-A-S-O-N. Capital L-A, capital M-A-R-R
17 W-A-S-D-E-N. I am a member of the UNLV Benefits Advisory
18 Board, a UNLV faculty senator, a member of the
19 President's Advisory Committee, and a chair of the UNLV
20 administrative faculty committee. Additionally, I am a
21 taxpayer, father, and concerned citizen.

22 Often, we hear that state employees are
23 overpaid and over-benefitted. This is not the case in
24 the state of Nevada where many cannot remember the last
25 time they had an increase in their income or benefits.

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1 The reality is our benefits are slowly eroding away. We
2 want to focus this discussion on our health benefits
3 because our vision and dental benefits are just not worth
4 mentioning.

5 My understanding in 2010 is that we have a
6 low-deductible option for the PPO plan and a surplus of
7 funds in PEBP. And due to the surplus, the legislature
8 decided not to fund an increase in the state
9 appropriation. Additionally, a decision was made by this
10 Board to switch from a low-deductible to a
11 high-deductible plan. Since the switch, we have had
12 material surpluses every year in the CDHP plan. We would
13 appreciate this Board supporting the governor and
14 restoring most of the cuts made during the November
15 meeting at our health plan, the exception being the level
16 of funding for our dependents' contribution to the HSA,
17 the only thing that has not proposed being restored.

18 We know many of our colleagues are postponing
19 utilization of health benefits until they have saved
20 enough money on their HSA to pay for their needed medical
21 treatment. Additionally, they go outside the network for
22 procedures because the doctors they need are not part of
23 the network, thus increasing their out-of-pocket
24 contribution in order to meet the out-of-network
25 deductible. We applaud using the Aetna network, as we
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1 believe it will provide more network options. If the
2 Board chooses to stay with the high-deductible plan, we
3 believe it is extremely important to increase the amount
4 of money in the HSA to prevent an individual --

5 CHAIR CATES: We just lost the audio.

6 Can you hear us down there? We lost the
7 audio.

8 MR. WASDEN: Are you back?

9 MEMBER COCHRAN: Yes, we can hear you.

10 CHAIR CATES: Yeah, we can hear you now.
11 We're back.

12 MEMBER COCHRAN: We'll just continue with
13 comment.

14 CHAIR CATES: Go ahead, sir. If you could
15 just wrap up, we were getting close to three minutes
16 before we lost you.

17 Go ahead.

18 MR. WASDEN: All right. Should I try a
19 different microphone?

20 If the Board chooses to stay with the
21 high-deductible plan, we believe it's important to
22 increase the amount of money in the HSA to prevent an
23 individual family from having to come out of pocket with
24 \$7,799 for an individual or \$15,599 for a family during
25 the calendar year because they crossed the plan years

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1 after experiencing a catastrophic event. Even worse, if
2 they have to go out of network, they could potentially
3 pay \$21,199 for an individual, or \$42,399 for a family.

4 We firmly believe a deductible should be
5 reduced to the IRS specified amount, and the maximum out
6 of pocket should be decreased for both the individual and
7 family for both the in-network and out-of-network
8 deductibles unless you choose to reinstate a
9 low-deductible option.

10 Out-of-pocket costs are rising faster than
11 what it costs insurance companies to cover premiums.
12 According to the Kaiser HRET Survey of Employer-Sponsored
13 Health Benefits from 2011 to 2016, employee contributions
14 and deductibles increased by 63 percent and workers'
15 earnings increased 11 percent.

16 We know in Nevada, for state employees, we
17 have not seen increases in our earnings, so the 11
18 percent increase in workers' earnings average will
19 probably not apply to us, but our contributions to
20 deductibles are going up. We fully support Assembly
21 Concurrent Resolution No. 6 sponsored by Assemblymen
22 Ellison and Anderson that you -- thank you for your time,
23 and I hope we can restore our benefits for state
24 employees. They deserve to have affordable access to
25 health care.

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1 CHAIR CATES: Thank you, sir.

2 Do we have any other public comment in Las
3 Vegas?

4 MEMBER COCHRAN: Yes.

5 MS. CAMERON: My name is Vicky Cameron. I am
6 a retired public employee, non-state retiree, non-
7 Medicare eligible.

8 My questions to the Board are why should the
9 rates have to go up when PEBP's costs are decreasing
10 yearly due to some of the other programs of not using the
11 emergency room and using urgent care and things such as
12 that? Also, we have a \$33 million in reserve, and my
13 other question is, what funds the reserve? Thank you.

14 CHAIR CATES: Thank you.

15 Do we have any other public comment in Las
16 Vegas?

17 MR. UNGER: Yes. Professor Douglas Unger at
18 large, representative of the executive committee of UNLV
19 Faculty Senate. First, I'd like to thank the, members of
20 the board for their service. That we have a board such
21 as this one in place with governmental authority to
22 oversee and approve or disapprove both proposals and
23 contracts for Nevada state employee health care and other
24 benefits has been one of the most welcome innovations in
25 our state government for more than 18 years.

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1 and quote, "Transition the Board to an advisory body
2 only," thus concentrating authority overall
3 decision-making about state employee benefits to the
4 Department of Administration.

5 Now we're looking at another notation on the
6 legislative calendar, Bill Draft Resolution 18979 which
7 would -- or so we're told, since we have not seen the
8 text of this bill yet -- attempt to achieve the same
9 result: to take away this governing board that's done
10 such due diligence and much appreciated service to Nevada
11 state employees.

12 Transitioning the PEBP board in this way is a
13 bad idea, top to bottom. Such legislation, if passed,
14 would take away a much needed check and balance in our
15 state employee benefits system that has, for the past
16 18 years, helped to protect it against the kind of
17 misuse, misallocation, pay for play, and even criminal
18 activities that afflicted our state benefits system in
19 the past, which was the reason for the PEBP board being
20 created in the first place.

21 In my statement to the Board about SB 80 on
22 March 9th, I cited several examples of states around the
23 nation that are currently litigating abuses and misuses
24 of state funds in very distressing cases, and I won't
25 cite them again now. We can at least take comfort for
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1 the moment that while we still have an authoritative PEBP
2 board with such a diversity of honest, hardworking
3 representatives appointed from -- by our governor from
4 their knowledgeable fields and varying walks of life,
5 that our system is as safe, honest, and effective as it
6 can possibly be in the current social and political
7 climate and circumstances in our state and in our
8 country.

9 Still, we wonder, why is such legislation
10 being proposed in the first place? We would like to
11 point out that in addition to the numerous objections to
12 this legislation already on record, arguing against it
13 because of the increased risk to the integrity employee
14 benefits, that taking authority away from the PEBP board
15 and placing it solely in the Department of Administration
16 that reports directly to the governor would also have the
17 effect of putting the governor and his office in perhaps
18 the very uncomfortable place of being the only public
19 forum with any real authority, and thus the target at --

20 CHAIR CATES: Sir?

21 MR. UNGER: -- which we would --

22 CHAIR CATES: Sir?

23 MR. UNGER: -- in the future, direct our
24 public comments.

25 CHAIR CATES: Sir, sir, we are at almost four
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1 minutes. I would ask you to please wrap up.

2 MR. UNGER: Well, please let's just leave the
3 current system in place. There's little to be achieved
4 potentially and a lot to lose by taking governing
5 authority away from the PEBP board. We strongly oppose
6 any legislation that would attempt to do this, and we
7 very respectfully request members of the board to vote to
8 oppose any legislation which would in effect strip it of
9 its governing authority. And I'm sorry for going over
10 time.

11 CHAIR CATES: No problem. Thank you, sir.
12 Just need to hold everybody to the same limit.

13 Do we have any other public comment? Looks
14 like, I think, we have.

15 MR. FRANKLIN-SEWELL: Yes.

16 CHAIR CATES: Go ahead in Las Vegas.

17 MR. FRANKLIN-SEWELL: For the record, my name
18 is Shaun Franklin -- can you hear me?

19 CHAIR CATES: Yes, sir. Go ahead.

20 MR. FRANKLIN-SEWELL: All right. For the
21 record, my name is Shaun Franklin-Sewell. That's:
22 S-H-A-U-N, F-R-A-N-K-L-I-N, dash, S-E-W-E-L-L.

23 Today, I am not publicly commenting in my
24 role as chair of the UNLV Employee Benefits Advisory
25 Committee. Rather, I'm here to tell you a personal
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1 story. I'm married to a man who has had the human
2 immunodeficiency virus for more than 20 years. The virus
3 went untreated for the great majority of that time since
4 he simply could not tolerate the side effects of the
5 three-drug cocktails often prescribed to treat it. In
6 2015, he was prescribed a one-pill, once-a-day HIV
7 antiretroviral therapy. Lab tests can no longer detect
8 the virus in his blood, and his body is producing T cells
9 again.

10 Recently, PEBP staff informed me that HIV
11 antiretroviral therapy was not included in the Express
12 Scripts preventive drug list for Plan Year 2018. As you
13 know, PEBP participants will be able to access certain
14 drugs prior to meeting their high deductible. Other
15 Express Scripts clients have included antiretroviral
16 therapy drugs in their preventive drug lists. Excluding
17 these drugs from the preventive drug list is shortsighted
18 and discriminatory.

19 I note here that I am not accusing PEBP staff
20 of discrimination. A decision that's perhaps an
21 understandable one was made to use the ESI standard
22 preventive list. But excluding these drugs is
23 discriminatory because other drugs on the list prevent
24 the advent or progress of heart disease, asthma, and high
25 blood pressure, just to name a few.

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1 Simply, HIV antiretroviral therapy both kills
2 the virus in the bloodstream and prevents its recurrence.
3 Excluding these drugs is also shortsighted. Here, I'll
4 illustrate my point with a narrative I've seen happen too
5 many times since I've moved to Las Vegas. An individual
6 cannot afford to pay for these drugs, even using their
7 insurance. The virus continues to ravage their body
8 until such time as they begin to suffer opportunistic
9 infections. Then they are hospitalized, likely over
10 weeks or months, and eventually are transferred to
11 hospice to suffer through their remaining days.

12 The bill for the hospitalizations runs to the
13 thousands, perhaps tens of thousands of dollars per
14 covered souls, hospitalizations that could have been
15 prevented by simply helping these covered souls afford
16 these drugs. Whether for Plan Year 2018 or Plan Year
17 2019, I would urge the PEBP board to include these
18 life-saving medications, which both treat and prevent the
19 human immunodeficiency virus in the preventive drug list.
20 Thank you.

21 CHAIR CATES: Thank you, sir.

22 MR. WILSON: Good morning.

23 For the record, my name is Conrad Wilson.
24 I'm a past chair of the classified staff here at UNLV. I
25 just wanted to bring up a few points basically for the
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1 classified staff.

2 You know that we make up a big portion of the
3 Nevada System of Higher Education as far as employees,
4 but most of us don't make the kind of money that some of
5 our other constituents make. That has hurt us quite a
6 bit, you know, that when you're talking about a family of
7 four or even a family of two or three, and let's say that
8 one of their children has, you know, has some kind of
9 illness and that family has to begin to shell out money,
10 you know, you're talking about quite a bit of that
11 person's salary for the year, not just for a month, but
12 for a year.

13 And then if they go on to actually have -- to
14 actually have to take medicine that is very costly, let's
15 say \$100, you know, or \$300 to \$500 for just one
16 prescription, that family is in dire need of help. I
17 feel like that the Board itself, that when you basically
18 take a job, that you're there to make sure that you're
19 going to afford all of us the same kind of health care
20 that's available to everyone else and not just give it to
21 us, but give it to us at a fair price.

22 You know, most of these people, they have to
23 make that decision whether or not they're going to take
24 care of their children's health or their health or their
25 family's health or whether or not they're going to

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1 actually feed their family or put basically -- you know,
2 keep a roof over their heads. I feel that you guys have
3 undertaken a job in that position, and that that should
4 be the main goal. It shouldn't be that we just go along
5 and we just keep doing the status quo and we just keep
6 saying that our premiums are going to constantly be the
7 same.

8 Maybe we need to start to think about
9 bringing in competition. Maybe you need to look, you
10 know, that way in the sense of being able to go out and
11 offer us different types of health care within your
12 system rather than it just be one straight across the
13 board, this is what you get. You know, it would be nice
14 to see us bring in other people, like, let's say, Kaiser
15 or, let's say, somebody else that we would have options
16 to be able to go through you -- to be able to still carry
17 our health care through that, but they may have an option
18 that's better, you know, actually better suited for us.

19 You know, I really would like for you to kind
20 of take a look at that and maybe discuss that between
21 each other, because I feel that that is a very viable
22 alternative. And if we don't begin to look for
23 alternatives, then we're going to be stuck in the same
24 place doing the same things and getting the same results,
25 and I don't think most people are very happy with that.

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1 Thank you very much.

2 CHAIR CATES: Thank you, sir.

3 Any more public comment in Las Vegas?

4 MEMBER COCHRAN: No.

5 CHAIR CATES: Okay. Thank you.

6 Go ahead in Carson City.

7 MS. LEAR BOWEN: Good morning. My name and
8 words for the record. My name: Peggy Lear Bowen.
9 P-E-G-G-Y, space, L-E-A-R, space Bowen, B-O-W-E-N.

10 I come to you this morning a bit tired. I
11 left the hospital at 6:30 this morning. As a direct
12 result of what was put in place in 2011-2012, a friend of
13 mine had to piecemeal out her medication and several
14 medications, including diabetic medication to the point
15 that it wasn't meeting the needs of her body because of
16 the type of situation she's in.

17 For the record, I am not part of any
18 OneExchange. I do not have A and B Medicare, and
19 therefore, I am speaking as one who has seen the results
20 of what is going on. But rather than grouse about that
21 today, I want to talk to you about a possible solution.
22 And the solution would be this: In talking with
23 legislators and coming up with a plan, I said, "What if
24 the State of Nevada met its obligations to the folk who
25 worked for them, who put in their 20, 30, 35, whatever
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1 number of years and earned in what was promised to them,
2 an insurance situation when they retire and their
3 abilities" -- "and it's not a gift. Nobody is giving
4 anybody anything. It's pre-earned. It was earned
5 through people working and in place in lieu of salary
6 increases."

7 The plan would be as this. And these are the
8 words that I was given to use after doing much research.
9 When the member, the retiree, state or non-state retiree
10 with A and B Medicare, reaches the threshold or otherwise
11 known as the "donut hole" regarding prescriptions and
12 they are notified that there's no more money left from
13 Medicare, and that's when the threshold's met. And it
14 varies, so you use the word "threshold." It's \$3,700 or
15 \$3,900, whatever it is for the year, that the State of
16 Nevada go forward in their insurance. And they have the
17 dates when that threshold is met. Go forward. And they
18 are included in the prescriptions and how they are
19 handled within the state within -- for people like me, an
20 orphan, I don't hit a donut hole because the promises of
21 the State are at least met if I were taking vast
22 quantities of medication.

23 So you have a situation in which you even
24 have - maybe will have some legislation. Maybe we could
25 encourage you to do some legislation, not as a new bill,
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1 not as a BDR, but working with legislators as an
2 amendment. And coming from you, the Board, makes a lot
3 more sense than coming from me as an individual and
4 saying, "We need to keep our promises to our members in
5 retirement," and to make sure that once they meet that
6 threshold, that the State of Nevada comes forward and
7 does the 20/80 or the 30/70, and that there is no more
8 out of pocket incurred by our members in the situation
9 for that to take place.

10 And I believe legislation could be through an
11 amendment from this Board taking the power that it can so
12 that our members never hit a donut hole, because they
13 never were meant to because the State of Nevada opted out
14 of Social Security and Medicare, and, therefore, putting
15 back in the State's responsibility and promises kept.

16 Thank you very much. And I hope all is well
17 and that you have a good day.

18 CHAIR CATES: Thank you.

19 Any other public comment in Carson City?

20 Seeing none, I will close public comment.

21 We'll move on to Agenda Item No. 3. This is
22 a consent agenda. We have several reports on here:
23 Agenda Item 3.1 through 3.6.

24 Would any member like to poll any of these
25 items for discussion?

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1 MEMBER ANDREWS: Mr. Chair?

2 CHAIR CATES: Go ahead.

3 MEMBER ANDREWS: Anna Andrews for the record.

4 I have questions and clarifications for the following:

5 3.41, 3.43, 3.52.

6 CHAIR CATES: I'm sorry? That's 3.52?

7 MEMBER ANDREWS: 52. And then also I missed

8 the first one, 3.1 on the minutes, there is a date

9 correction that I think applies.

10 CHAIR CATES: Okay. Are there any other

11 items that any member would like to poll to discuss?

12 MEMBER GARCIA: Mr. Chairman, this is Rosalie

13 Garcia.

14 CHAIR CATES: Go ahead.

15 MEMBER GARCIA: I just have a comment. I do

16 have a comment or question on 3.2.

17 CHAIR CATES: On 3.2? Okay.

18 MEMBER GARCIA: Yes.

19 CHAIR CATES: Does anyone have any other

20 items that they would like to discuss?

21 Seeing or hearing none, let's go ahead and

22 start with 3.1: Approval of the action minutes from

23 January 19th, 2017 Board meeting.

24 Go ahead, Anna.

25 MEMBER ANDREWS: Mr. Chairman, Anna Andrews.

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1 Under No. 3, Action Item 3.1, it says,
2 "Approval of the action minutes from the January 17th,
3 2016." I believe that is 2017, maybe.

4 CHAIR CATES: Yes, it looks like 2017. I'm
5 getting a lot of nods of heads. Okay. We'll note that
6 correction.

7 MEMBER ANDREWS: And one more. Just a typo.
8 Under 6, under discussion, halfway down the page, second
9 paragraph, Member Garcia asked about the reciprocity
10 between the two plans, and Executive Officer Haycock
11 replied that he would be provide an answer.

12 Maybe providing.

13 EXECUTIVE OFFICER HAYCOCK: For the record,
14 Damon Haycock.

15 We'll just strike the word "be," and it
16 should make more grammatical sense.

17 MEMBER ANDREWS: That's fine. That's it.

18 CHAIR CATES: Thank you.

19 Let's go ahead and move on to Item 3.2:
20 Receipt of the PEBP Biennial Legal Compliance Review
21 report performed by Aon.

22 Rosalie, I think you called this one.

23 Do you have a comment?

24 MEMBER GARCIA: Thank you.

25 Yes, I did. Some of the findings do not have
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1 a course of action, although they are still findings. I
2 would like to recommend that PEBP staff follow up on all
3 of the findings even though they're not specifically
4 required by a course of action.

5 EXECUTIVE OFFICER HAYCOCK: For the record,
6 Damon Haycock.

7 Thank you, Ms. Garcia.

8 The format that was used in our compliance
9 review this last review period did show all of the
10 concerns or questions that Aon had.

11 We wanted to make sure that we addressed all
12 of the requirements first and any other recommendations
13 or concerns, of course we will address, but we wanted to
14 adhere to the statutory requirement for our compliance
15 review as a stand-alone response, and we are looking into
16 every one of those findings and determining first if they
17 truly do apply because there were some discrepancies that
18 we had with Aon. And if so, how can we improve the ones
19 that do? And yes, we take that very seriously. Thank
20 you.

21 MEMBER GARCIA: Thank you.

22 Also, I was wondering if you could lead me to
23 -- I'm referring to Section B, Executive Summary, B2,
24 page B2, the final report just right four pages under
25 "Claims and Appeals" which addresses our timeliness. And
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1 I was wondering if anybody could lead me to some
2 statistics with regard to that particular subject,
3 whether it's historical or current. I just would like to
4 see how we've been, and if we're tracking progressively,
5 how we respond to our appeals.

6 EXECUTIVE OFFICER HAYCOCK: So for the
7 record, Damon Haycock.

8 Ms. Garcia, our appeals are part of a
9 required report to the Nevada Division of Insurance that
10 we present to the Board every January for approval, so we
11 can definitely point you back to the last full board
12 meeting that wasn't telephonic which shows exactly how
13 many appeals we had as well as our complaints that were
14 submitted not only to, of course, you all for approval
15 but to the Nevada Division of Insurance and the
16 legislature, as required.

17 MEMBER GARCIA: Thank you very much. I
18 appreciate that.

19 CHAIR CATES: Okay. Thank you.

20 So now we're moving on to 3.4.1: Hometown
21 Health Case Management Or Case Utilization Management
22 Report.

23 MEMBER ANDREWS: Mr. Chairman, Anna Andrews
24 for the record.

25 On page 16 of the report, inpatient discharge
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1 information, the header is "First Quarter Plan Year
2 2017," and then the dates are October 1st through
3 December 31st. I think that's Second Quarter Plan Year
4 2017.

5 EXECUTIVE OFFICER HAYCOCK: For the record,
6 Damon Haycock.

7 I believe you are correct, Ms. Andrews. I
8 don't believe there's someone here -- I don't see -- from
9 Hometown Health.

10 Oh, Heather. Hi, Heather. Sorry. But we
11 will make sure that that is updated appropriately. I
12 think that was just a carryover from the last report.

13 MEMBER ANDREWS: Thank you.

14 CHAIR CATES: Okay. So now we're moving on
15 to 3.4.3.: Standard Basic Life and Long-Term Disability
16 Data and Performance Report.

17 Go ahead.

18 MEMBER ANDREWS: It's me again, Anna Andrews
19 for the record.

20 On page 9 of the Standard report, claims
21 appeals quarterly update for plan year to date July 1,
22 '16 to December 31st -- and it has life insurance claims,
23 long-term disability claims, and it has the statistics.

24 The question I have for the standard or for
25 Damon or whomever can answer the question is how long
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1 does the process take or should it take from, like for a
2 life insurance claim, if you file a claim, what is the
3 time frame that the person should expect to know that
4 they will get a check in the mail?

5 EXECUTIVE OFFICER HAYCOCK: For the record,
6 Damon Haycock.

7 I'm going to bring up Marty Klinkhammer from
8 the Standard to answer that question.

9 MR. KLINKHAMMER: For the record, it's Marty
10 Klinkhammer from the Standard.

11 That really depends on the circumstances for
12 each claim. Most of the time, when there's an appeal, we
13 need to gather more information which we do by requesting
14 information either from the claimant, physician, LPD
15 claim situation or from a beneficiary, and it really
16 depends on how long it takes to get that information
17 back. During the process, we're in contact with the
18 claimant at least every 15 days to make them aware of the
19 situation. Generally, those reviews take less than
20 60 days.

21 MEMBER ANDREWS: You said that -- Anna
22 Andrews for the record again -- that your staff would be
23 in touch with the survivor that's asking for the benefit
24 every 15 days?

25 MR. KLINKHAMMER: In a life claim situation,
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1 yes.

2 MEMBER ANDREWS: In a life claim?

3 MR. KLINKHAMMER: That's our standard, yes.

4 MEMBER ANDREWS: Thank you.

5 CHAIR CATES: Thank you.

6 Now we're moving on to 3.5.2: Utilization
7 Report.

8 MEMBER ANDREWS: Guess who?

9 CHAIR CATES: Go ahead.

10 MEMBER ANDREWS: It's just a correction. I
11 believe that I think I know the answer. It's on page 23:
12 Savings summary medical claims. So halfway down the
13 page, it talks about total participant pay for Plan Year
14 '16, total plan pay for Plan Year '16, and since the
15 report has got the Plan Year '16 and then the two
16 quarters of Plan Year '17, I believe the second column of
17 the data, the PPPM, maybe, needs a header that says,
18 "Plan Year '17 Second Quarter."

19 MS. GLOVER: This is Celestena Glover for the
20 record.

21 I'll work with HealthSCOPE -- we get this
22 data from them -- to have that added to the header.

23 MEMBER ANDREWS: Thank you.

24 MS. GLOVER: The table on the top is Plan
25 Year '17 up to the December 31st in this case. The
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1 smaller table for Plan Year '16 tells us how we ended up
2 Plan Year '16.

3 MEMBER ANDREWS: Thank you.

4 CHAIR CATES: We're good? Thank you.

5 So that covers all of the --

6 MEMBER GARCIA: Mr. Chair?

7 CHAIR CATES: I'm sorry. Go ahead.

8 MEMBER GARCIA: This is Rosalie Garcia.

9 Regarding 531 (sic), I was wondering if --

10 CHAIR CATES: I'm sorry. Which item are you
11 looking at?

12 MEMBER GARCIA: 3.5.1, regarding the --

13 CHAIR CATES: Oh, 3.5.1. Got you.

14 MEMBER GARCIA: Yeah.

15 CHAIR CATES: Go ahead.

16 MEMBER GARCIA: 3.5.1, the summary, where it
17 indicates that our reserves are \$33.2 million projected,
18 I believe. This might be a good time to provide a brief
19 layman's summary on how and where the funds are
20 accumulated for the surplus.

21 Does it come from premiums? Does it come
22 from our budgeted moneys from the State? Et cetera.
23 Just for the general public.

24 MS. GLOVER: This is Celestena Glover for the
25 record.

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1 So your reserves are coming from a
2 combination of things. If you look in that table, you'll
3 see state subsidies. Right now, we're showing a surplus
4 of \$10.6 million. Contributions from employees are
5 actually a negative 1.2, meaning they have not
6 contributed at the level that we've budgeted for.

7 And then allover contributions, this is our
8 treasurer's interest and things of that nature, we're
9 ahead right now by \$1.4 million. So the net effect is we
10 have revenues at \$10.8 million more than we were --
11 we're projecting them at, more than we were expected to
12 collect. The offsetting of that is any savings and
13 expenditures. So if we have less costs going out, so in
14 our fully insured product, the HMO, we budget a certain
15 dollar amount to pay, but based on enrollment, we are not
16 going to spend funds at that level. Same thing in
17 self-funded admin costs. We're seeing that we are going
18 to spend a little bit more there and a little bit less in
19 claims.

20 So when you take everything together, the net
21 effect gives us our excess reserves or it may increase or
22 decrease them according to what our expenditures and our
23 revenues really look like. This is projected. The
24 middle column tells us where our actuals are, so we're
25 currently sitting, as of December 31st, at \$19.4 million

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1 in reserves. That's the real number as of that date.
2 The projected number, obviously, can change as we get
3 more data in.

4 MEMBER GARCIA: Thank you.

5 CHAIR CATES: Okay. Thank you.

6 Any other comments on anything in Agenda Item
7 No. 3? If not, I'll call for a motion to accept the
8 items in Agenda Item No. 3 with the noted changes that
9 occurred in the discussion.

10 Anybody would like to make a motion?

11 MEMBER ANDREWS: So moved.

12 CHAIR CATES: We have a motion.

13 Do we have a second?

14 VICE CHAIR BAILEY: Second. Don Bailey.

15 CHAIR CATES: We have a motion and a second.

16 Any discussion on the motion?

17 Seeing none, I'll call for a vote. All of
18 those in favor of the motion, say "Aye."

19 THE BOARD: Aye.

20 CHAIR CATES: All opposed?

21 MEMBER COCHRAN: Aye.

22 MEMBER GARCIA: Aye.

23 MEMBER ZACK: Aye.

24 CHAIR CATES: The motion carries unanimously.

25 Okay. Close Item No. 3 and go to Item No. 4:
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1 Presentation on the Employer Contribution (Subsidy)
2 portion of the overall rate. Celestena Glover; Chief
3 Financial Officer.

4 EXECUTIVE OFFICER HAYCOCK: For the record,
5 Damon Haycock.

6 Tena is getting the laptop set up so we can
7 project it on the projector for folks here in Carson City
8 as well as show through the screen for Las Vegas, so it
9 will just take a minute or so and then we'll be able to
10 display it.

11 CHAIR CATES: Okay. Thank you.
12 Ready? Go ahead.

13 MS. GLOVER: Good morning.

14 My name is Celestena Glover. For the record,
15 I serve as the chief financial officer for the Public
16 Employees' Benefits Program. We put together this "How
17 Employer Contributions Work" because we get a lot of
18 questions. We find that individuals look at the subsidy
19 bill and then call us and ask why they're not getting the
20 \$699 that their employer is paying on their behalf. So
21 we put a quick set of slides together to try to explain
22 how the whole process works. And hopefully, this will
23 help people understand going forward.

24 So what we're going to discuss is what makes
25 up the overall rates. And the things we're going to

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1 consider are the base rates, which is what the plan
2 design itself costs; the loaded rates, that's the plan
3 design costs plus all of our administrative costs, so
4 that includes payroll and things of that nature. The
5 various plan tiers, so are you an employer or retiree on
6 your own on the plan or do you have dependents on the
7 plan? The employer contribution percentages, which is
8 the subsidy. This is what the Board approves, and then
9 the monthly employer contribution.

10 So essentially, this set of slides is going
11 to attempt to explain how we get from what's in the bill
12 to what you actually see when you pay your rates. So the
13 first thing you see is the base rate. The base rate
14 includes all of the things that make up the plan cost, so
15 your medical costs, your prescription drug costs, and
16 your dental costs.

17 For the CDHP, there are no other costs in
18 that amount. So for participant, at \$466.90, that is
19 what FY '17 or Plan Year '17 rates were for a single
20 individual on the CDHP before any administrative costs
21 are considered. On the HMO side, that's \$718.25. That
22 is the blended rate for the northern and southern HMOs.
23 This takes into account the medical, prescription, and
24 dental and then any taxes or other fees that the HMOs are
25 required to include when they set their rates.

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1 I take that number and then I load them, so
2 we refer to loaded rates. That is the full cost of your
3 plan based on whichever plan and tier you select. The
4 loaded rates include the cost of your life insurance
5 premiums. This is for the base life insurance at \$10,000
6 and \$5,000, not the enhanced \$25,000 that we have been
7 seeing; the HSA and the HRA contributions, so your health
8 savings account and your health reimbursement
9 arrangements. This is again at the base rate. This does
10 not include anything that is paid for by excess reserves.

11 The PEBP operating costs. So my paycheck,
12 Damon's paycheck, all of our staff's paychecks and all of
13 the fees that are associated with that. Our office
14 supplies, information technology, the payment for our
15 office space, all of those are part of our operating
16 costs. Obviously, we can't do this for free.

17 And then administrative costs. This includes
18 costs that we pay to our vendors to assist us with
19 running the plan, so our TPA who pays the claims, any
20 fees for our pharmacy benefits manager, so there's an
21 administrative cost in addition to the claims cost.

22 All of these costs are considered, and then
23 it is loaded into the previous rate, the base rate, and
24 this is where you get what you see on your screen, which
25 is the CDHP for a single person at \$598.69, and for the
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1 HMO, it's \$764.03. And then it's broken out all the way
2 down for participant and spouse, participant and
3 children, participant and family.

4 We take those loaded rates and we determine
5 -- we assume what we believe enrollment will be for each
6 plan at each tier and then we develop an employer
7 contribution. So the first thing we consider is our
8 total cost. What is the plan going to cost for the year?
9 We take that, we divide that by the number of employees
10 and retirees, not dependents. These are the primary
11 participants on our plan regardless of the tier or plan
12 they choose. We divide that by 12, and we come up with a
13 monthly contribution. Where we landed was a total
14 employee costs for Plan Year 2017 was projected at
15 \$212 million.

16 With the number of employees that we expected
17 took on the plan, this worked out to a contribution of
18 \$699.25 per month for each individual employee. We do
19 the same thing with the retiree cost: \$22 million. The
20 reason it's so much lower is because we have so much
21 fewer retirees on the plan. And then their cost:
22 \$451.15. These are the numbers you see in the bill. In
23 this case, it was SB 513, I believe, that was approved in
24 fiscal year, calendar year 2015. I take that, and then I
25 say, "Okay. How does this really break out?" So we look
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1 at plan tiers. There are four tiers to each of the
2 plans.

3 We have a participant tier, we have a
4 participant and spouse, so everybody who has a spouse --
5 and this includes domestic partners -- participant and
6 children, so you have children on the plan but not a
7 spouse, and then participant and family. This is those
8 that have both spouses or domestic partners and children
9 on the plan. So the rates are broken out into those
10 tiers, and this is true for the CDHP and the HMO.

11 The Board approved an allocation that we used
12 to determine what the subsidy is going to be on each
13 plan. So for an active primary on the CDHP, the State
14 pays 93 percent of that \$598, and the participant pays
15 the other 7 percent. If you are on the HMO, it's at
16 78 percent that the State pays, and the remainder is paid
17 by the participant. And this is broken down by primary
18 or dependent, retiree primary or dependent. And so we do
19 allow for an amount to be paid by your employer for any
20 family members you have on the plan.

21 We take these allocations and we say, "Okay.
22 How does this work when you are looking at your actual
23 rate?" So the first thing, the example I'm providing is
24 a participant with a spouse on the CDHP. The rate, if
25 you go back to the previous table, is \$1,000- \$1,078.66.

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1 So what we look at is, "Okay. What happens first?"
2 Well, of that thousand dollars, a portion of that is for
3 the employee. So the State pays 93 percent of that,
4 which works out to \$556.78. Then they'll pay 73 percent
5 of the spouse's portion, which works out to \$350.38, so
6 this employee is, in fact, not getting \$699. They're
7 getting more than \$900 toward their rate.

8 And this is, I think, where employees do get
9 a little sideways with what is going on with the
10 contributions. They don't realize that their spouses are
11 being subsidized in addition to themselves. The employee
12 then pays the 7 percent of his or her portion and then
13 the 27 percent of their spouse's portion, which works out
14 to \$171.50 of the \$1,078 that this really actually costs
15 them.

16 So this is what the rate table looks like. A
17 single person on the plan: \$598.69. They're receiving
18 \$556.78 and they pay \$41.91. If you're trying to
19 determine what your dependents are receiving, all you
20 have to do is go to the base subsidy column, take the
21 \$907 for the spouse, subtract \$556, and that will give
22 you what your spouse is receiving on the plan from your
23 employer. And you can do that with each tier. Your
24 children, employee children, can be less expensive than
25 employees and spouses, so that's why that amount is

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1 lower. Their base rate is lower, and then employee and
2 family. So an employee with a family is \$1,043.92. So
3 when you say why is my employer not paying my \$699? It's
4 because they're paying \$1,043.92. The individuals who
5 are not getting the \$699 are the single people on the
6 plan because they are, in fact, subsidizing the families
7 that are on the plan by receiving a lower contribution
8 from their employer.

9 You can take the same math and do the same
10 thing with the HMO. So with the \$764 is the base rate
11 for an employee only. They're getting \$595, and they're
12 paying \$168. And you can take that right down for each
13 plan and tier. So we do the same thing with the retiree.
14 They have a lower subsidy level, but they still have the
15 same methodology applied. So a retiree on a plan -- this
16 is based on a retiree with 15 years of service, they
17 receive -- their rates are \$1,060.75. So initially, the
18 employer pays 64 percent of the retiree's portion and in
19 this case, it's \$371.70. They pay another 44 percent on
20 behalf of their spouse on the plan. That works out to
21 \$211.19. The retiree then pays 36 percent of his rate or
22 her rate and 56 percent for the spouse, which works out
23 to \$477.86 in this case. Again, this is for a 15-year
24 retiree on the CDHP.

25 The same math can be applied for the HMO. So
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1 this is what the CDHP table looks like. A retiree only,
2 the rate is \$580.78. The base subsidy for that
3 individual is \$371.70, and they pay \$209. Now, these
4 subsidies are adjusted up or down according to the years
5 of service. So this table explains the HMO similar to
6 the CDHP.

7 When you have adjustments, so if you have
8 more than 15 years of service, everything from the 16 to
9 the 20, 20 is our cap, you get an increased subsidy and a
10 reduced premium. So the example I used is a CDHP member
11 with 20 years of service. Their subsidy is \$371.70.
12 Well, they will receive an additional \$161.36. So their
13 subsidy actually comes down by \$533.06 or goes up to
14 \$533.06. That same amount that's increasing the subsidy
15 is reducing their premium. So that retiree, \$209.08
16 minus \$161.36, that single retiree on the CDHP is paying
17 \$47.72.

18 Now, this is the example for a state retiree.
19 Obviously, those numbers would be different for non-state
20 retirees. But essentially, a state retiree on the plan
21 is not paying more than \$7 more than what an employee is
22 paying on the plan. So when you compare the two, it
23 makes a significant difference.

24 And with that, I'll take any questions.

25 CHAIR CATES: Thank you.
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1 Do we have any questions from the members?

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

4 CHAIR CATES: Go ahead, Chris.

5 MEMBER COCHRAN: Just for the sake of
6 comparison to previous years, how do these rates for --
7 we're assuming this is for the upcoming plan year, how do
8 these rates compare to previous years? Are we seeing an
9 increase in these overall rates?

10 MS. GLOVER: This is Celestena Glover for the
11 record. So this is Plan Year '17 rates. This is not
12 upcoming. This is just to demonstrate how we actually
13 apply the contribution across the board. We have used
14 the 93 percent for employees for the last several years.
15 The subsidy table itself has not changed. We just apply
16 it to whatever the rates actually are.

17 EXECUTIVE OFFICER HAYCOCK: For the record,
18 Damon Haycock. I want to kind of dovetail on what
19 Ms. Glover said. What we wanted to do with this process
20 is to answer the question where did my money go from the
21 subsidy bill just to try explain how the math feeds into
22 the rate.

23 The question you asked, Mr. Cochran, is
24 actually in the next presentation on a year-by-year,
25 rate-by-rate cost. And so I will go over that here after
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1 we begin that presentation. We just wanted to kind of do
2 a how to because this can be quite confusing for folks
3 who say I'm supposed to get \$700 from the State, and I'm
4 paying \$42, and where did my \$700 go? And this is just
5 to kind of a Health Insurance 101 when it comes to
6 multitiered contributions. And this has been pretty
7 standard, I think, for at least the last three years, if
8 not longer. So I think we'll be able to answer your
9 question in the next presentation.

10 MEMBER COCHRAN: Okay. Thank you.

11 I was under the impression that a few years
12 ago, that our rates were a little bit higher than this.
13 That's why I was asking the question.

14 MEMBER GARCIA: Mr. Chairman, this is Rosalie
15 Garcia.

16 CHAIR CATES: Go ahead.

17 MEMBER GARCIA: My appreciation to Celestena
18 for this packet. Very nice, very layman, very
19 explanatory. I was wondering if it could also be
20 provided for our non-state participants.

21 MS. GLOVER: This is Celestena Glover for the
22 record. I can put something together, and we can get it
23 out onto the web site for people to look at and make it
24 available for questions. The same process applies
25 because back in 2015 when we changed the contribution
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1 methodology for the non-state retirees, we used that same
2 percentage and apply it to whatever their rate is. So
3 their contributions, at least for every tier except the
4 HMO with a single person, has actually gone up. On the
5 subsidy side, though, those employees are right now
6 paying more than they have in the past.

7 Previously, that \$451 you saw on the slide,
8 that's all they would get regardless of the plan or tier
9 they were on. So most of them didn't get the subsidy
10 levels that you see for the state retirees.

11 MEMBER GARCIA: I appreciate that.

12 Thank you again very much.

13 CHAIR CATES: Any other questions from the
14 members?

15 Seeing none, we'll go ahead and close that
16 agenda item and move to Agenda Item --

17 MEMBER COCHRAN: Mr. Chair, we do have
18 another question.

19 CHAIR CATES: I'm sorry. Go ahead.

20 MEMBER ZACK: Mr. Chair, Kristine Zack for
21 the record. I just had a comment, not a question. And I
22 wanted to point out that -- first, I wanted to thank
23 Ms. Glover for preparing this. And I actually did a
24 comparison with my own private sector what I pay in the
25 private sector for medical and for dental.

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1 And if I calculated this correctly, it looks
2 like the share for a current active employee on the CDHP
3 is \$33 a month. Correct me if I'm wrong, but I pay
4 almost \$200 a month for a similar plan. So to the extent
5 that we're hearing a lot of complaints that state workers
6 expect enhanced benefit because they're taking lower
7 compensation for it, I just want to point out in the
8 private sector, there is a much more significant cost to
9 me for a similar plan.

10 Does that make sense?

11 CHAIR CATES: Makes sense.

12 MEMBER ZACK: \$33 for a state employee versus
13 \$191 for me.

14 MS. GLOVER: And this is Celestena Glover for
15 the record. It's \$41.91 for a state employee, but yes,
16 you are correct. This is significantly different from
17 what you see in the private sector.

18 MEMBER ZACK: Thank you.

19 MEMBER COCHRAN: Mr. Chairman, just for the
20 record, though, I think it's important to note that we
21 need -- if we're going to be making those kinds of
22 comparisons, we need to be comparing plan benefits as
23 well. So it's, I think, you know, we may be comparing
24 apples to --

25 CHAIR CATES: Oh, we just lost you.
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1 MEMBER COCHRAN: I'm sorry. It keeps going
2 out. We may be comparing apples to apples, but I'm not
3 sure that we are exactly doing that when we look at other
4 plans. So I think that that's what we have to keep in
5 mind as well.

6 CHAIR CATES: Okay. Thank you.

7 Any other comments on this item? Going once?
8 Going twice. Closing Agenda Item No. 4.

9 Move to Agenda Item No. 5: Discussion and
10 possible action to include approving Plan Year 2018 final
11 plan benefits and rates for state and non-state employee,
12 retirees and their dependents for the statewide
13 consumer-driven health plan, standard health maintenance
14 organization plans, alternate health maintenance
15 organization plans, dental benefits, benefits for
16 Medicare retirees, contributions to health savings
17 accounts, health reimbursement arrangements, and basic
18 life insurance benefits. Wow. We've got a lot of ground
19 to cover.

20 EXECUTIVE OFFICER HAYCOCK: I want to thank
21 Mr. Belcourt for that long agenda item. We had to make
22 sure we had everything for open meeting, so that's why
23 that's a little bit longer. Dovetailing off of
24 Ms. Glover's presentation, we wanted to try to break down
25 this process into layman's terms and really walk through
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1 some education, not just for the public, but also if
2 there's any new board members who haven't participated in
3 this rate setting process. It gives good background as
4 to how we get to where we are.

5 So there's a lot of slides here, folks.
6 There's 33 of them. And there used to be 32, and I
7 thought, gosh, we really need a new executive summary.
8 So what the real burning issue of this entire
9 presentation is that we're looking to shift many of the
10 enhanced benefits that were approved over the last three
11 plan years to the base plan, being funded by an increased
12 employer contribution, which is known as the subsidy,
13 versus spending excess reserves to cover those
14 enhancements. And I'm going to go into a little bit
15 later as to how we were capable of doing that at this
16 point.

17 We have some recommended rates, and what's
18 truly important to our membership is what they pay. And
19 so for a participant share on the consumer-driven health
20 plan, today, PEBP's recommendation for state employees is
21 that we keep them flat to the penny on what people are
22 paying today for next year.

23 We also are looking to do the exact same flat
24 rate for the state retirees. However, you will see a
25 very sizable increase to the non-state retirees of 13 to
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1 16 percent. And it wasn't done as a personal affront to
2 that group, but there were some significant costs that I
3 will go over later in this presentation.

4 On the health maintenance organization side,
5 if you remember, as the Board, you approved and ratified
6 the contracts with Hometown Health and Health Plan of
7 Nevada. We had a projection of 7 to 9 percent increases
8 for rates. And based on that increased employer
9 contribution as well as a little change to the
10 methodology, we believe we can offer that same standard
11 HMO plan that was approved with only 3 to 5 percent
12 increases on the state employee's side, 4 to 7 on the
13 state retirees, and 8 to 10 on the non-state retirees.
14 This is again less than what we anticipated, and we feel
15 very, very hopeful that these are appropriate.

16 We also have an alternate HMO plan that was
17 part of that contract ratified at the last board meeting
18 where we wanted to offer an alternative HMO plan for
19 reduced rates to mitigate those increased costs for our
20 employees and retirees. And we, at that time, believed
21 it would be between a 1 to 3 percent increase just to
22 maintain that plan. And with this employer contribution
23 and again, a more aggressive methodology, we believe that
24 we can offer state employees, state retirees, and
25 non-state retirees a rate that is the same that they're

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1 paying on the regular HMO plan today so they have a
2 flat-rate option for those folks. Seeing how our HMO
3 plans are more costly, as you sigh in Tena's
4 presentation, we feel this helps mitigate that
5 affordability issue.

6 So today, we're going to go a little bit over
7 the history of the CDHP rates and talk about the history
8 of the enhanced benefits, and then we're going to go into
9 a very simple, hopefully, rate development process. You
10 understand kind of how we put it all together. Tena did
11 a very good job going over it, so I'll probably steal a
12 lot from hers, and then we're going to talk about which
13 benefits we want to shift, the current board decisions on
14 cost containment, and then PEBP's recommended consumer
15 driver health plan design.

16 We will move back in and discuss our starting
17 excess reserves reconciliation and talk about our excess
18 reserves recommendations on this new process and then
19 landing back down onto the recommended employer subsidy.
20 Then finally, recommended CDHP rates for employees and
21 retirees, and we do all of the same thing again for the
22 HMOs. Last but not at least, page 33 of this
23 presentation is PEBP's recommended course of action for
24 the Board to deliberate and ultimately either approve or
25 change.

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1 For those that haven't been with PEBP for the
2 last five, six years, we put a history of the rates, and
3 as Tena had changed, she shared with you an overall rate.
4 That's what PEBP has put their admin load on top of what
5 the rates were to cover claims, and so on the
6 consumer-driven health plan -- and I think this answers
7 Mr. Cochran's question -- have we had rate increases
8 where we are now less than we were?

9 If you look at the 2013-2014 levels, and then
10 you look at 2015 through '17 levels, you'll see that yes,
11 we are less. But what I want to point the attention to
12 is the percent change overall since this CDHP has been
13 implemented is at a negative 1.2 percent. And that is
14 much different than what you hear about health plans
15 today across our nation. They're talking double-digit
16 increases. I think I heard Senator McCain this morning
17 talk about Arizona and the hundred percent increases on
18 premiums for his state. I like negative 1.2.

19 Moving forward -- that was for the employees.
20 On the state retirees, you'll see a very similar type of
21 situation; that overall, they're at a negative 1 percent
22 as far as when we unleashed this plan in 2012 and where
23 we're at today. And overall, the average of those
24 increases and/or decreases put us at about a negative 1.

25 On the non-state retiree side -- and I've
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1 spoken at length, I think, PEBP has spoken at length and
2 we will continue to -- the non-state retiree pool is
3 shrinking, potentially rapidly, and there isn't enough
4 employees to offset the costs, so their costs have gone
5 up. On our consumer-driven health plan, though, the
6 average is about 6 percent over the six years. But I
7 want you to pay attention to 2014 where there was a
8 22 percent increase and in 2015, there was a negative
9 12 percent, and that's somewhat similar to the other
10 groups. We actually, as I believe the Board, bought down
11 the trend that was recommended from Aon so that way we
12 could mitigate rates, and that's why you see kind of that
13 swap over from 2014 to 2015.

14 A little bit on the history of the enhanced
15 benefits. For most of us, we recognize over the last
16 three years, we've had the same benefit plan. That's
17 important to the recommendation we're having today where
18 we've increased HSA/HRA funding, dental payouts,
19 deductibles we've lowered, we've increased coinsurance,
20 we've increased life insurance, and we've a provided an
21 annual vision exam.

22 You'll notice in 2013 and '14 there were some
23 creative methods to try to expend reserves. Those are
24 the first couple of years after the first year of the
25 CDHP. And the initial policy by the PEBP board was to
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1 adjust excess reserves through the use of HSA and HRA
2 funding, and then my opinion is that by the time 2015
3 rolled around, there were too much reserves and we needed
4 to enhance the plan. But you couldn't just give out
5 hundreds and hundreds and hundreds of dollars of more HSA
6 and HRA funds. And so that's I believe you're seeing the
7 same plan design for the last three years that people
8 have gotten used to, and that's an important thing to
9 remember.

10 How we develop the rate. Tena did a great
11 job going over it. I'm just going to hit on the
12 highlights. We start with our population. We need to
13 know how many people are in our plan and where they're
14 going to go in our plan and which plan they're going to
15 sign up for. Then we look at our claims, and we look at
16 what is provided over the last -- really, the last two
17 years.

18 The reason you're seeing a different
19 recommendation today than what you saw in January and
20 November is because we have up-to-date experience. There
21 was a statement made in public comment: "Why can't we do
22 rates earlier?" We could, but then we wouldn't have any
23 experience to know if we were even remotely close. And
24 so the latest you get your information, the more you can
25 front load the most recent experience to have a better or

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1 more truer picture of where you think you're going.

2 For those of us that build budgets at the
3 state, we often get a little heartburn knowing we have to
4 develop a budget two and a half years before we know what
5 we really need. It can be difficult, but we do it. With
6 rates, we really don't want to charge people any more
7 than we have to, so we don't wait to the last minute
8 because we're procrastinators. We wait until this period
9 of time because it's the latest we can approve them to
10 insure that they're as accurate as they can be.

11 Our actuaries then trend toward their claims,
12 they look at what inflation will look like and what
13 utilization on our plan will be. You saw the trend
14 presentation in January that our actuaries came up with a
15 4 to 7 percent projected inflation on medical and
16 pharmacy and a 1 to 3 percent for dental. They take that
17 and they apply that to the experience, and you'll see in
18 another slide here exactly how that math filters out. So
19 they come up with that total base rate. As Tena
20 explained, we get it in from Aon, and then we add our
21 load onto it and determine our final overall rate.

22 Then PEBP recommends an employer contribution
23 percentage for employees, retirees and their dependents.
24 We come to the board and we say, "We think you should do
25 X." And you guys deliberate and decide ultimately what

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1 you want to approve. And then leads into the final
2 participant premium. So the employer contribution plus
3 the -- or the total cost of the rate minus the employer
4 contribution, the remainder is what the employee pays or
5 the retiree pays. So by default, whatever is left over
6 is what the participant is paying.

7 Then the Board approves those final rates.
8 That's what we're here to do today. But ultimately, the
9 legislature approves the employer contribution. We
10 present a budget to the Nevada Legislature that has a
11 contribution amount that is built not only into our
12 budget as a totality of those contributions, but into
13 every other employers' budget as far as the State is
14 concerned for their cost per person. And Tena mentioned
15 it was \$699.25 for this plan year, fiscal year, but the
16 budget today that the governor is recommending includes
17 an increase to \$743 in the first year, and I believe it's
18 \$741.92 or something like that, in the second year. And
19 we'll get to that. So that's kind of in a nutshell how
20 do we bake the cake, right? These are the ingredients,
21 we put it together, presto, a pound cake comes out, you
22 guys approve it, and hopefully it tastes good.

23 So we're going to move on tiers. Tena
24 explained that we have four different tiers, but how do
25 we determine the rate for the those tiers? This has been
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1 in place for the last five years. We have a certain
2 dollar amount that we need to cover the participant only,
3 and if we add the spouse, it's twice the amount. If they
4 have a child, it's the amount of a participant plus
5 amount for children, and if it's family, it's two times
6 the amount of the participant plus that amount for
7 children. This is pretty standard as far as how we
8 develop rates to ensure that we don't charge for a child
9 the same that we charge for an adult if they
10 traditionally use less of the services.

11 Here's a snapshot of our enrollment. Our
12 average enrollment was based on the last 48 months plus
13 any known changes. So when the State decides they want
14 to increase employees, there was a push to increase
15 employees in the Medicaid or welfare call center last
16 session, and you saw, I think, a hundred or a couple of
17 hundred added there. When we know that there's going to
18 be increases to that population, we ensure we budget for
19 them. We also take the budgeted amount directly from the
20 governor's recommended budget. We want to be consistent.
21 And so we're looking at an overall increase, just for
22 this next fiscal year, or plan year, of 2.55 percent.

23 So here's the real story I want to get into
24 and discuss kind of why we are recommending the shift to
25 enhanced benefits. If you'll see on the left there, for
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1 those have it in color, it's blue. If you don't, it's
2 the left table. We received these base rate cards from
3 our actuaries. And what I want to point your attention
4 to -- and I got this laser pointer, so I might as well
5 use it -- is that the trend that 4 percent, 7 percent,
6 and 2 percent for medical, RX and dental is the same for
7 both state and non-state. This was what you basically
8 saw in January when Aon came up and said, "This is what
9 we think is going to happen." So they kept to their
10 trend, but that trend needs to be applied to experience,
11 and I'm going to tell you folks, I had no idea that the
12 medical experience on the state side would be almost
13 negative 9 percent.

14 Had I known that and I couldn't, in November,
15 I wouldn't have presented such negative decision-making
16 criteria about cutting benefits because that right there,
17 that's not a good year. That's a great year. And that's
18 the projected grade process moving forward. You will see
19 that the pharmacy is going up, and that is pretty true to
20 form. Pharmacy is going to go up regardless right now
21 until any national changes occur. But our dental is down
22 as well.

23 Now I also want to point to you to experience
24 for the non-state, and they're looking at a 10.6 percent
25 with a 6 percent or almost 6 and a half for prescription

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1 drugs, but they too have a lower negative 6.8 percent.
2 So when you take their experience and you add the trend
3 to it, you come up with a final amount.

4 What I want to point your attention to most
5 importantly is on the stateside, the final overall
6 inflation is negative 2.3. On the non-state side, it's a
7 positive 11.2. Well, we all recognize that PEBP was
8 provided about a \$43, almost \$44 increase per person in
9 the recommended budget by the governor. And that
10 recommended budget was built off of the assumption that
11 we would have an overall positive 3.6 percent inflation.
12 So when you have 2.3 percent negative but you build it at
13 3.6 percent positive, you have an almost 6 percent swing
14 towards PEBP.

15 And we could have done a couple of things.
16 We could say, "Well, we're going to keep cutting benefits
17 and then we're going to see if we can lower rates, or we
18 can increase those benefits and keep rates flat." So I
19 went back to Aon and said, "You know what ? I've been
20 asked by folks, multiple people, both for our advocacy
21 groups" -- "I know the Retired Public Employees of Nevada
22 have asked me, 'Well, what would it look like if you just
23 built this into a regular plan, these enhancements
24 benefits, and stop making them enhanced?'

25 And then I was asked by the legislature as
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1 well, you know, "When are we going to stop enhancing
2 plans with reserves and actually build the plan as it
3 should be as it's being experienced?"

4 So I went back and asked Aon, I said, "Could
5 you just throw all of the plan design into there?" Now,
6 they couldn't have done the additional HSA funding
7 because they don't do that, and they couldn't have done
8 life insurance because they don't do that. But what they
9 did do is look at what happens when you return the
10 deductible back and what happens when you put that
11 coinsurance level away from reserves and into the plan,
12 the base plan itself, and the dental, what happens when
13 you move all of this stuff over.

14 And so they came back and gave me a new rate
15 card. And again, look at that negative 5.9 percent
16 expected for medical for the state. 8 percent for
17 prescription drugs, and 4 percent for dental. So the
18 overall increase is a 1.4 percent when you add trend plus
19 experience. Again, our budget was built at 3.6 percent
20 increase to rates, so we're still 2.2 percent ahead.

21 The unfortunate nature when you move enhanced
22 benefits from reserves being paid for away from the plan
23 basically, to the plan, the heaviest utilizers end up
24 paying more for it. And so right now, you take this
25 10.6 percent for the non-state before you move the

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1 benefits over, and now you move the benefits over, it's
2 14.3 percent. Same goes up in Rx, same goes up in
3 dental. And so their overall increase is almost
4 16 percent as far as what the inflation is projected to
5 be. And that, we can spend hours discussing why is the
6 non-state retiree pool so high. I presented a
7 presentation to the legislature on it. It is a difficult
8 decision and a difficult notion. No one want to do this
9 to folks, but right now, legislatively, we have a
10 requirement -- and I'll get into that a little bit later,
11 but we have a requirement to separate the risk pools and
12 that their employers cannot pay any higher portion for
13 their retirees than what the state pays for its retirees.
14 So unfortunately, this becomes an example of math.

15 Moving forward, why do we want to shift?
16 Again, I kind of explained it. The last three years
17 we've enhanced benefits, I would imagine if you ask a
18 standard employee, "Hey, how do you feel about your
19 enhanced benefits?" they're not even going to know they
20 had benefits that were enhanced, and that we now have an
21 increased state employer contribution in the governor's
22 recommendation. And initially before we did the shift,
23 we were looking at a negative cost. So to be completely
24 honest and transparent and in layman's terms, I didn't
25 want to give the money back.

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1 So what does the shift look like? It's
2 making the deductible that everyone is used to today --
3 the deductible everyone is used to today and having the
4 plan pay for it, continuing on with the coinsurance, the
5 dental maximum, and then that annual vision exam. We
6 still want to keep the \$25 co-pay, not as a punishment,
7 but again, when it comes down to how can we keep rates
8 flat, we picked something that we felt was well received
9 and we hadn't heard a big issue with the co-pay, and so
10 this is again a balancing figure.

11 However, we want to talk about some of the
12 previous cost containment activities that this Board had
13 approved and maybe because we recommended them. So we
14 recommended that we do an HRA rollover cap. We wanted to
15 cap our future liability moving forward. And in an
16 accounting or financial world, that makes complete sense.

17 However, we did that because we needed the
18 money. We were concerned that we would not be able to
19 sustain or have enough money to continue the benefits
20 that we have today into the next plan year. Well, we
21 don't need that money at this point, and we recommend
22 reversing this decision now based on feedback from
23 participants, advocacy groups, and the legislators. And
24 when I presented the budget to Assemblywoman Swank, she
25 basically said, "Why are you doing this? These people

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1 have been saving for future health care, and I don't
2 understand why you guys would do this."

3 My answer to Ms. Swank was, "I'm really
4 sorry, but we have limited resources and we need the
5 money." Now we can do this.

6 As far as the Medicare exchange paying their
7 HRA fees, you've heard this issue back and forth. It
8 went one way in November. You guys voted. RPEN came
9 back up in January and they heard a lot about it on their
10 end. We have folks that are on a fixed income, and we
11 believe that by shifting excess reserve benefits to the
12 base plan, that frees up the money to pay for these. And
13 since we've been doing it all along, I can't in good
14 conscience recommend anything but us continuing to pay
15 that \$6 a month for these folks.

16 You guys approved hearing aid and reference
17 based pricing cost containment that we were going to put
18 in our master plan document. We have an NPD update
19 later. We are still recommending those. It doesn't harm
20 the participant. It actually helps the participant
21 indirectly by reducing the cost to the plan, which
22 hopefully gives us more negative increase years. So this
23 is just a good plan decision.

24 So what does our recommended design look
25 like? So I wanted to put it out there for everybody that
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1 there is a base plan and then what are the remaining
2 enhancements left. So we want to now make the discussion
3 moving forward that this deductible is the base plan,
4 that this coinsurance that people have been used to is
5 the base plan. Same with dental maximum, that annual
6 vision that we provided a hundred percent that we want to
7 throw that \$25 co-pay, it's still a million dollars that
8 we're paying towards this process on average, and we feel
9 that this can be absorbed into the base plan.

10 Also, we've heard from multiple participants
11 why since the Medicare part B premiums have gone up, why
12 are you not giving us the higher contribution or the
13 higher credit? And before, the answer was, "We didn't
14 have been the money." Well, we do. We can afford to, at
15 PEBP, increase that to \$134, which is the rate today, and
16 provide some of the relief to some of these retirees.
17 And what's important about this -- and I'm going to uses
18 the non-state retirees on our consumer-driven health
19 plan, right now they're getting \$104.91?

20 MS. SPINELLI: \$104.90.

21 EXECUTIVE OFFICER HAYCOCK: \$104.90.

22 I gave them an extra penny. Sorry. \$104.90
23 going up to \$134. So that's almost a \$30 increase. Keep
24 that in mind when we talk about what we're doing to the
25 rates moving forward and how much of that rate increase
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1 is being mitigated by this \$30. So I know it's not
2 great. I know I can't believe no one is throwing stuff
3 at the back of my head right now, but we are trying to
4 help folks out in all different groups to ensure that we
5 mitigate increased costs of care.

6 The preventative drug list. It's something
7 I'm very passionate about. I think it's important, it
8 makes sense, and I want this to be part of the base plan,
9 and I think we can afford to do that.

10 The life insurance, we could have made the
11 increase to life insurance part of the base plan, but we
12 would had to raise rates, and I really don't want to do
13 that when we have the reserves to pay for the life
14 insurance now, so you'll see that my recommendation for
15 enhancements is to return it to the \$25,000 level and
16 \$12,500 level that was in the plan today and over the
17 last couple of years. Again, we were asked by the
18 legislature, we've been asked by advocacy groups and
19 participants why do we keep missing around with this
20 thing? Why don't we just set it and fund it? We can.

21 My goal in the next session -- I hate talking
22 about the session during -- another session during the
23 session we're in, but my goal is --

24 CHAIR CATES: Don't jinx us.

25 EXECUTIVE OFFICER HAYCOCK: Yeah, don't jinx
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1 us. But my goal is to keep doing well, keep managing our
2 plan well, keep saving money and finding a way to move
3 this life insurance back to the base plan in the next
4 session. So that's what we're looking at doing, kind of
5 a "two-year'd" out teaser.

6 Then the HRA fees, you guys had approved that
7 the Medicare retirees paid them. I think that that's
8 still appropriate. However, we have the money, so I want
9 to use excess reserves to pay for them. If it turns out
10 that we don't have the money in future years, then they
11 may have to pay for their own way on the Medicare
12 Exchange and the life insurance premiums, but today,
13 today they don't have to. And so at least per PEBP's
14 recommendation, so I think clean up this issue as well.

15 So what did that do to our starting excess
16 reserves? Well again, you saw the top. This is in blue
17 if you have it in color. This is what I presented to
18 discuss excess reserves what you see that bottom line,
19 \$24,924,409. What was that start figure we've all been
20 using to chip away at to figure out what are the best
21 benefits? Well, because we have those excess reserve,
22 we're moving stuff over. We initially wanted to get
23 aggressive with our HRA reserve. We wanted to get
24 aggressive not because we like to absorb risk, but we
25 wanted to be aggressive because we really wanted to save

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1 as many benefits as possible. So if we can save these
2 benefits, we'd like to return that liability to back to
3 where it is.

4 And why we want to do that and put that money
5 back into our HRA reserves is no matter what you guys do
6 and approve, I still have to show 100 percent liability
7 on my financial statements. So I still have to show this
8 liability. I might as well fund it. And if we don't
9 have the money, that's one argument, but when we do,
10 that's what's protected the solvency of this plan for
11 years, is insuring that we have the appropriate level of
12 reserves so poor Damon Haycock doesn't have to go to the
13 legislature and ask for a \$20 million bailout.

14 And so this, I think, is good business and it
15 makes sense. I recommend being for aggressive because I
16 thought we had to. I don't think we have to, so I'd like
17 us to revisit that. That leaves us with about \$19 and a
18 half million dollars of starting reserves. So where do
19 we spend them? There you go. Medicare Exchange life
20 insurance premiums, Medicare Exchange HRA admin fees, our
21 regular life insurance, returning it back to the level
22 people have today, and that I still believe very strongly
23 in the HSA/HRA enhanced funding that is tied to a
24 preventive benefit because it's just good health
25 insurance business, and it's just good health care.

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1 With that, my total amount I want to spend is
2 just under half of what's available. Why? Because I
3 really don't want us to scare folks again this summer
4 when I send out another survey about cutting benefits and
5 what do you guys want to do? I want us to basically, if
6 all things remained the same, which they don't
7 necessarily, that we're looking at saving the money for
8 the off years so we don't have to fight this process come
9 this November. And so by spending about \$9 million of it
10 right now and leaving about \$9 million of it for Plan
11 Year '19, you still have a buffer of \$1.6 million.

12 And as you heard today in public comment,
13 people are concerned about what's going on with the
14 Affordable Care Act repeal and replace plan, what's it
15 going to do to the provider community? Are rates going
16 to go up? There's a huge concern about people losing
17 insurance. I like to put a small buffer in there to deal
18 with this to see if we don't have the appropriate
19 inflation in place. That's what my recommendation is for
20 the excess reserves.

21 Here's just kind of a chart we took from our
22 legislative presentation. As you can see there under
23 "Fiscal Year 2018," our governor's recommended amount,
24 that's there \$743 for our employees and then \$445.03 for
25 the non-Medicare retirees and \$180 for the Medicare

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1 retirees.

2 What Tena did not go into is where that \$180
3 comes from. It's an average. It's for those folks on
4 the Medicare Exchange. They're going to get exactly what
5 their years of service determined. And so what's the
6 total average? We have to put a number in there, and it
7 averages at about \$180. You'll see that it's an increase
8 from Fiscal Year '17 and '16, so it goes from basically,
9 \$700 to \$743. So we appreciate that the retiree amount
10 stays relatively the same, but you'll see from the rates,
11 at least on the State's side, which is where this is
12 from, this is state retiree contributions, that their
13 rates are flat on the CDHP, so we don't feel that this
14 contribution level is unfair.

15 What are the contribution percentages? Now
16 for the last X amount of years -- I know someone will
17 correct me. I know it's been at least three, but it
18 could have been longer. You have guys had approved a
19 93 percent for the consumer-driven health plan and a
20 78 percent for the HMOs, and then there's a 20 percent
21 differential for dependents. So basically, with this
22 additional contribution, we believe -- and we've done the
23 math -- that we can increase the employer share to offset
24 the cost of these enhanced benefits. And this honestly
25 is just the math. This is the math on how we get there.

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1 If you pull the Senate bill, Senate Bill 513
2 in the 2015 session, if I remember correctly -- and I'll
3 look to Tena -- there's not a percentage in there. It is
4 a dollar amount. So we talk about percentages, and we
5 get the Board to approve a percentage, and then we do a
6 dollar amount. So what we're trying to do here is kind
7 of bridge that gap and say, "This is what that percentage
8 would look like," but really, we want to spend all \$743
9 that is provided to us by the State for employees and the
10 \$450 for whatever it was, the \$445, excuse me, for the
11 retirees and the \$180 for the Medicare Exchange. So this
12 is what those look like.

13 And you'll see that we've been able to bump
14 these up a bit because we recognize not only for the CDHP
15 but on the HMO plan that those rates are increasing. And
16 how we were able to get it from 7 to 9 percent increase
17 down to 4 to 6 or 3 to 6 is by doing this. So this is
18 how we've been able to have the employer pick up a little
19 more of the cost of the insurance.

20 What I want to do right now, because this is
21 pretty long, I'm going to pause and see if there's any
22 questions so far or I can just plow through and then we
23 can save them, Mr. Chair.

24 CHAIR CATES: Does anybody have any questions
25 at this point?

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1 MEMBER COCHRAN: Mr. Chair, this is Chris
2 Cochran in Las Vegas. I just want to be clear. So
3 Damon, what we had worked on last month, you're
4 essentially proposing we go back to what we had for our
5 current year, I believe. And then we are able to do this
6 because the governor is kicking more into the per
7 individual for members? Is that how we're able to afford
8 to do this? Because last month, we couldn't afford to do
9 this, so I just want to have it clear in my head.

10 EXECUTIVE OFFICER HAYCOCK: For the record,
11 Damon Haycock. These are excellent questions,
12 Mr. Cochran, and I've had these questions asked of me
13 already since --

14 MEMBER COCHRAN: Dr. Cochran.

15 EXECUTIVE OFFICER HAYCOCK: Dr. Cochran. I
16 apologize. It's not that the governor is giving us more
17 money. It's that we had a negative experience year when
18 we didn't know we were going to have a negative
19 experience year. So when you take the money that the
20 governor has given us and apply it to the starting figure
21 that is less, you actually end up being able to have
22 more. I know it's kind of confusing, but I'm going to go
23 back to a slide and really hone in on this.

24 What we had last month was the trend: 4, 7,
25 and 2. What we didn't have last of the month was the
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1 experience: Negative 8.8, 5.4, and negative 4.8. And so
2 the knowledge that we were using was based on well, if
3 our budget is accurate, then we're going to trend it
4 forward 3.6 percent and that's what we need to do. But
5 when the experience came in so much less, then basically,
6 our total claims cost is less. And so we need less
7 premiums. But if we keep the governor's money, then his
8 money chews into more of the participants' premium. And
9 that's really how that happens.

10 And then to answer your question on am I
11 saying go back completely? I will summarize at the end.
12 There's really only three changes that I'm recommending
13 for this plan as far as it is compared to today. One is
14 that the HSA, the enhanced HSA still stays at the \$200,
15 and it is tied to preventive benefits; and two, that the
16 preventive drug benefit still moves forward. That's a
17 new benefit we haven't done. And three, that the
18 Medicare Part B premium credit is increased.

19 If you were to summarize all of the
20 recommendations into those three things, that's the
21 difference between today and what I'm recommending for
22 Plan Year '18.

23 So I'm going together move forward,
24 Mr. Chairman.

25 MEMBER COCHRAN: Okay. Thank you. This is
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1 very encouraging.

2 CHAIR CATES: Go ahead.

3 MEMBER LAMBORN: Thank you. Mr. Chairman,
4 Leah Lamborn for the record.

5 So this is very good news. Like Christmas,
6 almost.

7 Question, though: You say we have in the
8 budget a 3.6 increase in the budget, and I'm looking at
9 the two different groups where the bigger group is 1.4
10 but the non-state is 15.8.

11 Do you have a blended increase for that, or
12 are they treated separately? And is the 3.6 also for
13 that, or how does that work?

14 MS. GLOVER: So this is Celestena Glover for
15 the record. When we build a budget, they are separate.
16 We initially start with the trend that Aon gives us. The
17 3.6 is where the budget office wanted us to land, and
18 then we look at the non-state retirees separately because
19 we do pull in what is really happening. We start out
20 with the 4, 7, 2, and then when we get the real numbers
21 from Aon, then we make the adjustments accordingly.

22 MEMBER LAMBORN: So again, sorry, Leah
23 Lamborn for the record.

24 Do you have a blended projected increase for
25 those two populations?

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1 MS. GLOVER: Again, Celestena Glover for the
2 record. We do not have a blended increase because they
3 are separate pools, so we don't blend even the overall
4 with everybody. We look at them as two separate pools of
5 people, and it's required.

6 MEMBER LAMBORN: Sorry. Just one more
7 follow-up question. Leah Lamborn for the record.

8 So in the budget then for that non-state
9 group, are they also the 3.4 percent, or was it 100
10 percent?

11 MS. GLOVER: I don't have -- this is
12 Celestena Glover for the record. I don't have the
13 numbers in front of me, but I think they were more like a
14 6 or an 8 percent increase. Obviously, not as much as
15 we're seeing.

16 MEMBER LAMBORN: Thank you.

17 CHAIR CATES: Any other comments or
18 questions?

19 Go ahead, Tom.

20 MEMBER VERDUCCI: Thank you, Mr. Chair.

21 Tom Verducci for the record. I just wanted
22 to point out that I think PEBP staff has done an
23 excellent job in containing their costs.

24 Damon, with your effective management, I'm
25 very impressed with this presentation and, in fact, this
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1 is probably the happiest moment I've spent here.

2 CHAIR CATES: One of many happy moments, I'm
3 sure.

4 MEMBER VERDUCCI: And, you know, it just
5 seems what the state employees have endured over the last
6 several years: furloughs, pay cuts, whatever we can do
7 to maintain your recommendation, I think, would be in the
8 best interest of the members of the programs. Just my
9 thoughts.

10 CHAIR CATES: Any other comments from the
11 members?

12 Hearing none, let's --

13 EXECUTIVE OFFICER HAYCOCK: All right. I'll
14 continue. Damon Haycock for the record. I'm going to
15 move back down to the percentage recommended employer
16 subsidy slide, and we're going to take it from there.
17 That's slide 19, so now we're moving to slide 20.

18 What we've shown you in the past is here's
19 the overall rates, and then we show you this wonderful
20 kind of synopsis and this attachment. But I wanted to be
21 able to truly point to why, why the rates are doing what
22 they're doing for each subgroup of each risk pool. So
23 you'll see here for the recommended rates for the
24 consumer-driven health plan for state employees, when you
25 take the new recommended plan that I'm recommending today

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1 and you apply that, those rates, you'll see that we are
2 anticipating still a reduction in medical costs, a decent
3 increase for pharmacy costs, and another increase for
4 dental.

5 But what we've been able to be do, thanks to
6 the additional employer contributions, starting from a
7 lower figure, is you'll see the participant premium is
8 penny for penny the same.

9 So the actual rate goes up, right? It goes
10 up a little bit. \$598.69 to the \$599.29 or \$12,066.01 to
11 \$1,281, but the State has coughed up or covered the rest,
12 and your rates stay the same as a participant.

13 Moving on the state retirees, the exact same
14 thing. They are grouped together as a risk pool on our
15 plan, and so we have the same increases that we're
16 applying to the state employees, and you'll see again
17 that the rate has gone up a little bit, but the State has
18 covered it in the subsidy, and therefore, to the penny,
19 the rates are flat as our recommendation for next plan
20 year.

21 Here's the non-state retirees. I want you to
22 see something in here. So look at the increases that
23 this group is experiencing and what we anticipate they're
24 going to experience again and why. Why would we think
25 it's going to be so high? Just in medical and dental

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1 alone, not even counting pharmacy, in Plan Year '16, they
2 had, on a per person basis, almost a 25 percent increase
3 in costs from the year prior. So we can't just hope this
4 group is going to get less costly. We have to
5 appropriately and soundly and actuarially -- I think
6 that's a word -- actuarially develop the rates that are
7 appropriate for this risk pool per statute. And so
8 you'll see that their premium is going up.

9 So for a retiree only plan, it's going from
10 \$344 to \$391, right? You're talking a \$46 increase. But
11 let's not forget that we're increasing, for those that
12 qualify, the Medicare Part B, we're giving them another
13 \$30. So we're trying to mitigate this problem. I know
14 it's not perfect, and I hate being the bearer of bad
15 news. I feel like that's my job here at PEBP is to give
16 bad news, but this is what the numbers are.

17 And there's some relief in here that no one
18 knows because the contribution percentage change that
19 we're applying to the plan affects both the non-states
20 and the states equally because statute says that the
21 employer has to pay the same contribution. And so the
22 percentage contribution to the non-state retirees we're
23 recommending is going up, so we're actually going back to
24 their employers and getting a little bit more money to
25 help offset this cost. That's why you see a 19 percent

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1 increase in medical, but you only see a 13 to 16 percent
2 increase in overall rates. We're trying to mitigate this
3 by using what the statute provides us and allows us to
4 do.

5 Now we can go to history of the HMO rates.
6 This is what you've seen since 2012. On average, they
7 have an 8 percent increase, so they're a little bit --
8 you know, you could attribute that to a plethora of
9 things. Either they have higher risk or they have more
10 profit or they have more fees or it's because they have
11 to pay HMO premium tax, or maybe PEBP has just done a
12 better job. I'm not going to say we have, but their
13 increases have been pretty steady.

14 If you continue, that's for the state
15 employees. It's about the same for the state retirees.
16 Overall, about a 7 percent increase. And on the
17 non-state retirees, they're at a 10 overall.

18 So what are the approved HMO designs? You
19 guys already did this. We're not recommending a change.
20 This was part of the contract ratification in January.
21 I'm just putting this up here for reference. The plan on
22 the left is the standard HMO. The plan on the right or
23 the green is the alternate HMO. We're not changing any
24 of this. This is exactly what you guys approved. We're
25 not recommending a change. And honestly, it's approved

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1 in contract. We'd have to make a contract amendment if
2 we really wanted to change this dramatically.

3 But what do those rates look like? Yet
4 again, you're looking at their experience that they have
5 this. This is blended, folks. 11.4 percent increase on
6 medical and prescription because they put them together,
7 and then dental: 6.1. And you so you're looking at an
8 increase of 3 to a 5 percent, which is still an increase,
9 and we recognize that, but it's less than what we
10 anticipated last month, which was 7 to 9. So we're proud
11 of the ability to try to provide some relief, and we did
12 that cleverly with the employer contribution.

13 Same with the state retirees. They have a 4
14 to 7 percent increase. These are the proposed rates.
15 You have the rate of the subsidy and the participant
16 premium. Earlier we showed you we were going to get,
17 potentially from the budget, \$445 right, per retiree as
18 Tena mentioned. Let's look at this. If you have a
19 spouse, you're actually getting more. If you have a
20 family, you're actually getting more. Look at how much
21 you're getting over here on the base subsidy, and so
22 you're really getting more than the \$400, depending on
23 your years of service, the R445. Those are the rates for
24 the HMO. They're actually lower than what we anticipate
25 when you approved the contract back in January.

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1 Non-state retirees. Again, you'll see that
2 their increase is less than ours. PEBP believes that
3 there's been some migration of non-state retirees onto
4 the CDHP because of the HMOs going up so high. That or
5 the folks on the HMOs may have been just leaving, but
6 they have projected these increases on the HMOs, and we
7 were able to provide a little less of an increase, so
8 they're about 8 to 10 percent for the non-state retirees.

9 And then on the alternate HMO plan, the whole
10 point of this was to mitigate rates. We wanted to
11 provide some relief to folks that like the HMO model but
12 didn't want to pay the going HMO rates. We asked our HMO
13 vendors to come up with a different plan. That was the
14 plan you all approved and ratified in January.

15 And why you don't see anything here is
16 because we have no current numbers because we haven't
17 started this plan, but these rates here on the right are
18 the exact participant premiums people are paying for
19 their HMOs today. So it's, in effect, a flat rate.
20 State retirees, same thing. And non-state retirees, same
21 thing. So for those non-state folks that are on the HMO,
22 can't afford that current plan but they like that HMO
23 model, if they're willing to have a narrower network and
24 pay a lot more when they go to the emergency room or to
25 have outpatient surgeries, this plan gives them that

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1 opportunity for a flat rate.

2 So what do I want to occur is I would like
3 you to approve slide 33, in a nutshell, which is approve
4 the shift of these enhanced CDHP deductibles,
5 coinsurance, dental and vision benefits that were
6 outlined in slide 13 above to the base plan. Let's just
7 move them over and make them part of the base plan of
8 benefits.

9 I would like you to increase the Medicare
10 part B premium reimbursement. It should say credit. I'm
11 using the wrong vernacular, and my CFO will hit me later,
12 but it's a credit, still \$134, and I want you to also put
13 that preventative drug benefit in the base plan because
14 it makes sense. To approve the final cost saving
15 activities for Plan Year 2018, that's undoing the HRA
16 rollovers. That's undoing the Medicare exchange,
17 retirees paying those fees because we have the money.

18 And then the four bullets there you see on
19 number four to approve the use of excess reserves for
20 Plan Year '18 and Plan Year '19 because I've presented it
21 that way. And don't forget, you can go back and change
22 for next plan year. You have had that opportunity every
23 year we've had decisions that are made. But basically
24 say this is what we want to do like you did for the
25 excess reserves for the last three plan years on the

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1 current plan design to approve them for those fees and
2 premiums for the Medicare Exchange, increase life
3 insurance amounts. That was a very contentious and
4 difficult decision, and I'd like to help you all out with
5 that and return it back to where it was and to approve or
6 to continue to support the HSA/HRA amounts of \$200 to the
7 primary participant upon completion of the preventive
8 program.

9 Then we'd like you to approve the rates as
10 I've outlined them here and allow us to make technical
11 adjustments. Why do we ask for technical adjustments?
12 Because session isn't over.

13 And with that, I will take any more
14 questions, Mr. Chair. Thank you.

15 CHAIR CATES: Thank you, Damon, and thank you
16 for getting us a better suite of choices than at the
17 November meeting.

18 Any questions?

19 Go ahead, Anna.

20 MEMBER ANDREWS: Anna Andrews for the record.
21 Damon, on that increase CDHP HRA/HSA upon completion of
22 the preventive program, will you have the whole plan year
23 to meet those requirements? Because if I wait until the
24 end of the plan year, I won't get that additional funding
25 until then? Is that how it's done?

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1 EXECUTIVE OFFICER HAYCOCK: Yeah. So for the
2 record, Damon Hancock. Thank you, Ms. Andrews. Great
3 question.

4 Currently today to get enhanced HSA funding,
5 you have to be enrolled in the consumer-driven health
6 plan on July 11th. If you don't come on to the State
7 until July 2 and your insurance doesn't start until
8 August 1st, you don't get the enhanced funding, and
9 that's how it's been here at our plan for years.

10 This actually allows you the opportunity to
11 earn this enhanced funding for 365 days from the
12 beginning of the plan year to the end. If you
13 procrastinate or you can't get in or you have other
14 issues and you don't get it done until June, we will pay
15 you the \$200 into your account, your HSA account or
16 increase your balance on your HRA by that \$200 once
17 you've met those four simple processes. Go to the
18 doctor, take whatever lab work that they ask you to do.
19 And, in fact, we're going to define it so it's simpler.
20 It's only a couple of things. Then go to the dentist and
21 get your teeth cleaned once.

22 You do all of those things in July, we'll put
23 your money in your account probably two to three months
24 later. And this is very important. There is a process
25 on this preventive program that is tied to claims. Our

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1 providers have a year to submit claims. So you may do
2 your process in July, and your provider may take their
3 time and not bill us until December. And until we get
4 that claim from the provider, which is the trigger for
5 your enhanced benefit, we can't put that enhanced benefit
6 to you.

7 So this is really a partnership between PEBP,
8 the provider, and the participants to receive this
9 funding, and it's the fairest way to do it. You get --
10 the claim comes over, we validate it, they ask PEBP, PEBP
11 goes through a small administrative process to make sure
12 that you get your funding and then it gets rolled onto
13 your account. It will not happen immediately, and that's
14 something that we're going to be highlighting in some
15 information we plan to send out next month.

16 MEMBER ANDREWS: Thank you.

17 CHAIR CATES: Any other questions from the
18 members?

19 MEMBER LAMBORN: Mr. Chair, I have one.

20 CHAIR CATES: Go ahead.

21 MEMBER GARCIA: Mr. Chairman, this is
22 Rosalie.

23 CHAIR CATES: Hang on, Rosalie.

24 MEMBER LAMBORN: Leah Lamborn for the record.

25 So on the alternative HMO -- and I know that we've
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1 already passed this and so forth, I'm just a little
2 concerned that some participants may jump to that plan
3 because of the lower cost. And so what are their options
4 if they get on that plan and decide oh, this is not
5 working for me? Is it still they only can disenroll or
6 enroll into the other plan within the following year or
7 do they have an option?

8 EXECUTIVE OFFICER HAYCOCK: For the record,
9 Damon Haycock. Excellent question, Ms. Lamborn. We have
10 already started sending out correspondence about what are
11 the ramifications of enrolling in this alternate plan.
12 We sent out something initially when the contract was
13 approved. We sent out something recently, I think in the
14 last couple of week or the last week on the real
15 definition between each plan, and then we'll be sending
16 something out again.

17 One of the things that we bolded in our
18 correspondence is if you enroll in this plan and the
19 provider you want isn't on that network, you won't be
20 able to disenroll from this plan and enroll in another
21 plan until the next plan year. So this is a definite
22 choice that needs to be made, and we have articulated
23 this choice, and we will continue to articulate this
24 choice throughout the process in open enrollment all the
25 way up until, obviously, July 1.

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1 We also have a newsletter prepared already
2 for this that includes this alternate plan that again
3 points to all of the rest of our correspondence and
4 reiterates if you choose this plan, you may have to
5 travel for care outside of your normal area, and you are
6 stuck, basically. That's my words. You are stuck in
7 this plan until next plan year, so choose, but choose
8 wisely. And we will have folks from the HMOs and our own
9 staff at all of our open enrollment meetings to really
10 get in depth with this to anyone who is interested in
11 making this switch.

12 The reason why these plans or this alternate
13 plan is less costly is because we're limiting choice.
14 The more choice you have in health insurance,
15 traditionally, the higher you have to pay for it. And so
16 this is a lesser choice plan to help mitigate that HMO
17 model cost increase. We're not sure how many people are
18 going to enroll onto this plan, but we're going to
19 evaluate it this year, and we'll be able to provide
20 utilization reports through these HMOs to the Board so we
21 can see what's going on with it. But at this time, no,
22 we do not have the ability for you to hop on and off
23 plans midyear until unless they have a qualifying life
24 event.

25 CHAIR CATES: Any other questions?
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1 Rosalie, you had a question?

2 MEMBER GARCIA: Yes, I do. I'm just going to
3 say it again. I am wondering. I had to stop on slide 23
4 for the history of HMO rates, and it has been said that
5 HMO plans are more costly. And I'm looking at the
6 history, and it's looking as if that is so very true, and
7 I'm wondering why.

8 EXECUTIVE OFFICER HAYCOCK: For the record,
9 Damon Haycock.

10 Is that a rhetorical question, or would you
11 like me to try to answer that?

12 MEMBER GARCIA: No. I would love to hear
13 from you, Damon. Thank you.

14 EXECUTIVE OFFICER HAYCOCK: For the record,
15 Damon Haycock. I think if we break it down -- and I'm
16 going to try to break it down into what I call Damon
17 speak like layman's speak, but even simpler.

18 The cost of a rate is the claims plus any
19 fees divided by population. And so if a plan experiences
20 increased claim costs, that plan is going to raise
21 premiums to cover it. HMO plans have -- and if you
22 recall, the health information on demand report that
23 Dr. Krier from Aon traditionally presents every summer,
24 shows the risk factors of our current employees. Not the
25 retirees, but he does it for our actives. And if I

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1 remember correctly, the risk factor for the HMOs has been
2 higher than the CDHP.

3 I think it's a situation that is in a spiral.
4 So when HMO plans start experiencing higher costs, just
5 like we would, we raise rates. When they raise rates,
6 people that are traditionally healthier don't want to pay
7 those rates, and they move off of that plan. Well, when
8 you move off healthy people from a health plan, what's
9 left is those that may not be as healthy, and now claims
10 go up on a per person basis and rates go up. And so it
11 becomes a spiral.

12 These HMO plans, I believe, are raiding rates
13 because they're losing people. And they're losing people
14 because they're raising rates. And so it's a spiral that
15 I don't know if we can right the ship, but PEBP has been
16 actively looking into alternatives to ensure we provide
17 high-quality healthcare to our employees, retirees and
18 families, regardless of what three-letter acronym is on
19 our plan. And so right now, this is what has been put in
20 place as we have, if I remember correctly, 28 percent of
21 our non-Medicare Exchange participants are on HMO plans.
22 We want to provide what the people want.

23 But I agree with you, Ms. Garcia. What's
24 going on with this is that their risk is increasing,
25 and their healthy folks are leaving and migrating, and

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1 what's left has to pay the remainder. And no greater
2 illustration of this situation can be seen outside of
3 looking at our current non-state retiree pool. That pool
4 has been reduced year after year, and who is left are
5 stuck having to pay for those claims.

6 And so when you enroll in an HMO plan today,
7 you are enrolling with whoever else is enrolled in it,
8 and that rate is predicated on your expected risk. And
9 tell me if that answers your question any better,
10 Ms. Garcia.

11 MEMBER GARCIA: Yes, it does provide an
12 answer. Thank you.

13 EXECUTIVE OFFICER HAYCOCK: For the record,
14 let me add one more thing. Damon Haycock. Let's also
15 not forget that HMO plans today, through our contract,
16 are fully insured. And so fully insured means they
17 absorb all of the risk. However, they also have certain
18 requirements to the Nevada Division of Insurance. They
19 have to pay a 3.5 percent premium tax. They also have to
20 pay their own fees. They also have to develop profit.
21 And so when you add their load onto their base rates,
22 they have to account for all of those things.

23 And there was a new rule that came out that
24 the home office exemption from paying the 3.5 percent
25 premium tax, they used to have to only pay 1.75, that

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1 went away. And so now that 1.75 percent of premium has
2 to go to the Division of Insurance on top of the original
3 1.75. And so let's not joke, folks. They're going to
4 put that onto the rate, and that rate is going to be put
5 onto the participant. I don't know any health plan that
6 says, "Wow, we have to pay a new fee. We'll just eat
7 it." So that cost already is embedded in there, whereas
8 PEBP, as a self-insured consumer-driven health plan, does
9 not have to pay that premium tax.

10 MEMBER GARCIA: We lost you.

11 EXECUTIVE OFFICER HAYCOCK: Sorry. Can you
12 hear me now, Ms. Garcia?

13 MEMBER GARCIA: I'm sorry. We're losing
14 communications here.

15 So can you hear me?

16 EXECUTIVE OFFICER HAYCOCK: We can hear you
17 just fine.

18 Can you hear us?

19 MEMBER GARCIA: Hello?

20 EXECUTIVE OFFICER HAYCOCK: I'm going to
21 pause.

22 CHAIR CATES: Can you hear us?

23 MEMBER GARCIA: Off and on, but please
24 continue. It's chopping up.

25 EXECUTIVE OFFICER HAYCOCK: PEBP's
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1 consumer-driven health plan is self-insured, so we are
2 not required to pay certain fees and taxes. And as a
3 state plan, we're not paying tax or we're not paying --

4 (Member James Wells arrived.)

5 EXECUTIVE OFFICER HAYCOCK: -- stockholders
6 any profit that we make. We don't make profit here. I
7 don't get the bonuses that my colleagues get running
8 health plans in the commercial world nor their pay. So
9 we take every dollar that we get and we try to put it
10 back into the plan. We're not trying to get a profit.
11 So the HMO fully insured plans have those aspects to
12 their plan that they will cost for it.

13 CHAIR CATES: Are you still having difficulty
14 hearing us down there?

15 MEMBER COCHRAN: We're having technical
16 difficulties.

17 CHAIR CATES: All right. I think maybe we'd
18 better take a break and see if we can resolve that.
19 Let's go ahead and take a ten -- let's convene at 11:45
20 recess.

21 (Recess was taken.)

22 CHAIR CATES: Call the meeting back to order.
23 Damon, pick up where you left off.

24 EXECUTIVE OFFICER HAYCOCK: For the record,
25 Damon Haycock. I just want to make sure down south you
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1 guys can hear us. I don't want you to miss anything.

2 MEMBER COCHRAN: Yes, we can hear you.

3 EXECUTIVE OFFICER HAYCOCK: Excellent. Thank
4 you, Dr. Cochran.

5 Sorry for the technical issues between Carson
6 City and Las Vegas. I'm trying to see where we were at.

7 I think we were still talking about the HMO
8 rates. Oh, no. Actually, my presentation was complete.
9 You guys were talking and deliberating as a board. So
10 I'll turn it back to you, Mr. Chair.

11 CHAIR CATES: Very good.

12 So question, comments from the Board?
13 Nobody? Anybody want to make a motion? Thought there
14 would be a little talk about this. Go ahead.

15 MEMBER VERDUCCI: Tom Verducci for the
16 record.

17 CHAIR CATES: Oh, I'm sorry.

18 Are you going to make a motion, or do you
19 have a comment.

20 MEMBER VERDUCCI: Mr. Chair, I was ready to
21 make a motion unless there's further discussion.

22 CHAIR CATES: Hang on one second. I just
23 want to check with legal counsel.

24 Is this the point we should open it up for
25 public comment before we do a motion?

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1 MR. BELCOURT: I think so.

2 CHAIR CATES: Thank you for keeping me in
3 line. Let's go ahead and open it for public comment
4 starting in Carson City.

5 MS. LOCKARD: Thank you, Mr. Chairman.

6 And again, my name is Marlene Lockard
7 representing the Retired Public Employees of Nevada. I
8 just wanted to reiterate my thanks that I expressed at
9 the beginning of the hearing. And if you think I've been
10 a broken record here, I want you all to know that I've
11 also been a broken record at the legislature.

12 And for RPEN members that fall into the
13 orphan category, I just would like them and all of you to
14 know that we have also been working very hard on that
15 issue at the legislature. And stay tuned is about all I
16 can say right now. Thank you.

17 CHAIR CATES: Thank you.

18 MR. ERVIN: Kent Ervin, E-R-V-I-N,
19 representing the Nevada Faculty Alliance, the association
20 of faculty at all eight NSHE institutions.

21 Well, thank you very much for the rollbacks.
22 Language is very important, and I really appreciate the
23 change from base -- enhanced to base. As we've said for
24 quite a long time, enhancements were really just partial
25 restoration of the 2011 to '12 cuts, and they are still,
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1 now in the base, still just partial restoration of those
2 cuts, but it is important. It is a very important step
3 that as a program, we start from where we have been for
4 three years that people have gotten used to and really
5 not make little changes that can cause more issues.

6 I wish we had had a policy discussion with
7 the Board or on the Board of relative values of adding to
8 HSA's lowering deductibles versus out-of-pocket costs.
9 Probably a little too late for that right now, but I do
10 feel the need to point out that the \$7,800 maximum out of
11 pocket for a family is catastrophic for our -- especially
12 the classified employees, and we had a member in the
13 audience talk about this, but at NSHE, at least
14 17 percent of our classified staff have annual incomes
15 below the \$33,000 Medicaid threshold. So, you know,
16 \$7,800 for them, and I say at least because my data set
17 doesn't distinguish employer paid versus employee paid
18 PERS, so it could be higher than that. So just need to
19 say that one of the main aims of this program is to
20 prevent catastrophic costs, and for those employees, I
21 really don't think we're doing it yet.

22 I have three kinds of things in the
23 categories of questions that I hope can be clarified.
24 One is in the slides, I did not see what the new
25 individual deductible for a family will be. It's

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1 \$15,700, \$1,500, \$3,000 for a family. I get a lot of
2 constituents telling me, "Why isn't that just the same as
3 an individual single employee in a family?" That higher
4 deductible -- I don't know if it's scaled or not.

5 The other thing is -- and this may be a
6 different discussion -- but, you know, standard versus
7 alternative HMO doesn't mean anything to me, the words,
8 and maybe we can come up with some more -- not much time
9 before enrollment, but maybe come up with some more
10 descriptive words. I also noticed that the cost
11 difference has kind of shrunk since -- with these new
12 numbers.

13 And the other thing I didn't hear about and I
14 thought we were going to get more information is what's
15 the true cost of the true estimated cost from the
16 actuaries of the \$200 per HSA contribution factoring in
17 participation rate, which you have to estimate, and the
18 cost of those extra visits for people who are pushed to
19 do those extra preventive care items. So thank you very
20 much. Overall, great motion today on furthering this
21 plan for all of us. Thank you.

22 CHAIR CATES: Thank you.

23 MS. LEAR BOWEN: My name and my words for the
24 record. P-E-G-G-Y, L-E-A-R, B-O-W-E-N. I feel like I've
25 been in a time machine and gone back several years, and
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1 especially when I heard "flat rates." And what
2 transpired and where I heard that way the presentation
3 was done before was before the Nevada State Legislature
4 or one of the subcommittees, and the question was asked,
5 "Are the rates now flat?" during last session. I know
6 exactly when it happened.

7 And the answer to the question by the
8 executive director at a time was "Yes, the rates are flat
9 for the state employees and the state retirees in that
10 group." And that was the end of comment.

11 Then the executive director went out into the
12 hall and was pressed by the press and said, "Were the
13 rates slapped for the non-state employees?"

14 And he said, "Oh, no. Those rates are going
15 up." Whatever term he used.

16 But the point was that today, and for
17 whatever reason, I really wanted the slide up there
18 saying for the record what was going to happen with the
19 non-state employees. And it's not acceptable, and I'm
20 not being mean about it. It's not acceptable to you,
21 "We'll get the figures to you. We're talking about lives
22 here. We're talking about quality of life, and we're a
23 talking about our future involved in this program and
24 promises made and not made." And it's not fair to us to
25 have exclude us from "The rates are flat" statement and
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1 not say exactly -- and for the record, what is happening.
2 That's just not fair.

3 The other comment I would like to make is a
4 lot of our plan in some ways have become a diagnostic
5 plan. The vision plan, I was really surprised when 92
6 percent of our participants said they wanted to have
7 glasses hardware, contacts, whatever, things that I don't
8 use, be enhanced back into the plan so that it's not just
9 go get an eye visit, find out what's wrong and then
10 you've got to pay for it. And the dental plan, thank you
11 very much for enhancing it back. That is helpful.

12 The hearing aids plan, I don't think there
13 should be, for people who have lost their hearing or need
14 in need of hearing aids, why aren't those incorporated
15 back in just the way you enhanced and to keep a \$25
16 deductible just because it looks good or feels good, I
17 don't believe is -- I don't in my heart think that co-pay
18 for the vision plan is appropriate at all whatsoever. If
19 we're using the money that's excess reserves, that's
20 money we've paid. That's money that has been paid for
21 this plan to be used by this plan for our benefits. And
22 we've gone from a plan that provided to a plan that lets
23 you find out what's wrong but doesn't cover you for
24 getting those things corrected.

25 And I love you very much and I appreciate
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1 your hard work and I appreciate that maybe you worked a
2 little bit harder, and in your motion that you
3 incorporate back in some of the things that I've said at
4 this moment in this public comment only because they've
5 been part of the discussion before, and I know the rules.
6 You can't act on what a person says at the public comment
7 at the moment.

8 But I also know the rules that say that you,
9 if you've discussed it before and it has been your
10 Board's discussion, that that's available to you to do to
11 get back the vision plan, to get back the hearing aid
12 plan because you do have excess moneys, and they aren't
13 reserves. What they are are moneys that we overpaid and
14 that maybe we should get to pay for our benefits that
15 exist. Thank you very much. I hope I didn't go too much
16 into overtime.

17 CHAIR CATES: A little. It's okay.

18 MS. LEAR BOWEN: Thank you.

19 CHAIR CATES: Thank you.

20 MR. RANFT: Good afternoon.

21 My name is Kevin Ranft with ASFCME Local
22 4041. And again, I just want to commend Damon Haycock
23 for really bringing this forward to the fact that there
24 is an alternative option. The fact that there's base and
25 there's enhancements. But by bringing these and putting

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1 them to the base, I think it really opens the eyes up of
2 state employees knowing every year that this is going to
3 be here. Yeah, there's going to be costs, but at what
4 point are we going to say, you know, stop saying let's
5 take these and let's carry the stick?

6 Are we really going to keep them, or are we
7 going to set them aside every single year? And I think
8 state employees like stability.

9 So we're really encouraged to see that on
10 some of the stuff, and I just want to go into a few
11 things regarding like I said, we would have liked to have
12 seen option one for HMO remain flat. We understand, but
13 at the same time, there's some single mothers out there,
14 there's a lot of state employees with families, and even
15 if it's just \$5 or \$26, it does increase. And when they
16 do get the COLA, they're going to have something that
17 really impacts them and their family on living that
18 paycheck to paycheck. So again, we would have liked to
19 have seen that, but we appreciate the fact that
20 everything else is going to remain flat and those
21 benefits are going to be staying the same with a few
22 exceptions.

23 On the option two alternative HMO plan,
24 that's already been signed, sealed, and delivered. The
25 contract has already been done and signed off by the
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1 governor's office, but there's some education needs of
2 really what that's all about. So I'd spoken with Damon
3 Haycock a little bit last board meeting, and I really
4 appreciate his opportunity -- optimistic discussions
5 about education, but I think it needs to be taken a step
6 further.

7 Really, this option two, the alternative
8 plan, people can get really caught up in this. There's
9 really no savings unless you live in Washoe County.
10 Churchill, Carson City, Douglas, anybody else, they've
11 got to drive if they've got to go to a specialist because
12 it's all Renown-based. So really, there's not going to
13 be any savings there. It's going to be fuel costs and
14 other added stuff by going there.

15 So really, I think that if they would add
16 that component into the education process on selecting
17 the plan, I get it. You guys can't tell somebody you
18 should select this plan, but I think we could educate
19 people on how, especially when it comes to picking this
20 plan and they're only going to have a short period of
21 time to do it. So if we could really dive into the
22 education component of it further, not only on this
23 alternative plan but everything else on all of these
24 other selections, I think it will be a huge cost savings
25 for not only this plan year but the future plan years

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1 coming forward.

2 Education. I know that he's working on web
3 site enhancements to educate, but I just want to let you
4 know under "NAC 284.589," there's that admin leave
5 available for state employees to attend whatever
6 functions you guys have. So if we could get these state
7 employees to these functions and do numerous different
8 functions, that way, they can actually attend, because
9 some people do alternative shifts. There's a lot of
10 correctional officers that have the different three
11 shifts, and we really have to make sure that everybody is
12 available to select the proper plan. And again, we know
13 we can't tell them what plan to do, but we can give them
14 more education to help them decide.

15 So really looking forward to that, and I'd
16 like to see how the governor's office, once the
17 legislation approves these final subsidies, the governor
18 recommendation, it increased the subsidy, and we really
19 appreciate that. But state employees want to see, what
20 is that percentage? We have a number, but what is the
21 percentage that the governor believed in that state
22 employee and says, you know, "I'm increasing it this
23 amount." So we have the COLAs, but we also have an
24 increase in the subsidy.

25 So I'd like to see that, you know, something
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1 broken down by all of the stakeholders to make sure that
2 that's again brought to the state employees to be
3 educated on the fact that they're actually getting that
4 increase.

5 And with that being said, again, I just want
6 to appreciate every single each and every one of you for
7 making this decision today. And I know that it's always
8 about funding, but what I don't want to see are those
9 excess reserves just sit there, and I appreciate the
10 Board by using those and making them into an asset for
11 state employees. Thank you for your time.

12 CHAIR CATES: Thank you.

13 More public comment in Carson City?

14 Do we have any public comment in Las Vegas?

15 MEMBER COCHRAN: Yes, we do.

16 MR. FRANKLIN-SEWELL: For the record, this is
17 Shaun Franklin-Sewell. So I have a couple of concerns.
18 I've shared one of them with Damon. And that is I'm
19 worried about adverse selection to the CDHP from the HMO
20 because of the switch on specialty drugs to a 40 percent
21 co-pay. I know I'll be switching to the CDHP for that
22 reason.

23 And then the other thing that I just want to
24 point out is that our negative medical claims trend may
25 be due to decreased destabilization due to the continuing

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1 high deductible. And that's the end of my public
2 comment.

3 CHAIR CATES: Thank you, sir.

4 Any other public comment in Las Vegas?

5 MR. WASDEN: For the record, my name is Jason
6 Wasden; J-A-S-O-N, W-A-S-D-E-N. And I just want to
7 provide a word of caution and focus on state employees.
8 While I understand the argument that the private sector
9 pays more, I think it's very important that we make sure
10 we are comparing apples to apples when we look at
11 benefits, plans, salaries.

12 Our current high-deductible plan should not
13 be compared to low-deductible plan rates, and our current
14 plan can result in the maximum amount of out-of-pocket
15 expense for employees of over \$15,000 or \$40,000
16 respectively in a calendar year. I know an employee who
17 took out an \$11,000 loan to pay for needed medical
18 treatment above what was in her HSA because she crossed
19 the plan year. She was lucky because she had a good
20 credit score that allowed her to take out the loan.

21 So thank you for all that you do. I know
22 these are difficult, and I appreciate your allowing
23 openness in this process.

24 CHAIR CATES: Thank you, sir.

25 Any other public comment down south?
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1 MEMBER COCHRAN: No.

2 CHAIR CATES: Okay. Thank you.

3 So we'll close public comment and take it
4 back to the Board.

5 Any further discussion by the Board?

6 Go ahead.

7 MEMBER LAMBORN: Thank you, Mr. Chair. Leah
8 Lamborn for the record.

9 So before we make a motion, I do have a
10 question. I would like to know if at this time we're
11 able to approve -- I'm looking at page 15 -- the base
12 plan and not the enhancements, but at a later date, add
13 the enhancements back if reserves and trends hold true
14 or approve the base plan and one or two of the
15 enhancements but then add whatever was not approved in
16 the enhancements back later. Sorry.

17 EXECUTIVE OFFICER HAYCOCK: So for the
18 record, Damon Haycock. Thank you, Ms. Lamborn.

19 When you guys approve your rates today, those
20 rates are predicated off of all of the benefits that go
21 along with those rates. And although the base plan
22 supports the base rates, it will be difficult for folks
23 who make a decision not knowing if these enhancements
24 will be there. If we were to somehow add them in
25 midyear -- and it becomes administratively burdensome and

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1 difficult to explain why we started giving benefits in
2 the middle of a plan year. Had folks known that, they
3 may have picked our consumer-driven health plan instead
4 of, say, the HMO plan. So it's important to have one
5 complete plan document ready to go for open enrollment
6 that really states what it is that we are offering so we
7 can help folks make the right decision for them and their
8 families.

9 So technically, is there a way to do it?
10 Probably. Is it advisable? My recommendation is not.
11 If you want to approve less of these enhancements, that
12 is, of course, your prerogative as a Board. My
13 recommendation is to of course approve the entirety of
14 the presentation, but you can adjust up or down and just
15 recognize that once the contribution level is approved by
16 the legislature, anything that goes above and beyond what
17 we're asking for or what you approve ends up going back
18 onto the participants. There's no way to go back and
19 say, "Hey, we'd like to change and do something different
20 with the contribution."

21 Once it's in and approved by the legislature,
22 that's what you get for two years. So we have to be very
23 cognizant about flipping around some benefits either in
24 the midyear or even in the off year because the
25 legislature is approving a contribution amount predicated

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1 off the benefits they think they're buying. And I've had
2 that exactly told to me by one of the legislators at a
3 committee meeting. So yes, you probably could, but it's
4 not advised to do a midyear change. And yes, you can
5 approve less than or more than what we've recommended, as
6 is the Board's prerogative.

7 MEMBER LAMBORN: Thank you.

8 CHAIR CATES: Any further discussion?

9 Go ahead, Jim.

10 MEMBER WELLS: Thank you, Mr. Chair.

11 Jim Wells for the record. The governor was
12 very committed to making sure that the inflationary costs
13 that were seen by the program were covered with
14 additional contributions from the State to that there
15 wasn't this additional burden. I don't think what was
16 predicated or believed at the time is that we would have
17 the negative inflation that we had again this year.

18 And so to be honest, I have some concerns
19 about the sustainability of the program at the levels
20 that we are being asked to approve today. I think that
21 you're asking for basically what amounts to a \$1,500
22 deductible with \$700 -- even with \$700, you're looking at
23 an \$800 deductible plan, and the State is paying 94 and
24 1/2 percent, so the employee is paying 6 and 1/2 percent
25 or 93 and 1/2 and 6 and 1/2.

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1 I just believe that the next -- if it's not
2 in the next plan year, I think you're looking at the
3 2021. I think that you're going to start to see that
4 this is not a sustainable benefit structure and
5 contribution structure. So I think that I just would
6 urge caution. I just don't know that I can support
7 everything being added all back at once.

8 CHAIR CATES: Okay. Thank you.

9 Any further discussion? Motions?

10 Go ahead.

11 MEMBER VERDUCCI: I'd like to make a motion
12 that we accept staff's recommendation of Item No. 5.

13 CHAIR CATES: Okay. We have a motion.

14 Do we have a second on the motion?

15 VICE CHAIR BAILEY: I second that motion.

16 CHAIR CATES: We have a motion and a second.

17 Any discussion on the motion?

18 MR. WELLS: I want to be clear as to what the
19 motion is what the exact staff recommendation is.

20 CHAIR CATES: So that would be slide 33:
21 Board approval. It would -- just run through that real
22 quick just so we're clear.

23 EXECUTIVE OFFICER HAYCOCK: Thank you,
24 Mr. Chair.

25 For the record, Damon Haycock.
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1 Staff is recommending everything that you see
2 on slide 33, Mr. Wells, that the shift of enhanced CDHP
3 deductible, coinsurance, dental and vision benefits
4 outlined in slide 13 to the base plan, that the increased
5 Medicare part B premium -- it should said "credit," not
6 "reimbursement" -- it's relatively the same of \$134, and
7 that the new preventive drug benefit to the base plan,
8 that the final cost saving activities for Plan Year 2018,
9 those are outlined on slide -- back up here -- these are
10 outlined on slide 14, those Plan Year 2018 cost
11 containment activities.

12 And then approve the use of excess reserves
13 for 18 and 19 for the Medicare exchange admin fees, the
14 Medicare exchange plan life insurance premiums, increase
15 life insurance amounts to the \$25,000 employee; \$12,500
16 retiree, the rate of level we have today, and that the
17 previously approved CDHP HSA/HRA amounts of \$200 to the
18 primary participant upon completion of that preventive
19 program, and then, of course, approve the rates as
20 submitted in the four or five slides above this
21 recommendation. That's kind of it in a nutshell, and I
22 can go over any more, if you'd like.

23 CHAIR CATES: Any further discussion on the
24 motion?

25 MEMBER WELLS: Mr. Chair, I'm going to vote
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1 no on this because it's an aggregate motion. There are
2 some things in here, I believe, that we should be doing,
3 but as an aggregate motion, I can't support it.

4 CHAIR CATES: Okay. Any other discussion on
5 the motion?

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

8 THE BOARD: Aye.

9 CHAIR CATES: All opposed?

10 MEMBER WELLS: No.

11 CHAIR CATES: The motion carries. Okay.
12 That will close Agenda Item No. 5.

13 Let's go ahead and break for lunch. We've
14 got a lot of legislative items to do after lunch, so
15 let's reconvene at 1:15.

16 (Recess.)

17 CHAIR CATES: Call the meeting back to order.
18 So we finished Agenda Item No. 5.

19 Now we'll move to Agenda Item No. 6:
20 Approval of the proposed changes to the master plan
21 document for Plan Year 2000 and -- sorry. I had that
22 off. Can everybody hear me down in Vegas? I just called
23 the meeting back to order.

24 We're on Agenda Item No. 6: Approval of the
25 proposed changes to the master plan documents for Plan
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1 Year 2018 for medical, dental, life and long-term
2 disability benefits for enrollment and eligibility rules
3 and for privacy and security requirements, to reflect
4 previously approved plan design modifications, changes in
5 the legislative or regulatory requirements and technical
6 corrections of updates.

7 MS. SPINELLI: Thank you.

8 Nancy Spinelli for the record, quality
9 control officer for PEBP. And my report today is on the
10 updates to the plan documents. They have been updated to
11 include plan design changes previously approved by the
12 Board. The revisions also include changes recommended by
13 PEBP staff, HealthSCOPE benefits, Express Scripts, and
14 findings from Aon's legal compliance review.

15 And in the report, you can see a table there.
16 We have the Board decisions on the first page here. It
17 shows the deductible increases, which we know previously
18 was approved at \$1,600 for an individual and \$3,200 for
19 family. And as of today's action, that's going to go
20 back to \$1,500 for an individual and \$3,000 for a family.

21 The vision exam was previously approved by
22 the Board, and then preventative drug benefit, I'm going
23 to go through those, those changes. For the compliance
24 review, I'll point out some of the updates that we made
25 to the master planned document, and then we do have a few

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1 housekeeping items. But primarily, what I want to go
2 over with you today is the PEBP partner recommendations
3 to the master plan documents.

4 So on page 3, the Board decisions for plan
5 design that was previously approved, the revised
6 deductibles, as of today, or as of today, \$1,500
7 individual to \$1,600. And then for family, \$3,000 to
8 \$3,200. Again, I'll be making adjustments on that based
9 on the Board action.

10 We updated the annual vision exam to a \$25
11 co-pay. That co-pay -- the maximum benefit is \$95 under
12 the plan. The participant will pay \$25. The \$25 will go
13 toward the out-of-pocket maximum. We also inserted
14 language for the preventive drug program that states
15 participants may purchase certain preventive medications
16 and bypass the deductible and go straight into the
17 coinsurance phase. Coinsurance will be applied to the
18 out-of-pocket maximum, and then the preventive drug
19 examples include hypertension, asthma, and high
20 cholesterol.

21 We also inserted cost parameters for hearing
22 aids at \$1,500 per ear, subject to deductible, and then
23 we updated the HSA/HRA contributions that are tied to the
24 preventive program, \$200. For the compliance review
25 changes -- and this is for the medical and prescription

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1 drug NPD -- we added language referencing a new Section
2 125 document that we're in the process of creating. That
3 document will be on the PEBP web site prior to open
4 enrollment. We also updated the definition of "autism
5 behavioral interventionist," and we updated the Level 1
6 appeal process to comply with the State time frame.

7 Currently, we're been complying with the
8 federal time frame of 30 days, and we're required to
9 comply to the State time frame, so we're going to be
10 changing that. We also added clarifying language that
11 family members whose expenses are covered under the HRA
12 are tax dependents and covered under the CDHP plan.

13 At the bottom of page 3, one of the
14 housekeeping changes that I'd like to point out to
15 everyone is for the mammograms. The first billed
16 procedure in the plan year will be covered under
17 preventive regardless of the diagnosis. And then also --
18 and that's for a 2D mammogram that's covered under the
19 preventive program. If a participant chooses to have a
20 3D mammogram, the plan will pay at the level of a 2D
21 mammogram, and the participant would be responsible for
22 the difference in the cost.

23 We also updated the calendar year health
24 savings account limits according to IRS of \$3,400. And
25 then on number 13, for the diabetes care management

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1 program, we removed the requirement for participants to
2 participate in regular telephonic phone calls with a
3 diabetes health coach, and we added a requirement for
4 them to complete a biometric assessment form annually.

5 We also added clarifying language that the
6 diabetes care management co-pays, so the prescription
7 drug co-pays, and the diabetic supplies co-pays do not
8 apply to deductible, but they do apply to the
9 out-of-pocket maximum. And then we also added language
10 -- this is says number 17 -- that out-of-network
11 prescription drugs purchased at an out-of-network
12 pharmacy do not apply to deductible. They're not
13 eligible for reimbursement.

14 And then moving down, this is the compliance
15 on number 18, we added language behavioral health
16 services stating that the plan covers residential
17 facilities for intermediate care, and that complies with
18 the mental health care rules. And then we have had
19 members call requesting coverage for service animals, so
20 we added an exclusion here that says, "The purchase,
21 maintenance, and care of service animals are not covered
22 under the plan." And then 20 is just updating the
23 Participant Contact Guide.

24 On 21, 22, and 23, this is kind of all
25 combined together, we did all precertification
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1 requirements for inpatient, for non-emergent elective
2 surgeries for inpatient and outpatient, and that kind of
3 ties back to the reference-based pricing for the hips and
4 knees surgeries, and the precertification process will
5 also determine the location of service and whether it's
6 high quality and the lowest cost, and if the UM company
7 requires a participant to travel more than 50 miles for a
8 precertified surgery, the participant will be eligible
9 for certain travel reimbursement costs. And this is
10 similar to what we do currently for the transplants and
11 the bariatric surgeries.

12 And then moving down, 24, we added an
13 exclusion for medical marijuana.

14 And then 25, we updated the subrogation and
15 rights of recovery language in the NDP, and this is
16 through a recommendation through HealthSCOPE benefits and
17 through our attorney general's office.

18 So moving to page 10, for the wellness
19 services, currently in the NDP, we have several tables of
20 wellness benefits listed. The problem with that is the
21 wellness services changed midyear, and so what we did is
22 we removed all of those tables and we inserted language
23 regarding what is available, links to the United States
24 Services Task Force, and then the Federal Centers of
25 Disease Control, and so members can go there, they can

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1 see what's eligible under the preventive care, and then
2 they will be contacting HealthSCOPE benefits for
3 confirmation on what's covered under the preventive
4 program.

5 And then moving to page 12, for the dental,
6 life and long-term disability NDP, about the only change
7 we needed to make there was the plan year throughout the
8 document and then the basic life insurance. We had
9 updated that from 25,000 employees to 20,000, and then
10 for a retiree from \$12,500 to \$10,000. Of course after
11 today's action, we'll be changing that.

12 And again, for the compliance review changes,
13 we did add some language pointing to the Section 125
14 document that will be available prior to open enrollment.
15 We also updated general provisions to the Michelle's law
16 and the privacy notice and the appeals process in the
17 dental NDP. And we also included the subrogation
18 language that matches the medical plan document.

19 Moving to on page 13 to the enrollment and
20 eligibility plan document, this came out of the
21 compliance review. We added a HIPAA special enrollment
22 notice, and we also updated the privacy notice and
23 nondiscrimination language in that document, and then
24 again pointing to the section 125 document. There were a
25 couple of -- we did add a couple of qualifying events

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1 just for clarification.

2 On page 14, under Item No. 43, we inserted
3 that SCHIP, Medicaid, and Nevada Check Up are considered
4 qualifying events as far as eligibility goes to enroll or
5 decline coverage for a dependent. And then we also added
6 clarification that enrollment in Medicare Part A or B or
7 in Medicaid is not considered a qualifying event under
8 our program for active employees.

9 And then moving down on page 14 to the HIPAA
10 privacy and security document, we've inserted the special
11 enrollment notice that was identified through the
12 compliance review. We've updated the privacy notice and
13 the privacy notice definition. We also added language
14 regarding the workplace provisions and access to PHI for
15 employees and added restrictions on use of genetic
16 information.

17 And with that, staff requests Board approval
18 for the following documents: the medical, prescription
19 drug and vision NDP, dental, life and long-term
20 disability NDP, the enrollment and eligibility, and the
21 HIPAA privacy and security document, approval for the
22 changes made today with the allowance to make technical
23 adjustments as a result of today's action.

24 CHAIR CATES: Thank you.

25 Questions from the members?
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1 MEMBER COCHRAN: Mr. Chair?

2 CHAIR CATES: Go ahead.

3 MEMBER COCHRAN: This is Chris Cochran in Las
4 Vegas. A couple of questions. On the Medicaid
5 eligibility, do we have any idea how many employees in
6 Nevada or their family members may be eligible for
7 Medicaid?

8 EXECUTIVE OFFICER HAYCOCK: For the record,
9 this is Damon Haycock. Dr. Cochran, we can try to get an
10 updated number. We figured that out a while ago, but I
11 don't want to give you a misleading answer. I'd like to
12 go back and actually get it from HR, but we can get that
13 information to you as quickly as we get the reports from
14 them.

15 MEMBER COCHRAN: I appreciate it, Damon.
16 Thank you.

17 The main thing is I think about that is
18 obviously, it's not something that we would want to think
19 about our employees anywhere in the state qualifying for
20 Medicaid because they don't make enough -- they don't
21 earn enough salary, but I was just kind of curious from a
22 policy perspective if we know how many are doing that.

23 And then on the medical marijuana issue, had
24 we -- I'm trying to recall. Have we discussed that in
25 the past? Is there a reason why we are excluding medical

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1 marijuana from coverage?

2 EXECUTIVE OFFICER HAYCOCK: For the record,
3 Damon Haycock. As long as I've been here since was it
4 August of 2015 now -- good God -- that we haven't brought
5 it up, but I don't know if Mr. Wells has brought up --
6 oh, you haven't either? So I'm going to go with no.

7 MEMBER COCHRAN: Yeah, I heard you. That may
8 actually be the issue. I'm just wondering, do insurance
9 plans cover medical marijuana? For some people, it a lot
10 of relief, so I was just throwing that out there.

11 MS. DAILEY: Amy Daily for the record.

12 MR. HAYCOCK: Come up.

13 MS. DAILEY: Amy Daily for the record. With
14 Express Scripts, there's actually no -- the federal
15 government doesn't recognize medical marijuana. It's
16 recognized at the state level. And as a result, there's
17 no -- the Food and Drug Administration has not approved,
18 granted approval for medical marijuana, so there's no
19 assigned NDC number, and so there's no way for insurance
20 plans to actually cover that at this time. It would be
21 considered experimental and not covered given it's not
22 approved by the FDA.

23 MEMBER COCHRAN: Thank you for that
24 information just as a follow-up.

25 So we are only including drugs that are
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1 approved by the FDA; is that correct.

2 MS. DAILEY: That's correct.

3 MEMBER COCHRAN: Okay. Thank you.

4 CHAIR CATES: Thank you.

5 Any other comments from the members? I have
6 one comment, just a minor typo on page 4, item 13.

7 "Remove the requirements to participate in the regular
8 telephonic engagement calls." I believe the word "for"
9 should be stricken, that's my substantive contribution.

10 Any other comments from the members?

11 MEMBER WELLS: Thank you, Mr. Chairman.

12 Jim Wells for the record.

13 Number 22. Nancy, can you remind me what
14 failure to follow required management procedure says as
15 to how the "may" is determined for denial of benefits if
16 you don't get the precertified?

17 MS. SPINELLI: For the precertification of
18 surgery? Well, actually, it just depends. It could be
19 totally denied, or it could be reduced by 50 percent.

20 MEMBER WELLS: So who makes the
21 determination?

22 MS. SPINELLI: We would make that
23 determination. We would go through HealthSCOPE benefits.
24 I'm going to have actually -- Mary Katherine, could you
25 come up and answer that question?

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1 MS. PEARSON: Mary Catherine Pearson with
2 HealthSCOPE benefits for the record. Actually, that
3 decision is made by Hometown Health. Hometown Health is
4 the medical management organization for the PEBP plan, so
5 any determinations about precertification are made by
6 Hometown Health and then provided to Health Script
7 Benefits for the payment of the claims.

8 MEMBER WELLS: And do they have criteria that
9 they use for a may? I guess where I'm going with this is
10 we're telling people they have to get this stuff
11 precertified, and then we're saying if you don't get
12 precertified, we may or may not cover it.

13 And so who is making that determination and
14 what criteria are being used under a may scenario.

15 MS. PEARSON: Mary Katherine Pearson for the
16 record. So the situation there is, it's not "may." It
17 has to do with what type of service it is. So when Nancy
18 was referring to that, it depends on is it a single
19 service or is it that a day of a stay is denied.

20 Do you see where I'm coming from, Jim? It
21 has to do with how the benefit is applied.

22 And I think the other component of this is
23 that from a practical matter, the suggestion would be
24 that members or providers call HealthSCOPE benefits, they
25 confirm the benefit, and then we direct them towards

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1 Hometown Health for the items that need the
2 precertification. And Nancy also pointed out
3 emergencies, obviously, do not apply as well.

4 MEMBER WELLS: Correct. These were elective.

5 MS. PEARSON: Right. Purely elective.

6 MEMBER WELLS: My understanding was purely
7 elective knee surgery.

8 MS. PEARSON: Exactly.

9 MEMBER WELLS: And so if we're saying you
10 have to go here for this purpose for quality and cost,
11 and then we may or may not pay for it if you do or don't
12 get it precertified seems confusing to me.

13 MS. PEARSON: Got you.

14 CHAIR CATES: Any other comments?

15 MEMBER COCHRAN: Mr. Chair, as a follow-up,
16 Chris Cochran in Las Vegas. I agree with Jim's point.

17 Do we need to include language in that that
18 specifies precertification for elective -- what we would
19 consider to be elective procedures?

20 EXECUTIVE OFFICER HAYCOCK: For the record,
21 Damon Haycock. The intent behind this language change
22 was to try not to paint us into a corner and have two
23 separate precertification rule sets that may be confused
24 by either our UM company or our participants. We try to
25 come up with a global response that says if you have a
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1 service that needs to be precertified that it will go
2 through the precertification process. And as Mary
3 Katherine and Nancy spoke, I think the reason that "may"
4 is in there -- and I'm going to give probably a really
5 bad example, but if you need a knee surgery, that knee
6 surgery may be approved at a specified location through
7 our utilization management company, but then the doctor
8 there may want the person to stay for a week and that
9 won't be approved, and so therefore, those services may
10 not be approved, but the knee surgery itself will be.
11 And I think it's meant to give some flexibility and the
12 ability to apply the appropriate precertification.

13 We work very closely with our utilization
14 management vendor and HealthSCOPE benefits to ensure we
15 are precertifying the exact things that we need to, and
16 this year, we're adding a location of service to this to
17 help address the knee and hip surgeries but also leave
18 the opportunity open to the Board at a later date or PEBP
19 to include additional areas where we may be getting
20 gouged on. And so we don't have to change the NDP
21 midyear, we can come back and say, you know, "It turns
22 out that providers are charging us way too much for this
23 other type of elective surgery." And so we wanted to
24 keep it kind of general to give us the flexibility to be
25 successful in our cost containment strategies.

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1 We could and try to make it a little bit more
2 specific, but then if we need to make a change, we've got
3 to bring it back to you guys, and often, we won't do that
4 that midyear because it confuses folks who have already
5 signed up for our plan, so I think this language here
6 provides us the greatest leeway to protect the plan and
7 give us the ability to make those decisions as plan
8 administrator. Anything that we paint ourselves into a
9 corner may prevent that.

10 CHAIR CATES: Any further comment?

11 Go ahead.

12 MEMBER COCHRAN: Just going to thank Damon
13 for the explanation. I may want just to ask a question
14 of him off record in the future about that based on an
15 individual experience that I'm aware of on
16 precertification. But this far predates the plan, so I
17 just want to make sure those types of things don't happen
18 again in the future. But I can discuss that with staff
19 off the record.

20 CHAIR CATES: Okay. Any other comments?

21 Anybody care to make a motion? Everybody awake after
22 lunch?

23 MEMBER VERDUCCI: I'll make --

24 VICE CHAIR BAILEY: I'll make a motion. For
25 the record, Don Bailey. I make a motion to approve Item
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1 6 with the Chair's change recommendation.

2 Do you need more?

3 CHAIR CATES: I think so. So you're
4 approving the staff recommendations with the one
5 grammatical change on --

6 VICE CHAIR BAILEY: Yes.

7 CHAIR CATES: -- item 13? Do we have a
8 second for that motion?

9 MEMBER LAMBORN: Leah Lamborn. Second that.

10 CHAIR CATES: Okay. We have a motion and a
11 second.

12 Any discussion on the motion?

13 Seeing none, I'll call for a vote. All of
14 those in favor of the motion, say aye.

15 THE BOARD: Aye.

16 CHAIR CATES: Opposed?

17 MEMBER COCHRAN: Aye.

18 CHAIR CATES: The motion carries.

19 EXECUTIVE OFFICER HAYCOCK: So for the
20 record, Damon Haycock. Just to clarify, we are going to
21 make those technical adjustments based off of the
22 decisions made on the rates presentation today. I just
23 want that for the public to understand.

24 You'll see in this report that we didn't want
25 to assume anything, and so that's why you see the old
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1 approvals. But as Nancy has specified, indeed, the Board
2 has just approved we will be making those technical
3 adjustments before posting these NPD's, and I'll turn it
4 back to you.

5 CHAIR CATES: Thank you.

6 Okay. With that, we will close Agenda Item
7 No. 6, move to Agenda Item No. 7: Discussion and
8 possible action regarding potential Board position,
9 recommendations, and direction to staff about the 2017
10 legislative bills that they may impact PEBP, including
11 the following: Assembly bills, Senate bills, Bill Draft
12 Requests.

13 Damon?

14 EXECUTIVE OFFICER HAYCOCK: Thank you,
15 Mr. Chairman.

16 For the record, Damon Haycock.

17 I'm going to go over those that we've
18 already, of course, gone over. There's been a couple of
19 changes and some updates, and then this Monday of this
20 week, it was like legislative introduction day at the
21 legislature. There were 204 bills that came out that
22 day, and we quickly but efficiently and thoroughly went
23 through those bills, and I believe we've added eight that
24 we feel PEBP needs to watch. And if there's any position
25 that needs to be taken by the Board, we want to make sure

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1 we have that before these bills move out of a committee
2 and into a work session where we'll have very limited
3 ability to comment.

4 I'm just going to kind of go down the list.
5 AB 249. That was that 12-month supply of contraceptives.
6 You guys initially had wanted to oppose this bill. There
7 hasn't been another opportunity to go to the table to
8 oppose it based on the language that was in there,
9 especially when it came to certain restrictions: the not
10 being able to use step therapy or prior authorizations.
11 I know there was a patient safety issue on this one as
12 well as a cost, but I have no additional updates for you
13 at this time.

14 I'm going to skip Senate Bill 80. We'll do
15 that last, so I'll let Mr. Cates talk about that just
16 because I want to go kind of more of the housekeeping
17 stuff. But really, Senate Bill 80, there hasn't been a
18 single meeting to my knowledge where they have announced
19 it to be discussed. It has had some tertiary discussions
20 and mention where there wasn't jurisdiction, but I
21 haven't seen that being scheduled yet for a meeting, and
22 I haven't seen the BDR that Chair Cates mentioned at our
23 last telephonic meeting get language yet, and I checked
24 right at the beginning of this meeting.

25 CHAIR CATES: Why don't I just go ahead and
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1 address that. Thank you.

2 Yeah, just to follow up what Damon said, the
3 SB 80, we are not seeking that to go forward to a
4 hearing. It has been referred to government affairs. It
5 has not been scheduled for a hearing.

6 BDR 18-979 is the replacement bill for SB 80.
7 Language has not been -- has not come out yet. It is a
8 fiscal bill, so it therefore is exempt from the
9 deadlines. Because it's a fiscal bill, it shows that
10 it's sponsored by the Governor's Office of Finance, as
11 all fiscal bills are. It's really SB 80, the
12 reincarnation of SB 80. I have gone through an overview
13 of what the differences are between this BDR and SB 80,
14 but I'll refrain until we get some language. I am
15 hopeful we will see language soon.

16 As Damon indicated, March 20th was the
17 deadline for legislators to submit their BDR's, to submit
18 the language, and there was about 200 that dropped on
19 Monday. There's another deadline this coming Monday for
20 committee bills. And I think shortly thereafter, we
21 should start seeing the fiscal bills. I saw language on
22 one fiscal bill from my department that related to
23 librarian archives. They're getting to them, so I'm
24 hoping we'll have that language here pretty quick.
25 That's really all I have to say about that.

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1 EXECUTIVE OFFICER HAYCOCK: Thank you,
2 Chairman Cates, for the update.

3 Moving right along, Senate Bill 139, the
4 Board had asked me as of the last telephonic legislative
5 update meeting to monitor this. It had a -- this is the
6 one on patient-centered medical homes, and the required
7 incentives that were to be approved through an advisory
8 counsel and an advisory group that would then set those
9 required incentives. PEBP had placed a fiscal note
10 showing different levels of incentives that may affect
11 PEBP.

12 This was heard by the Senate Committee on
13 Health and Human Services on Monday at about 3:30, 3:40
14 in the afternoon, and what looks promising is that there
15 was an amendment provided by the Nevada Primary Care
16 Association. It's linked to this update. But basically,
17 the amendment changes the "must" to "may" when it comes
18 to incentives. And so that provides health plans the
19 ability to not be forced to pay those incentives and it
20 allows health plans also and networks the ability to
21 negotiate with patient centered medical homes as they may
22 spring up across the state. But without that stick, that
23 must, it kind of reduces the impact. And really, there's
24 no new impact to PEBP. It's just easier for us to manage
25 our plan if there's not a requirement.

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1 And it also -- this amendment also shifts the
2 responsibility away from the commissioner of insurance to
3 the director of the department of health and human
4 services, so they're doing some administrative changes.
5 This amendment is not official. It was an exhibit. You
6 can go out to Nellis and see it. But we are hopeful that
7 it will be included, as the individual presenting this
8 amendment sat right next to the sponsor and they both
9 kind of announced it together. So I'm looking for an
10 actual amendment to be posted, and we will continue to
11 monitor it.

12 On Senate Bill 233, that's again another --
13 that's kind of the companion bill to 80249. Again, it's
14 the 12-month contraceptives. But it also -- the whole
15 point, I believe, is to allow folks to be able to get a
16 12-month supply. We initially presented these bills to
17 the Board earlier this month and talked about the concern
18 we have for being forced to issue 12-month supply of
19 contraceptives.

20 After rereading the bill and speaking with
21 folks at the governor's office, it says that we must
22 honor a 12-month supply of contraceptives as prescribed.
23 And so if a doctor wants to prescribe a shorter amount
24 because they want to do some form of their own step
25 therapy or their own trial when folks takes

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1 contraceptives that aren't necessarily doing it for birth
2 control, but maybe for some other hormone balancing or
3 for some other issues, that it won't force a plan to pay
4 for a 12-month supply if the prescription wasn't for a
5 12-month supply.

6 So I want to make sure that that's clarified
7 and that still the only concern that we have here at PEBP
8 is the idea that we issue a 12-month supply of a
9 contraceptive, and it was prescribed in the first couple
10 of months, and then the individual loses it. And then
11 they want to come back and get another 12-month supply.
12 How do we handle that? What do we do? What's our
13 benefit? Because if our benefits are provided on a
14 12-month rolling period, we've technically satisfied our
15 development -- or excuse me, our benefit in the first
16 couple of months. And then if they come back, it's
17 almost like it's resetting. And who is responsible to
18 pay for that? Because these are supposed to be 100
19 percent covered from the health plans. So that's one of
20 the other concerns that we have about Senate Bill 233 and
21 really also the same for AB 249.

22 And then the big issue on 233 is they also
23 require PEBP to require hormone replacement therapy. You
24 heard Hometown Health and their team come up earlier this
25 month and discuss the concern about the abuse of things

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1 satisfy a deductible. They pay their \$25 a month for
2 their diabetes meds, and so this part wouldn't really
3 apply. But this is really trying to ensure that health
4 plans don't request reimbursement or rebates from a
5 pharmacy manufacturer and keep it and not settle back up
6 with the participant who officially paid for the drug.

7 This would also apply to our HMO's, but we're
8 not too concerned about this bill, as it has been kind of
9 rewritten and really focused on the diabetes side of it.

10 I don't think -- did we do a fiscal note on
11 this one, Tena? We did? Yeah.

12 When I'm done, if you guys have questions, I
13 can have Tena talk about fiscal notes, but Mr. Chairman,
14 do you have a question?

15 MEMBER LAMBORN: Thank you, Mr. Chair.

16 Damon moon, I'm sorry. Could you remind me,
17 does this have an impact on your drug rebate program?

18 EXECUTIVE OFFICER HAYCOCK: So for the
19 record, Damon Haycock. The initial review of this bill,
20 the rebates are guaranteed through our contracts and not
21 necessarily -- I don't believe that they apply. We're
22 concerned that they might. And so from my first reading
23 of this bill and our first reading of this bill, we're
24 not as concerned about that because it's as if we were
25 going and trying to get specific rebates on diabetes

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1 drugs because they overcharged for them, and that is a
2 different setup than your traditional pharmacy rebates.
3 But if it becomes interpreted that all rebates are
4 subject, then we have a major issue. And I think that's
5 what your fiscal -- if you want to talk a little bit
6 about that, Tena.

7 MS. GLOVER: So this is Celestena Glover for
8 the record. For exactly the reasons Damon had talked
9 about, if it does affect all of our rebates, we did put a
10 fiscal note on it, and the fiscal note amounted to a
11 decrease in revenue -- it's relatively conservative at
12 this point -- of about \$1.1 million in the first year,
13 \$1.3 million in the second year, and \$3.4 million in the
14 future biennia.

15 Obviously, with our rebates, if they come in
16 higher, than that could be significantly more. So the
17 caveat to the language was if we lose the rebates because
18 of this bill, then that affects our overall rate because
19 this helps offset our rates.

20 MEMBER LAMBORN: Okay. Thank you.

21 EXECUTIVE OFFICER HAYCOCK: The next one is
22 Senate Bill 289. It requires health insurance to cover
23 services provided by out-of-network physicians. And we
24 maintain multiple networks of providers with our
25 guaranteed discount to control our costs. That's why we

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1 preach please go to an in-network provider because the
2 economies of scale and the negotiations between our
3 networks and those providers present receive savings to
4 PEBP and other health plans that are on those networks.

5 If this bill passed, out-of-network
6 physicians will be reimbursed at higher rates than
7 in-network positions, incentivizing a migration away from
8 the networks altogether. The concern is that they put a
9 requirement that we have to pay out-of-network folks at a
10 certain percentile of basic, usual and customary. Well,
11 we blow that discount away with our networks today.

12 And so if you're a doctor and you are in the
13 network and you see you're getting paid \$500 for a
14 service, but if you decided to leave the network, you'd
15 be paid \$700 for a service, guess what you think that do
16 doctor is going to do? And if there's a requirement to
17 do that, then there's no incentive to have anyone as an
18 in-network physician in your networks because you're
19 incentivizing people to leave. And we feel that this is
20 a huge issue.

21 We currently average just under 63 percent
22 in- network discount for all of our services, and we have
23 a 96 percent utilization rate for all of our services, so
24 we have really tailored this plan and really pushed folks
25 into using high-quality low-cost providers of care, and

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1 this basically flies in the of that.

2 And so we put a pretty large fiscal note,
3 depending on how many people may leave that network. If
4 25 percent of our physicians leave, if 50 percent, if
5 75 percent, and if all of them do. And it's into the
6 millions of dollars, and I'll let Tena kind of walk
7 through that.

8 MS. GLOVER: Celestena Glover for the record.

9 So the initial fiscal note that we placed on
10 the this particular bill, we based it on the 25 percent
11 migration out of our networks. And between the
12 self-funded plan and the HMO, that is about \$12.9 million
13 in the first year, \$13.4 million in the second year, and
14 then about \$29 million going forward. Obviously, if the
15 migration is higher, that cost will go up. If it's
16 lower, than the costs will come down. So we still -- we
17 believe that's kind of conservative also because we just
18 don't know how physicians will respond to this bill.

19 CHAIR CATES: Sounds like a bill color of a
20 fiscal note.

21 MS. GLOVER: I'm getting to that.

22 EXECUTIVE OFFICER HAYCOCK: So for the
23 record, Damon Haycock. We have opposed this bill, but we
24 recommend opposing this bill. Of course, it's the
25 Board's decision to provide whatever position you want,
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1 but we're against this because it's just bad. It just
2 doesn't do what it's supposed to do, which is provide
3 some form of choice and allow people to choose whatever
4 doctor they want to go to. I think that's what the
5 intent is. But it just puts these restrictions on our
6 ability to manage our plan.

7 As far as AB 331, this came out on Monday.
8 This creates the Nevada System of Community Colleges.
9 Not going to go through all of the administrative
10 functions that are in this bill, but how does it affect
11 PEBP? It separates them out, I believe, from the Nevada
12 System of Higher Education, and then there's a request in
13 there for them to add a member to our board. So our
14 board, if passed, would go from 10 to 11 with a member
15 from the Nevada System of Community Colleges.

16 We're not -- PEBP isn't suggesting is nil
17 position. You guys take -- you're the Board. You decide
18 if you want an 11th member, but that's how it's really
19 going to affect PEBP. We're not going to put a fiscal
20 note because on a per board member basis, you guys aren't
21 expensive, right? There's a little bit of education
22 credits and flights to and from Vegas and some board
23 packets that we send out, so you guys don't cost us a
24 whole lot. I think it's \$80 a day if you don't work for
25 the State, but these people would, so again, we don't

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1 have a fiscal note we're going to put on this bill, but
2 if you have a position you'd like us to take, we'll
3 gladly go to the table and take it.

4 Then we have Senate Bill 352 also introduced
5 on Monday; provides for continued coverage for healthcare
6 for certain chronic health conditions. It prohibits us
7 from requiring pre-authorization or other preconditions
8 for coverage or from denying coverage for a chronic
9 condition for which approval had already been provided by
10 the present insurer or by the immediately preceding
11 former insurer.

12 So this basically says we would have to
13 accept someone else's pre-authorize or precertification
14 if they come from another plan to ours without the
15 ability for us to reassess those decisions for patient
16 safety or for fiscal impact or does it even make logical
17 sense why someone did what they did?

18 And patient safety, we believe, is in
19 jeopardy, and the cost controls are completely nullified.
20 We would not be able to implement our own
21 precertification. And it's not that we want people to
22 jump through hoops. It's that not all health plans are
23 equal. Not all health plans approve things the same way.

24 And what we would be doing, in effect, is
25 accepting the risk and liability from someone else's

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1 decisions and owning those results within our plan. So
2 it prevents us from managing ourselves, and it also
3 affects our HMO plans for PEBP participants coming onto
4 their plans from outside PEBP plan sources, so they would
5 be affected as well.

6 We are submitting a fiscal note citing how
7 much we are actually spending or how much we're saving on
8 precertification and preauthorization processes because
9 depending on how much we have to get rid of those will
10 depend on how much impact, and Tena can walk through real
11 quick that note.

12 MS. GLOVER: So initially, what we have done
13 -- this is Celestena Glover for the record -- is look at
14 the UM reports for the last three years in Fiscal '15
15 forward. We're seeing a little over a \$7 million savings
16 annually on -- or not annually, excuse me, in total for
17 those three years. This type of bill potentially null
18 and void. And that's on a voluntarily program. So this
19 type of bill where you can't even require it on a
20 voluntarily basis potentially takes that \$7 million and
21 says, "Well, you get to pay it instead of save it."

22 We've asked for information from all of our
23 vendors, and the fiscal note is due on Monday, the 27th.
24 So our plan is to submit our data tomorrow.

25 EXECUTIVE OFFICER HAYCOCK: I think -- for
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1 the record, Damon Haycock -- I think it's pretty obvious,
2 but PEBP -- the PEBP staff recommend opposing this bill
3 because it prevents PEBP and the Board from managing the
4 plan. AB 381 revises provisions governing prescription
5 drugs covered by policies of health insurance.

6 This one prevents insurers like PEBP from
7 being able to move a prescription drug between tiers,
8 going from a lower tier or like a preferred tier to a
9 non-preferred tier during the middle of the year, and it
10 forces us to have to make that decision at the end of the
11 year. And what concerns that we have here is that
12 oftentimes, pharmacy benefits managers like Express
13 Scripts, who is with us today, they will often change the
14 tier of a drug because something bad has happened. And
15 we don't want people to actually have to continue taking
16 those drugs, and we want to dissuade them from taking
17 certain drugs for patient safety.

18 There's also -- and I'm overgeneralizing it.
19 Naomi (phonetic) is here to talk a more about it if you
20 guys want, but it also prevents things like midyear
21 generic issues. So when a drug during the middle of our
22 plan year goes generic, we want people to use generics.
23 And unless they have a specific situation where they
24 can't, and we recognize that, we have things for that, we
25 have rules for that. There's no reason to continue to

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1 accepted for emergency services for out-of-network
2 hospitals and their out-of-network physicians to be paid
3 at either the greater of the in-network negotiated rates
4 or 125 percent of Medicare. So it's basically allowing
5 health plans to not have to pay more, which we wouldn't.
6 We'd pay usual and customary, but what happens is they
7 balance bill the member.

8 And so this right here says they have to
9 accept the greater of the in-network negotiated rates or
10 125 percent of Medicare. So the providers aren't going
11 to really like this, but our participants that end up
12 having to go to out-of-network places, I think, will.
13 We're still reviewing the bill for impact. There are
14 still some concerns, especially when it comes to
15 ambulatory services, but we have this one again pitched
16 out to our partners.

17 And at this point in time, we're not
18 recommending any position on it. We think we want to
19 keep an eye on it, and if you want us to be for it, we
20 can, but we don't think that there's really anything bad
21 about this bill today.

22 We also have AB 408. AB 408 has a companion
23 bill, which is Senate Bill 394, which I'll talk about at
24 the end just because this is the chronology of these, but
25 they're both basically saying the same thing. They are

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1 providing provisions relating to Medicaid and health
2 insurance that follow along with what the Affordable Care
3 Act has done. And so if the Affordable Care Act is
4 repealed, this is -- and I'm going to give an opinion,
5 right, not fact. This is my opinion that that is our
6 state trying to protect the provisions of the Affordable
7 Care Act in case it was repealed. It has stuff like
8 allowing your children to stay on your plan until you're
9 26. It has benefits that we must cover maternity and
10 newborn care. We still have to do preventive benefits at
11 a hundred percent. We can't exclude people because of
12 their health status or what happened to them during the
13 year. We can't discriminate, that we can't have
14 out-of-pocket lifetime limits and/or not out-of-pocket,
15 but the plan can have lifetime limits.

16 A lot of the things that the Affordable Care
17 Act had put in place as patient protection is what they
18 receive announced in this bill, and they did it in both
19 houses. So they did it in AB 408 and Senate Bill 394.
20 PEBCP was asked if we wanted to put a fiscal note on
21 there. We're doing the stuff today. And so at this
22 point in time, we don't feel we should put a fiscal note
23 on the idea that if it goes away, we'd have to absorb all
24 of these costs when they're already absorbed today,
25 they're already built into our rates, they're already

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1 built into the rates you guys just approved earlier
2 today.

3 And so we feel that this bill, I mean, if you
4 want to take a political stance to say we support it or
5 you want to just take no stance, we don't believe that
6 there's anything at this point wrong with either of
7 these, Senate Bill 394 or AB 408.

8 Senate Bill 366, that one is more of a
9 reporting requirement. It's kind of interesting. I'd
10 love to find out what was the catalyst of this bill
11 because it requires insurers who provide health insurance
12 to us on a contract, i.e. our HMOs, to give us basic
13 utilization data. And in the past, I think we haven't
14 always received the data that we were looking for or that
15 we hadn't requested it or it wasn't delivered. But when
16 we signed the latest round of HMO contracts, we kind of
17 preempted this law and made sure we were going to get
18 that data and get it on a monthly basis.

19 And so for the most part, the only issue that
20 we've heard so far from our HMOs is that -- which to be
21 completely candid, it kind of concerns me, is that their
22 issue is they're afraid that they don't have the required
23 statistician on staff to verify their numbers. I'm a
24 little worried about that, to be honest with you. If you
25 don't have a statistician, where are you getting your

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1 numbers from? But we can work with our HMOs, and maybe,
2 hopefully they've got actuaries, right? Hopefully,
3 they've got the right numbers. But we're looking at this
4 not being too much of an effect on PEBP. And if it just
5 forces those people we contract with to report to us
6 regularly, we're all for it. But we don't think there's
7 going to be an impact to PEBP on this bill.

8 I already talked about 394, but I'm going to
9 go to AB 382, which is or -- sorry, I did that one. So
10 394, we talked about.

11 Last, we're going to talk about Senate Bill
12 404, and this one revises provisions relating to health
13 insurance coverage of certain cancer treatment drugs. If
14 passed, it forces PEBP to disregard step therapy and
15 precertification for certain cancer treatments.

16 Now, they specifically outlined if you're
17 already in stage 4 cancer and they give some other
18 issues, right, it's in the bold statements here. If you
19 have meta- how do you say that word?

20 MS. GLOVER: Metastatic.

21 EXECUTIVE OFFICER HAYCOCK: Right. Metasta-
22 whatever, that word, cancer including, with limitation
23 stage 4, I think the intent of this bill was don't make
24 folks that are already advanced in cancer have to go
25 through these various steps before they get the drug that

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1 they need.

2 The concern, though, is that potentially,
3 some of the drugs that can be utilized are experimental
4 and investigational, and our plan right now prohibits
5 those. And so if it turns out that those types of
6 investigational or experimental drugs are approved, we
7 won't have any controls around it. We won't know if
8 they're safe. We won't necessarily know. It's supposed
9 to be approved by the FDA, so they did put that in there,
10 but again, we do have a patient safety concern. And
11 then, of course, anytime you take away our cost control
12 mechanisms, we need to put a fiscal note. And we reached
13 out to Express Scripts, we reached out to our TPA's to
14 find out what that looks like.

15 At this point, I wouldn't recommend
16 necessarily opposing this bill and watching it and at
17 least until we see what the fiscal impact because I think
18 the idea of this bill is to try to help folks not jump
19 through hoops to get the treatment they need, but by
20 holding our hands tied, it prevents us from providing,
21 again, patient safety and cost controls to our plan.

22 With that, all of that stuff, I will take any
23 questions on any bills that you have and then we'll be
24 looking to see if you have any new positions on old bills
25 that we've already taken motions on or if you have new

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1 positions on new bills that you would like us to take.

2 CHAIR CATES: Thank you, Damon.

3 Any questions or comments from the members?

4 Nobody?

5 Go ahead.

6 MEMBER VERDUCCI: Tom Verducci for the
7 record. In reviewing these, I would say that in my
8 opinion, that we should continue to be opposed with SB
9 289 and also oppose AB 352 and maybe 381, just based on
10 increased costs in the program.

11 We made a lot of decisions today to reduce
12 costs in the program, and I think that just to be safe
13 going forward, that we don't reduce costs and then we
14 have new bills that come in and increase costs at the
15 same time. We want to be able to sustain the changes
16 that we've made today. So my opinion would be to oppose,
17 continue to oppose SB 289 and to oppose AB 352, 381 --
18 yeah. SB 289, AB 352, and AB 381.

19 CHAIR CATES: Okay. Thank you.

20 Any further comments?

21 Is that a motion?

22 MEMBER VERDUCCI: Mr. Chair, I can turn than
23 into a motion unless there's input. Either way there.

24 CHAIR CATES: So your motion is to continue
25 opposition to SB 289 and to be opposed to AB 352 and 381;
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1 correct?

2 MEMBER VERDUCCI: Yes. That is correct,
3 Mr. Chairman.

4 CHAIR CATES: Okay. We have a motion.
5 Is there a second to the motion?

6 MEMBER LAMBORN: I second the motion. Leah
7 Lamborn for the record.

8 CHAIR CATES: Okay. We have a motion and a
9 second.

10 Any discussion on the motion?

11 Go ahead, Jim.

12 MEMBER GARCIA: Mr. Chair, this is Rosalie
13 Garcia.

14 CHAIR CATES: One minute, Rosalie.

15 Go ahead, Jim.

16 MEMBER WELLS: Thank you, Mr. Chairman.

17 The governor's office has made it merely
18 clear that agencies are not to take positions of
19 opposition or favor and testify in the neutral position
20 with the fiscal impacts that are related to the
21 particular legislation.

22 So for that reason, I would be voting no on
23 taking a motion to either oppose or testify in favor of
24 any legislation.

25 CHAIR CATES: Thanks, Jim.
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1 As a fellow director, I would take the same
2 position. And hopefully, I won't be called upon to break
3 a tie. I won't vote on this anyway, but good point.

4 MEMBER ANDREWS: Anna Andrews for the record.

5 So does that apply to me as well since --

6 CHAIR CATES: As your director, you can vote
7 however you choose. I think we're serving as board
8 members, and I think if you as a board member want to
9 take a position with your fellow board members, that's
10 fine.

11 So we have a motion and a second.

12 Any further discussion? Oh, I'm sorry.

13 Rosalie, go ahead.

14 MEMBER GARCIA: There you are.

15 I do not recall having taken a position on
16 any of these before.

17 Had we?

18 EXECUTIVE OFFICER HAYCOCK: For the record,
19 Damon Haycock. These are the new bills that you guys
20 have not taken a position on, so 289, I don't believe you
21 have taken a position on it. I'm trying to remember the
22 date. What was our meeting? It was on March 9th. So
23 this one came out after, as well as AB 352 and AB 381.
24 And so these are bills to gain any new positions on. And
25 if that needs to be clarified, let's clarify it now.

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1 MEMBER GARCIA: Okay. I just wanted to
2 confirm that because the vote is on continuing. I
3 believe the word "continuing" was in there. It just
4 could be a nuance.

5 MEMBER VERDUCCI: Tom Verducci for the
6 record.

7 So as far as SB 289, we should drop the word
8 "continue" and we should oppose it, in my opinion.

9 CHAIR CATES: Thank you.

10 I assume that's okay with the second?

11 MEMBER LAMBORN: Yes.

12 CHAIR CATES: Okay. Any further discussion
13 on the motion?

14 MEMBER COCHRAN: Mr. Chairman, this is Chris
15 Cochran in Las Vegas.

16 CHAIR CATES: Yes, go ahead.

17 MEMBER COCHRAN: Can we confirm?

18 On 289, did we vote to oppose that bill? I
19 thought we -- we did not? Did we not oppose that bill
20 two weeks ago? I'm getting confused here because -- I
21 just want to make it clear.

22 EXECUTIVE OFFICER HAYCOCK: For the record,
23 Damon Haycock.

24 Dr. Cochran, you had not seen this bill
25 before. This came out after you guys made your initial
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1 assessments, and so this is a new reading, and that's why
2 Mr. Verducci has taken out the "continuation" from his
3 motion.

4 MEMBER COCHRAN: Okay. And also then, as
5 board members and as State of Nevada taxpayers, we do
6 have the opportunity to discuss these bills with our own
7 legislators. I'm also uncomfortable with the Board
8 taking positions beyond the fiscal notes that are
9 requested from PEBP. I think that's what we should
10 instruct staff to do, is to provide the fiscal notes, and
11 they've been asked to do that anyway. I don't know that
12 we need to do that. But if we have certain positions on
13 these bills, that you contact your legislator.

14 CHAIR CATES: Okay. Thank you.

15 I need to back up for a minute, and I'm
16 looking at legal counsel here, making sure. We have a
17 motion. We're discussing the motion. But I failed to
18 ask for public comment.

19 I'd like to ask for public comment at this
20 time, if that's okay.

21 MR. BELCOURT: That would be okay. Dennis
22 Belcourt for the record.

23 CHAIR CATES: Okay. Thank you.

24 So do we have any public comment on this item
25 in Carson City?

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1 MR. ERVIN: Kent Ervin, Nevada Faculty
2 Alliance. I'm reading in the duties, policies, and
3 procedures of PEBP adopted in April 2016 in the section
4 on board responsibilities.

5 "Board members are entrusted with the
6 responsibility of ensuring efficient administration of
7 program in accordance with all applicable laws and
8 regulations and shall" -- and there's several items --
9 Item No. 5 says, "Shall take a position on any proposed
10 legislative matters affecting the program and direct
11 agency employees to make that position known to the
12 legislature."

13 I think you have a fiduciary responsibility
14 to take positions on items that affect the participants
15 in the program. That's really what you're here for. If
16 individuals have a conflict of interest because of their
17 employment with the State, I don't know how you square
18 that with "shall take a position," but that's your own
19 procedures. I suppose anyone can abstain. But to me,
20 "shall take a position" means favor oppose or neutral,
21 not just not take a position if it does affect the
22 program, which is the stipulation.

23 We do have some comments on some of the other
24 bills, but I just wanted to bring that for this
25 discussion right now.

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1 CHAIR CATES: Thank you. Appreciate that.
2 Any other public comment on this agenda item?
3 Anyone in Las Vegas?

4 MEMBER ZACK: Mr. Chair, it's Kristine.

5 CHAIR CATES: Go ahead.

6 MEMBER ZACK: Mr. Chair, Kristine. Sorry.
7 My microphone keeps switching off. Kristine Zack for the
8 record. I think that we should investigate whether or
9 not the language is correct that we shall take a
10 position. And if it is, I think we should table this to
11 either a future meeting or call to give us all enough
12 time to do our due diligence on our fiduciary duties as
13 well as on each of the individual bills.

14 CHAIR CATES: Okay. Thank you for that.
15 Any further comments?

16 MEMBER COCHRAN: Mr. Chair, Chris Cochran
17 again.

18 CHAIR CATES: Go ahead.

19 MEMBER COCHRAN: Just one last thing. If it
20 is found that we have the ability to do this, I would
21 prefer that whatever bills we're going to consider, we
22 consider them individually and not consider them as a
23 group of bills because we may support one bill and not
24 support the other. So I think if we're going to do this,
25 they probably need to be taken individually.

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1 CHAIR CATES: Okay. Thank you.

2 MEMBER ANDREWS: Mr. Chair?

3 CHAIR CATES: Go ahead, Anna.

4 MEMBER ANDREWS: Anna Andrews for the record.

5 The only question I have, and this would be
6 for Tena and Damon, is that if we do not take a position
7 or whatever, how could that affect the fiscal notes? Do
8 you have a deadline to submit those, or can you wait?
9 Like if you follow Ms. Zack's proposition that we wait or
10 table it, how does that work?

11 EXECUTIVE OFFICER HAYCOCK: So for the
12 record, Damon Haycock. The fiscal notes process is going
13 to exist regardless. We are asked, as a state agency, to
14 determine fiscal impact to the state, and we must -- we
15 feel it is our due diligence.

16 I believe what Mr. Ervin just read does not
17 say that PEBP will not submit any fiscal notes until the
18 Board makes a position. You can take a position and not
19 have a fiscal note. You can have a fiscal note and not
20 have a position on a bill. And I think no position,
21 unfortunately, is a position because it's the absence of
22 a position and you chose not to take one.

23 But the concern that I would just provide the
24 Board here to think about when you table certain things
25 is we had -- you guys were, I believe, opposed last
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1 meeting to the contraceptive bill for patient safety and
2 other issues, and then they'd already scheduled the
3 committee before we had a chance to talk about it. And
4 so if we table this for a couple of weeks, we may miss
5 the window to get up to the table. And if you don't give
6 me a position, I'm not going to go to the table and say,
7 "This is how PEBP feels."

8 And so if there's something that you really
9 oppose or you're really for, I suggest you take those
10 positions as soon as you feel comfortable in a public
11 meeting so that way we can accurately and appropriately
12 share your positions to the legislature. We will
13 continue to provide those fiscal notes regardless.

14 CHAIR CATES: Thanks for that. And I didn't
15 close public comments.

16 Peggy, why don't you go ahead.

17 MS. LEAR BOWEN: Thank you.

18 My name and my words for the record;
19 P-E-G-G-Y, L-E-A-R, B-O-W-E-N. And this is just a
20 cautionary reminder. That you are not any entity or
21 spokesperson regarding any of these matters except for
22 your clients, us. You are our voice. That's why I've
23 gone to the table at the legislature and emphatically
24 requested that you remain separate not advisory because
25 we need to have a voice to our employer where we can meet
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1 in a public way to put forth the information and our
2 needs and our wants and our directives so that there is
3 another voice coming to rather than just an
4 administrative voice or those for whom they don't walk in
5 our shoes, they don't live our lives for us, they have an
6 administrative -- and not putting it good, bad or
7 indifferent -- they have goals that they need to meet,
8 and we have goals that we need to meet, and you are our
9 voice to meet them. And that's why I think that you do
10 have to say in public what you accept or don't accept
11 whether it's administratively.

12 I've seen people sit at this table over the
13 years and put their jobs on the line to say what we, the
14 constituents, ask them to say. And they did that at
15 great peril to themselves, but they had the courage to do
16 it. And I understand that you all have certain positions
17 in your jobs, in your employment, and for the sanctity
18 and safety for your family, and that puts a really,
19 really tight tightrope that you have to walk. And people
20 do it because they choose to and choose to serve. And
21 from the bottom of our souls, thank you for serving, but
22 don't diminish our voice by having it be impacted by
23 other concerns at this point.

24 You have to remember your goal and your duty,
25 and I don't think you need to go weighted time or delayed
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1 time or anything else. We need your voice available for
2 us at that legislature tomorrow. Not in two weeks. Not
3 at any other time. So that's just my comment. You guys
4 are the Jiminy Cricket and the conscience of the state
5 insured, and we need you there with no strings attached
6 to anything else other than conveying the voice of the
7 people you represent. Thank you very much.

8 CHAIR CATES: Thank you.

9 With that, I'll close public comment, bring
10 it back to the committee.

11 Do we have a motion and a second?

12 MEMBER GARCIA: Mr. Chair?

13 CHAIR CATES: Go ahead.

14 MEMBER GARCIA: Rosalie Garcia.

15 My question is with regard to voting on any
16 of these bills, PEBP is going to submit fiscal notes on
17 certain ones, and I would find it difficult to submit a
18 vote without knowing what that fiscal note is. That's my
19 opinion.

20 CHAIR CATES: Yeah, this is Patrick. You
21 know, my thoughts, having been through a few sessions, is
22 we always really try to separate the fiscal note piece
23 from the policy piece. And it's very common for agencies
24 to submit a fiscal note for a bill, but they don't have a
25 position. It's not that it necessarily makes bad policy,
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1 it's just that there's a cost to that policy.

2 And so we always try to separate those two
3 issues. And you can be opposed to a bill that doesn't
4 have any fiscal impact and vice versa, and that's just
5 kind of the way we've always tried to approach it.
6 They're really two separate things. The fiscal note --

7 MEMBER GARCIA: Okay.

8 CHAIR CATES: -- kind of speaks for itself.
9 It's silent opposition. It's opposition with dollars.

10 MEMBER GARCIA: All right. Very good. Thank
11 you.

12 CHAIR CATES: Thank you.

13 MEMBER ZACK: Mr. Chair, Kristine Zack.

14 CHAIR CATES: Go ahead.

15 MEMBER ZACK: And the NRS on point says the
16 Board may make recommendations to the legislature
17 concerning legislation that it deems necessary or
18 appropriate regarding the program. So there might even
19 be a conflict between the NRS and what was just read to
20 us, and this is why I'm really urging that we table this
21 and perhaps even get an opinion, a legal opinion.

22 CHAIR CATES: Do you have any opinion?

23 MR. BELCOURT: Dennis Belcourt, deputy
24 attorney general. I think the duties, policies, and
25 procedures would be an implementation of statutory and/or
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1 regulatory authority. I think you'd want to reconcile
2 them to the extent they are reconcilable.

3 I think the "shall" may be interpreted a
4 little less peremptorily and "shall" would come forward
5 and make recommendations as you see fit. So I don't
6 think you're -- I mean, certainly, you don't have to make
7 a recommendation as to each and every piece of
8 legislation that is pending in the legislature. It might
9 affect your program. So I think you have discretion over
10 which items you take a position on.

11 CHAIR CATES: Okay. Thank you for that.

12 Any further comment?

13 Given how wide ranging the discussion is, I'm
14 not sure how the vote is going to go on this. If this
15 doesn't pass, maybe we'll want to take them one at a
16 time. If there aren't any other questions, I'll call for
17 a vote. All of those in favor of the motion, say aye.

18 THE BOARD: Aye.

19 CHAIR CATES: All of those opposed?

20 MEMBER WELLS: No.

21 VICE CHAIR BAILEY: No.

22 MEMBER COCHRAN: No.

23 MEMBER ZACK: Nay.

24 MEMBER GARCIA: No.

25 CHAIR CATES: So what was the tally?
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1 EXECUTIVE OFFICER HAYCOCK: For the record,
2 could we just do a roll call vote to make sure so we can
3 have Carrie call each person and their votes so we don't
4 miss this?

5 CHAIR CATES: Yes.

6 EXECUTIVE OFFICER HAYCOCK: Thank you.

7 MS. PEDROZA: Anna Andrews?

8 MEMBER ANDREWS: Aye.

9 MS. PEDROZA: Don Bailey?

10 VICE CHAIR BAILEY: No.

11 MS. PEDROZA: Chris Cochran?

12 MEMBER COCHRAN: No.

13 MS. PEDROZA: Rosalie Garcia?

14 MEMBER GARCIA: No.

15 MS. PEDROZA: Leah Lamborn?

16 MEMBER LAMBORN: Aye.

17 MS. PEDROZA: Tom Verducci?

18 MEMBER VERDUCCI: Aye.

19 MS. PEDROZA: Jim Wells?

20 MEMBER WELLS: No.

21 MS. PEDROZA: Kristine Zack?

22 MEMBER ZACK: No.

23 MS. PEDROZA: That is five noes.

24 CHAIR CATES: Okay. Thank you.

25 The motion fails.

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1 Any more discussion or motions?

2 MEMBER COCHRAN: Mr. Chairman, this is Chris
3 Cochran. I am not opposed to taking these bills up one
4 at a time, if that's how we want to do it. I don't know
5 if we need to have a special session in order to do that,
6 but my no vote reflects primarily taking collective
7 actions on bills.

8 We are relying on staff input in order to
9 make these decisions based on what staff has informed us
10 the status of these bills. And as such, I think they
11 need to be taken up independently. And I frankly
12 wouldn't mind having a fiscal note when we consider that
13 because I think that is part of the responsibility,
14 particularly the fiduciary responsibility we would have
15 as a board.

16 CHAIR CATES: Thank you for that.

17 Any further comments?

18 MEMBER VERDUCCI: Tom Verducci for the
19 record. I would agree on taking each bill individually.
20 I don't know if that should be done today or perhaps as a
21 follow-up on a teleconference call.

22 CHAIR CATES: If leave it up to the
23 committee, if anybody wants to make a motion.

24 I guess I would echo -- it was Damon that
25 echoed that the concern that if we delay and table these
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1 things, don't take positions, the legislation moves very
2 fast and we may miss the opportunity. That's the only
3 comment I'd have about deadlines.

4 MEMBER VERDUCCI: Tom Verducci for the
5 record. My suggestion is we take up each bill separately
6 now. It's fresh in our mind, and we've gone through it.
7 If we have time permitting.

8 CHAIR CATES: Okay. Sounds reasonable to me.

9 VICE CHAIR BAILEY: For the record, I echo
10 Tom's words. I think we should take them up
11 independently, and I'd rather see physical notes, but on
12 the other hand, we can't get them, and we are running out
13 of time.

14 CHAIR CATES: Very good.

15 Does anybody want to make a motion on an
16 individual bill? I don't think we need to discuss each
17 one in turn.

18 MEMBER VERDUCCI: Yes, Mr. Chairman. I'll
19 make that motion that we take each individual bill
20 individually.

21 CHAIR CATES: Okay. You'd like to start at
22 the top of the list?

23 MEMBER VERDUCCI: Yes, sir.

24 CHAIR CATES: And take a vote on every one?

25 MEMBER VERDUCCI: Yes.

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1 CHAIR CATES: Okay. Let's do that.

2 AB 249? I guess I need somebody to make a
3 motion. I think it's kind of hard to go through every
4 single one one at a time and take a vote without a
5 motion. I think what I'd prefer is if somebody wants to
6 oppose a bill, if somebody wants to take a position on a
7 bill, make a motion on that specific bill rather than go
8 through each one and try to do it a vote on ones that
9 nobody is interested in taking any position on.

10 Does that make sense?

11 MEMBER VERDUCCI: Yes.

12 MEMBER LAMBORN: I'm ready to make a motion.

13 CHAIR CATES: Go ahead.

14 MEMBER LAMBORN: Thank you, Mr. Chair.

15 Leah Lamborn for the record. I make a motion
16 that we, the PEBP board, opposes AB 249.

17 CHAIR CATES: AB 249.

18 So we have a motion to oppose AB 249.

19 Do we have a second?

20 MEMBER ANDREWS: Anna Andrews. Second.

21 CHAIR CATES: Okay. We have a motion and a
22 second.

23 Any discussion on the motion? Sorry. I'm
24 trying to get to the page. All right. I'm with you.

25 We're on the same page now. We have a motion and a
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1 second.

2 Any discussion on the motion?

3 Go ahead, Jim.

4 MEMBER WELLS: Mr. Chairman, I would prefer
5 that we take a neutral position and allow staff to
6 provide testimony as to the policy and fiscal impacts of
7 the piece of the legislation under this agenda item. I
8 will not vote in favor of or opposed to a position.

9 CHAIR CATES: Okay. Any other comments on
10 the motion?

11 MEMBER ZACK: Mr. Chairman, Kristine Zack.

12 CHAIR CATES: Go ahead.

13 MEMBER ZACK: I agree with Jim.

14 CHAIR CATES: Okay. Any other comments?

15 EXECUTIVE OFFICER HAYCOCK: May I add
16 something?

17 CHAIR CATES: Go ahead.

18 EXECUTIVE OFFICER HAYCOCK: For the record,
19 Damon Haycock. From a personal I'm-up-at-the-table
20 standpoint, I really like being able to say we are
21 neutral. It's traditionally what state agencies do when
22 they go to the table, and then they share some of their
23 concerns such as it's an unfunded mandate, it's going to
24 cause us some heartburn here, we're concerned about
25 safety patient there, but we allow our fiscal note to

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1 really dictate how we feel because it's the math, and
2 then we share the concerns, or I would be very willing to
3 share the concerns with the Board on any of the policies.

4 But throwing out there in opposition,
5 especially on AB 249, which is supported very highly by
6 both houses, and I think what they're just trying to do
7 is to protect women's rights for contraceptives, and
8 there's some interesting language that needs to be
9 revised, obviously. But I think if we have the ability
10 to show up neutral and then share our concerns, our
11 fiscal note by themselves traditionally will share, as
12 you have stated, Director Cates or Chairman Cates, the
13 silent opposition to bills. And that's what I've been
14 able to do, at least in my 12-year career with the State,
15 is we testify neutral and then we share a fiscal note,
16 and that often wins the day.

17 CHAIR CATES: Thank you, Damon.

18 Any other comments on the motion?

19 VICE CHAIR BAILEY: I've got a comment on his
20 comment.

21 CHAIR CATES: Go ahead.

22 VICE CHAIR BAILEY: For the record, Don
23 Bailey. Well, dang it, I understand that, but we're not
24 going to get fiscal notes. So should we stay neutral on
25 every bill?

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1 MS. GLOVER: So this is Celestena Glover for
2 the record.

3 The first couple of bills on the list, we do
4 have the fiscal notes. Those are the things I was
5 talking about earlier, so if you need them repeated, I
6 can do that. It's the new bills that we haven't
7 submitted the fiscal notes on yet. They're not due until
8 Monday and Tuesday for those particular ones, but
9 anything that has been requested prior to today, they're
10 in because of the due dates were a few days ago. So
11 maybe that will help.

12 CHAIR CATES: Go ahead.

13 MEMBER VERDUCCI: Mr. Chairman, it would be
14 my opinion that this motion be amended for us to take a
15 neutral position.

16 CHAIR CATES: Do we have a second to amend
17 the motion?

18 MEMBER LAMBORN: I made the motion.

19 CHAIR CATES: Oh, you made the motion, right?

20 MEMBER VERDUCCI: So her's would have to be
21 withdrawn first.

22 CHAIR CATES: She'll have to be willing to do
23 that.

24 MEMBER LAMBORN: Leah Lamborn for the record.

25 I withdraw my previous motion on opposing AB 249.

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1 CHAIR CATES: Okay. So now we don't have any
2 motion at all on the table.

3 Go ahead, Tom.

4 MEMBER VERDUCCI: Tom Verducci for the
5 record. I'd like to make a motion we take a neutral
6 position on AB 249.

7 CHAIR CATES: Okay. We have a motion to take
8 a neutral position on AB 249.

9 Do we have a second?

10 VICE CHAIR BAILEY: Don Bailey. Second.

11 CHAIR CATES: Okay. We have a motion and a
12 second.

13 Any discussion on the motion?

14 MEMBER LAMBORN: Mr. Chairman, Leah Lamborn
15 for the record.

16 I have a concern just making a motion to go
17 neutral without providing any comments or how the
18 testimony would be. I mean, neutral, but we provide
19 testimony kind of one way or the other. The fiscal note
20 speaks for itself, but even though there's a fiscal
21 impact, it doesn't necessarily mean you're opposing the
22 bill. It could be a good thing, it just costs money.

23 So can we -- I don't really know how to go
24 about it, but if we go neutral, do we add any comments of
25 what we would like to be heard through testimony?

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1 Concerns?

2 CHAIR CATES: Yeah, I think that's a
3 legitimate point. I'm not sure the value of going
4 neutral on a bill without some sort of commentary.
5 Otherwise, it's no different than not taking a position
6 at all, I would think.

7 Damon, do you have any thoughts on that?

8 EXECUTIVE OFFICER HAYCOCK: Yeah. For the
9 record, Damon Haycock.

10 Without direct language from the Board, I was
11 going to summarize your concerns about patient safety,
12 the ability to appropriately manage plans through step
13 therapy and any prior authorization as well as the
14 potential fiscal impact on the plan. And that's close to
15 word for word what I would tell them, is that the Board
16 has taken a neutral stance, but we do have some concerns
17 about the following. And that's pretty much throughout
18 this entire process, that if you wish to take a neutral
19 stance, I will echo the conversations that take place at
20 these board meetings to share the concerns of the Board.

21 CHAIR CATES: Okay. Thank you.

22 That helps. Okay.

23 Any other discussion on the motion?

24 Seeing none, I'll call for a vote. All of

25 those in favor of a neutral stance on AB 249, please
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1 signify by saying aye.

2 BOARD MEMBERS: Aye.

3 CHAIR CATES: Opposed?

4 MEMBER COCHRAN: No.

5 CHAIR CATES: One no. The motion carries.

6 MEMBER GARCIA: I will abstain.

7 CHAIR CATES: Very good.

8 So we got through one bill. I don't see the
9 point of going and hitting every single bill unless
10 there's a desire to take a position. I'd say if any
11 member wants the Board to take a position, make a motion
12 on whatever bill on this list you would like to, and
13 we'll work from there. I don't think we need to take a
14 vote on every single one.

15 Any discussion? Motions?

16 MEMBER LAMBORN: Mr. Chair?

17 CHAIR CATES: Go ahead.

18 MEMBER LAMBORN: Leah Lamborn for the record.

19 I know in our prior conversation we had made a motion, it
20 passed for SB 139 on the patient-centered medical homes.

21 Now that the language has been changed from must or
22 "must" to "may," it sounds like we're going to go neutral
23 on all of the bills, positions, but anyhow, I just wanted
24 to get on record that we'd opposed that, but now I think
25 it we've gone neutral on it but which apparently we're

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1 going to do anyhow.

2 CHAIR CATES: Well, I wouldn't say we're
3 going to do it anyhow. I don't think our position would
4 change unless we voted to change it.

5 MEMBER LAMBORN: Okay. Well, I would like to
6 make a motion to change our position on SB 139 from
7 opposed to neutral.

8 CHAIR CATES: Okay.

9 MEMBER LAMBORN: Based on the language in the
10 amendment.

11 CHAIR CATES: Thank you.

12 Do we have a second to that motion?

13 MEMBER ANDREWS: Anna Andrews. Second.

14 CHAIR CATES: Okay. We have a motion and a
15 second to change our position on SB 139 from opposed to
16 neutral.

17 Any discussion on the motion?

18 Seeing none, I'll call for a vote. All of
19 those in favor of the motion, say aye.

20 THE BOARD: Aye.

21 CHAIR CATES: All opposed?

22 MEMBER GARCIA: No.

23 CHAIR CATES: The motion carries.

24 Any other brave souls wish to take a position
25 on these bills or make a motion to take a position on
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1 these bills?

2 MEMBER LAMBORN: I would just like to, if I
3 may.

4 CHAIR CATES: Go ahead.

5 MEMBER LAMBORN: Mr. Chair, I don't know
6 about a motion, but I would just like to have a
7 discussion on SB 366 where any testimony provided from
8 PEBP on behalf of Board and the members that we support
9 this, or I do believe that this would be good for
10 oversight of any agency that has oversight of health
11 insurance costs and a program, it would be very good to
12 have this data on a regular basis. So I think we should
13 support that or our testimony should be in support that I
14 think it would be a benefit to the program.

15 CHAIR CATES: Okay. Is that a motion?

16 MEMBER LAMBORN: No, as just you're
17 testifying and conversation, I mean, we aren't taking
18 motions on these, right?

19 CHAIR CATES: We can take a motion on it. If
20 we want the Board to take a position on any of these
21 bills that we've not previously taken a position on,
22 somebody needs to make a motion to do that, and we need
23 to vote on it. Otherwise, there's no position.

24 MEMBER LAMBORN: Okay.

25 EXECUTIVE OFFICER HAYCOCK: For the record,
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1 Damon Haycock. Without a position taken, I can't go up
2 to the table and share your position. I can't share the
3 concerns because I have no position to take. I wouldn't
4 know to go for, against, or in neutral position. And I
5 don't want to assume that you've taken a neutral position
6 and hurry up to the table if you guys haven't provided me
7 that guidance. And so I would really -- if you want me
8 to go to the table and some of these deserve that, I
9 would really like a motion and a Board direction so I'm
10 not confused as to exactly what you guys want me to do
11 with the legislature.

12 MEMBER LAMBORN: Okay. Then in that case --
13 Leah Lamborn for the record -- I would like to make a
14 motion that the PEBP board supports SB 366 in support of
15 management, oversight, and the ability to do projections
16 in the future.

17 CHAIR CATES: Okay. Do I have a motion to
18 support SB 366? Do we have a second?

19 MEMBER VERDUCCI: Tom Verducci for the
20 record. I'd second.

21 MEMBER COCHRAN: This is Chris Cochran.

22 CHAIR CATES: Chris, I think Tom beat you to
23 it.

24 MEMBER COCHRAN: That's fine.

25 CHAIR CATES: So we have a motion and a
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1 second.

2 Any discussion on the motion to support SB
3 366?

4 Hearing none, I'll call for a vote. All of
5 those in support of the motion, signify by saying aye.

6 THE BOARD: Aye.

7 CHAIR CATES: Opposed?

8 MEMBER WELLS: No.

9 CHAIR CATES: The motion carries. Okay.
10 Any other takers? Any other bills you want
11 to discuss?

12 Go ahead, Tom.

13 MEMBER VERDUCCI: Tom Verducci for the
14 record. I'd like to discuss AB 389, prescription drugs
15 that are covered. And my concern would be the increase
16 in costs, management costs, and we do not know the fiscal
17 impact at this point, and my suggestion would be to take
18 a neutral position without Damon having the ability to
19 testify at the legislature.

20 CHAIR CATES: That was, I'm sorry, 389?

21 VICE CHAIR BAILEY: 289.

22 CHAIR CATES: Oh, I'm sorry. 289.

23 VICE CHAIR BAILEY: That's a motion.

24 MEMBER VERDUCCI: That would be AB 381. AB
25 381.

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1 CHAIR CATES: 381.

2 MEMBER VERDUCCI: Governing prescription
3 drugs. Now, it does not allow PEBP to manage their own
4 funds, which would add a dramatic fiscal cost to the
5 plan.

6 CHAIR CATES: I apologize.

7 So your position was? That was a motion?

8 MEMBER VERDUCCI: Yes, sir, Mr. Chair. That
9 would be a motion to take a neutral position on AB 381.

10 CHAIR CATES: Okay.

11 VICE CHAIR BAILEY: For the record, Don
12 Bailey. I second that motion.

13 CHAIR CATES: Okay. Thank you.

14 So we have a motion and a second.

15 Any discussion on the motion?

16 Hearing none, I'll call for a vote. All of
17 those in favor of the motion, say aye.

18 THE BOARD: Aye.

19 CHAIR CATES: All of those opposed? The
20 motion carries. Any other discussion or motions?

21 Any motion, it's better to take these one at
22 a time or just throw it out there for whoever wants to
23 make a motion, but here we are.

24 EXECUTIVE OFFICER HAYCOCK: For the record,
25 Damon Haycock. We're going to, as we submit fiscal
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1 notes, shoot them out to the board. My apologies for not
2 having that done sooner. So once we get it submitted and
3 it's in the system and it's out of our hands, we will
4 ensure that you have the most up-to-date information to
5 assess your fiscal impact of that specific bill.

6 We don't have the ones for the new ones
7 today, obviously, because we're still gathering data and
8 we want to make sure that we are as accurate as possible
9 in the fiscal notes because we will get called on why we
10 put certain numbers in there. That's why we don't have
11 that information to you available to you today.

12 At our last telephonic conference, we had
13 that information available and we were able to walk
14 through those fiscal notes. So again, this is really the
15 timing of 204 bills hitting my personalized legislative
16 tracker at 11:00 p.m. on Monday night, and I apologize
17 for that, but we did not have enough time to create
18 fiscal notes for this board meeting.

19 CHAIR CATES: Thank you, Damon.

20 Any other comments from the Board? Motions?

21 Go ahead, Tom.

22 MEMBER VERDUCCI: Thank you, Mr. Chair.

23 Tom Verducci for the record.

24 I wanted to discuss Assembly Bill 352,
25 requiring us to accept prior authorization. And since
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1 that takes away our decision-making ability and it also
2 jeopardizes patient safety, I am suggesting since we
3 managed our own plan, that we take a neutral position on
4 AB 352.

5 CHAIR CATES: Okay. Do we have a second?

6 That was a motion or a comment? That was a
7 motion; correct?

8 MEMBER VERDUCCI: That was a motion.

9 CHAIR CATES: Okay. Thank you.

10 Do we have a second to that motion to take a
11 neutral stance on AB 352?

12 VICE CHAIR BAILEY: For the record, Don
13 Bailey. I second that motion.

14 CHAIR CATES: Okay. We have a motion and a
15 second.

16 Any discussion on the motion?

17 Hearing none, I'll call for a vote. All of
18 those in favor of the motion, signify by saying aye.

19 THE BOARD: Aye.

20 MEMBER COCHRAN: Mr. Chair?

21 CHAIR CATES: I'm sorry. Go ahead. Hang on
22 a second. Go ahead.

23 MEMBER COCHRAN: Okay. So we're taking --
24 this is Chris Cochran for the record -- we're taking a
25 neutral position on this. There are no future scheduled
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1 meetings for this particular bill? This has not been
2 draft called up? Is that correct?

3 EXECUTIVE OFFICER HAYCOCK: For the record,
4 Damon Haycock.

5 Dr. Cochran, yeah, this thing has been read
6 for the first time Monday on the 20th. It has not been
7 scheduled as of yet. The scheduling does sometimes come
8 fast and furious, but we don't have any notification as
9 of right now that there has been a scheduled committee
10 meeting for this.

11 MEMBER COCHRAN: Okay. So all right.
12 Because this is something that actually I can support.
13 So I'll just go ahead and let the motion go through the
14 vote.

15 MEMBER GARCIA: Mr. Chair, this is Rosalie
16 Garcia.

17 CHAIR CATES: Go ahead.

18 MEMBER GARCIA: I'm sorry. I could not fully
19 hear what Member Verducci said with regard to why we
20 would want to take a neutral stance.

21 Could that be repeated?

22 MEMBER VERDUCCI: Yes. Tom Verducci for the
23 record.

24 As I read this, it requires PEBP to accept
25 decisions on preauthorization from other providers, so
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1 we're not making the decision ourself as opposed to what
2 we're doing, is we're accepting another provider's rules,
3 and it doesn't give us the ability to make proper
4 decisions. We're just accepting. And also, the issue of
5 patient safety would be in jeopardy, and cost controls
6 are nullified with this bill, so we're accepting
7 decisions that somebody else is making which could result
8 in dramatic cost increases.

9 MEMBER GARCIA: Thank you.

10 This is Rosalie Garcia again.

11 Why would we take a neutral position instead
12 of an opposing position?

13 MEMBER VERDUCCI: Tom Verducci for the
14 record.

15 I think the neutral position allows Damon to
16 be able to get in front of the legislature and let them
17 know what the issues are, and it's not quite as
18 aggressive as an opposing position. I personally oppose
19 it, but I think it's a little friendlier with the neutral
20 stance.

21 MEMBER GARCIA: Ah, got you.

22 We're being politically correct. Okay.

23 Thank you.

24 CHAIR CATES: Any other discussion on the
25 motion?

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1 Seeing none, I'll call for a vote. All of
2 those -- sorry.

3 Go ahead. Go ahead.

4 MEMBER COCHRAN: That's okay. Go ahead. Do
5 the vote.

6 CHAIR CATES: Okay. All of those in favor of
7 the motion, signify by saying aye.

8 THE MEMBERS: Aye.

9 CHAIR CATES: Opposed?

10 MEMBER ZACK: No.

11 MEMBER COCHRAN: No.

12 CHAIR CATES: It sounds like the motion
13 carries.

14 Any other takers?

15 VICE CHAIR BAILEY: I have a question.

16 CHAIR CATES: Go ahead.

17 VICE CHAIR BAILEY: For the record, Don
18 Bailey.

19 This is for Damon and Stan.

20 In your earlier presentation, SB 394, AB 408,
21 and AB 382 recommended approval or a yes vote?

22 EXECUTIVE OFFICER HAYCOCK: For the record,
23 Damon Haycock. Thank you, Vice Chair Bailey.

24 We're saying we don't have a problem with
25 this bill. We don't think that there's any concerns, at
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1 least from a fiscal standpoint. And I'm talking about
2 the Affordable Care Act requirements being built back
3 into the state law.

4 From a fiscal standpoint, we are doing this
5 today. These rules are already in our master plan
6 document, so we don't see a new net effect. We don't
7 necessarily feel that we need to go up there and say that
8 we're for this bill, but we can't find a reason with
9 staff today to find to be opposed to this bill. And so
10 we could do nothing, we can just watch it and report back
11 to the Board. And at our telephonic and our regular
12 board meetings, if you would like us to go and show some
13 support to it, we can, or some not support to it, we can
14 take a -- you can take a neutral stance and give me some
15 marching orders. I you can go up there and say we like
16 this or you can take a firm supportive position and we
17 can get up there when they say, "Who is in support of the
18 bill?" And PEBP can sit up there and say PEBP supports
19 this bill.

20 So you have options. We're not asking for a
21 specific position on this one. We really wanted to ask
22 for positions on bills that scared us, not ones that we
23 feel that are probably going to go just fine without us,
24 but it's your call, sir.

25 VICE CHAIR BAILEY: Okay. Can I ask another
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1 question?

2 CHAIR CATES: I just want to make a comment.
3 "Firm and supportive" sounds like a mattress. Just
4 trying to break it up a little.

5 VICE CHAIR BAILEY: I'm trying to break it
6 up. I'm trying to move it along, and I was wondering if
7 we could take those three bills and put them in a neutral
8 motion and let the Board -- let the staff answer the
9 questions for us at the hearings. That was a question,
10 Damon.

11 EXECUTIVE OFFICER HAYCOCK: For the record,
12 Damon Haycock.

13 We can do whatever it is that you would like
14 us to do, Mr. Bailey. We can get up there and share your
15 guys' opinions on these bills and take them all as a
16 group and say you want us to be neutral and we'll just
17 share the discussions that were had at these board
18 meetings to include what was said today.

19 VICE CHAIR BAILEY: Well, let's see what the
20 Board thinks.

21 CHAIR CATES: So we've had some objections to
22 taking them a block of bills. I'm not sure where the
23 votes are on that.

24 VICE CHAIR BAILEY: Okay. All right.
25 Withdraw my question.

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1 CHAIR CATES: Go ahead.

2 EXECUTIVE OFFICER HAYCOCK: For the record,
3 Damon Haycock.

4 The only bill that's left that really
5 concerns PEBP is Senate Bill 289. Senate Bill 289 makes
6 us pay higher rates to nonnetwork providers, and it
7 really paralyzes our ability to control costs. If you
8 don't want to take an opposition, we would love to have a
9 neutral so I can get up there and share how bad of a bill
10 that we feel this is.

11 CHAIR CATES: In a neutral fashion.

12 EXECUTIVE OFFICER HAYCOCK: In a neutral
13 fashion.

14 CHAIR CATES: Go ahead.

15 MEMBER VERDUCCI: Tom Verducci for the
16 record.

17 I've been staring at this SB 289. It's the
18 last one that I wanted to comment on. And because it
19 requires certain policies of health insurance covered
20 services provided by an out-of-network physician, we lose
21 the ability of managing our own plan. There would be a
22 fiscal impact, and I think that we should take a neutral
23 stance to allow Damon to be able to testify on this bill
24 at the legislature.

25 CHAIR CATES: Okay. Is that a motion?
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1 MEMBER VERDUCCI: Yes, Mr. Chairman.

2 CHAIR CATES: Okay. Do we have a second to
3 the motion to be neutral on SB 289?

4 MEMBER ANDREWS: Anna Andrews for the record.
5 Second.

6 CHAIR CATES: Okay. We have a motion and a
7 second.

8 Any discussion to the motion?

9 MEMBER GARCIA: Yes.

10 CHAIR CATES: Go ahead.

11 MEMBER GARCIA: I'm sorry. This is Rosalie
12 Garcia.

13 Just a little discussion with regard to SB
14 289, is that there are aspects of this bill that I would
15 support. I think that it's really, at this point, kind
16 of vague. I, of course, don't like the idea that
17 out-of-network physicians would be reimbursed at higher
18 rates, but I do support the position that members would
19 have flexibility in their health insurance.

20 There was another thought I wanted to say,
21 but now it just flew away. There it goes. But that's
22 all. That's all I have right now.

23 CHAIR CATES: Okay. Thank you.

24 Any other comment on the motion?

25 Hearing none, I'll call for a vote on the
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1 motion. All of those in favor of the motion, signify by
2 saying aye.

3 THE BOARD: Aye.

4 CHAIR CATES: All of those opposed?

5 MEMBER LAMBORN: No.

6 CHAIR CATES: One no? Okay. The motion
7 carries.

8 Anybody else got any bills they want to
9 discuss or take a motion on?

10 Hearing none, I think we'll go ahead and
11 close this agenda item.

12 So now we're onto Item No. 8: Executive
13 Officer Report.

14 Damon?

15 EXECUTIVE OFFICER HAYCOCK: Thank you,
16 Mr. Chairman. Damon Haycock for the record.

17 In this iteration of my Executive Officer
18 Report, I want to highlight a few things. One, that the
19 Plan Year 2018 out-of-state network change, if you recall
20 back, I believe it was either May or June of last year,
21 HealthSCOPE provided the Board a report on some
22 cost-saving activities and opportunities.

23 One of those was to switch from the first
24 health network to the Aetna network. That is for those
25 folks that reside outside of Nevada. It was

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1 approximately 810 people, and they were hoping that we
2 may be able to save, if all claims were equal from the
3 year prior, about \$2 million, so it was kind of a
4 no-brainer for a great cost-saving opportunity.

5 We recently had HealthSCOPE audited as they
6 are every quarter for claims, and I asked the health
7 claim auditor, Bob Carr, to investigate what the actual
8 results were for the first half of the year, and he came
9 back and showed that we saved close to \$870,000 already
10 in the first six months. And so this is something that
11 we feel is a good thing and that we want to continue, and
12 so I asked HealthSCOPE. I said, "Well, what about the
13 folks in Nevada that live and work in Nevada and then
14 travel outside of Nevada? What about the savings that
15 could be garnished or created from switching to the
16 network for those people?" Because this network actually
17 has higher net work fees, but it has significantly better
18 discounts. So it's a trade-off, but as you can see,
19 we're \$870,000 already for the out-of-state folks now.

20 What would it look like if we were to take
21 last year's claims and rerun them through and reprocess
22 them through the Aetna network as if they were our
23 network, and they came back and said that would have
24 saved you another \$850,000. And so to make things
25 simple -- we've had confusion before from either our

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1 vendors or from our participants, what network do I use
2 when I'm outside of Nevada? We would like to move
3 everybody over or we plan to move the rest of the network
4 to the Aetna network and to basically no longer provide
5 the First Health Network.

6 And for those that weren't part of when the
7 original HealthSCOPE contract was signed, they actually
8 responded to our RPF with the Aetna network. So this
9 isn't a change in scope. We weren't able to, at that
10 time, guarantee the data integrity and protection, but
11 now Aetna has been able to come back and satisfy those
12 requirements, and so we believe that this is another way
13 to save money in the upcoming year, and we want to
14 definitely take active steps to perform that and then
15 send out new ID cards because of it.

16 So to summarize because people always ask,
17 "Well, are you doing now?" The bottom of the first page,
18 you see that this is our PPO networks utilized for our
19 consumer-driven health plan. We have the Hometown Health
20 in Northern Nevada, we have Sierra Health-Care Options in
21 Southern Nevada, and now we'll have that one singular
22 network of Aetna outside of the state, and we think this
23 is a great idea and it's going to save us money and it's
24 going to, as you heard from public comment, hopefully be
25 well-received by our participants. I haven't personally

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1 heard a single complaint of the folks living outside
2 using this network today.

3 We're going to be providing overflow call
4 center training. In the last open enrollment, we
5 utilized Morneau Shepell, our eligibility enrollment
6 vendor, to help as we get those influx of calls, and so
7 we want to ensure that we can continue to improve
8 customer satisfaction and we can reroute those calls that
9 are -- make sure that those calls don't get rerouted back
10 to PEBP for certain things that really our overflow call
11 center should be able to handle, and so we're going to
12 send a couple of staff out to Pittsburgh, Pennsylvania,
13 to provide in-person training to ensure that they are
14 ready to receive the calls from our membership. We're
15 going to do that next month.

16 As far as diabetes care management, we have
17 come to a decision with our Hometown Health utilization
18 management case management group that they had amended
19 the contract or we amended the contract with them back in
20 2015 to have them pick up diabetes care management
21 because the outgoing vendor, I think it was USPM that was
22 doing it for us, was no longer going to be available, and
23 so Hometown Health stepped up and provided that option
24 for us, and we signed a contract.

25 We struggled a bit with being able to
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1 transfer data and, really, we've come to a group decision
2 that there's probably a better way to do this, and we're
3 going to shift it over to HealthSCOPE benefits. That's
4 why you saw, in the NDP changes today, some information
5 about what are the requirements because HealthSCOPE has
6 graciously accepted performing these services to us at no
7 additional cost, and so we're looking at still taking
8 care of these folks and providing that value-based
9 insurance design co-pay process to really insure folks
10 get the diabetic supplies and drugs that they need and
11 really clean up some of the enrollment issues and data
12 integrity issues that we had been experiencing with our
13 previous vendor.

14 The preventive drug benefit list has been
15 finalized. It's attached to this report, so when people
16 say "What drugs are going to be on it," you'll see as an
17 I attachment, this is the list for 2000- really for Plan
18 Year 2018, and that's what we're going to move forward.
19 You'll notice that there are no diabetes drugs on there.
20 There was public comment at the legislature saying, "Why
21 don't we do preventive drugs for diabetes?" It's because
22 we do it for diabetes care management, and it's a better
23 benefit on diabetes care management. It costs the
24 participant less. And so we're not going to duplicate
25 that when we have a disease management program that we

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1 part of this. He wanted to be at this board meeting, but
2 he got called to Vegas and so he couldn't, but he was
3 planning to be here to introduce himself as well. So I
4 think you're going to see a little bit more of him.

5 And so in conclusion, we're continuing to
6 analyze these programs. We are a looking for
7 cost-effective solutions, but we're also trying to insure
8 highest level of access and quality while still
9 maintaining affordability. Today was one of those days
10 where I didn't have to be the bad guy and tell you that
11 we're cutting benefits and doing bad things, so it was a
12 good day for me, but I want you all to know that every
13 day when we come to work here, PEBP staff try very hard
14 and often succeed at finding high-quality cost-saving
15 situations that really propel us forward, so that way we
16 can have more meetings like today and we can protect
17 benefits and we can offer opportunities, and we are very
18 cognizant of what is occurring with the federal
19 marketplace or the federal rules and regulations.

20 We know that the Affordable Care Act may be
21 repealed and replaced, but no one has a crystal ball at
22 this point place to determine what will occur, but at
23 this point, we feel that we are positioned rather
24 conservatively, and we will continue to monitor that as
25 we move forward and present more information to the

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1 Board.

2 With that, I'll take any questions.

3 CHAIR CATES: Any questions from the members?

4 MEMBER ANDREWS: Mr. Chair?

5 CHAIR CATES: Go ahead.

6 MEMBER ANDREWS: Anna Andrews for the record.

7 I think I know the answer, but Damon, could you -- I know
8 that under the preventive drug benefit list, the second
9 paragraph at the very bottom of the page is talking about
10 the Smart90 Network.

11 Could you just refresh from our minds so that
12 we know exactly? Thank you.

13 EXECUTIVE OFFICER HAYCOCK: Yes, of course.

14 Thank you, Andrews. This is Damon Haycock for the
15 record.

16 I appreciate that. I did gloss over that,
17 and I wanted to definitely describe what occurred. Back
18 in January, I recommended that we move to this network
19 because there would be a cost savings. However, based on
20 conversations with our pharmacy benefits manager, in
21 order to implement this thing effectively to guarantee
22 the cost savings, we needed to implement it across the
23 program as a whole.

24 And at that time, with all of the changes
25 that we're providing our program participants, right,
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1 we're adding an alternate HMO plan, we're going to add
2 this preventive drug benefit, we're going to do a change
3 to HSA and the preventive program. I just felt at the
4 time that it wasn't worth making a major program change
5 and recommending that you all approve it when it turned
6 out that we had the money to keep the benefits that we
7 had, and so everything that you've seen today in the
8 rates discussion, this program is fully funded without
9 having to use the Smart90 Network. I think it's the
10 right answer. I think it's the right answer for PEBP and
11 for Nevada. I just don't know if it's the right time to
12 add to the already plethora of changes that we're going
13 to be rolling out in July, and so that's why we're
14 backing away from that at this point, but you're going to
15 see this come back in November when we talk about changes
16 for the following year.

17 MEMBER ANDREWS: Thank you.

18 CHAIR CATES: Thank you.

19 Any other comments from the members?

20 Seeing none, we'll close that agenda item,
21 move onto Agenda Item No. 9: Discussion and possible
22 action regarding Tower's Watson's OneExchange's service
23 improvement plan.

24 MR. GARCIA: Chris Garcia with Tower's
25 Watson's OneExchange for the record.

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1 Again, Board, thank you again for the
2 opportunity to come to you and present this information
3 on our service improvement plan. This update is as of
4 March 8th, and there's a few updates that I want to go
5 through with you that I think are interesting and you'd
6 like to hear.

7 So the first thing that we'd like to talk
8 about is our HRA on-site assistance program. So that
9 program has now been live for six months. With that HRA
10 assistance program, we have our HRA team specialist
11 available to assist Nevada PEBP retirees for one week per
12 month starting in September of last year at the office
13 here in Carson City. We're tracking the number of
14 appointments that Stacie Nelson is taking. She's our HRA
15 team specialist that is on-site, and we are tracking the
16 number of appointments that she's taking as well as the
17 number of walk-ins, and we've gone through the stats from
18 September, October, November, and December in the past,
19 but we've had the stats for January and February. And
20 when you look at the stats for January and February,
21 you'll see that they really didn't increase too much.
22 They stayed about level.

23 January was a little bit of a decrease, and I
24 think there were some weather concerns up here in
25 Northern Nevada at that time. So I think that played a
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1 part into it. I did get the stats recently. Stacie was
2 here last week, and I got the stats from her earlier
3 today from the number of appointments and walk-ins that
4 she had, and so it's good to see that it actually
5 increased for March, we had 20 appointments last week and
6 we had one walk-in. So we're seeing that increase, so I
7 think the January/February, the weather probably played a
8 part into that, so we're obviously going to continue to
9 track that.

10 We have the weeks that she's going to be
11 available here in Carson for April, May and June, those
12 are listed below. And I think overall, the program is
13 going really well. We've got a lot of great feedback
14 from some of the retirees here, from RPEN, and we
15 continue to look forward to having her up here on a
16 weekly basis once per month.

17 In February, we did retiree meetings in Las
18 Vegas that were focused on the HRA. We did a retiree
19 meeting on February 27th in the morning and then followed
20 by that, we did one-on-one appointments, and then we did,
21 on February 28th, we did a full day of one-on-one
22 appointments that were available to retirees to come and
23 actually speak with Stacie as well as another HRA
24 assistant person specialist that came up to assist her.

25 For the retiree meeting that occurred in the
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1 morning, we had over 50 participants that attended that
2 meeting. For the one-on-one meetings, there were 10
3 one-on-one meetings on the 27th and then 25 one-on-one
4 meetings on the 28th, so the participants had questions
5 that changed from submitting a claim or how to submit a
6 claim to what expenses are eligible for reimbursement, so
7 they ran the gamut of different types of services that
8 the HRA provider or general questions that you would
9 receive regarding the HRA. So overall, these meetings
10 were successful, especially with the individual
11 appointments and having that large number of individual
12 appointments available on the 28th.

13 Upcoming, we have our spring retiree meetings
14 in Las Vegas, Carson City, and Reno, so we're going to
15 host a couple of retiree meetings during the following
16 days and locations that are listed below. There will be
17 two meetings per day, one focusing on the participants
18 that are aging into Medicare and then the other focusing
19 on participants that is are already Medicare eligible.
20 So in Las Vegas, it will be on April 5th; Carson City, on
21 April 6th; and in Reno on April 7th.

22 We have -- Stacie Nelson will be there.
23 She'll have an assistant with her as well as we will have
24 Debbie Nelson, who is our transitioning meeting
25 specialist, and she comes in and actually leads those

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1 meetings and goes through that presentation with those
2 retirees, so we're looking forward to those. We do those
3 twice a year, typically in the spring and then again in
4 the fall right before the open enrollment season for
5 Medicare.

6 We do have an upcoming communication that we
7 wanted to make the Board aware of. That communication is
8 an HRA refresh communication that's going to be mailed
9 out to participants during the month of April. The
10 reason that we're doing this mailing -- there's a couple
11 of different reasons that we decided to do this mailing
12 now. One is we realized that many retirees, when they
13 first became eligible for their HRA, they received their
14 welcome kit for their HRA. That could have been four or
15 five years ago, right? And so we felt that it was time
16 to do a refresh communication. We know that there are
17 people that are leaving money on the table as far as they
18 are not submitting claims, they're not utilizing their
19 HRA, and this purpose of this communication is to remind
20 participants how to effectively utilize their HRA funding
21 account so they can be reimbursed for their eligible
22 expenses. So this is a refresh communication. It's
23 going to talk to them about how they can get a
24 reimbursement for their premiums, we're going to look at
25 auto reimbursement and recurring reimbursement options

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1 that they could have for claims that they don't have auto
2 reimbursement available for them, making them aware that
3 they have out-of-pocket expenses that they can receive
4 reimbursement for.

5 It's interesting. A lot of retirees aren't
6 aware that they can receive reimbursement for dental or
7 vision expenses, so making them aware of those types of
8 expenses, and then providing tips of on how to
9 effectively submit their reimbursement request so that
10 they're not denied. So that's going to be a key part of
11 that communication as well.

12 So those are the updates I wanted to provide,
13 and I'll answer any questions.

14 CHAIR CATES: Thank you, sir.

15 MR. GARCIA: Thank you.

16 CHAIR CATES: Any questions from the
17 committee?

18 Go ahead.

19 VICE CHAIR BAILEY: For the record, Don
20 Bailey.

21 Chris, how do you feel Tower's Watson's feels
22 to the membership? How is that relation? Has it gotten
23 a lot better?

24 MR. GARCIA: I think that -- for the record,
25 Chris Garcia.

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1 So, Mr. Bailey, absolutely, I think that our
2 relationship has improved. Going from last year into so
3 last open enrollment season, we had extremely long wait
4 times. And so this year, we're not seeing those long
5 wait lines. That was a big improvement. We talked about
6 that during our last season. Having Stacie here once for
7 an entire week for one week out of the month has been an
8 improvement for the north. Bringing those retiree
9 meetings back down to the south, Las Vegas, we just did
10 in February, that opened up those lines of
11 communications. I personally have gone to RPEN meetings
12 in Las Vegas as well. I went there last summer, and we
13 did a presentation of an RPEN meeting there. So I think
14 we're developing those relationships again, and I think
15 we're starting to see that turn around.

16 In the quarterly, our quarterly report that
17 was earlier in the presentation that you have, we have
18 our customer satisfaction results, and those actually
19 increased. We've seen an increase and an uptick,
20 especially when you compare last open enrollment season
21 to this past open enrollment season. So quarter four of
22 2015 to quarter four of 2016, we saw an increase in that
23 customer satisfaction. So we sent out a survey to
24 participants giving them the opportunity to give us
25 feedback, and we saw that uptick there as well.

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1 VICE CHAIR BAILEY: And the wait time has
2 improved?

3 MR. GARCIA: Absolutely.

4 VICE CHAIR BAILEY: Because that's a big
5 point.

6 MR. GARCIA: So if you look at the back of
7 the presentation, I do have running stats for our wait
8 times on a monthly basis.

9 VICE CHAIR BAILEY: I did read it.

10 MR. GARCIA: We added, of course, January and
11 February. I don't have March's, of course, yet. January
12 is a bit busier of a month. If you look back at January
13 of this year, we had an average wait time of almost two
14 minutes, which for January, because it's the start of the
15 new calendar year, it is a busy time.

16 If you go back and look at the prior January,
17 January 2016, it was over six minutes wait time. We did
18 see a significant decrease from one year or the next.
19 But in February, we were less than half a minute wait
20 time. So as it slowed down, those wait times decreased.
21 We have decreased abandoned calls. We had five abandoned
22 calls in all of February for PEBP. So an abandoned call
23 would be somebody calling in waiting for something to go
24 through the automated system. Now they're in the cue to
25 wait to speak to somebody, and if they hang on for a

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1 couple of minutes and they drop off, that would be
2 considered an abandoned call. So we only had five of
3 those, whereas in prior months, we've seen significant
4 abandoned calls.

5 During open enrollment season, December of
6 2015, we had over a thousand abandoned calls, so it's
7 definitely much improved historically going back and
8 looking at the same periods in the past.

9 VICE CHAIR BAILEY: Okay. Good. Thank you,
10 Chris.

11 MR. GARCIA: You're welcome.

12 CHAIR CATES: Any other comments?

13 Go ahead.

14 MEMBER VERDUCCI: Chris, thank you very much
15 for coming in. I know you're coming in from out of
16 state.

17 MR. GARCIA: I'm in Vegas.

18 MEMBER VERDUCCI: Thanks for coming up.

19 CHAIR CATES: That's out of state depending
20 on where you're from.

21 MEMBER VERDUCCI: Chris, I'm a little
22 concerned with retirees that might be a little bit
23 elderly and they don't know what claims are covered and
24 some are falling through the cracks.

25 Can you expand a little bit on the auto
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1 reimbursement?

2 MR. GARCIA: Absolutely. I'd be happy to.
3 So auto reimbursement is where we have relationships set
4 up with our carriers, and about 90 percent of our
5 carriers have plan or have a file set up with us where
6 they send us the premiums that somebody pays for on that
7 file, and we load that file to their HRA accounts as a
8 claim. Now they have to select to turn on that
9 functionality with that by the participant. The person
10 has to contact us and select to turn on auto
11 reimbursement.

12 The benefit to have that is the claim comes
13 from the carrier after they pay it, so the participant
14 will pay the carrier for the premium. Let's say it's a
15 \$150 premium. We get that on a file about two weeks
16 later, maybe a month later, depending on the carrier,
17 that file comes over to us. We load that to their HRA,
18 and as long as they have a balance in their account, we
19 will reimburse them for that claim.

20 Now, with the way that PEBP is structured
21 with your monthly allocations that we receive for your
22 HRA, you may have somebody who has a zero balance on
23 their account because they're exhausting their funding
24 every month. That claim will still load, and it will be
25 approved pending allocations. So the allocations will

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1 then come in, and then we will process that
2 automatically. We won't be waiting for a claim to be
3 submitted by the retiree to reimburse them. So we highly
4 recommend participants sign up for auto reimbursement if
5 they have it as an available option for them.

6 There are those retirees that don't have auto
7 reimbursement available because it's part of the plan
8 that they selected, and they have the choice then of
9 doing what's called a recurring premium reimbursement
10 where it's a form that they fill it once a calendar year
11 for that claim, and they'll send us documentation to
12 substantiate that claim, and then we will go ahead and
13 set up an automatic payment once a month at the beginning
14 of the month for that reimbursement for that calendar
15 year.

16 So if they do it in June, it will last until
17 December. And then January of the new year, they'll have
18 to resubmit the form. And we do that just in case the
19 premium amount changes. We don't want to reimburse them
20 for a lower premium than what they could get, or maybe
21 the premium actually decreased, and then we would be
22 reimbursing them for a higher amount.

23 So there are two options there. So both of
24 them are viable options, depending on the preference of
25 the participant. The participant doesn't have to do auto

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1 reimbursement. They could instead select to do the
2 recurring premium reimbursement and do that form, if they
3 choose to.

4 MEMBER VERDUCCI: How do they decide if
5 they're going to do auto reimbursement? Are there
6 announcements and advertisements from the carriers?

7 MR. GARCIA: So it's typically discussed
8 during the enrollment that they have when they initially
9 enroll in the plan. So if they are an aging-in retiree,
10 and they have that initial conversation with one of our
11 benefit advisors, the benefit advisor will discuss that
12 functionality with them. Again, it's such a -- they're
13 going through -- most enrollment calls are about an hour
14 and 15 minutes long. I don't know if many people know
15 that, but I've seen them go as long as three and a half
16 hours where a participant is speaking with a benefit
17 advisor brand new to Medicare, they don't understand it,
18 they want to get as much information as possible. So
19 they're getting a lot of information at one time, and the
20 last thing they're probably concerned about is their HRA
21 and auto reimbursement. It doesn't make any sense to
22 them. So some people think about it and they will then
23 call us back later on and turn it on.

24 The way that we're trying to communicate that
25 to them outside of that initial enrollment period is with
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1 communicate to those participants later this year,
2 probably closer to the is start of open enrollment.
3 That's still being reevaluated at this time, but because
4 we were doing this additional communication, they decided
5 to table the auto reimbursement communication at this
6 moment.

7 MEMBER VERDUCCI: Good stuff. Thank you very
8 much.

9 MR. GARCIA: You're welcome.

10 CHAIR CATES: Any other comment or questions
11 from the members?

12 Thank you, sir.

13 MR. GARCIA: Thank you.

14 CHAIR CATES: We'll close Agenda Item No. 9
15 and move onto Agenda Item No. 10: Public comments.

16 Do we have any public comments in Carson
17 City?

18 MR. HARRIS: Jack Harris. I'm the state
19 president, Retired Public Employees of Nevada. And I'd
20 just like to follow up on a couple of comments about the
21 -- Chris had brought up about OneExchange.

22 Very quickly going back -- and I know there's
23 some members -- Mr. Wells was here, I think Mr. Bailey's
24 been in the process since the very beginning, I know

25 Nancy Spinelli has been on and PEBP staff has been on the
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1 process. We've come a long ways, you know, for many,
2 many years for many times, it seems like we never had
3 anything positive to say. It was always negative. But
4 we've come a long ways and kind of answering my question
5 of following up on the importance.

6 In the beginning, there really was very
7 little communication. It was finally after about three
8 years and coming up for renewal that Tower's Watson's,
9 OneExchange whatever we call it at that time, came
10 forward after a legislative -- interim legislative
11 meeting and said, "You know, we need to sit down and we
12 need to talk" because we are addressing concerns,
13 bringing the same concerns over and over and over, and
14 they were kind of falling on deaf ears. That started the
15 process. I know there's ones in the room. Elaine was
16 one of them. There's ones down in Las Vegas, members of
17 our organization that we've sat down with Tower's
18 Watson's staff hours and hours and hours giving their
19 concern.

20 In fact, we had a meeting, I happened to have
21 a meeting with John Seacrest, he's the vice president in
22 charge of the customer service element. I think he
23 thought it was going to be a short dinner meeting, but it
24 lasted -- Chris was there. It lasted over three hours of
25 us addressing our concerns. And when I look through the

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1 service improvement plan, most of those, many of those
2 have been addressed. At least they're around the table
3 now and we're following. It's important.

4 It's important when Damon and Laura took the
5 trip back to Salt Lake City. It was important when the
6 Board came forward, you know, initially said, "We have
7 need to have an improvement plan. We need to have on
8 paper what are the problems, how are we addressing them."
9 And it's important that this Board and many of the new
10 members have taken it and followed up and continued to
11 follow up on it because the improvement plan is not going
12 to go away.

13 Again, we look forward to -- in April, it
14 will probably be my 12th or 13th or maybe 14th time that
15 I've sat through the enrollment process or I've sat
16 through the reimbursement process. Over the years, that
17 has become as greatly improved, and maybe it's because
18 being an educator, a teacher, an administrator, we kind
19 of put it together to people who can understand it.

20 Nancy has gone out into the field out into
21 the hither lands and brought the message out here. And
22 there are things that we're going to continue to work on.
23 The communication part of it, that's something that we
24 still need is the concern, getting information out.

25 There's what we call the seminar that you put on the
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1 video, they're talking about putting one of those
2 together, working on that so we can get the message to
3 those who can't get to Carson City or can't get to Reno
4 or Las Vegas.

5 So I don't know if it's a positive for
6 Tower's Watson's, but we're going to continue to be
7 there, and we're going to continue to bring -- as I found
8 out in my career, concerns -- when you solve one concern,
9 you identify it, you bring the solution, there's another
10 one that comes up. So we've come a long ways. We still
11 have a difference, and Chris and I've talked about this,
12 what constitutes wait time? When the phone is answered
13 or when you talk to a customer service person?

14 But to give you an example, is that now when
15 we make the phone call, you're going to get a PEBP
16 representative, somebody that's identified with the PEBP
17 program. When we first started this, we found out that
18 when you called somebody, they might have had 12
19 different states that they were dealing with or 12
20 different clients that they were dealing with.

21 So we appreciate what Tower's Watson's has
22 done. We look forward to working with them in the
23 future. And again, as a resource, I think they feel that
24 we're a valuable resource. I know PEBP has always felt
25 that we are a valuable resource. I think our value is

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1 because we're the ones that are living through this
2 system, this process.

3 And I just want to go back one thing on what
4 Mr. Bailey said, that as we go out into the state and we
5 go to the different chapters, I find very, very few that
6 really want to go back to the old system. Once you got
7 into the system, once we got into the exchange, there's a
8 lot of advantages to it that we have as retirees. I know
9 that those in the rural areas would like to have more
10 choices because they're very limited on their choices.
11 Sometimes they only have two. Thank you.

12 CHAIR CATES: Thank you, sir.

13 MR. ERVIN: Kent Ervin, Nevada Faculty
14 Alliance.

15 Again, I'd like to thank you for the actions
16 that you took today on rolling back some of the --
17 restoring some of the enhancements.

18 A couple of points. The discussion we had
19 about the ability of the Board to take positions, I
20 think, does bring up a broader issue of when Board
21 members have other responsibilities that conflict with
22 their duty to do due diligence and fiduciary for the plan
23 and participant, that's a problem. And maybe through the
24 reincarnation of SB 80, that's something that could be
25 addressed, but I really do see that as a problem that the

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1 Board members ought to -- regardless of their
2 employment -- ought to be able -- when they're on this
3 body, be able to work for the program and, you know,
4 that's your job.

5 The other thing I wanted to mention was that
6 Laura Rich and Dr. Steven Zell came to UNR's Faculty
7 Senate and made a presentation on Zell's new program for
8 primary care graduate education which was very well
9 received. It's on a grant, so it's free for the first
10 year and can be done through the normal billing
11 procedures. They're already a provider, but the idea of
12 almost a concierge service of you have a physician, you
13 can call after hours, lots of extra services, but
14 ultimately, containing costs at some level, we hope. So
15 certainly excited about that possibility, and Dr. Zell
16 happens to be my own physician, so I'm going to be happy
17 to take them up on that program. Thank you very much.

18 CHAIR CATES: Thank you.

19 MS. LEAR BOWEN: My name and words for the
20 record; P-E-G-G-Y, L-E-A-R, B-O-W-E-N.

21 Two things, and this is regarding earlier
22 actions that you've already taken and that you might want
23 to vote to reconsider the not handling three bills at one
24 time. I think you said, Mr. Bailey, three bills that
25 were to preserve what was in the Affordable Care Act

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1 within the State of Nevada statutes, and it's things
2 you're already doing, and it's a way to sound your horn
3 and say PEBP has been meeting and done what people have
4 asked for in regards to the Affordable Care Act. And you
5 might want to reconsider that not taking a body of three
6 that were the things that we didn't consider and
7 reconsider it right now before you leave so that
8 Mr. Haycock can speak to the legislature and do it in a
9 neutral position just like he would do the others that
10 you've brought on and show how PEBP has been responsive
11 and reactive and has it within their plan, and we've been
12 doing it for years, and so it doesn't have -- didn't have
13 a fiscal impact or anything, if I remember what you said,
14 and it gives you a chance to say and do what you can do.

15 And I think because of how the discussion
16 was, that the only thing you need to reconsider is
17 closing that item on the agenda and you just reopen that
18 item and ask permission of the maker of one bill at a
19 time, "Could you please put those three together?" and
20 move forward as a neutral position and show that PEBP is
21 responsive in hearing what their members say and
22 responsive to the law of the land and doing their due
23 diligence and just being wonderful. That was one part of
24 what I wanted to say.

25 And the second part, only because I was a
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1 little concerned in people -- in what you were going over
2 rather rapidly in what was material in actions, and I
3 heard something about where care could be provided when
4 you were discussing about the changes and things that
5 were on the -- I'm sorry. Two and a half hours of sleep
6 does not bode well for me. When you were talking about
7 what my concern is, is there anything in any of the new
8 plans or anything that you're working on that would limit
9 we up in the north from going to not only Renown but also
10 to Northern Nevada Hospital? I want to make sure that we
11 at least have two places to consider going and that we
12 are not going to be even more constricted as to where we
13 can seek service. And that is a major concern to me.
14 And so that was my only other.

15 And I hope that you all have a good Easter
16 and have a beautiful day. And just for the good of the
17 order, yesterday, the 36th state in the union became the
18 36th state to ratify the ERA.

19 CHAIR CATES: Thank you.

20 Any other comment in Carson City?

21 Any comment in Las Vegas?

22 Seeing none, I will go ahead and close Agenda
23 Item No. 10, and I think with that, we are adjourned.

24 (The meeting concluded at 3:33 p.m.)

25 -o0o-
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1 STATE OF NEVADA,)
2 CARSON TOWNSHIP.)

3

4 I, NICOLE J. HANSEN, Official Court Reporter for the
5 State of Nevada Public Employees' Benefits Program, do
6 hereby certify:

7

8 That on the 23rd day of March, 2017, I was
9 present at said meeting for the purpose of reporting in
10 verbatim stenotype notes the within-entitled public
11 meeting;

12 That the foregoing transcript, consisting of pages 1
13 through 213, inclusive, includes a full, true, and
14 correct transcription of my stenotype notes of said
15 public meeting.

16

17 Dated at Reno, Nevada, this 28th day of
18 March, 2017.

19

20

21

NICOLE J. HANSEN, NV CSR #446

22

23

24

25

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