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

Agenda Item No. 1, roll call.

MS. PEDROZA: Anna Andrews?

MEMBER ANDREWS: Here.

MS. PEDROZA: Don Bailey?

VICE CHAIR BAILEY: Here.

MS. PEDROZA: Chris Cochran?

MEMBER COCHRAN: Here.

MS. PEDROZA: Rosalie Garcia?

MEMBER GARCIA: Here.

MS. PEDROZA: Leah Lamborn?

MEMBER LAMBORN: Here.

MS. PEDROZA: Tom Verducci?

MEMBER VERDUCCI: Here.

MS. PEDROZA: Kristine Zack?

MEMBER ZACK: Here.

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

And Chair Cates?

CHAIR CATES: Here.

MS. PEDROZA: You have a quorum.

CHAIR CATES: Thank you.

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

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

Do we have any public comments here in Carson City?

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

With that being said, there's challenges to always meet, but there's a lot of concerns on the state employees' side as well. We understand you guys try your hardest. But with that being said, state employees, for many, many years, have had the budget balance on their back, and enough is enough. You know, at what point do

we say, "What are we going to do for our state employees?" Is it burdened on this board? Is it burdened on the state government? Is it burdened on the legislators? Who is it burdened on to stop having this budget balanced on the state employees' back?

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

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

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

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

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

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

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

CHAIR CATES: Thank you, sir.

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

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

CHAIR CATES: Thank you.

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

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

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

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

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

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

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

CHAIR CATES: I appreciate your comments.

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

MR. ERVIN: Kent Ervin representing the

Nevada Faculty Alliance, the statewide association of NSHE faculty at all eight institutions.

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

CHAIR CATES: On action items, yes.

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

CHAIR CATES: Okay. Thank you.

Any other public comment in Carson City?

Do we have any public comment in Las Vegas?

MEMBER COCHRAN: Yes.

CHAIR CATES: Go ahead.

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

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

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

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

We know many of our colleagues are postponing utilization of health benefits until they have saved enough money on their HSA to pay for their needed medical treatment. Additionally, they go outside the network for procedures because the doctors they need are not part of the network, thus increasing their out-of-pocket contribution in order to meet the out-of-network deductible. We applaud using the Aetna network, as we

believe it will provide more network options. If the Board chooses to stay with the high-deductible plan, we believe it is extremely important to increase the amount of money in the HSA to prevent an individual --

CHAIR CATES: We just lost the audio.

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

MR. WASDEN: Are you back?

MEMBER COCHRAN: Yes, we can hear you.

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

MEMBER COCHRAN: We'll just continue with comment.

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

Go ahead.

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

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

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

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

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

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

CHAIR CATES: Thank you, sir.

Do we have any other public comment in Las Vegas?

MEMBER COCHRAN: Yes.

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

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

CHAIR CATES: Thank you.

Do we have any other public comment in Las Vegas?

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

That the PEBP Board exists and your good service on it is a great comfort to our state employees, including the UNLV faculty that I represent. We can't express enough our gratitude for the conscientious attention you pay to stewarding our benefits and to the due diligence you bring to these meetings and to this essential task of state government that helps to fulfill its duties and obligations as an employer. And by your service, doing so in the most open, honest, and conscionable manner possible.

The PEBP Board is a public service in the public spirit. And furthermore, the Board, in the service of the governor, provides an essential forum at these meetings at which we can express our views and advocate for our best interests and be assured that we are being heard. Whether at times we agree or disagree, thank you all for listening.

I'm here today to reiterate the position of my constituents regarding possible upcoming legislation that may or may not reach the floor of our legislature during this biennial session. For the last special PEBP board meeting on March 9th, 2017, held to discuss such legislation, I submitted a detailed statement that reviewed, point by point, Senate Bill, SB 80, that would, in effect, take stewardship authority from the PEBP board

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

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

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

In my statement to the Board about SB 80 on March 9th, I cited several examples of states around the nation that are currently litigating abuses and misuses of state funds in very distressing cases, and I won't cite them again now. We can at least take comfort for

the moment that while we still have an authoritative PEBP board with such a diversity of honest, hardworking representatives appointed from -- by our governor from their knowledgeable fields and varying walks of life, that our system is as safe, honest, and effective as it can possibly be in the current social and political climate and circumstances in our state and in our country.

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

CHAIR CATES: Sir?

MR. UNGER: -- which we would --

CHAIR CATES: Sir?

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

CHAIR CATES: Sir, sir, we are at almost four

minutes. I would ask you to please wrap up.

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

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

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

MR. FRANKLIN-SEWELL: Yes.

CHAIR CATES: Go ahead in Las Vegas.

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

CHAIR CATES: Yes, sir. Go ahead.

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

Today, I am not publicly commenting in my role as chair of the UNLV Employee Benefits Advisory Committee. Rather, I'm here to tell you a personal

story. I'm married to a man who has had the human immunodeficiency virus for more than 20 years. The virus went untreated for the great majority of that time since he simply could not tolerate the side effects of the three-drug cocktails often prescribed to treat it. In 2015, he was prescribed a one-pill, once-a-day HIV antiretroviral therapy. Lab tests can no longer detect the virus in his blood, and his body is producing T cells again.

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

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

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

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

CHAIR CATES: Thank you, sir.

MR. WILSON: Good morning.

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

classified staff.

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

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

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

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

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

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

Thank you very much.

CHAIR CATES: Thank you, sir.

Any more public comment in Las Vegas?

MEMBER COCHRAN: No.

CHAIR CATES: Okay. Thank you.

Go ahead in Carson City.

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

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

For the record, I am not part of any OneExchange. I do not have A and B Medicare, and therefore, I am speaking as one who has seen the results of what is going on. But rather than grouse about that today, I want to talk to you about a possible solution. And the solution would be this: In talking with legislators and coming up with a plan, I said, "What if the State of Nevada met its obligations to the folk who worked for them, who put in their 20, 30, 35, whatever

number of years and earned in what was promised to them, an insurance situation when they retire and their abilities" -- "and it's not a gift. Nobody is giving anybody anything. It's pre-earned. It was earned through people working and in place in lieu of salary increases."

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

So you have a situation in which you even have - maybe will have some legislation. Maybe we could encourage you to do some legislation, not as a new bill,

not as a BDR, but working with legislators as an amendment. And coming from you, the Board, makes a lot more sense than coming from me as an individual and saying, "We need to keep our promises to our members in retirement," and to make sure that once they meet that threshold, that the State of Nevada comes forward and does the 20/80 or the 30/70, and that there is no more out of pocket incurred by our members in the situation for that to take place.

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

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

CHAIR CATES: Thank you.

Any other public comment in Carson City?

Seeing none, I will close public comment.

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

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

MEMBER ANDREWS: Mr. Chair?

CHAIR CATES: Go ahead.

MEMBER ANDREWS: Anna Andrews for the record. I have questions and clarifications for the following: 3.41, 3.43, 3.52.

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

MEMBER ANDREWS: 52. And then also I missed the first one, 3.1 on the minutes, there is a date correction that I think applies.

CHAIR CATES: Okay. Are there any other items that any member would like to poll to discuss?

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

CHAIR CATES: Go ahead.

MEMBER GARCIA: I just have a comment. I do have a comment or question on 3.2.

CHAIR CATES: On 3.2? Okay.

MEMBER GARCIA: Yes.

CHAIR CATES: Does anyone have any other items that they would like to discuss?

Seeing or hearing none, let's go ahead and start with 3.1: Approval of the action minutes from January 19th, 2017 Board meeting.

Go ahead, Anna.

MEMBER ANDREWS: Mr. Chairman, Anna Andrews.

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

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

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

Maybe providing.

EXECUTIVE OFFICER HAYCOCK: For the record, Damon Haycock.

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

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

CHAIR CATES: Thank you.

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

Rosalie, I think you called this one.

Do you have a comment?

MEMBER GARCIA: Thank you.

Yes, I did. Some of the findings do not have

a course of action, although they are still findings. I would like to recommend that PEBP staff follow up on all of the findings even though they're not specifically required by a course of action.

EXECUTIVE OFFICER HAYCOCK: For the record, Damon Haycock.

Thank you, Ms. Garcia.

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

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

MEMBER GARCIA: Thank you.

Also, I was wondering if you could lead me to -- I'm referring to Section B, Executive Summary, B2, page B2, the final report just right four pages under "Claims and Appeals" which addresses our timeliness. And

I was wondering if anybody could lead me to some statistics with regard to that particular subject, whether it's historical or current. I just would like to see how we've been, and if we're tracking progressively, how we respond to our appeals.

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

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

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

CHAIR CATES: Okay. Thank you.

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

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

On page 16 of the report, inpatient discharge

information, the header is "First Quarter Plan Year 2017," and then the dates are October 1st through December 31st. I think that's Second Quarter Plan Year 2017.

EXECUTIVE OFFICER HAYCOCK: For the record, Damon Haycock.

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

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

MEMBER ANDREWS: Thank you.

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

Go ahead.

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

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

The question I have for the standard or for Damon or whomever can answer the question is how long

does the process take or should it take from, like for a life insurance claim, if you file a claim, what is the time frame that the person should expect to know that they will get a check in the mail?

EXECUTIVE OFFICER HAYCOCK: For the record, Damon Haycock.

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

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

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

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

MR. KLINKHAMMER: In a life claim situation,

yes.

MEMBER ANDREWS: In a life claim?

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

MEMBER ANDREWS: Thank you.

CHAIR CATES: Thank you.

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

MEMBER ANDREWS: Guess who?

CHAIR CATES: Go ahead.

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

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

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

MEMBER ANDREWS: Thank you.

MS. GLOVER: The table on the top is Plan Year '17 up to the December 31st in this case. The

smaller table for Plan Year '16 tells us how we ended up Plan Year '16.

MEMBER ANDREWS: Thank you.

CHAIR CATES: We're good? Thank you.

So that covers all of the --

MEMBER GARCIA: Mr. Chair?

CHAIR CATES: I'm sorry. Go ahead.

MEMBER GARCIA: This is Rosalie Garcia.

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

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

MEMBER GARCIA: 3.5.1, regarding the --

CHAIR CATES: Oh, 3.5.1. Got you.

MEMBER GARCIA: Yeah.

CHAIR CATES: Go ahead.

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

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

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

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

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

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

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

MEMBER GARCIA: Thank you.

CHAIR CATES: Okay. Thank you.

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

Anybody would like to make a motion?

MEMBER ANDREWS: So moved.

CHAIR CATES: We have a motion.

Do we have a second?

VICE CHAIR BAILEY: Second. Don Bailey.

CHAIR CATES: We have a motion and a second.

Any discussion on the motion?

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

THE BOARD: Aye.

CHAIR CATES: All opposed?

MEMBER COCHRAN: Aye.

MEMBER GARCIA: Aye.

MEMBER ZACK: Aye.

CHAIR CATES: The motion carries unanimously.

Okay. Close Item No. 3 and go to Item No. 4:

Presentation on the Employer Contribution (Subsidy) portion of the overall rate. Celestena Glover; Chief Financial Officer.

EXECUTIVE OFFICER HAYCOCK: For the record, Damon Haycock.

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

CHAIR CATES: Okay. Thank you.

Ready? Go ahead.

MS. GLOVER: Good morning.

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

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

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

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

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

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

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

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

All of these costs are considered, and then it is loaded into the previous rate, the base rate, and this is where you get what you see on your screen, which is the CDHP for a single person at $598.69, and for the

HMO, it's $764.03. And then it's broken out all the way down for participant and spouse, participant and children, participant and family.

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

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

at plan tiers. There are four tiers to each of the plans.

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

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

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

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

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

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

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

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

The same math can be applied for the HMO. So

this is what the CDHP table looks like. A retiree only, the rate is $580.78. The base subsidy for that individual is $371.70, and they pay $209. Now, these subsidies are adjusted up or down according to the years of service. So this table explains the HMO similar to the CDHP.

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

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

And with that, I'll take any questions.

CHAIR CATES: Thank you.

Do we have any questions from the members?

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

CHAIR CATES: Go ahead, Chris.

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

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

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

The question you asked, Mr. Cochran, is actually in the next presentation on a year-by-year, rate-by-rate cost. And so I will go over that here after

we begin that presentation. We just wanted to kind of do a how to because this can be quite confusing for folks who say I'm supposed to get $700 from the State, and I'm paying $42, and where did my $700 go? And this is just to kind of a Health Insurance 101 when it comes to multitiered contributions. And this has been pretty standard, I think, for at least the last three years, if not longer. So I think we'll be able to answer your question in the next presentation.

MEMBER COCHRAN: Okay. Thank you.

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

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

CHAIR CATES: Go ahead.

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

MS. GLOVER: This is Celestena Glover for the record. I can put something together, and we can get it out onto the web site for people to look at and make it available for questions. The same process applies because back in 2015 when we changed the contribution

methodology for the non-state retirees, we used that same percentage and apply it to whatever their rate is. So their contributions, at least for every tier except the HMO with a single person, has actually gone up. On the subsidy side, though, those employees are right now paying more than they have in the past.

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

MEMBER GARCIA: I appreciate that.

Thank you again very much.

CHAIR CATES: Any other questions from the members?

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

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

CHAIR CATES: I'm sorry. Go ahead.

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

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

Does that make sense?

CHAIR CATES: Makes sense.

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

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

MEMBER ZACK: Thank you.

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

CHAIR CATES: Oh, we just lost you.

MEMBER COCHRAN: I'm sorry. It keeps going out. We may be comparing apples to apples, but I'm not sure that we are exactly doing that when we look at other plans. So I think that that's what we have to keep in mind as well.

CHAIR CATES: Okay. Thank you.

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

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

EXECUTIVE OFFICER HAYCOCK: I want to thank Mr. Belcourt for that long agenda item. We had to make sure we had everything for open meeting, so that's why that's a little bit longer. Dovetailing off of Ms. Glover's presentation, we wanted to try to break down this process into layman's terms and really walk through

some education, not just for the public, but also if there's any new board members who haven't participated in this rate setting process. It gives good background as to how we get to where we are.

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

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

We also are looking to do the exact same flat rate for the state retirees. However, you will see a very sizable increase to the non-state retirees of 13 to

16 percent. And it wasn't done as a personal affront to that group, but there were some significant costs that I will go over later in this presentation.

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

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

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

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

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

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

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

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

On the non-state retiree side -- and I've

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

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

You'll notice in 2013 and '14 there were some creative methods to try to expend reserves. Those are the first couple of years after the first year of the CDHP. And the initial policy by the PEBP board was to

adjust excess reserves through the use of HSA and HRA funding, and then my opinion is that by the time 2015 rolled around, there were too much reserves and we needed to enhance the plan. But you couldn't just give out hundreds and hundreds and hundreds of dollars of more HSA and HRA funds. And so that's I believe you're seeing the same plan design for the last three years that people have gotten used to, and that's an important thing to remember.

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

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

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

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

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

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

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

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

So we're going to move on tiers. Tena explained that we have four different tiers, but how do we determine the rate for the those tiers? This has been

in place for the last five years. We have a certain dollar amount that we need to cover the participant only, and if we add the spouse, it's twice the amount. If they have a child, it's the amount of a participant plus amount for children, and if it's family, it's two times the amount of the participant plus that amount for children. This is pretty standard as far as how we develop rates to ensure that we don't charge for a child the same that we charge for an adult if they traditionally use less of the services.

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

So here's the real story I want to get into and discuss kind of why we are recommending the shift to enhanced benefits. If you'll see on the left there, for

those have it in color, it's blue. If you don't, it's the left table. We received these base rate cards from our actuaries. And what I want to point your attention to -- and I got this laser pointer, so I might as well use it -- is that the trend that 4 percent, 7 percent, and 2 percent for medical, RX and dental is the same for both state and non-state. This was what you basically saw in January when Aon came up and said, "This is what we think is going to happen." So they kept to their trend, but that trend needs to be applied to experience, and I'm going to tell you folks, I had no idea that the medical experience on the state side would be almost negative 9 percent.

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

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

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

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

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

And then I was asked by the legislature as

well, you know, "When are we going to stop enhancing plans with reserves and actually build the plan as it should be as it's being experienced?"

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

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

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

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

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

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

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

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

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

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

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

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

So what does our recommended design look like? So I wanted to put it out there for everybody that

there is a base plan and then what are the remaining enhancements left. So we want to now make the discussion moving forward that this deductible is the base plan, that this coinsurance that people have been used to is the base plan. Same with dental maximum, that annual vision that we provided a hundred percent that we want to throw that $25 co-pay, it's still a million dollars that we're paying towards this process on average, and we feel that this can be absorbed into the base plan.

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

MS. SPINELLI: $104.90.

EXECUTIVE OFFICER HAYCOCK: $104.90.

I gave them an extra penny. Sorry. $104.90 going up to $134. So that's almost a $30 increase. Keep that in mind when we talk about what we're doing to the rates moving forward and how much of that rate increase

is being mitigated by this $30. So I know it's not great. I know I can't believe no one is throwing stuff at the back of my head right now, but we are trying to help folks out in all different groups to ensure that we mitigate increased costs of care.

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

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

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

CHAIR CATES: Don't jinx us.

EXECUTIVE OFFICER HAYCOCK: Yeah, don't jinx

us. But my goal is to keep doing well, keep managing our plan well, keep saving money and finding a way to move this life insurance back to the base plan in the next session. So that's what we're looking at doing, kind of a "two-year'd" out teaser.

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

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

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

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

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

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

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

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

retirees.

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

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

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

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

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

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

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

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

MEMBER COCHRAN: Dr. Cochran.

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

What we had last month was the trend: 4, 7, and 2. What we didn't have last of the month was the

experience: Negative 8.8, 5.4, and negative 4.8. And so the knowledge that we were using was based on well, if our budget is accurate, then we're going to trend it forward 3.6 percent and that's what we need to do. But when the experience came in so much less, then basically, our total claims cost is less. And so we need less premiums. But if we keep the governor's money, then his money chews into more of the participants' premium. And that's really how that happens.

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

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

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

MEMBER COCHRAN: Okay. Thank you. This is

very encouraging.

CHAIR CATES: Go ahead.

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

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

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

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

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

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

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

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

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

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

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

MEMBER LAMBORN: Thank you.

CHAIR CATES: Any other comments or questions?

Go ahead, Tom.

MEMBER VERDUCCI: Thank you, Mr. Chair.

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

Damon, with your effective management, I'm very impressed with this presentation and, in fact, this

is probably the happiest moment I've spent here.

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

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

CHAIR CATES: Any other comments from the members?

Hearing none, let's --

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

opportunity for a flat rate.

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

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

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

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

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

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

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

Any questions?

Go ahead, Anna.

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

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

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

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

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

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

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

MEMBER ANDREWS: Thank you.

CHAIR CATES: Any other questions from the members?

MEMBER LAMBORN: Mr. Chair, I have one.

CHAIR CATES: Go ahead.

MEMBER GARCIA: Mr. Chairman, this is Rosalie.

CHAIR CATES: Hang on, Rosalie.

MEMBER LAMBORN: Leah Lamborn for the record. So on the alternative HMO -- and I know that we've

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

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

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

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

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

CHAIR CATES: Any other questions?

Rosalie, you had a question?

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

EXECUTIVE OFFICER HAYCOCK: For the record, Damon Haycock.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MEMBER GARCIA: We lost you.

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

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

So can you hear me?

EXECUTIVE OFFICER HAYCOCK: We can hear you just fine.

Can you hear us?

MEMBER GARCIA: Hello?

EXECUTIVE OFFICER HAYCOCK: I'm going to pause.

CHAIR CATES: Can you hear us?

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

EXECUTIVE OFFICER HAYCOCK: PEBP's

consumer-driven health plan is self-insured, so we are not required to pay certain fees and taxes. And as a state plan, we're not paying tax or we're not paying --

(Member James Wells arrived.)

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

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

MEMBER COCHRAN: We're having technical difficulties.

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

(Recess was taken.)

CHAIR CATES: Call the meeting back to order.

Damon, pick up where you left off.

EXECUTIVE OFFICER HAYCOCK: For the record, Damon Haycock. I just want to make sure down south you

guys can hear us. I don't want you to miss anything.

MEMBER COCHRAN: Yes, we can hear you.

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

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

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

CHAIR CATES: Very good.

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

MEMBER VERDUCCI: Tom Verducci for the record.

CHAIR CATES: Oh, I'm sorry.

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

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

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

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

MR. BELCOURT: I think so.

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

MS. LOCKARD: Thank you, Mr. Chairman.

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

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

CHAIR CATES: Thank you.

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

Well, thank you very much for the rollbacks. Language is very important, and I really appreciate the change from base -- enhanced to base. As we've said for quite a long time, enhancements were really just partial restoration of the 2011 to '12 cuts, and they are still,

now in the base, still just partial restoration of those cuts, but it is important. It is a very important step that as a program, we start from where we have been for three years that people have gotten used to and really not make little changes that can cause more issues.

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

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

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

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

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

CHAIR CATES: Thank you.

MS. LEAR BOWEN: My name and my words for the record. P-E-G-G-Y, L-E-A-R, B-O-W-E-N. I feel like I've been in a time machine and gone back several years, and

especially when I heard "flat rates." And what transpired and where I heard that way the presentation was done before was before the Nevada State Legislature or one of the subcommittees, and the question was asked, "Are the rates now flat?" during last session. I know exactly when it happened.

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

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

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

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

not say exactly -- and for the record, what is happening. That's just not fair.

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

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

And I love you very much and I appreciate

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

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

CHAIR CATES: A little. It's okay.

MS. LEAR BOWEN: Thank you.

CHAIR CATES: Thank you.

MR. RANFT: Good afternoon.

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

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

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

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

On the option two alternative HMO plan, that's already been signed, sealed, and delivered. The contract has already been done and signed off by the

governor's office, but there's some education needs of really what that's all about. So I'd spoken with Damon Haycock a little bit last board meeting, and I really appreciate his opportunity -- optimistic discussions about education, but I think it needs to be taken a step further.

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

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

coming forward.

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

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

So I'd like to see that, you know, something

broken down by all of the stakeholders to make sure that that's again brought to the state employees to be educated on the fact that they're actually getting that increase.

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

CHAIR CATES: Thank you.

More public comment in Carson City?

Do we have any public comment in Las Vegas?

MEMBER COCHRAN: Yes, we do.

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

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

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

CHAIR CATES: Thank you, sir.

Any other public comment in Las Vegas?

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

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

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

CHAIR CATES: Thank you, sir.

Any other public comment down south?

MEMBER COCHRAN: No.

CHAIR CATES: Okay. Thank you.

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

Any further discussion by the Board?

Go ahead.

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

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

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

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

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

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

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

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

MEMBER LAMBORN: Thank you.

CHAIR CATES: Any further discussion?

Go ahead, Jim.

MEMBER WELLS: Thank you, Mr. Chair.

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

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

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

CHAIR CATES: Okay. Thank you.

Any further discussion? Motions?

Go ahead.

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

CHAIR CATES: Okay. We have a motion.

Do we have a second on the motion?

VICE CHAIR BAILEY: I second that motion.

CHAIR CATES: We have a motion and a second.

Any discussion on the motion?

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

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

EXECUTIVE OFFICER HAYCOCK: Thank you, Mr. Chair.

For the record, Damon Haycock.

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

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

CHAIR CATES: Any further discussion on the motion?

MEMBER WELLS: Mr. Chair, I'm going to vote

no on this because it's an aggregate motion. There are some things in here, I believe, that we should be doing, but as an aggregate motion, I can't support it.

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

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

THE BOARD: Aye.

CHAIR CATES: All opposed?

MEMBER WELLS: No.

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

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

(Recess.)

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

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

We're on Agenda Item No. 6: Approval of the proposed changes to the master plan documents for Plan

Year 2018 for medical, dental, life and long-term disability benefits for enrollment and eligibility rules and for privacy and security requirements, to reflect previously approved plan design modifications, changes in the legislative or regulatory requirements and technical corrections of updates.

MS. SPINELLI: Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

On 21, 22, and 23, this is kind of all combined together, we did all precertification

requirements for inpatient, for non-emergent elective surgeries for inpatient and outpatient, and that kind of ties back to the reference-based pricing for the hips and knees surgeries, and the precertification process will also determine the location of service and whether it's high quality and the lowest cost, and if the UM company requires a participant to travel more than 50 miles for a precertified surgery, the participant will be eligible for certain travel reimbursement costs. And this is similar to what we do currently for the transplants and the bariatric surgeries.

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

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

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

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

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

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

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

just for clarification.

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

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

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

CHAIR CATES: Thank you.

Questions from the members?

MEMBER COCHRAN: Mr. Chair?

CHAIR CATES: Go ahead.

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

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

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

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

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

marijuana from coverage?

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

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

MS. DAILEY: Amy Daily for the record.

MR. HAYCOCK: Come up.

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

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

So we are only including drugs that are

approved by the FDA; is that correct.

MS. DAILEY: That's correct.

MEMBER COCHRAN: Okay. Thank you.

CHAIR CATES: Thank you.

Any other comments from the members? I have one comment, just a minor typo on page 4, item 13. "Remove the requirements to participate in the regular telephonic engagement calls." I believe the word "for" should be stricken, that's my substantive contribution.

Any other comments from the members?

MEMBER WELLS: Thank you, Mr. Chairman.

Jim Wells for the record.

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

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

MEMBER WELLS: So who makes the determination?

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

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

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

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

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

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

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

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

MEMBER WELLS: Correct. These were elective.

MS. PEARSON: Right. Purely elective.

MEMBER WELLS: My understanding was purely elective knee surgery.

MS. PEARSON: Exactly.

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

MS. PEARSON: Got you.

CHAIR CATES: Any other comments?

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

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

EXECUTIVE OFFICER HAYCOCK: For the record, Damon Haycock. The intent behind this language change was to try not to paint us into a corner and have two separate precertification rule sets that may be confused by either our UM company or our participants. We try to come up with a global response that says if you have a

service that needs to be precertified that it will go through the precertification process. And as Mary Katherine and Nancy spoke, I think the reason that "may" is in there -- and I'm going to give probably a really bad example, but if you need a knee surgery, that knee surgery may be approved at a specified location through our utilization management company, but then the doctor there may want the person to stay for a week and that won't be approved, and so therefore, those services may not be approved, but the knee surgery itself will be. And I think it's meant to give some flexibility and the ability to apply the appropriate precertification.

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

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

CHAIR CATES: Any further comment?

Go ahead.

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

CHAIR CATES: Okay. Any other comments? Anybody care to make a motion? Everybody awake after lunch?

MEMBER VERDUCCI: I'll make --

VICE CHAIR BAILEY: I'll make a motion. For the record, Don Bailey. I make a motion to approve Item

6 with the Chair's change recommendation.

Do you need more?

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

VICE CHAIR BAILEY: Yes.

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

MEMBER LAMBORN: Leah Lamborn. Second that.

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

Any discussion on the motion?

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

THE BOARD: Aye.

CHAIR CATES: Opposed?

MEMBER COCHRAN: Aye.

CHAIR CATES: The motion carries.

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

You'll see in this report that we didn't want to assume anything, and so that's why you see the old

approvals. But as Nancy has specified, indeed, the Board has just approved we will be making those technical adjustments before posting these NPD's, and I'll turn it back to you.

CHAIR CATES: Thank you.

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

Damon?

EXECUTIVE OFFICER HAYCOCK: Thank you, Mr. Chairman.

For the record, Damon Haycock.

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

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

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

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

CHAIR CATES: Why don't I just go ahead and

address that. Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

like anabolic steroids, which are considered part of hormone replacement and other potential drugs that are abused for other reasons outside of standard clinical outcomes. And so we still have that concern, and the fact that we'd have to cover hormone replacement therapy at 100 percent and not allow step therapy or precertification or preauthorization. We have attached a fiscal note that we are concerned we would have to absorb. And we haven't seen this come back to a committee yet, and we'll be prepared to testify when it does.

So moving along, 265 -- again, these are all of the ones I think you've seen already before. The bill on prescription drugs, this was the -- I think this was the scary one that was going to have the potential of a $500 out-of-pocket max. That has been stricken from the language before becoming a bill, so it really, it ensures we post formulary changes on diabetes drugs on our web site and, you know, timely, and that if we receive a reimbursement from manufacturers for diabetes drugs under one of the sections of this bill that we would need to refund to participants deductible, but not apply it to the purchase.

What's interesting is for folks that are on our diabetes care management plan, they don't have to

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

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

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

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

MEMBER LAMBORN: Thank you, Mr. Chair.

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

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

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

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

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

MEMBER LAMBORN: Okay. Thank you.

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

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

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

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

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

this basically flies in the of that.

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

MS. GLOVER: Celestena Glover for the record.

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

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

MS. GLOVER: I'm getting to that.

EXECUTIVE OFFICER HAYCOCK: So for the record, Damon Haycock. We have opposed this bill, but we recommend opposing this bill. Of course, it's the Board's decision to provide whatever position you want,

but we're against this because it's just bad. It just doesn't do what it's supposed to do, which is provide some form of choice and allow people to choose whatever doctor they want to go to. I think that's what the intent is. But it just puts these restrictions on our ability to manage our plan.

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

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

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

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

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

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

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

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

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

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

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

EXECUTIVE OFFICER HAYCOCK: I think -- for

the record, Damon Haycock -- I think it's pretty obvious, but PEBP -- the PEBP staff recommend opposing this bill because it prevents PEBP and the Board from managing the plan. AB 381 revises provisions governing prescription drugs covered by policies of health insurance.

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

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

pay high dollar amounts for these really expensive drugs, especially on the specialty side, when we're all sitting here holding our breath waiting for the generic to come out. And if it comes out in the middle of our plan here, we can't make that change, and we're forced to continue paying for these high-dollar cost drugs when there's no medical reason to do so.

And so again, PEBP is -- and I won't tip this to Tena this time because any of these fiscal notes that we're preparing right now, we're working with our pharmacy benefits manager, we're working with our HMO plans, we're working with our TPA's, and all of these are due, I believe, on Monday and Tuesday. So we are looking at having these done tomorrow and Monday, but we're developing a plan to show or a fiscal note to show what happens when we can't make these changes from a fiscal standpoint. But equally terrifying is from a patient safety standpoint. So obviously, PEBP is against this bill and recommends taking opposition to AB 381.

AB 331 here, oh, sorry. I flipped to the wrong page. AB 382 establishes provisions governing payment for the provision of emergency services and care to patients.

This one, we kind of like. This bill basically says that the -- requires payments to be

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

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

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

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

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

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

built into the rates you guys just approved earlier today.

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

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

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

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

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

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

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

MS. GLOVER: Metastatic.

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

they need.

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

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

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

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

CHAIR CATES: Thank you, Damon.

Any questions or comments from the members? Nobody?

Go ahead.

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

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

CHAIR CATES: Okay. Thank you.

Any further comments?

Is that a motion?

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

CHAIR CATES: So your motion is to continue opposition to SB 289 and to be opposed to AB 352 and 381;

correct?

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

CHAIR CATES: Okay. We have a motion.

Is there a second to the motion?

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

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

Any discussion on the motion?

Go ahead, Jim.

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

CHAIR CATES: One minute, Rosalie.

Go ahead, Jim.

MEMBER WELLS: Thank you, Mr. Chairman.

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

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

CHAIR CATES: Thanks, Jim.

As a fellow director, I would take the same position. And hopefully, I won't be called upon to break a tie. I won't vote on this anyway, but good point.

MEMBER ANDREWS: Anna Andrews for the record.

So does that apply to me as well since --

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

So we have a motion and a second.

Any further discussion? Oh, I'm sorry.

Rosalie, go ahead.

MEMBER GARCIA: There you are.

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

Had we?

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

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

MEMBER VERDUCCI: Tom Verducci for the record.

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

CHAIR CATES: Thank you.

I assume that's okay with the second?

MEMBER LAMBORN: Yes.

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

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

CHAIR CATES: Yes, go ahead.

MEMBER COCHRAN: Can we confirm?

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

EXECUTIVE OFFICER HAYCOCK: For the record, Damon Haycock.

Dr. Cochran, you had not seen this bill before. This came out after you guys made your initial

assessments, and so this is a new reading, and that's why Mr. Verducci has taken out the "continuation" from his motion.

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

CHAIR CATES: Okay. Thank you.

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

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

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

CHAIR CATES: Okay. Thank you.

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

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

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

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

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

CHAIR CATES: Thank you. Appreciate that.

Any other public comment on this agenda item?

Anyone in Las Vegas?

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

CHAIR CATES: Go ahead.

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

CHAIR CATES: Okay. Thank you for that.

Any further comments?

MEMBER COCHRAN: Mr. Chair, Chris Cochran again.

CHAIR CATES: Go ahead.

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

CHAIR CATES: Okay. Thank you.

MEMBER ANDREWS: Mr. Chair?

CHAIR CATES: Go ahead, Anna.

MEMBER ANDREWS: Anna Andrews for the record.

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

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

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

But the concern that I would just provide the Board here to think about when you table certain things is we had -- you guys were, I believe, opposed last

meeting to the contraceptive bill for patient safety and other issues, and then they'd already scheduled the committee before we had a chance to talk about it. And so if we table this for a couple of weeks, we may miss the window to get up to the table. And if you don't give me a position, I'm not going to go to the table and say, "This is how PEBP feels."

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

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

Peggy, why don't you go ahead.

MS. LEAR BOWEN: Thank you.

My name and my words for the record; P-E-G-G-Y, L-E-A-R, B-O-W-E-N. And this is just a cautionary reminder. That you are not any entity or spokesperson regarding any of these matters except for your clients, us. You are our voice. That's why I've gone to the table at the legislature and emphatically requested that you remain separate not advisory because we need to have a voice to our employer where we can meet

in a public way to put forth the information and our needs and our wants and our directives so that there is another voice coming to rather than just an administrative voice or those for whom they don't walk in our shoes, they don't live our lives for us, they have an administrative -- and not putting it good, bad or indifferent -- they have goals that they need to meet, and we have goals that we need to meet, and you are our voice to meet them. And that's why I think that you do have to say in public what you accept or don't accept whether it's administratively.

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

You have to remember your goal and your duty, and I don't think you need to go weighted time or delayed

time or anything else. We need your voice available for us at that legislature tomorrow. Not in two weeks. Not at any other time. So that's just my comment. You guys are the Jiminy Cricket and the conscience of the state insured, and we need you there with no strings attached to anything else other than conveying the voice of the people you represent. Thank you very much.

CHAIR CATES: Thank you.

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

Do we have a motion and a second?

MEMBER GARCIA: Mr. Chair?

CHAIR CATES: Go ahead.

MEMBER GARCIA: Rosalie Garcia.

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

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

it's just that there's a cost to that policy.

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

MEMBER GARCIA: Okay.

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

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

CHAIR CATES: Thank you.

MEMBER ZACK: Mr. Chair, Kristine Zack.

CHAIR CATES: Go ahead.

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

CHAIR CATES: Do you have any opinion?

MR. BELCOURT: Dennis Belcourt, deputy attorney general. I think the duties, policies, and procedures would be an implementation of statutory and/or

regulatory authority. I think you'd want to reconcile them to the extent they are reconcilable.

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

CHAIR CATES: Okay. Thank you for that.

Any further comment?

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

THE BOARD: Aye.

CHAIR CATES: All of those opposed?

MEMBER WELLS: No.

VICE CHAIR BAILEY: No.

MEMBER COCHRAN: No.

MEMBER ZACK: Nay.

MEMBER GARCIA: No.

CHAIR CATES: So what was the tally?

EXECUTIVE OFFICER HAYCOCK: For the record, could we just do a roll call vote to make sure so we can have Carrie call each person and their votes so we don't miss this?

CHAIR CATES: Yes.

EXECUTIVE OFFICER HAYCOCK: Thank you.

MS. PEDROZA: Anna Andrews?

MEMBER ANDREWS: Aye.

MS. PEDROZA: Don Bailey?

VICE CHAIR BAILEY: No.

MS. PEDROZA: Chris Cochran?

MEMBER COCHRAN: No.

MS. PEDROZA: Rosalie Garcia?

MEMBER GARCIA: No.

MS. PEDROZA: Leah Lamborn?

MEMBER LAMBORN: Aye.

MS. PEDROZA: Tom Verducci?

MEMBER VERDUCCI: Aye.

MS. PEDROZA: Jim Wells?

MEMBER WELLS: No.

MS. PEDROZA: Kristine Zack?

MEMBER ZACK: No.

MS. PEDROZA: That is five noes.

CHAIR CATES: Okay. Thank you.

The motion fails.

Any more discussion or motions?

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

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

CHAIR CATES: Thank you for that.

Any further comments?

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

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

I guess I would echo -- it was Damon that echoed that the concern that if we delay and table these

things, don't take positions, the legislation moves very fast and we may miss the opportunity. That's the only comment I'd have about deadlines.

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

CHAIR CATES: Okay. Sounds reasonable to me.

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

CHAIR CATES: Very good.

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

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

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

MEMBER VERDUCCI: Yes, sir.

CHAIR CATES: And take a vote on every one?

MEMBER VERDUCCI: Yes.

CHAIR CATES: Okay. Let's do that.

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

Does that make sense?

MEMBER VERDUCCI: Yes.

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

CHAIR CATES: Go ahead.

MEMBER LAMBORN: Thank you, Mr. Chair.

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

CHAIR CATES: AB 249.

So we have a motion to oppose AB 249.

Do we have a second?

MEMBER ANDREWS: Anna Andrews. Second.

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

Any discussion on the motion? Sorry. I'm trying to get to the page. All right. I'm with you. We're on the same page now. We have a motion and a

second.

Any discussion on the motion?

Go ahead, Jim.

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

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

MEMBER ZACK: Mr. Chairman, Kristine Zack.

CHAIR CATES: Go ahead.

MEMBER ZACK: I agree with Jim.

CHAIR CATES: Okay. Any other comments?

EXECUTIVE OFFICER HAYCOCK: May I add something?

CHAIR CATES: Go ahead.

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

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

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

CHAIR CATES: Thank you, Damon.

Any other comments on the motion?

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

CHAIR CATES: Go ahead.

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

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

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

CHAIR CATES: Go ahead.

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

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

MEMBER LAMBORN: I made the motion.

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

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

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

MEMBER LAMBORN: Leah Lamborn for the record. I withdraw my previous motion on opposing AB 249.

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

Go ahead, Tom.

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

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

Do we have a second?

VICE CHAIR BAILEY: Don Bailey. Second.

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

Any discussion on the motion?

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

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

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

Concerns?

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

Damon, do you have any thoughts on that?

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

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

CHAIR CATES: Okay. Thank you.

That helps. Okay.

Any other discussion on the motion?

Seeing none, I'll call for a vote. All of those in favor of a neutral stance on AB 249, please

signify by saying aye.

BOARD MEMBERS: Aye.

CHAIR CATES: Opposed?

MEMBER COCHRAN: No.

CHAIR CATES: One no. The motion carries.

MEMBER GARCIA: I will abstain.

CHAIR CATES: Very good.

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

Any discussion? Motions?

MEMBER LAMBORN: Mr. Chair?

CHAIR CATES: Go ahead.

MEMBER LAMBORN: Leah Lamborn for the record. I know in our prior conversation we had made a motion, it passed for SB 139 on the patient-centered medical homes. Now that the language has been changed from must or "must" to "may," it sounds like we're going to go neutral on all of the bills, positions, but anyhow, I just wanted to get on record that we'd opposed that, but now I think it we've gone neutral on it but which apparently we're

going to do anyhow.

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

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

CHAIR CATES: Okay.

MEMBER LAMBORN: Based on the language in the amendment.

CHAIR CATES: Thank you.

Do we have a second to that motion?

MEMBER ANDREWS: Anna Andrews. Second.

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

Any discussion on the motion?

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

THE BOARD: Aye.

CHAIR CATES: All opposed?

MEMBER GARCIA: No.

CHAIR CATES: The motion carries.

Any other brave souls wish to take a position on these bills or make a motion to take a position on

these bills?

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

CHAIR CATES: Go ahead.

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

CHAIR CATES: Okay. Is that a motion?

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

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

MEMBER LAMBORN: Okay.

EXECUTIVE OFFICER HAYCOCK: For the record,

Damon Haycock. Without a position taken, I can't go up to the table and share your position. I can't share the concerns because I have no position to take. I wouldn't know to go for, against, or in neutral position. And I don't want to assume that you've taken a neutral position and hurry up to the table if you guys haven't provided me that guidance. And so I would really -- if you want me to go to the table and some of these deserve that, I would really like a motion and a Board direction so I'm not confused as to exactly what you guys want me to do with the legislature.

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

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

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

MEMBER COCHRAN: This is Chris Cochran.

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

MEMBER COCHRAN: That's fine.

CHAIR CATES: So we have a motion and a

second.

Any discussion on the motion to support SB 366?

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

THE BOARD: Aye.

CHAIR CATES: Opposed?

MEMBER WELLS: No.

CHAIR CATES: The motion carries. Okay.

Any other takers? Any other bills you want to discuss?

Go ahead, Tom.

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

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

VICE CHAIR BAILEY: 289.

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

VICE CHAIR BAILEY: That's a motion.

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

CHAIR CATES: 381.

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

CHAIR CATES: I apologize.

So your position was? That was a motion?

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

CHAIR CATES: Okay.

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

CHAIR CATES: Okay. Thank you.

So we have a motion and a second.

Any discussion on the motion?

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

THE BOARD: Aye.

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

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

EXECUTIVE OFFICER HAYCOCK: For the record, Damon Haycock. We're going to, as we submit fiscal

notes, shoot them out to the board. My apologies for not having that done sooner. So once we get it submitted and it's in the system and it's out of our hands, we will ensure that you have the most up-to-date information to assess your fiscal impact of that specific bill.

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

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

CHAIR CATES: Thank you, Damon.

Any other comments from the Board? Motions?

Go ahead, Tom.

MEMBER VERDUCCI: Thank you, Mr. Chair.

Tom Verducci for the record.

I wanted to discuss Assembly Bill 352, requiring us to accept prior authorization. And since

that takes away our decision-making ability and it also jeopardizes patient safety, I am suggesting since we managed our own plan, that we take a neutral position on AB 352.

CHAIR CATES: Okay. Do we have a second?

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

MEMBER VERDUCCI: That was a motion.

CHAIR CATES: Okay. Thank you.

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

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

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

Any discussion on the motion?

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

THE BOARD: Aye.

MEMBER COCHRAN: Mr. Chair?

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

MEMBER COCHRAN: Okay. So we're taking -- this is Chris Cochran for the record -- we're taking a neutral position on this. There are no future scheduled

meetings for this particular bill? This has not been draft called up? Is that correct?

EXECUTIVE OFFICER HAYCOCK: For the record, Damon Haycock.

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

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

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

CHAIR CATES: Go ahead.

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

Could that be repeated?

MEMBER VERDUCCI: Yes. Tom Verducci for the record.

As I read this, it requires PEBP to accept decisions on preauthorization from other providers, so

we're not making the decision ourself as opposed to what we're doing, is we're accepting another provider's rules, and it doesn't give us the ability to make proper decisions. We're just accepting. And also, the issue of patient safety would be in jeopardy, and cost controls are nullified with this bill, so we're accepting decisions that somebody else is making which could result in dramatic cost increases.

MEMBER GARCIA: Thank you.

This is Rosalie Garcia again.

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

MEMBER VERDUCCI: Tom Verducci for the record.

I think the neutral position allows Damon to be able to get in front of the legislature and let them know what the issues are, and it's note quite as aggressive as an opposing position. I personally oppose it, but I think it's a little friendlier with the neutral stance.

MEMBER GARCIA: Ah, got you.

We're being politically correct. Okay. Thank you.

CHAIR CATES: Any other discussion on the motion?

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

Go ahead. Go ahead.

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

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

THE MEMBERS: Aye.

CHAIR CATES: Opposed?

MEMBER ZACK: No.

MEMBER COCHRAN: No.

CHAIR CATES: It sounds like the motion carries.

Any other takers?

VICE CHAIR BAILEY: I have a question.

CHAIR CATES: Go ahead.

VICE CHAIR BAILEY: For the record, Don Bailey.

This is for Damon and Stan.

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

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

We're saying we don't have a problem with this bill. We don't think that there's any concerns, at

least from a fiscal standpoint. And I'm talking about the Affordable Care Act requirements being built back into the state law.

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

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

VICE CHAIR BAILEY: Okay. Can I ask another

question?

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

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

EXECUTIVE OFFICER HAYCOCK: For the record, Damon Haycock.

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

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

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

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

CHAIR CATES: Go ahead.

EXECUTIVE OFFICER HAYCOCK: For the record, Damon Haycock.

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

CHAIR CATES: In a neutral fashion.

EXECUTIVE OFFICER HAYCOCK: In a neutral fashion.

CHAIR CATES: Go ahead.

MEMBER VERDUCCI: Tom Verducci for the record.

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

CHAIR CATES: Okay. Is that a motion?

MEMBER VERDUCCI: Yes, Mr. Chairman.

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

MEMBER ANDREWS: Anna Andrews for the record. Second.

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

Any discussion to the motion?

MEMBER GARCIA: Yes.

CHAIR CATES: Go ahead.

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

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

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

CHAIR CATES: Okay. Thank you.

Any other comment on the motion?

Hearing none, I'll call for a vote on the

motion. All of those in favor of the motion, signify by saying aye.

THE BOARD: Aye.

CHAIR CATES: All of those opposed?

MEMBER LAMBORN: No.

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

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

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

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

Damon?

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

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

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

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

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

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

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

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

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

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

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

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

We struggled a bit with being able to

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

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

are going to utilize that we can also track and insure people are meeting specific requirements. And so as a package, diabetes is best situated currently with PEBP as a stand-alone program, and so diabetes meds are not on the preventative drug list because it's made up for in another area.

And last, but definitely not least, I had a meeting -- or we had a meeting -- PEBP had a meeting with Nevada's chief medical officer, Dr. John Dimuro. There's a little write-up on him here. He is very interested and excited to partner with PEBP on anything that we would like him to be a part of. He's interested in helping us out if we have clinical questions, if we need a doctor to respond to maybe program enhancements or program questions, he's also offered to sit with our quality control officer on utilization management reviews and sit on RFP's. And so we're real excited to work with Nevada's chief medical officer as the State's representative and really tie that and increase that relationship, so that way we have that resource available to us where we can just get up, drive down the road and have a conversation with him.

So we're excited to announce that, and we're very excited and very appreciative and honored that he is willing to step out of his everyday busy schedule to be

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

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

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

Board.

With that, I'll take any questions.

CHAIR CATES: Any questions from the members?

MEMBER ANDREWS: Mr. Chair?

CHAIR CATES: Go ahead.

MEMBER ANDREWS: Anna Andrews for the record. I think I know the answer, but Damon, could you -- I know that under the preventive drug benefit list, the second paragraph at the very bottom of the page is talking about the Smart90 Network.

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

EXECUTIVE OFFICER HAYCOCK: Yes, of course. Thank you, Andrews. This is Damon Haycock for the record.

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

And at that time, with all of the changes that we're providing our program participants, right,

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

MEMBER ANDREWS: Thank you.

CHAIR CATES: Thank you.

Any other comments from the members?

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

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

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

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

January was a little bit of a decrease, and I think there were some weather concerns up here in Northern Nevada at that time. So I think that played a

part into it. I did get the stats recently. Stacie was here last week, and I got the stats from her earlier today from the number of appointments and walk-ins that she had, and so it's good to see that it actually increased for March, we had 20 appointments last week and we had one walk-in. So we're seeing that increase, so I think the January/February, the weather probably played a part into that, so we're obviously going to continue to track that.

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

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

For the retiree meeting that occurred in the

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

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

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

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

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

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

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

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

CHAIR CATES: Thank you, sir.

MR. GARCIA: Thank you.

CHAIR CATES: Any questions from the committee?

Go ahead.

VICE CHAIR BAILEY: For the record, Don Bailey.

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

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

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

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

VICE CHAIR BAILEY: And the wait time has improved?

MR. GARCIA: Absolutely.

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

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

VICE CHAIR BAILEY: I did read it.

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

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

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

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

VICE CHAIR BAILEY: Okay. Good. Thank you, Chris.

MR. GARCIA: You're welcome.

CHAIR CATES: Any other comments?

Go ahead.

MEMBER VERDUCCI: Chris, thank you very much for coming in. I know you're coming in from out of state.

MR. GARCIA: I'm in Vegas.

MEMBER VERDUCCI: Thanks for coming up.

CHAIR CATES: That's out of state depending on where you're from.

MEMBER VERDUCCI: Chris, I'm a little concerned with retirees that might be a little bit elderly and they don't know what claims are covered and some are falling through the cracks.

Can you expand a little bit on the auto

reimbursement?

MR. GARCIA: Absolutely. I'd be happy to. So auto reimbursement is where we have relationships set up with our carriers, and about 90 percent of our carriers have plan or have a file set up with us where they send us the premiums that somebody pays for on that file, and we load that file to their HRA accounts as a claim. Now they have to select to turn on that functionality with that by the participant. The person has to contact us and select to turn on auto reimbursement.

The benefit to have that is the claim comes from the carrier after they pay it, so the participant will pay the carrier for the premium. Let's say it's a $150 premium. We get that on a file about two weeks later, maybe a month later, depending on the carrier, that file comes over to us. We load that to their HRA, and as long as they have a balance in their account, we will reimburse them for that claim.

Now, with the way that PEBP is structured with your monthly allocations that we receive for your HRA, you may have somebody who has a zero balance on their account because they're exhausting their funding every month. That claim will still load, and it will be approved pending allocations. So the allocations will

then come in, and then we will process that automatically. We won't be waiting for a claim to be submitted by the retiree to reimburse them. So we highly recommend participants sign up for auto reimbursement if they have it as an available option for them.

There are those retirees that don't have auto reimbursement available because it's part of the plan that they selected, and they have the choice then of doing what's called a recurring premium reimbursement where it's a form that they fill it once a calendar year for that claim, and they'll send us documentation to substantiate that claim, and then we will go ahead and set up an automatic payment once a month at the beginning of the month for that reimbursement for that calendar year.

So if they do it in June, it will last until December. And then January of the new year, they'll have to resubmit the form. And we do that just in case the premium amount changes. We don't want to reimburse them for a lower premium than what they could get, or maybe the premium actually decreased, and then we would be reimbursing them for a higher amount.

So there are two options there. So both of them are viable options, depending on the preference of the participant. The participant doesn't have to do auto

reimbursement. They could instead select to do the recurring premium reimbursement and do that form, if they choose to.

MEMBER VERDUCCI: How do they decide if they're going to do auto reimbursement? Are there announcements and advertisements from the carriers?

MR. GARCIA: So it's typically discussed during the enrollment that they have when they initially enroll in the plan. So if they are an aging-in retiree, and they have that initial conversation with one of our benefit advisors, the benefit advisor will discuss that functionality with them. Again, it's such a -- they're going through -- most enrollment calls are about an hour and 15 minutes long. I don't know if many people know that, but I've seen them go as long as three and a half hours where a participant is speaking with a benefit advisor brand new to Medicare, they don't understand it, they want to get as much information as possible. So they're getting a lot of information at one time, and the last thing they're probably concerned about is their HRA and auto reimbursement. It doesn't make any sense to them. So some people think about it and they will then call us back later on and turn it on.

The way that we're trying to communicate that to them outside of that initial enrollment period is with

the communication I mentioned earlier, the HRA Refresh Newsletter. That's really our first attempt to kind of do something outside of that initial conversation that occurs or when somebody calls in during the open enrollment period and looks to change their plan. Because if they look to change their plan and they make a change, we want to stress that they want to sign turn on auto reimbursement for that new plan as well. So this HRA Refresh Newsletter that I mentioned is kind of that initial attempt. And we're looking to make an annual communication. We're probably going to change the structure of the communication a little bit based off of some feedback that we expect to receive from participants as well as from clients, and then we may change the timing of it, but we're looking to make that HRA refresh newsletter an actual annual communication to hopefully prompt participants to do auto reimbursement.

And if you remember last January or over this past January, the last board meeting, I mentioned that we had an auto reimbursement communication that we were looking to send out. That's actually been tabled because we have this Refresh newsletter coming out first.

The auto reimbursement communication is going to be a direct communication for those participants who don't have auto reimbursement turned on and try to

communicate to those participants later this year, probably closer to the is start of open enrollment. That's still being reevaluated at this time, but because we were doing this additional communication, they decided to table the auto reimbursement communication at this moment.

MEMBER VERDUCCI: Good stuff. Thank you very much.

MR. GARCIA: You're welcome.

CHAIR CATES: Any other comment or questions from the members?

Thank you, sir.

MR. GARCIA: Thank you.

CHAIR CATES: We'll close Agenda Item No. 9 and move onto Agenda Item No. 10: Public comments.

Do we have any public comments in Carson City?

MR. HARRIS: Jack Harris. I'm the state president, Retired Public Employees of Nevada. And I'd just like to follow up on a couple of comments about the -- Chris had brought up about OneExchange.

Very quickly going back -- and I know there's some members -- Mr. Wells was here, I think Mr. Bailey's been in the process since the very beginning, I know Nancy Spinelli has been on and PEBP staff has been on the

process. We've come a long ways, you know, for many, many years for many times, it seems like we never had anything positive to say. It was always negative. But we've come a long ways and kind of answering my question of following up on the importance.

In the beginning, there really was very little communication. It was finally after about three years and coming up for renewal that Tower's Watson's, OneExchange whatever we call it at that time, came forward after a legislative -- interim legislative meeting and said, "You know, we need to sit down and we need to talk" because we are addressing concerns, bringing the same concerns over and over and over, and they were kind of falling on deaf ears. That started the process. I know there's ones in the room. Elaine was one of them. There's ones down in Las Vegas, members of our organization that we've sat down with Tower's Watson's staff hours and hours and hours giving their concern.

In fact, we had a meeting, I happened to have a meeting with John Seacrest, he's the vice president in charge of the customer service element. I think he thought it was going to be a short dinner meeting, but it lasted -- Chris was there. It lasted over three hours of us addressing our concerns. And when I look through the

service improvement plan, most of those, many of those have been addressed. At least they're around the table now and we're following. It's important.

It's important when Damon and Laura took the trip back to Salt Lake City. It was important when the Board came forward, you know, initially said, "We have need to have an improvement plan. We need to have on paper what are the problems, how are we addressing them." And it's important that this Board and many of the new members have taken it and followed up and continued to follow up on it because the improvement plan is not going to go away.

Again, we look forward to -- in April, it will probably be my 12th or 13th or maybe 14th time that I've sat through the enrollment process or I've sat through the reimbursement process. Over the years, that has become as greatly improved, and maybe it's because being an educator, a teacher, an administrator, we kind of put it together to people who can understand it.

Nancy has gone out into the field out into the hither lands and brought the message out here. And there are things that we're going to continue to work on. The communication part of it, that's something that we still need is the concern, getting information out. There's what we call the seminar that you put on the

video, they're talking about putting one of those together, working on that so we can get the message to those who can't get to Carson City or can't get to Reno or Las Vegas.

So I don't know if it's a positive for Tower's Watson's, but we're going to continue to be there, and we're going to continue to bring -- as I found out in my career, concerns -- when you solve one concern, you identify it, you bring the solution, there's another one that comes up. So we've come a long ways. We still have a difference, and Chris and I've talked about this, what constitutes wait time? When the phone is answered or when you talk to a customer service person?

But to give you an example, is that now when we make the phone call, you're going to get a PEBP representative, somebody that's identified with the PEBP program. When we first started this, we found out that when you called somebody, they might have had 12 different states that they were dealing with or 12 different clients that they were dealing with.

So we appreciate what Tower's Watson's has done. We look forward to working with them in the future. And again, as a resource, I think they feel that we're a valuable resource. I know PEBP has always felt that we are a valuable resource. I think our value is

because we're the ones that are living through this system, this process.

And I just want to go back one thing on what Mr. Bailey said, that as we go out into the state and we go to the different chapters, I find very, very few that really want to go back to the old system. Once you got into the system, once we got into the exchange, there's a lot of advantages to it that we have as retirees. I know that those in the rural areas would like to have more choices because they're very limited on their choices. Sometimes they only have two. Thank you.

CHAIR CATES: Thank you, sir.

MR. ERVIN: Kent Ervin, Nevada Faculty Alliance.

Again, I'd like to thank you for the actions that you took today on rolling back some of the -- restoring some of the enhancements.

A couple of points. The discussion we had about the ability of the Board to take positions, I think, does bring up a broader issue of when Board members have other responsibilities that conflict with their duty to do due diligence and fiduciary for the plan and participant, that's a problem. And maybe through the reincarnation of SB 80, that's something that could be addressed, but I really do see that as a problem that the

Board members ought to -- regardless of their employment -- ought to be able -- when they're on this body, be able to work for the program and, you know, that's your job.

The other thing I wanted to mention was that Laura Rich and Dr. Steven Zell came to UNR's Faculty Senate and made a presentation on Zell's new program for primary care graduate education which was very well received. It's on a grant, so it's free for the first year and can be done through the normal billing procedures. They're already a provider, but the idea of almost a concierge service of you have a physician, you can call after hours, lots of extra services, but ultimately, containing costs at some level, we hope. So certainly excited about that possibility, and Dr. Zell happens to be my own physician, so I'm going to be happy to take them up on that program. Thank you very much.

CHAIR CATES: Thank you.

MS. LEAR BOWEN: My name and words for the record; P-E-G-G-Y, L-E-A-R, B-O-W-E-N.

Two things, and this is regarding earlier actions that you've already taken and that you might want to vote to reconsider the not handling three bills at one time. I think you said, Mr. Bailey, three bills that were to preserve what was in the Affordable Care Act

within the State of Nevada statutes, and it's things you're already doing, and its's a way to sound your horn and say PEBP has been meeting and done what people have asked for in regards to the Affordable Care Act. And you might want to reconsider that not taking a body of three that were the things that we didn't consider and reconsider it right now before you leave so that Mr. Haycock can speak to the legislature and do it in a neutral position just like he would do the others that you've brought on and show how PEBP has been responsive and reactive and has it within their plan, and we've been doing it for years, and so it doesn't have -- didn't have a fiscal impact or anything, if I remember what you said, and it gives you a chance to say and do what you can do.

And I think because of how the discussion was, that the only thing you need to reconsider is closing that item on the agenda and you just reopen that item and ask permission of the maker of one bill at a time, "Could you please put those three together?" and move forward as a neutral position and show that PEBP is responsive in hearing what their members say and responsive to the law of the land and doing their due diligence and just being wonderful. That was one part of what I wanted to say.

And the second part, only because I was a

little concerned in people -- in what you were going over rather rapidly in what was material in actions, and I heard something about where care could be provided when you were discussing about the changes and things that were on the -- I'm sorry. Two and a half hours of sleep does not bode well for me. When you were talking about what my concern is, is there anything in any of the new plans or anything that you're working on that would limit we up in the north from going to not only Renown but also to Northern Nevada Hospital? I want to make sure that we at least have two places to consider going and that we are not going to be even more constricted as to where we can seek service. And that is a major concern to me. And so that was my only other.

And I hope that you all have a good Easter and have a beautiful day. And just for the good of the order, yesterday, the 36th state in the union became the 36th state to ratify the ERA.

CHAIR CATES: Thank you.

Any other comment in Carson City?

Any comment in Las Vegas?

Seeing none, I will go ahead and close Agenda Item No. 10, and I think with that, we are adjourned.

(The meeting concluded at 3:33 p.m.)

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STATE OF NEVADA,)
)
CARSON TOWNSHIP.)

I, NICOLE J. HANSEN, Official Court Reporter for the State of Nevada Public Employees' Benefits Program, do hereby certify:

That on the 23rd day of March, 2017, I was present at said meeting for the purpose of reporting in verbatim stenotype notes the within-entitled public meeting;

That the foregoing transcript, consisting of pages 1 through 213, inclusive, includes a full, true, and correct transcription of my stenotype notes of said public meeting.

Dated at Reno, Nevada, this 28th day of March, 2017.

NICOLE J. HANSEN, NV CSR #446

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