In The Matter Of:

PUBLIC EMPLOYEES BENEFITS PROGRAM BOARD VIDEOCONFERENCED OPEN MEETING

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PUBLIC EMPLOYEES' BENEFITS PROGRAM BOARD

TRANSCRIPT OF PROCEEDINGS

VIDEOCONFERENCED OPEN MEETING

THURSDAY, OCTOBER 26, 2017

CARSON CITY AND LAS VEGAS, NEVADA

The Board:	PATRICK CATES, Chairman LEAH LAMBORN, Member DON BAILEY, Member ANA ANDREWS, Member GLENN SHIPPEY, Member TOM VERDUCCI, Member CHRISTINE ZACK, Member CHRIS COCHRAN, Member LINDA FOX, Member
For the Board:	DENNIS BELCOURT, Deputy Attorney General
For Staff:	DAMON HAYCOCK Executive Officer LAURA RICH Operations Officer CELESTENA GLOVER Chief Financial Officer NANCY SPINELLI Public Information Officer KARI PEDROZA Executive Assistant LAURA LANDRY Executive Assistant
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I N D E X

THURSDAY, OCTOBER 26, 2017, 8:30 A.M.

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CHAIRMAN CATES: Let's call the Public Employees Benefit Program board meeting to order. Roll call.

MS. LANDRY: Ana Andrews.

MEMBER ANDREWS: Here.

MS. LANDRY: Don Bailey.

MEMBER BAILEY: Here.

MS. LANDRY: Patrick Cates.

CHAIRMAN CATES: Here.

MS. LANDRY: Chris Cochran.

MEMBER COCHRAN: Here.

MS. LANDRY: Linda Fox.

MEMBER FOX: Here.

MS. LANDRY: Leah Lamborn.

MEMBER LAMBORN: Here.

MS. LANDRY: Glen Shippey.

MEMBER SHIPPEY: Here.

MS. LANDRY: Tom Verducci.

MEMBER VERDUCCI: Here.

MS. LANDRY: Christine Zack.

MEMBER COCHRAN: She's here. She's just not in the room.

MS. LANDRY: And then Member John Packham is excused.

CHAIRMAN CATES: Thank you. Let's move to Agenda Item Number 2, public comment. Public comment will be taken during this agenda item. No action may be taken on any matter raised under this item unless the matter is included on a future agenda as an item on which the board may take action. Public comments to the board will be taken under advisement but will not be answered during the meeting. Comments will be limited to three minutes per person. An additional three-minute comment period will be allowed on individual agenda items at the discretion of the chairperson. These additional comment periods should be limited to comments relevant to the agenda item under consideration by the board. Persons unable to attend the meeting and persons whose comments may extend past the three-minute time limit may submit their public comments to PEBP.

With that, do we have any public comment in Carson City? Really? Happy Nevada Day.

Seeing none in Carson City, do we have any public comment in Las Vegas?

MEMBER COCHRAN: None.

CHAIRMAN CATES: Wow, okay. Let's close Agenda Item Number 2. Move to Agenda Item Number 3, consent agenda. We have multiple reports on this agenda. This is a consent agenda. Does any member wish any of these items to be pulled for discussion?

Seeing none, okay. This is going to be a quick meeting. Seeing none, I'll call for a vote. All those in favor of accepting the items on the consent agenda signify by saying aye.

(The vote was unanimously in favor of the motion)

CHAIRMAN CATES: All opposed? Okay. Motion carries. I combed through that looking for questions. I didn't have anything.

Okay. Let's move to Agenda Item Number 4, presentation on the state of PEBP. Damon.

MR. HAYCOCK: Thank you, Mr. Chair. Good morning, everyone. Damon Haycock for the record.

This report is the same format that we presented last year. And we start off with the mission and values statements that the board had approved back in April of 2016. You'll see later today that we are presenting another opportunity to revise, but this is solely for plan year 17. We, of course, continue to provide the consumer driven health plan alongside two regional HMO plans. And we on the consumer driven health plan had an excellent year.

I'm going to summarize a lot of this stuff so I don't have to -- This is mostly for the stakeholders. All of you board members have received these reports alluding to these statistics and these success stories all last year.

But one of the biggest success stories that PEBP

had with the consumer driven health plan is that although we had increased population, we had increased costs. So we had a negative trend on the medical side and effectively on the pharmacy side by switching to a new pharmacy benefits manager.

You'll see here on page two we go in to more of the specifics on where we've reduced costs or saved funding and saved -- saved money basically on our health plan. And then we have some tables here to show some of our accomplishments.

Moving on to page three, you'll see that from our pharmacy benefits manager comparison that we were able to increase our members that are on the plan but our costs effectively went down. We basically had a three percent increase in unit cost, the overall cost to the program. But we tripled our rebates. And therefore the ending cost to the plan on our pharmacy benefits is actually a negative three and a half -- negative three percent trend.

And that's excellent. There is no one else that I've talked to that had a negative trend on pharmacy across any plan. Even returning from the International Foundation of Employee Benefits Plans conference this week, this was the gasps and wows when I was able to share those in the section with them.

We did have that new out-of-state PPO network

where we moved those out-of-state residents on to a new Aetna network and we effectively saved two million dollars that year as well. And then we launched a new virtual visit telemedicine provider, Doctor on Demand. We received a national award from SALGBA, the State and Local Government Benefits Association, for our specialty drug management practices.

As you all well know, we went through the biennial budgeting process and had a successful session through the 79th legislative session where we are were able to finally with coordination with the advocacy groups, RPEN, AFSCME, Nevada Faculty Alliance, and, of course, the Department of Administration and the governor's office, solve a multi-year problem for the non-state retirees, affectionately the orphans, where they saw significant reduction to their premiums starting July 1. So that is something that we are very proud of.

We also continued to provide additional in-person assistance. We ramped up our opportunities to help retirees who are aging in to Medicare with weekly meetings at our office. And we also were able to in place with the assistance of Towers Watson a health reimbursement arrangement advisor or HRA specialist that was able to participate in our Carson City office one week a month and now has extended those in to Las Vegas.

As in the contracting section on page five, again, we signed that contract with Express Scripts that I had talked about earlier. We also renewed the HMO services statewide through two regional HMO's, Hometown Health Plan and Health Plan of Nevada. We continued to provide excellent customer service to our membership through PEBP. We received about 45,000 phone calls last year and we even had average speed of answer hold time and drop call statistics below industry standards. We also had just over 1500 total walk-ins. And we had about 13,000 e-mails that we answered. So that's becoming the new norm where we're answering many more e-mails than we had in the past.

We, of course, continued in-person education and outreach. This is on page five if you're following along. About 533 state employees attended a series of open enrollment meetings across the state. All of our presentation materials, of course, are on the website.

As far as our fiscal year performance indicators, on page six, you'll see that we met all of our goals with the exception of the claims loss ratio. Our goal was to spend about 119 percent of our budget and we only spent a hundred and two and a half percent of our budget. The idea of why we would ever spend more than what we were budgeted for was to reduce those or spend down those excess reserves. But because of our excellent year, we couldn't spend all of that

money. I don't necessarily think that's a bad thing. But if you look at the goal, it could be perceived that way.

Our generic drug utilization is higher than our goal. Our in-network utilization is in the high nineties. Same on both medical and dental. And, of course, our appeals are .26 per thousand.

Our finances, we are just under half a billion dollars a year in revenues and expenses. And you'll see the charts on page seven that go in and distinguish those different categories.

Under our financial overview, we have about, at the end of June, about 27.6 million dollars in the program above those required reserve levels. And that's strictly on a budgetary basis. I'll talk about reserves later when we go over the plan design opportunities. There's kind of a true-up or reconciliation as was provided in years past. We talk about where we get our revenue from. As we all know, we get it from state subsidies as well as the member contributions and any funds carried forward.

There is a recap of the reserve utilization that was claimed for plan year 17 and the types of enhanced benefits -- At that time they were still called enhanced -- and what the costs were projected to be. And that the board had planned three years ago to have those fully extended. Of course, that's not what occurred.

Some of the future challenges though that I placed in to this report -- This is the final on page nine. We have had increasing risk associated with our health maintenance organization, our HMO plans. That is the types of members and their costs. Not to put it uncompassionately, but there are folks that are paying higher premiums on those HMO plans and using those plans more than folks that are on our plan for the most part, which means that the risk of those plans continue to grow. This is why you see increased rates.

And then, of course, we are all still waiting to see the final disposition of the Affordable Care Act and how that trickles down to our program and how that trickles down to our state. I don't have any updates on that because they're still introducing bills and arguing about them at the DC level.

So with that, I will turn it back over to you, Mr. Chair, and see if there's any questions.

CHAIRMAN CATES: Thank you, Damon. Good report.

Any questions of Damon?

MEMBER COCHRAN: Mr. Chair. This is Chris Cochran in Las Vegas. I do have a question for Mr. Haycock. I know that the docs on demand is -- the Doctor on Demand is a fairly new program. That was something that we, presentation, the board had a presentation on that a couple

years ago, I believe, in the fall of 2015. Did we have any targets for that program? 600 visits doesn't seem to be a whole lot of visits. I don't know overall. Do we know -- Do we have any information on this? And this may not be something that you can answer at this point. But I'm just kind of -- I'd like to get more detail on the visits. Who's utilizing it? Where are they coming from? Are we seeing more utilization of this from members who live in the rural areas or just all over the state? So I don't know if you've got any updates on that.

MR. HAYCOCK: For the record, Damon Haycock. All excellent questions, Dr. Cochran. We did a monthly utilization report for Doctor on Demand. Unfortunately, out of the hundreds of pages of stuff I brought today, that is one that I did not. I can definitely provide that to the board. I'll make sure you guys have it in November.

We have some internal targets. But because it's an opt-in program at this point, it's difficult to try to incentivize folks to utilize it, unless we put some form of carrot, which the carrot in and of itself by the design is a lower cost. Doctor visits on line are through your cell phone or tablet. But I have challenged our communications teams to double those numbers. And we are already seeing a huge uptick. We have been marketing this program like mad, right. I don't know if you've seen all the newsletters and

e-mails and announcements. We even had folks trying to push the program or at least share the benefits of the program in our flu shot clinics that we hosted. And we are dedicated to making this a successful program as it not only saves the plan money eventually but it truly saves the member-first dollar coverage when they utilize these services.

So we have a huge marketing push on Doctor on Demand. I'm waiting to hear people tell me they're tired of hearing about it because I push it so hard. And we really started this ramp-up probably in beginning of summer, late, late spring of this year. So we are seeing a significant uptick. Bit we are pleasantly waiting on meeting those internal goals. And we can share them. But I don't even think that doubling them is enough. But that was the first milestone. And if there's any additional information that you all would like to see, I can come back and bring it to the board.

MEMBER COCHRAN: Okay. Thank you. I think that answers most of my questions. I just wanted to have a little more detail and see how well it was working. I think there are opportunities there. But, you know, knowing then that it didn't really start until this year, you know, it's realistic that it's not been pushed, and, you know, it is probably more about people not knowing enough about it even though you may be pushing this. You know, a lot of times we don't read our

stuff from PEBP until we're sick. And so it's just something that we probably need to just watch and see how well we can get more information out there. Thank you, though.

MR. HAYCOCK: For the record, Damon Haycock. Thank you, Dr. Cochran. Just as a quick follow-up. I have an idea on how to get more utilization that we'll talk a little bit later about the plan benefit opportunities for next plan year that may drive utilization or at least drive sign-ups so people are aware of and can use this service. But I'll talk about that at a later agenda item.

CHAIRMAN CATES: So, Damon, I have a question of you. It's probably a question you can't answer with any precision, but when I look at page one and two and all the experience that we've had in the plan in 2017, I guess I just feel a little nervous. It just seems like we have gotten lucky in terms of cost trends in a lot of ways. And I know that some of it is due to demographic change who is in the population. And some of it is a result of how you're managing plans and how PEBP is being managed. But can you give me any sense or gut feel of how much this last years experience is just luck or do we have any sense that some of these savings are going to persist in to the future?

MR. HAYCOCK: For the record, Damon Haycock. I'll try to clear the fog from my crystal ball, Mr. Chairman. I appreciate the comments and the realization that PEBP is

managing this plan efficiently and strategically. We are doing every possible thing we can to stay out in front of inflation. This concern and this fear of are we just having a good year or are we lucky, it's hard to claim luck when it happens year after year for the last six years. I mean, if you go back and look at the utilization report for last plan year in the consent agenda, you'll see that the medical trend is roughly flat. I think it's even at negative one percent since 2012. So if you look at that six-year trend, I don't know if we can claim luck anymore. I think we're going to have to put some of it towards skill. And, yes, we've had the opportunity to receive an additional population that utilized the plan less than the previous population was utilizing, which also saved us funds. But that saved us about five million dollars. And you'll see in a later report that we saved 20 million dollars. So that only accounts for a portion of it. It doesn't hurt that our plan continues to have flat rates and the competing plans, the HMO's continue to have increased rates. And so folks that want to have a lower rate plan are traditionally going to move over to our PPO plan. And those who really, really need the services and are afraid of that high deductible are going to move to an HMO plan so they don't have to pay that first dollar coverage out-of-pocket co-pay. So that in and of itself, that design drives heavier utilizers to our HMO plan and our PPO plan

still receives that benefit.

But we have done things very, very purposeful that have shaved a lot of costs while not reducing the quality of services to our members. And that's key. It's how do you save money without harming the membership. And switching to out-of-state network, saving two million dollars -- And I can't remember -- And I'll let Nancy answer if she can. And I don't remember a single complaint on that network that came in last year. And she's shaking her head no. So we made a two million dollar savings on 800 people. I mean, that's huge. And it's finding those situations where we can make the biggest impact without negatively affecting our membership are some of the reasons why we've been able to stay ahead.

And as I brought to you all over the summer a series of contract extensions, they were all for either cut cost or increased revenue. And we haven't even realized that yet. Those don't happen until the future. So we are purposefully planning for those unlucky years where claims may increase or where situations that we don't know may surface. And so normally when you have your big year you kind of sit back and you relax and you kind of ride it out. But I'm deathly afraid of what's going to happen later and so I'm constantly trying to push my team and my partners to find successful ways to be proactive instead of reactive. And I

think it's that type of philosophy and the great decisions of this board in supporting these types of recommendations are why we're in the position we're in today.

CHAIRMAN CATES: Thank you, Damon. Well said.

Do we have any other questions for Damon?

MEMBER VERDUCCI: Mr. Chairman, Tom Verducci for the record. Damon, can you speak for a moment in terms of reducing pharmacy costs through mail order? I know that in mail order typically you have to order a 90-day supply in advance. What type of reminders go out through E Script or whatever the process is to try to convince members of the program to order their pharmacy on a reduced cost basis through the mail?

MR. HAYCOCK: For the record Damon Haycock. Thank you, Mr. Verducci. If PEBP through our pharmacy benefits manager, Express Scripts, offers a 90-day mail order benefit, so to break it out of health and look at it just from a typical economy scale scenario, the more you buy at one time, the lesser the costs are because you get that bulk discount, that works for a lot of drugs that aren't too expensive on a monthly basis. There are certain drugs that cost a hundred dollars a month. And if you go to the pharmacy and get them, you pay your hundred dollars each month and you can hopefully afford that. It's hard to ask someone to pay $260 a month or $270 at one shot to try to get

all three months at a time. But our utilization of our mail order is not where I think it should be. The book of business from Express Scripts is much higher than what we currently use. And, ironically, as you mentioned this today, I just challenged our marketing staff, our communications team, to push the knowledge and some of those savings out to our membership. And that's one of the things that they've been tasked with.

Right now when you sign in to your account on PEBP and you click on Express Scripts, it pulls up all of your recent claims. And there's this call out that comes across the screen that says you could have paid. I see it every time because I'm not as efficient with my own money as I am with PEBP's. And I could save a couple hundred dollars a year. And it reminds me every time I log in that these are the prescriptions that my family takes today where I could save some funds or save some costs if I were to implement those -- this as soon as possible.

So we are going to push that. That is something that's important. We have a low utilization of that mail order. I think people aren't used to receiving it. But it is definitely one of our priorities.

MEMBER VERDUCCI: Thank you very much, Damon. Just one follow-up question on a different subject. Are we seeing participants in the program utilize the preventive

aspects where they do have an increased contribution in to their HSA contributions? Are they utilizing those programs?

MR. HAYCOCK: For the record Damon Haycock. Good question, Mr. Verducci. Yes, they are using those. We have a couple hundred who have already gone through the process so far. But recognize that most folks that use these services annually have them set up on a specific schedule. Whether they have it on their birthday month or January of the year or June of the year and it's difficult for them to change that process. So we anticipate seeing a much higher utilization as the year unfolds. We haven't received our full end of first quarter reporting yet, so I don't want to give some bad statistics until we actually get those. But we'll be able to provide more information at the November meeting, as we usually do, on the first quarter utilization of all of the subjects. But, yes, the short answer is people are using it and HSA funding is being deposited.

MEMBER VERDUCCI: Thank you very much.

CHAIRMAN CATES: Thanks, Tom.

Any other questions?

Okay. Let's go ahead and close that item and move to Agenda Item Number 5, discussion and possible board direction regarding updating the PEBP board's duties, policies, procedures and strategic plan. Damon.

MR. HAYCOCK: Thank you, Mr. Chair. For the

record Damon Haycock. This report is in response to the clean-up language that we recommended at a previous board meeting in response to the latest legislative session. Senate Bill 502 was passed and there were some changes that were not reflected in the current policies and procedures. There's also an opportunity that I took in revising these to provide more flexibility to the board. And I'm going to walk through some of those opportunities here.

But, as requested, there are two versions. The first version of the report is the red line version. And typical of legislative write-ups you'll see that the information in blue is what is added, whereas the information in red is what is eliminated. Once I put this together, I ran it by our deputy attorney general, Dennis Belcourt, so we had an opportunity to have a legal perspective. So it has gone through his review. And I'm just going to take you through some of the highlights now. Obviously we changed the dates on all of this stuff to be more applicable to this board meeting.

And before I -- Let me back up for a second. There is no required action. If the board doesn't want to approve these today or they want me to make changes, I can go back and make those and bring them back for a future board meeting or they can be approved if you like them with a few changes as part of the motion. So, as far as process goes,

this isn't one of those here it is you need to approve it. This is one of those please review and provide PEBP feedback and if there's something we can do to make it better, we will.

You'll see there's some right there on page three we start going through some basic clean-up language. And then we move in to one of the biggest changes by the way is under board responsibilities on page four. A, board responsibilities, subsection five, it originally said take a position on any proposed legislative matters affecting the program and direct the agency employees to make the position known to the legislature. That was one of your board responsibilities. That is a key part of what you all do as a governing board.

One of the issues that I ran in to at this last session that provided me some concern was that the legislature was running so fast as they do with only 120 days, and once I got notified of a bill or an amendment to a bill, it went to committee immediately before we could get your opinion or your position. And I did not feel I had the authority to hop up to the table and talk about a bill if I didn't at least have a position point where I could walk up there.

And I don't ever want to be in a position where I can't at least share with the legislature what potential

impacts may affect this agency. Whether you all, you know, support it or don't support it, there's always going to be an impact even if that impact is not in.

And so I added some language here to provide a little flexibility to you and a little flexibility to me to represent you at the legislative level, to authorize that I take a position of neutral on any new bill by default. And that way I can come to you all when we have those weekly or bi-weekly legislative update meetings next session and say these are the bills that were introduced, these are the committees that were introducing them prior to this meeting and here is the position of neutral. What would you like me to revise it to? And at least that way we don't miss that critical opportunity to share something that could potentially basically affect our membership.

We also -- I struck eight and nine from there. Nine is totally different now that the quality control officer for Senate Bill 502 reports directly to the director of Department of Administration. And that's where you see that new number eight.

As far as the old number eight where do you all approve a job description and evaluate the performance of the executive officer annually. I think there's been two evaluations for the last two executive officers over a period of something like seven years. And so they're very difficult

to have in a public setting. Unfortunately, they have to. We want you as board members to be able to provide candid feedback. But we recognize that it's difficult to do that in the public sector. A lot of boards have gone away from doing public evaluations. And so I'm presenting an opportunity to kind of not have to dance that line.

Moving -- Well, you know what, and please, Mr. Chair, if you guys want me to stop or if there's questions, I can stop. If not, I'm just going to kind of roll through this and highlight the big stuff.

You'll see on board member conduct, number four, it was stricken in accordance with Senate Bill 502 that eliminated the continuing education credits both for the board and for the executive officer.

Moving forward, there is on the top of page six it says the board will meet during the first quarter of the fiscal year to conduct the strategic planning session. We did a strategic planning session that I'll talk about after these policies and procedures that I thought the process was very successful and it worked very well. And it allowed everybody to be able to have that significant day-and-a-half period. It's hard to do those in public board meetings. But we're going to present those results to you. And if you'd like it within this part of the process or policy it's unnecessary. We'll just continue to do what we're doing or

what we just recently did. If you'd like to keep it, we can of course leave it in there.

One of the things that Mr. Belcourt from the attorney general's office had put in, and I agree, I think it's important, because it's not as clear, is that, of course, as the executive officer I report to you all, however, that you all delegate the responsibilities so that I can implement the plan of benefits.

There's always questions about what is a delegated power and an implied power and what is a direct power. And this allows you to delegate to me or this puts in policy that you're delegating to me basically the title of and the operation of the plan administrator. So that way you don't have to make every decision on the plan and we have to have, you know, daily board meetings.

Moving forward, and again, to continuing education credits on page seven for my position were eliminated per Senate Bill 502, so that's clean-up language.

You will also see on page eight one of the things that Mr. Belcourt added that I thought was very important, nothing herein precludes a board member from directly contacting the commission on ethics. This is under the ethics session. And that we changed that the chair -- We took out operations officer and I put myself since I feel it's important that I own the ethical activities of my

agency. And if you ever have issues or questions about that, you can reach out to PEBP, you can reach out to the attorney general's office. But, most importantly, you can reach out to the commission on ethics. And their director is excellent and she's always there to help. You will see her at the January board meeting giving ethics training to the board.

As far as the travel policy goes on page nine, I'm a big proponent of not repeating things that are standard. It goes through and it just says what's in SAM. And SAM is the State Administrative Manual. Basically as board members when you travel you are treated like a state employee is treated. So you have the same GSA requirements, the same travel policies. It's to make it clean and easy. But I don't feel like we need to put down here when you guys get to have breakfast, lunch, or dinner. I think it gets too far in to the weeds. It's outlined in SAM. So I replaced that section and it basically just said you are subject to the same travel requirements and it cleans that up.

Then the big one, this is in section three under contracts. And it goes in to the procurement process. And I took a stab at trying to encapsulate what occurred in Senate Bill 502 and share all the different options and opportunities that the board has. And I'm not going to read all of this to you and I can answer specific questions. However, I want to draw your attention to section five.

You'll see that on page 11 that if I offer a couple of opportunities for actions in collaboration with the Nevada Faculty Alliance and AFSCME and RPEN, they reveal that that isn't -- one of those options wasn't annotated in Senate Bill 502. So I appreciate their assistance. And I need to change that piece and add in that there is an opportunity for a closed session for reviewing the evaluation criteria. Or sorry. The evaluation committee's results. So that way you all know why the evaluation committee chose what they chose. And and it will be done in a closed session. And that's per Senate Bill 502. So I need to add that language in here. And I can either add it in here and basically -- and that was going to carbon copy it from the Senate Bill 502. Or I can summarize it and then either bring it back to you all for approval or you can trust that I will have that done and approve it with that exception.

But it basically goes through and says all the different things that you can do with contracts, where you can approve them, how you approve them. And then what happens if you choose not to and what PEBP has to do to respond if you don't.

We've taken out all the other stuff about the May board meeting we have to go to X, Y, Z. And I say that we took it out now because we don't want to do these functions. But it pigeon holes us in to only one time of year to do

this. And the health care marketplace is dynamic. We want to be able to bring you all opportunities for RFP's or further procurement strategies outside of May and sometimes we want to get out way ahead because of the current market place situations.

Then we took out at the very end the proposals will be valued be an evaluation committee and that you guys can -- We -- Let me back up. We cleaned it up, this whole section, so that it's simple and it falls in line with not only Senate Bill 502 but NRS 333. So all the things that we took out of there are either redundant or no longer applies.

One of the biggest things that we made a change on is under part four, premiums and contributions rate setting processes. First of all, I wanted to make a call out to the contract -- our contracted actuaries because they do the actuarial work. They are licensed and certified through a significant amount of education and training to be able to legally and appropriately develop rates for us. And I thought competent counsel wasn't quite strong enough. But I also cleaned up some of the language on the reserves just for the actual titles of what they are.

However, one of the things on the reserve policy on page 14, the reserve policy says that you can reduce overall -- that you can only use reserves to reduce overall rates and these excess reserves or increase HSA/HRA

contributions. But it doesn't talk about if you wanted to designate these for new programs or a new service. And so I wanted to get that flexibility because that's basically what you did for the last three years anyway is you've enhanced the plan in one way or another and I want the policy to reflect that you have that flexibility.

And then, of course, we talked about what confidence level. That's one of the things that is important at the legislature, they always ask if what we are submitted is at that 95 percent confidence level as determined by our actuaries.

And then the contribution itself, and let's talk about -- let's move on to page it looks like 16. Initially you all would make your final determination regarding plan design changes, not later than four to five months prior to open enrollment. If we do the math and you make a change at the March board meeting, you don't have four to five months before open enrollment begins in May.

So I wanted to make the initial determination. That's what you guys are going to do next month and that's what has been done at the board level every November for many years.

But as we realized last year, we had a certain financial situation that we had to deal with in November. It got a little better in January. And it got a heck of a lot

better in March. And you were all able to make final plan design decisions. And this policy now supports that process by giving you the flexibility and an opportunity to not only approve design but also adjust rates at that March meeting.

We add more flexibility under the strategic planning process that you will review and revise and approve the strategic plan on an annual basis. Strategic planning is critical, especially in the health care marketplace with all of the dynamic changes that occur over and over. And if you liked the process that those that participated in August with PEBP and if you would like to see that process continue, this allows you all that policy to do it on an annual basis.

We wanted to have it done -- You'll see that every effort we made to review and approve the strategic plan prior to the initial and annual plan benefit design approval meeting. Why is that important? If your strategies are approved for the next year before your benefit design is, then the decisions on those benefit designs are a lot easier to make because they are tied back to your strategies. It's a very clean kind of domino effect. What do you want to do? What's your mission? What's your vision? Who do you want to be? How do you want to be? And then what are your goals and objectives for the next year. And then now what plan benefit design will you approve to meet those goals and objectives. So it's really clean that way.

Then the legislative agenda that we wanted to make sure that we outlined how we're going to have bill draft requests recommendations. And then I cleaned up -- I changed data gathering to program reporting. We have statutory program reporting. You'll see on page 17. So that's taken directly out of the statute. Moving on, there's a couple of other housekeeping changes you'll see for language.

On page 19, and this is the appendix on plan year rating methodology, I took out the two currently contracted HMO plans, not because they're not going to remain with us. That's not indicative of that discussion. It's that I don't like to put specific vendor names in policies because you never know when they're going to change. It's important I think just to show that we are going to have them now and if we ever decide not to we can go back and strike them from the policy.

We also need to talk about -- I clarified on the bottom of page 19 that there's two types of health reimbursement arrangement methodologies, one that applies to the consumer driven health plan and HMO plans where you get an HRA amount just like we get an HSA amount. It's a dollar amount one time at the beginning, whereas those on the Medicare exchange receive a monthly allotment, and that wasn't annotated here. So it's just clarifying.

Then there was a -- If you advance to page 21 at

the bottom, there was discussions of multiple different types of catastrophic reserve buckets. We only have one. It's category 86. And it basically says that you will use reserves to reduce rates. And that's not necessarily true. And so I want to make sure that it didn't paint the board in to a corner there.

Moving in to the subsidy allocation on page 22. One of the things that the board has done for years is they have declared that they want a certain type of subsidy percentage. Well, if you remember back in March, we had an opportunity to adjust that percentage to keep rates low, to apply more of the available funding from the state, and then move those enhanced benefits over. And, honestly, had you all stuck to the 93 percent and 64 percent that you see on page 23, we couldn't have done that. And I want to give you all the opportunity to make those decisions, as you are the fiduciaries of this program, that if you want to change how that contribution works, you have the right to do that and you are not pigeon-holed in to following a specific percentage when in total reality the legislature awards the dollars to us in a dollar amount. They don't award it to us in a percentage. And so this gives you that opportunity to make those adjustments based on marketing conditions. And so it will be especially helpful in the off year where the legislature does not meet and you are stuck with a specific

amount of contribution and you have to try to make that money work and you can't. If you are stuck with these percentages and if it turns out you don't have enough money yet you keep these percentages the way they are, you're actually obligating future legislative dollars. That's the way we'll make up and get those. And I'm never a supporter of making the legislature fund something that they didn't approve in future years without getting their feedback. So there's some flexibility built in to here.

Again, there's also, on the top of page 23, you'll see that there is a percentage split from the primary plan and the non-primary plan and that's talking about the CDHP versus the HMO plan. Traditionally, the difference was 15 percent in contribution. Last year we were able to reduce that and apply more contribution to the HMO's. And so the proposed high increase in rates became very, very small once we finally put it in to practice that you all approved. So, again, all of these types of changes are there to add flexibility so that you as the board can make those decisions at the time you need to make them with the best information you have available.

And then it also talks about, at the bottom of 23, that I -- I took out the rigidity of the part B premium as published by CMS, because there are multiple premiums that are published by CMS. So what's the right one? So I just

said as approved by the board. So, if you remember, you guys approved an increase in the Medicare part B premium credit from 104.90 to 134 this year. This is giving you that opportunity to do that as you approve plan method designs year after year.

And I'm going to stop here, Mr. Chairman, and then ask for questions and feedback and then we'll move on to the strategic plan.

CHAIRMAN CATES: Do you have any questions or comments of Damon? Go ahead.

MEMBER BAILEY: Mr. Chairman, to Damon, that statistic planning meeting was superb. And I hope that continues. It's in the written format as a procedure now. So that will be an ongoing meeting; correct?

MR. HAYCOCK: That is correct.

MEMBER BAILEY: And we rolled in all of the input of your staff and the members of the board were there.

MR. HAYCOCK: For the record Damon Haycock. Yes, Mr. Bailey, not only did we roll any input from staff and the board members that attended but also all the partners that attended as well. It was a true collaboration on a strategy that touches all facets of what we do.

MEMBER BAILEY: I have to point out that that meeting went very well. So continue with that. Thank you.

CHAIRMAN CATES: Go ahead, Tom.

MEMBER VERDUCCI: Tom Verducci for the record. I just wanted to also point out that it was a very successful strategic planning session. And I really like how you pointed out that the mission statement was too long. You've modernized it, brought it up to -- in terms of being super current. And I thought it was very good input from really all the vendors. I thought it was extremely valuable and I would encourage you to do that every year.

CHAIRMAN CATES: I think I'll just pile on that and say that it was a really good process and I was very thankful to Damon and his staff for how that was put together and everybody that he brought together to do that. And I'm also grateful for the members who were able to participate in this.

Any other questions from members or comments? I do have one. This is a thought that just came to me as you were going through this. The continuing education, just to talk about that for a minute, so the continuing education was removed from statute as a result of the bill that I proposed. That portion being removed from statute really was to meet budgetary requirement in the budget office and some discussions about how other boards and commissions don't have continuing education specified in the statute. So PEBP's budget was submitted along with that bill with the funding for continuing education being removed. The legislature

approved the bill which removed the requirement from statute. But they restored the funding for continuing education in PEBP's budget.

I think there is value in continuing education. I would hope the board members would agree as well. And I would suggest that we keep some language about continuing education in the policy, maybe say something, like, to the extent funds are available or something like that, not necessarily a requirement, but it's something that we value and we should try to do.

My fear in taking it out completely is we have funding in this budget right now for it, but should those funds not be spent, we would go into the next budget cycle, we have no grounds to increase funding for continuing education because it's not a statute. It's not policy. If it's in policy then we at least have something to use to make sure that gets help. Any thoughts on that?

MR. HAYCOCK: For the record Damon Haycock. As you were explaining your position, Mr. Chair, a light donned on me. We were doing that kind of in the background. But there's no reason why this policy can't be adjusted to leave that in there. And even though there's no statutory requirement, there's a lot of things that aren't statutorily required that this board does, right, and the board does very well. From a practical standpoint, we do provide funding and

opportunities for continuing education for the board. Mr. Shippey just got back from one of those opportunities. I just got back from that opportunity Tuesday night. And so it's not that we are halting continuing education. It's just that it was my initial blush at trying to adhere the policy to the bill.

But, as you mentioned, putting the caveat upon available funding, I think that we would add that to the end of those sections, I can put them back in and it still meets the intent. Because I don't believe anybody here nor anyone at the legislature was too fond of the fact that we were cutting continuing education out from such a very important board and executive staff that has to run a billion dollar biennial program. So I am all for putting continuing education back in and I can add that caveat at the end of the section and un-remove it.

MEMBER BAILEY: Mr. Chair, on behalf of some of the board members, I attended at least two of these sessions. In my first year I attended maybe one. And I'm telling you because as a board member I didn't know a lot about insurance. I know a lot about it now. But the point is that I feel it's extremely necessary for the board members to have the right to attend these educational programs. So I encourage that to be put back in to our program. Maybe not legislatively but at least on our procedures.

CHAIRMAN CATES: I think Dr. Cochran.

MEMBER COCHRAN: Yes, Mr. Chair, thank you. I wanted to address that as well because I know that we do periodically in these -- in our meetings where we have trainings, for example, HIPAA training and other trainings, and I would assume that those are also part of continuing ed. If I'm wrong, you can let me know. But since we do have some strict requirements on -- regarding the health of our -- the health care of our population, it probably would be a good idea to restore at least some section on that that we make available to board members' continuing education to keep them up to date on current practices.

CHAIRMAN CATES: Thank you.

Any other comments on that? Any other comments on this agenda item?

Go ahead, Damon.

MR. HAYCOCK: Mr. Chairman, we still need to go over the strategic plans. This was just a pause in the middle.

CHAIRMAN CATES: Gotcha. Sorry. Go ahead and continue.

Did you have a question, Tom?

MEMBER VERDUCCI: Yes. Mr. Chairman, Tom Verducci, for the record. I just had one comment on the board responsibilities. And on number two reads provide

health care, life insurance, and other voluntary benefits. It would seem to me that it would make sense to throw the word insurance benefits in there because the state has a deferred comp plan. This is not part of the responsibility of this board. And I think just to be more clear and concise, throw the word insurance in there would be more of a clear definition of our responsibilities.

CHAIRMAN CATES: Okay. Thank you.

Are we ready to move on? Okay. Go ahead.

MR. HAYCOCK: Thank you, Mr. Chair. For the record Damon Haycock. I noted that in there. We'll make sure that gets added.

The next part of this agenda item is the strategic planning overview that was held on August 22nd and 23rd. This was as a strategy session. So this is the overview of those results.

This was a process that we started back in December of 2016 on a very, very small basis on how we're going to internally prepare for the session. If some of you remember, we wanted to make sure that we were ready to pivot on any bills that were coming out. As you all remember, there was some discussion about PEBP moving under Department of Administration and we wanted to make sure we had our ducks in a row with a very small group.

We felt that was successful, so we expanded it to

include more partners and, of course, the opportunity for board members to attend. And I'm very pleased to say that the board chair attended on a portion of this, the board vice chair attended on a portion of this, and another board member, Mr. Verducci, attended on a portion of this. And, really, that feedback was critical to kind of testing the waters and the temperature of where we were headed, because the last thing that we would ever want to do is make it appear that the agency is driving the strategy when it's really the board that drives the strategy and it's the agency's responsibility to respond to and implement your goals and objectives.

But we wanted to create an opportunity to put something in front of you all so that you had something different to look at.

Before I go in to this, I want to share how successful and how appreciative I know I was when I got to PEBP when I was able to go back and see what the previous board committee had done on policies, procedures, and strategic planning and from those strategic planning goals, I was able to create what I call my one-year plan on how I was going to try to meet those.

And if those that were on the board remember, one of the first things that we did is we developed that communication plan. That was something that the previous

committee and previous board felt was very important, as do I.

And so the strategic plan is only as good as the people that actually implement it. And if it doesn't get implemented it's just a lot of text and pictures on paper. And so this is important because it drives all the other discussions and, really, if you all approve it or we make some changes or whatever you want us to do here at PEBP at the agency level, you will see that when we make recommendations we will consistently tie back to this, so that way you can see how are we meeting the strategies of the organization, the strategies of the board.

One of the first things that we talked about at the session was the idea of a mission statement. Could anybody without looking at it recite it to anybody else? And I think that the mission statement was a very robust and well thought out mission statement. It's just something that is difficult for anybody to kind of roll off the tongue in an elevator to say what's your mission of your organization and what's the mission of your program.

And so what we thought would be an opportunity is to kind of split that mission statement in to a mission and vision and therefore make it a little bit easier to share and hopefully still meet what the goals and objectives are of the board.

So one of the -- You'll hear kind of a consistent theme through this, but there are three words that I highlighted in blue for those of you that have color copies or are following along in the audience, that the proposed mission is to provide employees, retirees, and their families with, and here's the key, access to high quality benefits at affordable prices, access, quality, and affordability.

And, yes, it's a departure from the original vision of recognizing the fiduciary responsibility of the board, the program, all right. We can roll that. But I think once you see the proposed vision and the goals and the objectives, that it kind of expands upon that in certain areas and constricts it in others.

But in taking that same strain of access, quality, and affordability, the vision, we didn't have a vision, right. You had vision statements, which is a little bit different. However, just to kind of help those who are following along, and I know the board understands this, you know, what's the difference between a mission statement and a vision. That vision has to be powerful, passionate, and focused.

So what are we all about? What do we want to be? Who are we as we explain ourselves to other folks? And we are a member-focused, right out the gate -- And I want to thank Ms. Lockard from RPEN for helping me rearrange some of

these in the most appropriate order. PEBP will be a member-focused, nationally-recognized, affordable program of employer-sponsored benefits serving employees, retirees, their families, and the Nevada taxpayer.

When I came here today and sat down at this chair, the last time I was in this room, I was up at the testimony table trying to get this job. And I had a flashback about the interview questions I received. And one of them was how do you balance the needs of the program, the membership, with the needs of the taxpayer. And I could only think of one word at the time. And I didn't know how true it was. But the word I provided was carefully. Right? If you remember, those that were on the board. You have to be careful about it.

And this right here shows that there are multiple competing priorities but that they are all priorities to the agency and all priorities to the board. So that's our proposed vision statement.

We also had a little bit of fun with our logo. You've seen it before, but we wanted to add those three powerful, impactful tag lines to it: Access, quality, and affordability, right. When you look at a logo and you look at tag lines, you get what is important to the organization right there without ever having to see anything else. And we are the Public Employees' Benefits Program and these are the

things we care about.

We had an opportunity to go round-robin at the strategy session with the values. And one of the other things -- And I'll get to it later -- but we also had an opportunity once the session was over to send this to RPEN, AFSCME, the Nevada Faculty Alliance. And I sat with them and got their input so you'll see some -- I will showcase certain areas where their input was invaluable.

But we look at those value statements that the board had provided before, and I was trying to find a way to work them and just make small tweaks, but as we were going around the table, we really had some pretty powerful values that we could say in one-word answers. What is important? And I bet if I asked everybody at the table here today and I asked everyone out in the audience, they would add something to this list, because values are important to each and every one of us. And in no way do I feel that this is the sum total of the values of the board or the program. And I would always encourage additional comments and additional values to be added or to be re-tweaked.

But right there, the top value, first thing is service, right. We are all here to serve, to serve our membership, we serve the state, we serve our local jurisdictions. We serve our -- We serve each other. And I serve you. So it's all service. It's all service-oriented.

Innovation, that's something that was in the last value statement that we wanted to include.

Accountability. PEBP has to be accountable for the decisions that are made. The board, of course, has to be accountable for the decisions they make, and our members need to be held accountable. This is like a social contract that we all have to work on this process together to successfully implement a comprehensive program with benefits.

Transparency. That is near and dear to a lot of folks and that's why we continuously present massive binders full of reports and everything is on our website because we don't want to ever be accused of hiding the ball.

Fairness. Fairness is important and I believe that came from my meeting with the Nevada Faculty Alliance, RPEN, and AFSCME. But the idea of is it fair to provide one thing to one and not to someone else and how does that balance.

And take in compassion, sustainability, and collaboration. And I'm more than willing to swap some out, change some, if you guys want to redo all of those. These are just the suggestions that we all came up with when we did that strategy session.

Then we go in to what are the goals of the program. And I took the goals out of the categories that was in the previous strategic plan and tried to expand upon them.

And I'm not going to necessarily read all of these to you, but you'll see that there's a series of them in program administration, transparency, collaboration, and communications. And how are we going to -- how do we designate these. We basically got input from all the folks that participated and we landed on these it looks like 18 different goals.

But before we're able to determine a strategy, we have to do analysis. And I'm going to pause for a second and share a story that I just had coming back from the International Foundation of Employee Benefits Plan, their annual conference in Vegas this week. And I attended a program, it was the administrator's masters program. It's supposed to be for those people that administer programs or are trustees and it's supposed to be at that masters level. And then I also attended multiple sessions at the rest of the conference.

And one of the major focus areas was strategy. And when they went through the process of how to do strategic planning, I felt very proud that we were basically doing these things in this strategy session, that we first analyzed who we are and then we develop what goals that we want, and then we develop strategies. The next step is to execute those strategies and then to evaluate how we did. Those two parts haven't been done yet because I want the board to

obviously provide direction, guidance, and approval on what those goals and strategies are. But following that basic playbook of analysis, goals, strategies, execution, and evaluation, we were able to -- I was able to share a lot of positive feedback to those sessions and participate in those strategy discussions.

So, again, it's not something new. Strategic plans have been around for a while. But it's not always done in health care.

So moving on to what our strengths, our SWOT analysis is strengths, weaknesses, opportunities, and threats. You know, number one strength is support the board, all right. I appreciate having a supportive board. We have plan solvency. We do have excess reserves. We're innovative, transparent. We do have strong relationships with our advocacy groups that we're proud of. We can negotiate well. We have good operations. And we are starting to become nationally recognized.

And why is that important? It leads to the credibility of what we do. And so no longer do we need to ask others for their -- I shouldn't say that. No longer should -- Hopefully we be told we need someone else to validate what we do, perhaps to say we're doing a good job, we've already taken those steps to do that nationally.

Some of the weaknesses that we need to work on,

right, lack of member and staff tools. We did have a struggling IT program. We're in the process -- We have an open IT manager. It was a very under -- I don't want to say underutilized. It was overutilized. But we didn't have a lot of resources associated with that IT department and we need to bolster that and we've been able to do so through hiring position and getting positions approved. But it was struggling to keep up with all of the requirements that we put on them.

We have that increased fully insured plan risk. We talked a little bit about that earlier. And right now we have a one size fits all fully insured design. And if I were to bring up both of the HMO's right now, they would talk about some of the disadvantages of having to be exactly the same even though the systems of care are dramatically different in both regions.

So there was a goal at the board when I first arrived that we needed to have the same plan across the state, we only had one plan one vendor for HMO's. And the problem that we ran into is that it was too costly. There wasn't a single HMO plan that would produce that one plan across the state less expensive than two regional plans which are married together, which is why we have what we have today.

But those regional plans were successful in the

region because they maximized their ability to provide care based on those systems. And those systems are different.

And so I think that a one size fits all is a great idea if you want to pay for it. But once the rates come in, it doesn't appear to have -- no one appears to have the appetite to dramatically increase rates to have that one size fits all.

We also had another issue, and I'll go in to it quickly. We changed the specialty drug tier, all right, on HMO plans for a one size fits all co-insurance level. And I think we've heard that at previous board members folks that have been drastically impacted by that change, by that one size fits all approach. And so, again, there wasn't the ability to maximize those systems of care in those regions and folks have had to suffer because of it.

We also can't make changes rapidly. That's not a PEBP issue. That's not a PEBP board issue. That's a state issue, right. We all have rules to follow, the board of examiners, interim finance committee, the legislature. I can't have you guys come to a board meeting every day to make changes. And so we have to recognize that we're more of a cruise ship and not a speed boat when we make turns.

We also have some turnover in our office. It does happen. We do have a tendency to burn some folks out. We go a hundred miles an hour. I worked at a previous agency

for a previous director who would sit in the audience and we used to say we don't walk here, we run here. Well, we run at PEBP too. So it often burns folks out. But we're doing everything we can to keep morale up and keep those important staff positions where they need to be.

And then we have a lack of appropriate level of staffing. That's what we addressed with those increases and those requests to the legislature which were ultimately approved.

But what are our opportunities? That's really the fun part; right? We have opportunities for additional member tools. We have an opportunity to approve that credibility through accreditation, through national speaking, and through national awards. I am very proud to have been offered the opportunity to go to the annual national SALGBA conference next April and May and to be provided a session to speak about our innovative solutions here at PEBP in Nevada. So we're getting that face time to share some of our success stories and our best practices so other clients across the nation can learn from us the way we have learned from them.

We also, of course, are big on innovation, system upgrades, right. And we're going to be coordinating with the state's ERP system. That's a huge project for the State of Nevada. We're excited to be part of it. We want to be able to pitch and catch data so that our employees and the state

have all access to their world through this system and be able to support the roll out and the project as it is designed and approved through the legislature.

And then we have an opportunity to, of course, improve communication, leverage other partner resources. If you've seen the latest newsletter you'll see that we've been working with both Health Plan of Nevada, Hometown Health, HealthSCOPE Benefits. And we are constantly working with other folks, Willis Towers Watson, to try to coordinate those communications to ensure our membership has the ultimate opportunity to have PEBP what they need to be successful.

But some of the threats; right? There is the rising cost of the non-Medicare retirees, right. Because they're not on the exchange, we don't just provide an HRA to them. We have to make sure we can absorb those. And we all know more people are retiring and they're being backed by employees, and so that employees to retiree ratio is swinging more towards retirees every year and it's something we have to be cognizant of.

There's also public opinion. I know that there's specific legislators that believe that the idea of a wellness program is bad. It's going to take a while to shift that paradigm. Wellness and preventive services are not bad. But perhaps the former rollout in the former system was not appreciated or was not utilized to the legislature's best

result. And so if we're going to roll out anything new, we have to be cognizant.

We are going to have a new administration in 2019. We don't know who the new governor is. We have a very supportive governor in Governor Sandoval. And he is going to term out and there will be a new governor. And our hope, cross your fingers, that whoever is elected is pro employee and retiree benefits. That's what we hope.

We also have member perceptions of our plan, right, that they're not -- our plan isn't a good plan. Interestingly enough at this latest conference what one of the other private plans did is they decided they were going to start marketing their plan using the Affordable Care Act metal tiers so that way people can see how great their plan was. So instead of saying we have this high deductible health plan with a health savings account that people don't like high deductibles, they started marketing as a platinum plan because of the actuarial equivalent.

And so it's a different type of message that we have some threats, we have to try to help our members perceive that we really do offer a rich benefit of plans for our employees and our retirees.

Federal rule making. We talked about that earlier, the ACA Cadillac tax. We are positioned well for the Cadillac tax. I think our nation's overall rate was

around $600 before contributions, where the Cadillac tax starts in once you hit about 850. But the HMO plans are getting there if they haven't already. And that's a definite fear or threat.

Increasing cost to specialty drugs. I could spend three hours talking to you about that. We all know the costs. We've seen things like the Epipens and Humira, right, if you've seen those commercials. Those commercials aren't paying for themselves. They're being paid for by the cost of those drugs.

And then we have some contracts that are designed with their percentage off billed, which is unfortunate because the bill charges can be adjusted and therefore that percentage isn't as attractive as it may have initially appeared to be.

And last but definitely not least, there is the opioid epidemic. I heard it on the news again this morning on what is occurring across the nation and the president declaring a national emergency on it. So opioids are here and we have to come up with collective and collaborative ways to address it. So that's basically our SWOT analysis.

What does that mean? I won't read them to you because it will take too long. But we look at three overall strategies and every other strategy that we develop should support those. And I wanted to make it simple so that way no

matter what decisions are made or what recommendations PEBP provides that we tie it back to these three strategies.

We want to increase access to care. We want to improve the member experience. And we want to reduce cost to the program. If we could do all three, the trifecta, it's a slam dunk and we hope that we will discover those opportunities to the board and the board will approve them.

Then if we can only do two of the three, if the decision on recommendation doesn't meet all three of them, well, then there needs to be some discussion and debate, are you willing to not do one to get the bigger bang on the other two. If you can only do one of those three things, it better be a really amazing opportunity to sacrifice either access, experience, or cost, right. And if you do none of those three, you won't hear me bring them to you. And hopefully you're all right with that.

So, if you take those three overall strategies, then we have a series of strategies that we've repeated all the goals and some of the strategies to get there. I didn't get too much in to the weeds because, again, this is an overview and if you say, Damon, you did a lot of work, but we don't like it, I didn't want to do a ton more work and have to redo it all.

So here's some of those strategies like maintain sufficient reserves and implementing only value added

benefits, make sure we continue to research and present offers if there's a viable option in how we prioritize.

We're in the process of overhauling our communications now because we want to increase that member experience. We want to implement opportunities as we discover them, not put them in a folder and wait a year before we present them to you. We want to continue to be transparent. A lot of those transparency goals are a continuation of what we're doing today and the strategies. And then we want to continue with a lot of our collaboration with other stakeholders, get that critical input from them, make sure that we also get input from our vendors and partners and really develop that road map of program improvement. It's nice when we have ideas, but how do they fit together, how do we align them so you can get them done in an appropriate and efficient matter. And then encourage communication and coordination. Between our partners we at PEBP have suffered from the Silo effect where certain entities don't talk to others or are not allowed to. And I'm trying to break down those barriers so that our partners can come together and present opportunities to PEBP so that PEBP can present them to the board.

Communication of the board to maximize the different channels and how we're going to do that, how we're going to evaluate communication tools. And we're going to

continue to update that formal communications plan. But we want to engage subject matter experts. It's interesting where a part of these groups and we don't always take advantage of their expertise. And so I reach out to my counterparts across the nation to see what they're doing. And it really helps us with our ability to maximize communication.

So what's the operational plan from a hundred dollar input view? We need to justify this imposition that we talked about in July. They were approved by the interim finance committee. So that's excellent. Of course, we needed to finalize this overview, and we did that. And then sent it to AFSCME, RPEN, and the Nevada Faculty Alliance for early input. And we did that and sat with them and got some great information and some opportunities to include their information in this strategic plan.

The next thing that we can do, obviously we're presenting the strategic plan overview to you all today and we're going to discuss later on some opportunities for the plan design, right. We're going to tee up this conversation in October for November's discussion.

Then you guys can either approve the strategic plan overview if you like it or if you want me to go back and make changes I can make changes and bring it back in November or what have you. But if we don't get some kind of sense of

urgency on it, this thing can go for a long time. And I think that might have been one of the issues that previous folks had with trying to nail down a strategic plan is that it keeps going and we're trying to get really, really perfect at it and then the strategies need to change by the time we're perfect. So I would hope that there would be a little bit of urgency in this, whether it's today or whether it comes back in November. And then if we need to develop any procurement solicitations, I've already reached out to Jeff Haag, the administrator of the Division of Purchasing. He knows that we're doing this today and that if there's any strategies that come out of this or any approvals that come out of this that require procurement, we will, of course, take those appropriate steps.

And then the last thing we always do is implement new plan designs for July.

So that was a lot of information that I just fired off to you guys, what our next steps are and those dates, October, that's what we're doing now. You can approve it or hopefully by no later than November. I will draft a formal strategic plan where I will take this overview and really flush it out even more and bring it back to you either to the November meeting if you approve it today, this overview, or to the January meeting if you wait until November because you have some changes you would like made.

And then, as you mentioned, Mr. Bailey, the policy to do this every year, we're going to review the plan every year in September. I would like to continue to hold those August strategy sessions in preparation for that.

And with all of that information, I'm sorry for talking so long, Mr. Chair, I'll turn it back over to you.

CHAIRMAN CATES: Thank you, Damon. Very thorough. Again, I commend you and your staff and everybody that participated in the process that led to this overview. I personally think it's a great document, well thought out. And I don't see any need for any changes personally. But do the board members have any comments? Ana.

MEMBER ANDREWS: Ana Andrews for the record. Actually I want to thank everybody that participated. I was unable to participate. And I like what I see. I just need clarification on the strategic session that's going to be held in August, just so we know what to expect. It's not a session where every single board member has to attend because otherwise we would have to do it in a public forum. So it's going to be so that we don't have a quorum. How is that going to work? Thank you.

MR. HAYCOCK: For the record Damon Haycock. Thank you, Ms. Andrews. Excellent question. In order to be able to really roll up our sleeves and get in to the nitty-gritty and talk about things that can be kind of

disparaging either to ourselves, right, or to our partners, we like to hold it in a session that is not where a quorum is held. It's not an open meeting law session. It's not done to hide anything. Because, as you see, we will present a thorough accounting of what occurred and the steps and processes that we did to get there.

What we did this year and what I hope to continue to do next year and every year that I'm here with PEBP is offer the opportunity for board members who have the availability to attend to ensure that we don't crest over that quorum, but most importantly we have our attorney general's office representative there the whole time to ensure there's no deliberation and that there's no voting and that there's no pre-voting and that it was strictly talking about strategy and not decision making of those board members to really support the integrity of the open meeting law and to allow the public to feel very confident that we had our legal oversight there to ensure that we did not break any of those rules.

And then, Dennis, could you add a couple of things hopefully in support.

MR. BELCOURT: Dennis Belcourt for the record, deputy attorney general. I was present and I made sure it didn't shade in to deliberation at any point. I tried to stay with -- You have to stay with the open meeting law

rules. And there was no deliberation. There was no quorum.

MEMBER ANDREWS: Ana Andrews for the record. I didn't mean to imply that there might have been any rules broken. The reason I brought this up is because we have one, two, three, four, five relatively new board members. And so I think that we all need to kind of raise our hand when the time comes so that we'll get to participate, and especially if we have an interest in participating -- in making this -- bringing this program forward and make it the best that we can have. Thank you.

MR. HAYCOCK: For the record Damon Haycock. And, Ms. Andrews, I apologize if I implied that you implied anything other than we follow the rules. I want to make sure that the public knew without a shadow of doubt that we did everything above board and we had our -- we had our oversight there to ensure that we did that. And I would never have insinuated that you implied otherwise. But thank you for your comments.

CHAIRMAN CATES: Thank you.

Any other comments from the board? Go ahead.

MEMBER SHIPPEY: Mr. Chair, thank you. For the record Glen Shippey. I just want to thank Damon and his staff and the others that participated in the development of this strategic plan. But for purposes, before we move forward on anything, I just want for clarification, this is a

single agenda item, a single document. We are just discussing the strategic plan, it sounds like, for possible action and that the proposed changes to the procedures that we went through and the executive director went through in detail, that is not something that I would be prepared to support approving today because I'm going to need some time as a board member to go through each of those proposed revisions to the procedures. Thank you.

CHAIRMAN CATES: Fair enough. Thank you.

Are there any other comments on this item from the board members? This is an action item and I do want to open it up for public comment. Does any member have anything else before we do that? No?

Okay. So let's go ahead and open up Agenda Item Number 5 for public comment. This is public comment on both the documents, both the policy document, as well as the strategic planning overview. Welcome.

MR. ERVIN: Kent Ervin for the record, E-r-v-i-n, representing the Nevada Faculty Alliance, the statewide association, NSHE institution.

One comment first on the policies and procedures a little bit. First of all, I agree with the general discussion about continuing education and how important it is for board members, whether you have educational sessions at board meetings and even bring in outside people to do that or

give opportunities for people to go talk to their colleagues at conferences and other programs, that's very valuable.

I did want to discuss the section on the request for proposals. That was a big part of SB 502 that we had a hand in negotiating at the legislative session. The fix for this document is because parts of it do conflict with SB 502 is just to take the language from NRS 287.04345 verbatim and put it in here for now. That will make clear that those are in your procedures.

But I want to mention a couple things about that. The first statement there is the program is subject to the provisions of Chapter 333 of NRS. That's the purchasing code. You can't make up your own rules. You follow the state purchasing rules. That was very important to the offers of SB 502.

The second statement is that the board, you, shall act as the chief of the using agencies for the purposes of NRS 333.335. That means you guys, the board, control this process and what -- and then the rest of it is a mechanism to maintain the confidentiality of competitive bids and review of those even though you are a public body. And the mechanism for that is to appoint an evaluation committee that can include board members that is not subject to the open meeting law as long as you don't do other board business. So that's very important. But this is trying to strike that

balance.

But I want to mention what the duties of the chief of the using agency, which now you as the board is, according to NRS 333. And Mr. Belcourt may need to chime in here. But how is this evaluation and confidential evaluation committee appointed according to NRS 333? Either the chief of the using agency appoints the evaluation committee or the administrator of the purchasing division does if the purchasing is an administrative process and basically I think they get to decide.

So if you as the chief -- the board as the chief of the using agency, you get to appoint the evaluation committee. And then it further says any number of board members can be on that evaluation committee.

And so that's the mechanism for you to keep hold of the process, by in as much as you need to for a particular bid or procurement so that board members are involved and understand what went in to it if you need to be or you can delegate that to other people to be on the evaluation committee. But it's all done confidentially in following purchasing rules.

And then, finally, the board once the evaluation committee does its work, the board can only take three actions. First you get to review it in private in a closed meeting just so you know what the results were. But the

board in a public meeting can only either go ahead and approve the contract with the highest scoring bid by the evaluation committee. If you decide that this process just didn't work, we didn't write the RFP right, whatever, you can cancel the RFP entirely or you can modify and reissue the RFP, which is practically the same thing as cancelling it. But that's really up to purchasing how much modification you can do.

But, most importantly, the board can't second guess the evaluation committee's scoring of the highest bid. You can't delve down in to that process. And that's to keep it above board and transparent.

However, according to NRS 287.0424, the Court may delegate to protect the officer any exercise or the exercise or discharge of any power. And that would include the duties of the chief of the using agency.

So I think you want to think about -- The fix to the policy and procedures is right now just put in the language from the statute. But I think on a case-by-case basis over the next year the board needs to decide, okay, is this a minor service that you want to delegate to the accepting officer or is it one of these really important provider contracts like HealthSCOPE, third party administrator, the HMO's that really there needs to be board members involved so that you know what's going on and when it

comes back to the committee or to the board you have confidence in the results of the process.

So that's really what I wanted to say about that. It's going to be a new process and you want to get it right the first time. And so I appreciate the opportunity to provide input on that.

CHAIRMAN CATES: Thank you. I appreciate that.

Any other public comment on this item? Go ahead.

MS. MALONEY: Good morning to the board. Priscilla Maloney with AFSCME retirees. And I also got notified this morning that Kevin Brown, who worked during the session as a lobbyist for the AFSCME actives, asked me to make just a couple of comments on the plan design changes.

So, first of all, I absolutely with a thousand percent vigor want to thank Damon Haycock for the approach that has been taken since he was last here in this building. I think it's gone a huge way to repairing a lot of positive -- some controversy over perceptions, whether they were justified or not, of how the program was being run. And part of that was just historically it was a big change for the state work force to go to a consumer driven high deductible plan, which both in the public and private sector. That's a big cultural change in our country. A lot of people don't even -- You know, they just take it for granted that there's some cost to their health care, the employer picks

that up as part of their benefit package, and they just go forward. So that was a big see change culturally across the country in 2011. So thank you very much, Mr. Haycock, for all of your hard work on this and your willingness to reach out to us. And when I say us, I mean my coalition partners, RPEN, NFA, and Damon has made it clear anybody else that represents a group, whether it's some of our public safety officers or corrections or any other groups that may have unique individual concerns. His open door policy has been really positive in sort of healing some of the controversy that happened back in 2011.

So, I would ask that the board follow the wise comments of our newest board member over here about looking at this as an essential template and framework going forward but not taking any formal action to formalize any of the actual pieces today. I think now you need to go forward and have further board discussion and make whatever changes were called out, corrections, additions, that kind of thing. And then if we in the coalition could have a look at the final product before it's agendized in some future meeting, whether it's November or January, because if I understand the timeline, that is the goal, if we could have a look at the finalized product just to make sure that there's nothing that was missed.

For instance, two things came to mind. And I'm

tempted -- I was tempted, but I'm not going to do it, to bring down my notes that I was taking back from our September 28th strategy session and then comments that were made today.

For instance, the reserve policy. The reserve policy, as you know, from a public relations standpoint was a huge matter of controversy, partly because of how things shook out after the switch to the consumer driven high deductible plan. But that reserve policy needs to be worded extremely carefully in my opinion representing the AFSCME retirees. It's a bang right now. May be used for this, that or the other as opposed to a shall. I would just be very careful would be my counsel to avoid again sometimes it's a perception, it's not technically real. But it's people's feelings about it. We have these reserves, this is an open door, they can be used for anything. Both in the members and the public and the legislature's eyes. I would just say that the subject of the reserve policies have been very controversial.

And then I think there was one other area where it was sort of a similar concern. Just going forward we want to make sure that the language is simple, easy to understand, and defensible, a defensible, something that can be explained as a public policy matter.

So there was one other thing. And, Damon, I'll just let you know off line what that was.

But, overall, like I said, I'm very proud of the work that everybody did on this. And I think we've got a really good product, which basically just needs some polishing and then board consensus on that polishing and those tweaks.

But I'm really happy that we're doing this this way as opposed to, again, not to revisit, but sort of have to put in historical context what happened in 2011 where there was an administrative decision that we were going to go to a consumer driven health care and then out it went. And, you know, we've been kind of working backwards from that controversy ever since. And so I think that we're in a really good place and good shape.

Oh, that's what, the legislature, yes. So, like, the language -- I don't have to go off line. The language around the percentages and the discussion that we had with our coalition meeting was very helpful in explaining that. That's a big deal to the legislature. It sounded to me like we still need to have some more dialogue about how that actually works with both our legislative partners and the coalition partners.

So thank you again for this time to say all of that. And I look forward to just continuing to work with you folks in the future. Thanks.

CHAIRMAN CATES: Thank you.

MS. LOCKARD: Thank you, Mr. Chairman. My name is Marlene Lockard, representing RPEN, who represents retired and public employees.

I also want to echo my thanks to the executive director, Damon Haycock, for his willingness to spend so much time with us in developing the strategic plan. I think we learned a lot. And it afforded us an opportunity to have input in to what you're reviewing today. And we very much appreciate it.

I just have one quick comment, and it was not clear to me in going through the duties, when Mr. Haycock mentioned the interviewing process that is a public process and that is deleted from the duties. But he said that he was -- I wasn't sure of the substitute language. Because right now as it stands, that is in statute that the public officer has to be reviewed in a public setting. So maybe I missed something somewhere. So I just had a question mark on that piece. Thank you.

MR. HAYCOCK: For the record Damon Haycock. There's two parts. There's interviewing someone for a public position. That doesn't change. That has to be done in public. And whoever takes my place has to be as terrified as I was sitting there going through this process.

But the actual, say, annual review or evaluation, you'll see a lot of boards have kind of gotten away from it

because of some of the administrative problems that it has created both publically and privately. We're just giving opportunity, since it's something that I know this board, previous board of the Public Employees' Benefits Program has struggled and has stated so on record. So I'm not putting words in their mouth. Struggled on trying to come up with the best way to evaluate the executive officer when they only see the executive officer every couple months for so many hours. So that was what we were looking at eliminating, not the actual interview process. That doesn't change.

MS. LOCKARD: If I may, Mr. Chairman. My point being the evaluation piece is in statute that it be public. So if that's going to change, I think it requires the statutory change is the point I was trying to make.

CHAIRMAN CATES: Thank you.

Any other public comment in Carson City?

MS. BOWEN: Good morning. Good morning. Good morning. My name and my words for the record, Peggy, P-e-g-g-y, Lear, L-e-a-r, Bowen, B-o-w-e-n.

First and foremost, thank you, thank you, thank you for all the work that you have done and what you are going to do.

A couple of notes that I made. Mr. Haycock, prior to your time when the legislature was really working hard and the wellness program came in to question, the

wellness program was never called -- the concept was never called back. What the legislature was doing was desperately looking for money to fund and help alleviate some of the burden of the non-state employee insurance cost because they've been separated out, not only as a record keeping matter but they've been separated out for their benefits. And they were paying an extraordinary amount of premium.

We have a former executive director sit in front of a legislative committee and state for the record that all rates were flat and then he delineated which rates were flat for the public employee, present employee, for the retired employee, and going forward. He mentioned every group except for the orphan group. And I coined that phrase during that session. I said I felt like an orphan.

And so when he went out in the hallway after he had testified as a matter of record that all rates were going to be kept flat that year, that in the hallway we had a reporter ask him, well, what about the orphans, are their rates going to be flat. And he said absolutely not. He had answered the question correctly because he delineated as to whose rates were flat and then he went out in the hallway and went forward. And that's old news.

But what the result was is we lost the wellness program monies for that year and wellness took on a stage that it should have -- a reputation it should have never

taken on. The healthier your employees and your retirees and your non-state employee retirees are, the better and less impact on the plan.

And so going forward and talking about wellness as a benefit and make sure that the plan itself is not onus. The plan itself required so many hoops to go through that many people just finally gave up and didn't meet the criteria. And, therefore, they weren't receiving their benefit. You had to go through all the hoops of the wellness plan of the given year or you weren't given the benefit of a lesser premium to be paid. And I'm sorry about -- It's been a long time since the right words are being used. And so I hope I'm encapsulating the concept here.

So wellness program is a good concept to be done. But it shouldn't be penalized if you didn't do it right or if you didn't answer the questionnaire, which was horrific.

The next point being that a program that you call rich in benefits that provide all the evaluations but do not provide for the care. I'll give you an example of the vision program. You can go in -- Oh, I'm sorry. I watched everybody. I thought they went beyond three minutes. The vision program --

CHAIRMAN CATES: That's okay. Just take your time and wrap up as soon as you can.

MS. BOWEN: Okay. Thank you so much for your

kindness. The vision program you can go in and get your evaluation each year and they can tell you you need contacts or glasses or whatever. And then the bottom line is that's on you. The same with the dental programs. And this one is important regarding your prescription program. The prescription program is now tied to your meeting your overall out of pocket rather than you meeting your prescription deductible I believe was a hundred dollars before. And then you went and your prescriptions were covered 80/20 until you met other out of pockets or whatever -- however it worked.

But now everything is tied to the overall deductible. So people can't afford their prescriptions, so they're not getting their prescriptions and they're getting sicker and dying.

And I had one other I guess I can save to another comment. But it had to do with what happens with pre-authorization. And it's too hard to use the plan when it comes to pre-authorization and what you have to do in order to save your life. I almost -- I could have died this summer when I was bitten by a yellow jacket and went through the process of trying to get an Epipen and everything that was -- and the difference between pre-authorization and non pre-authorization is that Epipen was going to be $735 but with pre-authorization it was knocked down to $305. And so those are things -- Please look in to that detail.

And do not advocate the director of Department of Administration appointing your quality control officer. You need to make that appointment or at least have input and that the purchasing remains with you and not with any other state entity. Thank you very much.

CHAIRMAN CATES: Thank you, Peggy.

Any other public comment? Any public comment in Las Vegas?

MEMBER COCHRAN: None.

CHAIRMAN CATES: Okay. Thank you. We'll bring it back to the board. Any further comment or discussion by the board members? We do have two items here for action. One is the policies. Based on the feedback I've heard, I don't think there's an appetite to approve that one today. But we also have the strategic planning overview, if anybody would like to consider moving to approve that or any other motions, discussions. What do you guys think?

MEMBER VERDUCCI: Tom Verducci for the record. So in terms of making language changes to the policies and procedures, that appears there needs to be more work. As far as the strategic plan, does it appear that that too is in the same ballpark of needing more work or is the appetite of the board to try to -- perhaps try to approve that here today?

CHAIRMAN CATES: Yeah. My opinion, I think the strategy document is good and solid and worthy of approval.

MEMBER BAILEY: Was that a motion, Tom?

MEMBER VERDUCCI: Tom Verducci for the record. I would like to make a motion to approve the strategic plan.

CHAIRMAN CATES: Do we have a second?

MEMBER COCHRAN: Mr. Chair.

CHAIRMAN CATES: I'm sorry. Dr. Cochran, go ahead.

MEMBER COCHRAN: I just want to be clear, what we have in our packets for those of us who were not able to attend the strategic planning meeting is the strategic plan overview. Is there a strategic plan document that we should have received that has more detail on this?

MR. HAYCOCK: For the record Damon Haycock. Dr. Cochran, that will be the result if you all approve this overview. Or once an overview is approved I will then create a true strategic plan down to the gnat's eyelash and that will be brought back for board approval at the next board meeting.

MEMBER COCHRAN: Okay. Then, yeah, then maybe we want to revise the motion to approve the overview and not the strategic plan document.

MEMBER VERDUCCI: Tom Verducci for the record. I think that is a reasonable request and I would be willing to change my motion accordingly.

MEMBER COCHRAN: Thank you. I'll second the

motion.

CHAIRMAN CATES: Okay. So we have a first and second on the motion, which is to approve the strategic plan overview. 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 vote was unanimously in favor of the motion)

CHAIRMAN CATES: All opposed? Motion carries.

Okay. Let's move to --

(The court reporter interrupts)

CHAIRMAN CATES: Let's come back at 10:30.

(Break was taken)

CHAIRMAN CATES: We are now on Agenda Item Number 6, executive officer report, including discussion and possible board action on the following: New positions approved, ratification of the HealthSCOPE benefit two-year contract extension for national preferred provider network services, and the on-site near-site health clinic options. Damon.

MR. HAYCOCK: Thank you, Mr. Chair. Damon Haycock for the record. As I already spoke about earlier, I'll gloss over the first part. We did get our two new positions approved. One is an information technology professional at the three level that was approved by the interim finance committee and again approved by the Division

of Enterprise IT Services through their approval committee. That position is announced. I think we've already received a list. So we're working through that. We also received approval for health program manager. That person will be designated to head up as the liaison with our other vendor partners and our internal processes to help promote program utilization throughout the organization. Those include things like diabetes care management program or the preventive drug benefit program or any of the other programs that we either currently have or plan to implement in the future. So we have some at that caliber, at that level, to be the oversight. That position has been announced. It's closed. And we are doing interviews I think as early as next week. There is no action item or recommendation on that. That was just an information update.

As far as the contract extension for the national PPO network, when we were going through and doing a robust review of all of the contracts that we have at PEBP, one of those that we realized that did not follow the same timeline was the national PPO network. HealthSCOPE benefits has multiple contracts with us and there's a lot of history behind why it all isn't and so we wanted it. However, we wanted to align this contract with the other TPA services that they have already been signed and approved to provide us. And we just wanted to kick the date out a little bit

longer. Let's not forget that this national PPO network and their ability to switch vendors for us saved us that two million dollars last year and that will be moving those folks in Nevada who travel outside of Nevada on to this network. We started that this July and they are projected to save another 800,000 for that switch.

So it's a good contract. It's a good partner. And it continues that cost savings and improving the members' experience and access to care on those three strategies that you all just approved in the strategic plan overview.

So that's the contract extension. Our recommendation is that you ratify the two-year extension to that national PPO network contract as described above.

I'm going to go ahead and move unless -- I'm sorry. I'm going to go ahead and move on to the near-site clinic update. I'm going to spend a little bit of time on this one. I think the story is important to understand where we are and why we are where we are. As you remember back in January at the board meeting, there was a discussion about a new near-site clinic benefit opportunity and that we were to work directly with purchasing to develop our request for qualifications and develop a solicitation, which is exactly what we did. We did it for a pilot program in Carson City, Nevada. It was RFQ 3442. And we were able to have multiple vendors qualified and then ultimately bid on the scope of

work that we sent out in accordance with that procurement supported time frame.

We began negotiating in good faith with the selected vendor and to bring a contract for board ratification, right. And as we were negotiating the costs and the start-up fees and the profit margin, it was quickly apparent that PEBP was going to be able to guarantee savings, but that savings would be shifted over to that vendor. And I basically could not support in good conscious saving money and then giving it away back to the vendor and breaking even after three years. And I didn't feel that was appropriate and the vendor that we did select was the only vendor that would honor the return on investment of those fees at that level at a hundred percent.

And so the other options were -- It just got worse from there. And one of the things that we realized in our discussions and our negotiations was that none of these vendors had a full medical near-site clinic outside of workers compensation, right? Those have popped up across the nation. But none of these had a near-site clinic for a state entity like ours. And I had a flashback with my time at the Silver State Health Insurance Exchange when we decided to work with a vendor at the time known as Xerox Health Care, LLC, and they had never built an exchange before and we thought, wow, they're nice and low cost, let's work with

them. And most of us hopefully remember what happened and we had to end that relationship.

I don't like to be the trendsetter on new processes and gamble with funds that you are all the fiduciary for and that our members rely on us to continue to provide excellent service at costs they can afford.

And, last but not least, something that Ms. Zack down in Vegas had mentioned repeatedly is that the big issue on access to care is not Carson City, Nevada. It's in Las Vegas. And I'm very cognizant of that.

And so once we went back and looked at the procurement and I spoke with the folks at purchasing, I said can I just swap this down south and rerun it for a southern procurement. And they said, well, you would have to redo it because you got very specific, Damon, in what you were looking for as what is important but it kind of changes you in a corner and it wouldn't support the procurement process if you just decide I want to pick Vegas now. You would have to redo the procurement. And then I thought, well, maybe, maybe, this type of major change to our program might be best implemented in a year that we can also pitch it to the legislature.

Because one of the comments that I did receive when we got our positions approved at the interim finance committee is what are all of these new programs and how come

the legislature wasn't informed about them. And so that's something to be cognizant of as well.

So we have a couple of options, but what I've done is I've paused. So the negotiations ended with that vendor. Not only were the fees moving over to them but they were going to save us money, but then they had a pretty high stated profit margin that I didn't feel was appropriate. It was about three times the profit margin that we allow anyone else that we vendor with or partner with. So, again, it didn't seem like the best feel. And, ultimately, it didn't seem like the best place to pilot one of these. And based on Ms. Zack, I saw the light, and if we're going to do one of these, I would suggest and recommend that we start in Las Vegas, not end in Las Vegas, where the real active and care issues can be impacted.

So here's kind of the options that are available. You can direct us to negotiate with a second place vendor and we can still try to implement a clinic but with the ramp-up time, the fact that we, unfortunately, had to push board meetings, there's no way for us to get a new clinic on the ground in Carson City by July 1. So we would do a mid-year implementation, which causes some issues with migrating folks in to that plan if we create a new plan, as well as if we don't create a new plan, how are we going to get the money out of it if it's just an add-on or bolt-on to our current

plan offerings.

You can direct us to pause and develop a clinic benefit for the next biennium through the state's budgetary and legislative process. We can wait on this. It's not like we're trying to solve an immediate problem with the clinic. And it's not that we are hemorrhaging our costs right now. And we can do this more methodical and then decide through the budget process that we'll bring back to you next year if we want to do a budget enhancement to build this clinic and where is the best place for it.

We've got a lot of great information, so I don't feel like the time was wasted or the process resulted in a negative response, because ultimately we learned an immense amount of information from it and can apply it to another process.

Or we can just decide, you know what, we're not going to get in to the clinic game yet. Other state entities are still warming up to it. We'll let them guinea pig this process. We'll wait until we see some success across the nation and we'll let them kind of go through the honeymoon phase and the heartburn of implementing a new program and once they found the right way to do it, then we'll go out and do it. And so there are different options that are available.

Option one, you know, gives us that -- the

problem of media implementation and that's something that I would be very concerned about. Option two does solve the issues and it gives you all the opportunity to implement a clinic benefit through the next budgetary process. Option three takes us out of the environment altogether.

Right now we recommend that you at least pause on the current RFQ for near-site clinics and reevaluate it for a future implementation through a budget enhancement. Or, honestly, I wouldn't be against option three and just taking us out of that right now and letting the people that build clinics build clinics and our providers do what they do best and we do what we do best.

So any comments I would love to hear or any questions. But the two recommendations are to ratify the two-year extension on HealthSCOPE's national PPO network and then to pause on the current RFQ and re-evaluate for appropriate budget enhancement next spring.

With that, I'll turn it over to you, Mr. Chairman.

CHAIRMAN CATES: Thank you, Damon.

Any comments on these items?

MEMBER ZACK: Mr. Chair, Christine Zack.

CHAIRMAN CATES: Hang on. Let's go to Las Vegas. Go ahead, Christine.

MEMBER ZACK: Thank you, Mr. Chair. I just

wanted to point out that option two isn't actually a pause for Las Vegas. I mean, it may be a pause for Carson City, but there's now a recognition of what I've been saying that the access issues are really down here. There's no pause because there was never going to be a clinic in Vegas through the current proposal. So to me it seems like it's just an opportunity to gather more information and develop the clinic first in Vegas. Am I reading that incorrectly or understanding it incorrectly?

MR. HAYCOCK: Yeah. For the record Damon Haycock. Excellent question, Ms. Zack. It's a couple of options. I would imagine that's the direction it would head in with the conversations I've heard from the board. But I don't want to speak for the board. If the board decided, no, we still want to start one in northern Nevada, then you can pause and then again start it again in northern Nevada. But this is the best opportunity to take the work that has been done and implement it in other locations, specifically Las Vegas. So it's kind of yes and no to answer your question.

MEMBER ZACK: Christine Zack for the record. Thank you, Damon. So maybe a slight pause for the north but there's no pause for the south. It just gives us an opportunity to actually participate.

CHAIRMAN CATES: Thank you.

Any other comments? Nobody has anything?

MEMBER SHIPPEY: Mr. Chair.

CHAIRMAN CATES: Go ahead.

MEMBER SHIPPEY: Thank you again, Mr. Chair. For the record Glen Shippey. Just through you to the executive director, Damon. On the national PPO network, the methodology for calculating the two million dollars in savings last plan year, was that actual savings relative to the prior plan year? Did you take the utilization out of state in the network from two plan years ago and did you rerun it with the Aetna network to get a, kind of a true savings so we don't have it skewed by maybe a drop in utilization of services out of state?

MR. HAYCOCK: For the record Damon Haycock. Excellent question, Mr. Shippey. We did a couple of things. We had our third party administrator re-price them as if we were still on the old network and we also had our auditor verify it. So if you remember the last audit report, the last two audit reports for HealthSCOPE benefits, they show that -- And it's been a focus audit. They wanted to validate and verify those savings and not take some skewed what if, you know, and try to trend that forward. Those are actual savings realize applying the percentage discounts from the previous network to the one that we moved.

CHAIRMAN CATES: Thank you. Any other questions on this item? Go ahead, Ana.

MEMBER ANDREWS: Ana Andrews for the record. On the near-site clinic, I understand what Christine is trying to say. I guess I'm a little -- I guess it's always been implied that the clinic was going to be for the north first, correct. And so do we need to change -- I like the number two option just because if we get buy-in from the legislature and we put it in the budget, to me, it has more teeth. But to be able to do that, do we need to then put this on a future agenda to make sure that we're addressing Vegas first per Damon's recommendation? That's my question.

MR. HAYCOCK: For the record Damon Haycock. Thank you, Ms. Andrews. I want to try to clarify a little bit more about what I'm suggesting that occur. Everything you said is accurate. Everything you said is what I was planning to do. And we are going to bring to the board a budget overview that we do every two years. I know it seems like we just did one of these. But we're going to start again next spring and we're going to be bringing it to the board to talk about whether the policy changes and whether the opportunities that exist for building our budget for the next biennium. And I would like to if you approve this second option is to come back and to develop a Las Vegas clinic response to show what that would look like and to be able to have that conversation and that dialogue at the board. So if you approve it, Tena and I will build it in to

a budget document so that way it can go through the channels and it will be transparent to the legislature, as they will get a heads-up as to what's occurring prior to us kind of moving forward and building one of these, which you are absolutely correct, it grows more teeth when you kind of align all of the different interested parties.

So, yes, a long answer, but yes, we want to bring it back as a Vegas option. We've had the feasibility study done. We've had the procurement done. We just need to tweak the procurement and reissue it and reissue it for Vegas instead of reissue it for Carson City. But we've done a lot of work. And lessons learned through the negotiations will be implemented in that RFQ. So we will get it better this time and make sure that any participating bidders know exactly what we're looking for and our tolerance for savings.

MEMBER ANDREWS: Thank you.

CHAIRMAN CATES: Thank you.

Any other comments on this item?

MEMBER VERDUCCI: Tom Verducci for the record. I just personally think there's a lot of risk that we would be taking on with the on-site clinic at this point in terms of uncertainty, contractual issues that you were running in to. And my position is that we pause on the on-site clinic.

CHAIRMAN CATES: Thank you. You know, I wasn't going to take public comment on every action item, but I

think the discussion around the clinics is a pretty important one. So I would like to go ahead and open this item up to public comment if anybody would like to make public comment on Agenda Item Number 6. Any in Carson City? Anybody in Las Vegas? It doesn't look like we have any takers. Okay. Can't say I didn't ask.

All right. We'll bring it back to the board. Any further discussion or a motion? We have two items here, to approve the extension of the two-year contract extension with HealthSCOPE as well as the recommendations regarding the near-site clinic. Go ahead.

MEMBER LAMBORN: Can I make a suggestion or can we take these two items separately because I think separately might be --

CHAIRMAN CATES: Yeah, we can take them separately, if you'd like to make a motion.

MEMBER LAMBORN: Yes. Leah Lamborn for the record. I make a motion to extend the current PPO network HealthSCOPE contract.

CHAIRMAN CATES: Okay.

MEMBER LAMBORN: To 2020 -- 2022.

CHAIRMAN CATES: Do we have a second?

MEMBER BAILEY: We have a second.

CHAIRMAN 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 signify by saying aye.

(The vote was unanimously in favor of the motion)

CHAIRMAN CATES: Opposed? Motion carries.

Okay. So now we're down to the near-site clinic. Anybody want to make a motion?

MEMBER ZACK: Mr. Chair, Christine Zack for the record. I make a motion to develop a clinic benefit for the south and/or north for the next biennium through the state's budgetary and legislative process.

CHAIRMAN CATES: Okay. That sounds good. Do we have a second? Ana.

MEMBER ANDREWS: Ana Andrews. Second.

CHAIRMAN CATES: Great. 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 signify by saying aye.

(The vote was unanimously in favor of the motion)

CHAIRMAN CATES: Any opposed? Motion carries.

Okay. We'll close Agenda Item Number 6 and move to Agenda Item Number 7, discussion and possible direction from the board to staff on potential program design changes for plan year 2019 for which the board requests additional information and costs to be presented at the November meeting. Damon.

MR. HAYCOCK: Thank you, Mr. Chairman. For the record Damon Haycock. This report is really similar to what was done the last few years. We implemented this excess reserve reconciliation at the request of some of our partners. They wanted to see exactly how we determined those reserves and we kept the same format for consistency. You'll see at the bottom of the first page that the starting cash on hand, this is how we closed the last fiscal year, this is 134 million dollar range. And then we have certain ear-marked reserves that are approved to the legislative budgeting process to earmark some of those funds necessary for plan solvency.

And then as is the case as we continue to have good years and we continue to have good experience in certain areas but we also need to plan for other market issues and others, you'll see that Aon created another analysis, and they do this for us all the time on where we need to sit on those budgeted reserves. Let's not forget that we initially develop our budget a year before the actual session begins. And so times do change. And this is the second year of the biennium and so it's kind of a best guess until we actually get the real numbers in. And by getting those numbers we needed to decrease the incurred but not reported reserves by 1.9 million but increase the catastrophic reserves by 6.4.

You'll also see that we have -- we are adjusting

our health reimbursement reserve. If you remember we were talking about last year reducing it from being a hundred percent funded down to 85 percent. And then we found the rest of the money to maintain a hundred percent. This keeps it at that hundred percent level. And so we would like to continue to increase that as more folks, you know, retire and then need to use and have the HRA. We didn't do any rollover caps either. So, again, this is as those balances increase we need to make sure that we have the funds available.

So that leaves us with just under 40 million dollars. And then if you remember back in March, you guys approved for this current plan year and for next plan year a series of small enhancements to the program, those that we couldn't quite absorb in to the base plan. That was that increased life insurance amount that was paying for the Medicare exchange admin fees for their HRA and also for their premiums on life insurance. And those totalled just under 17.9 million dollars.

We're going to assume, and you'll see the questions up here in the table later, but we're going to assume that those decisions are going to hold for plan year 19. And if of course you want to make a change you can. That is your prerogative. But based on those, we have a remaining balance of 21.7 million dollars, which I know this is probably a broken record, hey, we have no money, we have

no money, and now we have a lot of money. But we were able to as tying back in to the state of PEBP report and of your utilization report and consent agenda having a negative trend when you budget for increases creates excess reserves. And we have those funds available that, you know, we can have a conversation about. And my initial first-blush suggestion is it will also be this is not to extend it immediately and just go burn it completely down. There's a lot of unknowns right now in the health care market place we have to plan for.

But you'll see starting on page three the familiar table of here is some plan benefit design opportunities. This is not the sum total of everything that can occur. We took some of the things that you guys have already proved to make sure that they're back up there so you know that you're reapproving those again. Because you have that opportunity to change your mind. And then some other additional new opportunities that PEBP has thought of. But this isn't just a one-way communication. We're here today to tee up those ideas so we can go back and analyze these and bring them back to you next month for plan benefit design approval.

And so if you guys have specific ideas that you would like PEBP to go analyze, please recognize that we have about a month, right, to put it all together, probably less. So major actuarial types of analysis is going to be tough.

Unfortunately that's the result of pushing the board meeting. But we will do everything we can to endeavor to create that solution and that analysis for you.

But basically going down the list, we categorize the plan design. Anywhere you see the word keep, you guys have already done. So it's basically staying with what you have already approved but keeping that enhanced HSA/HRA contribution of $200 tied to preventive activities. I will bring forth a report on what those proposed costs will be for '19 as well as the current utilization of that program like you had asked as part of the recommendation if PEBP recommends keeping it in plan year 19.

Then because of the excess reserves, we can't go back to the traditional increasing those contributions. However, we could potentially tie those increases to other behavioral things that we think are going to benefit our membership.

Dr. Cochran talked about no utilization of Doctor on Demand. And there's an opportunity to tie HSA funds not to the actual utilization because you don't want to drive utilization, but just enrolling in the program. Signing up, taking the ten minutes to have it on your phone, your computer, your tablet. And, therefore, when you do need it at two in the morning on Sunday, you're not trying to load an application and get on to talk to your doctor. You've

already gotten that process lined up. You don't have to do that. I'm not saying we need to do that. But there's opportunity to do that.

There's also another plan benefit I'm going to talk about later that we can tie some additional HSA funding to signing up for that program. And I'll go in to that as we move on.

You know, there's the diabetes care management. There is always, you know, a better way to build a mouse trap, right. Right now we currently run it through our third party administrator. We feel at PEBP that they're doing a good job at implementing that value-based insurance design, but there are other entities out there that go above and beyond to try to take care of your diabetes population or diabetics. And there's some opportunities we can analyze if you're interested in making that more robust.

I honestly haven't heard any complaints about our program. But we offer diabetes or insulin replacement at $25 co-pay. That's unknown anymore. It's funny, during the session they made a lot in to diabetes and transparency on drugs and PBM's and they kept saying, you know, it's not like it was back in the day when you got $25 co-pay for insulin. And I was, like, actually we're still doing that. So we offer a very good benefit to those that enroll.

And if you've seen our latest newsletter that

released yesterday, it's heading out to the public today, we're highlighting that program. And so we want people to use it. But there are other ways to make it more robust if you want to put more money in to it.

We would like to, this is all me, implement pre-authorization for specialty drug infusions to control cost. So the award we won from SALGBA was the fact that we created this program that once somebody paid too much or once the plan paid too much we were notified through claims and then we started to do all the things that we won an award for.

The problem I have is that we've already paid a provider too much for the specialty drugs initially and I'd like to run them through the prior authorization program. And, again, I'm not asking for any support today. I'll bring back an analysis and some ideology behind it. But that's one of the opportunities that's more of a cost savings.

So to give you an example, we do something called a pay and educate. So we pay the first claim and then we educate the providers and the member about what needs to happen. Well, some providers are waiting to bill us that have multiple claims and then send it all in so they get two, three, four, five infusions at that exorbitantly high rate. So this can address that.

There's also radiology. If you've been listening

to the news, I think it was Anthem that said they would no longer support across their book of business in the -- our hospital-based radiology programs unless it was for inpatient or for emergent or urgent use. There are some opportunities that PEBP can try to curb the cost on radiology. Whenever I give a presentation that I have access to the internet, I actually log in to my own account and I go to our health smart look-up tool and I show what it costs to get an MRI in this town as outpatient and what it costs at one of the hospitals and the difference. And I won't pick on providers here publically, but the difference is $539 in Carson City and 1300 plus at a hospital. And it's just amazing how much more it can cost depending on the situation.

So we can address it. It's not breaking the bank. We have 21.7 million dollars of excess reserves. But it's something that we can look at. We can also take the stance that we did with our lab work where we say you have to go to a free-standing facility to get your lab work unless you are in pre-op or you're in an inpatient setting. So we made that decision years ago because we were tired of paying the high cost of lab work. So we have some opportunities. This is a cost-saving one.

We can talk about, you know, HMO's and what is the long term strategy and short term strategy for those costs. I am currently working with both of our HMO partners

very diligently. They have been very forthcoming and willing to work with PEBP. We appreciate their partnership and we want to try to find a way to deal with this issue. But if we let it go at the current rate that it's at, these costs are going to skyrocket out of control. And we just solved the non-state retiree premium issue. Because those costs were out of control. And now the costs on the HMO are starting to be the same.

And so there's a definite opportunity. I think previous board members that were on this board, I think those that have been here for a while have heard do we self fund the HMO's, do we look at replacing the HMO's with an internal plan? Let's not forget that when you self fund you don't have to pay certain taxes and fees and that premium tax that is required, the three and a half percent of premium that all fully-insured products must pay to the Division of Insurance. And so the costs can generally be cheaper if you can manage that program as good or better than the fully insured product. And that's a big if.

There's some ability -- This one, number eight, is in response to a lot of public feedback that the co-insurance on specialty drugs on the HMO plan was too high at 40 percent. You heard that gentleman from UNLV come up to the board I think it might you have been in July saying that he can't afford it and he's going to have to look for work

elsewhere. We don't ever want to put someone out of a job because of the plan design. So they're saying it's an opportunity to reduce that and what does that do to the net rates to our HMO.

Again, keep paying the Medicare exchange, HRA fees, and life insurance fees for excess reserves. You guys already approved that in March of this year. So this is just kind of a nod if you want to continue to do that.

We also have an opportunity to provide a one-time supplemental HRA funding to the exchange retirees. We didn't give them one last year because of all the financial concerns. And as we were going through the process we wanted to move more program benefits to the base plan. We wanted to take it from enhanced to base. So we didn't have the reserves left to do that at the time. But there's an opportunity. There is an opportunity. They didn't get a supplemental this year. Are they supposed to? Maybe, maybe not, depending on the cost of those premiums going up. And we need to reach out to Towers Watson and to our actuarial consultant at Aon and say give us what the trend is on Medicare gap and advantage plans and then let's see if it makes sense to increase those. But quick blush back-of-the-napkin math, it's about 2.7 million dollars for every dollar per month per year of service that we do. So it's a decent chunk, but it's something we've done in the

past.

Keeping enhanced life insurance levels is something that you already approved before. You will hear a recommendation for me to do that in November.

And then here's something that's new. It's something that we added to this report that wasn't in the September board meeting packet, but we feel now it is appropriate to implement 3-D mammograms with a hundred percent cost sharing as a wellness benefit or preventive benefit. The specs for the control and prevention still do not require it to be part of that preventive benefit. But information we've received from our third party administrator and other advocacy groups and other entities dedicated to helping folks with cancer, and breast cancer specifically, that 3-D mammograms is where it's going and I think we have the money to support it.

Under consumer resources, here's an amazing opportunity, and we'll talk to you more about it in November's board meeting. But to implement an incentive program for high quality, low cost provider utilization. And just as a teaser, there's a way to incentivize behavior by basically sharing some of the savings back with a member for selecting lower cost high quality providers and those that don't have to. They don't have to participate. But as we are a PPO plan, we are about choice, so you can choose to go

to the higher cost one, you can choose to go to the lower cost one. If you go to the lower cost one, we can give you back some of that savings and you save yourself at the door and at the table when you make that payment and if the member does and the plan saves in paying the claims. So it's a really amazing opportunity. I don't want to let the cat out yet because we're still negotiating with some entities to see who we like the best. But it will be guaranteed savings to the program, guaranteed, or we won't pay them and there will be money going back to the members for making those decisions.

And as I talked about earlier, you can create an enhanced HSA/HRA benefit that we tie currently to preventive services but you can also tie it to just signing up for these programs and then they use it or they don't. We're not requiring anyone to use it. But this way they have access immediately so when they're at the doctor's office and they're told to go get an MRI, they can look up on their phones, they can call a call center that says, hey, where do I go to get an MRI where I get paid and they'll tell you. And you go and you get that and the vendor does the entire thing. They'll send a check to the member. They'll send a 1099 at the end of the year for tax purposes. They'll maintain call center of support and provide excellent reporting back to the agency. So it's a great opportunity to

help more consumers become consumer knowledgeable on the consumer driven health plan.

Number two under consumer resources, we can always contract with a health care communication center, the overhaul of communications, we've been toying with this internally. My communications team is knocking it out of the park. I don't know if that's something we want to put the money towards, but it is an opportunity and we will do some analysis to see what they looks like.

On the network side, there is implement voluntary narrow pharmacy network. We talked about this last year when you guys approved the preventive drug benefit as a cost control. It was called the smart idea network. I said we would revisit it this year. Here's the part where we're revisiting it and we will bring back that opportunity. Understand the big word here, voluntary, so we're not making anybody do anything. But if they voluntarily join these pharmacy networks and purchase their drugs through retail or mail order, they save money when they go and pay for them. So that's hugely beneficial to the member.

So opportunity to directly contract with hospitals that aren't in our network right now. Like I said earlier, we're about choice. And there are some hospitals that are not in our participating networks that people have been asking us to establish a relationship with. And we have

reached out and have had some responses and some, I think, some very viable options. It did look like it was going to be viable recently until our last generation of negotiations and I think we're going to be able to do something like this. And really do remember those three things. Increase access to our membership, that will do it. Improve the member experience. Yeah, we have a little more hospitals that you can go to that are cost-effective. And save on the cost of the plan for sure because there's an opportunity to set these contracts up on a new reimbursement plan that protects the plan after.

And last but not least, on-site near-site clinic development, northern Nevada pilot. I put that in there not knowing how you would react to the last agenda item. We now have our marching orders, so we'll fix that moving forward per the benefit discussion.

But that's what PEBP and our staff and our partners have been able to come up with. There's, you know, here's the opportunity to hear from you all if there's other things that you would like us to analyze or if you've seen something here that you just can't get behind and you want me to take it off.

And I'll turn it over to you, Mr. Chairman.

CHAIRMAN CATES: Thank you, Damon.

Any discussion on the item? Go ahead.

MEMBER SHIPPEY: Thank you. For the record Glen Shippey. Mr. Chair, just through you to Damon, I want to go back to the non-emergency facility-based imaging item that you talked about. And you brought up an example of Carson City and where you can look it up and see a difference, state versus facility based. And this is going to tie to that consumer resource you were discussing too. Currently a member wouldn't have the ability that you had in looking up the actual cost of an MRI from one provider versus another. Is that correct today? And is that something that this consumer resource that you're working on would give members the opportunity to actually shop for the lowest cost service?

MR. HAYCOCK: Excellent question, Mr. Shippey. For the record Damon Haycock. How I looked up those two differences is as a member, not as the executive officer. So I log in to my own member account through PEBP. If you go to the website in the top orange log-in button and you put in your user name and password it takes to you this landing page and one of those takes you to the HealthSCOPE Benefits side. And most people will actually kind of bounce around and not even go through PEBP, which is unfortunate. But once you land on HealthSCOPE, in the top left corner is something called health spark, and it's a tool we implemented years ago for every member to do exactly that, cost comparisons. Not a lot of people know about it. Every where I go, people say,

wow, this is amazing, you know, why didn't you tell anybody about it or why haven't we seen this before. And so we're doing our best to try to promote the current tools. But this additional tool is going to be another opportunity so that way you just have it. It's an application that's on your phone. It's on your tablet. Or you just need to have the number written down on a sticky note in your wallet or purse and you call and say where can I go. And they will help you with that shopping process. So we want to implement both.

CHAIRMAN CATES: Thank you.

Any other questions? I did have one question about the radiology. I'm wondering how this would affect somebody in a rural area where there may not be standalone clinics? How do they deal with that? Do we make exceptions for them?

MR. HAYCOCK: For the record Damon Haycock. My initial response to that, Mr. Chair, is that we make an exception. The idea isn't to send people all over the state. We need to save money where we can. But we can't, again -- And tell me if I'm sounding like a broken record, but it's got to hit those three overall concepts. Does it improve access to care? If it doesn't, we've got to think about it. Does it improve the member experience? Getting in your car and driving three hours for an MRI does not improve your member experience, right. Does it save money? Yes. So it

meets one but maybe not the other two, so that one is tough.

But we can implement a plan and then we could do either one offer or develop exceptions for the small pockets that don't have access to care, just like we do today in the rurals.

CHAIRMAN CATES: Thank you.

Any other questions or comments? Tom.

MEMBER VERDUCCI: Tom Verducci for the record. In the plan design we should consider dropping that awarding enhanced benefits. It seems like it would be -- the results we're having with reserves and surpluses that that would be the standard as opposed to enhanced going forward.

And I also wanted to comment on the 3-D mammograms. That's a huge preventive service to all of the members. And I had a personal experience this summer. Someone very close to me came down with cancer and because of early prevention, five months later, she's cancer-free. And I think that would be a huge benefit.

And what I'm reading here is that Damon is just looking in his recommendation to approve the analysis. And it would appear to me that coming up with improved benefits, reduced costs, that's a very reasonable recommendation.

CHAIRMAN CATES: Any other comments, discussion? Go ahead.

MEMBER SHIPPEY: Thanks again. For the record,

Glen Shippey. I just wanted to discuss, you know, time, increased HSA contributions, other activities, and something that just kind of popped in to my mind. There's such a thing as financial wellness that we may have the potential to encourage, because the data that I've seen on the member voluntary contributions to HSA sort of our own contributions is pretty low. Is it possible to have this increased HSA contribution by the system treated as kind of a match so that somebody could, you know, access an enhanced contribution or matched contribution if they choose to contribute a little bit more out of their own pay? Is that something that's been discussed or looked in to in the past?

MR. HAYCOCK: For the record, Damon Haycock. That was one of those -- And I know you weren't on the board last year, Glen, but we actually presented as an option for HSA funding is to do a match process. There are some definite advantages to it. There's some definite disadvantages. I won't get in to it here today. But I think it merits another look and I'll bring back the analysis to the board in November with the pros and cons and costs so that way you all can make the most informed decision.

CHAIRMAN CATES: I do have one question on number one, the $200 contribution to the HSA/HRA. Can you explain what the development status is, participant may bear entire cost of benefit and increased rates.

MR. HAYCOCK: For the record Damon Haycock. Excellent question. I think that's a holdover from my last time. There is no participant bearing the entire cost. So just scratch that. Pretend you didn't see it and we'll go forward.

CHAIRMAN CATES: Thank you. I feel better. I don't know. This is going south.

Okay. Any other questions?

MEMBER LAMBORN: Leah Lamborn for the record. So just to make sure that I understand. This is a document that you provided to us to start thinking about for next meeting when we design the next years plan, which starts July 1st of 2018; correct? Okay.

So can we get it and put it in a different format, keep everything that we agreed to that we most likely want to keep, because you don't want to take anything away if you don't have to. Those are kind of priority number one. Any efficiencies, I see some cost savings here. So if we know which ones for sure. If this is going to be budget neutral or efficiency cost savings. And then the last column would be your additional enhancements.

And then for today's purpose are we to identify the ones that we like so you can start working on developing costs or what is the plan today?

MR. HAYCOCK: For the record Damon Haycock.

Thank you, Ms. Lamborn. And your format is exactly what I was going to do. I learned from last year and we need to do a better job of showing what the, kind of the ala carte price tag is as things get approved. So I'm going to work very hard, very diligently with staff to try to make it more transparent this year.

You are not -- What you are here to do today, what you can be here today to do -- Maybe that's a better way of putting it. Here is some opportunities that the staff has seen. If you want us to analyze those, you can approve those. We're going to add the match HSA. That's something that Mr. Shippey put in. So I'm taking notes. If there's anything that you want us to look at and I'll let you know if that's something that's way out. And I'll give you an example. Let's get rid of the CDHP and go back to the old PPO. I can't analyze that fast enough for November, nor would I recommend it. But if it's nothing that's that earth-shattering, we can look at other benefits. I didn't put it in here, but I talked to Mr. Verducci on another date, is what about that enhanced vision benefit, right? And so we're reaching out to analyze what those vision benefits would look like from a voluntary standpoint as well as you kind of knew what the price tag was if we offered it and we can revise those numbers. But I want to come back with that one as well. And so I need some ideas from you guys. And

then that's basically you're saying you want to go forward and look at this.

MEMBER LAMBORN: Mr. Chair, thank you. Again, Leah Lamborn for the record. So I know for sure that I would like an updated analysis on any of the ones that we would keep just so we have new numbers. And then I certainly am interested in seeing any savings, cost efficiencies. So if we can just have those next meeting, that would be great. And then if I can get a minute to go through the list, I know there's a couple. Thank you.

CHAIRMAN CATES: Are there any other comments? I guess one thing I would ask the members, is there anything on this list that you would be opposed to having staff pursue? These all seem like good ideas to me. At least worth investigating.

MEMBER LAMBORN: Mr. Chair, can you go in to a little bit further on the self plan HMO plan, what that is.

MR. HAYCOCK: For the record Damon Haycock. Thank you, Ms. Lamborn. Currently the HMO plans are fully insured and they are managed by those entities. They maintain all the risk and they present us with a rate every year for an annual renewal that you all will approve that says, yes, we want those benefits and we recognize that the rate is going to be what the rate is going to be and that you approve those. And that's been pretty standard for many

years here at PEBP. That's the arrangement with a fully insured program is that we're collecting money and we're pitching it in premiums and rates to another vendor to manage that population. They're also known as managed care organizations. They have to follow a lot of the rules and regulations as the managed care organizations.

If we were to self fund, there are multiple ways to do that. One we could just say we're getting an administrative fee and that we maintain the risk but we want you to help us manage these folks or we basically replace them and self fund that plan design internally and pull that risk back and potentially add that risk in to one risk pool with our CDHP leverage some of those cost savings in one plan to offset any increased cost in another and bring that risk inside. And the potential benefits of doing that are that group health insurance works because the healthy subsidize the sick and the young subsidize those that are older and the single subsidize the families and that's basic group insurance. So the more people you have participating, the easier it is for those folks that need health care to afford it. So maintain that risk.

So we have right now 22,000 primary participants and another 18,000 or so dependants where sum total is about 40,000 people on our plan. But the HMO's have drastically less than that. When you put them together, they're in the

15, 16,000 person range with another so many dependants that it becomes harder for them to manage that. It would become hard for us too. So it's not a knock on them. It's just by design.

So we're going to continue to work with our HMO partners and see what is the best recommendation we can. And hopefully we agree at the end of the day. We have some deadlines approaching, but we know we need to address this issue. It was a very important issue that we talked about at our strategic planning session because we don't want to see these go off a cliff. And we know right now that especially if we need to do some form of massive rate increase to meet these increased risk population, how is that going to work in an off year? Legislature didn't know it was going to happen. I'm going to imagine the governor didn't know it was going to happen. And all of a sudden we're asking these employees who finally got a cost of living adjustment on the HMO plan to go backwards and pay a lot more money.

And so we're still finalizing it. I don't want to let too much out because I don't want to paint PEBP or the HMO's in the wrong light. But I think our dedication to solving this problem will have a series of options for you and then what PEBP recommends and why.

MEMBER LAMBORN: Thank you.

CHAIRMAN CATES: Thank you. I would just add

that I'm very interested in pursuing this one. We have some clear systemic problems with increasing costs on the HMO plans with the shrinking pools. And I don't know if this is the answer, but I think we need to be prepared with alternatives.

Any other questions or comments? Yeah, let's go ahead and open this to public comment. Anybody have anything they would like to add on Agenda Item Number 7?

MR. ERVIN: Kent Ervin for the Nevada Faculty Alliance. First, let me ditto what Marlene and Priscilla said about thanking Damon for the opportunity for input from advocacy organizations.

On this agenda item, I really have a plea that you include in the list the deductibles and maximum out-of-pocket costs. That's what affects most of the people who have major incidents in a year or have chronic conditions. And I would look there first before HSA -- increased HSA contributions or some of the other enhancements.

Currently, the IRS minimum deductible for a high deductible plan is 1300. We're above that. And the IRS minimum maximum -- I think it's a minimum maximum out of pocket is 6650, twice those for families. And if we could move even partially down to those minimums, I think that's what helps the people who need it the most. And at least

costs out from Aon, you know, how much an increment costs.

The second thing is -- that I'd like to see on the list is to increase the employer contribution or some people call that a subsidy, the employer contribution for the employees a hundred percent. Right now the $42 a month for a single employee gets taken out of your paycheck. That's $503 a year. But then we -- PEBP puts back in 700 in to an HSA, so it's out of the employee's pocket here and in to the employee's pocket in a different form. And I just think we ought to be looking every time if there's an opportunity to reduce the employee contribution to the premium back to many years ago when it was at a hundred percent for the employee's contribution and at least cost that out.

We have a 19 million dollar excess reserve. That would cover completely if my back-of-the-envelope calculation is right would completely cover the $42 a month. So I would like -- hope the board members would at least put those on the list down at the bottom where we have the possible enhancements, because I would suggest you consider some of those things before some of the other things. Thank you.

CHAIRMAN CATES: Thank you.

MS. BOWEN: My name and words for the record, Peggy Lear Bowen, P-e-g-g-y L-e-a-r B-o-w-e-n. My name and words for the record. Going directly to the imaging part and as long as we have hospitals and insurance companies owned by

the same entity, I am concerned about the imaging taking place. It's taken two and a half years for imaging regarding my accident that I had and I know about have been suffered but I'm going to tell you anyway. And what basically happens is there are two points of view in doing any imaging that are taking place, whether they be MRI's, x-rays, CT scans.

One point of view the insurance company loves when they tell you your pain and breathing and everything else is all in your head. The other point of view especially with my sinuses in this area, after Renown did the imaging and said there's absolutely nothing wrong, that my ENT happened to have a CAT scan recently added to his office and he redid the imaging from another direction. And as a result, I had the surgery done, so I can breathe. Just a little minor activity that I enjoy.

And it has to do with how the imaging does. Many of you have maybe incurred knee situations, knee pain, and going on with this therapy, that therapy, the shots. And the imaging says there's nothing wrong so we got to find something else here. And then the other imaging says this is where there is a problem and this is what can be done. And I've had three, over my 68 years, you're now talking to an older woman, three knee surgeries and four foot and ankle surgeries based on first imaging every single time saying nothing wrong and then reimaging at the direction of

specialists and that sort of thing outside of the emergency room, outside of being an inpatient in the hospital when you're trying to discover what is going on. That imaging was corrected. It was discovered what was wrong. And I'm walking and doing very well with those surgeries that were finally allowed because of the imaging.

And I'm probably close to my three minutes. The -- Thank you, thank you, thank you for the recommendation about the 3-D mammograms. But my question involved in that is that I hope it is as ordered by a physician and that there's not more cost incurred by the patient because they had to go to 3-D rather than to single. Just if you keep it as a recommendation of three mammograms as ordered by a physician, then that makes it so that those who need the mammograms, male and female, can have whatever the doctor feels is necessary and not what the insurance company is willing to pay for without added take away from us.

Thank you, thank you so much. Heartfelt thank you. Especially the mammograms. You heard the imaging community on that. And let the imagings be by doctor order and not by being in the hospital or being in the emergency room, because you get a lot of pro work done so you don't get to a point where you are in the hospital or in the emergency room because you have the work done to say what was wrong and what needed to be fixed and don't penalize people for doing

that, please. Thank you very much.

CHAIRMAN CATES: Thank you.

Any other public comment in Carson City? Any public comment in Las Vegas?

MEMBER COCHRAN: There does not appear to have any comments.

CHAIRMAN CATES: Okay. Thank you.

I will bring it back to the board. I'm not sure, do you think we need to take a motion? We've been given a lot of input. Do we need to go through this whole list as a motion? I'm not sure what the pleasure of the board is.

MEMBER BAILEY: I would say no.

CHAIRMAN CATES: I don't think so.

MR. HAYCOCK: For the record Damon Haycock. My understanding is I need to continue to go through all of these, add the things that have been said today, bring back an analysis in what you've already done, what saves money and each cost as you guys can go through a laundry list of additional benefits at the November board meeting. That's my understanding, unless somebody says otherwise.

CHAIRMAN CATES: I do have one question for you, Damon. We didn't take anything off of this list and we added some things. Do you and your staff have the wherewithal to grind through all of these issues?

MR. HAYCOCK: For the record Damon Haycock.

There's a couple that we may not get the best analysis on due to timing. We can do, like, the hundred percent pay premiums. That's easy math. The deductible and out of pocket max change, we'll work with our actuaries to see if we can turn those around pretty quickly.

The match HSA, I have some IRS concerns, but I think we can come up with something there.

So I think we're all right. We've been doing a lot of analysis already. We don't wait until -- To be honest, we don't want until you guys say go for it before we analyze. We are analyzing all the time. My TPA is present here and she's probably tired of my 10:00 o'clock at night e-mails that say, hey, what are we doing here and how about this. So we are always analyzing. But I want to make sure that we pick up anything additional that you're looking for. So I think we're going to be okay.

CHAIRMAN CATES: Good. I'm glad to hear that. I just want to be mindful of your resources and not ask too much.

MEMBER LAMBORN: Sorry, Mr. Chair. I just wanted to make sure that you captured vision. You're going to do that analysis on the glasses.

MR. HAYCOCK: For the record Damon Haycock. I already started.

CHAIRMAN CATES: Okay. Well, I guess we'll move

on then. We'll close Agenda Item Number 7 and move to Agenda Item Number 8, discussion and possible action regarding Towers Watson's One Exchange operations report.

Mr. Garcia, welcome.

MR. GARCIA: Thank you. Chris Garcia with Willis Towers Watson for the record. Thank you, PEBP board, for the opportunity again to come and present our operations report to you. We have quite a few updates to the presentation as well as an additional section regarding a --

(The court reporter interrupts)

MR. GARCIA: -- new section in the operation report. Participants issue log. Again, we originally were doing a service improvement plan and we have now moved to an operations report. We're in a position where we're providing quality service to your participants, your retirees on a day-to-day basis. And the mission of this report is to share that information back to the board.

Like I said, I did add a new section to this report as well as additional information going back to July through current September.

The first section of the report is regarding our HRA on-site assistance program. As you're aware, we started this program just over a year ago and we've seen quite a bit of improvement within that program. We do have an HRA specialist that is attending once a week per month at the

Nevada PEBP office in Carson City. And just in October we started having them do meetings in Las Vegas as well. And we'll get to that section in just a moment.

For the last three months, July, August and September, you'll see on the second page or page four, excuse me, of the document we had four appointments in July. We had ten appointments in August. And five appointments in September. So although the numbers are rather low, we are still being able to have that representative assist participants directly and with a one-on-one appointment. And now you'll see that in the following page we are actually doing appointments in Las Vegas and we have our HRA specialists attending meetings and setting up appointments in Las Vegas for three weeks -- for three days out of the week and then coming back up to Carson City for the remaining two days of those weeks. So they just started doing that on October 9th, 10th, and 11th. And then we'll be doing that again in Las Vegas on November 13th, 14th, and 15th. And on December 11th, 12th, and 13th.

Unfortunately, the Las Vegas numbers weren't as high as we anticipated, but it was the first time that we've been back to Las Vegas in a while. We don't have the numbers right now because at the time the initial report was created we didn't have the data yet. This report was created right before the end of the week of October 13th. We had about

five appointments for those three days in October with a couple of walk-ins. And we'll be able to share more details in the next board meeting.

We did have fall retiree meetings in Las Vegas, Carson City, and Reno. Those are meetings that we have every year. We do them twice a year, once in the spring and once in the fall. For our fall meeting, they occurred on September 7th, September 28th, and September 29th. And in the comment section to the right of the chart you'll see the attendance that was captured for each meeting. On the September the 27th meeting in Las Vegas we had 21 attendees for our aging meeting. That's the meeting that we have in the morning to assist participants that are brand new or aging in to Medicare. And then we had 34 attendees for the second meeting in the afternoon, which is for the Medicare eligible retirees who -- that's more of a focus on the HRA.

In Carson City we had 20 attendees for the aging meeting in the morning and 36 attendees for the Medicare eligible meeting in the afternoon. And then in Reno we had ten appointments -- Excuse me -- ten attendees for the aging meeting in the morning and 24 attendees for the Medicare eligible meeting in the afternoon.

One thing I do want to point out that the Las Vegas meeting it was the first time since I have been at One Exchange that we have had an actual teleconference of the

meeting to different locations. We actually teleconferenced that meeting to Elko as well as Henderson. So there are people who attended those meetings remotely from those locations and they wanted to get the information and ask questions as well.

So I think that's something that we'll look forward to doing in the future in the spring as well as next year in the fall.

Moving on to our communication section, we have three communications that we either started mailing or will start mailing. Our first communication that I want to point out to you is our HRA fall balance reminder communication. This started mailing on September 5th and will be staggered over a seven-week period of time. We have to do that just to even out the mailing so that we don't send 500,000 communications out to the post office at one time. But we do stagger them overtime and it gives participants the opportunity to see what the balance is in their HRA and hopefully contact us so they can determine how they can go about submitting claims to get reimbursed for those expenses.

The second communication I would like to mention is our fall newsletter. This is a communication designed to inform participants about the upcoming open enrollment period, which actually started back on October 15th. That outlines any actions that need to be taken and updates the

recipients on brand new changes to Medicare. That communication started mailing the week of October 2nd. And we are actually mauling that with an additional communication, which is the third item I would like to mention in this section, which is the HRA qualification reminder communication. This communication is designed to remind retirees about Nevada PEBP's requirement to enroll through One Exchange and the Medicare medical plan to qualify for HRA funding.

It is designed to help prevent participants from enrolling outside of One Exchange, which could cause them to lose their funding qualification. As I mentioned, this communication is actually mailed with the fall newsletter. And that started mailing as well the week of October 2nd and will be staggered over about a four-week time period.

The next section is our historical call stats. And we have historical call stats going all the way back to 2016. But we want to focus on the more recent call stats for 2017. So if you could turn to page ten, you'll see that the most recent months would be July, August, and September. Those are the months since our last board meeting that I wanted to clarify for you are going out to you.

For July we had over 1300 calls. But those callers had an average wait time of 13 seconds to speak to a customer service representative. In August we had an

increase of calls. It was over 1500 calls. And they had an average speed -- average wait time of 17 seconds. And then in September the call volume decreased down to just shy of 1200 calls in to our service center. And they had an average wait time of 15 seconds. So as you can see, we are consistently having wait times under 30 seconds. If you look back to even going back to February of this year, it was captured a little bit differently up until April, but it was a .26 of a minute, 100 being a minute. So it was always under 30 seconds except for January where we had a bit of a longer wait time. So we're consistently seeing those lower wait times for participants calling our service center and being able to speak to a customer service representative.

We have just started open enrollment season. As I mentioned, historically our busiest time of the year and that started on October 15th. And we are seeing higher wait times currently and these are our peak times of the year. Our busiest time of the season will be the beginning of the season, October 15th really through the end of December -- Excuse me -- the end of November to the beginning of December. In our next board meeting we'll have more specific stats on the wait times for the open enrollment season.

And the next section is our new participant escalation issues log. This is something that I mentioned at our last board meeting that I wanted to add to this report.

It gives you an idea of the number of escalations that we receive directly from PEBP and how we address those and turn those around.

So the below chart will reflect the actual number of accounts on the participants issues log that One Exchange tracks for Nevada PEBP participants. The accounts on this log are typically generated from the participant issues Nevada PEBP sends to One Exchange for research. However, some accounts can be added to the log based on One Exchange notifying Nevada PEBP of an issue that may require additional research.

The report is provided to PEBP every Tuesday to share weekly updates on accounts on what we call an active tab. One Exchange and Nevada PEBP meet every two weeks to discuss the status of the accounts on the active section of the report.

The common reasons that a participant is on the log are they need enrollment assistance, there's HRA research, something like a denied claim or a balancing period, an allocation discrepancy, either the amount of the allocation or the start date of the allocation, an eligibility discrepancy, say, a start date or some sort of missing information.

We went back and recaptured data all the way back to the start of 2017. And, as you can see, on January 3rd of

2017, we had 17 accounts on the active tab and we had 165 on the closed tab. So what we did is we went back and looked at once a month, typically the beginning of the month, what's the number of accounts were on the active tab versus the number of accounts on the closed tab. And as you can see, February was 17 accounts on the active tab. And they do -- This is a very fluid account or very fluid report. It changes day to day, week over week so that the same 17 accounts that were on the January tab are not the same 17 accounts on the February tab. They're going to be different accounts that were researched and then moved to the closed section.

What I want to point out is you can see in May we had four accounts on the active tab. But then in July it jumped back up to 11. And July, of course, is the beginning of PEBP's fiscal year. So that can give us an idea of why we may have seen an increase in the June/July time period. And in August you can see it decrease down to five. September, the beginning of September, we had ten accounts at the beginning of that month on the active tab. And then at the beginning of October we were down to two accounts. By that point we had 397 accounts in the closed tab.

So, as I mentioned, it's a very fluid report, a very fluid process. Many of our escalations that we research for PEBP, they can respond within 24 to 48 hours. So we're

getting inquiries in from PEBP and we're responding to them, researching them. They're calling the business back and directly working with them to resolve their issue or providing research responses back to PEBP so then they can follow up with the participant.

But I think this is a good -- gives a good idea of the type of escalations that we're receiving, the number of escalations that we receive, and our effort to close that out.

And with that I would like to offer any questions.

CHAIRMAN CATES: Thank you very much for your presentation.

Do we have any comments or questions from the board? Tom.

MEMBER VERDUCCI: Thank you Mr. Chair. Tom Verducci for the record. Chris, I just wanted to ask. I know you're doing teleconferences with Elko and Henderson. Has there been any discussion about perhaps including Winnemucca and Ely for that concentration of employees out there?

MR. GARCIA: I know that there has been talk about actually having us do physical presentations in Ely and Elko because Damon and I had a recent conversation about that of having some of our folks in our Salt Lake City office

drive out to Elko and Ely. Winnemucca was not discussed, but that's certainly something we can look in to.

MEMBER VERDUCCI: Thank you very much.

CHAIRMAN CATES: And I would just like to add that, you know, using NSHE system you could reach about any town in rural Nevada, so that's a good opportunity to expand that.

Any other questions, comments? It looks like we're good. Thank you.

MR. GARCIA: Thank you.

CHAIRMAN CATES: Okay. Let's close Agenda Item Number 8 and move to Agenda Item Number 9, public comment. Do we have any public comments in Carson City? Come on down.

MR. ERVIN: Kent Ervin, Nevada Faculty Alliance. For the record, and recognizing that I'm between you and lunch, but we're getting out at a good time today.

I would like to address a couple, just a couple of issues. And, again, echoing the thank you to all of you board members for the hard work you do and to Damon and his staff as well.

I do want to talk about the report from Willis Towers Watson. They talked a lot about service issues and so forth. One thing that's not in the report was how much that service costs. My understanding is, and I could be wrong, that they earn roughly $250 per participant per year in

commissions back from the insurance companies, the plans they help provide, those are hidden expenses. I'm not sure that's been on your radar screen. But I think as a fiduciary duty to participants the board needs information about that. It seems to me as a potential conflict of interest if this provider is recommending plans that they earn differential commissions on, I have no idea whether that rate is, A, accurate, and B, a fair market rate for the services provided. But it's something that really, you know, you ought to know.

Second, I know in the retirement plan industry, so-called revenue sharing arrangements from investment providers back to plans are going by the wayside because of these types of problems and instead you go to a process where those kinds of commissions are to the plan, meaning PEBP in this case, and then you pay the provider for the services rendered and their cost can be determined by an RFP or other open process.

So I just wanted to put that on the radar screen as something to look at in the future.

And, second, completely different subject, is I don't want to forget about the post-2011 hires to the state who are getting no retirement health care benefits by law. This is the law currently and this will become an increasing problem as time goes on. Active employees who are post-2011

are going to be subsidizing the benefits, the retirement benefits, that they will never get by law. And this is probably something that the legislature needs to address, of course, but PEBP can help provide solutions or possibilities, you know, what's possible.

One simple idea might be -- And recognizing that I'm sure there's no political stomach to have any unfunded future liability for the state for this -- but perhaps an additional contribution to HSA's for that class of employees could help pre-fund their retiree benefits or some other strategy to take care of this problem which will be increasing as time goes on. Once those become the majority and then they're funding retiree benefits for the older folks who are pre-2011, that's going to be a real problem. I just think we ought to keep that on the radar screen as well.

So thank you very much for the opportunity to provide a comment.

CHAIRMAN CATES: Thank you.

Any other public comment?

MS. BOWEN: Again, thank you for not only a beautiful meeting and wonderful news in many different areas and for your deliberation has just been -- My name and words for the record, my name is Peggy Lear Bowen, P-e-g-g-y L-e-a-r B-o-w-e-n. I want to thank you for, on the record, for all your diligence today and every day with what you do

in protecting the employees.

The legislature became readily aware of, piggy-backing on what was said of the no post-retirement benefits for their worker come 20 -- with the 2011 changes that were made in that legislature and they are working very hard to reestablish and have a retirement program for the workers because it's only fair. It was in lieu of benefits that those workers had the insurance and to enhance -- have insurance as a reason to go to work for the State of Nevada was one reason they gave for underpaying them in lieu of salary for all the years. And now that's going away and people are not being encouraged to stay and work for the State of Nevada after they've gotten all of the training. Anyway, that happened at the legislature, and they're working on it and with great intensity.

What I want to talk to you about, prescriptions, because I've been one who's never had to take a prescription until recently with having to get the Epipen. And what I became very, very much aware of is that the prescription benefit is tied to the all over out of pocket now. Instead of having a set this is your prescription benefit and kept -- you meet your deductible for your prescription and then you can get your prescriptions. This is major.

The idea that I have to reach not only a deductible for myself as an individual, and I'm only an

individual on this plan. I have no family that are on the insurance plan. I also had to meet an out-of-pocket family deductible for a period of time. And that didn't make any sense. I'm meeting -- My out of pocket was too much, plus my individual came together, and I still couldn't get a prescribed aspirin until I met a tremendous amount of out of pocket of, what, close to $4,000 altogether. I'm just throwing numbers around.

You need to have within your program regarding your prescriptions a separate in the sense of you have a deductible, you meet that deductible, and then your prescriptions can go to 80/20, you reach a maximum out of pocket on your prescriptions and then they're covered at a hundred percent. And it needs to be treated that way so people can afford to take their medicines to stay alive, healthy, and happy. And that's what I wanted to bring to the table today in the public.

With the Medicare plan that I had to buy part B -- Am I at my three minutes? Okay. Thank you very much. I'll talk about part B on another day. And thank you for your deliberations. You guys are awesome.

CHAIRMAN CATES: Thank you, Peggy.

Any other public comments? Any public comments in Las Vegas?

MS. BOWEN: Happy Nevada Day.

CHAIRMAN CATES: Okay. Seeing none, I'll make a public comment as well and echo what you just said, Happy Nevada Day. Come to the parade.

MS. BOWEN: Yes.

CHAIRMAN CATES: Okay. Close Agenda Item Number 9 and move to Agenda Item Number 10, this meeting is adjourned.

(Hearing concluded at 11:52 a.m.)

STATE OF NEVADA)
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CARSON CITY)

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

That on Thursday, the 26th day of October, 2017, I was present at The Legislative Building, 401 South Carson Street, Carson City, Nevada, for the purpose of reporting in verbatim stenotype notes the within-entitled public meeting;

That the foregoing transcript, consisting of pages 1 through 130, inclusive, includes a full, true and correct transcription of my stenotype notes of said public meeting.

Dated at Reno, Nevada, this 8th day of November, 2017.

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CHRISTY Y. JOYCE, CCR
Nevada CCR #625

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