

**In The Matter Of:**  
*PUBLIC EMPLOYEES BENEFITS PROGRAM BOARD*  
*VIDEOCONFERENCED OPEN MEETING*

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*October 26, 2017*

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*Capitol Reporters*  
*208 N. Curry Street*

*Carson City, Nevada 89703*

Original File 102617.txt

**Min-U-Script® with Word Index**

1 PUBLIC EMPLOYEES' BENEFITS PROGRAM BOARD

2 TRANSCRIPT OF PROCEEDINGS

3 VIDEOCONFERENCED OPEN MEETING

4 THURSDAY, OCTOBER 26, 2017

5 CARSON CITY AND LAS VEGAS, NEVADA

6  
7  
8 The Board: PATRICK CATES, Chairman  
LEAH LAMBORN, Member  
9 DON BAILEY, Member  
ANA ANDREWS, Member  
10 GLENN SHIPPEY, Member  
TOM VERDUCCI, Member  
11 CHRISTINE ZACK, Member  
CHRIS COCHRAN, Member  
12 LINDA FOX, Member  
13  
14 For the Board: DENNIS BELCOURT, Deputy  
Attorney General  
15  
16 For Staff: DAMON HAYCOCK  
Executive Officer  
LAURA RICH  
17 Operations Officer  
CELESTENA GLOVER  
18 Chief Financial Officer  
NANCY SPINELLI  
19 Public Information Officer  
KARI PEDROZA  
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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.

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

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

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

20                   MEMBER COCHRAN: None.

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

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

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

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

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

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

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

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

25           But one of the biggest success stories that PEBP  
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1 had with the consumer driven health plan is that although we  
2 had increased population, we had increased costs. So we had  
3 a negative trend on the medical side and effectively on the  
4 pharmacy side by switching to a new pharmacy benefits  
5 manager.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19           CHAIRMAN CATES: Thank you, Damon. Good report.  
20           Any questions of Damon?

21           MEMBER COCHRAN: Mr. Chair. This is Chris  
22 Cochran in Las Vegas. I do have a question for Mr. Haycock.  
23 I know that the docs on demand is -- the Doctor on Demand is  
24 a fairly new program. That was something that we,  
25 presentation, the board had a presentation on that a couple  
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1 years ago, I believe, in the fall of 2015. Did we have any  
2 targets for that program? 600 visits doesn't seem to be a  
3 whole lot of visits. I don't know overall. Do we know -- Do  
4 we have any information on this? And this may not be  
5 something that you can answer at this point. But I'm just  
6 kind of -- I'd like to get more detail on the visits. Who's  
7 utilizing it? Where are they coming from? Are we seeing  
8 more utilization of this from members who live in the rural  
9 areas or just all over the state? So I don't know if you've  
10 got any updates on that.

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

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

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

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

18 MEMBER COCHRAN: Okay. Thank you. I think that  
19 answers most of my questions. I just wanted to have a little  
20 more detail and see how well it was working. I think there  
21 are opportunities there. But, you know, knowing then that it  
22 didn't really start until this year, you know, it's realistic  
23 that it's not been pushed, and, you know, it is probably more  
24 about people not knowing enough about it even though you may  
25 be pushing this. You know, a lot of times we don't read our  
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1 stuff from PEBP until we're sick. And so it's just something  
2 that we probably need to just watch and see how well we can  
3 get more information out there. Thank you, though.

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

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

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

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

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1 still receives that benefit.

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

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

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

4 CHAIRMAN CATES: Thank you, Damon. Well said.  
5 Do we have any other questions for Damon?

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

14 MR. HAYCOCK: For the record Damon Haycock.  
15 Thank you, Mr. Verducci. If PEBP through our pharmacy  
16 benefits manager, Express Scripts, offers a 90-day mail order  
17 benefit, so to break it out of health and look at it just  
18 from a typical economy scale scenario, the more you buy at  
19 one time, the lesser the costs are because you get that bulk  
20 discount, that works for a lot of drugs that aren't too  
21 expensive on a monthly basis. There are certain drugs that  
22 cost a hundred dollars a month. And if you go to the  
23 pharmacy and get them, you pay your hundred dollars each  
24 month and you can hopefully afford that. It's hard to ask  
25 someone to pay \$260 a month or \$270 at one shot to try to get  
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1 all three months at a time. But our utilization of our mail  
2 order is not where I think it should be. The book of  
3 business from Express Scripts is much higher than what we  
4 currently use. And, ironically, as you mentioned this today,  
5 I just challenged our marketing staff, our communications  
6 team, to push the knowledge and some of those savings out to  
7 our membership. And that's one of the things that they've  
8 been tasked with.

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

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

23 MEMBER VERDUCCI: Thank you very much, Damon.  
24 Just one follow-up question on a different subject. Are we  
25 seeing participants in the program utilize the preventive  
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1 aspects where they do have an increased contribution in to  
2 their HSA contributions? Are they utilizing those programs?

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

18 MEMBER VERDUCCI: Thank you very much.

19 CHAIRMAN CATES: Thanks, Tom.

20 Any other questions?

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

25 MR. HAYCOCK: Thank you, Mr. Chair. For the  
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1 record Damon Haycock. This report is in response to the  
2 clean-up language that we recommended at a previous board  
3 meeting in response to the latest legislative session.  
4 Senate Bill 502 was passed and there were some changes that  
5 were not reflected in the current policies and procedures.  
6 There's also an opportunity that I took in revising these to  
7 provide more flexibility to the board. And I'm going to walk  
8 through some of those opportunities here.

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

20 And before I -- Let me back up for a second.  
21 There is no required action. If the board doesn't want to  
22 approve these today or they want me to make changes, I can go  
23 back and make those and bring them back for a future board  
24 meeting or they can be approved if you like them with a few  
25 changes as part of the motion. So, as far as process goes,  
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1 this isn't one of those here it is you need to approve it.  
2 This is one of those please review and provide PEBP feedback  
3 and if there's something we can do to make it better, we  
4 will.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25                   Then there was a -- If you advance to page 21 at  
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1 the bottom, there was discussions of multiple different types  
2 of catastrophic reserve buckets. We only have one. It's  
3 category 86. And it basically says that you will use  
4 reserves to reduce rates. And that's not necessarily true.  
5 And so I want to make sure that it didn't paint the board in  
6 to a corner there.

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

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

10           Again, there's also, on the top of page 23,  
11 you'll see that there is a percentage split from the primary  
12 plan and the non-primary plan and that's talking about the  
13 CDHP versus the HMO plan. Traditionally, the difference was  
14 15 percent in contribution. Last year we were able to reduce  
15 that and apply more contribution to the HMO's. And so the  
16 proposed high increase in rates became very, very small once  
17 we finally put it in to practice that you all approved. So,  
18 again, all of these types of changes are there to add  
19 flexibility so that you as the board can make those decisions  
20 at the time you need to make them with the best information  
21 you have available.

22           And then it also talks about, at the bottom of  
23 23, that I -- I took out the rigidity of the part B premium  
24 as published by CMS, because there are multiple premiums that  
25 are published by CMS. So what's the right one? So I just  
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1 said as approved by the board. So, if you remember, you guys  
2 approved an increase in the Medicare part B premium credit  
3 from 104.90 to 134 this year. This is giving you that  
4 opportunity to do that as you approve plan method designs  
5 year after year.

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

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

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

15 MR. HAYCOCK: That is correct.

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

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

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

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

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

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

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

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

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

18 MR. HAYCOCK: For the record Damon Haycock. As  
19 you were explaining your position, Mr. Chair, a light donned  
20 on me. We were doing that kind of in the background. But  
21 there's no reason why this policy can't be adjusted to leave  
22 that in there. And even though there's no statutory  
23 requirement, there's a lot of things that aren't statutorily  
24 required that this board does, right, and the board does very  
25 well. From a practical standpoint, we do provide funding and  
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1 opportunities for continuing education for the board.  
2 Mr. Shippey just got back from one of those opportunities. I  
3 just got back from that opportunity Tuesday night. And so  
4 it's not that we are halting continuing education. It's just  
5 that it was my initial blush at trying to adhere the policy  
6 to the bill.

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

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

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1                   CHAIRMAN CATES: I think Dr. Cochran.

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

13                   CHAIRMAN CATES: Thank you.

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

16                   Go ahead, Damon.

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

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

22                   Did you have a question, Tom?

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

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

8 CHAIRMAN CATES: Okay. Thank you.

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

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

13 The next part of this agenda item is the  
14 strategic planning overview that was held on August 22nd and  
15 23rd. This was as a strategy session. So this is the  
16 overview of those results.

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

25 We felt that was successful, so we expanded it to  
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1 include more partners and, of course, the opportunity for  
2 board members to attend. And I'm very pleased to say that  
3 the board chair attended on a portion of this, the board vice  
4 chair attended on a portion of this, and another board  
5 member, Mr. Verducci, attended on a portion of this. And,  
6 really, that feedback was critical to kind of testing the  
7 waters and the temperature of where we were headed, because  
8 the last thing that we would ever want to do is make it  
9 appear that the agency is driving the strategy when it's  
10 really the board that drives the strategy and it's the  
11 agency's responsibility to respond to and implement your  
12 goals and objectives.

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

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

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

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

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

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

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

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

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

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

22           So what are we all about? What do we want to be?  
23 Who are we as we explain ourselves to other folks? And we  
24 are a member-focused, right out the gate -- And I want to  
25 thank Ms. Lockard from RPEN for helping me rearrange some of  
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1 these in the most appropriate order. PEBP will be a  
2 member-focused, nationally-recognized, affordable program of  
3 employer-sponsored benefits serving employees, retirees,  
4 their families, and the Nevada taxpayer.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 But those regional plans were successful in the  
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1 region because they maximized their ability to provide care  
2 based on those systems. And those systems are different.

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

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

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

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

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

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

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

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

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

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

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

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

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

3 We are going to have a new administration in  
4 2019. We don't know who the new governor is. We have a very  
5 supportive governor in Governor Sandoval. And he is going to  
6 term out and there will be a new governor. And our hope,  
7 cross your fingers, that whoever is elected is pro employee  
8 and retiree benefits. That's what we hope.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23 Communication of the board to maximize the  
24 different channels and how we're going to do that, how we're  
25 going to evaluate communication tools. And we're going to  
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1 continue to update that formal communications plan. But we  
2 want to engage subject matter experts. It's interesting  
3 where a part of these groups and we don't always take  
4 advantage of their expertise. And so I reach out to my  
5 counterparts across the nation to see what they're doing.  
6 And it really helps us with our ability to maximize  
7 communication.

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

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

22           Then you guys can either approve the strategic  
23 plan overview if you like it or if you want me to go back and  
24 make changes I can make changes and bring it back in November  
25 or what have you. But if we don't get some kind of sense of  
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1 urgency on it, this thing can go for a long time. And I  
2 think that might have been one of the issues that previous  
3 folks had with trying to nail down a strategic plan is that  
4 it keeps going and we're trying to get really, really perfect  
5 at it and then the strategies need to change by the time  
6 we're perfect. So I would hope that there would be a little  
7 bit of urgency in this, whether it's today or whether it  
8 comes back in November. And then if we need to develop any  
9 procurement solicitations, I've already reached out to Jeff  
10 Haag, the administrator of the Division of Purchasing. He  
11 knows that we're doing this today and that if there's any  
12 strategies that come out of this or any approvals that come  
13 out of this that require procurement, we will, of course,  
14 take those appropriate steps.

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

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

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

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

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

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

22           MR. HAYCOCK: For the record Damon Haycock.  
23 Thank you, Ms. Andrews. Excellent question. In order to be  
24 able to really roll up our sleeves and get in to the  
25 nitty-gritty and talk about things that can be kind of  
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1    disparaging either to ourselves, right, or to our partners,  
2    we like to hold it in a session that is not where a quorum is  
3    held. It's not an open meeting law session. It's not done  
4    to hide anything. Because, as you see, we will present a  
5    thorough accounting of what occurred and the steps and  
6    processes that we did to get there.

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

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

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

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

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

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

19 CHAIRMAN CATES: Thank you.

20 Any other comments from the board? Go ahead.

21 MEMBER SHIPPEY: Mr. Chair, thank you. For the  
22 record Glen Shippey. I just want to thank Damon and his  
23 staff and the others that participated in the development of  
24 this strategic plan. But for purposes, before we move  
25 forward on anything, I just want for clarification, this is a  
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1 single agenda item, a single document. We are just  
2 discussing the strategic plan, it sounds like, for possible  
3 action and that the proposed changes to the procedures that  
4 we went through and the executive director went through in  
5 detail, that is not something that I would be prepared to  
6 support approving today because I'm going to need some time  
7 as a board member to go through each of those proposed  
8 revisions to the procedures. Thank you.

9 CHAIRMAN CATES: Fair enough. Thank you.

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

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

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

21 One comment first on the policies and procedures  
22 a little bit. First of all, I agree with the general  
23 discussion about continuing education and how important it is  
24 for board members, whether you have educational sessions at  
25 board meetings and even bring in outside people to do that or  
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1 give opportunities for people to go talk to their colleagues  
2 at conferences and other programs, that's very valuable.

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

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

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

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1 balance.

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

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

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

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

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

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

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

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

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

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

7 CHAIRMAN CATES: Thank you. I appreciate that.  
8 Any other public comment on this item? Go ahead.

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

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

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

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

25 For instance, two things came to mind. And I'm  
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1 tempted -- I was tempted, but I'm not going to do it, to  
2 bring down my notes that I was taking back from our September  
3 28th strategy session and then comments that were made today.

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

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

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

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

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

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

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

25           CHAIRMAN CATES: Thank you.  
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1 MS. LOCKARD: Thank you, Mr. Chairman. My name  
2 is Marlene Lockard, representing RPEN, who represents retired  
3 and public employees.

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

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

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

24 But the actual, say, annual review or evaluation,  
25 you'll see a lot of boards have kind of gotten away from it  
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1 because of some of the administrative problems that it has  
2 created both publically and privately. We're just giving  
3 opportunity, since it's something that I know this board,  
4 previous board of the Public Employees' Benefits Program has  
5 struggled and has stated so on record. So I'm not putting  
6 words in their mouth. Struggled on trying to come up with  
7 the best way to evaluate the executive officer when they only  
8 see the executive officer every couple months for so many  
9 hours. So that was what we were looking at eliminating, not  
10 the actual interview process. That doesn't change.

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

15 CHAIRMAN CATES: Thank you.

16 Any other public comment in Carson City?

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

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

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

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

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

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

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

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

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

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

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

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

25 MS. BOWEN: Okay. Thank you so much for your  
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1 kindness. The vision program you can go in and get your  
2 evaluation each year and they can tell you you need contacts  
3 or glasses or whatever. And then the bottom line is that's  
4 on you. The same with the dental programs. And this one is  
5 important regarding your prescription program. The  
6 prescription program is now tied to your meeting your overall  
7 out of pocket rather than you meeting your prescription  
8 deductible I believe was a hundred dollars before. And then  
9 you went and your prescriptions were covered 80/20 until you  
10 met other out of pockets or whatever -- however it worked.

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

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

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

6           CHAIRMAN CATES: Thank you, Peggy.

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

9           MEMBER COCHRAN: None.

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

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

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

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1 MEMBER BAILEY: Was that a motion, Tom?

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

4 CHAIRMAN CATES: Do we have a second?

5 MEMBER COCHRAN: Mr. Chair.

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

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

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

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

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

25 MEMBER COCHRAN: Thank you. I'll second the  
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1 motion.

2 CHAIRMAN CATES: Okay. So we have a first and  
3 second on the motion, which is to approve the strategic plan  
4 overview. Any discussion on the motion? Hearing none, I'll  
5 call for a vote. All of those in favor of the motion signify  
6 by saying aye.

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

8 CHAIRMAN CATES: All opposed? Motion carries.  
9 Okay. Let's move to --

10 (The court reporter interrupts)

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

12 (Break was taken)

13 CHAIRMAN CATES: We are now on Agenda Item Number  
14 6, executive officer report, including discussion and  
15 possible board action on the following: New positions  
16 approved, ratification of the HealthSCOPE benefit two-year  
17 contract extension for national preferred provider network  
18 services, and the on-site near-site health clinic options.  
19 Damon.

20 MR. HAYCOCK: Thank you, Mr. Chair. Damon  
21 Haycock for the record. As I already spoke about earlier,  
22 I'll gloss over the first part. We did get our two new  
23 positions approved. One is an information technology  
24 professional at the three level that was approved by the  
25 interim finance committee and again approved by the Division  
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1 of Enterprise IT Services through their approval committee.  
2 That position is announced. I think we've already received a  
3 list. So we're working through that. We also received  
4 approval for health program manager. That person will be  
5 designated to head up as the liaison with our other vendor  
6 partners and our internal processes to help promote program  
7 utilization throughout the organization. Those include  
8 things like diabetes care management program or the  
9 preventive drug benefit program or any of the other programs  
10 that we either currently have or plan to implement in the  
11 future. So we have some at that caliber, at that level, to  
12 be the oversight. That position has been announced. It's  
13 closed. And we are doing interviews I think as early as next  
14 week. There is no action item or recommendation on that.  
15 That was just an information update.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 plan offerings.

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

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

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

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

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

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

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

20 CHAIRMAN CATES: Thank you, Damon.

21 Any comments on these items?

22 MEMBER ZACK: Mr. Chair, Christine Zack.

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

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

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

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

24 CHAIRMAN CATES: Thank you.

25 Any other comments? Nobody has anything?  
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1 MEMBER SHIPPEY: Mr. Chair.

2 CHAIRMAN CATES: Go ahead.

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

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

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

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

11           MR. HAYCOCK: For the record Damon Haycock.  
12 Thank you, Ms. Andrews. I want to try to clarify a little  
13 bit more about what I'm suggesting that occur. Everything  
14 you said is accurate. Everything you said is what I was  
15 planning to do. And we are going to bring to the board a  
16 budget overview that we do every two years. I know it seems  
17 like we just did one of these. But we're going to start  
18 again next spring and we're going to be bringing it to the  
19 board to talk about whether the policy changes and whether  
20 the opportunities that exist for building our budget for the  
21 next biennium. And I would like to if you approve this  
22 second option is to come back and to develop a Las Vegas  
23 clinic response to show what that would look like and to be  
24 able to have that conversation and that dialogue at the  
25 board. So if you approve it, Tena and I will build it in to  
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1 a budget document so that way it can go through the channels  
2 and it will be transparent to the legislature, as they will  
3 get a heads-up as to what's occurring prior to us kind of  
4 moving forward and building one of these, which you are  
5 absolutely correct, it grows more teeth when you kind of  
6 align all of the different interested parties.

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

16 MEMBER ANDREWS: Thank you.

17 CHAIRMAN CATES: Thank you.

18 Any other comments on this item?

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

24 CHAIRMAN CATES: Thank you. You know, I wasn't  
25 going to take public comment on every action item, but I  
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1 think the discussion around the clinics is a pretty important  
2 one. So I would like to go ahead and open this item up to  
3 public comment if anybody would like to make public comment  
4 on Agenda Item Number 6. Any in Carson City? Anybody in Las  
5 Vegas? It doesn't look like we have any takers. Okay.  
6 Can't say I didn't ask.

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

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

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

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

20 CHAIRMAN CATES: Okay.

21 MEMBER LAMBORN: To 2020 -- 2022.

22 CHAIRMAN CATES: Do we have a second?

23 MEMBER BAILEY: We have a second.

24 CHAIRMAN CATES: We have a motion and a second.

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

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

4 CHAIRMAN CATES: Opposed? Motion carries.

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

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

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

13 MEMBER ANDREWS: Ana Andrews. Second.

14 CHAIRMAN CATES: Great. We have a motion and a  
15 second. Any discussion on the motion? Seeing none, I'll  
16 call for a vote. All of those in favor of the motion signify  
17 by saying aye.

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

19 CHAIRMAN CATES: Any opposed? Motion carries.

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

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

13 And then as is the case as we continue to have  
14 good years and we continue to have good experience in certain  
15 areas but we also need to plan for other market issues and  
16 others, you'll see that Aon created another analysis, and  
17 they do this for us all the time on where we need to sit on  
18 those budgeted reserves. Let's not forget that we initially  
19 develop our budget a year before the actual session begins.  
20 And so times do change. And this is the second year of the  
21 biennium and so it's kind of a best guess until we actually  
22 get the real numbers in. And by getting those numbers we  
23 needed to decrease the incurred but not reported reserves by  
24 1.9 million but increase the catastrophic reserves by 6.4.

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

10 So that leaves us with just under 40 million  
11 dollars. And then if you remember back in March, you guys  
12 approved for this current plan year and for next plan year a  
13 series of small enhancements to the program, those that we  
14 couldn't quite absorb in to the base plan. That was that  
15 increased life insurance amount that was paying for the  
16 Medicare exchange admin fees for their HRA and also for their  
17 premiums on life insurance. And those totalled just under  
18 17.9 million dollars.

19 We're going to assume, and you'll see the  
20 questions up here in the table later, but we're going to  
21 assume that those decisions are going to hold for plan year  
22 19. And if of course you want to make a change you can.  
23 That is your prerogative. But based on those, we have a  
24 remaining balance of 21.7 million dollars, which I know this  
25 is probably a broken record, hey, we have no money, we have  
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1 no money, and now we have a lot of money. But we were able  
2 to as tying back in to the state of PEBP report and of your  
3 utilization report and consent agenda having a negative trend  
4 when you budget for increases creates excess reserves. And  
5 we have those funds available that, you know, we can have a  
6 conversation about. And my initial first-blush suggestion is  
7 it will also be this is not to extend it immediately and just  
8 go burn it completely down. There's a lot of unknowns right  
9 now in the health care market place we have to plan for.

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

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

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

4 But basically going down the list, we categorize  
5 the plan design. Anywhere you see the word keep, you guys  
6 have already done. So it's basically staying with what you  
7 have already approved but keeping that enhanced HSA/HRA  
8 contribution of \$200 tied to preventive activities. I will  
9 bring forth a report on what those proposed costs will be for  
10 '19 as well as the current utilization of that program like  
11 you had asked as part of the recommendation if PEBP  
12 recommends keeping it in plan year 19.

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

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

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

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

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

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

25 And if you've seen our latest newsletter that  
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1 released yesterday, it's heading out to the public today,  
2 we're highlighting that program. And so we want people to  
3 use it. But there are other ways to make it more robust if  
4 you want to put more money in to it.

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

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

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

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

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

23 We can talk about, you know, HMO's and what is  
24 the long term strategy and short term strategy for those  
25 costs. I am currently working with both of our HMO partners  
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1 very diligently. They have been very forthcoming and willing  
2 to work with PEBP. We appreciate their partnership and we  
3 want to try to find a way to deal with this issue. But if we  
4 let it go at the current rate that it's at, these costs are  
5 going to skyrocket out of control. And we just solved the  
6 non-state retiree premium issue. Because those costs were  
7 out of control. And now the costs on the HMO are starting to  
8 be the same.

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

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

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

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

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

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1 past.

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

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

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

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

12           And as I talked about earlier, you can create an  
13 enhanced HSA/HRA benefit that we tie currently to preventive  
14 services but you can also tie it to just signing up for these  
15 programs and then they use it or they don't. We're not  
16 requiring anyone to use it. But this way they have access  
17 immediately so when they're at the doctor's office and  
18 they're told to go get an MRI, they can look up on their  
19 phones, they can call a call center that says, hey, where do  
20 I go to get an MRI where I get paid and they'll tell you.  
21 And you go and you get that and the vendor does the entire  
22 thing. They'll send a check to the member. They'll send a  
23 1099 at the end of the year for tax purposes. They'll  
24 maintain call center of support and provide excellent  
25 reporting back to the agency. So it's a great opportunity to

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

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

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

21           So opportunity to directly contract with  
22 hospitals that aren't in our network right now. Like I said  
23 earlier, we're about choice. And there are some hospitals  
24 that are not in our participating networks that people have  
25 been asking us to establish a relationship with. And we have  
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1 reached out and have had some responses and some, I think,  
2 some very viable options. It did look like it was going to  
3 be viable recently until our last generation of negotiations  
4 and I think we're going to be able to do something like this.  
5 And really do remember those three things. Increase access  
6 to our membership, that will do it. Improve the member  
7 experience. Yeah, we have a little more hospitals that you  
8 can go to that are cost-effective. And save on the cost of  
9 the plan for sure because there's an opportunity to set these  
10 contracts up on a new reimbursement plan that protects the  
11 plan after.

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

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

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

24           CHAIRMAN CATES: Thank you, Damon.

25           Any discussion on the item? Go ahead.

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

13           MR. HAYCOCK: Excellent question, Mr. Shippey.  
14 For the record Damon Haycock. How I looked up those two  
15 differences is as a member, not as the executive officer. So  
16 I log in to my own member account through PEBP. If you go to  
17 the website in the top orange log-in button and you put in  
18 your user name and password it takes to you this landing page  
19 and one of those takes you to the HealthSCOPE Benefits side.  
20 And most people will actually kind of bounce around and not  
21 even go through PEBP, which is unfortunate. But once you  
22 land on HealthSCOPE, in the top left corner is something  
23 called health spark, and it's a tool we implemented years ago  
24 for every member to do exactly that, cost comparisons. Not a  
25 lot of people know about it. Every where I go, people say,  
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1 wow, this is amazing, you know, why didn't you tell anybody  
2 about it or why haven't we seen this before. And so we're  
3 doing our best to try to promote the current tools. But this  
4 additional tool is going to be another opportunity so that  
5 way you just have it. It's an application that's on your  
6 phone. It's on your tablet. Or you just need to have the  
7 number written down on a sticky note in your wallet or purse  
8 and you call and say where can I go. And they will help you  
9 with that shopping process. So we want to implement both.

10 CHAIRMAN CATES: Thank you.

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

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

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

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

6 CHAIRMAN CATES: Thank you.

7 Any other questions or comments? Tom.

8 MEMBER VERDUCCI: Tom Verducci for the record.

9 In the plan design we should consider dropping that awarding  
10 enhanced benefits. It seems like it would be -- the results  
11 we're having with reserves and surpluses that that would be  
12 the standard as opposed to enhanced going forward.

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

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

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

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

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

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

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

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

8 Okay. Any other questions?

9 MEMBER LAMBORN: Leah Lamborn for the record. So  
10 just to make sure that I understand. This is a document that  
11 you provided to us to start thinking about for next meeting  
12 when we design the next years plan, which starts July 1st of  
13 2018; correct? Okay.

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

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

25 MR. HAYCOCK: For the record Damon Haycock.  
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1 Thank you, Ms. Lamborn. And your format is exactly what I  
2 was going to do. I learned from last year and we need to do  
3 a better job of showing what the, kind of the ala carte price  
4 tag is as things get approved. So I'm going to work very  
5 hard, very diligently with staff to try to make it more  
6 transparent this year.

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

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

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

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

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

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

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

22 So we have right now 22,000 primary participants  
23 and another 18,000 or so dependants where sum total is about  
24 40,000 people on our plan. But the HMO's have drastically  
25 less than that. When you put them together, they're in the  
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1 15, 16,000 person range with another so many dependants that  
2 it becomes harder for them to manage that. It would become  
3 hard for us too. So it's not a knock on them. It's just by  
4 design.

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

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

24 MEMBER LAMBORN: Thank you.

25 CHAIRMAN CATES: Thank you. I would just add  
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1 that I'm very interested in pursuing this one. We have some  
2 clear systemic problems with increasing costs on the HMO  
3 plans with the shrinking pools. And I don't know if this is  
4 the answer, but I think we need to be prepared with  
5 alternatives.

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

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

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

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

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

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

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

21           CHAIRMAN CATES: Thank you.

22           MS. BOWEN: My name and words for the record,  
23 Peggy Lear Bowen, P-e-g-g-y L-e-a-r B-o-w-e-n. My name and  
24 words for the record. Going directly to the imaging part and  
25 as long as we have hospitals and insurance companies owned by  
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1 the same entity, I am concerned about the imaging taking  
2 place. It's taken two and a half years for imaging regarding  
3 my accident that I had and I know about have been suffered  
4 but I'm going to tell you anyway. And what basically happens  
5 is there are two points of view in doing any imaging that are  
6 taking place, whether they be MRI's, x-rays, CT scans.

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

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

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

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

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

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1 that, please. Thank you very much.

2 CHAIRMAN CATES: Thank you.

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

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

7 CHAIRMAN CATES: Okay. Thank you.

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

12 MEMBER BAILEY: I would say no.

13 CHAIRMAN CATES: I don't think so.

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

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

25 MR. HAYCOCK: For the record Damon Haycock.  
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1 There's a couple that we may not get the best analysis on due  
2 to timing. We can do, like, the hundred percent pay  
3 premiums. That's easy math. The deductible and out of  
4 pocket max change, we'll work with our actuaries to see if we  
5 can turn those around pretty quickly.

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

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

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

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

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

25 CHAIRMAN CATES: Okay. Well, I guess we'll move  
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1 on then. We'll close Agenda Item Number 7 and move to Agenda  
2 Item Number 8, discussion and possible action regarding  
3 Towers Watson's One Exchange operations report.

4 Mr. Garcia, welcome.

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

10 (The court reporter interrupts)

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

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

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

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

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

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

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

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

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

23 One thing I do want to point out that the Las  
24 Vegas meeting it was the first time since I have been at One  
25 Exchange that we have had an actual teleconference of the  
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1 meeting to different locations. We actually teleconferenced  
2 that meeting to Elko as well as Henderson. So there are  
3 people who attended those meetings remotely from those  
4 locations and they wanted to get the information and ask  
5 questions as well.

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

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

21 The second communication I would like to mention  
22 is our fall newsletter. This is a communication designed to  
23 inform participants about the upcoming open enrollment  
24 period, which actually started back on October 15th. That  
25 outlines any actions that need to be taken and updates the  
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1 recipients on brand new changes to Medicare. That  
2 communication started mailing the week of October 2nd. And  
3 we are actually mailing that with an additional  
4 communication, which is the third item I would like to  
5 mention in this section, which is the HRA qualification  
6 reminder communication. This communication is designed to  
7 remind retirees about Nevada PEBP's requirement to enroll  
8 through One Exchange and the Medicare medical plan to qualify  
9 for HRA funding.

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

16 The next section is our historical call stats.  
17 And we have historical call stats going all the way back to  
18 2016. But we want to focus on the more recent call stats for  
19 2017. So if you could turn to page ten, you'll see that the  
20 most recent months would be July, August, and September.  
21 Those are the months since our last board meeting that I  
22 wanted to clarify for you are going out to you.

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

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1 increase of calls. It was over 1500 calls. And they had an  
2 average speed -- average wait time of 17 seconds. And then  
3 in September the call volume decreased down to just shy of  
4 1200 calls in to our service center. And they had an average  
5 wait time of 15 seconds. So as you can see, we are  
6 consistently having wait times under 30 seconds. If you look  
7 back to even going back to February of this year, it was  
8 captured a little bit differently up until April, but it was  
9 a .26 of a minute, 100 being a minute. So it was always  
10 under 30 seconds except for January where we had a bit of a  
11 longer wait time. So we're consistently seeing those lower  
12 wait times for participants calling our service center and  
13 being able to speak to a customer service representative.

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

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

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

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

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

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

24 We went back and recaptured data all the way back  
25 to the start of 2017. And, as you can see, on January 3rd of  
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1 2017, we had 17 accounts on the active tab and we had 165 on  
2 the closed tab. So what we did is we went back and looked at  
3 once a month, typically the beginning of the month, what's  
4 the number of accounts were on the active tab versus the  
5 number of accounts on the closed tab. And as you can see,  
6 February was 17 accounts on the active tab. And they do --  
7 This is a very fluid account or very fluid report. It  
8 changes day to day, week over week so that the same 17  
9 accounts that were on the January tab are not the same 17  
10 accounts on the February tab. They're going to be different  
11 accounts that were researched and then moved to the closed  
12 section.

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

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

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

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

10 And with that I would like to offer any  
11 questions.

12 CHAIRMAN CATES: Thank you very much for your  
13 presentation.

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

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

22 MR. GARCIA: I know that there has been talk  
23 about actually having us do physical presentations in Ely and  
24 Elko because Damon and I had a recent conversation about that  
25 of having some of our folks in our Salt Lake City office  
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1 drive out to Elko and Ely. Winnemucca was not discussed, but  
2 that's certainly something we can look in to.

3 MEMBER VERDUCCI: Thank you very much.

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

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

10 MR. GARCIA: Thank you.

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

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

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

21 I do want to talk about the report from Willis  
22 Towers Watson. They talked a lot about service issues and so  
23 forth. One thing that's not in the report was how much that  
24 service costs. My understanding is, and I could be wrong,  
25 that they earn roughly \$250 per participant per year in  
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1 commissions back from the insurance companies, the plans they  
2 help provide, those are hidden expenses. I'm not sure that's  
3 been on your radar screen. But I think as a fiduciary duty  
4 to participants the board needs information about that. It  
5 seems to me as a potential conflict of interest if this  
6 provider is recommending plans that they earn differential  
7 commissions on, I have no idea whether that rate is, A,  
8 accurate, and B, a fair market rate for the services  
9 provided. But it's something that really, you know, you  
10 ought to know.

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

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

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

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

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

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

18 CHAIRMAN CATES: Thank you.

19 Any other public comment?

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

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1 in protecting the employees.

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

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

24 The idea that I have to reach not only a  
25 deductible for myself as an individual, and I'm only an  
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1 individual on this plan. I have no family that are on the  
2 insurance plan. I also had to meet an out-of-pocket family  
3 deductible for a period of time. And that didn't make any  
4 sense. I'm meeting -- My out of pocket was too much, plus my  
5 individual came together, and I still couldn't get a  
6 prescribed aspirin until I met a tremendous amount of out of  
7 pocket of, what, close to \$4,000 altogether. I'm just  
8 throwing numbers around.

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

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

22           CHAIRMAN CATES: Thank you, Peggy.

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

25           MS. BOWEN: Happy Nevada Day.  
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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.)

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1 STATE OF NEVADA )  
2 CARSON CITY )ss.  
3 )

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

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

11 That the foregoing transcript, consisting of pages  
12 1 through 130, inclusive, includes a full, true and correct  
13 transcription of my stenotype notes of said public meeting.

14  
15 Dated at Reno, Nevada, this 8th day of November,  
16 2017.

17  
18  
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20 CHRISTY Y. JOYCE, CCR  
21 Nevada CCR #625

22  
23  
24  
25 CAPITOL REPORTERS (775) 882-5322

	<b>112:3</b>	<b>119:1,24;120:3,13;</b>	<b>administrator (7)</b>	<b>60:17</b>
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VIDEOCONFERENCED OPEN MEETING**

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