In The Matter Of:

Public Employees' Benefits Program Board

Transcript of Proceedings Telephonic Open Meeting

March 28, 2019

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PUBLIC EMPLOYEES' BENEFITS PROGRAM BOARD

TRANSCRIPT OF PROCEEDINGS

TELEPHONIC OPEN MEETING

THURSDAY, MARCH 28, 2019

CARSON CITY AND LAS VEGAS, NEVADA

The Board:	DEONNE CONTINE, Chairwoman LINDA FOX - Member JOHN PACKHAM - Member TOM VERDUCCI - Member LEAH LAMBORN - Member. CHRISTINE ZACK- Member MANDY HAGLER - Member
For the Board:	BRANDEE MOONEYHAM Deputy Attorney General
For Staff:	DAMON HAYCOCK Executive Officer LAURA LANDRY Executive Assistant CARI EATON Chief Financial Officer LAURA RICH Chief Operating Officer NANCY SPINELLI Quality Control Officer
Reported by:	CAPITOL REPORTERS Certified Shorthand Reporters BY: KATHY JACKSON Nevada CCR #402 123 W. Nye Lane, Suite 107 Carson City, Nevada 89703 (775) 882-5322

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THURSDAY, MARCH 28, 2019, CARSON CITY, NEVADA

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CHAIRWOMAN CONTINE: Good morning. Welcome to my first meeting as Chair of the PEBP Board. I'll do my best to maintain the processes and the procedures that everyone is used to. So I'll start out with saying this is the meeting of the Public Employees' Benefits Program Board. It's March 28, 2019, at 9:00 a.m. We are in the Richard Bryan Building at 901 South Stewart Street, Suite 1002 in Carson City, with videoconferencing to the Nevada State Business Center at 3300 West Sahara, Suite 140 in Las Vegas. We're streaming at www.pebp.state.nv.us., and I will open the meeting with role call from Laura, who is in the south.

MS. LANDRY: Deonne Contine?

CHAIRWOMAN CONTINE: Here.

MS. LANDRY: Linda Fox?

MEMBER FOX: Here.

MS. LANDRY: Mandy Hagler?

MEMBER HAGLER: Here.

MS. LANDRY: Leah Lamborn?

MEMBER HAGLER: Here.

MS. LANDRY: John Packham?

MEMBER PACKHAM: Here.

MS. LANDRY: John Verducci?

MEMBER VERDUCCI: Here.

MS. LANDRY: Christine Zack?

MEMBER ZACK: Here.

MS. LANDRY: And Don Bailey is excused.

We do have a quorum.

CHAIRWOMAN CONTINE: Okay. Thank you. Thank you.

So for public comment, I'm going to do public comment after each action item. So we won't do public comment -- overall public comment right now. We'll save the public comment for the agenda items.

So Agenda Item Number Three, PEBP Board disclosures for --

MR. HAYCOCK: I think you have some folks leaving that would like to have public comment at the beginning.

CHAIRWOMAN CONTINE: Okay. I guess I will do public comment in the beginning. Anybody who wants to make public comment come to the table now.

MR. DALEPY: Good morning. Thank you for that. I appreciate the time. I'm headed back over to the legislative building for another hearing. So my name is Kyle Dalpey with the Nevada System of Higher Education.

I'm here today to support benefit updates on health BDB participants. In particular, we look over the

ones that are involved in the Nevada System of Higher Education.

The NSHE Board of Regents passed a resolution for advocating for better healthcare benefits for our employees. Better options to help our current employees, classified faculty and administrative and will help retain these employees and by providing them a better package overall and also helps us to attract new employees and then take care of the ones who have years of service within the system. We look forward to following this discussion as progressive. We thank you for your work.

You will hear from others today during the agenda items in much more detail, information, and I thank you for considering alternative options that would include benefits of all employees and we thank you.

MS. JONES: My name is Nancy Jones. I'm a Douglas County resident, and I thank you for taking some public comment at the beginning. I dragged my little ladies along with me here and they are patiently waiting in the hall.

I'm here today to ask you to reconsider your policies or however you work it out with your in-network providers to allow Melinda Hoskins, who is a certified nurse midwife, to be part of the in-network program for Hometown

Health. She has applied, but they won't accept her application because she is an independent provider, and I don't think that that's right.

I live in Douglas County. The only certified midwives certified practitioner or excuse me, they are not nurses, certified midwives that are available in-network are in Reno and that's not practical for me. I'm a mom with little kids to use a provider so far away from home. Whereas, Melinda Hoskins practices in Douglas County, has a Carson City address. She's a certified nurse midwife and advanced practitioner nurse, and I ask you to please accept her application to be in-network so that she can be a provider for Douglas County, the whole of Carson Valley, as well as Carson City. Thank you so much.

CHAIRWOMAN CONTINE: Is there any public comment in Las Vegas?

MS. LANDRY: Yes, we do have public comment here.

MR. Hinckley: Good morning. My name is Richard Hinckley, H-i-n-c-k-l-e-y. First as a 20 plus year state employee, I want to express thanks to anyone affiliated with PEBP because over that time the claims experience has been really quite good.

But recently I've experienced a problem that I think is a process situation that I just want to bring to

your attention. At the end of January my wife had outpatient shoulder surgery at a PPO doctor and at a PPO facility. That procedure was also pre-authorized in mid-January. This surgery was not in any way related to an accident where a third party would be held responsible.

A full month after that surgery was completed the first EOP stated we are denying this claim. Details are needed and an accident questionnaire will be sent. That day I jumped right on that and through phone conversation and then e-mail definitively stated that no third party created the need for the surgery. And, of course, that conversation was with as you may know a law firm located in Ohio, who has been contracted to in some way interface with that issue.

Because my time is short, I just want to state several conclusions to you. The question of third party responsibility could have and should have been asked in my view much sooner, even at the time of pre-authorization.

Second, it is not efficient or reasonable that before claims are processed that have no accident situation as background that I have to communicate with a law firm in Ohio and explain my background situation.

Given the foregoing, it was nearly two months, just days ago that the surgeon's bill was processed. Now, why does that matter? It matters because the fact that my

wife had met her deductible responsibility, was not registered or accounted for almost two months while other medical billings were going on at other providers. And, of course, they asked for cash as if the deductible had not been there so that's the impact to me personally.

Lastly, as of last night, the surgery center and the anesthesiologist bill had not been processed, and I believe that a processing time of over two months is simply unreasonable, and that may be an applicable comment as you look at the audit of HealthSCOPE later in your agenda.

I fully appreciate that pursuing subrogation where there's third party responsibilities is entirely appropriate, but the entire detours when that's inapplicable penalize the members and that situation doesn't apply, and claims processing should be going on in the normal timeframe.

I appreciate your time this morning. Thank you very much.

CHAIRWOMAN CONTINE: Thank you.

MS. DAY: Good morning members and Chair of the PEBP Board. My name is Tondra Day and I'm an administrative faculty member at the University of Nevada Las Vegas. I'm here this morning to voice my support for the redesign CDHP plan that has been proposed by the NSHE Faculty and Nevada Faculty Alliance.

At UNLV I worked in the Office of Faculty Affairs, and I am also a long time member of the University's Faculty Senate serving as a senior senator. Because of these responsibilities I often get contacted by members of the academic and administrative faculty who have experienced serious health related concerns and want me to advocate for better health benefits.

The fact of the matter is that the great recession negatively impacted salaries of all state employees. The cost of healthcare rose dramatically during that period and continues to do so. Even though state employees have received some cost of living increases during the last few years, it's not enough to offset the rising cost of healthcare.

At the state and as a system of higher education, if we want to retain the best employees and faculty, we'll have to do something to make it more attractive to work in the state. I know that there are certain costs associated with our health insurance that the PEBP Board really can't do much about. Costs are rising everywhere. However, I feel that the use of the excess reserves that currently exist is something very much in our control.

I would urge you to make prudent use of those reserves and to approve the plan proposed by NSHE Faculty and

Nevada Faculty Alliance. The proposal would be of great benefit to our faculty. I encourage to give it the highest consideration, and thank you very much, and I appreciate the opportunity to speak this morning.

CHAIRWOMAN CONTINE: Thank you.

Is there any other public comment in Southern Nevada?

MS. LANDRY: No.

CHAIRWOMAN CONTINE: So the next item, Item Three, PEBP Board disclosures for applicable Board meeting agenda items.

And Brandee Mooneyham from the Attorney General's Office.

MS. MOONEYHAM: Thank you, Madam Chair. Brandee Mooneyham, deputy attorney general for PEBP.

On behalf of the Board members who are eligible for PEBP benefits and pursuant to Nevada ethics law, I offer this disclosure. Of the current Board members, except Ms. Zack and Mr. Verducci are eligible for benefits of the program, meaning they, their spouses and their dependents may receive health, dental, life insurance and other benefits through PEBP.

There are several items on today's agenda that relate directly to PEBP benefits to the members, specifically

Item Number Five regarding voluntary benefits available to members.

Item Number Six regarding amendments to PEBP contracts for plan year 2020.

Item Number Seven regarding changes to the Consumer Driven Health Plan for year 2020.

Item Number Nine regarding plan rates for plan year 2020 for the Consumer Driven Health Plan, HMO plan and the Premier Plan.

Item Number Ten regarding changes to the master plan documents for the Consumer Driven Health Plan and the EPO plan for year 2020, and that's it.

When PEBP Board members vote on the benefits for themselves or their spouses and/or their dependents that may trigger the disclosure requirements under NRS 281A.420. Therefore, on behalf of the Board members who are PEBP participants, I offer this as a general disclosure pursuant to the ethics law, and I invite any member who has anything else to add in this regard to please do so at the close of my comments.

I would also like to note that the Board members who are PEBP participants may still vote on the items directly effecting them if the benefit or detriment to them is not greater than that accruing to similarly situated PEBP

members. Thank you, Madam Chair.

CHAIRWOMAN CONTINE: Thank you.

Is there anybody else that has anything to add?

Okay. We'll move on to Item Number Four, the consent agenda. These consent items are considered together and acted on in one motion unless an item is removed to be considered separately.

Are there any Board members who wish to remove any items from the consent agenda? No one, okay. So I'm just going to remove the minutes just because I wasn't here to -- in that meeting so I won't vote on the minutes so I'll remove that item, and then if somebody would like to make a motion to approve the consent agenda, all items except for .1.

MEMBER VERDUCCI: Tom Verducci for the record.

MEMBER ZACK: Ms. Contine, Chair Contine?

CHAIRWOMAN CONTINE: Yes, sorry. Go ahead.

MEMBER ZACK: Christine Zack for the record.

I'll make a motion to approve the consent agenda with the exception of the action minutes from the January 24th, 2019 meeting.

CHAIRWOMAN CONTINE: Can I get a second?

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

CHAIRWOMAN CONTINE: Okay. I have a motion and a second. All in favor aye.

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

CHAIRWOMAN CONTINE: Any opposed? Sorry, any opposed? Okay. The motion carries.

And then Item 4.1, does somebody want to make a motion on the minutes?

MEMBER ZACK: Chair Contine?

CHAIRWOMAN CONTINE: Yes.

MEMBER ZACK: Christine Zack for the record. I'll make a motion to approve the action minutes from the January 24, 2019 PEBP Board meeting.

CHAIRWOMAN CONTINE: Okay. Is there a second?

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

CHAIRWOMAN CONTINE: Okay. All those in favor?

(The majority of the vote was in favor of the motion.)

CHAIRWOMAN CONTINE: Any opposed?

And the Chair is abstaining. The motion passes.

Item Number Five, discussion and possible action regarding an update to PEBP's Voluntary Benefit Platform implementation to include an update by the Nevada Division of

Insurance on vendor compliance with insurance law requirements to offer benefits in Nevada. This is Laura Rich, the operations officer.

MS. RICH: Good morning. For the record Laura Rich, operations officer.

This report provides an update on the new member portal and voluntary benefits implementation. Since we have new Board members, I'll start with recapping a little bit of industry behind this project. In July 2018, PEBP's -- PEBP's enrollment and eligibility from vendor Morneau Shepell presented a new member portal which included integrated voluntary benefits hub. This came as a result of the previous strategic planning sessions that we've had during that year where we came out with one of the goals is being the improvement of the member experience. So we wanted to shoot towards that goal and improving the member experience through the voluntary or through the member portal was one of those.

Our current enrollment, as some of you may know, is very antiquated. It has very limited functionality, and the process is difficult to get through for some members. If you want to see information or if you want to compare plans, you often times get bounced around the enrollment tool. Sometimes you have to go to the PEBP website. Sometimes you

have to go to vendor websites to get information. When the new portal is more of a one shop stop and gives the member a much smoother and more user member flow through that whole enrollment process.

The new tool will also provide members with new features that are not available today such as the ability to upload documents, supporting documents and correspond with member services through a secure messaging feature. Right now they have to do that through e-mail which there's no authentication. It's not secure, et cetera.

We're currently wrapping up testing on this and it is set to go live in mid-April. This way that members have that opportunity to log in, play around with it a little bit and get used to the system prior to open enrollment.

Part of the shopping experience in this new portal includes a voluntary benefit selection. In November of 2018 the Board approved a selection of new voluntary benefits that were to be offered through this portal. Because some of these voluntary benefits fall under the purview of the DOI, we have the DOI here today, Morneau Shepell and their subcontractor that is offering that Voluntary Benefit Platform, Corestream, began working and coordinating with the DOI to ensure that all of the licensing requirements were met by the time these products were made

available to them or to the members.

We have a few representatives here from the DOI, and I wanted to give them the opportunity to provide an update to PEBP and the Board what we see with these various tutorials.

We also have representatives both from Morneau Shepell and Corestream here, but we'll go ahead and start with the DOI and then if necessary we'll give them an opportunity to come up as well.

MS. PARKS: Thank you, Madam Chairwoman, members of the Board, Mr. Haycock. Thank you for having us here today. I'm Amy Parks. I'm the chief attorney for the Division of Insurance and with me today is Mark Garrett. He is our chief of the life and health and property and casualty sections of the division. I also have Erin Summers with me. She's an actuary in the property and casualty section of the division. So if there are any questions that I cannot answer hopefully they can answer for you.

We're here today to give you an update on what the division has been doing and its participation in reviewing this program for PEBP. Our review is limited to our regulatory jurisdiction which would be regarding the licensing companies that are proposed to be on the platform and the product approval of those products that are proposed

to be offered to PEBP members.

Today I brought with me two handouts which you each should have. The first handout is meant to be an educational piece, a very high view of insurance related matters for Board members who may not be familiar with certain insurance terms and participants in insurance and licensing and things like that. So it's not something that I need to go through with you today, but it does help explain generally some of the products that you proposed to offer on the platform whether they are individual products, group products, what a producer of insurance does, and Morneau Shepell is your producer who will advise you on the technicalities of the products and the insurance companies that you're discussing.

And I also provided as an attachment at the end for your assurance the licensing record for Morneau Shepell so that you're secure that that entity is a properly licensed Nevada producer to represent you in these insurance matters and the companies.

The second handout is really what we're going to go through today. It's this colored spreadsheet. The division put this spreadsheet together based on information that it received from Morneau Shepell and the carriers. And as we work with Morneau Shepell to get further details on the

products and the companies that you propose to have on the platform, we came up with this spreadsheet.

If you look at the far left-hand side, there's a column that says carrier. So after all of the information was boiled down as of today, these are the carriers, the insurance carriers that we understand who will be offering products on your Voluntary Benefit Platform, and this spreadsheet then is also further divided into life and health products at the top, and your property and casualty products follow that.

So if you'll see, we have an okay after the name of the insurance company who's offering certain products. The okay means that that company is properly certified in Nevada to offer insurance products in Nevada and also that the products that we understand that will be offered by that insurance company have been approved by the division.

When I say approved by the division, I mean that their insurance rate which is the basis of their premium and their forms which is the policy form have been approved by the Division of Insurance. Most of them are required to file both for pre-approval by the Division of Insurance.

If you'll look at the second insurance company listed, the standard insurance company, you'll see that under that name we have a red indication meaning that this -- one

of their products is still pending a final approval or review by the division of its forms, and so it is properly certified in Nevada to offer insurance products, but we're on the final phases of reviewing the filings that they have to make.

If you'll go then to page three of the spreadsheet, you'll look down in the carrier column where it says travelers property casualty insurance company, that's a property and casualty company. We're also reviewing some final matters regarding their rate filings with us. This is a new program that this company is putting out so these are new filings with us, and apparently there are a lot of pieces to it. It's looking good, but we still have to just complete the details of our review on that one which we should be able to let you know in probably a week.

Erin, a week on that one?

You also see a column that says group or individual and that column indicates the type of policy it is. And in the first handout we explain what the difference is between an individual policy and a group policy. The most important thing that you should note regarding a group policy is that typically there is a master policyholder on the group policy, meaning that that could be an entity and then people enroll in that entity's program, and then they receive certificates of insurance coverage but they are not a

policyholder.

So for example on the first one, the critical illness group policy, I believe PEBP is the master policyholder on that one. So as the master policyholders on these group policies, the master policyholder is responsible for negotiating the policy rates and discussing all of those pieces with the insurance company through their producer. It is not the individual member. So you all are responsible for the price that people are going to pay for this and the terms of the policies.

At this time everything is looking good with the information that we have been provided. I believe in another week, Mr. Haycock, we'll be able to provide you with the results of the travelers final rate plan.

The one for the standard, I don't believe that we have received that filing yet. It is an older filing. This product was around some time ago before the search system. The search system is the database where the insurance companies put all their filings into, and we wanted an informational filing so that we could make sure that this old filing is up to current legal standards with us.

Finally, we can make this spreadsheet available to you in an interactive way that if as time goes on, you all wish to add another insurance company or another product

that, Mr. Haycock, you can insert that and then help check off whatever approvals need to be -- be done with this.

With that, I'm done with our side of the report. If you have any questions we're here to help.

CHAIRWOMAN CONTINE: Mr. Verducci, do you have a question?

MEMBER VERDUCCI: Yes, I certainly do. Thank you, Madam Chair.

My question would be is we already are doing business with standard on the life end, and my question would be why would this have to be re-approved? Is this because it's part of the Morneau Shepell contract or since they are already a customer of ours, where is it in the approval process?

MS. PARK: Yes, that's a good question. If you see in that column, it says serve ID. And then if you look down into the first yellow box it says predetermined. So as I said earlier, this is -- it's an older product. It's been around a long time, so their filings were pre our electronic database, and they were submitted in paper format years ago.

Laws have changed since then, and so we just want an informational filing at this point to double check and make sure they don't need to add something to their rates or if they are not considering something in their -- in their,

excuse me, in their forms or their rates, they need to take out or need to add, it doesn't seem like it's something that is really critical right now, but we need to just complete that loop, that's what we do.

MEMBER VERDUCCI: Thank you for the clarification. That gives me a better understanding.

I do have one more question. I know it's been on the agenda or your packet for several meetings. Why is the registration being held up in the State of Florida? That seems to be the one out there -- okay. I'm going to put that one on hold.

MS. PARK: Okay.

MEMBER VERDUCCI: But thank you for being here today.

MS. PARK: Absolutely.

CHAIRWOMAN CONTINE: Ms. Rich, do you want to?

MS. RICH: Thanks, Ms. Park.

MS. PARK: Yes.

MS. RICH: Moving onto page two on the voluntary products and schedule piece. We do plan to launch the majority of the voluntary benefits on May 1st so they are available during open enrollment, but there are some of these products that are not going to roll out until July 1st.

You can see on the chart on page two of the Aflac

accident, critical illness and hospital indemnity plan, a legal plan, ID theft, buy-up vision, voluntary life and short-term disability will all be available to enroll in on-line on May 1st, but the three auto and home carrier and two pet insurance policies won't become available until July 1st for members.

There is one exception to that. PEBP currently offers a long term care policy through Unum and Unum had initially some challenges being able to accommodate on-line enrollment, but we worked through that. They have been working with Corestream to get on board onto the platform as quickly as possible. It's looking like we're going to be able to get them on board by July 1st so that they can be a part of the rest of those products.

Today members have the option of having their voluntary benefits premiums deducted from their paychecks automatically. The transition to the new system should not disrupt the process at all. We've worked with major pay centers to ensure that members can continue to take advantage of the automatic payroll deductions, but there are some smaller pay centers, boards and commissions that have two, three employees that will have to be direct billed that won't have that opportunity, at least initially until we can -- until we can establish those similar interfaces with our pay

centers. The number is quite small. It's about 500 eligible, so not all of those people will choose voluntary products but 500 eligible that will not have access to those automatic payroll deductions.

The next section is Aflac products for retirees. So back in November when PEBP presented the Aflac products to the Board, PEBP was under the assumption that the plans and rates that were presented at the time included all members. Well, we did discover that the group rates that were presented carved out the retirees. So including that retiree risk pool significantly increased rates for everybody so we asked Aflac to present an alternative.

As a result they came back to us and presented a similar product with similar benefits to retirees in a similar manner actually. Retirees will be able to purchase individually rated accident and critical care policies which it's different because this is the actives have a group rated plan.

Other than that, the only difference is that retirees won't be subject to an open enrollment period. So the actives purchasing Aflac products will be subject to that open enrollment, period. They can only purchase those products either open enrollment or a special enrollment period that PEBP decides to offer. Retirees will be able to

purchase all your round, and they will also be direct billed.

So as you can see on page three, we have presented the rates for these two policies and barring any issues, PEBP plans to roll this out with all of the other Aflac products on May 1st. Our recommendation is to approve the Aflac retiree policies to be offered on the Voluntary Benefit Platform. I'm happy to answer any questions.

We also have Brent Rosenthal here from Corestream that can address any benefit specific questions related to those Aflac products.

CHAIRWOMAN CONTINE: All right. Thank you.

Any questions?

MEMBER FOX: I have a question. Linda Fox for the record.

What will the logistics be for the members that sign up for the benefits that are available in May? So they can start signing up for the benefits in May and they will be available immediately?

MS. RICH: So the benefits that are available in May, they will work the same as open enrollment benefits. You enroll in them in May and they don't become effective until July.

MEMBER FOX: Even though the vision and all those voluntary add-ons?

MS. RICH: I'm sorry?

MEMBER FOX: Like the vision, the voluntary?

MS. RICH: Right. So all of those -- Laura Rich. All of those will begin on -- effective July 1st.

MEMBER FOX: Thank you.

CHAIRWOMAN CONTINE: Are there any other questions from Board members?

MR. HAYCOCK: I have something to add.

CHAIRWOMAN CONTINE: Mr. Haycock, go ahead.

MR. HAYCOCK: Thank you, Madam Chair. Damon Haycock for the record.

I just I would be remiss if I did not share that the appreciation that PEBP has with the Division of Insurance and the Commissioner. I know she couldn't be here today. We know what we're the experts at, and we know what you're the experts at and we rely heavily on your expertise, and we thank you for coming consistently to the Board and keeping us safe and keeping us educated on this process.

We want to continue to work through this. I will accept your offer to continue to utilize this if this is the easy process moving forward, and I just wanted to say thank you from PEBP and from myself, if you'll pass that on to the commissioner, I'll appreciate it.

Did you have a question?

CHAIRWOMAN CONTINE: Yeah, Ms. Parks, if you can come back to the table. I just wanted a clarification on the chart in the group in the individual. So on the group it's very clear that PEBP has responsibility and they negotiate the rate and the members pay whatever PEBP is negotiated on the individual.

Even though PEBP is involved in their working with the individual and company, the -- the actual person who chooses to purchase that is subject to working essentially with that company so that they are not as part of a group and so that distinction -- that's a distinction that plan participants might want to be aware of that this is a voluntary benefit that the Board or that PEBP is offering, but it's a little bit different than what a group negotiated, and so just having that information available for them would probably be helpful; is that correct.

MS. PARK: Yes. And I haven't been here for your other meetings where the commissioner was present, but I think she was relaying how important it is that the members understand what they are purchasing and that Morneau Shepell may be able to assist you in being able to help educate them better that way.

It is also my understanding that although there are the group products and then there are the individual

products that this platform is going to be an affinity type platform which means that, correct me, Mr. Haycock, if I'm wrong, but you all have worked out a negotiated something with the particular insurers to perhaps give the state employees a slightly different rate by joining onto the platform.

So I could be wrong about that but if that is the case, then although it's an individual policy, I think PEBP has been involved in a little more hands-on with structuring this -- this benefit.

MR. HAYCOCK: So for the record Damon Haycock. I'll chime in. Thank you, Ms. Parks.

I haven't heard the term affinity so I'll have to go research that. You are correct that PEBP has had our hands into all of these products, worked directly with Morneau Shepell and Corestream, their subcontractor, actually presented those individual rates to the Board for Board approval. So I think we've -- hopefully we checked the box on that.

But I think one of the most important things you said is basically who is responsible for approving those, and the initial approval of the rates on an individual product I believe is you all as the Division of Insurance, you do your due diligence to ensure that the rates are actuarial sound

and that they meet industry standard protocols. So that first process is really the go, no go before then if PEBP or anyone else can even renegotiate those rates.

And I'm unaware if you can renegotiate rates after they have been approved by the Division of Insurance, if there's a secondary filing that has to happen, but we have worked very closely, just for the record, with not only Corestream and Morneau Shepell but at times directly with insurance carriers to ensure that we provide the best pricing for our members, and we've been able to show that leveraging our group size even with individual products has lowered the cost because of economies of scale. So I think that kind of ties everything together.

CHAIRWOMAN CONTINE: Thank you.

MS. PARK: Thank you.

CHAIRWOMAN CONTINE: Ms. Rich, do you have another comment?

MS. RICH: For the record Laura Rich.

I just wanted to address Mr. Verducci's question regarding the Florida matter. So Morneau Shepell has informed us that there's just a holdup regarding fingerprinting. They submitted fingerprinting to finish up their licensing requirements. Somehow that got lost in the shuffle. Florida is looking for those fingerprints. If they

can't find them, they will resubmit the fingerprints but that's what is holding that up.

MEMBER VERDUCCI: Tom Verducci for the record. Thank you, Laura.

So can you speak for a moment. If the program gets rolled out and, you know, the issue of the licensing isn't resolved, how does it effect members? It seemed to me since it's Florida, it's going to be very isolated, but how would it effect the members?

MS. RICH: For the record Laura Rich.

We actually have members in I believe all 50 states. Hopefully it doesn't come down to that because it sounds like and Bruce Borgos is going to come up and speak to this. It sounds like we should have that problem resolved long before that.

MR. HAYCOCK: So for the record Damon Haycock.

I want to make it crystal clear that if there is any time at the beginning or in the middle or at any point where our vendors are not licensed and appointed with the carriers for the products that we're offering, those products will not be offered in those locations, period. We're not going to run amiss of the legalities of this problem. We have already talked to Morneau Shepell about it.

If for whatever their reason due to their fault

or someone else's that they cannot be licensed in the State of Florida in time products will not be offered in the State of Florida. We are not going to run amiss of the insurance law. So I wanted to make that abundantly clear before Mr. Borgos says anything.

MR. BORGOS: Good morning everybody. I am Bruce Borgos, vice president of administration services for Morneau Shepell. Last name is B-o-r-g-o-s.

So just to add onto Ms. Rich's statement about licensing in Florida, she captured exactly what our situation is with them right now. We actually expected Florida licensing to be wrapped up weeks ago. Their requirements for licensing are a little bit more stringent than many other states. As Laura mentioned, we are trying to track down, they are trying to track down the fingerprints which came from our CEO and couple of other people in our organization in order to complete that licensing.

We are, however, licensed in Florida through our designated producer. So we are licensed in all 50 states through our producer currently and in 49 states as Morneau Shepell as an organization.

Does that help clarify?

MEMBER VERDUCCI: Yes, it certainly does. The reason I bring that up is it's been a pending issue for the

last several meetings and it's -- I'm trying to get a grasp on the fingerprint issue and it seems like it's, you know, a fairly easy solution. So it would be nice to see you guys licensed in all 50 states.

MR. BORGOS: Yes, certainly, we agree. Again, Bruce Borgos for the record.

As I said, it's a process that we thought would be wrapped up long before now, and we're working everyday with them to try to complete this information. So we don't anticipate this should take much longer. I said that months ago however. So we will certainly keep the Board posted on that.

Just one other point on the question about rates and affinity, the affinity situation. So, again, as Mr. Haycock said very well, we have worked very closely with Corestream and various insurance carriers for this program to make sure that because of the size of the PEBP's population, PEBP gets the very best and most competitive rates in addition to competitive rates. We made sure that in every case possible we've also offered members choices on carriers and the particular products.

Because products vary somewhat for instance on auto and home products, we have three different carriers in place with products, and those coverages different slightly.

So we try to offer choice in every case possible as well.

CHAIRWOMAN CONTINE: Thank you.

Are there any other questions?

Okay. I'd open it up for public comment. Then is there any public comment on this item?

MEMBER ZACK: Chair Contine, we do have a public comment question down south.

CHAIRWOMAN CONTINE: Thank you. Go ahead.

MS. CAMERON: My name is Vicky Cameron. I'm the state vice president for Retired Public Employees of Nevada. Last name is spelled C-a-m-e-r-o-n.

My question is other than the Aflac voluntary product, are the other voluntary products going to be PERS deductible if our retirees sign up for it?

MS. RICH: For the record Laura Rich.

Yes, we are working with PERS to have those automatic payroll deductions come out of there, the retiree paychecks, yes.

MS. CAMERON: Thank you.

CHAIRWOMAN CONTINE: Is there any other public comments in Southern Nevada?

MS. LANDRY: No.

CHAIRWOMAN CONTINE: So it looks like on this agenda item in addition to the update, the -- the action item

is PEBP's recommendation for the approval of the Aflac accident and critical care policies, and so I would accept a motion to approve that recommendation or not.

MEMBER VERDUCCI: Tom Verducci for the record.

I'll make a motion to accept staff's recommendation to approve the Aflac accident, critical care policies to be offered as a voluntary benefit to retirees on a Voluntary Benefit Platform.

CHAIRWOMAN CONTINE: Is there a second?

MEMBER LAMBORN: Leah Lamborn. I second the motion.

CHAIRWOMAN CONTINE: Thank you.

All those in favor aye.

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

CHAIRWOMAN CONTINE: Any opposed? Okay. Motion carries.

So Item Number Six, discussion and possible action regarding approval of PEBP contract amendments beginning plan year 2020.

6.1 is amend the Morneau Shepell eligibility and enrollment contract to add language authorizing the contractor to coordinate payroll deductions for voluntary benefits.

6.2 is amend the HealthSCOPE Benefits Third Party Administration contract to reduce TPA collection of fees, subrogation recoveries and provider funds.

6.3, amend the Express Scripts Pharmacy Benefits Manager contract to reduce administrative fees and implement greater drug discounts and guaranteed drug rebates.

And four, extend and amend the Extend Health Willis Towers Watson Medicare Exchange contract to provide services for five years through 2025 and eliminate administration fees beginning July 1st, 2019. And for PEBP is Cari Eaton, chief financial officer.

MS. EATON: Thank you. Good morning. Cari Eaton, chief financial officer.

I'll just take one at a time if that's okay. So far 6.1 is the Morneau Shepell contract. The PEBP Board approved an amendment to the Morneau Shepell contract on September 27, 2018 that extended the contract through December 31st, 2023 and added a new wholly integrated benefits platform.

PEBP staff now needs to amend the contract to add language to allow Morneau Shepell or its PEBP approved subcontractors to act on PEBP's behalf in executing the provisions of NRS 281.129 and NRS 218F.510 to collect payroll deductions from participating pay centers for voluntary

benefits.

PEBP recommends the Board authorize staff to complete a contract amendment between PEBP and Morneau Shepell for eligibility and enrollment services to add clarifying language to the contract.

CHAIRWOMAN CONTINE: Great. Are there any questions or comments from the Board?

MEMBER VERDUCCI: Tom Verducci.

My question will go, this will be for Damon. How much will this result in our savings per year with all four contracts approved?

MR. HAYCOCK: For the record Damon Haycock.

I don't want to be flipping pages real quick and doing some quick math, but we're about 280,000 on HealthSCOPE. We're 5.3 million on Express Scripts so that's 5.7, almost 5.8 million dollars if I'm doing that right. No, I'm not. I'm in that globally. That's like 5.5 million, and then there's another about 240,000 a year on the Willis Towers Watson. So 240, 280 is 520 and 5.3 is 5.82 million dollars.

MEMBER VERDUCCI: That's a substantial savings, Tom Verducci.

And I also wanted to ask in terms of the Willis Towers Watson approval, I know in the past we had service

issues that were apparent, and my question is it seems like we're seeing an improvement on that, and are you comfortable with the number of years that we're going out in front of us based on prior service issues?

MR. HAYCOCK: For the record Damon Haycock.

If you're comfortable with me punching that question until we get to that part of the agenda, we can take these one at a time, and then I'll answer that after Cari gives the report.

MEMBER VERDUCCI: Thank you.

CHAIRWOMAN CONTINE: Okay. Any other questions on 6.1, the contract amendment for Morneau Shepell?

I'll go ahead and do public comment between each contract. If anybody has public comment on Item 6.1 in Carson City? Anybody in Las Vegas?

MS. LANDRY: No.

CHAIRWOMAN CONTINE: Okay. Seeing no other questions, can I get a motion on Item 6.1 to essentially to approve PEBP's recommendation for the contract amendment for -- oh, sorry, my mic was not on. I'm sorry about that. I'm new.

Is there a motion on Item 6.1, on PEBP's recommendation to complete a contract amendment between PEBP and Morneau Shepell for the element for the eligibility and

enrollment services and to add that clarifying language to allow for the deduction for the voluntary benefits?

MEMBER ZACK: Chair Contine?

CHAIRWOMAN CONTINE: Yes.

MEMBER ZACK: Christine Zack for the record.

I move to amend the Morneau Shepell eligibility and enrollment contract to add language authorizing the contractor payroll deductions for voluntary benefits.

CHAIRWOMAN CONTINE: Thank you. Do I have a second?

MEMBER FOX: Linda Fox for the record. I have a second.

CHAIRWOMAN CONTINE: Great. There's a motion and a second. All those in favor say aye.

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

CHAIRWOMAN CONTINE: Any opposed? The motion carries.

Go ahead with 6.2, Cari.

MS. EATON: Thank you. Cari Eaton for the record.

6.2 is our HealthSCOPE contract. PEBP entered into a five-year contract with HealthSCOPE Benefits for TPA services effective February 8, 2011 resulting from an RFP.

This contract has been extended through June 30, 2022. PEBP staff has negotiated a reduction to the medical claims admin fees from $14.50 per employee per month to 13.95 per employee per month, as well as reduced subrogation fee from 25 percent of recovery down to 18 percent of recovery and enhanced recovery fees from 25 percent of savings to 22 percent of savings. The reduction of fees will be effective July 1st, 2019 through the contract term with a total projected annual savings to PEBP of approximately $277,500 per year.

PEBP recommends the Board authorize staff to complete a contract amendment between PEBP and HealthSCOPE Benefits for TPA services to reduce fees.

CHAIRWOMAN CONTINE: Thank you. Are there any questions on Item 6.2?

All right. Is there a motion -- sorry, is there any public comment on this item number?

MS. MALONE: Good morning. Pricilla Malone representing AFSCME for retirees.

I just wanted to raise the issue of we had a prior Board discussion on subrogation policy in general, and so this is not a public comment yay or nay in support of this motion. It's simply I'm bringing that up again because Chair is new, and I know there was some concern last year about some litigation and how that effected PEBP's policies on

subrogation matters, if that could simply be addressed before you take a vote. Thank you.

CHAIRWOMAN CONTINE: Go ahead.

MR. HAYCOCK: For the record Damon Haycock. We had a potential, not a potential, we had litigation a few years ago where a member wanted to utilize their first party insurance. They purchased medical payments through their automobile insurance and they wanted to use that to offset the accumulators, the deductibles and co-insurance and out-of-pocket maximum for an accident that they -- that occurred that actually was at the fault of some or, no, it wasn't the fault of someone else. It was their own, but they wanted to use that -- that medical payments.

Before that litigation we would try to collect as much as we could through the subrogation laws that were passed many many years ago that allowed us to go after any and all subrogation dollars, whether it be third party or first party, but there was an argument as to the legality of it.

In the end, we ended up settling for a very small amount with the member. However, we went back and established a regulation that allows all PEBP members to utilize their first party insurance, specifically medical payments to satisfy any outstanding accumulators at the time

the claim hits. And so to kind of find a middle ground, we allow the members to -- to use the money that they are paying premiums for with their first party insurance today. That was unanimously approved by the Board, and it sailed through the legislative commission as a regulation, and we've been implementing that ever since.

And so this contract through TPA services has a subrogation part to it and that subrogation team has been successfully applying this and still collecting a significant amount of subrogation dollars a year. I think we're somewhere between $750,000 and almost $1,000,000, depending on the year. It's a huge cost savings to the plan. It's not meant to be punitive, and it's not meant to be difficult, but it is something that we utilize. And of those savings of that money we take back, the vendor will keep a portion of it to offset their cost to operate that process. We have been successful in negotiating down their cut.

And so my understanding of the subrogation world if you believe my subrogation team that the traditional was somewhere between 30 and 33 percent, we were at 25, and I cut it to 18. So I'm sure they are real excited I'm publicizing that but that's -- that's a good deal. We have probably had, not probably, I'm convinced we have the best third party administrator in the industry, and the way the services they

provide us every year and the cost savings I get credit that they create is second to none, and so this is an excellent contract. We have an excellent partner, and they came to the table to help us a deal with a budget issue which I will go into more detail when we talk about rates in a later, later item.

CHAIRWOMAN CONTINE: Okay. Thank you.

Is there any other public comment in Carson City? Okay, great.

On Item 6.2, is there a motion on PEBP's recommendation that the Board authorize staff to complete a contract amendment between PEBP and HealthSCOPE Benefits for TPA services to reduce fees?

MEMBER ZACK: Chair Contine?

CHAIRWOMAN CONTINE: Yes.

MEMBER ZACK: Christine Zack for the record. I move to amend the HealthSCOPE Benefits Third Party Administration Contract for TPA collection of fees, subrogation recoveries and provider refunds.

CHAIRWOMAN CONTINE: Is there a second?

MEMBER LAMBORN: Leah Lamborn, I second the motion.

CHAIRWOMAN CONTINE: Thank you. All those in favor aye.

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

CHAIRWOMAN CONTINE: Any opposed? Motion carries.

Go ahead.

MS. EATON: Thank you. Cari Eaton for the record.

6.3 is Express Scripts contract. PEBP contracted with Express Scripts, Inc. or ESI for Pharmacy Benefits Manager Services which began July 1st, 2016. Pursuant to the contract PEBP may perform or have performed on its behalf a market check to determine if the terms of the contract are competitive with the current market conditions.

Aon Consulting performed the market check and based on the results, ESI has agreed to additional negotiated discounts, additional rebate guarantees and reduced admin fees through the contract term. These reduced contract fees will begin July 1st, 2019 and are anticipated to save the CDHP and EPO plans approximately 5.2 million dollars per year.

PEBP recommends the Board authorize staff to complete a contract amendment between PEBP and Express Scripts, excuse me, for PBM services to reduce fees and increase negotiated discounts and rebate guarantees through

the contract term.

CHAIRWOMAN CONTINE: Thank you.

Are there any questions or comments on this Board or questions or comments on this item?

MEMBER PACKHAM: John Packham for the record. I just have a quick question.

That's an eye popping number, 5.2 million. I just was curious when it says approximate, so will that vary from year to year or?

MR. HAYCOCK: Yeah, for the record Damon Haycock.

Excellent question, Dr. Packham, and that really goes to show the dynamic volatility of insurance marketplace which I'm going to kind of segue into it later on the next agenda item, but that number is a number that we worked with Express Scripts and Aon as well to validate to ensure that is going to move forward.

What's really eye popping about that isn't just it's 5.2 million per year but it is in addition to what we got last year. Last year I think was 4.3 or something along those lines, and so there really is a lot of money available out there in the marketplace, and we are doing our due diligence on behalf of the Board to ensure that our members don't pay anymore for healthcare or for pharmacy benefits than they have to.

We appreciate the opportunity to do this market check. It isn't always cordial but it is always successful, and at the end we all agree that the member -- the member wins in this instance and so does the State of Nevada taxpayer who funds this program, and so this is an eye popping number. Discounts change. Negotiations happen between PBM's, Pharmacy Benefits Manager, various providers. New drugs hit the marketplace. So, of course, these numbers can change.

Based on the snapshot today, based on what we would save if we were to implement and nothing changes moving forward, and so it could change, but we don't see it changing dramatically one way or the other.

MEMBER LAMBORN: Madam Chair?

CHAIRWOMAN CONTINE: Go ahead.

MEMBER LAMBORN: Leah Lamborn for the record.

Cari or Damon, I'm not sure who would answer this better. Where are the majority of those savings coming from, additional rebates?

MR. HAYCOCK: For the record, I'll take it, Cari. Damon Haycock.

I want to make sure I don't breech any confidentiality requirements or trade secrets, but we were able to successfully negotiate greater discounts in a

multitude of areas and so applying that against all of the drugs we dispense on behalf of those that prescribe them, you're seeing a decent amount of savings there we were able to, of course, increase the -- the guaranteed rebates.

There's something important to note about guaranteed rebates. So there's the guarantee, and then we also have the ability to collect, not the ability, we have it in our contract to collect 100 percent of all available rebates. And the reason we have two different sections is if 100 percent of all rebates doesn't meet the minimum guarantee, the PBM will make up the difference. So that's -- some people think the rebate guarantee is the sealing but it's really a floor.

And so we see that we're getting significantly higher rebates. We report them to the Board every year. When I first got here in 2015, at the end of that plan year, we received just over $700,000 in rebates. Last year we booked over 7,000,000. So it's a huge increase and every time we do these the member wins. You know, the Board wins. PEBP wins.

So it's really kind of spread out over the discounts and the additional rebates, and then there's a small portion of that which is the administrative fees that have gone down, but the admin fees are a small part of our

overall pharmacy cost.

CHAIRWOMAN CONTINE: Any other questions?

MEMBER FOX: I have a question. Linda Fox for the record.

This question is for Damon. What happens if we get forced into sharing a formulary, does this all go away?

MR. HAYCOCK: So for the record Damon Haycock.

That's an excellent question, Ms. Fox. You know, I'm going to have to testify on these bills. In fact, I'm getting a little ahead of myself for the last agenda. I'm going to testify tomorrow on something very similar about adhering to someone else's formula.

The answer, as my lawyers like to give, it depends. It depends on the formulary that is approved by the authoritarian entity. So right now there are a few bills out there that say we may -- well, we will have to adhere to the department of health and human services formulary.

A while ago before session, we actually -- they reached out to us and we did kind of a gap analysis at the time, and it appeared for the most part our formularies were similar but there's always the issue that -- that when there's a multitude of drugs that are all equal in efficacy but some are higher cost than others.

DHHS through the department of health and human

services through their Medicaid program often get the best deals, not everybody, and so they are less inclined to try to steer to one drug or another because the deals are so good across the board where PEBP has to use economies of scale and volume discounts by steering folks to one drug versus all of the drugs.

So that's going -- you just heard my basic testimony you're going to hear tomorrow and the next week and the week after for the next so many days but really if we're -- we're stuck having to adhere to that formulary at the end of session, my recommendation will be to the Board that we find a way to ensure somebody from PEBP or this Board is on that committee that makes that decision to represent the cost impact and basically do rolling fiscal notes to DHHS to go through that process.

So, yes, there's always a gamble. To answer your initial question, there's always a gamble that the amount of money we want to save is predicated on a situation today and we're in the middle of session that could change that situation.

But so far my interaction specifically with the sponsors of a lot of these bills has been favorable, and I'm really hoping that they understand that there is an unintended consequence of some of these things and either

work to change language or amend language or come up with some fail safe support program.

MEMBER FOX: Thank you.

CHAIRWOMAN CONTINE: Any other questions? I have one, Damon. On this, the market check or an assessment of the market conditions, is that a regular process? Do you have like a schedule that you do?

MR. HAYCOCK: Yeah, for the record Damon Haycock. Thank you, Madam Chair.

It's built into our contract and we sign with Express Scripts that we will do an annual market check. We generally start that around January of every year, and we try to get it done in time for this meeting to help with any relief of costs, as well as to ensure that our Pharmacy Benefits Manager can program any changes by July 1st.

CHAIRWOMAN CONTINE: Okay. Thank you.

Okay. Are there any other questions? All right. Then I'll bring it up for public comment. Any public comment in Las Vegas on Item 6.3?

MS. LANDRY: No.

CHAIRWOMAN CONTINE: Anybody in Carson City want to comment on this item?

Okay. Is there -- is there a motion on PEBP's recommendation that the Board authorize staff to complete the

contract amendment between PEBP and Express Scripts to reduce fees and increase the negotiated discounts and rebates through the contract term?

MEMBER ZACK: Chair Contine?

CHAIRWOMAN CONTINE: Yes.

MEMBER ZACK: Christine Zack. I move to amend the Express Scripts Manager Contract to reduce administrative fees and implement greater drug discounts and guarantee drug rebates.

CHAIRWOMAN CONTINE: Thank you.

Is there a second?

MEMBER LAMBORN: Leah Lamborn. I'll second the motion.

CHAIRWOMAN CONTINE: Thank you. I have a motion and a second. All those in favor say aye.

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

CHAIRWOMAN CONTINE: Any opposed? Thank you.

Item Number 6.4?

MS. EATON: Thank you. Cari Eaton for the record.

Our last amendment for 6.4 is for Towers Watson Extend Health. PEBP has contracted with Willis Towers Watson, our Extend Health for Medicare Exchange Services

since 2011. Our current contract resulting from RFP is due to expire on June 30th, 2020.

PEBP surveyed our Medicare Exchange population in January and discovered that over 80 percent of our respondents are satisfied overall with Towers Watson, and over 72 percent of our respondents don't want anything to change with the current Medicare Exchange offering.

After reviewing the survey results, PEBP staff negotiated to eliminate the current 1.50 per participant per month HRA administrative fee and extend the contract five years through June 30, 2025. The total projected annual savings to PEBP is approximately $241,000 per year.

PEBP recommends the Board authorize staff to complete a contract amendment between PEBP and Willis Towers Watson Extend Health for Medicare Exchange Services to eliminate fees and extend through June 30, 2025.

CHAIRWOMAN CONTINE: Mr. Haycock?

MR. HAYCOCK: All right. For the record Damon Haycock. Thank you, Ms. Eaton.

And that was excellently concise. You know I like to talk a lot so I'm going to add a few things.

Willis Towers, and to answer your question earlier, Mr. Verducci, so Willis Towers Watson has continued to improve customer service. If you remember back in the

January Board meeting for those Board members that were part of the Board back then, there is an appeals and complaint summary that was presented as part of the consent agenda. It's part of our quality control process. That's a statutory requirement that we present to you all and Division of Insurance, and for a few years, I don't want to say many, but for a few years Willis Towers Watson won the lion share of those complaints, but that has completely turned around, and so they are not the issue that PEBP has had.

And we worked very diligently through previous, I think two Board chairs ago is who I went out to Salt Lake with, and they have been able to successfully adjust their processes and their internal workings and how they interact with PEBP to ensure all of our data is transferred appropriately, and we don't delay necessarily funding to our retirees. We feel that they are an excellent partner and their willingness to continue to provide additional benefits to the program for no additional cost is a testament to that.

If you recall last year, we asked, I asked Towers Watson or Willis Towers Watson if they would put an in-person liaison here for the health reimbursement arrangement issues, that has been one of the burning issues for our advocates since this thing went live, and we were successfully able to implement that here, and that individual is in Carson City,

and she travels to Reno. She travels to the rurals, and she travels to Vegas. They did that at no cost to us.

Then every year our health plan auditor goes out and does an audit and then reports on the commissions that they collect because they are acting as the broker of record for the Exchange. And from those commissions they recognized that, to be frank, we don't -- we don't feel we should be paying an administrative fee if they are going to be collecting commissions in that level, and so they acquiesced to that process as well.

The only issue that we have had consistently is with their third party administrator Pay Flex, their subcontractor, which they have agreed by I believe it's somewhere in the, I'm going to say the October range to be safe, November, October, November, that they are going to move that process in-house to provide us a one-stop shop seamless integration of the health reimbursement arrangement, third party administrator services and the eligibility and enrollment of the actual Exchange product, and so a member will be able to call one number and stay with that individual or at least stay within that entity to have their services met, and so this appears to be a win across the board.

Just as a piece of history, when we initially implemented this in 2011, and 2015 we went out to bid again.

When we went out to bid, we ended up selecting them again. To save the costs of a solicitation on everybody's part and the fact that our surveys show that the majority of our members want to remain on the Exchange with no change, we felt this was a no brainer as we were to save money in the process.

And with that, I'll turn it back over. Thank you.

CHAIRWOMAN CONTINE: Are there any other questions?

MEMBER LAMBORN: Damon, Leah Lamborn for the record.

I just want to make sure that all of the normal language, penalties and services do go array that we can terminate the contract.

MR. HAYCOCK: For the record Damon Haycock.

Yes, there are still performance guarantees that are in this contract which is kind of ironic because we're not paying them anymore. So if there is a service guarantee penalty they are paying us, but those are in there to protect the membership. There is the standard termination clauses in the -- in the language, the contract language. I believe it's a 180-day termination clause for no fault on their side, and so we have protections and safety nets in place if things

go array and this Board would like to make a different decision.

MEMBER LAMBORN: Thank you.

CHAIRWOMAN CONTINE: Any other questions, comments? Any public comment in Las Vegas?

MS. LANDRY: No.

CHAIRWOMAN CONTINE: Any public comment in Carson City?

Okay. Is there a motion on PEBP -- PEBP's recommendation that the Board authorize staff to complete a contract amendment between PEBP and Willis Towers Watson for Medicare Exchange services to eliminate fees and to extend the contract through June 30, 2025?

Mr. Verducci?

MEMBER VERDUCCI: Yes, Tom Verducci for the record.

I recommend that we accept staff's recommendation, authorize staff to complete a contract amendment between PEBP and Willis Towers Watson Extend Health for Medicare Exchange services and Contract Number 6 -- 16468 to eliminate fees and extend through June 30, 2025.

CHAIRWOMAN CONTINE: Is there a second?

MEMBER HAGLER: Mandy Hagler for the record. I will second.

CHAIRWOMAN CONTINE: Thank you. I have a motion and a second. All in favor please say aye.

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

CHAIRMAN CONTINE: Any opposed? The motion carries.

Okay. Moving onto Item Number Seven, discussion of possible action regarding changes to plan year 2020 Consumer Driven Health Plan Design to include reducing deductibles and out-of-pocket maximums, increasing dental benefit maximums and eliminating annual vision exam co-pays, and for PEBP is Damon Haycock.

MR. HAYCOCK: Thank you, Madam Chair. Damon Haycock for the record.

Before I get into this report, I want -- I want to kind of tee up a theme. It's a pretty simple two-word theme, but the theme is everybody wins. The idea of group health insurance is to leverage the groups resources to ensure that those that cannot pay for their health insurance costs because of these exorbitant amounts are leveraged across the entire group.

There's also opportunities where the entire group can win when we do things like rate decreases or rate polls that every member regardless of health status gets a benefit.

I think you've heard in the news today a lot about, you know, folks being concerned about losing or potentially losing healthcare if the federal government changes how healthcare is offered and starts to do away with preexisting conditions and those types of things, and so the idea again that I want to stress and say it a few times is everybody wins.

You heard -- for those of you that have been on the Board prior to this meeting, you've heard me say time and again that when PEBP has money, PEBP's mantra has generally been to help everybody, and we've offered supplemental funding in excess reserves to Medicare Exchange Retirees or to HSA contributions. That's the health savings account or to health reimbursement arrangement and contributions to the Consumer Driven Health Plan. We've looked to shorten the gap in employer contributions between the Consumer Driven Health Plan, PPO plan and our HMO plan to make things more affordable.

So the idea that we have been moving forward for at least the last three and a half years I've been here and I'm going to assume before me is that when we came, we tried to help our entire population as a whole. We do not carve out certain pieces of our population and say these people should get this, and these people should get that, and we

never wanted to pit our population against each other. I think it's something that was Ms. Lockard, from RPEN, who said that a few meetings ago.

So what we're going to talk a little bit about here is how we got here and what PEBP's recommendation is. So in January, you know, PEBP presented a report on the plan benefit design opportunities, and in there we provided a confirmation of the previously approved Board actions. And for those that are new on the Board, and for those that are in the audience that may not know this process, it is pretty standard from year to year.

In September of every year, we provide an opportunity to talk about plan benefit design, any changes or any ideas that we want to go and analyze, and then we run back after that meeting, and we work with our actuaries and our consultants and our partners, and we create some options for the PEBP Board to review at the November Board meeting. This has been going on for years.

And then in November, the Board generally will either approve the plan design or they may punt a few things into the January timeframe, even so much as March but generally speaking, the bulk of the plan is approved in November of every year.

Then our actuaries go back and in January they

present to the Board what the current trend is looking like on all of the plans we offer. And then in March we take -- they take that plan design and they build a rate off of it. So it's very difficult to do last second plan design changes because our actuaries have already developed the science to ensure that we maintain a program that is actuarial sound.

I do believe there may have been, and Nancy can correct me if I'm wrong, I do believe there has been times in March Board meetings where benefits have been discussed and they may have effected rates, but it's generally not something that our actuaries want to do which is do rates on the fly, right. They like to do peer review and go through the entire process.

So one of the things the previous Chair asked PEBP to do at the January Board meeting was take a look at this, and he had given a couple of disclaimers that he wasn't at the time, and I'm not saying this that you do this, Madam Chair, but that he wasn't at the time very supportive of making plan design changes in the middle of the legislative session. I know I have said that as well so I'll own that of that topic.

We have already introduced our budget. I already testified on our budget three or two different times, and I testified on our policies once to the legislature, and I

don't think I'm going to get an opportunity to testify again. So once our budgets have been presented to the subcommittees, it now goes forward into the overall budget, and then our Legislative Council Bureau analyst will then present our final budget closing which is scheduled some time in May, early may.

So we don't have an opportunity to talk about the whys of any changes that I am aware of and I don't believe that there will be that opportunity to get in front of these legislators again, at least from PEBP's staff perspective, and so we have already testified on the budget, and we are presenting rates today that is based off the current plan design.

So, yes, I'm kind of going way off this report. We did have Aon do the analysis. So you have those figures on the table on the top of page two that show what the cost would be for the requested changes that Nevada Faculty Alliance and other advocates presented to PEBP back in January, and we did our due diligence and performed the analysis with our actuaries to give a number. So we can talk about what that number looks like and how it moves forward.

I already started talking a little bit about the factors to consider, but let's hit on long term sustainability. One of the things that we did in 2014 when

we had a truckload of excess reserves, way more than we have today, almost triple what we have today is that the Board at the time decided that we wanted to enhance the benefits on the plan, and we were going to expend those down at approximately 30,000,000 a year for three years, and then we were going to take those benefits away. We were going to give something to the membership and take it away three years later.

And my predecessor did an excellent job of sharing that timely over and over that this is what was going to happen, and the Board understood that this is what was going to. And then he promoted to a different job and I had to own that, and I had to own a benefit offering that was going to be removed, and so for a few years we worked very hard collectively with our partners, with our staff, with the Board to find cost savings activities without eliminating benefits to our members to ensure that those enhanced benefits would no longer sunset.

And -- and I think, I hope that those of us that remember that, I don't know how many people are here from 2017 still, but those of us that were here, that was a good day at PEBP when we were able to save those benefits and ensure that our members did not kind of get teeter-tottered on what was going to happen every year, and so we moved those

over to the base plan, and we were able to fund them, and we were able to build them in the budget today, and they are all part of the rates that are being presented today.

But that was very difficult for PEBP to do, and I don't know if PEBP can do that again. And so long term sustainability, if we offer benefits at 3.9 million dollars or round up to $4,000,000 of excess reserves, we are owning those benefits until the end of time. That has been the mantra at PEBP. We would never recommend presenting these and accepting these and then taking them away.

Now, yes, there is great argument that PEBP may have excess reserves until the end of time, right? I mean, we constantly come back and say we have more money. We have more reserves, and so this is just another option to carve part of those reserves out and develop this plan.

But one thing that I don't know if everybody is aware of but when PEBP presents true benefit enhancements such as the Preventative Drug Benefit that we offer back I think a few years ago, that we said we were going to use excess reserves for the 3D mammography that we are offering this year that we said we are needing excess reserves for, I didn't come back to you and say next year we need excess reserves for these.

Because we recognize that when we're going to

present an enhanced benefit using excess reserves that it's going to become part of the base benefit because we don't want to take it away from our members.

And so just to give some statistics, when we introduced the Preventive Drug Benefit, for those that don't know what that is, they are maintenance drugs that many of us have to take to manage our health, and the current plan or the previous -- previous policy on the high deductible health plan is you must satisfy your deductible before the plan starts helping you pay for these drugs.

We were able to work with our partners at Express Scripts to utilize already approved preventive drug list to bypass the deductible so members would get instant relief they want. And the best example I could give you is a drug called Advair. It's in little purple disc and people that have asthma or COPD may be prescribed it, and it can cost $350, 400, $500 a month, and folks were not taking this drug because they couldn't afford the deductible at the beginning. However, now it's only 20 percent right out the gate, they are only paying 70 to $100 which is way more affordable for them to maintain their asthma treatment.

And so it was a huge benefit to our membership, and so many folks utilized it that the amount of excess reserves that PEBP presented, it would cost us $500,000

turned out to be 1.5 million at the end of the year. But, again, you haven't seen me come to the table and say, well, you know, the sky is falling. We need to cut or increase rates and cut benefits because we knew when we presented that that we were going to have to own that benefit moving forward forever. We can only do that many so many times until we artificially enhance our plan to the point where it's unsustainable. So there's a long term sustainability issue that I think needs to be considered.

And I already touched on the Governor's Recommended Budget and the legislative testimony part. Today we have untested rate reduction and our brand new exclusive provider organization plan. So we reduced rates for the first time to everybody in PEBP history last year. Yet we don't know how that's going to shake out. I wish I could tell you that every decision we make has an instant result but it doesn't. In healthcare often things have a runway. They take a little bit of time before you see the actual results. Again, the preventive drug benefit, right.

So we have these untested rate reductions and then we have this brand new plan that we absorb this risk from our Northern Nevada partner who had an HMO plan for years. We have not been able to have a single year yet of actual consumption of those benefits nor have we determined

if people are going to be able to migrate to and from. That risk is untested, and we don't know if we did it right. Now, today you're going to hear later in rates we still believe we were conservative and we can be successful, but we could be wrong.

And then finally a plan design philosophy, and I touched on this a little bit about the proposed solution, but recognize that PEBP is not a single plan offer. We don't just offer this Consumer Driven Health Plan. Every time we talk about the program, it feels, and that's probably unfair, for the most part we're talking about our CDHP, and we want to make changes to that. We want to lower those deductibles, and we want to lower those out-of-pocket maximums because people don't want to have to pay that much money at the doctor's office, right?

We have a plan that does that today and it's statewide. We have an HMO plan in Southern Nevada. We have an EPO plan in Northern Nevada and then zero dollar deductible. So folks really don't want to pay a deductible, and they want to just pay a co-pay at the doctor's office, we already have it. It already exists.

And so when the HMO plan and the CDHP plan were introduced as plan offers in 2011, the basic functionality was this, the basic policy was this, every member has a

choice to make. Do they pay more at the doctor and less in monthly premiums or less in or more in premiums, monthly premiums and less at the doctor's office, and we did that to try to adhere to the different levels of salaries and different levels of compensation that our members have, and their different situations and their healthcare needs. So we have both ends of the spectrum.

We also provide a significant amount of health savings account and health reimbursement agreement funding. We tell everybody we have a high deductible health plan, but we really don't. We have one by IRS standards, but we don't. So before we talk about excess reserves and enhanced funding, we already give $700 to the primary participant on the Consumer Driven Health Plan to offset that deductible.

So a single employee or a single retiree on our Consumer Driven Health Plan has a 1,500 dollar deductible on the books, but they already get $700 off of it. They are back down to $800 deductible which ironically is about what it was before we implemented the high deductible health plan to begin with.

Then we also give money out that they can earn. It used to be kind of just a guarantee now that they can earn it. This year it's an additional $200. We're continuing that process next year, but then we're also giving an

additional $200 for no requirements whatsoever. So it's $400 in earnable HSA/HRA funding. So you take the $400 and you take the $700 and you add them together and that's $1,100, and you have a 1,500 dollar deductible on the books. So what is your true deductible here? It's $400.

Now, I promise you, I promise you advocates are going to say what about families, that's not how it works for families. Families have the deductible doubles. It's $3,000. Well, we also give $200 of HSA funding and HRA funding per dependent max three. So we do chew into that. It's not a one for one, but it does chew into it.

So today if you are an individual on our plan moving forward, whether it's already been approved by this Board for next year, you have a 400 dollar deductible effectively on a high deductible as an individual. And if you're on the family side, you can have if you have three dependents on the plan, you have $1,700 off of 3,000 dollar deductible. You have a 1,300 dollar deductible as a family.

If you want to have your eyes explode, go look at what the individual market is charging a 60-year-old person here in Carson City for premiums and what deductibles and out-of-pocket maximums they have, and you will be thinking everything you believe in that PEBP is offering such a low deductible, high deductible health plan with all of this

additional funding that goes out to everybody.

So we want to be amenable to the consistent request by our members and by the advocates that represent them, and so we have a proposal today that we're not asking for an approval for. We're not saying put this in stone today, but we want to let you know that we're not just recommending a no. We're recommending a not now, and let's come up with a strategic process that works for everybody.

So there's been talk about a third tier plan, a middle tier plan between this high deductible which is a low deductible and this low deductible where the premiums are much higher. So what we're anticipating is that someone wants a middle tier premium and a middle tier deductible which would end up being under the IRS a low deductible plan with no HSA funding available. We can build that plan. We can create that plan, and we can have a third tier offering.

We will, if this is the will of the Board, do significant analysis and strategic planning because you don't want to adversely select one plan or the other, and there's some issues that will significantly effect our HMO plan down south if we do something like this. So we can make sure that we go in eyes wide open, but there are too many unanswered questions right now for us to recommend doing that today. What we want to do is to slow down and do a strategic

process.

And for those that weren't at the January Board meeting, it was my evaluation that occurred and Mr. Verducci said it and the advocates have said it time and time again that they wish that we would slow down and strategically and methodically make plan design decisions instead of coming to the Board last minute and asking for a vote, and so we are telling everybody today that we have listened. We have listened to what you have told us, and we believe that since the sky is not falling, since there is no crisis we're trying to solve like when the HMO plan provided us a very high premium increase of 13 percent that we should just slow down. We should work with our partners and strategically plan this through the normal process.

So as my favorite statement of Marlene Lockard says from RPEN, I wish she was here to hear it. So we do not have any unintended consequences from a rapid decision.

With that, I'll turn it over to the Board for questions.

CHAIRWOMAN CONTINE: Are there any questions or comments?

MEMBER PACKHAM: Well, John Packham for the record.

The proposed benefit changes in the grand scheme

of things seem modest and at a time in which, tell me if I'm wrong from this assumption, where reserves are increasing, maybe that may not be a long term trend, and I know we're talking about the use of excess reserves in the previous agenda item, you just made a case for cost savings of over $7,000,000, I think that this is just -- this is a good reserve and particularly bringing anything cost sharing related down to the IRS allowable would be the direction I would like to see the high deductible plan go.

CHAIRWOMAN CONTINE: Any other questions or comments?

MEMBER VERDUCCI: Yes, Tom Verducci.

I've struggled quite a bit with this one, and the way I perceive that our duties to do is to do what's best for the majority of the members and if we take a look at the contract savings that we just voted on and that this is coming out of excess reserves, I don't believe it's coming out of Governor's Recommended Budget, and we also have state employees went through the great recession.

And, you know, I've met with a multitude of employees that were really struggling, and I think this is a way of actually giving money back to employees, and I think that it does make sense. You know, if indeed and I feel like with the increase in the reserves that we do have long term

sustainability, and I would like to see the contract savings passed onto the participants. I think it looks good for the program and it's a goodwill effort.

CHAIRWOMAN CONTINE: Are there any other questions or comments?

MR. HAYCOCK: For the record Damon Haycock.

I can't disagree with what the Board members are saying in concept nor is it good for my long term career but the -- there's something to think about. There really is something to think about that I just I want to make sure that any decisions that are made they are done with eyes wide open.

We have at PEBP been very successful I believe at saving money, especially through contract savings. We come to you guys every year and show you where millions of dollars of savings exist and where we're able to successfully negotiate with our partners. I will tell you, and I'm probably one of the most aggressive negotiators, I think the well is dry now. I don't think I'm going to be able to come back to you next year and say I've cut fees on our TPA again or I'm cutting -- or, you know, I'm taking the zero dollar Towers Watson admin fee. Now they are paying us to play, right. I don't think there's anymore room to keep doing this.

But even when we've done this, even when we have created this excess reserves, and this is kind of jumping ahead to another agenda item, but in the rate development, we show what the expected claims and fees are going to be which drives our rates.

And on our Consumer Driven Health Plan, the plan we're talking about today, they are -- the actuaries are projecting almost a 17 percent increase next year in pharmacy cost. I am pretty good at saving money. I don't know if I can do that again, right, and we were able to present, and we'll talk about it, multiple options on rates that aren't all raising rates for employees, and so are we prepared, are you as Board members prepared that if we take on additional enhanced benefits that when times do downturn, and they will eventually, nothing lasts forever, that we have to own those benefits moving forward when our benefits are already so good as they are. I know I'm going to get tomatoes thrown at me for that.

But if you go look in the private sector and you go look at some of the other government sector programs, nobody that I know subsidizes dependents more than you. You look at the local governments, they are at 50 percent or they are at nothing. And if you look at our rates today, if you look at a 600 dollar rate today, which is the overall cost to

our program for the CDHP for a single employee, if we are only subsidizing the dependents on that 50 percent, right out the gate they are paying $300 just to add a spouse which is more than any of the tiers that we have offered today or in the past.

So, again, there's always a balancing act and normally like I, and hopefully this resonated, when we have money, I want to give it to everybody. Today we have worked with -- with the Governor's Recommended Budget to provide additional HSA funding. That goes to everybody. And so if you look at these reduced deductibles, they want to reduce the deductible $150 for the employee, but we're giving $400 of additional HSA funding. 200 of it we don't have to do anything. We already satisfied that lower deductible.

And the out-of-pocket max, if you look at what the out-of-pocket max is compared to the individual market or the private sector, it's grossly low, and people are receiving millions of dollars of services and we're giving them so much in HSA funding that at the end of the day with a 3,900 dollar out-of-pocket max today and we're giving at least $1,100 in HSA funding, is it fair to have someone spend $2,800 to cover hundreds of thousands, if not millions of dollars in healthcare, and we give everybody HSA funding and HRA funding, again, to go back to that theme, everybody wins.

These excess reserves are built on two parts. Well, they are really built on three parts. One, we negotiate our tails off on contracts and save administrative costs, right, that's PEBP's part of it. And then the rates themselves, if they are set a little bit too high, because we've negotiated after they have set the rates or we have approved the rates, which happens a lot, then the state and the employee pay just a little bit too much. When you add that together and carry it together year after year, we have those excess reserves, but it's not just the folks that utilize the plan that are paying more than they should, it's everybody. It's everybody.

And so the ideology is that everybody wins. If you give your excess reserves back in triple tax advantage health savings account funding, you're actually giving back more of a benefit, and let me go into that real quick. When we provide an HSA fund, it is pre-tax. When that funding sits out there and it isn't used, it gains interest pre-tax. And when it is used, it is used pre-tax.

When we lower deductibles, if people have to use their aftertax paycheck to pay for it, then they are actually paying more for that lower deductible than they would have had they received HSA funding to begin with just because of the tax implications.

And last but not least, we have not seen any bills drop yet that address the fact that post 2012 hires will never receive a retiree subsidy, and so this HSA is the only mechanism we have to give employees so they can save for retiree healthcare. Because when they turn a specific age, 65 years old, they can use them for premiums. So they will be able to use that money similarly to the Medicare Exchange retirees to pay for Medicare Advantage and Medicare supplement plans. And so if we lower the deductibles, yes, those folks that need to use the services will get a break, but those -- there's over 50 percent of our state employees today that will never receive a retiree benefit and this HSA funding may become, whether it's this year or next year or the year after an either or.

And do we want to lessen that benefit to our members and to our employees to -- to provide them this benefit when ultimately the funding is comparable and it's pre-taxed. Thank you, Madam Chair.

MEMBER LAMBORN: Chair?

CHAIRWOMAN CONTINE: Go ahead.

MEMBER LAMBORN: Leah Lamborn for the record.

I just wanted to get a few things on the record here about some concerns about this. And, Damon, I agree that you've done an excellent job negotiating, finding

pockets of money. I do know working in the Medicaid and the healthcare industry that that well is going to dry up soon and costs are going to increase eventually.

I have concerns that we're banking on or being proposed to change and use, basically use excess reserves to benefit just one population, the CDHP program, and not looking at it wholistically. I also have concerns about trying to change the plan currently during session when we already have the budgets submitted. It's a Governor's recommend, and I don't know how that process would work but when I know from working in session with budgets that trying to do something outside of that budget process is not looked at very well.

And so we could go ahead and make a decision to utilize these funds, but I don't know, I don't think that it would necessarily be approved in the budget and during session. I -- I understand change of things and using reserves outside of the session and the budget process, that's more favorable than trying to change it right now as Governor's Recommended Budget being submitted. Those are my concerns.

CHAIRWOMAN CONTINE: Thank you.

Are there anymore? Anybody else have anything?

So I'll just make a few comments as well. I'm

tending to agree with Leah and PEBP in this -- in this case because even though this proposal to use excess reserves, at some point this -- those -- we have to keep using excess reserves or those costs have to go into a Governor's Recommended Budget, and so I'm just concerned a little bit about where we are in the legislative process, the fact that we have a new Governor and, you know, I know the Governor is very interested in providing the best plan and lowest rates and best options for our employees, but I think this kind of takes the process out of the equation, something like this happening right now during the session when there's a new Governor and when some of these other market conditions are at play.

I would also note that, you know, everybody is talking about a, if not a downturn, at least a slow down, an economic slow down where growth is going to be less than it has been over the last few years and, you know, we don't know where we are as a state right now and we won't know until May 1st when the economic forum tells us how much money we're going to have in the next few years.

So I think just giving all of that, for me and for where we are in the process, having the time to develop and getting more input into this process seems like the more prudent way to go.

So with that, are there any other comments or anybody else have anything they want to ask or?

MEMBER PACKHAM: John Packham for the record.

It sounds like I'm going to be in the minority on this one. So next time around, could we possibly look at proposed changes like this earlier, November or January, the next cycle?

MR. HAYCOCK: For the record Damon Haycock.

That is exactly the recommendation PEBP is offering up today. This is -- all of these additional enhancements were not recommended or suggested by PEBP to come back from this meeting. It was from our advocates. And so we agree, Dr. Packham, that we wanted it to follow the typical process. And we, of course, will look at any of these things at our strategic planning session if the vote doesn't go this way, right, in August and look at again what costs would be in September and bring it back to the Board through our normal process.

I have outlined a solution here. This is just an idea. We don't have to do it this way, but we definitely want to work with the Board and any plan design changes in a timely but appropriate manner.

CHAIRWOMAN CONTINE: Okay. With that, I'll open it up for public comment. In Carson City?

MR. UNGER: Doug Unger, U-n-g-e-r, chair, council of Faculty Senate Chairs, Nevada System of Higher Education for the record.

First I would like to say on behalf of Nevada Faculty, I would like to extend a warm welcome to the new PEBP Board Chair, Deonne Contine. Thank you for taking on this role and for your years of praiseworthy service to our state, and thanks to all on this Board for your service and your careful deliberation which is so crucial to the wellbeing of Nevada state employees.

There have been a couple of issues raised before I deliver a brief statement. Nevada Faculty Alliance and the Nevada System of Higher Education Faculty Chairs began submitting possibilities for revising this high deductible plan down to the low deductibles allowable by the IRS and lowering out-of-pocket maximums September and October. We have e-mails back and forth with the executive director.

The history of this more modest plan and the way it developed is we developed a big ask for a much richer plan which we understood and I understood after serving on Governor Sisolak's Healthcare Summit on last December 14th, that was going to be too big an ask to make.

On January 18th, I believe it was when PEBP announced 14.6 million dollars in unanticipated excess

reserves, we developed this more modest plan and submitted it to the Board on the January 24th meeting and asked to have actuarial analysis to see if it would work.

Now my statement. Oh, also on the legislative issue, we have spoken to -- I have personally spoken to 12 legislators, including the Chair of Way of Means Committee and the Chair of Senate Finance Committee, and neither one of those chairs has voiced a single objection to readjusting the Governor's Recommended Budget in this way. We believe that this would be possible. We have also spoken to the Governor's Policy Director and though we had a very active exchange that agrees more with the majority feeling on this Board, we felt that there was a bit of an open mind toward considering this plan if we would go to the Governor -- Governor's office once more.

We're looking at a time of plenty compared to past years and when our health plans were cut. It may not seem like it to many state employees who live paycheck to paycheck but it's true. Unemployment figures are at a point where we face a hiring retention issue in our colleges and universities and at our state agencies, and proving health benefits is key to addressing this issue.

On Agenda Item Seven, you will consider the modest redesign of the CDHP self-funded plan proposed by the

NSHE Senate and the Nevada Faculty Alliance. This plan is supported by our Board of Regents and by our system about a quarter to one-third of PEBP members. The actuarial analysis is sound. It is affordable within the Governor's Recommended Budget. It is sustainable from excess reserves already available to PEBP which have been consistently accumulating year after year to the tens of millions of dollars.

We believe it's in our state's moral obligation to deliver the most health insurance to those who need it most, and that is the difference between our philosophy and the executive director's philosophy.

Our plan proposes this, to lower deductibles and out-of-pocket maximums to what is feasible while keeping premiums stable. We are convinced that PEBP could implement this plan without risking a thing. More, it could increase sustainability over the boom and bust strategy of dumping excess reserves into the HSA/HRA accounts then claw them back again the following year which we believe is wasteful.

Two examples illustrate the choice you will make today. The young, healthy enthusiastic business professor I know, with a good salary, who plans to purchase her fifth pair of designer glasses with her HSA Visa card this summer, I'm not criticizing her. She looks great in that eyewear, and she's a talent in her field or reallocate over time PEBP

resources to the Nevada Regents award winning humanities professor with a not so good salary who suffers from a serious chronic health condition that causes her to go broke the first quarter of every year until she meets deductibles and out-of-pocket costs. She sends me e-mails asking faculty leaders to do something and for this as much as her low salary, she feels undervalued.

Mr. Haycock, you've heard from this professor. You've read her e-mails. I ask you and this distinguished Board, in this time of plenty, who deserves health insurance more? Thank you.

MR. ERVIN: Kent Ervin, E-r-v-i-n, representing the Nevada Faculty Alliance, the statewide association of faculty, all eight institutions. We're the independent association.

But our goal is to increase faculty engagement and help student success by increasing faculty engagement and part of that is recruitment and retention that relies on us being able to have a strong health plan compared to our competitors and also for our classified staff 2,600 of them in the NSHE system who aren't so highly paid as some of the faculty members or coaches or whoever but rely on this system and for whom we compete with local governments which weren't really mentioned in the comparisons versus private exchanges

or the same.

Now, Washoe still has a low deductible plan. Sparks has a low deductible plan. Down south, same thing, that those are the health plans that we really compete with for our very able state employees.

As far as pitting one group against another, we've talked about that in the context of retirees against actives or single versus families. But if it's talking about putting money into HSA's that for everyone, including healthy folks who just pay that, which is great for them, versus modestly, very modestly helping the people who every plan year hit this out-of-pocket maximum because they have some of these high drug costs and so forth.

That's the group -- that's the purpose of the insurance is to help these people pay in and don't use it as much but then if you're sick, if you have a chronic condition, you get those benefits. And, you know, will this help a lot, no. It's a very modest proposal, but it will help a little bit at the margins for those people who are hitting that every time.

And so for a family getting that out-of-pocket maximum from 1,700 down to 7,000, that's $900 for that family and if that's an administrative assistant or an aide making 30 or $40,000, that's -- that's a big deal. At the same time

that HSA contribution, the contribution, well, that family is putting into $200 a month $2,400 a year, that -- yeah, that's just taking out of their payroll deduction and putting it into HSA.

As far as HSA somehow helping the post 21 -- 2011 hires, it doesn't. Certainly, it doesn't if they are on an EPO or HMO plan. It doesn't effect them at all, and you can't simultaneously say it's helping them to save for their future retirement with no state support versus, oh, we have a low deductible plan because we have these HSA's. It can't be doing both things, and it's not enough to save those people. That's a separate legislative issue.

As far as our proposal, the big items are the lower deductible down to the IRS maximum, yeah, that's only 150 for difference. And as far as sustainability, that's indexed to inflation so it might be 1,400 in a year. It might get back to where we are, but at least we're providing that help now. And I would say if we can just keep those where they are, reduce them a little bit out-of-pocket maximum, that will help between 2,000 and 4,000 of our plan participants and that's just taking the 1.7 million dollars cost and dividing by the reduction to estimate how many people might be effected by this. That's a large number of people. No, it's not all of the plan that when you don't

have money into HSA and they are saving it for their own future or their designer eyewear.

The dental plan maximum is at 1,500, that's below where it was right before the recession in raw dollar costs, and so we're just trying to get that kind of to keep up with inflation. People delay their crowns to the next plan year and we know how vital dental health is to overall health.

As far as affordability and sustainability, in your business report for Agenda Item 4.5.1, it says that cash reserves as of the end of last year were 29.4 million. Midyear, it's a moving target. Things change, but let's go back a year prior to 12-31 2017, it was 12.7 million. So it's gone up 17,000,000 at the same time of the plan year, and that's even after removing all of the EPO reserves as far as I can tell.

Maybe I'm wrong but I don't see how it's just not continuing to rise, those excess reserves. That's the biggest issue as far as the legislature or the Governor is concerned is that this plan keeps generating those excess reserves, and we need to have a plan to stop keep generating excess reserves.

We seem to have a plan every year, every biennium to spend them down, but they aren't getting spent down. The great job PEBP Executive Director Haycock has done with

saving cost maybe is contributing to those excess reserves, but there needs to be, you know, time.

As far as process, we asked in September and October for exactly these items to be priced out and as recommended not to price them out at that time, and the Board went along with that recommendation. We asked again. We had these, basically the estimates have not changed since November. They are very similar to what we had as rough estimates thanks to Mr. Haycock.

So especially the first two items, $3,000,000, very modest, sustainable. And if they aren't, if any part is not, you know, in those years over the past 30, I've been here that things have fallen short, the Board has done these hard choices but do you raise premiums a little bit. Do you cut benefits a little bit to keep the plan sustainable so we don't have a bailout like had to be done in 1999.

So this plan is so fiscally and stable right now with 29.4 million in excess reserves, beyond all of the mandatory reserves, spending $3,000,000 this year and it's sustainable certainly for the second year of the biennium rather than planning again to put $400 per person into everyone's HSA, we just think that's what makes sense for this plan at this time, and we urge your support and a vote on this issue. Thank you.

MS. LAIRD: Thank you. My name for the record is Terri Laird, and I'm the executive director of the Retired Public Employees of Nevada.

And I'm just going to sit here today in support of the previous two speakers. RPEN primarily has a membership that are retired public employees essentially, but we do have a small group that are still working and members of our organization, so I just want to reiterate our support for their issues here. Any money that can be spent to lower deductibles and lower premiums is always a good thing. Thank you.

MS. MALONE: Priscilla Malone with the AFSCME Retires.

And I wanted to weigh in. First of all, me too for what Ms. Laird expressed on behalf of RPEN, and I would clarify for the record too, going back to 6.2, I just wanted to give Director Haycock a shout out. That was his chance to shine and explain how they solved that subrogation record. I wanted to make that record. I was not inclined there was anything wrong. Because my understanding through the regulatory process is there was a nice resolution of that.

Now, getting back to this issue, again, obviously we're in support of all of the efforts. We piggyback on the efforts of the Nevada Faculty Alliance.

But I, again, need to clarify a couple of things for the record. I do not speak for the AFSCME actives. This will impact -- potential changes can impact the AFSCME actives, and I want to make it clear that my statements are on behalf of the retirees only.

And then the second piece of that, the vast bulk of our membership to the analytics of our membership is the vast bulk of our membership and the AFSCME Retiree Chapter Local 4041 are on the Medicare Exchange. So sometimes I'm loathe to jump in and -- and sort of stick my nose in on behalf of my clients at AFSCME retirees on matters that are for folks on the CDHP.

Having said that though, I even have board members let alone some members who were for a variety of reasons may be Medicare age but are defaulted to the CDHP or the HMO or the EPO because of things like our older folks there was a time when Nevada was not putting people into Medicare.

So -- so having done the lay up for all of that, I would suggest to this Board as you go forward considering this matter that from the 50,000 foot view, the ongoing problem, and I would say that Mr. Haycock inherited this when in 2011 the system, the plan went to a CDHP instead of the prior PPO basic structure that it had that going forward,

this has been a political hot button and that shouldn't drive policy, but you have to -- we have to get that elephant out of the room.

As Mr. Unger said, when we talk to legislators or other policy folks, it comes up every time. Why does the plan keep generating these excess reserves and if we're at 29,000,000, that I can promise you in the building that is going to be a discussion. One way or the other, it's going to come up whether it comes up through all of these healthcare bills. I'm tracking 37 alone, and that's not the entire amount of bills. That may, not always do, but may, in fact, any self-insured healthcare trust such as PEBP whether you're MGM, the culinary, PEBP, you may have a dog in your -- in the fight, at least 37 that I'm aware of.

So -- so this is a big issue, these excess reserves and the plan keeps generating those. So please just keep that in mind as you have your robust discussion around this agenda item. Thank you.

CHAIRWOMAN CONTINE: Is there any other public comment in Carson City? Is there any public comment in Las Vegas?

MS. LANDRY: No, there's none.

CHAIRWOMAN CONTINE: Mr. Haycock, do you have final thoughts?

MR. HAYCOCK: Yeah, for the record Damon Haycock.

Without trying to solicit hate mail, there's a couple of things that I think were very key that we just heard. And I just want again, eyes wide open as we move forward. Whatever decision the Board makes, PEBP will implement without complaint and without fail. You heard a couple of statements that I think could be potentially slippery slopes. One, who deserves health insurance more? That -- that frightens me that we are going to start determining who deserves health insurance. Instead of treating everybody equally, we are going to start deciding who should get health insurance more than somebody else.

You heard conversations about recruitment and retention, but you also heard will this help a lot, no. So I don't know if $150 deductible is going to magically fit the recruitment and retention problems at the State of Nevada. In fact, I would argue getting out of my lane that salary increases would have a much bigger impact.

You heard about modest decreases to the out-of-pocket maximum for families, right. And you heard the number of $900. Although, it's really an 800 dollar out-of-pocket maximum reduction from 7,800 to 7,000. However, today we give families $200 of HSA/HRA funding per family member up to three so that's $600 and then the

additional $400 that people are talking about shouldn't be given makes that $1,000. So how -- how -- how the request is to receive less money to help people is beyond me.

You heard that the process included that Mr. Haycock is wrong. The process did include the development of this request to the Board and it was brought up in September, November, but the Board at the time did not move forward with it. So as part of the process, one of the unfortunate parts is that sometimes when, and I've been on the receiving end of this, when I make a recommendation, the Board doesn't go with it, they don't go with it.

And so the decision on what should be in the plan design was already hashed out multiple times. In fact, it actually goes all the way back until I think either this meeting last year or at least the May meeting when we introduced the agency request budget framework, and the Board had an opportunity to talk about when they wanted to put into that -- that budget, and we had a very strict schedule to meet on August 31st agency request budget submission deadline.

And from there, everything has just kind of snowballed, and so the Board did have an opportunity to review additional plan benefit designs. You did see some rough numbers come out in September and again in November,

but the Board ultimately chose not to move forward.

So if we're going to talk about the process, I just want to make sure that we talk factually about the entire process that this was already talked about in multiple meetings, and the decisions of the Board were already made.

Now, yes, there's always an opportunity to change the decision but just for the record, they have been made. We hear about various faculty members, and I know who Dr. Unger is speaking about. When you are broke the very first month of the plan year, we do have members that are, that means that they have hit that 3,900 dollar or 7,800 dollar out-of-pocket maximum the first month. The premiums for the HMO or EPO plan are much less than that, and that would have insured that co-pays were paid versus a big lump sum out-of-pocket maximum.

So it's not that we're -- we keep treating this Consumer Driven Health Plan as a single plan option to the state, and we're going to kind of arm wrestle back and forth and play tug-of-war, and I recognize that, and I really respect the folks that come up here and advocate on behalf of their members, but it's always about the Consumer Driven Health Plan and not all of PEBP's plan offerings as a sum total.

And last but not least, well, not last. I have

two more points. One, the 29,000,000 million dollars of excess reserves is a point in time budget number that will adjust up or down, this is midyear, but let's assume it's going to stay. When I testify to the budget on the $400 of HSA funding that was an enhancement unit in the Governor's Recommended Budget, there wasn't enough excess reserves at that time to continue that into year two so it was reduced to $100.

The 9.5 million dollars associated with that 400 dollar HSA amount, we also have to add the million plus that we -- you guys have proved to take care of the Medicare Exchange Retiree Life Insurance. Now, we wiped out the HRA fees, thank you Willis Towers Watson, but the life insurance we're still paying for. So you're talking about ten plus, almost $11,000,000 that you already obligated through the Governor's Recommended Budget for next year, but there wasn't enough money to do it in the second year.

Well, ironically, the difference between the $100 in year two and the $400 of continued enhancements is what is left on the table in cash today, right. And so it's -- it really is a policy decision and I don't want to divide the population but recognize that when -- when people get HSA funding, everybody gets the funding, the sick, the healthy, the young, the old, you know, the single, the family,

everybody gets that funding.

When you only give it to a portion of folks, then when you run out of excess reserves, which I promise you some time in the future we will run out of excess reserves, it has to happen. No one can be that lucky every year, right. No one can be that lucky every year. When we do, we have already made the decision years earlier, today, that we've enhanced the plan instead of providing funding to everybody equal. So that's just something to keep your eyes open for.

I don't really want to get to the point where we're debating back and forth because I do respect the advocates. One thing you did hear today, and my last point, is nobody is here representing the entirety or totality of employees. You don't have -- unfortunately, Kevin Ramp isn't here from AFSCME to talk about his folks, and there are folks that do not pay dues to any of these entities that are not being represented today.

And because of the nature with how we do Board meetings, we host them during a time when employees could not actually attend these meetings, and so no one is really truly representing them as a whole. And, yes, RPEN represents those that participate that are heading towards retirement. The NFA represents those that are in the Nevada System of Higher Education, even the faculty folks or sorry, the

Faculty Senate, all of them, right.

But no one is representing my employees here today. No one is representing your employees here today, and we don't hear from them. And so we make these decisions and there is a significant part of the population that is not being represented to weigh in. So as part of this strategic process of figuring out to best develop the plan, I want to survey them. I want to ask them, employees, what would you rather have. Would you rather have -- when we have excess reserves, would you rather have HSA funding or would you rather have lower accumulators, just like Dr. Unger did with Nevada System of Higher Education, but we're missing that critical piece of information from part of our population.

And one of things Priscilla said very excellently is she's tracking, how many bills, 30?

MS. MALONE: 37.

MR. HAYCOCK: 37 bills. If any of them negatively effect PEBP, it starts to harm our costs, and we've already kind of given away excess reserves that we could have absorbed it with. So just food for thought, and then I will rest my case and not say anymore on this.

CHAIRWOMAN CONTINE: All right. Thank you, Damon.

Is there any other discussion? Any Board members

have any other questions or comments?

MEMBER LAMBORN: Madam Chair?

MEMBER ZACK: Chair Contine?

CHAIRWOMAN CONTINE: Yes, go ahead.

MEMBER ZACK: Christine Zack for the record.

I just wanted to echo Ms. Lamborn's comments that we need more global approach and not this piecemeal approach during a legislative session and if you were ready for a motion, I was ready to make one.

CHAIRWOMAN CONTINE: Ms. Lamborn would like to make a couple of more comments and then I'll come back to you, okay?

MEMBER ZACK: Thank you.

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

So I have a couple of more comments. You know, I don't believe there would be a legislature out there that if you talked about this today would be a great idea, but I think what you need to keep in mind, the time to ask the legislature, their opinions, senators and so forth is at the very end when you're down to the wire and they have to approve a balanced budget, at that point they have to start prioritizing, and then how do they feel about that, and that's kind of what Damon and staff have to deal with.

But as another -- and trust me, I would love to just say this is great. It would be beneficial for me personally, family members if I can say that, will I get in trouble, but I think that we need to look at it as a whole.

And then I just have one question for Damon. Are these changes that, and not that I'm trying to circumvent the budget and the legislative process, but are these changes that could be made in the future if excess reserves hold outside of the budget process?

MR. HAYCOCK: For the record Damon Haycock.

The Board generally determines what excess reserve utilization will be every year as the information is presented. If you remember this time last year, we came to you and said let's supplement the Medicare Exchange by giving them an additional couple of dollars per month per service because they didn't get anything out of the last session as far as increase in inflation. So there are times when you can make those decisions.

Technically the Board is authorized to fund the program on an actuarial sound basis. That's NRS 287.043 subsection 1B, right. I've been saying that a lot lately. I memorized, but we also recognize that we are part of a greater whole. We are part of the state. We are a state agency, and we work with the Governor and the Governor's

office to be part of his now Governor's Recommended Budget. So it's never quite as black and white as it feels, and we want to be good partners with the executive branch and the legislature in finding ways to, like you said so eloquently, prioritize the state funding for our membership.

Yes, there is an opportunity to talk about excess reserves. We always come up with opportunities to create them through cost savings and to spend them through new programs, and we will continue to follow that process as long as the Board is amenable.

MEMBER LAMBORN: Thank you.

CHAIRWOMAN CONTINE: And Deonne Contine for the record.

Just to follow on that again, on my comments earlier, it's not that I don't support this concept or providing a better plan at this point. I'm just concerned about using excess reserves and then how that -- how that goes into Gov RAC for the next legislative session or would we need to spend excess reserves again and what they are. If there are less excess reserves or if there's more, you know, it's needed in other areas so, again, I think just the process and the timing and I -- and I would be supportive of the, you know, the strategy and including it in the strategic planning sooner rather than later.

And so with that, I'll go back to Ms. Zack.

MEMBER ZACK: Thank you, Chair Contine.

I move to defer the discussion about the plan design changes and the new plan development to the August 2019 strategic planning session such that there will be agenda items for the session to discuss these two issues.

CHAIRWOMAN CONTINE: So that's essentially a motion also to not enhance the Consumer Driven Health Plan at this time, correct?

MEMBER ZACK: That is correct. As stated, I believe we need a global approach looking at all of the plans and possibilities.

CHAIRWOMAN CONTINE: Okay.

MEMBER ZACK: During the strategic planning session.

CHAIRWOMAN CONTINE: Okay, great. Thank you.

Is there a second?

MEMBER PACKHAM: I was going to ask you, is there any way we can take this recommendation here as separate?

CHAIRWOMAN CONTINE: The recommendation, you mean the two different pieces?

MEMBER PACKHAM: Yeah, I didn't know.

CHAIRWOMAN CONTINE: Separate motions?

MEMBER PACKHAM: Uh-huh.

CHAIRWOMAN CONTINE: Sure. If you want to vote differently on the two of them.

MEMBER PACKHAM: Well, yeah, I mean, I don't want to throw out the baby with the bath water, but I want more options.

CHAIRWOMAN CONTINE: Ms. Zack, can your motion be, the first part of it be that you recommend or that you are supporting or move to support PEBP's recommendation not to enhance the CDHP plan design further with excess reserves, period, and then we'll do another motion on the second part.

MEMBER ZACK: Chair Contine, then do we also need to do a third and fourth motion as it relates to discussing a new plan altogether? I was just trying to --

CHAIRWOMAN CONTINE: What I'm trying to accommodate and maybe Brandy can help me with the development of a motion that's within the open meeting law, but what I'm sensing is that Dr. Packham would like to vote yes on moving forward with this proposal right now but also vote yes on additional strategic planning for plan design. Is that what I'm --

MEMBER ZACK: Okay. So I can --

CHAIRWOMAN CONTINE: So if we do one motion, he can't do that.

MEMBER ZACK: So I will amend my motion to -- to

not initiate any enhancements to the CDHP today.

CHAIRWOMAN CONTINE: Okay.

MEMBER ZACK: And instead to defer the discussion on these enhancements to the August 2019 strategic planning session.

MEMBER PACKHAM: That will work in the interest of time.

CHAIRWOMAN CONTINE: Okay. Thank you.

Is there a second to that motion?

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

CHAIRWOMAN CONTINE: Thank you.

Okay. I have a motion and a second. All those in favor say aye.

(The majority of the vote was in favor of the motion.)

CHAIRWOMAN CONTINE: Any opposed?

MEMBER PACKHAM: Opposed.

CHAIRWOMAN CONTINE: Dr. Packham voted no.

MR. HAYCOCK: Gotcha.

CHAIRWOMAN CONTINE: How about if we come back at 11:30. Thank you.

(Whereupon, a brief recess was taken.)

CHAIRWOMAN CONTINE: Moving to Agenda Item Eight,

future Consumer Driven Health Plan and Exclusive Provider Organization Plan in-state network strategies for improving access and choice, and Damon Haycock for PEBP.

MR. HAYCOCK: Thank you, Madam Chair. Damon Haycock for the record.

This item was a request by Member Tom Verducci here to my right. He wanted to have a conversation about this. It's not an action item but to continue to strategically talk about where PEBP wants to go as far as potential network strategies. And with that, I'll turn it over to Tom.

MEMBER VERDUCCI: Thank you very much, Damon.

I appreciate you putting this on the agenda today, and I requested this item be added to the agenda today for discussion. I know that last year we ran into an issue of time, and I wanted to make sure that this appears on future agendas so we properly address this issue and we also develop a policy.

PEBP received complaints from members that they would like to have open access to their hospital of choice to avoid having to travel sometimes out-of-state or simply they might prefer to go to a hospital where they have a relationship with their own physicians, and they want to have the choice of where to go.

In 2013 there was a statewide bid for in-state network providers, and Hometown Health was chosen and has been a long term partner of PEBP. It was determined by our AG at the time that the contract we were discussing was exclusive. Hometown Health was under the impression that the contract was indeed not exclusive. So Hometown Health came forward with cost controls, and in April of 2018 we then entered into an exclusive arrangement with Hometown Health with a two percent cap and premium increases for a two-year period.

Then we had a very interesting Board meeting. We had a meeting where we had 100 people show up to advocate for open access that they wanted a choice. In fact, a lot of them were saying they were being held hostage, and the news media showed up, and specifically they would like to see access to the same areas, Banner in Fallon, Northern Nevada Medical Center, Carson-Tahoe Hospital. I'm sure that list goes on.

This group provided public comments that they felt that -- that it was a threat that Hometown Health would be raising their premiums. They were going to be held hostage. So we were forced to cancel the open access that we had already approved, and we accepted the offer from Hometown Health that included cost containments for a two-year period

with a two-year cap, two percent cap with a premium increases.

Then I requested a survey to go out to all of the members to see how the public felt about it, if they were willing to pay more for premiums than have the open access that was being requested.

The survey came back with 85 percent of the members that were unwilling to pay more for the open access. Since 85 percent of the members didn't support the change, I had to go along with the majority, but there's still a group out there. The other 15 percent, primarily Saint Mary's and, you know, I should throw in there Banner in Fallon that would like open access. They would have their own choice.

The Board has a choice of going out to bid one year early to solve the open access issue. However, that would mean that we give up the last year of the cost containments. So this comes down to a policy decision by the Board and if members are willing to perhaps pay more for open access and if so, that would have to appear on the May 2019 agenda as there's a 180-day out provision to cancel a contract early.

So we do not run into a time crunch again and are forced to make an important decision hastily, I am suggesting this item remain on future agendas until we formulate our

policy and determine what direction that we want to go in in terms of providing the open access and additional care for the members of the program and the policy could be we remain as is or we develop a policy of leaning towards open access.

And thank you for the opportunity of expressing these thoughts here today.

CHAIRWOMAN CONTINE: Thank you, Mr. Verducci.

Is there any other discussion or Board member questions or comments on the topic? Southern Nevada? Christine, anything?

MEMBER ZACK: Nothing from Southern Nevada. Thank you.

CHAIRWOMAN CONTINE: Go ahead.

MR. HAYCOCK: For the record Damon Haycock.

Just a couple of points of clarification. I think you summarized most of it very well, Mr. Verducci, and thank you for that, especially I'm sure for the new Board members and stakeholders who didn't experience that last year.

The initial contract was signed with Hometown Health to provide exclusivity to Renown, the Renown system of care, and it was the cost controls on Renown that we were able to negotiate to ensure that they retained that exclusivity for remainder of the contract. That is not

something that is necessarily new. PEBP does those types of things with other contracts today. For all of you that utilize the pharmacy benefit, you know you can only go to an in-network provider. There is no out-of-network benefits associated with our Consumer Driven Health Plan and our EPO plan, and so exclusivity isn't new. However, it is, as Mr. Verducci said, a trade off.

We get significant discounts from our PBM when we exclusively use in-network providers, and we get those cost controls today from Renown on exclusively using that hospital system. But as you stated, Mr. Verducci, accurately, there are members that are not allowed to go to other competitors, and PEBP has made a decision, not Hometown Health, to exclude Banner Churchill, and we did that due to a significant cost disagreement, but I think it's interesting and really kind of poignant that we're talking about cost around our excess reserves, but then we also are talking about access to care and is there an increase to those costs.

So just to give a timeline, we generally May of every year discuss what -- what contracts are expiring June of the next year so we can do an appropriate RFP process and the Board can approve and we can get implemented in time, especially for open enrollment next year if it effects that. This contract expires June 30, 2021. So the options on the

table, and I know that's not what he's saying today, but the thoughts on the table are is there an appetite to address what was brought to PEBP a while ago on access to care and cancel the contract a year early so end it by June 30, 2020 or wait it out and accept the cost controls from Renown all the way through the life of the contract through 2021. Is that fair, Mr. Verducci?

MEMBER VERDUCCI: That is very accurately stated.

MR. HAYCOCK: Okay. That's just a couple of points of clarification. That's all I needed to say. Thank you, Madam Chair.

CHAIRWOMAN CONTINE: Great, thank you.

Are there any other comments or discussion on the item?

Okay. So we'll move on. So I think Items nine and Ten are maybe a little bit longer. So I was just going to see how the Board felt about going -- going through and maybe taking the next couple of hours to go through these two items or whether people wanted to break for lunch and then come back and do the two items. Does anybody -- does anybody want to go to lunch?

MS. BOWEN: Yes.

UNIDENTIFIED SPEAKER: Yes.

MEMBER FOX: I would like to push through.

CHAIRWOMAN CONTINE: Yeah, how about if we do -- yeah, how about if we push through and we'll do Number Nine and then we'll take a 15 or 20 minute break and if some people want to get some food, they can get food in here.

MS. SPINELLI: I can rush through Agenda Item Ten.

CHAIRWOMAN CONTINE: Okay. So let's move onto Agenda Item Number Nine, discussion and possible action to include approving plan year 2020 rates for state, non-state employees, retirees and their dependents for the statewide Consumer Driven Health Plan, the Southern Nevada Health Maintenance Organization Plan and then Northern Nevada Rural PEBP Premier Provider Organization or EPO plan, and for PEBP is Damon Haycock.

MR. HAYCOCK: Thank you, Madam Chair. Damon Haycock for the record.

For the last couple of rate approval Board meetings, I presented a singular option that was pretty amenable I think to the Board and to the membership. We either flattened rates or lowered them. So there wasn't really a lot of contradiction or conflict in that process. However, we want to make sure that we present all options to the Board and we wanted to do the work ahead of time because there is some philosophical ideals that are assigned to how

rates should be approved, and today we have three different options that I will go into detail.

But just to preface why the rates are looking the way they are, we do see low inflation on medical and dental costs, but we have experienced very high pharmacy inflation, right, on the Consumer Driven Health Plan. And so when we talk about overall rates, that is the rate before the member and the employer contribute to the cost.

So you start with an overall rate and then you carve it into what the employer or what the state is going to pay and then what the employee or retiree is going to pay, and that's called a premium. We like to use the word rate for premiums to make them interchangeable but for the purposes of today, we want to keep them separate because there are a couple of things that the Board need to improve that are indistinct of those terms.

So in the executive summary on page two of the presentation, we outlined three different options. We tried to make them pretty simple. The first option is to go back to a pretty standard contribution philosophy that was implemented before I came to PEBP and when I continued my very first rate setting in 2016 which was approximately, not approximately which was 93 percent of that overall rate is -- is contributed by the employer and 64 percent -- for the

employee, and 64 percent of that rate is contributed by the employer for the retiree.

What that would do if we were to implement that philosophy today would be to increase premiums for all employees on all plans and increase for retirees on the CDHP. However, due to the way that the rates are developed, it would still be a decrease to rates for retirees on the HMO and EPO plans. I know it's kind of wonkey that way but that's how it shook out.

Option two is taking what we have approved as the contribution level in last year in 2018 and giving another small increase due to available Governor's recommended total dollar funds. So last year I believe we were at 94.5 percent in contribution level, and we are suggesting in this option a 95.1 percent for employees and taking it from I believe we're at about 65 or 66 last year and just increasing it slightly to 66.4 for the retirees.

What does that do for the premiums, for the actual cost that the members have to pay is it flatten those rates on the Consumer Driven Health Plan and it decreases those premiums, I got to stop using those words, the premiums on the HMO and EPO plan, and we'll go into this so you don't have to kind of collect notes later in the presentation.

And then the final option is using the philosophy

that PEBP has provided this Board for the last two years which is use all available funding which was approved in the budget, and that's taking the contribution levels and increasing them again to meet what the employer subsidy is in the current Governor's Recommended Budget today going to the legislature. That takes it up to the employee even higher to 96.3 percent. It doesn't change the retiree side because that's maximized to the most amount of money available.

However, what that does is it decreases premiums for employees on all plans. It does stay flat for retirees on the Consumer Driven Health Plan, very similar to option two because it's the same level, and it decreases it for retirees on the HMO and EPO plans. I know it's like a firehose so we're going to go into this little by little.

So today we're going to talk about briefly how we develop rates, the methodology, input, experience, plan tiers for coverage, suggested population and then those optional contribution percentages which I just highlighted above. Then we're going to talk about the overall rates. Those are the rates that our actuaries must attest that are actuarial sound. And then what are the optional state employee rates or premiums that are attributed to the contribution levels that the Board will approve today for state employees and for state and non-state retirees. It's on page four and

ultimately Board approval which is at the end.

So we develop rates the same way every year. This is a similar slide you've seen for the last two years, but we take the experience, that's the utilization of our members on our plan for healthcare activities, and then we figure out with our actuaries, we add to that what do we think that's going to trend forward. And when I mean experience, that is not only the utilization by our members but also the unit cost inflation. What do we think the cost of inflation will go up on a unit basis and how many people we think are going to use those increased costs. That turns out to be the basis. That is totally predicated on the claims or the actual services being provided to our members.

Then we take those base rates and we add administrative costs, and those can be anything from paying rent and salaries, travel, training to also paying for our vendors, their admin fees, our other premiums for like life insurance. It encompasses the totality of things that aren't directly associated with those medical and pharmacy and dental claims.

Also, if our reserves are projected to need to increase, and I'm not talking excess reserves, I'm talking incurred but not reported reserves or the catastrophic reserves based on experience, we will often have to build

that into the rate as an increase to rates.

But when we have excess reserves, we backfill which is by the way what we have been doing for the last few years with excess reserves is backfilling any other additional reserve increase, and our actuaries determine those through actuarial science.

So then we get the overall rating. That's the total cost of the plan, and it is separated out by tier coverage and by plan. That's what PEBP believes we need to collect in totality to pay all of our bills appropriately.

Then we take that overall rate and we figure out what the employer contribution or the subsidy as it is called in the legislative bill, what that is going to be, how much of that -- how much of that share the employer is going to pay and we -- and whatever is left over is what the member is going to pay in their premiums based on their tier of coverage. So if they are an employee only, they have a certain tier. If they are an employee plus spouse, we'll get into that shortly, but that's the basic of how we develop rates every year.

So what are the inputs? What are the things that we have to put into our rate development process? Well, we have to come up with and hopefully hone down the legislatively requested employer contribution for the next

fiscal year.

So just to give a history lesson, when the -- for employees we asked for, when it was all said and done and back into this number, we asked for $772 with our agency request from employees back in August of last year.

When the Governor's Recommended Budget was introduced, that number was reduced to $757.83. There's a myriad of reasons why. Most importantly our inflation assumptions were reduced to be more aligned with Medicaid and with the department of corrections. For those of you that were at the January Board meeting, we have a report out there that we presented and people can see it today that goes over the gap between what we requested and what was in the Governor's budget. So those numbers are the numbers hopefully you've all seen multiple times.

However, today's rate approval, we have three options. Option one, again, which is going back to that lesser contribution amount actually drops the contribution level down to $732.75. Option two drops it down to $747.75, and option three uses the entire available funding as described earlier.

On the pre-Medicare retiree side, we requested $472 back in August. We did not request funding shortfall that was in our system in conversations with the Governor's

Finance Office and the Legislative Council Bureau, we have seen the error of our ways and need to ensure that we fund that. That's how it went from 472 to 522.68. So today's approval really only had two options because the two -- option two and option three did not increase the contribution level so we're either at 5.968 which is a small increase or 5.4670 which is a larger increase.

Why is there an increase to the Governor's Recommended Budget? We have already worked with the Governor's Finance Office and Legislative Council Bureau to ensure that the shortfall is accurately reflected and that we -- we have updated years of service calculations, so we can ensure that we pay people in accordance with their years of service, right. That we allow them those premium reductions. So those are the inputs on the employer contribution side.

We have updated population. We are constantly looking at our population to look at a point in time projecting forward. We look at our experience again, and then we look at the plan design. So as the Board makes plan design changes, it will effect rates.

The population was updated for this. The experience we've already had. We got in our base rates from our actuaries, and the plan design as you had approved it

November 29th was already put in place. So -- so most of these inputs were ready at the time we were developing these rates.

So just to highlight on page seven here, this is what we got from our actuaries at Aon. This is the projected increase to experience. Again, that's the inflation, the unit cost and how many people are going to use that, and they figured out how much are costs going to increase just to cover claims by themselves.

A couple of highlighted pieces, if you look at state and let me back up. The reason why state employees and retirees are separate from non-state employees and retirees is because that is legislatively required risk cool. We are legislatively required to develop two risk pools and rate them separately. So they are combined into --the employees and retirees are combined, but they are also separated based on if they are state or local government.

So on the Consumer Driven Health Plan you'll see that one of the biggest numbers shooting out there is pharmacy at 16.19 percent but an overall increase of 4.35 percent. If you remember back in January we presented to you the Governor's Recommended Budget and they provided us with an assumption that we would be able to be held to 3.7 percent. So this is a little bit higher.

However, on the EPO plan that plan was rated conservatively. It was the very first year. We still don't know how it's going to turn out but all points -- all data is pointing that we -- it appears on the medical side, we're actually going to do better than what we initially rated the plan. Pharmacy is still up 5.34 percent. So overall it's just about flat.

You'll see on the HPN side, we get a renewal from the Health Plan Nevada every year. They give us a singular renewal for medical and pharmacy benefits combined, and then we add our dental benefits that we provide to it and our admin costs and that's how we come up with those rates.

You'll see two numbers there on the end. One is zero percent and one is 3.7 percent. Those are not medical and RX separate. Those are the two options that were provided by Health Plan Nevada. Health Plan Nevada, as the good partners as they are, back in November of last year provided us with an initial renewal of about four percent, if I remember correctly.

Then the Governor's Recommended Budget was being built. We were told we were going to be held to 3.7. So I went back to Health Plan Nevada and asked would they lower their rates to meet the Governor's Recommended Budget and as good partners, they said yes.

Well, as we were building the rates for the Consumer Driven Health Plan, the EPO plan, we saw there was an opportunity to keep premiums low or even lower them, we then reached back out to them and said are you interested in looking at your rates again. And they said if you are willing to lower the members share so we don't lose anymore members out of our plan, we'll cut those rates even further down and cut it to flat.

Now, that honestly, and I'll put my neck out there, I won't make my actuaries do it, but all of the data points to that that is not actuarial sound and they are potentially going to lose money next year on this program. And so why are they doing this? Well, they have hundreds of thousands of folks and they are a business and they can do some balancing, but they want to be good partners with the State of Nevada and they recognize that if we're willing to put the contribution toward the HMO plan that the member should get benefit the most, and so they have done this two years in a row.

They went I think flat for us or no, negative eight for us last year, and this year they are flattening even though all actuarial points to an increase in rates, that what's their experience is. That's why you keep up with those.

So you see on the map state employees and retirees are much different. Story a lot higher. Across, although HPN is still agreeing to honor it across the board for their rates. You're seeing that our non-state employees which I believe I think there's seven or eight of them at this point, and our retires which is about 1,200 are driving up some of those cost but compared to the total totality of the plans, they are not sending the plans into a tailspin, right.

Thanks to efforts last session rates aren't going up dramatically for the non-state folks because of the balancing that was done in the appropriations bill. I'll talk about that a little bit later.

So slide eight is something we've been doing forever, I think back in 2011, how do we determine what tier pays what. So there's a cost for -- an average cost for an adult and for adults that have spouses or domestic partners, we double that. For those that have children and no spouses or domestic partners, we come up with an average cost for children and add that to the adult cost. And then for adults and a family that includes a spouse or domestic partner and children, it's two times the participant level and plus the cost for children.

That right there is just a fancy formula for how

we tier out what the contributions are and what members are paying on our plan. It's been the same I believe at least since 2011 if not before.

Then the next slide is population. We have a modest population increase that we've been seeing year over year. It's about two percent. That's what we're anticipating. We have got no additional information that there's going to be a massive hiring or reduction in positions that the Governor's Recommended Budget, and so we have taken a multi year lookback and projected for based on conversations, of course, with those entities to ensure we're not overinflating or under-inflating the population.

Last but not least is the page ten, are those contribution percentages. So I've restated them here in this table, the 93 percent option one, the 95.1 percent option two, the 96.3 percent option three, these are for employees. And then retirees, either the 64 or the 66.4. So you'll see that the HMO/EPO plan has about a 12 -- it's really 12 and a half percent. I probably should have kicked out the decimals a few, a little bit further on the option one, but we have reduced the spread between the PPO or the Consumer Driven Health Plan and the HMO traditional product. It used to be a 15 percent spread difference in premiums, and we've reduced it over the years to make it a little bit more affordable for

our members.

So in 2017 we reduced it to 14 percent. I believe in 2018 it was somewhere closer to 13, and now we're down to 12 and a half.

We also have a dependent subsidization policy, that they are subsidized 20 percent less than the primary participant so that stuff isn't new. We just want to transparently show how we back into and come up with all of these rates.

So what are the overall rates? One of the recommendations today will be for you to approve the overall rates, and the overall rates on page 11 is the cost to the program before we get any premiums from the member or we get any contributions from the state. This is the overall total rate to make this plan solvent.

It's broken out by state employees, state retirees and non-state retirees, and you'll notice very quickly that the state retirees are about $20 less, and the reason they're $20 less isn't because they are using healthcare less or that they are less expensive, but it's because they don't pay certain administrative costs, like long term disability premiums and their life insurance premiums are a reduced level, right. The state retirees get 25,000 and the retirees -- excuse me, the state employees get

25,000, and the retirees get 12,500, which is half, so their premiums are less. That's why you see that smaller number.

But those are the numbers that we get from well, they initially start from Aon and then we add our administrative load, and then we pitch it back to our actuaries to verify that it is still actuarial sound which it is.

Normally we would show you what the overall rate is, what the subsidy is and what the members premium is in one table because we have normally been providing you with one rate option. If we were to do this on every rate option, this presentation would be about 30 pages, and we didn't want to saturate you with too many numbers so that's why we separated out the overall rates today.

But moving towards the premiums, this is what everybody shows up to the meeting for, right. They want to see what their premiums are going to be like next year. We matched member premiums to what is current. PY19 is for plan year '19. What option one would do to the premiums, what option two would do to the premiums and what option three would do to the overall premiums, and we do it for both the statewide PPO, our Consumer Driven Health Plan, as well as the PEBP Premier Plan and the HMO plan, recognizing that those plans are married together and they are blended rates.

So picking on a couple of numbers here for the employees first, that's on page 12, today, a single employee pays 31.73. Option one would increase their rates or their premiums to 42.45. Option two keeps them flat to the penny. And option three reduces them another almost $9.

On the HMO/EPO plan today, that single employee is paying $142.43 in monthly premiums. Option one would increase it by about $9. Option two would decrease it by about five. And option three would decrease it by somewhere around 16 -- $14, $16, and so you have some decisions to make on how you want to apply the employer contribution.

On page 13, we show you what the state and non-state retirees premiums are. Remember last session, the legislature solved the problem of the unsustainable non-state retiree premium hike every year. And what they stated in the bill that got approved was non-state retirees must not pay more in their monthly premiums than a similarly situated state retiree with the same years of service.

And that the Delta, the difference between the actual cost and making that balancing effort would be cost shared between the state through general fund appropriations and the local government employer, and it had a tiered structure. So at the beginning it was 100 percent by the state, and this year it's 75 by the state. And when these

rates get approval it's now 50 percent by the state and 50 percent by local government and 25 in the last year of the biennium. And moving forward, it's 100 percent funded by the local employers. That's how the bill was written.

So regardless of the non-state populations cost and risk increase, their premiums will never be higher than a similarly situated state retiree unless the legislature goes back and changes the law.

So what does it look like for state and non-state retiree premiums? Please recognize this is reflecting 15 years of service. There is more subsidy if you get up to 20 years, and there is less if you go down from 15. It is based on a tiered structure, has been like that forever at PEBP. But you'll see that today on the Consumer Driven Health Plan, it's almost $200 for a single retiree. It jumps up about $10 on option one. It stays flat for options two and three.

On the HMO/EPO plan, similar story, $379. It does go down about seven, maybe $6.50, but it goes down even further on option two and three. And, again, the HMO/EPO plan is reducing in overall costs which is driving the reduction in premiums. Compared to the Consumer Driven Health Plan which is increasing its overall cost which is either flattening the premiums if we apply the available

contributions or it increases them in option one.

So the last part, of course, is Board approval which is to approve the plan year rates as presented. That was those overall rates. That is what we have worked with our actuaries. That is on page 11. And then you all have a decision to make on which option you want to fund through the available employer contributions.

To select and improve the levels in the employee retiree premiums and please allow us to make technical adjustments if I fat fingered something or I missed a penny here or there, we may need to adjust. There's also adjustments that could occur if last second legislative things, like additional salaries or whatever that drives up anything else. I don't think salaries are going to effect this but that's a bad example, but we would like to make a couple of small technical adjustments.

Now, what does PEBP think you should do? I didn't put it into this recommendation on employer contributions and subsidy levels because there are actually pretty good arguments for all three. I think the, in my opinion, and I'll take this as a Damon recommendation instead of a PEBP recommendation. Recommendation three is probably the most dangerous because I believe it's unsustainable. And in insurance if the costs go up, you would assume that rates

would go up and premiums would go up, and that happens pretty equally across the board across the nation.

So if we take every dollar that was available in the Governor's Recommended Budget which their budget wasn't built on all of my latest contract commitments that reduce costs, we would then be lowering rates across the board for folks or almost across the board for folks that there's a high probability we would be raising them the next year, and the sticker shock would just bounce it back again.

If you remember in 2000, I think it was 2014, Nancy, correct me if I'm wrong, we actually used excess reserves to enhance the rates for the HMO plan because they were getting too high. It might have been 2013. It was right around there, and the next year we couldn't do it again, and those rates shot way up. It was a slingshot effect of potentially a difficult time for our members to increase the rates.

And so as much as I love to come here and say I found money and there's money in the budget, let's lower rates for everybody, we also have to look at long term sustainability and solvency for this program and for this plan and as you heard throughout today, we cannot expect to have excellent years, excess reserves and a boom of an economy forever. What is the long term sustainability of the

fiduciary responsibilities of the Board, right, that's what you guys have to decide.

Option two where it flattens rates on the Consumer Driven Health Plan or premiums for the members and on the employees on all of the plans, on the Consumer Driven Health Plan, excuse me, and then it lowers them for employees and retirees on the HMO/EPO plans. We feel that that is kind of a middle ground. It's still giving some of the contribution back to the state. It's still keeping rates flat or lowering them. It's still somewhat sustainable. It's leveraging the cost savings that we've been able to provide and going back to my theme at an earlier -- earlier agenda item, everybody wins. Everybody wins in the option two.

Option one is the most conservative option, and there are really good arguments for option one that the plan is continuing to increase its contribution level every year. That we were at 93 percent, 64 percent for many years, and then we went to 93 and a half in 2017 and 94 and a half I believe in 2018, and now we're looking at potentially going up to 95. And is that a sustainable model? What's going to -- should we expect to continue to go up a point or half a point every year? And can we offset that rate again contractual savings that we, as Ms. Lamborn said, know that

the well is getting dry. So there's a fiscally long term option out there in option one.

So if PEBP were to make a recommend -- and we are, PEBP, our recommendation today in priority order of these three is we believe we can sustain the plan with option two. Our next option that we would recommend would be the more fiscally sound one of, sorry, more fiscally conservative one of option one, and our last recommendation would be to lower rates across the board that we feel are unsustainable.

And with that, Madam Chair, I'll take any questions.

CHAIRWOMAN CONTINE: Okay. Is there any -- are there any questions for Damon? Ms. Lamborn?

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

Damon, explain to me, I got a little confused on the lowering and then the sticker shock of the next year with potential to increase, did we not get a 3.7 inflation in both years of the budget?

MR. HAYCOCK: For the record Damon Haycock.

Excellent question, Ms. Lamborn. And, yes, on the Consumer Driven Health Plan and the HMO/EPO plan, we got a 3 -- today the budget shows a 3.7 percent inflation. However, if you remember back to the experience slide, we're

at 4.5 at the Consumer Driven Health Plan with a pharmacy benefit that's almost 17 percent.

MEMBER LAMBORN: Okay.

MR. HAYCOCK: And so the idea is is 3.7 really fair on the Consumer Driven Health Plan? Is it fair on HMO/EPO plan? I know that our partners down south had an actuarial reason to be higher than that and, again, they are partnering this year but how many more years can we ask them to take -- potentially take a loss in supporting of this program moving forward.

MEMBER LAMBORN: Okay, got it. Thank you.

CHAIRWOMAN CONTINE: Any other questions or? Mr. Verducci?

MEMBER VERDUCCI: Thank you, Madam Chair.

You know, my comment would be I think option two looks the most reasonable compromise. It shows some goodwill to the state, and I believe that would be the right decision for the Board to make.

CHAIRWOMAN CONTINE: Anyone else? So I have a question.

In terms of what you want us to approve, this is just one of the -- this is just one of the options, and then we have to look at the other because some of them just have an option one and an option two or three. So do you want to

talk about those at all or?

MR. HAYCOCK: Yeah, for the record Damon Haycock. Thank you, Madam Chair.

So the first request is that you approve the original rate before we do anything to it, right, before we determine who pays what. That's on slide 11. That is adhering we believe to NRS 287.043 that says you will fund the program on an actuarial sound basis, right, so that checks that box.

Then the second thing we're asking you to do is to select one of those options. And in a nutshell option one reduces the employer contribution percentage that we have today to tomorrow, right, and those types, so I'll stop there.

CHAIRWOMAN CONTINE: So each of those options applies to the different groups?

MR. HAYCOCK: Yes.

CHAIRWOMAN CONTINE: Okay. And then I just had another quick question. Even though the one -- it's not actuarial sound, the costs that you talked about from that -- on the one plan, it is for us because they are guaranteeing to us a certain amount and then they are going -- they are going to deal with it if it's -- if it turns out not to be a good deal?

MR. HAYCOCK: For the record Damon Haycock.

Precisely, they absorb the risk in setting the premiums or the total rates that we will pay them. They live and die on those. We don't have to do anything about that.

CHAIRWOMAN CONTINE: Okay. Is there any other questions or discussion on -- so we would essentially have two motions or do you want them together or how, a motion to approve the rates on slide 11 and then determination of the options for the contributions?

MR. HAYCOCK: For the record Damon Haycock.

I think it's your choice that you can put it on one big motion or you can take separate, right. I think for open meeting law or even not even move for one of them and just do the other. I mean, really it's your call. We just wanted to present them to you transparently.

CHAIRWOMAN CONTINE: Okay.

MR. HAYCOCK: So you can either say we understand these premiums incorporate these rates. It's understood or however.

CHAIRWOMAN CONTINE: So let's do -- so I think we'll do it on the just approving the option because that incorporates the rates. So if there's -- yeah, I was going to say -- I was trying to. If there's no other Board comment or questions, public comment, please.

MS. BOWEN: My name and words for the record Peggy, P-e-g-g-y space Lear, L-e-a-r space Bowen, B-o-w-e-n, b as in boy.

I have several comments, but I need to bring this back to the fact that this has never been put out to bid. The -- way back in 2011 and prior to that that we need to have in order to get the best bang for our buck, not to discuss just what -- what Hometown Health and the others are doing, but we literally need to talk about going out to bid and having a fair and open transparent situation.

I would like to put the group on notice that I do believe that we are in potential violation of not exactly the law but the intent of the law for the open meeting that in order for people to attend this meeting, I don't believe the Governor or based on what I'm seeing and how it's being done, I don't believe anyone can access this meeting from outside of this room, and I don't believe that the packets could be mailed because no money has been provided for the mailing of packets the way they used to be given to every department head so the department would have input as to what the employees, active employees needed for their insurance benefit and what the retired employees need for their insurance benefits and for the orphans, which is the nickname I gave to those who said we didn't fit here, we didn't fit

here but we're part of the insurance because the school district, being involved in the school district.

And I know there's a three-minute time limit and I appreciate that but, in fact, your survey, I was never surveyed. Your survey was sent to certain people as determined by whoever sent out the survey. What was supposed to take place is they were to get a group together to put together the survey questions because it's what you ask and what response, and I don't believe that the benefits and what is being -- what has been going on has been -- it's not misrepresented based on the survey that went out, but I don't think it was the survey of the entire population, and you can send it with the PERS check or however you want to, that avenue is open to you to ask people what it is they want for their insurance.

And -- and if you're asking us to pay for things and be part of things in the premium things, then you should ask us what it is we want, what it is we need and not focus just on what the pharmaceuticals are doing.

And I think that way too much orientation toward Renown which does a good job but the point is there are people who are living three miles from Churchill County Hospital. It's not the expense of the program you should consider. It's the expense to us that travel, the getting

the rooms to put up the family, the doing everything coming back and forth and what those hospitals were actually offering and were discounted and to be included and to look at what Southern Nevada wanted in regards to more equalization and more standardization.

Thank you very much, and I assume I've just met my time limit.

CHAIRWOMAN CONTINE: Well, I was just going to say we're talking about the rate item and I just didn't want you to run out of time if you had anything to say about the rate.

MS. BOWEN: So the rates themselves are not as accurate as they seem. They thought they took care of the problems with the orphans which the legislature did the best to do. But when it comes to adding different things and making available the dental program and the hearing aid and all that kind of stuff --

CHAIRWOMAN CONTINE: Okay.

MS. BOWEN: What we have here is an insurance company whom holds into trust or holds into reserve -- I'm sorry, I've had a concussion and a minor stroke, and I'm doing the best I can. The reserves keep going no matter what.

And when you're talking about rates, you need to

take a look at those reserves that continue to grow and the person who holds the reserve, the company that holds the reserve is getting the interest on the reserves, and it just sort of works out that the interest that -- the amount of money that Aon and everybody would have earned is getting it in interest on the reserves instead of the state taking back their own program and handling it for themselves and make it Nevada's again instead of insurance companies making the profits instead of your employees having the benefits of their monies and what it is earning.

CHAIRWOMAN CONTINE: Thank you. I'm going to cut you off now.

MS. BOWEN: Nevada needs to take back Nevada's program.

CHAIRWOMAN CONTINE: Thank you. I appreciate all your input.

MS. BOWEN: Thank you very much.

MR. ERVIN: Kent Ervin for the record, E-r-v-i-n, representing the Nevada Faculty Alliance, all eight NSHE institutions.

This is the first time I recall ever at a rate setting meetings where we were talking about during session where we were talking about giving money back compared to what was already in the Governor's Recommended Budget. So I

would just like to ask the question, well, how much are we giving back for each of the options? What are those dollar amounts because that's a savings to the state.

We've talked about in the previous discussion about what is doing best for everyone, what's doing best for everyone to lower the employer/employee premiums. That's certainly the broadest way to adjust things for everyone, and it means they have more of their take-home pay if they choose to put that in an HSA they can and get those tax benefits. As far as the three options, of course, we would favor option three because it does that.

We understand the compromise of option two. It's a relatively recent phenomenon though that these percentages were set in these tiers. Before 2011, this Board actually did look at each tier. They were rated separately. That was not a great idea, and they were adjusted. The premiums were adjusted separately because one year because of the rating children would go up, and another year spouses would go up, and this is a much better system where there's one knob of this percentage.

However, it was never meant to be, as I recall those early discussions when it started being expressed as a percentage, the idea was to do the one times two times or two times plus Y as no knobs there, and the only knob was between

how much the state was going to pay and how much participant has to pay which before 2011 most years was zero what participants paid for a single employee which is what other local governments typically had. Admittedly, the state is very good to dependents. Thank you.

CHAIRWOMAN CONTINE: Thank you.

MR. UNGER: Doug Unger, U-n-g-e-r, Chair, Faculty Chair of the Council of Faculty Senate Chairs, the elected representative of all 7,000 faculty in the Nevada System of Higher Education.

There's an old adage that you probably shouldn't set healthcare policy based on political considerations but, of course, that's what we do. We set up -- we set our policy based on political considerations. Please know that we expected an improvement this year with the economy being so relatively good and looking forward toward to the future of this plan we expected an improvement.

Should this Board vote to increase rates and then next year remove HSA/HRA funding from the $400 that you have already approved for next year, it will be very politically and unwise for the current administration, and I don't think the Governor's office will be very happy with that, neither will Nevada Faculty.

I would recommend option three, lowering rates.

That allows for some sense of an improved plan. And if rates need to be raised a little bit later, maybe you raise them to the flat rate in option two, either that or fall back on option two and keep rates flat. Please just don't raise rates. If you raise rates and remove HRA/HSA contributions next year, there's going to be a human cry against PEBP and many complaints, and I don't think it will be viable politically into the future. Thank you.

MS. LAIRD: My name is Terry Laird. I'm the executive director at the Retired Public Employees Nevada, RPEN, and we'll go on the record as being in favor of option two for the same reasons as expressed by Mr. Verducci. Thank you.

CHAIRWOMAN CONTINE: Anybody else? Is there any public comments in Southern Nevada?

MEMBER ZACK: We have none.

MS. LANDRY: Is there any other discussion by the Board or is anyone prepared to make a motion or?

I guess I would say that I think Damon laid it out well in the various policy considerations behind the various options. I think -- you know, I don't think anybody wants to raise rates, but I think again being fiscally, I don't want to say conservative but, you know, being fiscally smart, having an option like two as opposed to three where

we're not essentially overextending, and I know -- and I know everybody, and I appreciate that everybody feels like where we are right now is in a really good place, but I think we've had several good years and the program has done some good things.

And I just, you know, what they say, there's a recession every ten years or seven years or eight years and we're -- we're kind of getting to the point growth is slowing down and all the things I mentioned when we did the other agenda item.

You know, I think the Governor is interested in providing our employees with the best possible plan, including a plan that's affordable and that provides good coverage, but also we have to keep in mind the fiscal ramifications of that and where we are now, and where we might be in two years or four years might be different.

And I appreciate the comments of Ms. Fox and Ms. Lamborn about all of the magic that Damon has been able to create, and I have a lot of faith in him, but I feel like some of that could be slowed down as well.

So with that, would somebody like to make a motion to approve an option? Do you have something, Christine?

MEMBER ZACK: Yes, Chair Contine. I move to

accept staff's recommendation to do option number two.

CHAIRWOMAN CONTINE: Okay. Thank you. And can we have in that to allow staff to make all of the technical changes they need to make.

MEMBER ZACK: Amend it to add and allow staff to make all technical changes they need to make.

CHAIRWOMAN CONTINE: Thank you.

MEMBER VERDUCCI: Tom Verducci. I would like to second the motion.

CHAIRWOMAN CONTINE: Okay. I have a motion and a second. All those in favor, eye.

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

CHAIRWOMAN CONTINE: Yeah, I think that was the discussion we had earlier that encompasses those.

MEMBER LAMBORN: Got it.

CHAIRWOMAN CONTINE: So we can go ahead onto Item Number Ten, approval of the proposed changes to the CDHP and EPO Master Plan documents for Plan Year 2020 for medical, dental, life, long term disability benefits for enrollment and eligibility rules and for privacy and security requirements to reflect previously approved plan changes or plan design modifications, changes in legislative or regulatory requirements and technical corrections or updates.

Nancy Spinelli.

MS. SPINELLI: Thank you, Madam Chair. I'm Nancy Spinelli, quality control officer.

This report provides revisions to the Plan Year 2020 Master Plan Documents, including Board approved plan design changes and staff and vendor recommendations to plan design for the PPO or the CDHP and the Premier EPO Plan, and the purpose of these plan design changes is to standardize the benefits across the HPN, EPO somewhat on the CDHP.

So the table on the report here, it shows the Board decisions. We have four. We're going to review those very briefly. And then the compliance and audit table there, we've got nine there. Last summer we had a compliance audit with Aon, and they provided some recommendations that we needed to insert into the MPD's so we've inserted those based on the recommendations.

The housekeeping, that's just formatting, grammar and things like that.

And then the PEBP partner recommendations, we -- when we update these plan documents, every year we get feedback from HealthSCOPE Benefits. Their team is great. They read from cover to cover in those documents, and they provide all of their recommendations. We also get recommendations from ESI and then Hometown Health, our

utilization management and case management company. We get recommendations from the chief medical officer, and then now beginning July 1st we will have American Health Holdings as our new UMC vendor and they have provided some recommendations as well.

So we're going to go through those, starting with the Premier Plan. The table at the top, these are the previously approved Board plan design changes from November and January. And a couple of things I want to point out here is on the table, row number A, the 25 dollar co-pay, that changed to a 20 dollar co-pay beginning July 1st, and then the specialist visit will change from a 45 dollar co-pay to a 40 dollar co-pay.

And then the table down below and Item Number Two, these are the additional recommended changes by staff and then our vendor partners, and one of the things that we looked at is by changing that primary care co-pay from a 25 dollar co-pay to a 20, it also impacted other types of services which for example, the Home Healthcare, the outpatient, the occupational therapy, physical therapy and what am I missing here, speech therapy, sorry, speech therapy, occupational therapy and physical therapy, that co-pay currently on the EPO plan is a 25 dollar co-pay, and we wanted to align that with the primary care physician care

co-pay and reduce that to a 20 dollar co-pay for visit.

For chiropractic visits, currently on the EPO plan or the maximum lifetime benefit for chiropractic visits is 100, and we actually brought that over from the HMO plan because we somewhat mirrored that plan this last July, and we would like to change that to align with HPN's benefit and retain the 20 visits per plan year but eliminate the lifetime maximum for chiropractic visits.

And then the Doctor On Demand, the psychologist visit is a 25 dollar co-pay and the psychiatrist visit is also a 25 dollar co-pay, and we would like to align that with the primary care co-pay on the -- for July 1st and change those to $20 each.

The home healthcare visits on the current EPO plan are limited to 30 visits per plan year, and we would like to increase those visits to mirror the CDHP plan from 30 to 60 beginning July 1st.

Hospice services, I know this was kind of a hot topic over this past week. We heard some feedback from our advocacy groups. The EPO plan currently as lifetime maximum of 185 days on hospice services, and it requires a pre-cert prior to accessing those services, and there's a zero co-pay. And what we would like to do is change this benefit to mirror HPN, closely mirror HPN and insert a 500 dollar co-pay for

inpatient, outpatient hospice one time co-pay, and what we'll do is eliminate the pre-certification process at the initial start of hospice and then when it -- when they get near the 185 days at that point then we will want to pre-cert it going forward.

And the reason for that there's a cost for all of those pre-certifications, and we want to reduce that burden on the members and the cost to the program, and they are typically approved as medically necessary. So the pre-cert would be at the end of the 185 days.

And then hearing aids, the current plan does not cover hearing aids, and we know there's a bill out there with the legislature to provide hearing aid coverage. We currently provide hearing aids on the CDHP, and there's a 1,500 dollar maximum limit per hearing aid per plan year, and you have to have a 50 percent hearing loss, and we would like to add that benefit to the EPO plan mirror HPN. HPN's co-pay is zero. So they have a very good hearing aid benefit, but we would like to implement a 25 dollar co-pay for hearing aid and then also have the 1,500 dollar limit per year.

On page three for the obesity care management program, there's weight loss medications that are available. Currently the plan covers both long term and short-term weight loss medications, and beginning July 1st we would like

to eliminate coverage for long term weight loss medication and only cover generic weight loss medications.

Varicose vein treatment, this is a benefit that's covered under the CDHP when medically necessary. The current EPO plans exclude that benefit, and so we would like to mirror the HP or CDHP plan and then also implement a preauthorization requirement for that benefit.

MS. BOWEN: Which one was that one?

MS. SPINELLI: That's varicose veins.

And then on C on page three, the healthy diet and physical activity, counseling and obesity, screening, counseling, this is a benefit that is recommended by the United States Preventative Services Task Force for adults ages 18 and older and they have to have a BMI over 30 and then additional cardiovascular disease factors. The current MPD provides coverage at 100 percent for this benefit.

And what we would like to do is incorporate a three-visit limit to be paid at 100 percent and anything after that three visit limit would be cost sharing unless the individual is enrolled in our obesity care management program.

And I will say this is, when we get to the CDHP revisions, this three-visit limit was actually approved by the PEBP Board in December of 2011, and we did have that as a

limitation in the plan document. And then at some point a few years ago, somehow that limitation got removed, but it should still apply. So we would like to go ahead and put that in effective July 1st.

For screening colonoscopies, the current benefit provides the coverage for the first colonoscopy for the plan year to be paid at 100 percent regardless of the diagnosis and regardless of the age.

And what we would like to do is implement the American Cancer Society's guidelines for colonoscopies and that would be for an individual with a family history of colon cancer. It would start at age 40 and without colon cancer or family history, they would begin at age 45, and they would be eligible either at 40 if they have a family history. Every five years they would eligible for another colonoscopy. And without a family history, it would be a rolling ten years, and those would be paid at 100 percent.

For screening mammograms, the plan currently pays the same thing. A mammogram would be covered first of the plan year at 100 percent regardless of the diagnosis and regardless of the age. So we want to follow the US -- USPSTF task force recommendations to allow screening mammograms. Those would be 3D or 2D covered under the benefit at 100 percent based on the age and frequency guidelines.

Other changes that we made to the EPO plan document, we revised the list of services that would require pre-certification and this list was recommended by American Health Holdings. Many of the outpatient services have, we've eliminated pre-certification for those because we -- the value and going through that pre-certification process and the burden and the delay in receiving services for our members, the value isn't there and so they are typically approved as medically necessary. So we've eliminated those, and we are following American Health Holdings pre-certification list.

The 3B, this is something that staff thought we should add or exclusion for marijuana. We expanded the marijuana exclusion language to include any derivative including CBD, TCH and edibles.

And then C, this is a benefit clarification in the EPO plan. We wanted to add the 20 dollar co-pay per visit for the outpatient, intensive outpatient program and partial hospitalization services.

For 3D, this is, came out of the compliance review. This is basically a statement that we have to include in the plan document that says that the PEBP plan sponsor certifies that we appropriately safeguard the use and disclosure of plan participants information.

And then E, that's a definition change for the Nevada Revised Statute and so we've added that to the plan document.

And then the last one that is just, again, that's just the housekeeping items.

So if you don't have any questions, I will move onto the Consumer Driven Health Plan.

CHAIRWOMAN CONTINE: Why don't we stop for just a moment, and we can ask questions on that one and maybe questions will get answered.

MS. SPINELLI: Sure.

CHAIRWOMAN CONTINE: Does anyone have any questions on the changes in number two and three? Mr. Packham?

MEMBER PACKHAM: Yes, John Packham for the record.

I was just kind of curious, this is my second time around on March meeting master plan changes and last time -- last year at this time when we did this, they were mostly housekeeping, and it seems like that is flipped now.

I just was wondering, given the number and maybe I can ask this at the end of your presentation, is there like a ballpark cost or cost savings estimate of all of these changes they have seen? Just the volume of them makes me

wonder.

MS. SPINELLI: Yeah, you know -- and, Damon, you can jump in and answer this obviously because you're more the financial side.

But we currently cover most of these benefits. The only thing, the co-pay reduction from the 25 dollar co-pay to 20 dollar co-pay, I don't think that that would have a very big impact on the plan.

The hearing aids, that will have some impact, but I don't think it will be major. Mary Catherine, you may have some input on that.

MR. HAYCOCK: For the record Damon Haycock.

Let me kind of segue in here. Since we're only talking about the EPO plan, first let's kind of carve that out.

MEMBER PACKHAM: Uh-huh.

MR. HAYCOCK: Outside of what was already approved by the Board, there's six increases to benefits, one decrease which is the long term drugs for weight loss and three clarifications, right. And these increased benefits, most of them are just a lower deductible, right. We're having hearing aids, as Ms. Spinelli said, and we're going to cover varicose vein treatment. It's not the major drivers of utilization. It's not going to break this plan.

We want to make sure that we continue to incentivize folks to seek the right care or more importantly not dis-incentivize them. I know that's a double negative but when it's cheaper to go to a primary care physician than to go to some of these other -- other things that are similar enough, we want to make sure that we're being consistent in what we're charging, but the co-pays themselves aren't going to make or break this plan, at least on the EPO side.

As we're learning, right. We have six months of data under our belt even though we're about seven, almost eight months into this plan. We want to make sure that when we -- when I get up here and say I'm going to make the plans the same, north and south, that we do that as much as possible as well. So that a member that exists in Northern Nevada as the same or similar situated job in Southern Nevada that they have access to the same types of plans and the same types of benefits.

So we'll never be able to get perfect with our Southern Nevada cohort. I wish I could sign capitated contracts. If you can help me do that, I'll take it. But what we will be able to do is get as close as we can on most of these benefits which is really the primary focus of today.

We're not trying to take benefits. Most of the time we're trying to give benefits but where it makes sense,

we make alterations in time so that they can be material to our -- to our costs. But, no, we don't have a total dollar figure for you today because it's still just too premature on that plan.

MEMBER PACKHAM: John Packham for the record.

It was a curiosity for me.

MEMBER LAMBORN: Madam Chair?

CHAIRWOMAN CONTINE: Go ahead.

MEMBER LAMBORN: Leah Lamborn for the record.

So I'm going to have a hard time I guess approving any of these without a dollar amount, and the one I'm really struggling on the most and I guess just I was completely unaware is the hospice service and the co-pay, $500. I just didn't even realize that that was a co-pay period for HPN. So I have a hard time with that because I just think you're at the end of your life and going to have to fork up $500 they may not have to be made comfortable, especially I'm struggling with that, especially with that dollar amount on there.

MS. SPINELLI: Just to add to that, HPN, they have a 500 dollar co-pay for inpatient, and I believe it's 25 dollar co-pay per visit for home health, and we didn't -- we just figured across the board we would do the 500. Based on your comments right there, end of life and it just seemed

appropriate, so.

MEMBER LAMBORN: And Leah Lamborn for the record.

And the inpatient, I get it. They are already there but outpatient, I'm having a hard time with that. Just to let you know, I'm going to have a difficult time approving any of these or making a decision without some more information.

MS. SPINELLI: The inpatient, just so because it's inpatient/outpatient, right, for hospice and when we looked at that, we not only mirrored HPN but we also looked at it as the inpatient co-pay this plan requires for a hospitalization so that's why we used the 500.

MEMBER LAMBORN: Right, I don't have a concern with inpatient. It's the outpatient.

MS. SPINELLI: Right.

MR. HAYCOCK: For the record Damon Haycock.

I suppose we could cut out the outpatient part of it and move forward. This is your decision, right?

MEMBER LAMBORN: That would be.

MR. HAYCOCK: I don't want it to be throw the baby out with the bath water, right. I mean, it's something that we can mirror co-pay with Health Plan Nevada and do a 25 dollar outpatient or we just leave it alone.

MEMBER LAMBORN: I would feel a lot better if you

threw out the -- eliminate it.

MS. SPINELLI: I would be a little concerned about doing the 25 dollar co-pay because per visit, that could exceed the 500 so, but that's, you know, your call. You guys can discuss that.

MEMBER LAMBORN: Sorry, maybe I can clarify. So are you saying it's a 500 dollar co-pay for inpatient only and the outpatient is $25?

MS. SPINELLI: It's $500 period.

MEMBER LAMBORN: Okay.

MS. SPINELLI: Inpatient/outpatient.

MEMBER LAMBORN: Okay. That's what I thought.

MS. SPINELLI: Sometimes they can be in longer.

So any other questions on the EPO?

MEMBER ZACK: Chair Contine.

CHAIRWOMAN CONTINE: Yes, go ahead.

MEMBER ZACK: Christine Zack in the south.

Would it be possible to take these, there are certain things that are required because of the legislative or regulatory requirements, could we take those separately? I mean, it seems to me we have no choice with those and perhaps on these other items, is it possible to come back at a later date with the associated costs as Ms. Lamborn suggested?

CHAIRWOMAN CONTINE: Go ahead, Damon.

MR. HAYCOCK: For the record Damon Haycock.

Technically, the answer is yes. The unfortunate part is open enrollment is right around the corner and if we're going to implement any benefit changes, even if they are small, it has been our practice here to have those available for review when people select plans on May 1st. The next scheduled Board -- full Board meeting isn't until the end of May, and so we'll be almost completely through open enrollment, as well as, of course, we all know we're in session, right, so getting folks together, especially those of us who have to testify can be a challenge.

As far as, you know, the Board approved plan design changes that you see right now on the top of page two, you already approved them. You don't have to reapprove them. That was just done to show that you know that we put them into the MPD. But it's really the additional recommended design changes, and I know in the past we've taken some of these as a one off. Where just like Ms. Lamborn said where I don't really like that, and we can always take the words or outpatient out of that recommendation and that was just inpatient at 500 dollar co-pay and leave it at that. So we can do some back and forth to get through three's or we can punt.

But whatever we do, we generally try to not make changes to the plan after open enrollment because we feel that members go to those documents to see what plan they want based on the benefits that you have approved. And if we change them afterwards, even though technically we can do it all the way up until 30 days before the plan year begins, we don't want to be accused a bait and switch.

MS. SPINELLI: But you could, you could eliminate the 500 for inpatient only, you can do that and then zero for outpatient, yeah.

CHAIRWOMAN CONTINE: All right. Are there any other questions on any of the PPO plan changes? Mr. Verducci?

MEMBER VERDUCCI: Yes, Tom Verducci for the record.

I wanted to ask about the screening mammogram on the CDHP and the point first on the mammogram of the plan year is paid 100 percent.

CHAIRWOMAN CONTINE: Are you talking about the CDHP?

MEMBER VERDUCCI: Yes.

CHAIRWOMAN CONTINE: Okay. Hold on for just a second, okay.

MEMBER VERDUCCI: Okay.

CHAIRWOMAN CONTINE: Are there any other questions on the EPO?

Okay. So go ahead and go into the -- sorry, go ahead and go into the CDHP.

MS. SPINELLI: Okay.

CHAIRWOMAN CONTINE: Thank you, Nancy.

MS. SPINELLI: You're welcome.

So at the bottom of page three, you'll see the Board approved plan change designs for the CDHP. So I'm not going to go into those. Those were just as a refresher.

I know, Mandy, you're new. I don't know if you're familiar with these plan design changes.

And then the bottom of page five, we have the additional plan design changes by staff, and they mirror the EPO plan and HPN for the physical therapy, occupational and speech therapies, we wanted to implement a 90-day visit for plan year. That's a combination, and this combination of all services or one specific type of service, and then anything beyond the 90 days would require pre-certification.

And then chiropractic treatment, the CDHP plan today covers 15 visits and then it excludes maintenance benefits, and then after 15 visits it requires medical necessity review, and we wanted to eliminate that medical necessity review and increase the chiropractic visits to 20

to mirror both HPN and the EPO plan.

There's not a lot of utilization in this. Just so you know, we looked at the over the last couple of years the utilization and typically it's under that number of visits. So I think -- I don't think there will be an additional cost there.

The hospice services, again, this would be the same thing under the CDHP. The plan allows for six months of hospice coverage. The way it's administered. We wanted to mirror the EPO plan, implement the 185 days and then after that point require our pre-certification if necessary.

And then the weight loss medications, this mirrors the EPO plan. We want to eliminate the long term weight loss medications and only include a covered generic short-term medication.

And then on page 6E, this is the three-visit limit for the healthy diet and physical activity counseling that was approved by the Board in 2011. We want to insert that back into the plan document and after three visits, there would be cost sharing that would be imposed unless they were enrolled in the obesity care management program.

And for screening colonoscopy, again here, we would follow the American Cancer Society's guideline. The plan would pay 100 percent based on the age and frequency of

as required by the American Cancer Society.

And then the screening mammogram, 3D mammogram or 2D mammograms, the plan would like to mimic or follow the US Preventive Services Task Force so we have implemented guidelines on age and frequency.

And the other changes, we increased the HR -- the HSA contribution limit for 2019 from 3,450 to 3,500 for an individual and for a family. The amount would be from 6,850 to $7,000.

And then E, other changes in B, this is a clarification of benefits, out-of-network benefits and this was recommended by HealthSCOPE Benefits basically stating if you receive services at an in-network facility that the physician is out-of-network, out-of-network physician would be paid at usual and customary.

And then for colonoscopies, this came out of compliance review. We needed to insert language to clarify that colonoscopy screening includes coverage for bowel preparation at no cost.

And then D, there's subrogation language in here that hopefully everybody had a chance to read. This is in each of the plan documents, there's a summary that points over to the bold language and so this is just basically the summary.

E is a compliance review requirement that basically states and the MPD that the HRA can only be used to reimburse qualified out-of-pocket healthcare expenses by the participant, participant spouse and participant dependents that are claimed on the tax return.

And F, this is also a compliance review recommendation. We needed to insert adverse determination language regarding HRA and the ability to appeal those.

And, again, we updated the autism spectrum disorder.

Any questions on the CDHP? This really isn't that dry. I love these documents. I'm probably the only one in this program.

So, okay, no questions?

MEMBER PACKHAM: John Packham for the record.

I just had a question on the hospice. Other than consistency with EPO plan, is there a compelling reason, I mean, a lot of people going over that 185-day limit?

MS. SPINELLI: Go ahead.

MR. HAYCOCK: For the record Damon Haycock.

I want to put some misconceptions on this hospice recommendation to bed. First of all, the six months or 185 days is pretty close together. I think that's in addition to five days, if you want to look at it that way.

But the idea is if anyone is going to go over that and that it's medically necessary and a provider reaches out to us, they will already be in case management. They will already be on our radar. We'll know ahead of time and precertified additional timeframe.

What this is really trying to do is eliminate the cost of automatic pre-certification for hospice. It just doesn't make sense for us to pay our utilization management vendor to pre-certify something that doesn't have any value to be pre-certified for. We define in all of our master plan documents that hospice is generally the last six months of life. Now, of course, it can be lower. It can be higher and we recognize that.

But what we're really trying to do is eliminate the cost to pre-certify things that add no value. So a lot of these things are pre-certification changes so we don't have to do so many. What was the number we had just for outpatient surgeries?

MS. SPINELLI: I think it was like 2,500 and we had 18 denied and that is -- that's a lot of -- that's a lot of cost there.

MR. HAYCOCK: There's a lot of people doing a lot of work and a lot of research, and we're paying on a per utilization process for things that we're just making our

core providers and our members to go through just to get approved anyway. So a lot of these recommendations are really trying to provide an opportunity to bypass some really rather bureaucratic red tape unnecessary low value processes. We're not trying to limit these benefits. We're just trying eliminate the hoop to jump through at the beginning.

CHAIRWOMAN CONTINE: Did you have a question?

MEMBER VERDUCCI: Yes. Tom Verducci.

I just went through a scenario with hospice. I was with an elderly family member that made it to 100 years old and was on hospice three times and with the third one, the third time he was on it went beyond his 185 days, and watching hospice nurses was amazing. And to throw something as complicated as re-certification or co-pay in there, someone at that stage in their life would really not be the right thing to do for the individual.

The other thing I want to point out was on the mammogram, the change here, screening mammogram to align to the screening with USPSTF, it's not really clear how that changes the services that they are going to receive. Another experience I had was a family member came down with breast cancer and a preventative screening kept this person still alive today. I'm not real crazy about the restrictions there as well.

MS. SPINELLI: So for the mammogram, the first mammogram would be -- starting at age 40, the mammogram would be covered at 100 percent as long as they use an in-network provider, and then they are eligible for a screening mammogram every plan year. Additional mammograms during the plan year would be subject to cost sharing. Those would be considered diagnostic.

MS. BOWEN: What if the doctor states --

MEMBER VERDUCCI: So as a response and thank you so much, Nancy.

MS. SPINELLI: Sure.

MEMBER VERDUCCI: That's very helpful information. But after the initial screening, there could be a procedure that comes up that the patient feels like, hey, I still have a problem here. And I just think the preventative mammogram screening is really important, and I would really not like to throw additional rules and restrictions.

MS. SPINELLI: So I agree 100 percent with that and this -- this benefit does provide 100 percent coverage as long as they go in-network and it would start out at age 40 or if they had a family history it could be younger, starting at age 40 and going forward every plan year.

MR. HAYCOCK: So let me add to that. This is Damon Haycock for the record.

So, Tom, I don't know if you're saying, and I think I heard from the audience, what if someone needs a second one, right, or third one. Let's also not forget we're talking at least on this portion the Consumer Driven Health Plan which is a high deductible health plan as defined by the IRS which makes it eligible for health savings account funding.

Health savings accounts are only authorized on high deductible health plans that do not bypass the deductible for a myriad of reasons. One of the things you can bypass the deductible for are preventative services. So we have to be very careful as to what we declare as preventive services so we don't run afoul of the IRS and the HSA funding. We were able to work with our partner, as I said earlier, on the pharmacy side to create a preventive drug list but using that same logic, what if someone is on one drug that's preventative and then they get diagnosed to take a different drug, why are we charging them more for that? That's just how the plan is designed to ensure we can continue to have a health savings account offering.

So we point to the United States Preventative Services Task Force and the HRSA, resource services administration I think is what it's called and other -- other nationally recognized entities that have clinicians that are

trained and they have to report to the United States Congress, and we point to all of these folks so that way it protects our high deductible health plan designator so we can keep giving out an HSA.

So when someone goes and has a preventive exam, whatever that could be, it could be mammography, colonoscopy. It could be your annual wellness visit, and there seems to be something else that needs to happen. That then moves from a preventive services into a treatment or diagnostic service and then it is subject to what are the normal plan rules are.

If we start to get more lenient on what we call preventive, we could run afoul with the IRS rules, and then we may no longer be authorized to provide an HSA account which is by far one of the most appreciated parts of our high deductible health plans. So just keep that in the back of your mind. So if someone needs to go get a second mammogram, they go, but then they are subject to their deductible co-insurance and out-of-pocket maximum and they can use their HSA funds to pay for it.

MEMBER VERDUCCI: Well, thank you for the clarification. The wording in here was a little tricky where it says aligned screening, and then there's an acronym which really isn't specific to the actual changes that are being requested.

MR. HAYCOCK: Right, we apologize, Mr. Verducci. We should be defining all acronyms as we go through these documents, and I don't know if we did earlier or not.

Another reason why we are aligned to them is because there are folks required to get a mammogram, men and women, for diagnostics reasons that are well under the age of 40, and those by all preventive services are considered diagnostic, but our plan today pays for them at 100 percent. So, again, we run that risk of not following the law.

MEMBER VERDUCCI: Thank you.

CHAIRWOMAN CONTINE: All right. Are there any other questions on the Consumer Driven Health Plan changes?

Okay. Nancy, if you want to go to the PPO dental plan, basic life and long term.

MS. SPINELLI: Okay. It's going to get much more exciting going forward.

For the PPO dental plan, the only change we really had to make to this document was subrogation summary language, and we wanted to put some clarifying language in there for our Medicare Exchange retirees. They had the option to enroll in our dental plan as a voluntary option.

If they enroll in that plan, we set them up for automatically reimbursement. So if they are PERS retiree, we take the premium out of the PERS check, and then we send a

file over to Via Benefits, and they automatically reimburse them for that premium into HRA, and we have had some retirees who requested that they do not get reimbursed out of that HRA plan. Unfortunately, we don't have a mechanism to stop that so we wanted to put some language in there that kind of explained that, and that is the PPO plan document for the dental.

CHAIRWOMAN CONTINE: Any questions?

Okay. You want to go onto the next one, the wrap plan.

MS. SPINELLI: For the welfare wrap plan document, this has a lot of the legal information. A lot of the documents point to this one, and this one has the full language, the subrogation language that was recommended by HealthSCOPE Benefits legal team, and I'm hoping that everybody had the opportunity to read that because unless you want me to go through this here, I'm happy to read all six pages.

CHAIRWOMAN CONTINE: I think it's okay if you don't.

MS. SPINELLI: Okay. And that's -- that's the only change to that document.

CHAIRWOMAN CONTINE: Okay. Anybody have anything, any questions? So the next one is page 14 then,

the Medicare and HRA summary plan.

MS. SPINELLI: Thank you. So this document, this provides information for our Medicare Exchange retirees, and we did get some information or some language from Via Benefits on a lot of different things on reimbursements and we have included that in here.

The first item, 1A, this is the provision regarding the automatic dental reimbursement from their HRA so we inserted the language in that document as well.

And then B, this is Item Number B here, this is basically language stating that the retirees can now go on-line and log into their portal through Via Benefits and they can submit reimbursement requests on-line and that provides a certification that the information that they are submitting is accurate and correct, and they do not have to submit a form so that just kind of clarifies that.

Item Number C, what is this one, Item Number C in accordance with IRS. Oh, this describes specific information and documents that are required by the IRS to receive reimbursement for their part B premium, and the rest of it is just going through this document. It's just specific information for certain types of reimbursement requests.

CHAIRWOMAN CONTINE: Any questions? All right. The flexible spending account summary plan description. Why

don't you just go ahead and finish up.

MS. SPINELLI: Okay. I'll do that. So the flexible spending account, the only change that we made to that is to increase the IRS FSA contribution or flexible spending contribution from $2,650 to $2,700.

And then the next document is enrollment and eligibility, just a couple of changes to that document per the compliance review. We were asked to insert language regarding adverse benefit determination language that's basically stating the type of events that would allow and disallow retroactive termination or rescission of coverage under the plan. So we inserted that language and then document formatting, and that concludes the changes for the master plan documents.

And the recommendation by staff is staff requests Board approval for the amendments to the following master plan documents, including the plan design changes for the Premier EPO Plan and Consumer Driven Health Plan, and then staff requests the ability to make any necessary technical adjustments at the Board action today, as well as any changes due to state and federal laws that may occur.

CHAIRWOMAN CONTINE: Okay. Thank you.

Are there any other questions, comments, discussion by the Board at this point? All right. Then I'll

open it up for public comment.

MS. MALONE: Now it's good afternoon to the Board, sorry. Just real quickly, Priscilla Malone with the AFSCME retirees.

And I'm sorry, I lost my link. I had a couple of links here for instance from the American Journal of Medicine July 2017. I want to clarify one thing about what my perception is that you are voting on. If you blanketly say as a policy that you are going to follow the, and I can't get the acronym, either the US Preventative Services Task Force's recommendation, you are going to have PEBP members who are 75 and older whom are on the CDHP or EPO or HMO who are still going to in a purely screening sense, not diagnostic, feel that they want to have a mammogram covered once a year or -- or you could use the lower end of the task force recommendation. It's biennial every two years.

And if I understand everything I heard today, the folks who were younger than 75 on those three programs, on those three policies are going to still maintain, that's what I hope I heard, the ability regardless of age up to age 74 to get their annual mammogram if that's what they and their doctor agree is the right step for them.

But this task force guide line recommends no mammograms after age 75, and that's been a subject of

controversy. So I'll just read this little bit into the record, and I'll conclude here. This is from July 2017 and, again, this is the American Journal of Medicine. So I have to scroll down because we would be here until dinnertime but efforts to standardized screening and incentivize providers to reach targets screening levels should be abandoned as mammographic choices must be made without pressure or coercion by informed women.

As of 2016 based on the evidence, there simply is no right answer to whether a woman should undergo mammographic screening. So I would ask you to keep that group in your mind, that demographic group which would definitely include the non-state retirees because they are by definition on one of those three plans. Thank you.

MS. SPINELLI: Can I just add to that?

CHAIRWOMAN CONTINE: Sure.

MS. MALONE: Do you want me to leave?

MS. SPINELLI: So there's, we follow the US Preventive Task Force and we are non -- grandfathered plan, and so we also follow the Public Health Services Act which there's two different recommendations for mammograms. One was in 2002 which we're all familiar with, that states that as of age 40, you're eligible for your mammogram either annually or biannually.

And then there was a change in 2016 that we would not follow that but that basically states that women are not -- they do not recommend a female to get a mammogram unless they are age 50 to 55.

MS. MALONE: Right, that was in controversy.

MS. SPINELLI: And also they take away at age 74, they don't recommend at all.

MS. MALONE: Right.

MS. SPINELLI: So we don't follow that. We follow the PHSA plus the USPSTF.

MS. MALONE: Right. And that's really I wanted to make that was clearly a part of this record today is so we don't have frantic folks who are 75, 76 saying did they just tell me and I lost my mammogram, you know.

MS. SPINELLI: I was going to say it wouldn't be paid at 100 percent.

MS. MALONE: Right. And, again, as a breast cancer survivor, this is a subject dear and near to me. This is a subject near and dear to me, and there's all sorts of different levels of -- in fact, I'm getting mine at Renown tomorrow, and mine is not within those guidelines because it's -- well, it's not diagnostic but now with my history of breast cancer, I better get one every year. So there's -- again, that's the point I believe of this July 2017 author

from the Journal of American Medicine point is that there is no one size fits all, and you want to make sure you're not cutting people out. Thank you.

CHAIRWOMAN CONTINE: Thank you.

MR. ERVIN: Kent Ervin for the Nevada Faculty Alliance.

I'm just confused now. The changes are first mammogram are paid at 100 percent per plan year and the, what you're approving is live screening mammogram, mammography benefit with the USPSTF age and frequency guidelines, other organizations not mentioned here. When I go to USPSTF, it has the biennial from age 50 to 74.

So, you know, the master plan document is for the providers to know what we provide and for patients to know what -- what we provide and benefits, and in past years the full document with the edits were included. This table, I just don't know what it means, and I guess ditto for the hospice.

And then the other comment is here we are in March doing plan design changes for open enrollment without an Aon analysis without being discussed in November. And, yes, a minor, sure, we could go ahead and do them. I'm not going -- you know, it's just a different standard that's being used. Thank you.

MS. LAIRD: Terri Laird, executive director for the Retired Public Employees of Nevada.

I would echo the remarks made here already. With regards to the mammograms and as well as the hospice proposed changes, that is a very sensitive topic. If you've never known someone whose been in hospice care and you never know from day-to-day and so we appreciate the Board's consideration of that. Thank you.

CHAIRWOMAN CONTINE: Thank you.

Is there anybody else in Carson City that want to make public comment?

MS. BOWEN: My name and words for the record, P-e-g-g-y, Peggy space Lear, L-e-a-r space Bowen, B as in boy o-w-e-n.

I have a couple of concerns, one about the mammogram and if you go in and have your mammogram done and if the doctor can't read it or requires more input to that with an additional mammogram, a lot of people are not getting the second mammogram, not even going in for the first mammogram because they feel they are being held responsible to pay for that second mammogram based on limits and things like that.

And it would be really appreciated if we thank you, thank you, thank you for all of the work you did to get

the 3D mammograms accepted and the mammogram of the day now for most places but not all places, so you need to remember that it's to include mammogram 3D if the first one was not a 3D.

And, secondly, you need to have something within this provision that if the doctor requires you to have more work done that it should be covered at 100 percent. It is not the patient who is asking and going in and requiring more mammograms but it is the doctor states as needed to please include that in the benefit would be very helpful.

To -- for the obesity program, you have not incorporated anywhere in your program any means or mechanism for the disabled. I know that with four foot and ankle surgeries and three knee surgeries, I don't walk as fast and I don't do this much, and I can go around Virginia Lake as many times as you want, and I can climb the steps and go to the gym and be in the obesity program all you want, but you're discriminating against me because of my disability.

Wait a minute, Ms. Spearman gave me a different terminology. My -- I'm not disabled. I am differently abled and the accommodations that my doctor and I follow following my doctor's recommendations should a -- should allow for whatever the weight is that if I'm following my doctor's recommendations for doing the best I can for my abilities

that you shouldn't discriminate against me and make me pay more because I'm not meeting your obesity requirements.

I can eat your food however you want me to. It won't make any difference. I can eat -- I can starve to death. It won't make any difference. If I can't walk or I can't do that which would allow weight loss but I'm doing everything the doctor says for me to do in the conditions that I have, four foot and ankle surgeries, three knee surgeries, severed -- there's one bone that works and one that doesn't, it impacts on how my weight is, and I should not be discriminated by your policy, by the policy that you have created or by the insurance companies that you accept regarding that.

When a pre-approval to go into an emergency room or not or what's going on there, you've heard my story before, but my point is that if a drug is prescribed by -- a drug is recommended by a -- by a doctor, I need an Epipen because I'm allergic to bees, wasps and any other critters that bite. And if that Epipen gets used because I was bitten by a wasp and went to emergency room and the emergency room wouldn't prescribe an Epipen, finally they did, and I went.

And the pharmacist says, well, if you get the prescription pre-approved then it's $300 instead of $800. We need those prescriptions not to need pre-approval as such.

And when you're going to the emergency room or any other state, the only way they would have covered the Epipen is if I had been admitted to the hospital, and I didn't -- I didn't need anything that needed admission at that point for that situation.

Later, I fell and had a concussion and -- and I was taken by ambulance to the hospital and because they would not determine or state that I had a concussion except they released me with concussion protocol to go home and be by myself and then if I passed out there and died is because they wouldn't admit me. This pre-admit approval that you have incorporated is keeping patients from going in, keeping patients from get prescriptions.

And for the mammogram, I have to tell you that it's keeping people from getting the initial mammogram because they don't want to know if there's something else and they can't afford the second one. We just simply need it as doctor recommended on each of those.

And pre-approval for medications, we need to have that stopped in the sense of what's required in a doctor recommended as recommended by doctor. We need you to do that. Thank you very much.

CHAIRWOMAN CONTINE: Thank you.

MS. BOWEN: Thank you for all you do, and thank

you for giving up this day, and Happy Easter coming up.

CHAIRWOMAN CONTINE: Thank you.

Is there any other public comment?

MS. BOWEN: Please because it's so important.

Mr. Damon Haycock, for whatever reason, and I didn't hear it discussed today but I was late because I had a doctor's appointment. The -- the use of a computer to be able to access any of these programs and be accepted in these programs and required, the only reason that the computer is involved in a person becoming part of the program, the PEBP program is so that you can have certain, do they know about your program.

And little old ladies and others and the poor, this discriminates against the elderly and the poor, actual discrimination. You need to eliminate the requirement. You did earlier, thank you very much, but you need to eliminate the requirement that we have to sign-in on your computers in order to be enrolled in -- Damon, please help me with the name.

MR. HAYCOCK: Doctor on Demand.

MS. BOWEN: Doctor on Demand. Thank you very much. We have people, we need the computer requirement that discriminates against the elderly and poor removed because all that program does is tell you what the program is. You

shouldn't keep us from using the program because we don't know about the program. Obviously, if this is how you know you're not sending the -- this is how a person knows they are not sending checks to people that don't exist anymore.

If we go to the doctor and we have our physical, if we have our blood work done, if we have our, there are four things, physical, blood work, Damon, would you help me once more, please.

MS. SPINELLI: Labs and dental.

MS. BOWEN: Labs and?

MS. SPINELLI: Dental.

MS. BOWEN: And dental done then you know we exist. We don't -- we should not have to be enrolled with, touch or have to deal with computers because our elderly are not accessing this program because they don't have computers. They don't use computers nor do the poor. They rather use three or four or $500 for a computer to put food on their table and roofs over their head and clothes on their back.

CHAIRWOMAN CONTINE: Thank you.

MS. BOWEN: So please eliminate the Doctor on Demand requirement from anything to do with any participation. We beg of you get the computer off our back and get us back to dealing with our doctors and our health and living well and long, and then we won't be using your

insurance program. Thank you very much, and Happy Easter.

CHAIRWOMAN CONTINE: Damon, do you have any final comments on this agenda item?

MR. HAYCOCK: Yeah, for the record Damon Haycock.

We don't want to cause any strife or cause any issues when it comes to things like mammograms or hospice, that wasn't the intent of this. If we need to get better at how we present these and present them at different times we go. We also don't want to be hypocritical and throw things at you at the last minute.

So if you go to the final page, there are seven recommendations. Recommendation three through seven are very much in line with what you've seen before. They are the housekeeping clarification languages. They don't change benefits. That's to the dental plan document, the health and welfare wrap document, the HRA summary document, the flexible spending account document and the enrollment and eligibility document.

So to answer Ms. Zack's question, can we separate out the simple, right, I know that's not how you put it, but I'm going to use my words, the simple from the things that need to be discussed, I think Items Three through Seven can be pretty much carved out and looked at separately.

For the Premier Plan we really only need two

things from you guys that we think are going to be very impactful from these additional recommended plan designs that we can -- we're going to have a hard time living without. We currently don't offer hearing aids which I already told the legislature that we're going to bring back and try to cover this. It's something that we should do. HPN does, the Consumer Driven Health Plan does, and so it just seems to be very, what is the term, punitive to not offer hearing aids to folks on any of our plans.

And so Item F under additional recommended plan designs we feel is something that we would like you guys to consider very seriously, and then it appears the table kind of resets the letters but on the very next page on page three, the OCM weight loss medications, we are currently paying for a newer long term weight loss medication on about 150 folks. On the first half of the year we're over $300,000 in plan costs.

The OCM or the obesity care management program has been very successful since 20, and I believe, 12 because it has emphasized the doctor/patient relationship more than anything else. So the patient gets in and talks to the doctor and it's about behavioral change with low cost short-term drugs that help you get over the hump so you can get to that place where you can start losing weight and

managing your health moving forward.

These long term drugs that are coming out are provided and they do some pretty interesting things. The one that we're talking about here today actually starts to adjust your cravings in your brain and it also adjusts how you process fat in your liver, and it sounds really great because it's working. But the problem is once you're off this drug, you gain all the weight back, and we're one of the few plans that actually cover these drugs right now.

To our knowledge, to our research, if a member on our plan gets this high cost drug, it works for them and then they leave the state and go to another plan that doesn't offer it, are we truly taking care of the Nevadan and that's a question that we had.

We also know that our pharmacy costs are very expensive and when you're paying 300,000 or potentially 700,000 by the end of the year for 150 people and if more people get on it, you're talking over $1,000,000 on one drug, is it really the highest value that we can put when we already had a successful program before the drug ever came out. So it's one of those types of things. So those are the two on the Premiere Plan.

CHAIRWOMAN CONTINE: Can I ask a quick question about that?

MR. HAYCOCK: Yeah, please.

CHAIRWOMAN CONTINE: I have a question on that. What is the distinction between a long term weight loss medication and short-term medication? Is there a time period that --

MR. HAYCOCK: For the record Damon Haycock.

I believe it's 90 days, but I'm going to phone a friend.

MS. MOONEYHAM: Your friend does not know that when we will not get the money in.

MS. SPINELLI: 90 days.

MR. HAYCOCK: It is 90 days. Okay, 90 days, final answer.

CHAIRWOMAN CONTINE: Okay. So 90 days is considered short-term.

MR. HAYCOCK: The drugs we're talking about you have to remain on the rest of your life.

CHAIRWOMAN CONTINE: Right, I see, okay. Thank you.

MR. HAYCOCK: And then on the CDHP, just again, the weight loss medication, it's on both plans. We can table hospice. We can table mammography. We can table the rest of these things. It's not going to make or break the plan. If you want the actuarial analysis, we can bring it back to you

guys in November. We were trying to make things a little bit cleaner, a little more consistent, but we recognize that there may be some trepidation making this level of changes today. So we're willing to, you know, compromise and go the middle ground, but those are the burning issues we need to address, the hearings on the EPO plan and long term weight loss on both EPO and CDHP plans.

And then all of the other changes that are after those tables are all pretty benign. They are pretty much clarification and housekeeping. So we would recommend -- we're willing to change the recommendation on number one which is the Premiere Plan, that you guys approve all other changes as outlined and approve the hearing aid and weight loss medication recommendation.

And then on the CDHP, all other changes as outlined and the weight loss medication.

MS. SPINELLI: Damon, can I add one other item to that. I believe colonoscopies should be based on the age and frequency not the way it's set up today.

MR. HAYCOCK: Not the way it's set up, all right. We'll add that, just trying to get what we can get.

MEMBER ZACK: Chair Contine?

CHAIRWOMAN CONTINE: Yes.

MEMBER ZACK: Christine Zack.

We actually have a public comment question down here.

CHAIRWOMAN CONTINE: Oh, sorry.

MEMBER ZACK: It's all right.

CHAIRWOMAN CONTINE: Go ahead.

MS. KELLY: Michelle Kelly from Nevada System of Higher Education.

I just have a clarification question about that long term weight loss drug. So if it's removed from the weight loss program, will those participants still have access to it under the regular prescription program so subject to deductible and co-pay?

MR. HAYCOCK: So for the record Damon Haycock.

That drug is I think a couple of thousand dollars a month. The benefit is designed what really dents the total cost of the plan because you hit your out-of-pocket max too quickly. I'm giving you the why before the answer. The answer is it would be excluded from the formulary across both plans.

So if a member wanted to stay on that drug or to get on that drug, they would have to pay full price for it and it wouldn't go toward any of their accumulators.

CHAIRWOMAN CONTINE: Go ahead, Ms. Lamborn.

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

I think maybe I can make this easier as long as the other Board members kind of agree. My only main concern was again the hospice and just removing the outpatient. And then I do have the concern of the screening colonoscopy and the screening mammogram, and I agree we should align. I just don't know what we're aligning to. I'm willing to make a motion to approve it, but I would like a document next meeting that says exactly what we approved. So at that time we can evaluate if we need to make some exceptions to our policy or change it next plan year, and so I don't know what the other Board members think or their concerns.

CHAIRWOMAN CONTINE: Does anybody have any comments on that or?

MEMBER VERDUCCI: Yes, Tom Verducci.

I do like the idea of removing the wording on the mammogram and also hospice, maybe incorporating the changes that Ms. Spinelli had made regarding the colonoscopy as well.

CHAIRWOMAN CONTINE: So having -- so going ahead and voting on this today and then having a document at the next meeting that outlines it. So you agree with Ms. Lamborn?

MEMBER VERDUCCI: Yes, absolutely.

MR. HAYCOCK: Make a motion?

CHAIRWOMAN CONTINE: Go ahead, would you like to

make a motion?

MEMBER LAMBORN: Yes.

CHAIRWOMAN CONTINE: Thank you.

MEMBER LAMBORN: I will try. Okay. I would like to make a motion to approve, just go with numbers three, dental, life and long term disability master plan document, number four, health and welfare wrap plan document, number five, Medicare Exchange HRA summary plan description. Number six, flexible spending account summary plan description. Number seven, PEBP enrollment and eligibility master plan document as is. I would like to include in the motion that we approve, number one, the Premier Plan Master Plan document with the exception of removing outpatient from Item E, hospice services and the inclusion of next Board meeting for number D's and E's that we know exactly what the American Cancer Society age and frequency recommendation is and also what for Number E what they USPSTF age and frequency guidelines are and then approve -- and add to that number two for the CDHP medical, vision and prescription drug master plan document with the same requirement, and I think the item numbers are different but just knowing what the American Cancer Society and the USPSTF guidelines are. Did I get it all?

CHAIRWOMAN CONTINE: I think that's good. Is

there a second?

MEMBER ZACK: Chair Contine?

CHAIRWOMAN CONTINE: Yes.

MEMBER ZACK: Christine Zack for the record. I'll second the motion.

CHAIRWOMAN CONTINE: Great. I have a motion and a second. All those in favor say aye.

(The vote was unanimously in favor of the motion.

CHAIRWOMAN CONTINE: All right. Motion carries. Thank you for making that simple.

Okay. Going onto Item Number 11, Executive Officer Report, and I'm told this is going to be the shortest report that Damon has ever given.

MR. HAYCOCK: For the record Damon Haycock. This is the shortest report I've ever written. So I really only have two things to update everybody on the Board and the stakeholders. First when we got the plan benefit design approved, we included a pilot program for nutrition with the University of Nevada Las Vegas or UNLV. At the time we got it approved in November, we thought we had all of the logistics nailed down as site of care and who was going to be doing what. We felt very confident and started sending around a memorandum of understanding to ensure that everybody knew what they were doing. We started collecting data, and

then we realized it was a little more complicated than we first collectively believed.

And so working with UNLV, we would like to postpone that to make sure that the logistics are appropriate and this pilot has the highest probability of success. What does that really mean? Well, today you have $100,000 earmarked for this program for this plan year. If it turns out we can get those logistics in place in the next 90 days, then we can move forward and do some midyear type of pilot or maybe get it done in January.

And if we still didn't get it done, we can look at it again for next plan year, but we have promised the UNLV the funding to develop this partnership pilot program that not only helps PEBP and our members but also proves some of their delivery system that they are trying to accomplish, and we want to be good partners with UNLV and continue to work with them. But our desire to get this thing rolled out July 1 is not going to happen, so we're just letting you know today that it's being postponed.

And then I like to share the Healthcare Blue Book updates because some of these figures are really staggering for a first year program. For those that don't know, we implemented Healthcare Blue Book. It's an on-line transparency tool where members can shop and select different

providers based on high quality and low cost. They are actually color coded in green, yellow and red, and we offer the ability for them to check on the smart phone or tablet. I believe there's even a call number.

To date we have had just under 58,000 searches as of February, and we have over -- of those, over 20,000 of them were on mobile devices. So this is one of those tools to be better consumers on the Consumer Driven Health Plan.

260 members have received reward checks ranging from $25 to $125. We paid out just over 13 grand not only to folks within the state but also folks that are out of state. That's my fast report.

CHAIRWOMAN CONTINE: Thank you.

Does anybody have any questions for Damon on his fast report?

Okay. Moving onto discussion and possible action regarding potential Board position, recommendations and direction to staff on 2019 legislative bills that may impact PEBP.

Go ahead, Damon, on starting with assembly bill.

MR. HAYCOCK: So for the record Damon Haycock.

I believe unfortunately in your packet, we decided to go senate bills first.

CHAIRWOMAN CONTINE: Okay.

MR. HAYCOCK: But we'll just start with those. We have already had a Board meeting on most of these already, and so I'll only go over just the updates to them. SP200 requires us to cover certain types of examinations or devices, requires us to provide hearing aids that are lost or broken every 12 months. This thing I don't believe has hit committee yet, and so we have another chance to talk to legislature. If you remember the concern we had is our replacement schedule is three years on hearing aids. This is every year on hearing aids. So there will be a cost. We don't think it's a bank breaker, but it's something we want to share with the sponsors of the bill when we get up to testify.

SB226 requires us to follow HHS's formulary, and it requires us to get rid of our co-pay accumulator program. That thing hasn't even hit committee yet. As you can see, we put a pretty decent fiscal note on there. I sent information to the bill drafters and haven't received any responses back. We're not sure at this point if it's going to move forward or not, but there is no update to that bill.

SB276, is the big one. It's about a 30,000,000 dollar fiscal note we put on there and that prohibits the PBM's that we work with and ourselves from collecting rebates and having to put them at the point of sale which means all

members have to get their rebates at the counter. There's sizable problems with this, but we went over this I believe in detail at the last telephonic meeting.

The only update is is I have spoken with the sponsor. She does -- she is pretty amenable to working with PEBP and understands we have these significant budgetary issues. I feel very confident that this is something that will resolve itself based on conversations with the sponsor.

SB287 is that public records bill. One of the things that I highlighted on your, it's not shown on this packet here, but it's on-line. But one of the things that we have concern about is on the fourth bullet down, this is something you guys haven't seen before. This eliminates the authority of a governmental entity to charge an additional fee for providing a copy of a public record when extraordinary use of personnel or resources is required.

Today PEBP does not really have a lot of public records request. To my knowledge since I've been here, we haven't charged anybody and most of the time we don't charge people in the other agencies that I've worked in. However, when you take away the ability to charge folks for an exorbitant amount of time and effort bad things can happen.

I worked at a former agency where I was asked to produce every document, correspondence, text message, e-mail,

letter, you know, singing telegram, whatever on everything we've done on the Affordable Care Act, and it was going to take us months, months to do this, and we had to scrub out PHI or protected health information because part of the things we were doing were also working with folks that were on the Exchange, and it was going to take a lot of effort.

We came up with the Attorney General's office, you know, something we thought was fair as in time and effort, and then I reached out to that person requesting it and I said do you realize this is what you asked for. And he said, oh, no, Damon. I just want to know this one thing but I wasn't sure how to get it so I wanted everything.

When I told him what the cost would be and I told him what the effort, if you'll send me this thing, and like an hour later I gave it to him. I don't know if anything is going to dissuade people from asking for the moon and the stars and the kitchen sink if we don't have some form of protections to government entities, especially when we'll find those, and this isn't all of the time, but you find some people that want to punish agencies. The easiest way to punish them is to have them circling around trying to collect all of this information that really has no value.

And so I plan on, this wasn't really a PEBP bill, but I plan on getting up there and talking about some of the

unintended consequences when it does hit committee because this one kind of scares me and my staff, especially with the mountains of information that we collect everyday here, so that's Senate Bill 287.

Senate Bill 359, this is the one that provides for care for certain chronic conditions. This one, this is the one that we're working with the sponsor today. It's kind of a redo from last time. It's Senator Picker's bill and he wants to adjust some of the unfair practices of pre-authorizations and some of the unfair practices that potentially health plans, not PEBP but health plans make folks jump through hoops to get the care they need.

One of the problems, the biggest problem this bill has for us is that there's provisions in it that is written today that requires a health insurance plan to accept the decision of a previous health insurance plan pre-certification.

And I will tell you from -- from changing plans over that sometimes health plans don't agree, and health insurance is all about risk. And when you take on some other health plans risky decision, it is a slippery slope, and we will always want to provide the best services for our members, but we pre-certify things for safety or for cost or for efficiency or for any of those reasons.

I do have examples if you want me to go into it where we have done this in the last year with another health plan, but that concerns us that the bill says we would be forced to accept the pre-certification of the previous health plan. Then I think that was SB359.

Yes, then SB361, this is the one that says you have to -- we already talked about this. I believe it was the fact that they want to be able to allow pharmacists to prescribe contraceptives. We have no problem with pharmacists prescribing contraceptives. Where we run afoul is that our pharmacy benefits program is only -- only allows for in-network.

And so if someone goes to an out-of-network pharmacy and gets an out-of-network pharmacist to prescribe that contraceptive and then dispenses it from the out-of-pharmacy network, our plan today does not support it. And so we just want -- we've reached out to the sponsor, and we've talked about some of the concerns we have with out-of-network because we want to be supportive of contraceptives being prescribed by not just primary care doctors which may take weeks to get into that, so there's that one. I don't think you -- actually, I don't think you guys have heard of that one. That one is relatively new and those are the senate bills.

I want to talk a little bit about some new assembly bills. The old assembly bills that we were tracking have resolved themselves. So we didn't put them back on here. Some of them are not effecting PEBP. Some of them PEBP has been written out of. Some of them amendments have completely altered the bill which doesn't effect anybody anymore.

I can -- so instead of having a just a consistent bill after bill after bill even though it doesn't effect PEBP, we want to really hone it down to effect this agency so you can guys can understand, but since we've posted this we have new bills.

Now, the new bills we can talk about but we can't take action on, right, Ms. Mooneyham? Okay. So I do want to talk about a couple of new bills but before I do that, is there any questions on the other ones that we were able to post? I think it's fair that you guys can take action or take positions.

CHAIRWOMAN CONTINE: Mr. Verducci?

MEMBER VERDUCCI: Thank you very much. Tom Verducci.

I just have a question. In terms of the sessions that you're attending at the legislature, are you attending each one as any potential fiscal impact on PEBP?

MR. HAYCOCK: For the record Damon Haycock.

Any time we put either a cannot be determined or we put a dollar amount I go to the table.

MEMBER VERDUCCI: Okay. So by us taking no action here, anything with fiscal impact would be following up on and attending session.

MR. HAYCOCK: For the record Damon Haycock.

Yes, I think it was fortuitous on accord when asked a policy that would allow me to do that because it really limits or it almost eliminated the red tape and the lack of responsiveness that we have been plagued with before. So, yes, I can still get up and testify and represent the Board's wishes.

MEMBER VERDUCCI: Thank you.

CHAIRWOMAN CONTINE: All right. Moving on.

MR. HAYCOCK: For the record Damon Haycock.

There's a couple of new bills. There is a bill, Assembly Bill 254 and that is a bill basically that requires that plans cover sickle cell anemia. We don't have an issue with that because we do, right, that's something we do today.

The issue is that they keep putting these in these bills, and I'm not quite sure why but they are. They want one formulary to be determined by one entity and everyone has to adhere to, and the entity that they keep

putting out there is the department of health and human services which I don't blame them. I think that that's a good place to start. That's where a lot of folks are at, but not all plans are the same. Medicaid and our plan and the commercial plans and the other government plans, we're all different. It's really hard to adhere to one formulary when we all sign different agreements for different drug prices and different drug opportunities and so that one is actually going to go to committee tomorrow afternoon. I will be testifying.

I'm just going to bring it to their attention that we didn't put a fiscal note of any dollar on there. If we're forced to adhere to a formulary where we're not allowed to leverage our economies of scale because someone else has already done it and they thought they got the best deal for them but it's not the best deal for us, our cost can increase, and that's basically what I'm going to say at the table tomorrow afternoon. I think once they understand -- so far I haven't seen these formulary bills move too much forward.

But I did cover sickle cell anemia and we support that as a health plan. It's just the process by which we're required to adhere to someone else's decision really kind of devalues you as a Board making plan designs as well. That's

mine in a nutshell that will be said tomorrow.

And then we have AB469 and that is -- so that's a difficult bill. That says that, first, it's basically trying to eliminate the balance billing problem they had. They took a run at this last session, and I applaud the legislature for trying to solve this problem because it is a big problem for folks on many plans.

And it requires a lot of things like if you -- and it's mostly emergency services. So if you can't decide where you go when you're in a car accident. You need to be care flighted somewhere and you need to get an ambulance, right? So often you may go to an out-of-network facility. I'll give you great a example, and I hope this never happens to anybody in this room, but if you get in a car accident, for some reason you're shot to Saint Mary's, they are out-of-network today, right. And so how do you reimburse them?

And there's always an argument because when an out-of-network facility that prides emergency services bills the health plan, they bill them for the bill of charges and if there's no contractual discount, the health plan then comes up with how they are going to pay. Usually it's usual and customary payment that's much less than what the facilities are charging.

So what facilities are known to do is that they will accept the payment from the health plan they will balance bill the member for the rest. This is really rampant in the air ambulance industry across the nation. It is, I think it's punitive but I'll leave it that.

So they have been trying to adjust, trying to figure out how are they going to ensure that this doesn't happen. So every session they keep coming up with something new on how to deal with these provider networks, and this bill says that basically that if there was a contract of service that was approved in-network before and it was less than 12 months from being terminated that the out-of-network provider has to accept what those prices were, plus eight percent, plus eight percent. I want to come back to that. If it's two years, it's plus 15 percent and if it's beyond that, it's some level that arbitration will determine.

So imagine that Damon Haycock is the emergency room doctor that has a contract with Tom's health plan here and I'm getting $1,000 for a service, and I find out that if I just cancel my contract, I'm going to get 1,080. I'm going to get an eight percent increase because that's what the law gives me. Why would I ever stay in-network with Tom's plan? I would move off the plan so I can get eight percent guarantee the next year. Oh, and by the way, I get

15 percent the next year. I get a seven percent increase, and I don't have to do anything but quit providing services in-network.

So this is going to be a very significant fiscal note that we are putting together because we're taking all of our emergency services that we pay today and assume what happens if they all go out-of-network and add eight percent to them for the first year, 15 percent for the second year and don't forget, once you set a payment amount, it's very easy for that to set a precedent for arbitration.

So if arbitration says, wow, you go up seven or eight percent every year, we should just keep doing that, it could cause a huge issue to the marketplace across the state. So as a neutral position, I'm going to come out with very strong concerns about what this does to the program. I wish I could present to you an opportunity to take a position today because this wasn't agendized and it just came out, we can't, but that's the really big ugly one on the assembly bill and that's 469.

And then last but not least, there was one last bill that came out. It was Senate Bill 472 that is requiring that a database of information concerning health insurance claims in the state, they want to create something I believe over at the department of health and human services and all

payer claims database. Which would mean HealthSCOPE Benefits would take all of our claims that we pay every year and shoot them over to this all payer database so DHHS can do analysis and really anyone is supposed to be able to do analysis, they are supposed to change the identifiers so, therefore, you can protect PHI, but DHSS would have that information.

There's not a lot of format information yet and we've requested some help from our HealthSCOPE Benefits to determine what the cost would be to pitch that information over, but it's something that we're watching right now.

PEBP isn't concerned with the concept because really legislators every two years are trying to make decisions, but they never have access to the data to do so. So PEBP supports this in concept but maybe not in practice, and we have to figure out how this looks, but right now it was simply introduced the first time on the 25th, but we wanted to let you know.

We will take these three bills that we just talked about, and we'll add them to this list as moving forward unless something dramatically changes, and that concludes my legislative update.

CHAIRWOMAN CONTINE: Any questions for Damon on the legislative update? Mr. Verducci?

MEMBER VERDUCCI: Yes, Tom Verducci.

One quick question. Are we still having a telephonic meeting on April 4th or has that been cancelled, postponed or rescheduled?

MR. HAYCOCK: For the record Damon Haycock.

Our recommendation at PEBP at this point because we don't seem to be in any danger even with the new bills that are coming out by next week, we recommend cancelling that meeting. Most importantly, the interim finance committee is meeting, and we have work programs that we may need to go testify for and can't be in two places at once.

If the Board still wants to have the meeting and we need to push the time into the afternoon, but we don't see any position changes from the conversations today.

MEMBER VERDUCCI: Thank you.

CHAIRWOMAN CONTINE: Thank you.

Any other questions?

Okay. Moving onto Item Number 13, public comment. Any public comment in Las Vegas?

MS. LANDRY: No, we have none.

CHAIRWOMAN CONTINE: Okay. Any public comment in Carson City? All right. We're moving onto item -- okay. I let you go over a little today.

MS. BOWEN: I'll be good.

CHAIRWOMAN CONTINE: Be concise, all right.

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

We need to -- once again, people are not accessing and utilizing our insurance because of the computer component. We need to have the Doctor on Demand not a requirement for being a participant in anything. We need to have you accept, I put stars here so I would do it.

Regarding the contraceptives network, I believe that Viagra is covered and yet there are things about birth control that are not being covered. If you cover one, you cover both. It's all equal access or equal input, however you want to word it. Both those drugs are covered at 100 percent without any limitation on how old. We have people getting pregnant, family members getting pregnant at 14, 15. We need to be able to access contraceptives.

As far as colonoscopies and mammograms, we have people dying from lung cancer, breast cancer, colon cancer, polyps that had they been discovered at an earlier age, then they could have been dealt with, and so we need that age limit not to be -- not to have an age limit on being able to have a colonoscopy as needed as recommended by doctors in that way.

And the same thing with mammograms, I have a strong history of breast cancer within my family. Every

single woman on my mother's side of the family have died with relationship to cancers and breast cancer and that being found, and the sooner that I can have follow-up that I can have mammograms done and not limit. You know, people die at 14, 15 years old from breast cancer. Children's cancer units, we want to eliminate children's cancer, and the children of your members should be included in being able to get those mammograms and get those colonoscopies much earlier because the disease by the time we get to be old enough we'll probably going to be dead.

And when they just did my colonoscopy, they discovered a polyp, and so what am I supposed to do now? I've had my colonoscopy. There's a polyp, and I need somebody to be able to go in and be able to go back into that colonoscopy and get that polyp out of there so I don't die from cancer down in that area. It's high risk.

We just need you to get the age requirements removed in what you're doing, and we need to get that Doctor on Demand, get the computer out of it. You know, we're using it if we do the four catchups and, gosh, there was one more, and I'm being apologetic.

CHAIRWOMAN CONTINE: I think we're going to wrap it up.

MS. BOWEN: Okay. Just wrap it up.

CHAIRWOMAN CONTINE: Happy Easter.

MS. BOWEN: Thank you very much, and thank you for being so consistent. But anything to do with PEBP and access to this plan or anything to do with PEBP at all, please remove the computer requirements. You don't need us to not sit home, Ms. Margi Prum (phonetic), and die of something because she didn't go back and redo the things so you know where she is or how she's doing or she knows about your plan.

And the survey, who did you survey? And make it a true survey so you know what the members need and want and not just surveyed by random members. Did you get a survey? Did you get a survey? Did I get a survey? I don't know about you, but I know I didn't get one, and he said all were surveyed. And, I'm sorry, Damon, I didn't mean it to sound quite like that.

MR. HAYCOCK: That's okay.

MS. BOWEN: But that's how it is, and have a great day.

MR. HAYCOCK: Thank you.

CHAIRWOMAN CONTINE: Thank you, bye.

Any other public comment?

Okay. Number 14, we're adjourned. Number 14, we're adjourned.

STATE OF NEVADA,)
) ss.
CARSON CITY.)

I, KATHY JACKSON, Official Court Reporter for the State of Nevada, Public Employees' Benefits Program Board, do hereby certify:

That on Thursday, the 28th day of March, 2019, I was present at the Public Employees' Benefits Program, Carson City, Nevada, for the purpose of reporting in verbatim stenotype notes the within-entitled public meeting;

That the foregoing transcript, consisting of pages 1 through 209, is a full, true and correct transcription of my stenotype notes of said public meeting.

Dated at Carson City, Nevada, this 10th day of April, 2019.

KATHY JACKSON, CCR
Nevada CCR #402

Kathy Jackson
Capitol Reporters
123 W. Nye Lane Suite 107
Carson City, Nevada 89703
(775) 882-5322

STATE OF NEVADA

PUBLIC EMPLOYEES' BENEFITS PROGRAM

AFFIRMATION

Pursuant to NRS 239B.030

The undersigned does hereby affirm that the following document DOES NOT contain the social security number of any person:

1) Public Employees' Benefits Program Board
Regular Meeting, 3/28/19

KATHY JACKSON DATE

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