SUMMARY MINUTES

November 16, 2022

Pursuant to NRS 241.020(3)(a) as amended by Assembly Bill 253 of the 81st Legislative Session, this meeting will be convened using a remote technology system and there will be no physical location for this meeting. The meeting can be listened to via telephone or viewed live over the Internet.

Agenda Item I - Call to Order, Welcome and Roll Call

Chairman Khan called the regular meeting to order at 9:00 a.m. Those in attendance and constituting a quorum were:

Commission Members Present

Bobbette Bond
Sara Cholhagian Ralston
Lilnetra Grady
Dr. Ikram Khan
Leann McAllister
Yarleny Roa-Dugan
Sandie Ruybalid
Dr. Tiffany Tyler-Garner
Mason Van Houweling
Tyler Winkler
Dr. Mark Decerbo

Commission Members Absent

Flo Khan – excused

Advisory Commission Members Present

Ryan High, Executive Director, Silver State Health Insurance Exchange
Laura Rich, Executive Officer, Public Employees Benefits Program (PEBP)
Barbara Richardson, Insurance Commissioner, Nevada Division of Insurance (DOI)
Richard Whitley, Director, Nevada Department of Health and Human Services (DHHS)

Commission Staff Present

Malinda Southard, Executive Director
Suzanne Sliwa, Deputy Attorney General
Kiley Danner, Policy Analyst

Agenda Item II – Approval of October 19, 2022, Minutes

Dr. Ikram Khan, Chairman

The Commission was presented with an email draft of the summary minutes of the October 19, 2022, meeting.

MOTION was made to approve minutes of the October 19, 2022, meeting as presented, by Commissioner Van Houweling. Seconded by Commissioner Winkler. Carried without dissent.

Agenda Item III - Public Comment:

Helen Foley, Nevada Association of Health Plans (NvAHP)

On behalf of the Nevada Association of Health Plans, Ms. Foley addressed some concerns to the PPC. Regarding the Draft Health Equity Plan, she discussed slide seven on guiding principles, which speaks about the PPC's work being informed by a diverse group of stakeholders and that the PPC will educate itself and actively collaborate with state agencies and organizations. The Nevada Association of Health Plans (NvAHP) has engaged with the PPC throughout its tenure, however, there is no representation by health plans on the PPC. Today, we ask how can we engage more meaningfully with this commission? We find that at almost every meeting, questions arise regarding insurance and there is no one to weigh in to provide needed information. An insurance executive was asked to be part of the Commission's stakeholder advisory group, but the expanded stakeholder group was rejected by the PPC. Regarding the cost growth mitigation strategies, NvAHP would like to reiterate concerns on impeding access to care with provider price caps/price growth caps – what mechanisms does the PPC envision having as guardrails in case this has unintended consequences? NvAHP is very concerned about including large groups in rate review. Large groups are rated based on their experience. However, the current proposal indicates that a community-type rating with a variable high-and-low amount is being proposed. Groups that would have gotten a lower premium because of their experience would now have to get a higher premium to offset a group that has higher medical costs. For example, a group that has 51 employees could end up subsidizing a group that has 2000 employees. Since large groups have more flexibility in designing their benefits than individual and small groups, this could also impact the plan design for large groups. We often have large groups wanting to provide more benefits, but there may be hesitancy based on the need to have rates approved. Better performing groups would have more incentive to self-insure and pull out of the fully insured market, which means that the cost for large groups would then go up. We also caution you to be very careful about inflation. The PPC cannot view these targets in a vacuum. Inflation will influence costs from the providers, in the hospital setting, and in premiums. The PPC is focused on reducing premiums by reducing administrative and provider costs. Everyone knows the rising cost of prescription drugs is one of the main drivers of premiums. We encourage the PPC to explore ways to reduce the cost of prescription drugs to have any meaningful impact of premiums. Thank you for your time. NvAHP looks forward to continued conversations regarding these important issues.

Patrick Kelly, CEO, Nevada Hospital Association

Mr. Kelly addressed the PPC Commissioners regarding questions that were raised at the last PPC meeting about markets and cost shifting. The Kaiser Family Foundation reports that Nevada's health care expenditures per capita are among the lowest in the country. In fact, Nevada has the third lowest health care expenditures per capita in the United States. All the other states participating in the Peterson Milbank Health Care Benchmark program are much higher. Nevada's health care expenditures per capita are $8,348.00. Massachusetts is $13,319.00. That is 55% more than Nevada. Delaware, Connecticut, New Jersey, and Rhode Island are all thousands of dollars higher than Nevada. An important question to ask and consider is, do states with higher health care expenditures per capita have better patient access? Nevada has the third lowest health care expenditures per capita in the nation and we have poor access. Some may say we have one of the

lowest health care expenditures per capita, but our insurance rates continue to increase. One of the reasons is cost shifting. Cost shifting occurs when some groups do not pay the full cost of care received and other groups make up the difference. In Nevada, cost shifting primarily occurs from government payers to non-government payers. This is important because Nevada hospitals treat a disproportionate number of Medicare and Medicaid patients. Medicaid and Medicare beneficiaries represent 37% of Nevada's insurance market, but they comprise 70% of the patients treated in our hospitals. This distinction is important because Medicaid and Medicare payments do not cover the cost of care. Additionally, approximately 5% of hospital patients are uninsured. Typically, they are unable to pay the full cost of their care. Approximately 75% of the care provided in Nevada's hospitals is subsidized by non-governmental payers. The remaining 25% of patients are charged their cost of care plus the shortfall. If we want to improve access to care and lower the increases to the 25% of commercially insured patients, cost shifting must be addressed. Government payors must cover at least the cost of care provided to their beneficiaries.

Nicole Chauvet

Ms. Chauvet questioned why organizations in Nevada are not following what Governor Newsom recently signed into legislation. In short, Governor Newsom is making an effort to modernize California's medical malpractice system. In doing so, they have raised the caps for wrongful death lawsuits to compensate for inflation. Also, the major concern is that patients do not have rights in this area. Many patients cannot obtain an attorney for medical malpractice because the caps are so low. This is wrong, especially when it comes to wrongful death. If you had a loved one who passed away, such as I have recently, you would understand the struggle that you go through when you feel as if you have no justice. I question how we got here. There is no way the community members of Nevada would vote for their rights to be taken away like this. I understand the concept of keeping our doctors in Nevada. However, there must be balance because the system is currently drastically skewed. What would it take to have a revote to create a system by the people and for the people in this area? Not by insurance companies or medical corporations.

Agenda Item IV – PPC Bill Draft Request Update

Malinda Southard, Executive Director

Executive Director Southard discussed that the drafted language for the three bill draft requests (BDRs) for the 2023 legislative session was received and reviewed by the commissioners for any obvious errors or omissions. She noted that one obvious error was noted regarding the electronic health records BDR in that the words, "ensure patients" were somehow omitted from the final version of the intent that was listed on the BDR form to the Legislative Counsel Bureau (LCB). Executive Director Southard has since been in contact with our Deputy Attorney General (DAG) and LCB bill drafter, requesting an appropriate revision of the language to match the full intent of the commission. That re-do language was received from LCB and immediately sent for review by the Commission on November 15th, 2022, with no additional feedback received from the commissioners. No other obvious errors or omissions were noted from the Commission and the three BDRs will be pre-filed today, per the LCB deadline. Upon printing, each pre-filed bill will be made public. With the PPC BDRs in the hands of the legislature, Executive Director Southard will be working with the legislature and transparently sharing the process along the way. Future meeting updates on the PPC bill progress will be for discussion purposes only. This is designed to help manage expectations and the realities of the Nevada legislative process and our responsibilities to follow open meeting laws in our state.

One Commissioner asked if she could have one more day to review the language and what would happen if the BDR was submitted to LCB a day later than the deadline. The DAG commented she would not recommend missing the deadline. The Commissioner requested to have until the end of the day to provide any feedback to Executive Director Southard on the Commission's BDRs. No opposition was stated to this request.

Agenda Item V – Discussion of Drafted PPC Health Equity Plan Requested for Feedback from the Commission for Posting on PPC Website

Kiley Danner, PPC Policy Analyst

Ms. Danner addressed the Commissioners and noted that each should have received a copy of the Draft Health Equity Plan. She discussed the recommendations and feedback that was received. Slide two was recommended to clarify the definition of health and health equity, and removal of slide three. Slide five was recommended to include a general summary of Nevada's health disparities. Lastly, slide eight included questions posed by a commissioner. Ms. Danner asked the Commissioners if they had any ideas for specific steps to ensure there are not any unintended consequences or inequities as a result of the Health Care Cost Growth Benchmark.

One commissioner opined that one of the steps to ensure no unintended consequences is to continue stakeholder engagement, ensuring the Commission receives feedback from various groups. Another commissioner opined along with ensuring stakeholder feedback, the Commission should take efforts to solicit general public feedback, as well, to make the Commission more accessible and available to patients in Nevada.

Agenda Item VI – Nevada's Health Insurer Rate Review Process

Barbara Richardson, Insurance Commissioner, Nevada Division of Insurance (DOI)

Insurance Commissioner Richardson provided an overview of the Nevada Division of Insurance (DOI) Rate Review process for the fully insured health benefit plans and addressed some questions from the Commission during the October meeting. She began with an overview of the updated projections for health care sources in Nevada. The information was derived from multiple sources as there is not a definitive set of data that provides an annual look at the Nevada health insurance market. Once annually, the DOI compiles the latest data from the same set of reliable data sources to create a clear picture of the current state of the health insurance market. The DOI has statutory authority to review and approve health benefit rates for the individual and small group markets, which covers approximately 7% of the state's population. Large group commercial plans account for 12% of the population's health insurance coverage. The timing of individual and small group product and rate review filings is based upon the federal Affordable Care Act requirements; individual and small group filings are annually due to the DOI during the first week of June. To create uniform meaning in the information that carriers must include in each rate filing, a rate checklist is provided prior to rate filing season, including all information the federal government, the State, and the DOI require for individual and small group filings. Carriers must also include actuarial memorandum to provide specific information related to the filing such as support for the development of proposed rates, required actuarial certifications, premium development template, and Nevada data template. The DOI contracts with an outside actuarial firm to conduct an independent, detailed, actuarial rate review of every submitted rate request. Throughout the review process, the outside actuarial firm and DOI staff each independently reach out to the carriers to get clarification of different elements within the carrier's filing, to maintain the integrity of an independent review. The objections period may relate to incomplete information and submission support related to included or not included trends or factors used for development that promotes weights; or anomalies, outliers, or inconsistencies which lack proper explanation or support. At the completion of the outside actuarial firm and DOI rate review, additional information is considered when determining the final approved rates. Next, a final rate gets approved and posted on the DOI website for consumer input. Then, a final rate is approved and submitted to the carrier, the public, the Centers for Medicare and Medicaid Services (CMS), and the Silver State Health Insurance Exchange. Insurance Commissioner Richardson then discussed the Nevada Medical Loss Ratio Rebates. In response to the Commissioner's requests during the last PPC meeting, Insurance Commissioner Richardson replied in detail. CMS timelines do not always factor into federal decisions on other issues and sometimes can end up affecting rates. Nevada relies on competition between carriers to create

the downward pressure on network contracts with providers, facilities, hospitals, and pharmaceuticals. These situations can result in rate increases to ensure a carrier has adequate surplus and capital to pay its consumer claims and liabilities. Otherwise, the rates would be inadequate. In response to a question about the DOI's ability to take on additional rate oversight to include the large group market in Nevada, Insurance Commissioner Richardson thought it would be helpful to understand why Rhode Island may have done that.

Chair Khan asked if the population data submitted for small and large groups includes the Employee Retirement Income Security Act of 1974 (ERISA) membership. Insurance Commissioner Richardson answered, the small group level funded plans and the association health plans are under the U.S. Department of Labor, which is the ERISA data. That population is very small in Nevada. A commissioner asked about what impact the public option might have on rates in the state. Insurance Commissioner Richardson replied the concern is the possibility of having the second lowest silver plan be the determining factor and regardless of what that plan is, it will be used as a bellwether for other plans regarding how much the federal government will give back to Nevada, and how much the risk adjustments provide back to the consumers. Relatedly, another commissioner inquired if a legislative remedy is required for this concern. Insurance Commissioner Richardson replied, a legislative remedy would be necessary to change the public option. The commissioner then opined this is something the Commission may want to consider in the future. Another commissioner opined that the information contained in the Forbes article about the most and least expensive states for health care needs to be taken in context of the average household income for constituents in the United States, as Nevada is well below the average household income. Therefore, everyone must consider what the average patient can afford here in our state. Another commissioner opined that one of the things not considered here is the percentage of profits that are tied to providers can be broken up between the hospitals and the physician/provider communities; profits are invisible when looking at the data presented today.

Agenda Item VII – Prioritization of Cost Growth Mitigation Strategies

Michael Bailit, President, Bailit Health

In September and October, Bailit Health presented overviews of four cost growth mitigation strategies summarized in the meeting materials for today. All four strategies are informed by the phase one cost growth driver analysis using both Nevada Medicaid and the Public Employees' Benefits Program (PEBP) data, which show that prices are driving high spending growth. These four strategies all have the opportunity and intention of helping Nevada keep health care spending below the cost growth benchmark.

Mr. Bailit gave a summary of provider price caps and price growth caps. Mr. Bailit then discussed the feasibility of implementation and potential impact of each. Political feasibility is challenging because it is likely for strong opposition from whichever provider types might be targeted. Whether administered through purchasing authority or insurance regulation, it is not that complex. In terms of impact, it can be significant, but depends on where the caps are set and how broadly they are applied.

Ms. Vangeli gave a summary of prescription drug affordability strategies and then discussed the feasibility of implementation and potential impact. The feasibility varies significantly based on which of the strategies would be pursued, but a high-level overview was provided. Political feasibility would be challenging due to the likelihood of strong opposition from the pharmaceutical industry. In terms of financial feasibility, a prescription drug affordability board would have high implementation costs for the state, whereas international reference pricing and penalizing excess drug prices would have medium/low costs for the state.

Next, Ms. Vangeli provided a summary of health insurance rate review and then discussed the feasibility of implementation and potential impact. Politically, this could be challenging based on the level of opposition from the health insurance industry. Financial feasibility and administrative complexity are low to medium based on mechanisms pursued. The potential impact on slowing health care cost growth is medium to low based on mechanism such that adding affordability/public interest criteria may result in lower premium

increases; expansion to large group market may result in lower premium increases for large businesses and their employees; and additional transparency through public hearings could help put downward pressure on premium increases. However, it is challenging to quantify what these impacts would be.

Chair Khan inquired what percentage of health care costs are related directly to prescription drugs. Mr. Bailit answered it depends on the market; meaning we only have data for PEBP because without an all-payer claims database, we do not have access to that broader data in the state. A commissioner stated that even though ERISA plans, which the Culinary Health Fund is a part of, do not provide that data publicly, she would be willing to pull that data and provide it to the PPC Executive Director. She further offered to ask the Health Services Coalition if they are interested in providing their pharmacy data voluntarily for the purpose of evaluating prescription drug costs. Mr. Bailit shared that across other states, in the commercial market, the percentage of health care costs related to prescription drugs are approaching a quarter of total spending. Further, if we look at medical pharmacy, the infusion drugs sometimes referred to as part B, that percentage will increase, and that spending is growing much faster than retail pharmacy.

Mr. Bailit continued with an overview of multi-payer value-based payment (VBPs), and then discussed the feasibility of implementation and potential impact. In terms of political feasibility, the level of support or opposition from payers and providers depends on the scope of VBPs and the extent to which providers are expected to take on financial risk. Depending on how this is done, it may not be quite as effective at slowing cost growth as the other strategies. Lastly, the impact depends on the model being selected and the type of budgeting mechanism applied to payments. Both Oregon and Rhode Island are pursuing this approach, and both had their payers and providers agree on compacts and targets for implementing these models

A commissioner asked what potential impacts on health outcomes (health equity, affordability, and access) are for each of these strategies and any others that may be explored. Further, he is interested in exploring all four of the strategies presented. Another commissioner is interested in exploring two of the strategies further: regulation of prescription drug payments with the international reference pricing and provider price caps. Further, she is interested in exploring if other states are only doing caps for people who live within the state, not having an impact on health tourism. Another commissioner is interested in exploring all four of the options further and would like to continue the discussion from the Nevada perspective. Another commissioner is also interested in exploring all four strategies, but specifically would like to concentrate on ensuring that patients come first and that there is equity and access. One commissioner opined that he is relatively opposed to the prescription drug affordability strategy unless pharmacy benefit manager (PBM) reform regulation is added and is therefore more interested in a deeper dive on the other three strategies. Another commissioner opined that she does not think any of the strategies should be taken off the table and that she supports further exploration of each of the strategies. Chair Khan opined that he would also like to further explore all four strategies. He asked Executive Director Southard to add one strategy to the agenda at a time starting in January 2023. Another commissioner concurred.

Agenda Item VIII – Implications of Inflation for Assessing Cost Growth Benchmark Performance; Options Presented

Michael Bailit, President, Bailit Health

Executive Director Southard introduced this topic as a request from Chair Khan. There are five potential options for responding to the pressures of inflation for assessing cost growth benchmark performance. However, per the Chair's request, this introductory conversation will include just three options.

Mr. Bailit began with a definition of inflation to ensure a common understanding. The cost growth benchmark, which used potential gross state product (PGSP), a forecast of future state economic growth, uses an inflation measure termed personal consumption expenditures (PCE). PCE is defined as a measure of the prices that people living in the U.S. pay for goods and services. It is derived from a survey of businesses and what they

sell and is the Federal Reserve's preferred measure when setting monetary policy. For context, when the governor issued the Executive Order establishing the cost growth benchmark, the methodology for establishing the value was a weighted average of forecasted median wage growth and forecasted gross state product or potential gross state product. Inflation was embedded in the gross state product value and the value that was embedded in it was the long-term forecast for inflation, the federal government's target rate, of 2%. The cost growth benchmark values reflect a shift in weighting from heavily on GSP or PGSP because it is long-term forecast to weighting more on median wages. The Executive Order for the Nevada health care cost growth benchmark states the PPC may recommend changes to the benchmark or changes to the way benchmark performance is assessed, should they find there have been significant changes to the economy. The statistical relationship between inflation and health care spending shows that inflation and growth in real gross domestic product (GDP) are highly predictive of growth in health care spending. However, the effect of inflation on health care spending lags over two years due to the prospective nature by which prices are set for health care services. Commercial payer prices are often set in multi-year contracts and public payers set prices prospectively, but do not change them frequently. Inflation (PCE) has climbed dramatically since late 2021 and health care prices began to rise slightly in the summer of 2022. General inflation is forecast to significantly drop in 2023, largely in response to rising interest rates.

Option number 1 presented to the Commission for responding to inflation and workforce cost pressures is to make no adjustments and commit to acknowledging the impact of inflation and labor shortages when interpreting results. The strengths of this option include consistency with the original intent for the benchmark values to be established for long-term use; and it maintains some degree of accountability for affordability during a period when wages are not growing as fast as inflation. Option number 2 presented to the Commission is to create a specific allowance for exceeding the benchmark on a time-limited basis for those years with very high inflation. This would be an adjustment applied assuming that lagged impact. This option maintains benchmark values but creates a temporary adjustment to inform interpretation of performance, thereby acknowledging the impact of inflation and labor shortages. It also maintains accountability for affordability, albeit at temporarily increased levels. Option number 3 presented to the Commission redefines the benchmark values on a time-limited basis for those years with very high inflation. Strengths of this option include that it acknowledges the impact of inflation and labor shortages and maintains accountability for affordability, albeit at temporarily increased levels.

A commissioner asked Mr. Bailit to clarify that these options are just for the benchmark and reporting and clarifying that there are no penalties for exceeding the benchmark in the program's current form. Mr. Bailit agreed and stated the only accountability mechanism currently in place is public reporting of who met or did not meet the benchmark. The commissioner opined that for that reason, she is in favor of option number 1. Another commissioner agreed that because the benchmark is not associated with any penalties right now, she also favors option number 1. Mr. Bailit shared there is some value in the other approaches, as the application of the benchmarks in other states, in practical terms, is when payers and providers sit down to negotiate contracts. If the benchmark value is viewed as being more reflective of what is happening with inflation and costs for providers, then it is more likely that the insurer and provider will negotiate a rate around the benchmark value. Therefore, the concern with option number 1 is that it might mean that the benchmark has the potential to lose its value in being a restraint on spending. A commissioner asked if the benchmark already includes inflation. Mr. Bailit answered that is correct, in part, because it is a weighted average. For the gross domestic product (GDP) measure, it assumes that inflation is 2%. Another commissioner opined she would lean towards option number 2. Another commissioner opined that he is in favor of option number 3, recognizing that we are in some extraordinary times. Another commissioner opined that she wants to heavily advocate for option number 1 because in her opinion, options 2 and 3 have the potential to hurt consumers more than option number 1. Another commissioner opined he is also in favor of option number 1 along with several other commissioners.

Agenda Item IX – Prioritizing Goals, Objectives, Activities of the Commission in 2023

Malinda Southard, Executive Director

Executive Director Southard began with an overview of the priority charge of the commission thus far in improving health care affordability, the health care cost growth benchmark. This project's continuous cycle is a focus on health care affordability and is expertly aligned with the primary charge of the PPC itself to systematically review issues related to the health care needs of residents of Nevada, and the quality, accessibility, and affordability of health care. Executive Director Southard also noted that she queried the commissioners to submit other topics or issues within the statutory charge of the commission they would like considered as an added priority and focus in 2023, and has received input to improve health care accessibility, thus far. Along with Chair Khan, she would like to suggest for discussion today that the PPC consider accessibility and affordability as the two main pillars for the commission's work over the year ahead. She noted the Commission can always review a range of strategies to improve provider accessibility in 2023 to help bring forward educated and thoughtful recommendations to the Governor and the Legislature on both proposed pillars and provided an outline of the suggested goals.

One commissioner noted that the Commission has discussed the shortage of nurses and physicians in Nevada and that it occurred to her that instead of the PPC trying to figure out why they are not staying, the Commission can instead look to ask them directly in a statewide survey. She asked the other commissioners for their support for this idea and suggested coming up with strategies on how to meet their needs after the PPC receives the results of the survey. Another commissioner seconded the proposal and thinks it is a great idea. She hopes there would be a section on how those nurses and physicians feel about raising families in our state. Another commissioner opined that she would like the commission to consider some sort of actionable item that empowers the Executive Director, in her capacity, to use the resources available to her. Specifically, she noted that the budget is small, and would like to ensure the Executive Director has the resources to be successful. Chair Khan opined that we would need a third party to help develop the survey questions and that the survey could be easily conducted before graduation. Another commissioner opined the need to also ask why some providers are not coming to the state and wondered if the PPC can ask the state licensing agency what the average time is for physicians moving into Nevada to get their license. Another commissioner opined that she agrees the survey is a great idea and suggested paying the Schools of Public Health to find a graduate student that incorporates the survey into their core assignment. Included in the discussion, another commissioner opined that he would like to find out what else affects accessibility such as transportation or cultural biases because that ties into our commitment to health equity.

Executive Director Southard then discussed the meeting cadence for 2023. She has asked the commissioners for their recommendations and came up with three options: to meet 100 percent virtually; meet in-person two times a year and otherwise virtual; or meet in-person four times a year and otherwise virtual.

Chair Khan noted that Wednesdays are challenging for him and suggested Thursday meetings in 2023. Further discussion was noted and a final meeting cadence for 2023 was not yet decided.

Agenda Item X – Public Comment

Barbara Richardson, Insurance Commissioner, Nevada Division of Insurance (DOI) indicated that she received two questions via chat during the meeting. The first question was whether Rhode Island was the only state to oversee the large group market. Insurance Commissioner Richardson answered no and that she was researching Rhode Island to give everyone an understanding. The second question asked why the DOI does not seem to be interested in overseeing some of the large group market since they often complain about not overseeing ERISA. Insurance Commissioner Richardson answered the DOI is not complaining about not overseeing ERISA, that it is just a fact. She apologized for coming across as possibly complaining and noted

that regarding the question about overseeing the large group market, her presentation was simply to explain to the Commission what the issues were and that overseeing the large group market could not be easily integrated into the oversight in the small and individual markets. There is no interest or disinterest from DOI, it is a policy decision that gets made through the legislative process.

Agenda Item # – Wrap up and Adjournment
Dr. Ikram Khan, Chairman

Meeting was adjourned at 11:06 a.m.

Respectfully submitted,

Kiley Danner
Office of the Patient Protection Commission

APPROVED BY:

Dr. Ikram Khan, Chair

Date: 12/22/2022

Meeting Materials

AGENDA ITEM	PRESENTER	DESCRIPTION
V.	Kiley Danner, PPC Policy Analyst	Draft PPC Health Equity Plan
VII.	Michael Bailit, President, Bailit Health	Cost Growth Mitigation Strategies Summary
VIII.	Michael Bailit, President, Bailit Health	Inflation Option Analysis