MINUTES OF THE
LEGISLATIVE COMMISSION'S COMMITTEE TO STUDY THE PUBLIC EMPLOYEES' BENEFITS PROGRAM (A.C.R. 10, 2003 LEGISLATIVE SESSION)
(File No. 91, *Statutes of Nevada 2003*)
February 7, 2006

The third meeting of the 2005-07 Interim of the Legislative Commission's Committee to Study the Public Employees' Benefits Program (A.C.R. 10, 2003 Legislative Session, File No. 91, *Statutes of Nevada 2003*) was held at 9:00 a.m. on February 7, 2006, at the Grant Sawyer State Office Building, 555 East Washington Avenue, Room 4401, Las Vegas, Nevada and videoconferenced to the Legislative Building, 401 South Carson Street, Room 2135, Carson City, Nevada.

COMMITTEE MEMBERS PRESENT IN LAS VEGAS:
Senator Mark Amodei, Chairman
Assemblywoman Chris Giunchigliani, Vice-Chair
Assemblyman Pete Goicoechea
Senator Bob Beers
Senator Bob Coffin

COMMITTEE MEMBERS PRESENT IN CARSON CITY:
Assemblywoman Bonnie Parnell

COMMITTEE MEMBERS ABSENT:
None

OTHER LEGISLATORS PRESENT:
Assemblyman Tom Grady

STAFF MEMBERS PRESENT:
Mark Stevens, Fiscal Analyst, LCB Fiscal Analysis Division
Gary Ghiggeri, Fiscal Analyst, LCB Fiscal Analysis Division
Bob Atkinson, Senior Program Analyst, LCB Fiscal Analysis Division
Linda Eissmann, Senior Research Analyst, LCB Research Division
Brad Wilkinson, Principal Deputy Legislative Counsel, LCB Legal Division
Becky Lowe, Secretary, LCB Fiscal Analysis Division

Exhibit A: Meeting notice and agenda.
Exhibit B: Attendance record.
Exhibit C: Anthem presentation handout entitled Discussions of Alternative Options for Providing Health Insurance to Participants of the Public Employees' Benefits Program.
Exhibit D: UnitedHealthcare presentation handout entitled State of Nevada Health Insurance Alternatives and Options.
Exhibit E: UnitedHealthcare presentation folder.
Exhibit F: Legal opinion prepared by Schreck Brignone, Attorneys at Law, for the Las Vegas Metropolitan Police Department.
Exhibit G: Selected Financial History of PEBP.

I. CALL TO ORDER AND OPENING REMARKS.

Senator Mark Amodei, Chairman called the third meeting of the PEBP ACR 10 Committee to order at 9:07 a.m. Ms. Parnell was present in Carson City and all other committee members were present in Las Vegas.

II. PRESENTATION AND DISCUSSION OF ALTERNATIVES AND OPTIONS FOR PROVIDING HEALTH INSURANCE TO PARTICIPANTS OF THE PUBLIC EMPLOYEES' BENEFITS PROGRAM (PEBP) AVAILABLE FROM PRIVATE INSURANCE CARRIERS.

Anthem Blue Cross and Blue Shield

Gabrielle Sansone, Sales Manager for Anthem Blue Cross and Blue Shield in Las Vegas, introduced Steve Scott, General Manager for Anthem's Public Entity Operations for Anthem West, and Dr. William Bannen, Regional Vice President for Health Care Management responsible for network development in Nevada.

Ms. Sansone confirmed that each committee member had a copy of the Anthem Blue Cross and Blue Shield presentation (Exhibit C). Being sensitive to time constraints, she said she would gear her presentation to the questions provided by the committee, including the following:

- High-level overview of Anthem Blue Cross and Blue Shield
- Self-funded versus a fully insured program
- Bundled versus unbundled offering
- North and south cost differences
- Actuarial expertise
- Implementation timeline
- Network discount analysis

Ms. Sansone said that Anthem Blue Cross and Blue Shield, now a WellPoint organization, was the largest healthcare benefits company, with $44 billion in annualized revenue, and insured 34 million members nationwide. She listed Anthem Blue Cross and Blue Shield's financial ratings: A.M. rating was A (Excellent); Standard & Poor's A+ (Very Good); Moody's A1 (Excellent); and Fitch AA- (Very good).

Ms. Sansome said that Anthem Blue Cross and Blue Shield had a very broad product portfolio (PPOs, HMOs, point-of-service). They had the ability to customize plans to the needs of the state. They offered consumer-driven health plans, high deductible health plans and Health Savings Account programs. Anthem Blue Cross and Blue Shield was one of the most recognized health plans in the United States; one in ten Americans held a WellPoint or Anthem I.D. card.

Anthem Blue Cross and Blue Shield offered unparalleled network access through the Blue Cross association throughout the country. Because of the vast availability of the

network, they had 96 percent market penetration. Anthem Blue Cross and Blue Shield has offered healthcare benefits in Nevada for over 35 years. There were offices in Las Vegas and Reno and there were over 250,000 members in Nevada. She said that Anthem Blue Cross and Blue Shield offered an innovative and effective approach to claims cost management including predictive modeling, data leveraging, wellness programs and disease management programs. Anthem Blue Cross and Blue Shield was the northern region option for the current PEBP HMO offering which had 5,000 members.

Ms. Sansome referred to a chart on page 5 of Exhibit C. Ms. Sansome said Anthem Blue Cross and Blue Shield had a vast number of providers in Nevada. She went on to describe the Blue Card program that allowed members to access any Blue Cross provider, in all 50 states under the PPO platform. Within the HMO platform, a member could utilize the Blue Card for any urgent need. The HMO had a feature called Away From Home Care that allowed any member traveling outside of the service area to use a guest HMO program. That feature allowed more flexibility over state lines.

Steve Scott, General Manager for Anthem's Public Entity Operations for Anthem West said that he would respond to the list of questions from a perspective of Anthem's experience working with other public sector organizations. He would relate Anthem's approach to similar issues encountered with other public sector employers. Mr. Scott said he would respond to questions from the perspective of a consultant rather than a sales representative.

Mr. Scott commented that the 2005 Aon Consulting report was the best work he had seen on the subject (page 29 of Exhibit A of the January 11, 2006 PEBP ACR 10 Committee meeting). He said that the level of detail showed the commitment of the committee to perform a good and thorough job in their analyses.

Mr. Scott said that he would present the advantages and disadvantages of being self-insured versus fully insured from the standpoints of both benefit plan design and the insurance company. He said that while an insurance company performed a number of functions including customer service, handling transactions and oversight of medical management programs, above all things, an insurance company was a financial institution. He noted that premium rates were based on the degree of risk that the insurance company had undertaken. In all capital markets, risk must be rewarded and that cost would be factored into the fully insured premium rate.

Mr. Scott said that if an entity was uncertain as to its ability to withstand fluctuations in costs throughout a period, or if it did not have the financial backing and stability to fund the peaks and valleys of large movements in cash flow, then that organization should insure the programs that they administer. He explained that was the function of an insurance company, and there was an associated charge. An organization large enough to take that financial risk would be a candidate for self-funding their program, because the organization would not have to pay a third-party or insurance company to take on the risk. He explained that insured plans were subject to local and state regulations and the regulations on mandated benefits could limit the flexibility of the plan

sponsor in some plan design decisions. A self-funded organization did not have the same limitations because it would not be subject to local entity regulations and would have more flexibility in structuring the benefits to meet its own fiscal needs and the needs of its constituents.

Mr. Scott said that, with the current ala carte contracting structure, PEBP attempted to contract with the "best in breed" of all entities. The third party administrator (TPA), network, medical and disease management vendors were selected through a request for proposal process because PEBP believed they were the best available, resulting in a program with the best level of expertise in all areas. If PEBP were to contract with a single entity to provide the same services, the plan could be compromised by an organization that was generally good in all of the areas, but not the absolute best.

Mr. Scott went on to discuss the value of integrated services. He explained that many resources were put into the administration of health insurance and health benefit programs because it was complicated and affected the lives of human beings. To be truly effective, the committee would need to look beyond how to have the most cost effective claims administration model, network contract or health improvement program. There would be a benefit to considering a fully integrated program that would communicate across all fronts. He said that as the emphasis on having programs to address the health needs of constituents becomes present, the committee would see the value of having programs that communicate and integrate with one another. He said that the bundled services approach, by a very good insurance company's administrative model, would bring a portfolio of services together that were better in concert than the sum of the individual "best in breed" contracts.

Mr. Scott said he found it intriguing that health care costs varied substantially by region; costs in northern part of the state were not the same as costs in the south. Rather than go into detail about the reasons, he would focus on how other programs approached the issue. He said that if the goal was to create a program that would mandate participation by public agencies throughout the state, then it would not matter whether health care costs were greater in the north and in the south, because no one would have a choice in their participation; they would pay whatever legislative mandates required. Under that model, the committee would probably find it simple to have one statewide average rate.

Mr. Scott said that he understood the committee wanted a program equal to or better than anything the marketplace had to offer so that public agencies would voluntarily participate. To achieve that, the plan needed to be structured to compete in the marketplace against the other plans available to public agencies.

Mr. Scott said that, as with most insurance companies, Anthem established prices on a regional basis because costs varied on a regional basis. If a program was to compete effectively in the marketplace, he would encourage the committee to consider adopting some of the practices under which the marketplace operated. He would encourage regionally rating the plan. The program should take advantage of scale. He said that, if the program was self-funded, risk charges and cash flow expenses would not be passed along, so the overhead model would compete effectively in the marketplace and would operate more efficiently than any that they would be able to offer.

Mr. Scott said that if the program met the overall needs for the entities to attract, recruit and retain employees, then it would be a program in which individuals would want to participate. Anthem recommended a move towards a model that public agencies wanted to be a part of, as opposed to a model in which the state would have to engage in the political fiat of mandate and the repercussions that come with that.

Mr. Scott said that Anthem had expertise in working with public sector organizations and public sector purchasing tools. Anthem health plans were involved in the administration of programs in many states. Anthem provided services to over 2 million members nationwide. Their oldest client relationship went back 40 years. He referred to a list of state programs on page 10 of Exhibit C.

Regarding the topic of how well Anthem predicted claims costs, Mr. Scott said that an actuary could make or break a program. He said the committee had probably seen the benefit of accurate forecasting to develop budgets, and they have probably had episodes where the actuarial work was less than accurate. Many of Anthem's senior executives belonged to the Fellow in the Society of Actuaries (FSA). There were 137 credentialed actuaries throughout the organization. The actuaries allowed Anthem to achieve 30 consecutive quarters of hitting financial targets that were communicated ahead of time to Wall Street. He said that demonstrated the quality of Anthem's actuaries. Mr. Scott said actuaries worked with the tools available to them.

Mr. Scott told the committee that Anthem had established a pricing discipline that would work well for the state. The pricing discipline was based on the belief that the underwriting cycle was self-generated and created by the industry and how it interacted with competitors. There would be no need for anyone to get caught up into the underwriting cycle if they exhibited and diligently applied a good pricing and underwriting discipline. A public entity pool had the political pressure to set prices at a point above what would be appropriate to continue the funding of the program. Other public entity pools have taken that approach and have borne the risk of making bad financial decisions, leading to disbanding the pool and financial failure. Good pricing discipline would prevent that. Good pricing discipline would require constant attention to the variables. He explained, that was what actuaries were commissioned to do.

Mr. Scott said there were lots of moving parts in the industry that would influence what to expect in the future. For example, the pipeline of pharmaceutical drugs, the development of biotechnology drugs, and the expiration of patents causing drugs to become generic. He reported that Anthem employed a process that looked beyond the

unit cost at utilization of services in conjunction with the overall risk of the individuals using the service. The technology was predictive modeling. Predictive modeling would be used to look at expected costs by considering the underlying health conditions of an individual to project whether their health status was improving or deteriorating, and then factor that into the overall model. A level of expertise was required to refine forecasting models, but there were tools available that help tremendously.

Mr. Scott recommended that good forecasting would require the ongoing integration of any change in the contracting status of the network as changes in the underlying structure of the contract have a direct impact on future costs.

Mr. Scott said Anthem successfully worked with large organizations to make major changes to administration and health improvement programs in as little as 30 days, although they would not recommend that for an organization the size of PEBP. They would recommend making changes to be effective in 180 days minimum. He explained that would give sufficient time to assure the interest of all constituents have been considered and integrated into the process. He would not recommend any significant change in a period shorter than 60 days.

Mr. Scott said that there were tools available to allow the state to make good decisions about the value of different networks with which it may contract. Anthem offered ClaimsQuest™ in conjunction with a third party actuarial firm known as Milliman. ClaimsQuest™ used live claims data, to review the real activity of the program and answer the hypothetical question, "if these services occurred under another network, would the outcome of paid claims be equal to, greater or less than?" Although it was a simple question, it took a complicated model to answer because of the complexity in billing systems and claims transactions.

Mr. Scott said that if the plan switched from the current method of directly contracting with vendors to contracting with an insurance company on a fully integrated approach fixed administrative costs would rise substantially. He would also submit that they should rise substantially because the cost of providing a well-managed, integrated program would require investment and resources. Mr. Scott reported that Anthem would invest almost half a billion dollars in information technology infrastructure in 2006 to bring valuable services to customers such as the ability to log onto a website to get information about claims history. He said that Anthem was working along with the medical community on the development of integrated medical records. In conclusion, Mr. Scott said that Anthem used lots of integrated technology, as did its competitors, and that technology was a worthy investment that would not be available when contracting with a TPA.

Ms. Parnell commented that although Anthem was the HMO choice for the northern region, it was only available in certain counties. For example, it was her understanding that Carson City did not have an HMO choice. She hoped statewide HMO coverage would be made available.

In response to a question from Mr. Goicoechea about how much the plan would benefit if the size of the pool was doubled, Mr. Scott replied that there was a critical point where there was enough mass to be considered a pool; the plan certainly achieved that. Increasing that size provided marginal benefits. Mr. Scott said, for example, an increase in size would stabilize fluctuations in health care costs. It would also add precision to the predictability process. Mr. Scott expected that there would be some marginal benefit as the result of direct contracting for administrative services.

Dr. Bannen said that, from a contracting perspective, the larger the pool, the more leverage; the more leverage, the more likely the plan would be able negotiate a much better contract on some of the more expensive services such as inpatient hospitalization, outpatient surgery and even physicians. He said they had about 51,000 contracts in Nevada and they were the largest provider in the northern area of the state, Reno.

Dr. Bannen said that the Nevada Division of Insurance approved Anthem to sell the HMO in all counties of the state, including Carson, so he did not understand why the HMO was not offered as an option.

Ms. Parnell asked someone from PEBP to comment.

Leslie Johnstone, PEBP said she believed there was only one county in the north that was not covered by the Anthem HMO.

Mr. Thorne said the Anthem HMO was offered in Carson City and the rest of northern Nevada. Anthem was offered in every county except for Clark County, were Health Fund of Nevada was offered.

Mr. Goicoechea said that he understood the benefit in contracting, but if the plan went from 40,000 to 70,000, would there be an immediate significant reduction in premiums?

Mr. Scott said that with the emphasis on the word “significant,” the answer would be no. He would expect marginal benefits, but the plan was already purchasing at a large volume level, and benefiting from its large size. Doubling the size would cause incremental benefits, but not of the magnitude that a single public agency that changed to direct purchase would experience. As Dr. Bannen indicated, Anthem contracted on behalf of 250,000 members in the state and that represented lots of market leverage. Mr. Scott did not expect that the state’s numbers would substantially influence negotiations with contractors because Anthem already negotiated in numbers larger than the potential state pool. Mr. Scott said that if the state were to bring something else of value to the negotiation discussion, such as a variation in physician network, hospital network or outpatient surgery network, the dynamics might be altered. That would open the question as to whether Anthem would be able to negotiate contracts, specifically on behalf of this entity, based on the exclusion of some of the providers from the community.

Ms. Giunchigliani asked for clarification on the statement that if the state and local government pooled its employees, administration costs would increase. Mr. Scott said that if all services were pooled into one insurance company, he would expect that the costs of administration would be higher than with PEBP. However, the collective value of services offered would merit a rate of return on that investment.

Ms. Giunchigliani asked Mr. Scott if he recommended regional rating. Mr. Scott said that he strongly recommended regional rating, as long as participation in the plan was optional. Mr. Scott said it was important to be seen by constituents as another choice offered by the marketplace.

Ms. Giunchigliani recalled that several years ago the committee asked PEPB to request bids for the whole package and they did. There were only two responses because the product was too narrow. She suggested that if there were more plans for participants to choose among – more competition – then they could accommodate some of the rural areas. Ms. Giunchigliani posed a question to Mr. Scott: If the plan was voluntary and allowed other public entities to opt in, what would be the ideal amount of time the local government entity would have to stay in the plan so that there was no cherry picking?

Mr. Scott said that it would be recommended that the entity remain in the plan for no less than two years, but preferably five years.

Ms. Giunchigliani said that eventually they would need to talk about a secondary issue of concern: pre-funding of retiree health care costs.

Senator Coffin said he had been an insurance broker for a long time. He asked for Anthem's approach to rating those in public employment versus private employment. Senator Coffin said that people sometimes assumed that a larger group must give more marketing power, but, depending on the population, the rate could rise if certain conditions existed. Public employees had sick leave and vacation time to use for elective surgery and/or post-op or pre-op. Senator Coffin said that the companies he worked for would "up rate" a population like the state pool, because making a group twice a large would not have a material affect on the rates. Senator Coffin asked if public employee groups were still rated considerably higher.

Mr. Scott said that insurance companies apply an "industry factor" when they establish rates. They consider the industry in which the individual works. Some were a more favorable risk than others were. On an overall basis, public sector underwriting did not include any "loading," but there were some factors that would give the appearance of a load. Compared to the average employer, there were striking differences for public sector organizations. The overall tenure of individual participants in a public entity tended to be much longer than for a private corporation. As a result, the overall average age of a public sector employer tended to be higher than a similarly situated private sector employer. Also, public sector employers had a population with a large mix of retirees while many commercial employers had disbanded their retiree medical plans. In fact, only 16 percent of private employers offered a retiree medical plan.

Senator Coffin said that illustrated the point that there were no miracle solutions. A private carrier could certainly do a good job carrying the load and negotiating, but they were not going to get a radically reduced cost from pooling the public sector employees because of the ages and gender mix and the ability to get time off work for medical purposes.

Chairman Amodei asked if one of the discriminators between a private and public group was that the age tended to be higher because of the longevity factor, and the public group tended to have a larger retiree element, where the private did not have a retiree element.

Mr. Scott said that private sector retiree health plans did still exist, but the last published statistic he saw said only 16 percent of private employers offered such plans.

Chairman Amodei said that the benefits of the self-funded medical plan could not be compared to the benefits offered to employees of non-public employer, such as a major resort property.

Mr. Scott agreed.

Chairman Amodei noted that according to the Aon study, which was already a couple of years old, PEBP had about 23,500 active employees with an average age of 47 or 48, and about 5,600 retirees. The separate non-state pool had about 600 actives and over 2,500 retirees. Chairman Amodei asked if the active to retired ratio was high or low.

Mr. Scott said the ratio was a little over 20 percent. The standard underwriting guidelines gave a threshold of 30 percent, so PEBP did not have an inordinate number of retired employees compared to active employees.

UnitedHealthcare

The committee was introduced to Troy Jelinek, Regional Vice President for Public Sector Solutions for the Southwest and Pacific Region, Tom Dameron, Senior Vice President for the Public Sector West Region, and Dan Cadriel, Senior Business Manager for the Public Sector of UnitedHealthcare and PacifiCare.

Referring to page 2 the handout provided to the committee (Exhibit D) Mr. Jelinek explained that his presentation would cover the following topics:

- Public sector experience
- Considerations driving health & welfare benefit strategies
- Fully insured versus self funded
- Self-funding operating models
- Carrier transition – implementation, timing and expense
- Managing and predicting cost

Mr. Jelinek told the committee that UnitedHealthcare was a Fortune 20 company run by a physician. The company focused on technology, consumer engagement and medical management philosophy. About three years ago, they recognized that there was a strong need for their services in the public sector, so, within their organization, they put together an end-to-end business solution focused solely on public sector. To date they have about 3 million members, including 14 state solutions that were a hybrid of HMO, PPO, self-funded and fully insured. Mr. Jelinek said UnitedHealthcare put together customer solutions across all business segments within the company that focus on public sector clients. That would extend anywhere from medical management services to pooling of other public sector entities that roll up with state solutions. About half of the 14 states roll up other public sector entities within those states, so they have lots of experience in that area.

Mr. Jelinek said it was important to understand the dynamics of each public sector client. He said that UnitedHealthcare liked to understand the culture first. In most public sector organizations, there was a cradle-to-grave approach with many longstanding, committed employees embedded in the program. However, some public sector organizations had a different focus, so it was important for them to understand what the organization wanted to accomplish to put together a solution that made the most sense. Those factors might keep high performing employees, increase employee productivity and job satisfaction. Mr. Jelinek said that they accomplished that by focusing on claims cost early on by putting together incentive-based wellness programs for specific populations to focus on their disease state. He said there were certain populations within the state that had varying needs, for example, different regional needs, different ethnicity needs.

Continuing the topic of organizational culture, Tom Dameron said that a call center would fit into the “churn-n-burn” culture because employees were usually younger and there was high turnover. As a result, health care rates would be lower and there would be minimum efforts towards disease management because the return on investment was not very good because the employees were not there long enough to make a difference.

Mr. Dameron continued saying that PEBP’s culture would fit more into the “cradle-to-grave” culture where employees were with the organization for quite some time. PEBP had a strong commitment to disease management and health risk assessment, which had an important return on investment because the employees would be with them for a long time.

Mr. Jelinek said that he viewed the differential between fully insured versus self-funded as a funding mechanism choice within each of the public sector entities. There were advantages and disadvantages to both, but for the most part, they had a blend of both. That would not dictate the health and wellness strategy put forth for the customer. As mentioned earlier, it would come down to risks, whether the insurance company or the state bore the risk of tax implications and advantages of cash flow if self-funded.

Mr. Jelinek said that one scenario may have a lower fixed cost that non-integrated approach, the other may have a bit higher fixed cost. Because 85 percent of cost was due to claims, the deciding factor would be which vendor had the ability to put together innovative wellness strategies and outreach to control that cost.

Mr. Jelinek referred to page 7 of Exhibit D to a comparison between an integrated model and a non-integrated model. He said that UnitedHealthcare demonstrated a significant return on investment in some scenarios both on the fixed and variable costs. It was assumed that fixed costs would be less with an integrated approach, but that was not always the case. Benefits might be seen in the coordination of care, physician data sharing, evidence-based medicine approach, predictive modeling and data mining. Participants who used a number of services would be given a health risk assessment and then a wellness initiative would be tailored for the employee. In a non-integrated approach, if a participant had diabetes and hypertension, there was no management of those co-morbidities. Things were done retrospectively to control costs rather than proactively. Mr. Jelinek said that UnitedHealthcare had a dedicated group of wellness personnel and health coaches that put together a personal program for each member of a public sector client. He said that factor differentiated their program. There was lots of analysis done up front to recommend a strategy to focus on the wellness solution set and the medical management solution set that was not as robust in a non-integrated approach.

Mr. Dameron said he would like to reinforce a couple of key points. From an administrative expense perspective, if the administrative expense was 10 percent of total costs, and that went up 10 percent that would be 1 percent of your total overall cost. If claims costs were reduced by 10 percent, there would be a net reduction of 8 or 9 percent. The challenge they saw with the non-integrated self-funded approach was that healthcare was fragmented enough to begin with. The key would be how well the factors were integrated. He questioned how effective the non-integrated model would be in identifying the moderate and severe risk diabetics and then managing their condition. Using the integrated model, his organization would identify these individuals quickly and would know whether they got their hemoglobin or the results of their tests.

Mr. Jelinek spoke on the topic of implementation, timing and expense of a carrier transition stating that, because they had a dedicated public sector business segment, all of their implementation services were built into that process. They had a dedicated implementation manager focused on the state solution. That individual would be the point person, and would have a team of individuals across all services to ensure successful implementation. Mr. Jelinek said six months would be an ideal timeframe, but they could make the transition given at least 120 days. He said the cost of the transition would be imbedded in the retention cost, or as part of the fees if on a self-funded basis.

Mr. Jelinek said that UnitedHealthcare was the technological leader within the United States in the healthcare industry. He said that his organization spent millions of dollars annually to assure they had the tools to perform predictive modeling, analysis and to be able give that information back to the organization. There was a physician portal where

physicians communicated with one another and exchanged medical records electronically. There were employer portals where the employer had access to information on a real time 24-hour, seven-day per week basis. In addition, there was an employee portal through myuhc.com with treatment costs estimators, physician and hospital profiles, as well as other consumer tools that allow employees to make educated decisions about their healthcare.

Mr. Jelinek said that managing and predicting costs was UnitedHealthcare's strong suit. There were three segments of employees (page 9 of Exhibit D). The "Staying Healthy" employees represented about 73 percent of the population, and their claims would amount to $1,000 or less, representing only about 9 percent of total medical expenses. The "Getting Healthy" category was a transitional category. This group consisted of about 25 percent of the population and drove about 55 percent of total medical costs. "Living with Illness" were those with chronic diseases or acute care conditions, which represented only two percent of the population, but 36 percent of medical costs. It was important to manage the right condition at the right time.

Mr. Dameron said that individuals moved in and out of the categories constantly. He said that a healthy individual might not be healthy next year, so the data must be mined consistently to find potentially high-risk individuals and manage them before they become high-cost. He said that, from an insurance company perspective, that was what his company did for a living. A TPA would focus on how well they were processing claims timely and accurately. That was the inherent difference between the integrated and non-integrated models.

Mr. Dameron said the advantages of doubling the size of the pool would depend on the individuals brought into the pool. If they were school district employees, would they be more or less healthy than the current population? What was the school district contributing towards employee costs? If it was a high percentage on the employee but zero on the dependent, was there a risk occurring relative to that dependent? Mr. Dameron said administratively, there would be diminishing returns. For example, if administrative costs for 50,000 members was $15, that would not be cut in half by doubling the number of members. He said doubling the pool would give more ability to take a leadership role in encouraging the physician/hospital community to practice in a different manner. He said that if the plan wanted to modify its reimbursement approach and reward physicians and hospitals for quality care and specific outcomes, certainly the bigger population would make it more likely that those kinds of initiative be implemented.

Mr. Jelinek spoke on the topic of managing and predicting costs and said that the graphic on page 10 of Exhibit D showed a continuum of health status and some of the programs and services embedded to manage healthcare costs. The graphic also showed solutions for each health status; some of the successes of their program were early-on engagement and follow through with a health coach, who was a personal advocate for the members. He referred to a packet of information distributed to the committee that described all services available to the public sector (Exhibit E).

Mr. Jelinek said that they were very proud of their ability to manage and control trend over time. UnitedHealthcare was the only national plan to reduce trend every year since 2001 (page 11 of Exhibit D). Some of the factors were that UnitedHealthcare promoted physician engagement and adherence to an evidence-based model. The engagement and data sharing with physicians drove variation out of the system. He said that UnitedHealthcare had consumer focus tools and information that enabled individuals to seek healthcare services from the highest quality and most efficient providers. With physician data sharing and consumer tools, UnitedHealthcare had both educated providers and members using quality facilities. That enabled them to control and manage costs over time.

Mr. Jelinek said one of the strong points that resonated through the presentation was that, because they were dedicated to the public sector, they approached customers as a partner rather than a vendor. He said they listened early on and focused on what was key for the organization because every public sector client had commonalities, but there was lots of variation. Lastly, they were able to put together national expertise as well as local presence to provide a solution that made the most sense for the employees and the different demographics.

Mr. Dameron returned to the question raised earlier about the proportion of the retirees to active employees. He said that ratio would change dramatically over the next 5-10 years. Currently, there were roughly 42 million Medicare members, but in 2030 that would almost double to 77 million. Ten thousand people every day turn 50 years old. He said that, if the group was already a little older than average, it would be important to look at the “age in” over the next five or ten years to see who would be “aging in” to the retirement system because it would happen lots faster then it had historically.

Chairman Amodei asked if the UnitedHealthcare representatives had any thoughts about dealing with the politics of how public sector health care budgets were funded cycle-to-cycle. He asked whether they were on a one-year cycle or two-year cycle and how variations in the budgets were handled.

Mr. Jelinek said that some of their state contracts were on a three-year basis, but most were on a five-year basis, with a renewal clause built in after that for one or two additional years.

Chairman Amodei asked if they used a three or five-year contract so the state knew what to expect for the next 36-60 month cycle.

Mr. Jelinek said that would depend on the funding type. For self-funded programs on the administrative costs, certain increases could be built-in, such as a certain percentage each year. For those costs, the program would have control and know what their fixed costs were going to be. However, the variation would fall on the claims side.

He continued, saying, on the insured side, UnitedHealthcare implemented a unique arrangement called a benefit care ratio or a medical loss ratio guarantee. Based on the performance of the group, a two or three year cap was established determining what the increase maximum would be for the fully insured rates based on their population.

Chairman Amodei asked for the ratio of the UnitedHealthcare public sector clients that were self-funded versus fully insured.

Mr. Jelinek said that two-thirds of the states were self-funded and one-third was fully insured. One state was on a retrospective risk-sharing arrangement where they shared in the losses and gains.

Chairman Amodei asked, for those states that were self-funded, what part of the governmental infrastructure was the primary contact for UnitedHealthcare?

Mr. Jelinek said most of the contacts were in the Executive Branch's Administration, Finance, Personnel or Human Resources Department. Personnel from the executive offices were involved in annual clinical consultations where UnitedHealthcare reviews the group's financials.

Mr. Dameron said due to the new GASB regulations, there was a refocus of the concept of insurance. Insurance traditionally meant someone was subsidizing someone else; the healthy 20-year old was subsidizing the less healthy 60-year old. On the public sector side there were different rating mechanisms. Sometimes the early retirees were combined with the active employees. Sometimes the early retirees were separate, or there was an explicit subsidy applied. Sometimes the Medicare and early retirees were combined for rating purposes. He told the committee to be mindful that the plan should not attract an unfair share of the higher risk population because that would create a higher level of expenditure and increase the GASB liability. Also, be aware of solutions to maintain the current benefit coverage and quality at a lower cost. For example, there were two different types of Medicare plans: 1. Medi-gap where Medicare was primary and then secondary coverage was paid through the TPA; and 2. Medicare advantage where Medicare paid the carrier up front the full amount and that carrier was at risk. Typically, there are Medicare HMO products. There was also a new product called Medicare Advantage private fee for service, which offered the cost benefits typically seen only in a Medicare HMO with the member physician-friendly attributes typically seen only in a Medi-gap plan because there was no network applied. Mr. Dameron said GASB was causing the industry to look for new solutions to manage the cost for retirees without affecting current physician accessibility or benefits. There had not been much of an appetite at this point to change the contribution formula dramatically. There had been a lot of rhetoric, but no state had been successful in making legislative changes.

Chairman Amodei told the presenters that if the committee were to request an RFP it would need to know the following:

- how the RFP should be structured
- the associated cost
- the timeline

He did not want for an RFP to be disregarded because the structure or timeline was wrong.

The committee observed a moment of silence in recognition of the memory of Sergeant Harry Prendes, Las Vegas Metropolitan Police Officer, who was killed in the line of duty on February 1, 2006, and whose funeral was scheduled today.

Sierra Health Services

Jack Kim, Director of Legislative Programs for Sierra Health Services, gave a brief overview stating that Sierra Health Services started in Nevada as a clinic run by a cardiologist named Dr. Marlon. The clinic still existed as Southwest Medical Associates. Currently there were 13 clinics and 200 providers in southern Nevada. Sierra Health Services was distinctively different from other health plans in that it had a group model similar to Kaiser. Sierra Health Services offered Health Plan of Nevada (HMO), Sierra Health and Life (PPO), and Sierra Healthcare Options provides TPA services, which was also contracted with the state of Nevada. The MedCare Advantage Plan covered 50,000 seniors on Medicare in an HMO, mostly in the Las Vegas area. There was a prescription drug benefit program for seniors in the Medicaid managed care program for the state of Nevada.

Mr. Kim said he agreed with many of the ideas already discussed. One of the advantages of a fully insured product was that costs were predictable. Costs were fixed so that premium costs could be predicted. If there was a catastrophic loss, or a trend toward additional costs, those costs would be borne by the insurance company rather than the state. A fully insured program required additional Department of Insurance oversight that was not required with a self-insured program. In the fully insured market, the Division of Insurance did solvency examinations, market conduct examinations and reviewed policies to ensure they were within state law. Nevada passed the Patient Protection Act of 1997, which meant that all members in fully insured plans would have those protections. These include grievance and appeals procedures, external review and prompt payment requirements. Sierra Health Services had complied with all the mandates listed in statute. He said that his organization also paid insurance premium tax, generally 3.5 percent, to the state General Fund. On the flipside, those could all be disadvantages to being in a fully insured product because the costs would be passed along to the state.

Mr. Kim said there were a number of advantages and disadvantages to being self-insured. Self-insured employers did not have to comply with the Patient Protection Act, which could be an advantage or disadvantage depending whether you were an employee or viewing it from the state perspective. Self-insured employers were not reviewed by the Department of Insurance, usually did not have to follow state mandates and did not pay premium tax. Self-insured employers experienced more peaks and valleys. Mr. Kim recalled that in the past, claims cost exceeded funds received, and General Fund money was used to pay the difference. He said ultimately in a self-insured from like PEBP, the taxpayer was responsible.

Mr. Kim outlined the advantages and disadvantages of a PEBP style system versus a fully insured system. An advantage to the insurance carrier would be that the employer could perform audits. In a similar program with federal employee benefits, the federal government audited to make sure the plan and the carrier were meeting the criteria and were solvent. With an insurance carrier, you could offer an HMO or PPO model, which might be appropriate for some employees. You could offer multiple insurance companies and tailor programs to meet employee needs, similar to the federal employee benefit plan.

Mr. Kim said that if the state chose to use an insurance carrier, the run-in would have to be taken into account. There would be claims and liabilities on the books that would have to be accounted for. He said that, with a group this size it could be fairly substantial and could take anywhere from three to six months.

Mr. Kim said the differences between the northern and southern regions in medical costs had been discussed repeatedly, so he would not go into detail. One option to address the cost differential between north and south would be to use a blended rate so the rate would be the same for everyone. By using a blended rate, the people in the south would end up paying more. Sierra Healthcare Services did not advocate for or against that option. Mr. Kim said there might be resentment from the people in the south because their premiums would increase.

Mr. Kim said Sierra Healthcare Services, through its subsidiaries, HPN, SHL and SHO, had lots of experience in Nevada. At the time of the meeting, they were providing the HMO to the state of Nevada under PEBP, with approximately 5,000 members. Sierra Healthcare Services offered a PPO under the Sierra Healthcare Options to approximately 8,600 employees of the state of Nevada. He said that his organization had extensive experience providing coverage to the public sector of Nevada, including the Clark County Teachers' Health Trust, Clark County Association of School Administration, Professional-Technical Employees, Education Support Employee Association, the city of Henderson, the city of North Las Vegas Housing Authority and the City of Las Vegas.

Mr. Kim said that using their system, it would be difficult for him to perform a claims run to find out whether there would be savings using an insurance carrier. That was because of the number of capitated arrangements in southern Nevada; all of their clinics' contracts were capitated. That differed from the fee-for-service of other contracts. Similar to the Kaiser mode, they paid a physician a set amount per month for each member, and that physician took care of all of the medical costs. For that reason, it was difficult to compare that to the Anthem or United model.

Mr. Goicoechea asked if there would be any real difference between being self-funded and fully funded when addressing the regional pricing issues.

Mr. Kim replied that the cost drivers and rules in northern Nevada were much different than in southern Nevada. Southern Nevada had a myriad of hospitals creating competition to reduce costs. In northern Nevada there was more emergency room use because there were fewer urgent care centers. There were two primary hospitals with exclusive contracts, which raised the cost. In rural Nevada there were fewer providers, and that drove up cost. He said that the problem could be addressed by having more providers and more competition and over the years that would happen because the area was growing. Mr. Kim said there would be no difference in the regional rating disparity being self-funded and fully insured.

Mr. Kim said Sierra Healthcare Services would provide the committee with a brief fact sheet stating what they thought the RFP should include.

Ms. Giunchigliani said the committee should discuss whether a federal "cafeteria" type model could be used where other public employers would be allowed to opt in. They would be required to stay in the group for a certain period. She said there would be a long-term inversion affect where many of the smaller groups would wind up with more retirees than actives, which was what happened to the non-state pool. She said that a federal model might be the best approach, then allow every private insurance group to bid and see which component they can best provide. She asked that the committee not lose sight of that option.

Mr. Kim said that Sierra's health plan was offered to federal employees. Some of the plans limited who could enroll. For example, the mail handlers had their own plan; a mail handler could elect another plan, but they were the only ones allowed into the mail handers' plan. Mr. Kim said the federal employee model was interesting because it made costs predictable. Mr. Kim said that, under the federal plan, the government paid a percentage of the premium and the federal employee received a book that outlined the plans offered in the area. If an employee traveled all around the country, an HMO limited to one geographical area would not be the best choice; rather, they would want a PPO that covered more costs elsewhere. However, if the employee stayed in one area, they would want an HMO that provided low costs and different services. He said that what was lost in these conversations was that the employees asked for more choices; they did not want to be limited to a self-funded plan with one HMO and one PPO. It empowered them to find a plan that fit their needs of price and quality of care. He

asked the committee to consider this, particularly when some non-state entities have indicated that they would not join the plan.

Chairman Amodei thanked Mr. Kim for his presentation and asked for any non-proprietary information the committee would need to include in the RPF.

III. PRESENTATION AND DISCUSSION OF THE FINANCIAL HISTORY OF PEBP.

Bob Atkinson, Senior Program Analyst, Fiscal Analysis Division, Legislative Counsel Bureau (LCB) asked the committee to recall that at the January 11, 2006 meeting, the committee discussed the development of reserves over the last four years. At that time, the committee asked for additional information, primarily on revenues broken into components of employer contributions or participant contributions. Mr. Atkinson explained that the program did not track revenues in this manner from the perspective of PEBP, but it would not matter whether the employer or employee paid the premium. Because the committee viewed the information from the perspective of the state, he showed the revenue for the entire program, broken down by the proportions relative to state employees. He asked the committee to note that under first row of the table (Exhibit G) employer contributions ranged from 81.8 percent to 88.6 percent with the participant picking up the balance. Mr. Atkinson said he used total revenues as 100 percent and then the percentages were shown for claims, insurance premiums, contractual obligations and other. He said that it appeared that in FY 2005 the increase in the insurance premiums and contractual obligations was due to having an HMO in the north again. Mr. Thorne agreed.

Mr. Atkinson pointed to the reserve line at the bottom of the table and explained that the net assets at the end of every year continued over to the beginning of the next year. Also shown was the incurred but not reported (IBNR) amount for the end of each of those years. The IBNR was taken into account as a liability before the net asset number was developed, but it was listed because there was some importance in having that funded. Below that were the state contribution and participant contributions. Mr. Atkinson said the retired participants' deduction varied depending on the number of years of service. The numbers listed assumed a 15-year retiree because they would get 100 percent of the base retiree subsidy. If the retiree had less than 15 years of service, the employee paid a higher portion and the state paid a lesser portion. If the retiree had more than 15 years of service, the state would pay a higher percentage and the participant would pay a lower percentage.

Chairman Amodei asked what conclusions could be drawn by comparing participants' increases or decreases in premium contribution compared with the state's, increases or decreases in contribution.

Mr. Atkinson replied that until 2005, the percentages for biggest part of the program, the active participants, the state contributions, seemed somewhat similar. The state contribution rose, then the participant cost also rose. That was because costs were rising. He said to remember that a portion of what the state and participant were paying to the program was used to continually dig itself out of a hole. In 2003, the legislatively approved budget included approximately $5 million each year to rebuild reserves and anticipated that would continue each year for the next four years to get to a break-even point where the IBNR was fully-funded.

Mr. Atkinson said the program started turning around in 2004 due to a change in behaviors in the plan. The program implemented cost saving measures at the direction of the Legislature and co-pays were increased. He said it did not take four years to build up the reserve. Therefore, in 2005, the piece of the state contribution that was building back reserves was no longer necessary. In 2005, revenue from the state was about 89 percent and from the participant about 10 percent. Mr. Atkinson noted that the state contribution rose about 12.6 percent while the deductions from the participants' checks decreased from the previous year's amounts.

Assemblywoman Giunchigliani noted that reserve for losses was $23 million, yet there were $31 million in assets.

Mr. Atkinson said that at the end of FY 2005 the IBNR reserve for losses was $23 million. The liability for IBNR was removed from the plan's net assets leaving about $54 million. The budget approved by the 2005 Legislature spent the reserve down to where it was anticipated that, at the end of the current biennium, the IBNR would be fully covered and there would be a $19 million rate stabilization reserve.

In response to a question from Ms. Giunchigliani, Mr. Atkinson explained there was no prohibition to use the reserves for pre-funding from a cost-allocation viewpoint because it would be allocated for retiree benefits. The discussion would evolve around whether the committee wanted to pre-fund in the end. If there was not the intent to begin pre-funding, then it would not be a logical use of the excess, because it would be a minor piece of the amount needed.

Ms. Giunchigliani agreed that using the reserves for pre-funding would not get us where we needed to go, but it would be a start. She said that the rates could be brought down with some of the extra, and the Medicare cost offset with some of what remained.

Woody Thorne, Executive Officer, PEBP, said that there was a GASB issue; either pre-fund, or pay-as-you-go, but the two cannot be mixed.

Mr. Thorne confirmed for Ms. Giunchigliani that that was under GASB rules.

Senator Beers asked if the GASB rules required that the plan either fully pre-fund, or not pre-fund at all.

Mr. Thorne said the plan did not have to fully fund that year's liability, but it would have to make a commitment to the pre-funding concept and there would have to be contributions toward that pre-funding. The plan cannot pay the pay-as-you-go portion and then set aside some funds on a one-time basis. There had to be a plan to fully fund the pre-funding requirement. Mr. Thorne commented that Jim Wells was the PEBP expert in that area.

Chairman Amodei said in the most recent budget cycle, there was $46 million budget amendment that dealt with funding premiums from the state side for the plan. He did not fault the PEBP administration for that, because the money committees approved it. However, at the time of the approval participant premiums were increasing. The overages were then made available to the General Fund through the budgeting process. He asked, if it was okay to spend it elsewhere in the General Fund why was it not okay to sequester it for purposes of benefit and rate stabilization?

Senator Beers said the information contained in Exhibit G was great, but he asked that it be expanded to include the two years that were budgeted as additional columns to the right, so that we would see the four years of activity and then two columns of the budget, denoting that it was speculative and budgeted. He said this information would help show long-term trends.

Senator Beers asked Mr. Thorne about the 80-90 percent increase in insurance premiums and contractual obligations from FY 2004 to FY 2005.

Mr. Thorne said that by comparison FY 2001-02 had a much higher percentage for insurance premiums and contractual obligations. That was the last year that the plan had an HMO in the northern region. The plan was able to get an HMO in northern Nevada again for FY 2005. That caused the amounts to rise up to the same level as FY 2001-02. He said the expense was an insurance premium as opposed to a claim cost.

Senator Beers said that in FY 2002 there was a 3 percent reduction in the state's contribution and an 8 percent increase in employee contribution. FY 2003 started with a 7.5 percent increase in the state's contribution, but the employee contributions were split all over the place. Senator Beers said it appeared to be a net of 2 percent, without any weighting. In FY 2003 there was a 6.5 percent increase in the state contribution, but that was actually over the $465.78 which was a 30 percent increase mid-way through FY 2002. Then another 6.4 percent, and roughly 8 or 9 percent increase in employee premiums. In FY 2005, there was a 12.5 percent increase in employer contributions and a staggering decrease in employee contribution, 50 percent on average. Senator Beers understood the causes for the changes in FY 2001-02, but he questioned the extreme changes between FYs 2002 and 2003 that caused the consistent treatment of plan costs to be tossed out the window and inconsistent treatment be developed for each subgroup.

Mr. Thorne replied that part of the cause was the shift to predictive modeling in FY 2003-04, which predicted claims cost based on the health status of the individuals in the group. PEBP tried to make some modification to allow for a smooth transition, so the decrease in FY 2005 was an attempt to return that year's surplus to the participants. Mr. Thorne reported that while the budget was being developed for the 2003 Legislative Session, PEBP was still experiencing high claims, and projections for the state contribution were made on that basis. He said the experience turned around through a combination of a reduction in large claims and a change in behavior, which reduced overall utilization. Then, the money PEBP was receiving from the state contribution was higher than was necessary. Therefore, based on the participants having to suffer through those changes and the big increase in rates, the board made a reduction to the participant contribution. He said the plan returned to the normal trend from plan year 2004 in plan year 2006, and the difference of that reduced contribution made it look like a huge increase. However, viewed over the two-year period, it was a more normal trend. Mr. Thorne said that would occur each biennium with the state's contribution. He explained the purpose of the rate stabilization reserve was to absorb fluctuations if there was a big increase in claims, and then adjust in the next budget cycle.

Senator Beers said the predictive modeling technique did not require that participant and spouses be considered as a different group than participants and children anymore than it requires that participant and spouses in the Corrections Department be considered differently than participants and spouses in the Welfare Department. Senator Beers asked who made the decision to create the many sub-groups; that seemed to be a departure from the concept of sharing risk.

Mr. Thorne responded that while there was no requirement to consider the groups separately, it did indicate where costs were coming from. In using a tier basis, which was a smaller proportion of the entire group, the commingling of claims experience was a continuum. For example, it was common among Taft-Hartley plans with unions to use a single composite rate, the entire experience of everyone in the group combined, and everyone would pay the same rate regardless of whether they were active or retiree or whether or not there were dependents. The decision of where PEBP should be on that continuum would be a policy decision.

Senator Beers asked if that was changed by statute in the 2002 Legislative Session.

Mr. Thorne said that there was no requirement regarding the tiers in the statute; more exactly, it referred to participant and dependents.

Senator Beers said it would seem to be more sensible to pool the risk of all state employees as was what appears to have happened in FY 2001-02 where all of the groups premiums increased or decreased at the same percentage.

Mr. Thorne agreed and said he would cover in the next agenda item what was proposed by PEBP and approved by the board for rates at the March meeting. He said that PEBP was in its third year of predictive modeling. Tier costs were consistent with the structure now in place. PEBP administrators proposed and the board agreed to consider the tiers, but also considered the overall effect on the composite rate for the group and applied that percentage to each of the tiers, so each of the tiers would get the same increase going forward. Mr. Thorne said that PEBP would continue to review the tiers to find out if there should be a change because of a radical change in the demographics of the group. For example, they found that the PEBP participant and spouse group tended to be empty nesters; older couples who were experiencing medical costs and were big drivers of the plan. The parents and children, and participant and spouse with children groups tended to be younger and healthier and have a lower costs. That would not change over the next several years. Mr. Thorne said, for that reason, PEBP would want to keep the structure and the relationship of the cost between tiers, but apply the percentage increase equally across the board.

Senator Beers said there were two issues: 1. The policy decision made by the board to segregate the group into defined tiers; 2. The policy decision to use predictive modeling. Senator Beers said predictive modeling itself did not require dividing the larger group into tiers. Mr. Thorne agreed. Senator Beers said that in FY 2002, the rate increase for the participant and children and participant and family was both 8 percent, in FY 2003 participant and children was down 7.3 percent and participant and family was the same. He noted that the following year showed an increase of double the amount for participant and children versus participant and family. The year after that brought a double decrease for participant and children compared to participant and family. Senator Beers said the children of state employees have been arbitrarily put into two different groups and if there was a catastrophic illness in one group or the other, the risk would not have been shared among the whole pool.

Mr. Thorne said prior to the use of predictive modeling, the plan predicted trend, based on the experience. In the past, when a large claim had a significant impact on one group or another, that cost influenced the rates for those groups. The costs were for all participants or all spouses with no differentiation for whether they were old, young or in between. Predictive modeling would reveal whether the tiers were the cost driver as opposed to the components of the tiers.

Senator Beers said that would be useful internal information, but for determining rates it would seem to be a random system. There was no difference in the medical issues of one thousand children of parents who were either single or had a spouse providing some other insurance plan for the spouse, versus one thousand kids who were either insured as both parents working for the state or one parent not working. He understood a tier based on age, for example. Senator Beers said age banding was common in the industry, because there was a correlation. He did not believe there was a valid correlation of expenses to tier definition when participants and children and participants and family were split into two different groups.

Mr. Thorne replied that the four-tier structure had been around for a long time. It was the primary tier structure in the group insurance industry for pricing.

Senator Beers said, that did not seem very sensible considering the incredible variability in the rates.

Mr. Thorne said that the stability that the committee sought was what PEBP wanted as well. However, there was a big variability in the claims experience and the funding of the program over a three or four-year period and PEBP was now becoming stable and had the necessary funded reserves to provide the kind of stability in the program and rates.

Senator Coffin recalled the wild gyrations in the plan and subsequent increase in premiums and decrease in benefits. To make up for those changes, there was another tremendous change in 2004 through 2005, primarily in the most recent two years. He said the percentages did look upside down, but in fact, since the participant contributions were only 10 percent of the premium in the plan, these percentages, while large in terms of their categorical change, do not reflect a huge change in terms of the total plan. Senator Coffin expected that the plan would be stable based on the changes made by PEBP and approved by the board. Senator Coffin said there was lots of unhappiness and it was nobody's fault. He said the benefits were cut too much due to an overreaction. Now it made sense to increase the subsidy, at least for a short period. Senator Coffin asked staff whether his assumption was correct.

Mr. Thorne said the increase was a smaller segment in actual dollar changes, were it in the same scope as those percentage changes. For many years, there was no support on a policy to fund fully the IBNR. The IBNR was satisfactory and for a couple of sessions there was an attempt to get a rate stabilization reserve. Mr. Thorne recalled that he first talked about a rate stabilization reserve as Risk Manager in 1991. Because of the fluctuation in the program in 1999 and again in 2002, the plan needed that cushion. Mr. Thorne said that with stabilization in the funding source, there is stability in benefit levels and in the rate contributions on the part of the participants.

In response to a question from Chairman Amodei, Mr. Thorne replied that he had been at PEBP since June 2001.

Chairman Amodei asked if he had any ideas to assist with the challenges of the budget generation process.

Mr. Thorne replied that he had been through two budgetary sessions; the budget was already approved by the 2001 Legislative Session when he joined PEBP. He said the 2005 Legislative Session had been the most productive. Mr. Thorne recalled that his staff worked hard to come up with projections in building the three-year budget. Their only tool was trend analysis, and that was risky business. He reported that when PEBP administrators discussed rates with the PEBP Board in January 2005, it became apparent that the projections were too high. Based on decisions made by the board using the actuarial numbers, the budget was re-worked and a proposed amendment was submitted.

Mr. Thorne said PEBP did not give any money back to the General Fund, but reduced its request for funding to bring it in line with the revised projections. He said that PEBP did not expect to have any work program requirements for the current fiscal year. PEBP recently received projections for the next fiscal year from its actuaries and the numbers were within one-half of one percent of the projections for the next fiscal year on the expense side. Mr. Thorne said PEBP considered putting the state funding into a separate budget account, which was approved during the 2005 Legislative Session, so the active subsidy would go into a revenue account and the retiree subsidy funding would go into a revenue account, then to the operating budget. Mr. Thorne said PEBP drew from those accounts and if the number of retirees was off, they could continue to operate using reserves. If there was a increase or decrease in costs, the next budget could be adjusted as to what went into the revenue account and the operating budget continued based on the actual expenses. Mr. Thorne said he thought the process was working well in providing the Legislature with a clearer picture of the plan.

Chairman Amodei noted that the topic had segued into the next agenda item.

IV. PRESENTATION ON PUBLIC EMPLOYEES' BENEFITS PLAN OPTIONS BEING CONSIDERED BY PEBP FOR THE 2006-07 PLAN YEAR.

P. Forrest Thorne, Executive Officer, PEBP, said there were three basic types of coordination of benefits. The first would be the current PEBP process which was maintenance of benefits (carve out) and under this type of coordination, PEBP calculated what benefits were due under PEBP and subtracted any benefits paid by another carrier.

Mr. Thorne explained that the second type would be the methodology that was in place in plan years 1991 through 1994, 1999 and 2006. This plan type was integration of benefits were the plan calculated benefits after deducting what the other plan paid. It used the unpaid balance and then calculated deductibles and co-insurance. This type was in place for plan years 2000 through 2005.

Mr. Thorne said the third would be regular coordination of benefits (COB). Under this method the plan picked up the difference between allowable expenses and what was paid and the deductible was usually picked up. The process was more complicated than that, but the result was the same. This methodology was in place during plan years 1995 to 1998.

Mr. Thorne said under the maintenance and integration options, since COB typically affected Medicare retirees in a greater proportion than any other participant, the Medicare participant would be subject to the same maximum out-of-pocket expense, deductible and co-insurance as any other active or non-Medicare participant. However, in full COB, they would have the distinct advantage over other participants that the only out-of-pocket expense would be the deductible. PEBP considered the cost of changing from the current maintenance level to the next two levels of coordination of benefits. For the non-state group with a much higher ratio of retirees to actives, there would be a much greater impact.

Mr. Thorne referred to a table on page 4 of the meeting packet (Exhibit A) showing a 1.3 percent impact on the overall composite rates for state, but a 4.6 percent increase for the non-state. The regular COB was a 3.8 percent impact on the composite rate, but a 10.6 percent increase for then non-state group.

On the topic of the reimbursement of the Medicare Part B premium, Mr. Thorne said the deciding factor was the COB. PEBP proposed that if the plan stayed with the current maintenance of benefits under COB, the entire amount on the Medicare Park B reimbursement should be reimbursed. There would not be any additional outside premium cost that was not covered by the subsidy provided by the state.

Mr. Thorne said if it was decided that the plan would share the cost, on the claims side of the equation, it should continue the 80 percent reimbursement of the Medicare Part B premium. If PEBP selected a regular or full COB there was an advantage on the claims side of the equation, so PEBP would propose eliminating the Medicare Part B reimbursement.

Mr. Thorne reported that the reserve levels that were recommended for June 30, 2006, were developed by Aon Consulting as $23 million for IBNR, rate stabilization of $25.5 million, for a total of $48 million. Assuming the numbers were correct, the plan was in an even numbered year setting the IBNR and rate stabilization reserve levels to be used in the next biennium. When the budget was finalized in the summer of 2006, PEBP would use it as the budgeting basis for the next biennium. For the current biennium, PEBP used a total of $43.3 million based on $19.2 million for IBNR and $24.1 million for rate stabilization. Those numbers were set in June of 2004 as PEBP prepared its budget. PEBP was attempting to gear finances and management of the plan to that biennial budgeting process.

Mr. Thorne reported that PEBP discussed wellness, disease management and disincentives for risk behaviors and the topics were still open for discussion. One of the issues was whether they conflicted with certain federal laws such as the Americans with Disabilities Act, continuation of coverage and privacy issues. Through predictive modeling on the various tiers on the rate structure the plan saw a 22 percent increase for state actives that were participant only, but only a 2-5 percent increase for those with a dependant structure. Mr. Thorne said this was the third year where predictive modeling by itself showed fluctuation within the tiers. PEBP proposes that the composite rate be used and applied to every tier so that everyone had the same level of increase.

Mr. Thorne said PEBP looked at the rate change from a composite standpoint, then asked: considering all the experience together, what was the cost per participant? With that information, it would be simple to measure the impact on the overall program under various plan designs using a basic. PEBP considered the three options discussed previously and recommended to the board option two, which was to move back to the integration form of coordination of benefits and continue reimbursing 80 percent of the Medicare Part B premium. PEBP also recommended applying the percentage change in rates based on the composite increase, which works out to a 12.7 percent increase for actives and retirees for the state, and 10.7 percent for the non-state group.

Ms. Parnell asked, if all participants were pooled, and the total cost was divided by the number of participants, what would be the cost per person?

Mr. Thorne replied that it would be roughly $644.59 per month for state-actives and retirees and $682.31 for the non-state group.

Ms. Parnell recalled that when Assemblyman Grady left the program and got his own coverage, the cost was half that. She asked why the per participant cost was so high. She expressed hope that the insurance companies that presented earlier could bring that number down. She said she shared the concern with Senator Beers that PEBP had made the plan complex and difficult to administer. She asked, what would the cost be if the plan were simplified?

Mr. Thorne replied that the defining factor was claims. If the benefit structure was improved, more would be paid in claims, and more would be collected in rates to cover those payments. How the claims payments were divided was a policy decision and it would not change the total revenue one bit, or the amount needed to pay those total claims. Rather, it was a question of who was going to pay. Mr. Thorne said with a single structure composite the singles were supporting those with dependents. With a two-tier system, those who have children only would support those with spouses only. In any scenario, there would be winners and losers. Mr. Thorne said the issues were commingling, from the active/retiree standpoint and from a regional rating standpoint because participants in the south were supporting those in the north. In addition, it was a commingling issue across tiers comparing those with dependents and those without. Mr. Thorne said there must be a policy decision as to the most appropriate way to divide those costs; however, the total would remain the same.

Mr. Atkinson asked, if the $644.59 per participant Mr. Thorne quoted included children.

Mr. Thorne said that was per participant regardless of the number of dependents. Participant meant either active or retired employee. If the dependents were included, the term per member, per month was used.

Ms. Leslie Johnstone said in plan year 2005, PEBP had large claims from 1,270 participants that equated to approximately $220 for all participants to pay towards the cost of those large claims. She said that, in essence, of the $644 composite cost, approximately $220 went toward large claims for the top 1,270 participants.

Ms. Parnell said that back in the 1990 session when they changed the plan, they worked on the assumption that the larger the group, the lower the premiums. She commented that was not how things turned out. She asked, if the pool grew by inviting in local governments, would the plan continue to see an escalation of costs, and therefore not solve any problems? Ms. Parnell said that they were all frustrated that costs were not kept down as anticipated.

Mr. Goicoechea asked Mr. Thorne about the $644 and the $682 on the non-state side. He assumed that the difference in the non-state amount was because the numbers were skewed with retirees versus actives.

Mr. Thorne agreed.

V. PRESENTATION AND DISCUSSION OF THE FEASIBILITY OF ESTABLISHING THE PROGRAMS OFFERED THROUGH PEBP ON A BIENNIAL BASIS.

Mr. Thorne said that the committee requested information on the feasibility of PEBP preparing biennial plans and rates. He said that there were two issues involved: 1. the plan itself and 2. the rates to be charged. The process of establishing the biennial budget results in the formation of a biennial financial plan for the program.

As with all state agencies, PEBP prepared a biennial budget request for submission to the Executive Budget Office by September 1 of each even numbered year. The initial budget submission was based on a plan design approved by the PEBP Board and the cost estimates from the actuarial consultants to provide those benefits. If the board desires to make a significant plan design change because of feedback from focus groups and participants, a separate “decision unit” would be included in the budget request for the highest priority items based on the actuarial estimates to provide for those enhanced benefits.

Mr. Thorne said that during the 2006 rate setting process in January 2005, PEBP discovered that costs projections were too high in the original budget request. PEBP reworked its budget and submitted a revision to the Executive Budget Office and the Governor’s Office, and that was then submitted as a budget amendment to the Legislature. That was the first time PEBP submitted an amendment of this type to the

Legislature. Mr. Thorne expected no significant work programs in the first fiscal year of the biennium and initial projections from the actuary for the second year were within one half of one percent (0.5 percent) of the legislatively approved budget for the next fiscal year. PEBP intended to continue the process in future biennia to provide the best information to policy makers during the budget development cycle.

Mr. Thorne said once a budget was approved by the Legislature, PEBP worked to manage the program within the framework of that budget. While the board had discretion to change program design, the intent of the biennial budget cycle was to maintain revenue neutrality for any plan changes requested by the board. Significant changes to the plan design should only be requested through an enhancement decision unit in the subsequent budget development cycle.

Mr. Thorne said that, from a ratings standpoint, there were several reasons why PEBP believed the budget should be set annually rather than biennially. Public hearings were held to discuss the rate proposals each year, and it would be difficult to receive meaningful public input for rates if they were not going to be in effect until two years later.

Mr. Thorne said in addition, the current predictive modeling actuarial analysis used to set rates was only valid for the first year of the biennium. If multiple year rates were created, it would be necessary to revert to traditional trend analysis to develop rates, which was a much less accurate method than predictive modeling.

Mr. Thorne said the plan needed the ability to make adjustments to meet changing conditions. The adjustments could be in the form of benefit changes or participant contribution rate changes, or both. While the board would attempt to keep as many of these changes as revenue-neutral as possible, there could be circumstances beyond the program's control that would result in a revision to its approved budget. In plan year 2002 there was a horrendous increase in large claims. Mr. Thorne said the plan hoped to cover that through the rate stabilization reserves, but needed to have flexibility through the biennium. Based on this information, PEBP believes that the biennial budget process previously outlined fulfilled the intent of a biennial plan for the program.

Chairman Amodei said that according to the letter in the meeting packet (page 21 of Exhibit A) PEBP believed the steps implemented have made things work smoothly; they were right on the money when estimating expenses. Chairman Amodei asked, if the steps were working, why then did they not want to commit to the same level of stabilization in the rates?

Mr. Thorne did not think the plan was in a position financially to weather any storm. They would be in a much better position to do so than if they were setting rates for two years. He said rates could set based on trend analysis in the second year. That would be riskier from a standpoint of how much PEBP may have to use the stabilization reserve. That was why the stabilization reserve was established. Mr. Thorne said, if it was decided to establish rates for a two-year period, PEBP could work with its actuaries

to develop a budget revision amendment to be submitted right before session to provide up to date information.

Chairman Amodei asked if predictive modeling could be used for a 24-month cycle. Mr. Thorne replied that predictive modeling could be used for the first year of the biennium, but trend analysis would be needed for the second year.

Chairman Amodei asked if there was anyone in the industry using predictive modeling for a 24-month period. Mr. Thorne replied that he knew of no one doing that.

Chairman Amodei asked Linda Eissmann to contact the presenters to find out if any of them use predictive modeling for a period of more than one year. He recalled one of them testified that they had three to five year programs in that context.

Chairman Amodei asked for clarification on the assertion that plan needed to reserve the ability to make adjustments to the plan to meet current conditions. He recalled that in the 2002 Special Session, the Legislature made a policy that the state would bear the cost of those increases. Chairman Amodei said he assumed that when Mr. Thorne said the state needed to reserve the ability to adjust the plan rates, which would be done in conjunction with the Legislative Branch as the branch that appropriates money.

Mr. Thorne said they were looking to stabilize that to the degree possible. He said he was being conservative and wanted as much flexibility as possible to maintain the financial stability of the program.

Chairman Amodei said that Mr. Thorne indicated that public hearings were held to discuss rate proposals each year and it would be difficult to receive meaningful public comment for rates that would not be in effect until two years later. Chairman Amodei asked if that could be effected through scheduling public comment periods in relation to when the rates would be effective.

Mr. Thorne said that if rates were guaranteed for the next two years, public comments would be needed at the time those rates were set in order for it to be meaningful.

Chairman Amodei asked if public comment would be needed after that to comply with the rate schedule that was adopted. Chairman Amodei asked if Mr. Thorne thought the public would be averse to complying with the rate set for the coming 24 months.

Mr. Thorne said that would depend on the situation. For example, there may be a projected increase in that second year with a risk factor built in to cover the variability further out. He said the plan might have a rate increase in the second year that was higher than necessary. He said that if rates for the second year were too high, there would be the option to reduce the rate.

Assemblywoman Parnell asked for the definition of the employee plus family tier. Mr. Thorne replied that it would consist of an employee, spouse and children.

Assemblywoman Parnell observed that for an employee, spouse and a child the premium would be $841, but for an employee and spouse it would be $1,088. She asked how it could be more expensive for a husband and wife, than it was for a husband, wife and children.

Mr. Thorne confirmed that Ms. Parnell was correct. Employee and spouse tended to be the older empty nesters with medical problems while the employee, spouse with children tended to be a younger, healthier group and thus cost less to the program.

Ms. Parnell said that deduction was based on a segregation of claims based on group.

Mr. Thorne said that pooling all claims would be based on the experience of those four tiers and that would effect how much they contributed to the overall pool.

Ms. Parnell said it was a segregation of experience.

Mr. Thorne agreed.

Ms. Parnell asked whether that was an appropriate way to establish rates. It seemed crazy to her that rates for a family of six would be less than for a participant and spouse.

Vice Chair Giunchigliani commented that if the claims and experience were pooled, they would be rated accordingly. She said the Legislature should decide how much the rate stabilization should be. She knew what the PEBP Board recommended, but that was still a policy decision for the Legislature.

Mr. Thorne said there were two factors: one was the recommendation from the actuaries and the second was the limitations under the federal reimbursement of Circular A-87. PEBP was going through the cost allocation negotiations with the federal government, and one issue was how many days of cash the plan could maintain over and above IBNR.

Chairman Amodei said the positions seemed inconsistent. The plan would either be volatile and the reserves should be increased, or the plan would be stable and the reserves should be reduced. Chairman Amodei said that if the forecasts by the actuaries were accurate, the federal government should approve the larger reserve because of the plan's volatility.

The committee recessed for lunch at 11:59 a.m.

VI. PRESENTATION REGARDING STOP LOSS INSURANCE.

The committee reconvened at 12:53 p.m.

P. Forrest Thorne, Executive Officer, PEBP, recalled that the committee had requested an explanation of stop loss insurance and its potential impact on the program. He said he would provide a couple of definitions, a plain English interpretation and then a review of the pros and cons of stop loss coverage.

Mr. Thorne said stop loss was a form of reinsurance under which the reinsurer paid some or retained losses in excess of a predetermined dollar amount on a specific or aggregate basis. Mr. Thorne said reinsurance was a practice whereby one party called the Reinsurer in consideration of a premium paid to him agreed to indemnify another party, the Reinsured, for part or all of the liability assumed by the latter party under a policy or policies of insurance it issued. The reinsured may be referred to as the Original or Primary Insurer, or Direct Writing Company, or the Ceding Company.

Mr. Thorne said this meant a self-funded program, such as PEBP, provided medical coverage to its participants in exchange for contributions, which were fixed annually. If the medical claims paid by the program were less than the contributions, there would be a surplus. However, if the medical claims incurred by the participants and paid by the program were greater than the contributions, there would be a deficit. The program bore the entire risk of a deficit in a given year, and maintained a catastrophic reserve to cover that risk, while the participants had no obligation beyond their fixed contributions. Stop loss was a mechanism whereby the program could purchase insurance coverage for medical claims paid in excess of a certain threshold thereby limiting the program's exposure to excess claims costs. Mr. Thorne said stop loss could be on a specific or aggregate basis.

Mr. Thorne said specific stop loss would reimburse the program for any individual's medical claims in excess of a certain level such as $50,000. Aggregate stop loss reimburses the program for all paid medical claims in excess of a certain level such as $150 million. Specific stop loss was much more common than aggregate stop loss and the threshold varied according to the size of the program. The threshold could be as low as $50,000 for smaller programs to $500,000 and up for larger programs such as PEBP.

Mr. Thorne said the stop loss market was volatile so cost and availability varied significantly from year to year. Major catastrophes such as 9/11 and the recent hurricanes in the Gulf Coast had a major impact and nearly eliminated availability. When PEBP last checked on this market in 2004, many reinsurance companies considered PEBP to be too large an account for coverage. In addition, only one carrier offered a guaranteed renewal with prescription drug coverage and a rate cap.

Mr. Thorne said, based on this information, the pros and cons of stop loss coverage were as follows:

- Pros
  - Smoothes out the PPO plan's annual incurred claims cost
  - Caps risk exposure given the PPO plan's $2 million lifetime maximum
  - Lowers contingency reserve requirements
  - Provides an additional cost containment measure in plan years with adverse experience
  - Requires use of "Centers of Excellence" for transplant coverage with "case rate" reimbursements

- Cons
  - Insurer charges profit margin and risk charge in addition to expected claims payout
  - Over long run, cost may exceed actual claims
  - Lag time for insurance company reimbursement since all claims were audited by the reinsurer
  - Policies structured to cover claims incurred and paid in the same 12-month period can result in a bare spot for claims incurred in the last few months of a fiscal year if coverage was not renewed on a paid basis. That could be limited somewhat by using a 12/24 policy where claims incurred in the 12-month period were paid within 24 months.

Mr. Thorne said stop loss analysis for PEBP showed that the benefits of coverage were marginal at best. The cost of coverage had essentially been shown to equal the claims reimbursement and this was in a period of good coverage availability and relatively low cost. Mr. Thorne said PEBP would continue to test the reinsurance market periodically, but there had been little or no positive cost benefit to date.

VII. PRESENTATION ON THE FEASIBILITY OF ESTABLISHING RATES FOR PEBP PARTICIPANTS ON A REGIONAL BASIS.

Mr. Thorne said that the ACR 10 Committee requested information on regional rating as it applied to the concept of bringing all Nevada public employees into a single health benefit program. His report would review the regional rating concept, the likely regions, and some of the implementation issues that would be addressed.

Mr. Thorne said the PEBP self-funded plan commingled claims costs from all cost areas of the state to develop a single rate structure for all participants regardless of location. This worked well for the state as a single employer because it provided uniform rates for all state employees and retirees regardless of where they were located. However, this did not work well for our current system of voluntary participation by local entities. A local entity in a lower cost area, such as Clark County, could self-fund or insure their participants at a much lower cost than the statewide cost structure used by PEBP to develop rates. Conversely, a local entity in a higher cost area of the state would benefit from this commingling approach. Commingling of the different cost regions into a single

rate structure would create winners and losers just as commingling the costs of employees and retirees caused some to pay more than their costs and others to pay less than their costs.

Mr. Throne said regional rating would develop separate rates based on different cost regions. The regional rate would then apply to employers who were fully contained within each region. Regional rating would reverse the practice of commingling statewide costs and would create a different set of winners and losers. The higher or lower cost regions would each be rated based on their own costs. He said the two primary cost areas would be Clark County and the rest of the state. Determining the exact boundaries of these rating regions would require more research.

Mr. Thorne said implementing regional rating should be relatively straightforward for all entities, except state government. As the only statewide, single employer, the state was uniquely affected by regional rating. Many national or multi-state employers provided similar health coverage, however they typically dealt with the regional differences from a "big picture" standpoint. Cost-of-living differences were calculated for different areas and pay for like positions in the different areas was adjusted accordingly. This would be a new concept for the state and would require the involvement of many stakeholder groups to develop a methodology that was both equitable and affordable. There could be other impacts on certain budgets depending on the agency's locations and personnel costs.

Mr. Thorne said four methodology options could be considered when implementing regional rating. Each plan was compared with the current practice followed by PEBP.

1. At the time of the meeting, the PEBP self-funded plan commingled claims costs from all cost areas of the state to develop a single rate structure for all participants regardless of their location. In accordance with Nevada Revised Statutes, one pool was evaluated for state participants and a separate cost pool was evaluated for non-state participants.

2. Regional Rating – Option #1. The basic approach to creating regional rating would result in one set of rates for each region whether they were state or non-state participants. Mr. Thorne referred to the graph on the top of page 27 of Exhibit A.

3. Regional Rating – Option #2. Separate regional rates could be developed for state and non-state participants, thus creating the four different groups shown below. This methodology however would not be consistent with the concept of regional rating since it would not treat the participants in the same region in a similar manner.

4. Regional Rating – Option #3. Another option may be to track the state's experience by region for the regional rating model but develop a blended rate for the state based on the proportion of personnel in each region. Non-state entities would be subject to regional rates that would be developed considering the experience of state and non-state participants in the area. Mr. Thorne referred to the graphic on page 28 of Exhibit A, which showed the state and non-state pooled together and that specific rate would be used for the non-state, north and rural area. There would also be a pool of state and non-state in the south and that separate rate would be used by the non-state localities in the south. The combination of the state's share in the north and the south would be blended into a single rate to be charged to the participants so it would not make a difference whether the employee worked in the north or the south, they would pay the same rate.

Before a decision was made on regional rating, considerable thought and planning would be required. It was important to remember that just as with the commingling issue, there would be winners and losers with each approach used for regional rating.

Assemblywoman Parnell asked if the northern and the rural participants would pay quite a bit more than the state and non-state in the southern part of the state.

Mr. Thorne agreed and said the cost factors in the north were substantially higher than in the south.

Mr. Goicoechea said that Option #3 clearly made the most sense because it balanced the state out, and most state employees were under one plan. However, he agreed with Ms. Parnell that ultimately the package would be unaffordable for the non-state north rural areas.

Mr. Thorne said that would be an issue in going to a regional rating concept. With a single statewide rate, the winners were the north and the rural areas and the losers were the southern participants. The non-state participants under the current voluntary system of participation were primarily in the north, not in the south. A mandatory system would create additional costs to the local entities that could self-fund at a lower cost. Mr. Thorne said there would be winners and losers under any of the options.

VIII. DISCUSSION REGARDING LEGISLATION THAT WOULD BE REQUIRED TO PROVIDE THAT RETIREES OF LOCAL GOVERNMENTS BE ALLOWED TO PARTICIPATE IN THE PROGRAM ONLY IF THE ACTIVE EMPLOYEES OF THAT LOCAL GOVERNMENT PARTICIPATE IN THE PROGRAM.

Chairman Amodei said, based on testimony heard throughout the first three meetings of the committee, there was universal concern regarding the plan receiving only retirees from local governments and becoming the plan of last resort. Although the ratio of retirees to actives was not technically considered to be out of proportion at this time, he did not want the plan to continue to attract retirees without active non-state employees coming onboard at the same time.

Chairman Amodei said there were two more meetings of the committee. He asked Mr. Wilkinson to prepare a memo to the committee stating what sort of legislation would be required if the committee and the 2007 Legislature wished to make statutory changes to limit the plan to those local government entities who were also using it for their active employees. Chairman Amodei said the policy would not affect anyone currently in the plan. Chairman Amodei said the practice of political subdivisions in the state directing their retirees to this plan while their own plan only contains actives would be ended.

Assemblyman Goicoechea said that we would have to consider how A.B. 286 would apply. If a non-state entity with retirees in the program chose not to enroll actives, technically it would be withdrawing from participation in PEBP. He understood that the non-state participants who were already in the program would stay in the program, but the program would not take any new non-state participants. He asked, after the passage of this legislation, would there be any requirement that the local government offer a retirement healthcare benefit program, and would the local government be responsible under A.B. 286 for a subsidy.

Chairman Amodei said that would be discussed under the next agenda item.

IX. DISCUSSION REGARDING LEGISLATION THAT WOULD BE REQUIRED TO STRENGTHEN THE REQUIREMENTS OF NRS 287.023 IN REGARD TO LOCAL ENTITIES PROVIDING GROUP INSURANCE FOR RETIREES.

Chairman Amodei said there was existing statute that provided a local government entity must offer retirees a health insurance program, but the statute did not say what would happen if they did not. He said the next step would be to define penalty provisions. The language should quantify that the program be at least comparable to what the retirees were receiving with PEBP. Although he understood that it was a mandate, a minimum level should be defined in the statute. Chair Amodei said that if the local governments wished to send retirees to the state program after this comes into effect they would need to enroll actives also. Should the local government chose not to send the retirees to the state program, it would offer health care benefits that would met the standard in statute (NRS 287.023, page 29 of Exhibit A).

Mr. Goicoechea said before the passage of A.B. 286 there were a number of local government retirees that were not offered a health care program.

Chairman Amodei said that was why the statute needed enforcement language. He asked Mr. Wilkinson to consult with Mr. Thorne's staff for their thoughts on potential problems, such as implementation issues so that the changes would be comprehensive within the existing system.

Chairman Amodei hoped the committee could have that discussion at the next meeting so that the competing proposals could be voted on and the following meeting.

X. DISCUSSION AND DEVELOPMENT OF DEFINITION OF COMMINGLING AS IT APPLIES TO MEDICARE-ELIGIBLE PARTICIPANTS IN PEBP.

Chairman Amodei told the committee that he met with Mr. Johnson to discuss PEBP generally, and the two regulations recommended for denial by the Legislative Commissions Subcommittee to Review Regulations, a subcommittee of the Legislative Commission (page 31 of Exhibit A). Chairman Amodei said he understood the PEBP Board needed to establish rates for the next biennium, which would pre-date any action of the Legislature in its 2007 Session. Chairman Amodei said Mr. Johnson asked about concerns of the PEBP ACR 10 Committee, the Legislative Commission and the Subcommittee to Review Regulations with respect to this regulation. Chairman Amodei told him that the committee and the Legislative Commission both had discussions on the topic. He asked staff to coordinate with the Legislative Commission members to provide input to Mr. Johnson for the board's consideration in establishing policy for the coming plan year.

Ms. Parnell asked for clarification of claim responsibility of the program for someone on Medicare. In looking at the figures, she thought that their maximum responsibility would be 20 percent of a claim versus 80 percent of the claim of a non-Medicare participant.

Mr. Thorne said the unpaid portion for Medicare was typically, 20 percent, however, there was no out-of-pocket limit for Medicare, so that 20 percent liability would continue until the number of days was exhausted. In the first six months of 2006, a number of Medicare claimants exceeded that $3,500 out-of-pocket threshold and PEPB paid over $500,000 for Medicare claimants in that catastrophic position.

Ms. Parnell said the most a Medicare retiree would be responsible for was the 20 percent that Medicare did not cover. Mr. Thorne said that was correct, up to the $2 million maximum. Ms. Parnell asked if that was after the $3,500 out-of-pocket the Medicare retiree paid. Mr. Thorne said that was correct, and it was the same as any other participant.

Chairman Amodei asked staff to coordinate with Mr. Johnson and then provide a brief summary of the information given to Mr. Johnson after coordinating with the Commission so that everybody knew what was relayed on our behalf.

Chairman Amodei said that in the meeting with Mr. Johnson there was another extensive regulation (R089-05) on administrative and procedural matters that was also not approved by the Subcommittee to Review Regulations and was then placed on the Legislative Commission agenda. Mr. Johnson had asked that we identify the portions of the regulations on which there were concerns. Chairman Amodei said he would do that and asked the committee members to do the same. He asked staff to meet with Ms. Buckley as Chair of the Legislative Commission to discuss her concerns in the hope that the objectionable parts of the regulations would be omitted and the non-objectionable parts go forward for implementation.

Chairman Amodei said that R164-05 dealing with the topic of commingling was on page 31 of Exhibit A and staff would provide copies of R089-05.

XI. PRESENTATION ON THE LOCAL GOVERNMENT PERSPECTIVE ON A HEALTH BENEFITS PROGRAM FOR ALL PUBLIC SECTOR EMPLOYEES IN THE STATE OF NEVADA.

Marvin Leavitt said he would like to review the process used by local governments to determine health insurance benefits and address issues of retirees in that regard. He said everyone was aware that most of the governments in the state determined health insurance benefits through collective bargaining with employees. Local governments and their employees often jointly determine the total amount of the benefit. Mr. Leavitt said before A.B. 286, most local governments offered health insurance coverage to their employees upon retirement, but without subsidy. Local governments had various policies as to how soon a participant could return to the program after they exited. He said it was no mystery that if an employee could join the state plan and receive a subsidy on a monthly basis, or stay with the local government plan, where they had a negotiated benefit that did not include a subsidy, they would naturally go to the state plan.

Mr. Leavitt said local governments began sending their employees to the state program. The reason they were sent to the state was that the state required a subsidy when they arrived there. In other words, legislation was enacted that required the local governments to do almost what the plan was complaining about the non-state employees doing. He said there were a number of ways to handle this. If the committee was concerned about the local government employees in the state plan, then eliminate the subsidy. Mr. Leavitt said that in his experience it would be rare for a subsidy to be eliminated. Therefore, another way it could be done would be to require the local government to provide the same subsidy in their own plan. The requirement could be strengthen to require that local governments cover their employees, although he thought the current language was strong. But we were in a difficult position. He did not think that most local governments tried to send their employees to the state plan; that was a decision made by the employees. He did not know if the local governments cared one way or the other, since they had to provide the subsidy anyway.

Mr. Leavitt said, related to the general subject of the mandatory participation in the state plan, he did not think it was any great shock to that local governments would be opposed to that for several reasons. First, this was seen as a benefit in many cases unique to the employees of a particular agency. Within the five cities that made up the urban consortium, benefits varied because employees determined them. Benefits could be higher or lower depending on how much the employees wanted compensation in benefits versus salary. Another concern was volatility. A review of the state plan in recent years showed rates and state contribution were all over the place. He hoped the plan was stabilized, but would feel better when two or three years had passed without volatility. Mr. Leavitt said he was not complaining about the management of the program. In addition, there was concern that there was no protection for the assets of the plan. He asked if the assets of the plan could be reverted to the state General

Fund. If so, that would be different from the joint, statewide PERS plan, which had constitutional protections. Mr. Leavitt was also concerned about the reserves built up by some of the agencies.

Assemblyman Goicoechea agreed with Mr. Leavitt that it was a local government issue and said he preferred that the retirees address the issues with their own city council and county commissioners, but unfortunately, pre-2003 PEBP actively solicited local government involvement. In 2003, pre-Medicare premium rates were $1,400 -$1,800, which was completely unaffordable. That was what drove A.B. 286. He agreed that the local governments should provide that subsidy.

Mr. Leavitt said if local governments had a choice between having the retirees in their own plan and subsidizing them or having all of the employees in the state plan, they definitely would go with the former. He said there was a much larger concern among local governments about having a mandatory participation in the state plan.

Assemblyman Goicoechea agreed that was the only way they could get around it because the healthcare plans and the enhancements were bargained for and varied from jurisdiction to jurisdiction. The solution may be to tell the local governments to enroll their active employees if they were going to enroll their retirees. In parts of rural Nevada, retiree healthcare benefits were not offered by the local jurisdiction. The only alternative was PEBP although rates were unreasonably high.

Chairman Amodei said that the local government health plans would invariably be compared to the state plan. If the local governments loaded retirees on to the state plan, making its own plan mostly actives, that would result in richer benefits and lower premiums for the locals. That was the reality of the insurance business. Chairman Amodei said the committee would not force anyone to do anything, but would quit giving other public plans the option of loading retirees into the state plan. In the future, when the plans were compared, each entity would pay for its own retirees. Chairman Amodei said the committee was committed to ending the practice of becoming the plan of last resort for retirees for entities that do not participate in PEBP with their active employees.

Allin Chandler told the committee that he had been with the Clark County Association of School Administrators since 1990. He said in the mid-1980s the administrators of the Clark County School District became active participants in the state health insurance plan. They brought their active employees and as people retired, they were in the plan as retirees. The plan worked very well for them until 1991 when legislation was introduced that allowed the public employees program (now PEBP) to rate groups differently. At that time, the rating was state-actives, non-state actives and retirees. Then they broke the non-state actives into non-state over 100 employees and non-state under 100 employees. In 1991, the first year of the individual ratings for the groups, there were some rather significant differences in the rates. He recalled that the rates were significantly different to the point that the non-state agencies were going to have a hard time paying the premiums. He believed in 1991 and 1992 there was a reserve and some of that was used to buy down the cost of the premiums, first for the non-state agencies and then for the state agencies. From 1991 to 1999, his organization was

actively working with the legislature and the state health plan to resolve the issues. They tried a single set of premiums. Mr. Chandler said if the non-state agencies were costing the plan more money, then they should be paying more, but he did not believe that they were. Mr. Chandler said they were successful in 1993 and 1995 in getting legislation passed that required, if the non-state agencies rates stayed within 5 percent of the state agencies rates, then there would be single set of premiums for all participants. According to the actuary for the state plan, not only were we within 5 percent of the state agencies, we were actually 5 percent cheaper to insure, yet the premiums were 23 percent more.

Mr. Chandler recalled that after working from 1991 to 1999 to repair the inequity, it was decided that, since the problem had not been fixed by legislation or by changing the plan, CCASA would go out on its own. In 1999, CCASA withdrew from the state plan and took whatever retirees wanted to come. He said although many retirees were unwilling, a number of them came into the new plan. All of the active employees went into the new plan, and from 1999 to 2003, he did not know that a single retiree opted for the state plan. As Mr. Leavitt indicated, the problem started in 2003 when legislation passed that said for a non-state participant in the state plan, the governmental entity where you worked had to provide the same subsidy that the state employees received. Mr. Chandler said, for some people that amount was more than $400. For a $400 reduction in insurance costs, retirees would go into a plan that they may perceive to be not as rich as the local plan. Since that time, more retirees went into the state plan because of that subsidy. Mr. Chandler agreed with Mr. Leavitt that the subsidy was very important to those people going into retirement. If that same subsidy was required of the governmental entity, he did not think many people would go into the state plan. NRS 287.023 stated that the governmental entity could provide a subsidy if they chose. A.B. 286 required them to do so. He said there was a belief that collectively bargained plans were not included in the requirement for the subsidy and he personally believed that that was correct. However, the Clark County School District had been paying those subsidies, not only for the active administrators, but also for the teachers and the support staff amounting to $6 or $7 million per year. He had encouraged the district not to pay because he did not believe they were required to. Nevertheless, because LCB and the Attorney General's opinions were that they should, they did. He said he believed if the governmental entities were required to provide the same subsidy in their own plan, the employees would not join the state plan. He did not believe his people would have gone into the state plan at all had that subsidy not been introduced.

Assemblyman Goicoechea said that when he was a freshman legislator in 2003 he had a number of phone calls and letters from Clark County School District (CCSD) retirees who were in the unaffordable PEBP plan. Apparently, once they opted to stay with PEBP, they were not accepted back into the other plan.

Mr. Chandler said their plan's eligibility requirement did not allow people to leave and come back to prevent adverse selection. However, he knew that in 2003 when Mr. Goicoechea was hearing from CCSD retirees concerned about the inequity, what they were really asking for was to go back to a single set of premiums. When premiums were segregated into state and non-state premiums, some premiums were as high as

$1,800 per month. The answer was the subsidy, which certainly provided a solution to those people because it reduced their premiums. He doubted that any of the Clark County administrators requested that.

Ms. Parnell asked Mr. Chandler, in 2003 when the non-state retirees in PEBP were paying about $750 per month per individual, what were the retirees within the Clark County Association of School Administrators paying. Mr. Chandler said the premium rates were dramatically lower. In fact, in 2006 an individual would pay $379 for a comprehensive plan that included medical, dental, vision and a $50,000 life insurance policy. Ms. Parnell said many of the local governments might find that subsidizing within, rather than subsidizing the state plan, would result in savings. Mr. Chandler said that was correct, and a lesser subsidy might be acceptable to keep people in the plan. If the people in the CCSD plan received a $250 subsidy, they would probably stay, as opposed to taking $400 to join a plan that costs considerably more.

Ms. Parnell said that if the legislation prohibited the entity from subsidizing more than the actual costs, for example $350 per month, in many cases you would be saving money. Mr. Chandler agreed and said that was why he quoted a $250 subsidy because that would leave the retiree $129 and if it was an HMO plan, the retiree would have virtually no costs out-of-pocket

Chairman Amodei asked Mr. Wilkinson to provide recommended language to indicate that nothing in the section prohibits a political subdivision from subsidizing the rates for its retirees should it choose to do so. Chairman Amodei said the committee was mindful of requiring an unfunded mandate of local government.

XII. DISCUSSION OF THE FEASIBILITY OF VARIOUS OPTIONS FOR PROVIDING HEALTH BENEFIT PROGRAMS FOR ALL PUBLIC SECTOR EMPLOYEES IN THE STATE OF NEVADA.

Chairman Amodei said that at the next meeting, the committee would vote on the following issues:

- Regional rating
- Solicitation of requests for proposals from private providers
- Self-funded versus privately insured
- Stop loss
- Length of rating periods
- Whether participation in PEBP should be mandated

Chairman Amodei said the following issues were of concern to the committee:

- Reserves for purposes of premium stabilization
- The extent to which the Insurance Commissioner was involved in setting rates and benefits
- Understanding the GASB changes
- Recommended changes to the PEBP budgeting process
- The definition of commingle

Mr. Atkinson asked that the committee begin formulating opinions on the issues in the original ACR 10.

XIII. PRESENTATIONS BY THE RETIRED PUBLIC EMPLOYEES OF NEVADA (RPEN) AND THE STATE OF NEVADA EMPLOYEES ASSOCIATION (SNEA) TO PROVIDE INFORMATION REGARDING PEBP.

Scott MacKenzie, Executive Director, SNEA, recalled that at the last meeting he gave his thoughts on how the state, city and county workers would interact in terms of the funds. He said his goal was to decrease administrative costs, stabilize the fund and increase purchasing power.

Mr. MacKenzie said that because SNEA's position was already on the record, he would relinquish his time to Ken Lange, Executive Director of the Nevada State Teachers' Association.

Mr. Lange said he had been working with SNEA for some time and believed that dialog across the spectrum was incredibly important on this issue. The welfare of many people was at stake both at the state level and in the local government jurisdiction.

Mr. Lange said he shared NSEA's experience in attempting to bring multiple employee groups together and that both organizations worked towards three goals:

- The best coverage at the best price
- Great savings to the public through efficiency and economy of scale
- Appropriate private sector engagement through appropriate fees and costs

Mr. Lange said, over the years NSEA received many complaints from members regarding rates, level of benefits, services, administration and more. He said the committee might be aware that five years ago the Clark County Teacher Trust was struggling. The NSEA health and welfare benefit trust was lost at about the same time. That had recovered and was provided through another set of carriers. There was a barrage of comments from the rural counties on the ups and downs of coverage and cost. Consequently, NSEA proposed legislation to allow of the creation of a multi-employee consortium. That was A.B. 388, which was then rolled into NRS 286.15. Mr. Lange recalled that every school district and every union in the room talked about joining. A consultant calculated after negotiating with Mutual of Omaha approximately $2.6 million in annual savings by pooling the seven largest counties. The savings

ranged from $810,000 in Carson City to $58,000 in Pershing County. Unfortunately, that effort came to naught; while there was great enthusiasm in the beginning, once the school districts met with their consultants and administrators, enthusiasm waned rapidly. NSEA continued to press to get a couple of thousand souls under coverage which was what they estimated to be the minimum necessary, but that did not work. Mr. Lange's group then proposed A.B. 480 in 2005, which was to provide transparency in reporting requirements by the district so that we could determine the administrative costs and relative fee structures. The bill passed in the Assembly but not in the Senate. There was substantial opposition from the school districts in terms of engaging in what they thought to be the cost of providing information to the public and to the Legislature. NSEA thought it was possible, based on that experience to create a framework to allow public employers to gain and keep access to quality health care as a benefit to the employee and to the public. There was a significant benefit to the public to provide a good level of benefits to employees so that they were healthy and were able to do the work they were asked to do and provide the services that they expect. That process should begin now rather than later. We kept going up to the brink and putting in steps to stabilize it for just a minute, and then it started to slide again and it was just a matter of cycling.

Mr. Lange said that any plan would need to be voluntary. He thought the marketplace and stability of a larger plan would be attractive to many groups. He knew from experience at NSEA that it was almost inevitable that plans would cycle through healthy and unhealthy periods. The model should be built on shared governance, whether it was an advisory board as suggested by NSEA or a trust arrangement. We believe the employees have a stake in the management of the plan, as do the employers. We do very well in most of our school districts in managing the process at the bargaining table or through district-wide committees of all of the interested parties.

Finally, the plan needed to have a good "product mix." NSEA believed there was an appropriate role for the industry in actively and competitively bidding to provide those services so that the plan paid appropriate rates and administrative fees that met an industry standard as opposed to some local political vagary.

On the issue of retirees, Mr. Lange said he considered the introduction of legislation to allow retirees to enter PEBP out of the school district to be a "tipping point" in the conversation. Mr. Lange said his organization shared the concerns of the Chairman. At some point, the provision of retiree health benefits becomes an implicit, or in some cases, explicit social and ethical contract. Public employees who value stability and longevity did not know if they would have retiree health benefits. There needed to be a decision by the state to do that, or not. Public employees needed to know that up front.

Mr. Lange said the multi-employer health trust idea was exciting because it would help to have the conversation and manage that contingency with employers with the private sector with the employee and the bargaining agents of those employees. This was an incredibly complex and interesting topic. Health benefits have long been a primary reason that public employees come to work. In most cases, salaries were not competitive, certainly not in the education profession. That was an important piece of

the puzzle. We need to provide those benefits in a stable committed fashion so that employees can anticipate, plan for and make adjustments when and where necessary.

Chairman Amodei asked Mr. Lange why the proposed legislation failed in 2003.

Mr. Lange said he attributed the failure to the interest of the contract administrators in TPAs that began moving back as kind of a counter attack. In a multi-employer trust, some of those TPAs would not have the state contract any longer. The other reason was that some did not want to give up control over their plan. The multi-employer model would require a different kind of governance and surrendering control to some degree. That was a perceived loss on the part of the school district and a couple of the local unions felt the same way.

Chairman Amodei asked if the legislation proposed in 2003 would be a starting place for the framework of a multi-employer trust.

Mr. Lange replied yes.

Chairman Amodei asked Mr. MacKenzie if he agreed.

Mr. MacKenzie said he thought it was very similar to what SNEA advocated. He had not read the document, but in conversations with Mr. Lange, he did not think they were very far apart.

Chairman Amodei asked staff to provide the committee with a copy of the bill and the legislative history for purposes of review at the next meeting.

Mr. Lange clarified that the legislation in 2003 passed, but the 2005 legislation died in committee (A.B. 480). The framework for the plan advocated by NSEA and SNEA was in NRS 286.15.

Chairman Amodei said that the committee would like to see the proposal advocated by NSEA and SNEA. If there were specific suggestions for the framework and implementation, the committee would like to have those.

Senator Beers said that in looking through the minutes of the hearing on the bill held by the Senate Finance Committee in the 2005 Legislative Session, Humboldt, Elko and Lyon County School Districts were in opposition. Senator Beers thought there might have been more school districts in opposition.

Chairman Amodei asked if the opposition was due to issues of control of the plan. Mr. Lange said that would be an accurate description, and in the 2005 legislation, there was a degree of work in providing the information in the format requested.

Marty Bibb, Executive Director, RPEN, was joined at the table by RPEN State President-elect, Colleen Bell, who was also the former City Clerk for Henderson. Mr. Bibb said that the topic continued to plague them. He said that Mr. Atkinson was very knowledgeable in the area of public employee health benefits and his advice and counsel had been very helpful. He said the plan had changed drastically in the past several years for retirees because the 1999 implementation of the Medicare carve out which had existed in one form or another under this name or that name ever since. At that time and until 1999 there was a full coordination of benefits for the Medicare retiree. In this plan, it meant that after Medicare paid its 80 percent and the retiree met his deductibles and co-pays, the state plan paid the other 20 percent entirely. PEBPs liability was limited by virtue of the fact there was another primary payer. Mr. Bibb said there should be reemphasized in some of the other debate relative to commingling.

Mr. Bibb agreed with the previous speakers that there had been a tremendous amount of volatility in the plan. Between the 2001 Legislative Session and the 2002 Special Session there was a total of about $42 million, which had to be approved by the Legislature and then signed into effect by the Governor to simply keep the plan afloat. That was about 5 years ago. In the 2005 Legislative Session, the original budget request for PEBP called for $47 million more than was needed. That volatility was something that all parties want to see addressed.

Mr. Bibb said, as far as the commingling issue itself, between one-half and two-thirds of the medical costs of the Medicare retirees in this plan were borne by Medicare and not by the plan. In addition, Medicare retirees used a significantly greater amount of health care prescriptions, since that time, the Medicare program at the federal level have elected to reimburse plans such as PEBP 28 percent of the pharmacy cost of those Medicare retirees who keep that coverage. That was an additional $500-$600 per year, per Medicare retiree, going to the plan. Mr. Bibb said there was Medicare Part A, Medicare Part B and an additional $500-$600 for the pharmaceutical benefit. For this segment of the plan, significant amounts of their costs were not borne by the PEBP plan, which was why the commingling issue remained a dilemma.

Mr. Bibb continued saying one of the issues dealt with reserves. As indicated in the meeting packet (page 5 of Exhibit A) there $25 million held as a contingency reserve. NSEA was pleased that the plan was able to create that in the past several years and it speaks well of the plan.

Chairman Amodei said it was appropriate to know that as of 18 months ago, for the first time, there was an attempt to create that mechanism and fund it. Chairman Amodei said the plan was moving in the right direction in that regard. He said he expected that in its final work product, the committee would recognize the areas in which PEBP was improving.

Mr. Bibb said the contingency/emergency reserve did not exist until the current managers of the plan took over. It was the responsible thing to do. Additionally, while there was not enough money to pay claims in 2001, the claim reserve was $12-$13 million today. It was a wide swing and a lot of volatility. Since the last board

meeting, PEBP applied to the federal government to request exemption from the limit of 60 days reserves, based in part upon the volatility of the plan. Mr. Bibb said he was very hopeful based on the remarks of Mr. Wells at the PEBP Board meeting last week. If that was approved, there would be more tools to manage the program and some create stability.

Mr. Bibb said there were other concerns centered on veteran state employee retirees who had Medicare Part B abut not Medicare Part A, and how they would be treated in the future relative to rating. RPEN was looking forward to working with the plan managers, the committee and the other groups, including the commission, who were working on the issues. Mr. Bibb said there was a real world relationship between rates and subsidies and premiums: they were called "out-of-pockets." Ultimately, that was what concerned everyone here today. Regarding the A.B. 286 subsidy, Mr. Bibb said the reason that was enacted was well described by Mr. Goicoechea. It seemed as if the local governments were offloading retirees to the state health plan as the plan of last resort. Mr. Bibb said he thought they could arrive at a better product, because whether it was rating methods of multiple employer pools or reenrollment into former plans, subsidies or commingling, all were concerns for retirees.

Chairman Amodei asked staff to coordinate with Mr. Wells to find out whom the application went to in the federal government. He then asked staff to contact that federal government agency and the members of the federal delegation and report back to the committee at the next meeting with draft correspondence to the federal delegation and any other relevant decision-making federal authority requesting their favorable and timely consideration of that request.

Chairman Amodei asked for a briefing on Medicaid including how it operated, and the changes expected in the future. For example, more and more Medicare eligible retired state employees were entering the program. The committee would need to know those circumstances if they were going to fashion legislation dealing with Medicare and the PEBP program.

XIV. SCHEDULING OF DATES AND LOCATIONS FOR FUTURE MEETINGS.

The next meeting was already set for March 16, 2006.

It was determined that all committee members were available for meetings on April 25, 2006, Tuesday, 9 a.m. in Las Vegas and May 25, 2006, Thursday, 9 a.m. in Carson City.

Chairman Amodei said it might be necessary to schedule one more meeting.

XV. PUBLIC COMMENT.

Chairman Amodei allowed Lieutenant Stan Olsen, Executive Director, Las Vegas Metropolitan Police Department (LVMPD), to testify on Agenda Item XI out of order so that he could attend the memorial service for Officer Prendes.

Lieutenant Olsen said that it was mentioned on several occasions that the Las Vegas Metropolitan Police Department declined to pay the supplement to the state. What had not been mentioned was that the department had a legal opinion saying they should not have to pay. He presented the legal opinion to the committee.

Chairman Amodei said that, meaning no disrespect to whomever provided the opinion, the Attorney General's opinions and Legislative Counsel's opinions would probably be given the same amount of deference, and the state would still want its $150,000.

Danny Coyle of AFSCME-Retirees said that, for state and local governments to retain long-term employees, post retirement benefits, pensions, and health care benefits were almost essential. Otherwise, employees would go to the private sector where the services and benefits were available. Mr. Coyle said the state system had been complaining that local governments, counties and cities were offering higher salaries for the same job classifications. One of the ancillary benefits of A.B. 286, which mandated local governments subsidize their retirees to the same extent that the state, was that it would take away some of the monies that these counties and cities have been offering. He did not know if that worked or not. Mr. Coyle hoped that A.B. 286 would provide local retirees with post retiree benefits such as health insurance. He did not perform a survey to find out whether more people have stayed in state employment, but it seemed that a significant portion of the local government budget was used to negotiate. Mr. Coyle said noted that the state still did not have collective bargaining, and he hoped that next session we that would changes.

Mr. Coyle said there was a difference of opinion between staff and the board members as to what constituted a Medicare retiree. Mr. Coyle said that Mr. Thorne stated both Medicare Part A and B were needed to be a Medicare retiree. Some of the board members considered Medicare Part B to be the defining factor. Mr. Coyle said that was significant as far as the rate setting process was concerned. Mr. Coyle reported that the PEBP Board instructed staff to return with a definition of a Medicare retiree. Mr. Coyle said that he was a 31½ year employee with the state of Nevada, so when he retired he did not have enough points on his social security to receive Medicare Part A.

Gary Wolf, Teamsters Local 14, said that his local represented several municipalities and law enforcement groups in the state. He said that he would like to take part in any proposed legislation on the topic, as it was an important issue to his members.

Tim DeRosa said he was a co-chair of the Advisory Committee to the PEBP ACR 10 Committee last interim. The Advisory Committee's function was to assist the legislative committee. Several meetings were cancelled and they never accomplished anything as far as he knew. He was encouraged that the committee now seemed prepared to solicit RFPs from the private insurance community. He was in favor of exploring the federal employee benefits delivery model. He served as a broker for the Clark County Association of School Administrators, so he worked for Mr. Chandler. Mr. DeRosa said they had success in delivering better benefits to those people over the past 8 or 9 years for less than the state paid. Obviously, that was done through the private delivery

system. He said that if the RFP was not written correctly, they could not provide quotes and the state would not be able to determine whether the private delivery method was something to consider. He asked the status of the RFP.

Chairman Amodei said those with an interest in that area were asked to give ideas on what items should appear in the RFP so that it would be a fungible request for proposal. But the participation was not limited to the three insurance companies that provided information on the RFP contents. He expected that the committee would vote at one of the following two meetings as to whether or not to suggest at RFP. If the majority of the committee wants an RFP, they would suggest that to the Legislature.

Mr. Goicoechea asked Mr. DeRosa if the Advisory Committee had drafted a preliminary RFP during the 2003 Interim.

Mr. DeRosa said they were headed in that direction. Although he was technically a co-chair, he clearly had limited control. That may have been his fault; he had never served in that position, but was glad to try. He said the information was readily available. Anyone of the companies that presented to the committee today would be able to provide a complete RFP with which they could all compete in an environment that would be positive to the state and local governments. Mr. DeRosa said his goal was to have the companies compete with one another to attract, in a voluntary environment, the state and various public non-state employees. If you created an environment with choices between attractive plans priced in a competitive environment, you would not have to force people to join.

Ms. Ruth Hart, President of Washoe Chapter of RPEN, said she tried to attend all of the PEBP Board meetings. She reminded the committee that plan rates and design for the next year would be set in early March. She noted that the PEBP ACR 10 Committee would not meet again before then. She asked if the committee would have any influence on the rate and plan design decisions made in early March by the PEBP Board.

Chairman Amodei said that was an excellent question, and he suggested it should be posed to the PEBP Board members. He said that the legislature was in session for 120 days in odd numbered years, but he was encouraged by the dialog with Mr. Johnson regarding the commingling and Medicare issues. Chairman Amodei said it was his intent that the committee have a briefing at the next meeting of exactly what was done in the March meeting by the PEBP Board with respect to benefit plan, structure, rates and the Medicare issue as far as commingling. Chairman Amodei said he hoped that in working with members of the board and conducting meetings in an open fashion, the PEBP Board knew what the Legislative Commission thought about various issues, such as, stability and predictability, Medicare and commingling. Chairman Amodei looked forward to a report next meeting as to what was done with respect to the coming benefit plan year in light of the work that the committee was doing and the concerns expressed by the Legislative Commission.

In response to a question from Ms. Parnell, Chairman Amodei said that the next Legislative Commission meeting was scheduled for February 22, 2006, 1:30 p.m. in the Grant Sawyer Building in Las Vegas.

He assumed that by that time, staff would have completed its coordination on the two regulatory issues and reported to Mr. Johnson.

XVI. ADJOURNMENT.

There being no further comment, the meeting was adjourned at 2:37 p.m.

Respectfully submitted,

_____
Becky Lowe, Committee Secretary

APPROVED:

_____
Senator Mark Amodei, Chair

Date:_____

Copies of exhibits mentioned in these minutes are on file in the Research Library of the Legislative Counsel Bureau, Carson City, Nevada. The library may be contacted at (775) 684-6827.