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*)

January 11, 2006

The second 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 January 11, 2006, at the Legislative Building, 401 South Carson Street, Room 2135, Carson City, Nevada. The meeting was videoconferenced to the Grant Sawyer State Office Building, 555 East Washington Avenue, Room 4412, Las Vegas, Nevada.

COMMITTEE MEMBERS PRESENT IN CARSON CITY:
Senator Mark Amodei, Chairman
Assemblyman Pete Goicoechea
Assemblywoman Bonnie Parnell

COMMITTEE MEMBERS PRESENT IN LAS VEGAS:
Senator Bob Beers
Senator Bob Coffin

COMMITTEE MEMBERS ABSENT:
Assemblywoman Chris Giunchigliani, Vice-Chair

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
Eileen G. O'Grady, Principal Deputy Legislative Counsel, LCB Legal Division
Becky Lowe, Secretary, LCB Fiscal Analysis Division

EXHIBITS:
Exhibit A: Meeting Packet and Agenda.
Exhibit B: Attendance Record.
Exhibit C: Copy of presentation on Feasibility Study Results, Statewide Public Sector Health Risk Pool, prepared by Aon Consulting, Inc.
Exhibit D: Post Retirement Health and Welfare Benefits Actuarial Valuation, April 2005, prepared by Aon Consulting, Inc.
Exhibit E: Copy of presentation on the Realities of Retiree Healthcare in Nevada in the wake of Governmental Accounting Standards Board (GASB) 43 and 45, prepared by PEBP.

Exhibit F: Information including a brief history of the financial status of the program; federal guidance on reserve levels; potential uses of excess reserves; utilization of General Fund savings from the 2005 Budget Amendment (including a memo from the Executive Budget Office on the subject of Executive Budget amendments dated February 25, 2005) compiled by Bob Atkinson, Senior Program Analyst, Fiscal Analysis Division.

Exhibit G: Letter to Committee from State of Nevada Employees Association dated January 11, 2006.

I. CALL TO ORDER AND OPENING REMARKS.

Senator Amodei called the meeting to order at 9:04 a.m. Committee members present were Senator Coffin in Las Vegas and Assemblyman Goicoechea and Assemblywoman Parnell in Carson City.

II. APPROVAL OF MINUTES OF THE NOVEMBER 21, 2005 MEETING.

THE MINUTES OF THE NOVEMBER 21, 2005 MEETING OF THE PEBP A.C.R. 10 COMMITTEE WERE APPROVED UNANIMOUSLY.

Senator Beers joined the meeting in Las Vegas.

III. PRESENTATION AND DISCUSSION OF THE RESULTS OF THE FEASIBILITY STUDY OF DEVELOPING AND IMPLEMENTING A HEALTH BENEFIT PROGRAM FOR ALL PUBLIC SECTOR EMPLOYEES IN THE STATE OF NEVADA.

Mr. Lew Emanuelson presented findings of the study prepared by Aon Consulting, Inc. He described the study as an exhaustive research and analysis of health care programs of the larger governmental entities located around the country. The study intended to find the potential savings of creating a statewide risk pool made up of all public sector employees in Nevada. The study also surveyed the local governmental entities of the state of Nevada. A copy of the report was included in the meeting packet (page 29 of Exhibit A).

Mr. Emanuelson said that the evaluation studied the opportunity and potential savings of creating a statewide risk pool of public sector employers in the state of Nevada. He referred the committee to a copy of his presentation (Exhibit C).

Mr. Emanuelson first researched other public sector risk pools around the country to find out how health and welfare benefit programs were handled. Next, a survey was prepared to collect data from Nevada public sector entities.

The purpose of the study was to identify:

- Eligibility.
- Retiree coverage.
- Plan offerings and plan information (HMO/EPO, PPO/POS, Consumer Driven, Dental).
- All plan offerings' insured/funding rates.
- Claim experience and plan expense components (administrative and fixed).
- Demographic breakdown of participant population by bargaining and non-bargaining groups.
- Broker information and sales service/commission fees.

The survey included interviews with executive officers of the programs to learn what was working and what needed to be improved.

Mr. Emanuelson estimated there would be a potential $700 million or more of premium equivalent if the state's public sector employees were consolidated to one risk pool. He predicted the larger pool would give leverage to improve provider reimbursements. Mr. Emanuelson reminded the committee that in the 1990s, HMOs were very effective in negotiating competitive provider reimbursements, and successful HMO's continued to do that.

Mr. Emanuelson said there were many public sector risk pools. Some were smaller pools that marketed in a specific geographic area, (i.e. county) or did not provide health coverage (i.e. workers compensation, errors and omissions, directors and officers, auto, general liability, bond, etc.).

Mr. Emanuelson said his organization identified 28 large public sector risk pools from $2 million to over $200 million in annual premium equivalent. The risk pools covered as few as 11 to over 1,500 member organizations. The member organizations included state employees, cities/towns, townships, counties, housing authorities, school districts, transit authorities and special purpose districts.

Mr. Emanuelson said that California, Kansas, New Mexico, Oklahoma, New Jersey and Wisconsin were similar to PEBP in that they covered state employees and made coverage available to other areas of government. For example, Kansas and Oklahoma included pools of education employees.

In response to a question from Chairman Amodei, Mr. Emanuelson stated that the programs were generally self-funded. Some were fully-insured and offered HMO coverage that was fully-insured. The other similar aspect was that non-state government agencies could join voluntarily.

Chairman Amodei asked if the plans were administered by a board like PEBP. Mr. Emanuelson replied that Kansas used a third-party administrator, Harrington Benefits, a division of Pfizer, the parent organization of Benefit Planners, the third-party administrator for PEBP.

Mr. Emanuelson said the other large public sector risk pools were municipal leagues and intergovernmental or school district trusts. Three were identified in California, three in Texas and one each in Michigan, Montana and New Jersey. He said public sector risk pools existed in many forms around the country, and there was a lot of latitude on what they covered, who was eligible and whether they were independent of state-run pools. He said the average plan had been in existence for 10 or 11 years, however, some had been in existence for as long as 30 years and may have been grandfathered under state and federal Multiple Employer Welfare Benefit Plan (MEWA) rules.

Mr. Emanuelson referred to page 4 of Exhibit C to a list of public sector risk pools. The list included the type of government entity, the amount of annual contribution or premium equivalent, assets and the number of pool members. He noted the pools with significant assets might offer other types of insurance other than health and welfare.

Mr. Goicoechea noted the table on page 4 of Exhibit C showed that Healthtrust had contributions of $205 million and assets of $30 million. He asked if that was cause for concern. Mr. Emanuelson said he presumed all the trusts were ongoing entities, but if Healthtrust were to terminate business, $30 million would not be sufficient to cover liabilities. Mr. Emanuelson estimated Healthtrust would need at least two times that amount to cover claim obligations and administrative costs.

Mr. Goicoechea asked if there was an ideal ratio of assets to contributions. Mr. Emanuelson said that ratio would be based on an analysis of the data, including the turnaround time of claims. Mr. Emanuelson said that Ronnie Thierman of Aon Consulting performed the analysis of reserves for PEBP.

Senator Coffin recalled that Mr. Emanuelson indicated there was a potential for a very large buying pool of all public employees in Nevada. Senator Coffin said that provider rates in Clark County, which made up 70 percent of the state's population, had been negotiated heavily since 1982 and nearly every public sector employee was insured at a negotiated rate. Senator Coffin did not expect that the state would have great savings in premiums due to an aggregation of groups. He advised those unfamiliar with the insurance industry that a larger group did not always result in lower premiums; in fact, the opposite could be true. Senator Coffin said the state could incur inherent risks based on demographics in state and county government.

Mr. Emanuelson did not disagree with that statement other than to say that he recently had the opportunity to look at a provider contract offering for the PEBP plan. He said there was the possibility of directly negotiating or limiting certain providers within the network. He said that if PEBP created more patient load within a facility, it might be able to negotiate additional savings. Mr. Emanuelson did not know if there was much opportunity for this kind of savings; it may amount to only a few percentage points. He did know that some provider contracts, particularly on the facilities side, showed that the providers preferred to discount bill charges on outpatients. Mr. Emanuelson said that If PEBP could move to fixed reimbursement, and cap the amount of increase allowed

from contract year to contract year, there would be savings. Mr. Emanuelson said that with technology and improvements of care, there was a movement towards outpatient services. Providers were conciliatory on the inpatient side and were retaining some pricing margins on the outpatient side. Mr. Emanuelson said there was opportunity for negotiation, but he did not know to what degree.

Mr. Emanuelson referred the committee to a table on page 5 of Exhibit C showing health benefits offered, the carrier and benefit options of the larger risk pools. He said some offered custom plan designs. Mr. Emanuelson said other carriers offered a menu of plan designs; for example, a carrier might offer one HMO and three point-of-services.

Mr. Emanuelson moved on to a table on page 6 of Exhibit C that showed the amount of time a member must stay in a pool, underwriting of run-out, and what the organizations reported they had learned over the years. Rules on the length of time a member must stay in the pool have been a key factor in preventing a plan from becoming the "carrier of last resort." Limiting "in and out" would keep the group solid year-to-year, recognizing that a plan would have years of high utilization and other years of low utilization.

Senator Amodei asked if PEBP was in danger of becoming the "coverage of last resort" in Nevada. In response, Mr. Emanuelson said enrollment had declined in the non-state pool. He said the non-state pool was not representative of governmental employees because the population was not equally dispersed of active and retirees; the population had a greater percentage of retirees.

Mr. Emanuelson said page 54 of the meeting packet (Exhibit A) specifically addressed the question of retiree coverage for health plans. The survey included the following three questions:

- Are retirees eligible to continue participation in the health benefits?
- Do retiree benefits differ from active employees?
- Does retiree health coverage cease at Medicare eligibility age attainment?

The response was summarized in a table on page 54 of the meeting packet (Exhibit A).

Senator Amodei asked why premium rates were lower in the rural region than the northern region. Mr. Emanuelson replied that only 16 percent of the respondents (governmental employers in the state of Nevada) reported that they offered the same benefits to retirees and active employees. Four of the respondents reported that they ceased coverage at age 65. He said that PEBP's situation with the non-state retirees did not create ideal pricing conditions for the participants.

Mr. Emanuelson returned to the table on page 6 of Exhibit C. He said that the column, "underwriting of run-out," described how the pool funded participant "ins and outs." The last column showed feedback from the respondents on what they thought was the single most important point they had learned over the years.

Mr. Emanuelson pointed committee members to a list of participants on page 7 of Exhibit C, which included the majority of public sector employers in the state. On page 9 of Exhibit C, there was a summary of responses. From that summary, Mr. Emanuelson reported there were 112 plans offered among the 60 employers, which was nearly two plans per employer. The average number of employees per plan was 543. Mr. Emanuelson said there were nearly 56,000 public sector employees covered in the survey; PEBP covered approximately 32,000.

Regarding the premium averages listed on pages 9 and 10 of Exhibit C, Mr. Emanuelson cautioned that the information was nearly a year old and prices probably increased 10 to 14 percent. The total represented nearly $400 million of premium equivalent, which was a substantial amount. There were 62 dental plans; most entities offered one dental plan. He said, on average, the price of health care in the Las Vegas region was lower than in the northern region, and the rural area rates were fairly close to the northern region rates.

In response to a question from Chairman Amodei, Mr. Emanuelson said the northern region included four counties as defined on page 59 of the meeting packet (Exhibit A).

Mr. Emanuelson said that the amounts shown on page 9 of Exhibit C were weighted averages by coverage tier. He pointed out that premiums for the "employee only" group were similar: $408.95 in the north; $414.62 in the south and $417.65 in the rural region. In addition, premiums for the "employee plus one" and "employee and children" categories were similar in the northern and rural regions.

Chairman Amodei said there was a stereotype that rural health care premiums were higher, but the survey results indicated that for the "employee with family" group the monthly cost was almost $50 less in Winnemucca than Reno. Chairman Amodei asked what that revealed about health care prices in the northern region. Mr. Emanuelson replied that managed care did not lower health costs in rural areas as it did in the urban areas. Rural providers did not need to negotiate reimbursements because there were not as many facilities or doctors in the rural regions. Mr. Emanuelson agreed that it was possible for rural region prices to be on par with northern region prices.

Chairman Amodei acknowledged that prices were lower in the south because there was more competition in the marketplace. He was surprised that health care costs in rural Nevada was slightly less than in Reno, which was the number two urban area in the state.

Assemblyman Goicoechea noted prices were higher in the rural areas for the "employee only" option.

Senator Coffin said that illustrated his comment about what happened in managed care. He cautioned against expecting large savings, because the southern region contracts were already meager. Senator Coffin said medical providers and hospitals did not want to negotiate in the northern region, and that was why the rural prices were comparable to prices in Washoe County.

Mr. Emanuelson referred to a table on page 10 of Exhibit C showing estimated annual premiums. He pointed out that in the southern region, estimated annual premiums for fully-insured individuals were $164,174,879 and $111, 326,210 self-insured for a total of $278,563,584. The total of all regions was just under $400 million and would likely be $400 million this year with the increases that had occurred. Mr. Emanuelson said there were 40,112 respondents in the southern region and 12,719 in the northern region.

Referring to the table on page 11 of Exhibit C, Mr. Emanuelson said there were a variety of eligibility provisions. Rather than using full or part-time status to determine eligibility, the plans used the length of time the employee had been with the employer. Mr. Emanuelson said the wide variety of the eligibility provisions for each of the entities could be an obstacle in putting together a statewide risk pool. For example, 16 of the plans began coverage on the first of the month following 30 days from the date of hire; 14 of the plans began coverage after 90 days. The decision of when eligibility would begin might be left to the organizations to determine, or it could be decided that, in order to police the program appropriately, a common standard should be used for all entities within the pool.

Senator Amodei asked what value judgments went into determining the eligibility dates. In addition, Senator Amodei asked if the employees would be expected to enroll in COBRA for a longer period from their previous job. Mr. Emanuelson replied that the longer an employee was out of the pool, the longer they went without coverage. He suggested being generous towards the employee and allowing coverage starting the first day of the month following 30 days of hire. Mr. Emanuelson noted COBRA premiums could be expensive, which could be a hardship with salaries being what they were.

Senator Amodei asked about individuals entering a new plan with a pre-existing condition. Mr. Emanuelson reported that fewer and fewer employers had pre-existing condition provisions within their plan. In addition, Health Insurance Portability and Accountability Act (HIPAA) regulations allowed portability of coverage; if an individual maintained their coverage within 63 days, they could have all pre-existing conditions waived under their new employer's plan. Given that, a pre-existing condition would be a non-issue. Mr. Emanuelson said federal and state legislation had almost removed the need for pre-existing condition provisions. He said it was important for recruitment and retention of employees, to employee moral, improving employee quality of life, and, creating a happier and more productive employee. The benefits program would be one aspect that might lead to an overall improved employee health and welfare.

Mr. Emaneulson moved to page 12 of Exhibit C, which summarized plan design. He said that of the 112 plans, 76 were PPO or point-of-service in design. Roughly, 20 percent did not have a front-end deductible, which left 80 percent that did. The minimum deductible was about $100 for single coverage, the average was $463, and the maximum was $1,000. PEBP's lowest plan had a $500 deductible, which was lowered to $250 with the completion of the health risk assessment. From that perspective, PEBP's plan was very competitive. About 15 percent did not have any out-of-pocket limit, but 85 percent had an out-of-pocket limit ranging from $100 to $2,000. The out-of-pocket limit was not inclusive of the deductible; after the deductible was satisfied, the participant would receive benefits on an 80 or 90 percent level. When the participant reached the out-of-pocket limit, the benefits would be covered 100 percent.

Senator Amodei asked if the survey included a question on how often the provisions could be changed either by election of the plan participant or by the plan administrators. Mr. Emanuelson said that was not a specific question in the survey. However, another recent national survey asked employers how they intended to managed their health care expenses. Respondents said they would cost shift to employees through deductibles, out-of-pocket limits, contributions or co-pays. Mr. Emanuelson said employers were deciding how much employees should share in the cost of benefit programs on an annual basis. In making these decisions, they sometimes implemented completely new plans, such as a consumer-driven plan, which was offered by less than 15 percent of employers.

Mr. Emanuelson continued to page 13 of Exhibit C to the topic of plan provisions. He reported that for primary care, nearly 20 percent of the plans required no co-pay. That could mean either that they did not cover office visits other than the front-end deductible, or they allowed participants to use the plan without a co-pay. Mr. Emanuelson said the average co-pay was $17 and ranged from $10-$30, but the co-pay for a specialist visit was usually higher. Inpatient hospital deductibles and co-pays ranged from $25-$500, but if there were no hospital admission, they would have a separate co-pay. For emergency room visits, co-pays were higher than for a specialist or a primary care physician visit. The higher co-pay was intended to encourage the employee to use a lower cost service.

Mr. Emanuelson said pharmacy co-pays ranged from $3 for generic drugs to as high as $60 for brand name drugs. He said employers recognized pharmacy as an increasing expense. There was a lot of activity to reduce the expense, from negotiating unit costs to adding high co-payments for specialty drugs, injectible and quality-of-life medicines that cost anywhere from $1,000 per month to $10,000 per month.

Mr. Emanuelson said that most of the HMO plans were typical in that they covered 100 percent of costs; there were no deductibles or co-insurance requirements. A small percentage had a co-payment or deductible.

For dental plans, Mr. Emanuelson said annual deductibles did not apply to preventive care (page 16 of Exhibit C). Mr. Emanuelson said that maximum amounts were becoming a sensitive topic for employees because dental care was expensive, particularly periodontal and crowns. A maximum of $1,000 would not adequately cover the cost of a crown, which was about $800 depending on the region.

Moving to a table on page 17 of Exhibit C showing the demographic breakdown between bargaining and non-bargaining employees, Mr. Emanuelson summarized the survey findings stating that that public sector risk pools existed in many forms. He reiterated that medical and dental costs were less expensive in the southern region of the state than in the northern and rural regions of the state. If a statewide risk pool was considered, regional rating may be needed to make the program viable. Many public employers utilized fully-insured rates; 48 percent were fully-insured, amounting to 53 percent of the total dollars. This was probably due to the small size of some of the entities. From a risk management perspective, it was common to transfer risk.

Mr. Emanuelson said bargaining employees made up a substantial portion of the survey group, so plan design options offered through the public sector would have to consider those employees. If the bargaining groups were aggressively negotiating plan design, those plan designs would need to be considered in legislation.

Mr. Emanuelson reported that the average PPO deductible was $470. Because a substantial portion of fully-insured programs utilized brokers, there were substantial savings to be had in sales commission. The average commission paid was about $32,000 per year, per plan. Mr. Emanuelson observed that, multiplied by the number of plans in the survey, that would amount to a substantial savings.

Mr. Emanuelson suggested a split pool containing larger employers that were self-funded and smaller employers who were fully insured, therefore giving the smaller employers the budgeting aspect they wanted and needed. He said that if the state did self-fund the larger groups, reserves should be held so that if the large group left the pool, reserves would be fully funded and available to satisfy those obligations.

Mr. Emanuelson stated there was an opportunity to leverage the PEBP program into a statewide public sector risk pool. There were experienced staff and experienced vendors already in place. As stated on page 19 of Exhibit C, Mr. Emanuelson said that excluding dental, the fully-insured medical premium amounted to about $198,000,000. Claims fluctuation and reserve margins typically ranged from 5 to 10 percent on a fully-insured basis, so the estimated margin and load savings on fully-insured programs could range from $10-$20 million. Mr. Emanuelson clarified that amount was an educated guess based on what was known about the insurance industry and the plans. The administrative fees on a fully-insured plan would generally exceed about $30 per employee per month versus $20 per employee per month in a self-funded plan (this amount would be all inclusive including claim administration, utilization management, case management, etc.). Based on nearly 26,000 currently insured employees, the savings estimate on administrative costs alone could be over $3 million. There were

25 entities that paid commissions to brokers, averaging about $32,000 per year per plan. The estimated annual fee savings on commission could easily be $800,000, and was probably closer to $1.5 million. Mr. Emanuelson said existing broker relationships could be maintained through ancillary lines, such as, life insurance, disability coverage or other voluntary benefits.

Mr. Emanuelson said that there were some employers within the survey that used stop loss. Therefore, raising stop loss levels would lower premiums. With a larger population, there would be more credibility and stability from year to year. There would be more predictability in the number and degree of large claims. Internal pooling mechanisms could be created within the funding strategy, whereby the plan would act as its own re-insurer. The plan would set aside a certain amount of funding dollars to offset a certain amount of anticipated liability. In summary, the total savings, at a minimum would be $14.5 to well over $25 million on the $371 million, excluding PEBP. In addition, volume purchasing on 50,000 employee lives would lower premiums by 10 percent, saving approximately $500,000.

Referring to page 20 of Exhibit C, Mr. Emanuelson suggested the new plan consider autonomy from state-mandated benefits. Mr. Emanuelson said the plans did not generally report to the Insurance Commissioner, but if benefits were fully-insured, those plans would typically be required to report to the Insurance Commissioner. Mr. Emanuelson said that by keeping it autonomous from state-mandated benefits, the plan would be better able to manage the liability and obligations of the risk pool.

Mr. Emanuelson suggested lifetime maximums be limited to $1 million; the PEBP plan lifetime limit was $2 million. He said when a $1 million limit was in place, claims usually did not go over that limit, not because the services were unnecessary, but because providers managed services and expenses.

Mr. Emanuelson recommended that the plan offer three to five levels of “open access” PPO plans and allow participants to choose from any available option, rather than options limited by the employer. A richer level of benefits would be required for bargaining groups because those groups viewed benefits as compensation. Mr. Emanuelson suggested splitting the benefits between children and adults. He explained that children tended to need routine and illness care, rather than catastrophic care, so an HMO with a low co-pay would be preferred. The adults would be allowed to have a PPO program. Mr. Emanuelson predicted offering this split might increase the number of participants with family to enroll.

Mr. Emanuelson suggested the plan offer two or three levels of “open access” PPO dental plan design to allow participants to choose from the options based on their needs. There were different needs for different parts of the population. For example, older individuals did not need to go to the dentist as often as younger people for cleaning and x-rays.

On the topic of funding structure, Mr. Emanuelson suggested the plan offer guaranteed liability rates and self-fund with stop loss reinsurance. Larger entities could have the option of being self-funded. Medium entities (between 100 and 500 lives) would have the option of guaranteed liability rates or self-funding with stop loss levels. Smaller entities below 100 participants should be fully-insured to enable them to budget for their obligation.

Mr. Emanuelson said stop loss could be purchased either through markets, set up internally through reserves, or a hybrid of the two. The plan could re-insure claims above $500,000 and set up an internal pooling mechanism between $50,000 and $500,000. Mr. Emanuelson said there were many approaches to creating stability in the rate structure.

Senator Amodei asked if the plan could use excess reserves to purchase stop loss coverage without conflicting with GASB requirements.

Mr. Emanuelson said that the plan had no stop loss coverage at the time of the meeting. He deferred the question to Ronnie Thierman, Aon's expert on GASB, who was to speak on the topic under Agenda Item IV.

Mr. Emanuelson reviewed the following underwriting structure suggestions shown on page 22 of Exhibit C. He said the structure would create an affordable environment as well as limit selection:

- The contribution strategy would require a 75 percent contribution for single coverage and 50 percent for a family, or require participating entities to pay 100 percent of the cost of the lowest option.
- Limit the number of eligibility options because the more options offered, the more expensive it would be to administer.
- Individually experience rate larger participating entities and demographically rate with diagnosis/prognosis information for smaller participating entities.
- Adopt a four-tier rate structure for single, employee plus spouse, employee plus children and employee plus family.
- Implement disease management and wellness education programs because, if the overall health status of participants improved, participants would need fewer services.
- Coordinate with Medicare on maintenance-of-benefit approach to determine the right level of benefits for Medicare-eligible retirees. Maintenance-of-benefits would essentially give retires the same benefits as an active employee.
- If the program was to be voluntary rather than mandatory, require three years of participation and exclude from eligibility for three years if an entity leaves.
- If the program was to be voluntary, self-funded entities would be assessed a deficit recovery to discourage leaving after a large claim period.

In closing, Mr. Emanuelson said the next steps would be to review the recommendations, decide whether the program would be mandatory or voluntary, and determine how flexible the plan would be in terms of serving the needs of the various eligible groups. Following that, it would be necessary to establish plan design, underwriting and funding structure. Finally, a request for information would be required to identify qualified vendors: third party administrators (TPA), utilization management, eligibility maintenance, provider networks, stop loss re-insurers, and a qualified actuary/consultant to assist in administering the plan.

Assemblyman Goicoechea asked if the number of lives (25,000) was the number of the respondents in the survey. Mr. Emanuelson responded in the affirmative. Mr. Goicoechea said that since that number represented only 20 percent of the total potential pool, there would be a lot of room for leeway. Mr. Goicoechea said PERS purported that if every public sector employee were in a single risk pool, the number of lives would equal approximately 120,000. Mr. Emanuelson said PERS number of 120,000 included retirees. In addition, Mr. Emanuelson said about half of the eligible non-state employees responded, and half of those were fully-insured.

Assemblyman Goicoechea said some retirees were not yet 65 years old and therefore did not qualify for Medicare benefits. Although this did not affect a large group of people, Mr. Goicoechea identified this as a serious problem for those individuals.

Mr. Emanuelson said legislation might be put in place requiring that individuals receive the same benefits as the active participants, even though they retired before age 65.

IV. PRESENTATION AND DISCUSSION OF THE ACTUARIAL VALUATION OF THE STATE OF NEVADA POST-RETIREMENT HEALTH BENEFITS PROGRAM AND RELATED DISCUSSION OF STATEMENTS NOS. 43 AND 45 OF THE GOVERNMENTAL ACCOUNTING STANDARDS BOARD.

Jim Wells of PEBP gave a presentation on the topic of retiree health care in Nevada in the wake of GASB 43 and 45. He said the section of the meeting packet under tab IV (page 75 of Exhibit A) included historical information. He said that he would give additional information, inform committee members on issues to consider, and make the committee aware of the meaning of the terms and numbers.

Mr. Wells said that in 2004, GASB issued two standards for other post-employment benefits (OPEB). The first, GASB 43, related to plans that administered OPEB agreements for entities and changed some reporting requirements for those plans. The second, GASB 45, related to the entities with retirees and changed the standards for measurement, recognition and display of expenses and liabilities associated with retiree health care subsidies, and added additional note disclosures and supplementary information. The changes would be in effect in Fiscal Year 2008. Included in OPEB was anything relating to health care, medical, dental, vision or pharmacy, as well as all other benefits not included or offered through a pension. Life insurance plans, disability long-term care and any other optional programs provided to retirees, but not as a

pension benefit, would be included in the OPEB calculation. Early retirement inducement and the conversion of sick pay at retirement to cover retiree premiums would not be included. He noted at least one of the public sector entities under PEBP allowed the conversion of sick leave to cover retiree health care premiums, which would fund a retiree health care subsidy without an associated OPEB liability.

Mr. Wells continued by saying GASB attempted to recognize the ongoing costs of these programs. There was concern that the standards in place before GASB 43 and 45 were implemented failed to recognize the cost of other benefits when the services were rendered and did not identify the value earned at the time it was earned. In essence, retirees were being paid now for benefits that had been earned 20-40 years ago. GASB wanted the financial statements to show the information as the retirees earned it for future retiree benefits, which would require a change from pay-as-you-go to accrual accounting for all entities. The new rules were similar to FASB 106 passed in the early 1990s for private sector corporations and were structured similarly to GASB accounting and reporting standards in that it required actuarial valuations of the plan and required showing the funded status of the liability in the footnotes of the financial statements. Mr. Wells explained that current liabilities for future costs would be shown in relation to retiree health care.

Mr. Wells referred to page 6 of Exhibit E, which compared financial statement reporting in the current method versus under the new GASB requirements. The $10,000 pay-as-you-go cost was reported as a $10,000 expense representing the actual payments. There was no balance sheet liability on either the government-wide or the governmental fund statement. Under GASB 45, the government fund financial statements would be on a modified cash basis. They would continue to show the $10,000 expenditure for the actual payments, but the entity-wide financial statements, which were shown on a full accrual basis, would show the $12,000 expense of the annual required contribution and $2,000 unfunded liability. The liability would be between the pay-as-you-go cost and the annual required contribution. If the plan were to fund the entire annual required contribution, there would be no balance sheet liability. If the plan funded the $12,000 there would be an operating expense of $12,000 in the fund financial statements, but no liability on the entity-wide statements.

Senator Amodei asked which accounting method the plan used currently.

Mr. Wells said the plan currently used the accounting method similar to the governmental fund financial statement where it reflected a pay-as-you-go methodology. The expense came out of the budget and went into the retired employee group insurance pool, which funded the retiree health subsidies. There was no estimated expense or liability recorded for the additional amount.

Senator Amodei ask for confirmation that in the example shown on page 6 of Exhibit E, there was a $2,000 liability entry to be added that was not there before. Mr. Wells agreed and said beginning in Fiscal Year 2008, the state would have to show that extra amount on its financial statements. Until Fiscal Year 2007, the state would continue under the pay-as-you-go methodology and the records would reflect the current payments from one year to the next.

Senator Amodei asked if the expense would be reflected in the budget of individual departments based on how many retirees that department had in the system or how many active employees they had at the time.

Mr. Wells assumed it would work similarly to the retired employee group assistance pool. An assessment would be made to the budgets related to the program participants. For NDOT employees, NDOT would pay a percentage of their salary into the retired employee group insurance pool that would then accumulate assets to pay for future retiree costs. The actual amounts that would come out of the budgets would be based on that assessment.

Chairman Amodei asked if that was a method of pre-funding. Mr. Wells agreed. Chairman Amodei asked if retiree contribution would also be pre-funded. Mr. Wells said there was no requirement to pre-fund any of the retiree's portion, only the part required to be paid by the state.

Mr. Wells said there were five potential misconceptions about implementing GASB 43 and 45:

- GASB standards would require advance funding of OPEB. This was not a true statement. The states or entities could continue under the pay-as-you-go methodology, but the liability must be shown on the financial statement (the difference between the pay-as-you-go and the annual required contribution under the GASB 45 rules).
- OPEB would wipe out General Fund balances overnight because of the enormity of the liabilities. This was not true because it did not appear on the governmental financial statements. There would not be a cash entry into the financial statements of the General Fund that would out that fund balance.
- Government would have to report a liability for all OPEB earned previously by its employees and retirees. The state did not have to recognize the entire amount of previous earnings of the employees and retirees, only a portion of it that was amortized over a 30-year period. That amortization amount was included in the annual required contribution.
- No written agreement meant no OPEB. GASB required what was known as the "substantive plan," which was defined as what was commonly understood between the employees and the employers as the plan as of the actuarial evaluation date. The fact that they had a subsidy methodology assumed that we would continue to have a similar methodology in the future.

- There would be no OPEB if retirees paid their full health care premium and there would be no implied subsidy (they were segregated and pooled separately as retirees) and no OPEB liability. If there was an explicit subsidy, or if retirees were commingled, creating an implicit subsidy, there would be an OPEB liability.

Mr. Wells continued to page 8 of Exhibit E. He said Nevada's numbers were small compared to others around the country. Maryland estimated its liability at $20 billion; Michigan, $30 billion; and California, $40 billion. Nevada's liability was expected to be between $1.75 and $4.5 billion. Mr. Wells said the liability would not be small, but would not be nearly as big as other state's liability.

Mr. Wells continued, stating that the money must be in a trust fund to count as pre-funded. He said the Health Insurance Trust Fund was structured as an internal service fund. PEBP was not a trust fund and could not manage the plan under the current circumstances; legislation would be required to establish a trust fund to put the pool's resources toward pre-funding.

Mr. Wells stated that if the plan made the annual required contribution, there would not be a liability on the financial statements.

Mr. Wells said that OPEB would be considered a form of compensation to attract and retain employees. The state had two plans: a single employer plan for state retirees and a non-state plan, considered an agent multiple employer plan. They had slightly different rules under GASB 45. It was important to note that PEBP actually had two different plans, because the two plans would be treated slightly differently. This was based on the method of projecting future payments and discounting those amounts to today's dollars; the amount would then be allocated rationally to the employee's years of service. The historical costs would be amortized over a period not to exceed thirty years and would not be reported immediately on the financial statements, but would be included as a portion of the annual required contribution computed every year.

Referring to page 10 of Exhibit E, Mr. Wells said that NRS 287 governed PEBP; established PEBP as an internal service fund; included provisions for providing retiree health benefits; and provided for retiree health insurance subsidies. Mr. Wells explained that session bills reestablished retiree subsidies each biennium. He thought that pre-funding would impact the ability to change that base amount. He explained that when pre-funding, there were restrictions on how quickly positive impacts made by actuarial changes could be amortized. If a future legislative body wished to cut the base subsidy rate because the state could no longer afford it, the amount in the pool would still have to be amortized over a minimum of ten years; there would not be the flexibility as with the pay-as-you-go methodology.

As outlined on page 11 of Exhibit E, Mr. Wells compared defined benefit plans with defined contribution plans. PEBP offered a defined benefit plan similar to PERS. PEBP offered a promise of a future benefit. The liability of making that promise good would fall on the entity that made the promise. A defined contribution plan would be like the

deferred compensation plans available to most employees whereas money was put into an account that the plan managed, and the employees were responsible for any shortfall on the account as the years progressed.

Ronnie Thierman of Aon Consulting, Inc. spoke on the topic of the actuarial analysis prepared by her organization (Exhibit D). GASB required a plan the size of PEBP to be evaluated at least every two years. If there were significant changes to the benefits or membership, the plan would need a valuation every year.

Ms. Thierman said because the evaluation was completed in April of 2005, before it was known that the state would opt for a 28 percent subsidy from Medicare Part D, the initial report excluded those numbers.

Ms. Thierman said she would explain what was involved in an actuarial evaluation of the liability. In order to perform the evaluation, there were a number of demographic and economic assumptions to be made. The demographic assumptions involved population: retirement rates; withdrawal rates; and mortality rates. She explained those factors would affect the benefit cost to the members. For example, if a participant retired earlier, the liability for medical and dental would be greater than if the participant deferred retirement. If a participant left the program before he or she was eligible for retirement, then he or she would not receive retiree medical benefits. Retiree medical benefits ceased when the participant died. Ms. Thierman said they used the demographic assumptions developed for PERS because it was made up of nearly the same group of people.

Ms. Thierman said there were numerous economic assumptions in the OPEB calculations that were not made in the pension calculations, the most important of which was medical trend, which was the rate at which the expected medical costs would increase year after year.

Ms. Thierman pointed out an anomaly in the GASB regulations regarding the discount rate. The discount rate would be the interest rate used to determine, in today's dollars, the promised benefit to be paid in future years. She compared it to an interest rate in mortgages; the lower the interest rate, the lower the monthly repayment amount to the bank. In discounting value of promised benefits at future dates, the opposite would be true because of the time value of money. She explained that with a lower discount rate, the time value of the future payment would be more. For example, if $100 were deposited in the bank today at 5 percent, in 10 years when a payment was due to a retiree for their medical benefit, the $100 would have grown at 5 percent. The plan would need more dollars at 5 percent than at 10 percent. She asked committee members to keep in mind that the higher the discount rate used to determine the present value of the benefit liability, or promise, the lower the expense.

Chairman Amodei asked how inflation of medical care costs would affect the discount rate. He wondered what would happen if medical care cost rose between 10 and 12 percent every year for the previous 10 years.

Ms. Thierman said medical inflation was a critical assumption. She explained that the double-digit medical inflation seen in recent years would be a factor when projecting future medical inflation. She said if the cost of medical benefits increased at 12 percent, ad infinitum, and the general GDP grew at a much smaller rate, there would be a point in the future where 100 percent of all of society's dollars would be spent on medical care, which obviously could not be true. When the actuarial assumptions were set for medical inflation, the rate began at current levels, but ultimately graded down to a more realistic level, taking into account the whole dollar basket of goods and services society buys. For this particular analysis, she started at the double-digit inflation rate of 13 percent, but then the ultimate rate was graded down to 4.5 percent, which had a tremendous impact on the results.

Ms. Thierman indicated another critical assumption was the actuarial funding method used to determine the cost to each year. She said that GASB allowed six different actuarial funding methods to be used at the discretion of the entity. The most common funding methods were the aggregate, the entry age normal and the projected unit credit. Another important assumption would be the actuarial asset method. She said this would only apply if the plan was pre-funded and had assets accumulating.

Ms. Thierman defined the substantive plan as a combination of any document used to communicate the plan to participants. That would include written documents, plan documents, summary plan description and plan provisions given to participants at open enrollment.

She continued citing another important element, the implied subsidy. The implied subsidy disclosed whether each group was paying its share. She explained that, if the experience was commingled, as it was for the state, there would be one uniform rate and one group could be potentially subsidizing other groups. The subsidized group was typically the under 65 retirees, a more expensive group because they were older and did not qualify for Medicare. Depending on how rates were set, there may be an implied subsidy that needs to be valued under the GASB rules.

Ms. Thierman moved to page 14 of Exhibit E to the topic of actuarial terminology. She said expected post-retirement benefit obligation (EPBO) was the total liability of the plan for all members currently in the plan. The term was also known as present value of benefits (PVB), which would be the benefit promised today to all participants, both active and retired, at the time of the calculation. The accumulated post-retirement benefit obligation (APBO) would be the portion of the EPBO accrued or earned to the valuation date. For retired people, the EPBO and the APBO would be equal, because the total expected present value of benefit payments had already been earned. The service cost was defined as the cost of the benefit earned during the current year. The future service cost was the present value of all the future, one-year service costs. The annual required contribution would be determined each year and would be made up of the service costs plus amortization of the unfunded APBO, if there were one.

Ms. Thierman said, from a legislative perspective, it was important to determine whether to pre-fund. Other assumptions or considerations would be the funding methodology determination, which was the method used to calculate the GASB expense. Inherent in this assumption would be the amortization period, which could be anywhere from 10 to 30 years, and the selection of the actuarial assumptions previously discussed. She said there might be a need for legislation if the state deemed the liability too large.

Ms. Thierman said the ultimate cost of the promise to pay benefits to retirees for medical, dental and life would be determined by the benefits provided and the individuals receiving those benefits. The cost of the plan had nothing to do with the funding method or amortization schedule; those were simply ways of allocating that promise over time.

Ms. Thierman continued stating that there was a potential issue with the implicit subsidy that should be considered from a legislative perspective. She said that whether or not to pre-fund was the number one question for the plan. Pre-funding was not a requirement of GASB; it would be left to each entity to decide whether to pre-fund or continue on a pay-as-you-go basis. She said one of the anomalies was the impact of the discount rate, which was the interest rate used to determine, in today's dollars, the expected benefit promise in the future costs. According to GASB, if the state pre-funded, and money was put into irrevocable qualified trusts, the plan would then have a funding policy the board would establish as to how those assets would be invested. The investment manager would rebalance to the strategy selected by the board. She explained the discount rate used to calculate the liability was a function of the expected long-term rate of return of those investments. Typically, a long-term expected return on that type of portfolio would be anywhere from 7–8 percent, which was higher than the internal rate of return for the state's own dollars. The discount rate GASB required if the state did not pre-fund was a long-term rate of return, which may be 3 or 4 percent, as opposed to the higher discount rate used if a trust fund was established. She said the higher the discount rate, the lower the liability. Therefore, if the plan was pre-funded, the expected long-term rate of return of the trust fund would be 8 percent and the liability would be substantially lower than if the plan had a 3.5 percent discount rate. She explained this was an anomaly because the benefits were the same and the people were the same, yet the expense booked would vary greatly depending on whether or not the plan was pre-funded.

Further, Ms. Thierman said the decision to pre-fund was made year-to-year. If there was money to put away to fund the benefit during one budget cycle, that could be done with no obligation to pre-fund in the following budget cycle. The annual required contribution (ARC) did not have to equal the actual contribution; it could be more, less or the same. GASB disclosed how actual contributions differed from the annual required contribution. She explained that if the plan contributed less, and did not

pre-fund, that difference would be noted as a liability and amortized in future year ARCs. For example, the discount rate for the same people with the same benefits (page 77 of Exhibit A) the actual EPBO (the total liability for all benefit promises) at 3.5 percent would be $4.4 billion. However, at an 8 percent discount rate, that liability would drop to $1.75 billion. She said this showed the huge impact the discount rate had on determining the actual liability.

Ms. Thierman suggested that the state select a funding policy that best fit it fiscal goals. The pre-funding initiative could be "seeded" with no obligation to continue in the next biennium. The state could elect a different method and determine contributions on a year-by-year basis.

Ms. Thierman stated that OPEB benefits and post-retirement health care benefits had a very long term horizon. They began at the date of hire, and ended when the person died. For example, an individual might be hired at age 25, work to age 55 and receive benefits to age 85. She reiterated that the cost of the program was a function of the benefit promise and the demographics of the group covered; the cost was not a function of the funding method. She said if the plan had set up a trust fund, the investment earnings from those assets might be used to defer the cost of the plan. Pre-funding typically funded more than the current benefit outlay because it put away money for future benefit payments. Over a period of 70 years, between pre-funding and pay-as-you-go, one would expect that if one paid less today, over time that cost would increase. If more was pre-funded than needed, and the difference was put in a trust fund, the plan would initially pay at a higher level, but over time, that level would be lower than with the long-term pay-as-you-go method. She said there was a crossover point dependant on the demographics of the group and depending on whether it was growing, shrinking or staying the same size. That crossover point would also depend on the funding method and amortization period selected and other actuarial assumptions that went into the calculations.

Ms. Thierman said the impact of GASB 43 and 45 was unknown. There was much discussion on what impact the GASB liability would have on the bond ratings of those entities who booked a high liability. All government entities had this promise to their retirees, so the rating liabilities would be even across the board. However, the rating agencies have not revealed how the liabilities booked by an entity will influence future bond ratings.

Ms. Thierman said the next step would be to determine a funding method. GASB allowed six funding methods that differed in how they allocated accruals over time. The liability was a function of the benefits promised and the demographics of the participants. The funding method simply spread the liability over time and allocated what was past service and what would be future service. In the end, no method was better or worse because the all reached the same place. She said it was important that the plan continue to use the method initially adopted, rather than switch back and forth. Plan expenses varied depending on which funding method was used. The funding method split the liability between past and future service and determined to some extent

the length of the period over which the unfunded liabilities were funded. She referred to the bottom of page 21 of Exhibit E showing the impact of the different funding methods on the ARC. She said the numbers showed the shorter the amortization period, the larger the annual expense.

She continued to the topic of selection of demographic assumptions, reiterating that the demographic assumptions used in the pension valuations should also be used in the GASB valuations. The most important assumptions in terms of influencing expense would be age at retirement, which varied between age 50 and 65 plus. The rate of termination was important, because when people terminated they would not be qualified to receive benefits. The rates of mortality were important because benefits ceased upon the death of the participant. Most of the economic assumptions were unique to GASB. The initial claims and premium rates would be very critical. The medical inflation rates would be equally or more important. She said that different rates were used in the analysis for the different health plans (self insured versus HMO versus prescription drug, dental, etc.) based on the trends seen in the plan and the expected future changes in those trends. Another important economic assumption would be the rate of increase in retiree contribution because the portion of the plan funded by retirees was not a liability of the state. The discount rate was a critical economic assumption. The salary scale was important depending on the funding method used.

Ms. Thierman said another consideration would be whether to amend the plan to decrease the state liability. Obviously, the GASB liability would be impacted by the level of the state liability, so the extent the benefits were changed would change the state's liability. She said the state's liability could be lowered by reducing the amount the state contributed to the current benefit levels. The plan could lower the current benefit levels and keep the state's relative contribution percentage the same. She suggested the best option would be to improve the health of the state's retirees because the cost of future medical benefits would decrease. She said some entities were closing their plan to new hires, which would impact the liability as well.

Ms. Thierman pointed to a graph (Exhibit E, page 25) that showed the implicit subsidy. The graphic showed how the active, non-Medicare retirees and Medicare retiree groups could be commingled. She said if the active and non-Medicare retirees were commingled, there would still be an implicit subsidy because the total rate would be higher than the actual cost for the active employees, and active employees would be subsidizing the non-Medicare retirees. From a GASB 45 standpoint, there would be an implicit subsidy. If the Medicare and non-Medicare retiree groups were commingled, there would not be an implicit subsidy because that group would be self-sufficient. Within that group there would be a subsidy because the people who received Medicare did not cost the plan as much as those who were not yet eligible for Medicare. Since the GASB liability looked at the post-retirement medical promise to both groups together, there would not be an implicit subsidy in the GASB 45 calculation.

Senator Beers commented that on page 6 of Exhibit E, there was an example of a current and post GASB 45 fund financial statement and government-wide financial statement. He asked about the journal entry that would be posted if the plan decided not to pre-fund. Specifically, Senator Beers asked if there would be a debit to expense and a credit to liability, which would drive the fund balance to negative.

Mr. Wells answered that under the current methodology, there was no requirement to make that entry. The entry would be a cash entry, so the expense was a debit, and the credit would be to cash, as it would be based solely on the actual payments. Under GASB 45, cash payments were required to be on the fund level statements, so the entry at the fund level was a debit to expense and a credit to cash. However, on the entity-wide statement, there would be a debit to expense for the entire amount of the annual required contribution. He said that cash would credit for the amount paid as actual payments, and the balance of that was the credit to the liability.

In response to a question from Senator Beers, Mr. Wells said it would not be shown in the General Fund as a consolidating entry.

Senator Beers asked if they could stop paying-as-we-go. Ms. Thierman replied that if the plan went to the pre-funded amount, the fund would be used to make the pay-as-you-go payments.

Senator Beers asked how often the plan was required to perform the actuarial evaluation. Ms. Thierman said every two years for a plan with 200 or more members. However, if the plan or demographics changed, then the actuarial evaluation would be performed every year.

Senator Beers asked if the written agreement for post-retirement benefits would be part of the contract. Mr. Wells replied that the written plan for the explicit retiree subsidy was part of NRS 287.046.

Mr. Coffin said that as a group insurance broker, he would discuss the topic with his peers in the insurance industry. He said insurance brokers provided a service and their fees were very low. In fact, fees were probably less than one percent in some cases, depending on the amount of service needed.

V. DISCUSSION AND REVIEW OF PROPOSED REGULATION (LCB FILE NO. R164-05) OF THE PUBLIC EMPLOYEES' BENEFITS PROGRAM TO INTERPRET THE TERM "COMMINGLE" FOR THE PURPOSES OF NRS 287.043, 287.0434 AND 287.0475.

Chairman Amodei spoke on the topic of proposed regulation on the definition of commingling that came before the Legislative Commission's Subcommittee to Review Regulations chaired by Assemblyman Oceguera. He reported the committee denied the approval to adopt the regulation. As a member of that committee, Chairman Amodei made the presentation to the subcommittee and also made the motion to deny

based on the fact the present wording in the regulation did not reflect what the majority of the members of the legislature had intended regarding commingling. There was little input from PEBP beyond the proposed regulation. He intended to ask the PEBP ACR 10 Committee to work on a definition that would consider the topics of structure of plans, the context of benefits, membership and premiums, GASB, excess reserves, pre-funding and stop loss issues. Chairman Amodei expressed hope that the committee, if they chose, would propose a BDR to define commingling statutorily that would pass in both houses of the legislature in the 2007 session.

Senator Coffin thanked Chairman Amodei for presenting the issue to the Legislative Commission. He hoped they could provide the Legislature with some guidance. Senator Coffin said the issue of commingling was too big for the agency to define on its own.

Assemblywoman Parnell said it would be very important to come up with a result that would eliminate any future discussion of Medicare carve outs.

VI. PRESENTATION ON THE DEVELOPMENT OF RESERVES IN THE PUBLIC EMPLOYEES' BENEFITS PROGRAM (PEBP), FEDERAL GUIDANCE ON THE LEVEL OF THOSE RESERVES AND POTENTIAL USES OF EXCESS RESERVES.

Bob Atkinson, Senior Program Analyst, Fiscal Analysis Division, Legislative Counsel Bureau (LCB) gave a presentation that covered the following points:

- History of the financial status of the program.
- State contributions for both actives and retirees.
- Current reserve status.
- Federal guidance on reserve levels.
- Potential uses of excess reserves.
- Utilization of General Fund savings resulting from the 2005 budget amendment.

Mr. Atkinson said his presentation covered the period from 2001 forward because, in 2001, the plan was at a break-even point. The fund balance on June 20, 2001 was $408,000. If the plan ceased operation, there would have been enough money in the bank to pay off the incurred but not reported (IBNR) liabilities. In Fiscal Year 2002, the plan lost $16 million. Mr. Atkinson said it was interesting to note that the 2001 Legislature approved the contribution rates recommended by the program and by the Governor, but those rates were 3.1 percent lower than the previous year, which would not have accounted for the entire $16 loss. At the time, the program was approximately $160 million per year and so the loss amounted to a 10 percent of the total amount of expenditures. For each one of the years, Mr. Atkinson showed the state contribution for active employees, the base retiree subsidy, the net income and the fund balance.

Mr. Atkinson said in Fiscal Year 2002-03, during the 18th Special Session, the Legislature increased the amount of the state contribution and the amount of the retiree subsidy contribution, which led to an increase in the assessment to cover the retiree subsidy. This resulted in an increase of $18 million to keep the program afloat. As a result, the program was about $15 million in the red at the end of Fiscal Year 2003. In the 2003 Legislative Session, the budget was approved as submitted by the Governor. The Legislature recommended the program implement cost-cutting measures to manage the extreme fluctuations in the program. If the plan had ended at that time, the state would have to come up with $15 million to pay off the claims. At the time the budget was developed in 2003, it was estimated that it would take about 4 years to bring the plan back to where it had enough money to cover its liabilities. PEBP made some plan design changes that changed things dramatically, and in 2004 the program had an income of $46 million, which was attributed to a decrease in the amount of large claims and a decrease in utilization. It did not take 4 years to rebuild plan reserves, and the plan ended 2004 with $31.5 million over and above the IBNR. Mr. Atkinson said the plan was in much better shape than it had ever been.

Mr. Atkinson reported that in an attempt to utilize some of the reserve and give something back to the participants, rates were artificially reduced in Fiscal Year 2005. In Fiscal Year 2005, the plan showed a profit of $23 million and ended with $54.9 million more than the required amount of reserves. In the 2005 Legislative Session, after The Executive Budget was submitted, the Governor submitted a proposed budget amendment stating anticipated costs in The Executive Budget were over-estimated by about $46 million, and that there would be about $13 million more in cash balance at June 30, 2005. Those combined amounts equaled $59 million. Approximately $48 million related to the state and the rest related to non-state and participant contributions. The $48 million translates to about $28.7 million of General Fund savings. The Legislature ultimately approved the budget amendment, resulting in reduced state contributions. For example, for FY 2006, the Governor recommended $570.55 per month. With the new projections, to spend down some of that excess reserve, and because the program anticipated costs would be lower in Fiscal Year 2006, the state contribution was lowered to $481.19. For Fiscal Year 2007, the original Governor's recommended budget of $590.76 for a state employee was lowered to $500.20.

Mr. Atkinson said that in the coming months he would ask the PEBP to report on Fiscal Year 2006. The last time he spoke with the Accounting Officer, he learned the program was on target. The budget for the current biennium was designed to spend down excess reserves so the IBNR would still be covered and there would be a catastrophic rate stabilization reserve of $24 million. Mr. Atkinson explained that was how the plan moved from being in a deficit at the end of 2003 to having excess money at the end of 2005.

On the topic of federal guidance on reserve levels, Mr. Atkinson said the Office of Management and Budget published *Circular A-87*, which established cost principles for state, local and Indian tribal governments. It was applicable to this program because some employees for which contributions were made were paid with federal funds and the federal government did not want to pay any more than its proportionate share. The relevant provisions were listed at the top of page 3 of Exhibit F and included:

- Any contributions to reserves must be actuarially based and updated at least biennially.
- Reserve levels related to employee-related coverage were normally limited to IBNR, but there could be a working capital reserve up to 60 days worth of cash expenditures.
- Reserve levels in excess of IBNR must be identified and justified.
- Whenever funds were transferred from a self-insurance reserve to other accounts (such as the General Fund), refunds must be made to the federal government for its share of the funds transferred.
- Working capital reserves of up to 60 days cash expenses for normal operating purposes were considered reasonable. Working capital reserves exceeding 60 days could be approved by the federal government in exceptional cases.

Regarding the potential uses for reserves, assuming it was desirable to spend them on something allowable under the federal guidance so there would not be a refund to the federal government, the following might be considered:

- Benefit enhancements. For example, at one time there was a second pair of glasses given in the vision program. Mr. Atkinson cautioned that this option could create ongoing costs if they were not one-time enhancements.
- Premium reductions. Premium reductions could create extreme variations in premium rates because participants will remember that they had a low premium, and when the rates were returned to normal would seem like a huge increase.
- Contingency reserves subject to the approval of the federal government.

In addition, Mr. Atkinson said reserves might be used for a pre-funding mechanism, but that would require consultation with experts to determine whether it was an appropriate use of the money.

Mr. Atkinson moved to the topic of utilization of General Fund savings from the 2005 budget amendment. He said that, of the reduction in the state contribution approved by the 2005 Legislature, about $28.7 million was reduced General Fund need over the biennium. While these savings were not earmarked and then spent on specific purposes, a memorandum from the Budget Division of the Department of Administration lists suggested budget amendments (see page 4 of Exhibit F). That list may provide some insight on where the Executive Branch thought that additional money would be spent. While the budget amendment for the PEBP program was approved by the Legislature, thus reducing the General Fund cost, staff has not verified that all of the other amendments utilizing this savings were approved.

Senator Beers asked if the $48 million moved from PEBP to the General Fund and other funds would require an unanticipated refund to the federal government.

Mr. Atkinson replied that there would be no refund to the federal government because the savings were being utilized by reducing the contributions required in future years. The federal government benefits in the same proportion as the state and would contribute less over the next two years to the extent of their contribution to the reserve.

In response to a question from Senator Beers, Mr. Atkinson confirmed that no funds were moved from PEBP to the General Fund. The savings resulted from a change in the projected amount of expenses that would be incurred in the next two years of $46 million and an additional $13 million in earnings through June 30, 2005, that had not been anticipated at the time the original budget was submitted.

Senator Beers asked that the spreadsheet detailing the history of the financial status of the program be expanded (pages 1 and 2 of Exhibit F). In addition to the net income or loss and the revenue and expense for each of those fiscal years, he asked for a further breakdown of the revenue into gross amounts paid by employees and gross amounts paid by the state, with a small carve out for the non-state participants.

Chairman Amodei asked that the spreadsheet clearly show the net increase or decrease in both the state's and the participants' contributions for Fiscal Years 2006-07.

Senator Amodei questioned whether the state's contribution decreased over those budget years at the same time that the "artificially low" rates of the 2005 year were increased for 2006 and 2007. He asked Mr. Atkinson to provide that information in the context of Senator Beers' request. Senator Amodei also requested a breakdown on what portion of employees in the plan was federally funded.

Senator Amodei asked Ms. O'Grady to prepare a legal opinion reviewing whether reserves could be used to purchase stop loss coverage, whether that was the smart thing to do, and whether reserves could be used for pre-funding in the context of the new GASB rules. Senator Amodei said those steps tended to stabilize rates and premiums if they were appropriately constructed, implemented and administered.

VII. PRESENTATION ON THE PLAN OF INSURANCE FOR PUBLIC EMPLOYEES AND RETIREES IN THE STATE OF MINNESOTA.

Woody Thorne, Executive Officer, PEBP, presented information on the Minnesota Advantage Health Plan (page 85 of Exhibit A). In 2004, the Midwest Region of the Council of State Governments gave the states of Iowa and Minnesota an innovation award for their health plans. Mr. Thorne referred to page 88 of Exhibit A, a table comparing the Minnesota Advantage Plan and PEBP. The Minnesota Advantage Plan was a hybrid HMO/PPO program. It had three networks for plan administrators who had each formed clinic groups made up of their provider panels. The clinic groups

functioned like HMOs in that each participant selected a primary care clinic that would approve most services. Services such as OB/GYN, chiropractic, vision and hearing could be self-referred, but everything else was referred through the primary care clinic. The three networks also offered preventative services, hospital case management, and disease management and were self-sustained networks. Each of the three divided their providers into the same four tiers using the same criteria and offering the same corresponding increases in deductibles and co-pays or co-insurance for each tier. The participants had the flexibility to choose their network and provider clinic during open enrollment. Within that network they could make changes within tiers up to two time each plan year. Participants in HMOs typically changed primary care physicians, but were limited to one change per month.

Mr. Thorne said the clinic groups were stratified into different tiers according to risk, adjusted costs and area availability negotiations. The least expensive primary care clinics made up Tier 1, the next most expensive were in Tier 2, on up to the most expensive in Tier 4. The clinics were re-evaluated annually and reassigned to determine their tier. This created competition among the providers to improve their services and try to get on the lower tiers.

Since its inception 2002, there have been adjustments to the Minnesota Advantage Plan every year. There were five tiers at first, then there were three, and then four. Currently within any of the three networks, the clinic groups ranged from Tier 1 to Tier 4. The fourth tier was added due to a demand for certain providers by participants who were willing to pay higher deductibles and co-pays to have access to those providers. The premiums and out-of-pocket expenses were the same for all participants, active and retiree, state or non-state. This placed the focus on deductibles, co-pays and co-insurance and which tier a participant selected.

Mr. Thorne reported the Minnesota Advantage Plan streamlined their rate structure by having only two groups: individual and family coverage (regardless of the number or type of dependant). Like PEBP, Minnesota adjusted deductibles, co-pays and co-insurance to fine-tune the plans, since these were the elements that participants used to select within the tiers. Like PEBP, Minnesota instituted a health assessment; they used a $5 deduction in the office co-pay as a reward for completing the assessment, whereas PEBP used a 50 percent reduction in the deductible as a reward.

The Minnesota Advantage Plan pharmacy program was divided into two groups: formulary and non-formulary. If a medicine had a generic form, that generic form would be placed in the formulary group and the brand name would be in the non-formulary group. If a participant chose a brand name when there was a generic available, he would pay have a higher co-pay plus the cost difference between the generic and the brand name.

Mr. Thorne said the actual savings for the Minnesota plan were still unknown. Several states in the region experienced a general slow-down in rate increases. This was not a result of a decrease in cost, but in smaller rate increases in 2002 and 2003. At this point, there was no way to know whether Minnesota's decrease was due to the plan or other factors. Rate increases rose in 2004 and 2005 for Nevada and other states. PEBP staff did not have information from Minnesota yet to see whether they went against this trend. However, for 2006, their medical rate had a zero percent increase, so the 2005 rates remained in place. The dental plan had a slight increase even though it was set up identically to the medical plan with tiers in different networks.

The Minnesota plan put a lot of responsibility on the plan administrators, which included Blue Cross/Blue Shield, HealthPartners and PreferredOne. The plan was simple, and made it easy for the participant to understand and make enrollment choices.

Mr. Thorne said since each tier was tied to providers and their costs, there was a direct link to the differences between the tiers. The plan was entirely cost driven, but Minnesota wanted to add quality to the equation. Other than the risk adjustment, quality was not a factor.

Mr. Thorne continued saying the biggest difference between the Minnesota plan and the PEBP statewide PPO was that Minnesota was able to set up statewide gatekeeper Personal Care Clinics (PCCs). It might be beneficial that the gatekeepers were clinics as opposed to individual providers, which would broaden both coverage and access to providers. However, that concept may be objectionable to those who were not in tune with the managed care concept of HMOs. Such a plan might be impossible to duplicate in a majority rural area like Nevada where the availability of competing provider networks and enough participants would be the key.

Mr. Thorne referred to a list of Minnesota Advantage Plan highlights (page 87 of Exhibit A) followed by information on the cost level of the gatekeeper or primary care clinic for each of the four tier levels in the Minnesota Advantage Plan and the high and low options for the PEBP plan (page 88 of Exhibit A). Page 89 of Exhibit A compared deductibles and costs for certain types of services such as office visits, hospital, etc. Page 90 of Exhibit A compared rates of the Nevada and Minnesota Advantage Plan. Finally, a comparison of the participant share of those premiums was shown on page 91 of Exhibit A.

Mr. Thorne said that they recently received information from the state of Minnesota on the 2002-04 years, but had not had a chance for review. PEBP was scheduled to receive the 2005 report, which would give more insight as to their cost/benefit.

Mr. Goicoechea asked how Medicare retirees were treated under the Minnesota Plan.

Mr. Thorne replied that he did not recall whether Minnesota moved Medicare retirees to a separate Medicare-supplement coverage when they become Medicare-eligible; all of their retirees were eligible for Medicare at age 65. He did know there was not a continuation of the existing program. Mr. Thorne said the plan changed to a Medicare supplement, but he did not think the state paid anything towards it. Because of Medicare, the retirees were essentially on their own at age 65 from a subsidy standpoint.

Mr. Goicoechea asked if the Minnesota Advantage Plan made that insurance package available, although not subsidized. Mr. Thorne replied that he was not sure whether it was a state-sponsored supplemental program. Mr. Thorne said he would find out and report to Mr. Goicoechea. Mr. Thorne said a number of states removed retirees from the plan at age 65 because all of their retirees were covered under Medicare. The state of Nevada did not begin participation in Medicare until 1986.

VIII. PRESENTATIONS BY THE RETIRED PUBLIC EMPLOYEES OF NEVADA (RPEN) AND STATE OF NEVADA EMPLOYEES ASSOCIATION (SNEA) TO PROVIDE INFORMATION REGARDING THE PUBLIC EMPLOYEES' BENEFITS PROGRAM.

Scott MacKenzie, Executive Director, SNEA Local 40-41, said his organization was grateful for the attention and energy being put forth to evaluate the current health insurance system for the state of Nevada employees. Since the 2003 Legislative Session, SNEA has supported the concept of pooling public employees into one statewide health insurance fund. He said increasing the size of the pool would inevitably decrease administrative costs, stabilize the fund, and increase the fund's purchasing power. SNEA suggested the state create a statewide pool of as many public sector employees as possible for purchasing medical services such as health care networks and pharmacy benefit manager services. He predicted such a group-purchasing structure would provide greater negotiating leverage with provider networks and facilitate higher-quality medical practice at reduced costs. Participating entities would retain their autonomy to set their own level of benefits and premiums, yet all participants would use the same provider networks and be charged the same costs for services by the providers.

Mr. MacKenzie proposed that regardless of whether claims were administered by each participating employer or by the statewide entity, each participating entity would be self-insured and there would be no pooling of risk. To ensure that no group suffered from inordinate adverse experience to which smaller groups were especially vulnerable, risks for large, catastrophic claims should be pooled.

Mr. Mackenzie said, with the diversity of governmental groups that had collectively bargained for various benefit packages and did not have or have not utilized collective bargaining rights, it would be necessary to establish a fund that was protected. To safeguard health benefit funds, he proposed funds be placed in an irrevocable trust dedicated to the plans and that the funds be used for the "exclusive benefit" of

participating employees. Mr. MacKenzie said cooperation from various local government groups would be dependent upon secure funding being developed. The long-term goal of the proposed trust was to provide affordable quality health care benefit coverage through more effective group purchasing and to retain autonomy for individual participating governmental entities.

Mr. MacKenzie said one trust fund noted as a success story was the Pennsylvania Employee Benefit Trust Fund-PEBTF (www.pebtf.org). It was the recommendation of SNEA/AFSCME that the committee request further investigation as to the inner workings of PEBTF.

Mr. MacKenzie summarized by stating there were many opportunities to reduce administrative and drug costs; where there were crossovers that could adversely affect different funds, the plan would need to retain independence. He said there were areas where risk could be shared, and other areas to use caution. He questioned how retirees would be included in the state fund. Under the current system, some of the municipalities put their retirees in the state fund, but retained the active employees. He suggested that municipalities that did not participate fully not be allowed to put their retirees into the fund.

Assemblyman Goicoechea said he understood the issue was complex. He met with the school superintendents and they told him the state would have to pay for whatever plan was chosen. He said there were approximately 41,000 active and retired employees in the school districts across the state of Nevada. He questioned why the groups were bargaining if the cost of health insurance was going to revert to the state. He said the state was paying for the school districts, they should be included in a statewide pool, which he approximated would include 75,000 members.

Mr. MacKenzie agreed the teachers and state workers were two groups likely to be put together. He thought it would be difficult for the teachers to give up their rights of collective bargaining over the benefits. He said low claim payments should be separate because one fund could adversely affect another, whereas larger claims should be pooled. That method would create a make-shift stop loss for the smaller counties and cities without actually having to pay a premium.

Mr. Goicoechea asked if, ultimately, local school districts would pay for bargaining with the teachers' union.

Mr. MacKenzie understood that a year after bargaining, some costs diverted to the state.

Mr. Atkinson said when the Distributive School Account was developed, all of the required or appropriate expenditures were funded with as much local revenue as was available. Anything over that amount would be funded with General Funds. If costs increased, that increase would also come from the General Fund unless there were savings elsewhere to offset. The General Fund became a backfill for the account.

Mr. Goicoechea said it would be beneficial for the state to come forward with a good quality and affordable health care plan and provide that coverage to actives and retirees through the system. Ultimately, the state was going to be on the hook for those expenses.

Chairman Amodei asked Mr. Emanuelson if a portion of his presentation addressed different levels at which different groups could elect to participate. Mr. Emanuelson said it was common for bargained benefits to be richer than non-bargained benefits.

Chairman Amodei asked if members of a bargaining unit could elect a level of benefits within the plan that reflected their bargaining and still be members of a larger group. Mr. Emanuelson said he did not know if eligibility would allow them to take the bargained benefits or go to another plan of benefits. Chairman Amodei asked if Mr. Emanuelson was aware of any plan made up of members of bargaining units and non-bargaining units who participated at two different premium levels. Mr. Emanuelson said that he had seen plans where bargained benefits were available to all employees, bargaining or non-bargaining.

Assemblywoman Parnell stated that school districts, counties and cities each hired staff to deal with the maze of health care, finding the program and negotiating rates. She said that by pooling all public sector employees, local government entities would save costs by reducing personnel.

Marty Bibb, Executive Director, RPEN, said he supported Mr. MacKenzie's view relative to pooling and purchasing. He said the plan was created as a self-funded plan in 1983 through legislative action. Since then many changes had been made, particularly relative to retirees. He said that in 1999 the plan went from full coordination of benefits to a carve out. Prior to that carve out, once deductibles and co-pays were met, Medicare paid 80 percent and the plan paid the remaining 20 percent. If a person met co-pays and deductibles and had a major event, the individual would be on a full 80:20 pay basis. If the event happened in January of 1999, that same individual would be required to pay an additional $3,000 out of pocket. That same Medicare carve-out existed in this plan, although it was under another name.

Mr. Bibb continued by saying there had been many changes that impacted retirees as well as actives. The carve out and the collapse of L&H Administrators caused serious financial problems, resulting in the non-payment of claims for a number of people in this plan. That event led to disbanding the former Committee on Benefits and creating the PEBP program. As has been mentioned before, there have been infusions of over $40 million to pay claims since that time. Mr. Bibb was stunned to find that under the former PEBP managers, there was another failure to pay claims. He said this showed a

continuing financial volatility that was of grave concern to retirees. As the packet indicated, many millions of dollars had to be appropriated to keep the plan afloat. Though he had serious concerns with the plan, it was in far better shape today because the current managers brought the plan to a level where it paid claims in a timely manner and responded to the needs of the people in the plan. Mr. Bibb described that as a serious improvement.

Mr. Bibb expressed concern with the proposal to the Legislative Commission on the topic of commingling because it would specifically exclude credit for an individual with Medicare Parts A and B. In 2001, the consultant to the plan found that Medicare-eligible retirees may have experienced lower costs of 50-67 percent by cost sharing with Medicare. In 2005, the end-of-the-session money committee compromise eliminated the lower set of Medicare retiree rates. Part of that compromise involved the request for an Executive Branch study to explore alternatives. He was sorry the study had not yet taken place. The fact that over $40 million originally slated for PEBP went to other budget categories did not help the situation. He understood that in 2004 there was a one-time reduction in rates, but there was a fairly significant increase in 2005 that resulted in $300-$400 per month more out-of-pocket for Medicare retirees by elimination of Medicare retiree category. Half the amount of the $5 million added in 2005 would be applied to the upcoming plan year beginning in July 2006. Those rates were to be discussed in February 2006 as PEBP plans for the upcoming year. He said rates were a big concern for RPEN; therefore, he would appreciate the committee's assistance in getting numbers as quickly as possible.

On the topic of reserves, Mr. Bibb said CALPERS, which oversees California's state employee health plan, had a 90-day emergency reserve and were unsure whether they received an exemption from the federal government. Historic plan volatility may be a consideration in determining whether there should be expansion of the typical 60-day financial reserve. He said the current PEBP management group should be given credit for creating a contingency reserve because previously there was only an IBNR. When the amount was found to be excess, they created an emergency reserve. He asked the committee to find out if it could be expanded to remove the highs and lows in premium rates and afford plan stability.

Mr. Bibb said that on the topic of the cost of Medicare retirees to the plan, the consultant mentioned that up to 67 percent cost-sharing for medical costs was done by Medicare, alleviating some of that liability from the state plan. That was for Medicare Parts A and B. Medicare Part D, the new prescription drug plan, will result in plans that elect to keep their own prescription benefit options because they were better than the new Medicare option. That will result in a 28 percent savings to the plan for the prescription costs of the Medicare retirees who elected to stay in PEBP for their prescription option. Aon Consulting estimated the plan would save $600-$700 per year per retiree in prescription drug costs. Mr. Bibb said those issues should be considered when deciding whether to return to a separate set of lower Medicare retiree rates.

Mr. Bibb identified another concern as the pre-1994 retirees. He said that pre-1994 retirees were eligible to receive 100 percent of the state subsidy approved by lawmakers. However, post-1994 retirees were eligible to get 137.5 percent of that subsidy amount. Another issue demanding attention was that some veteran public employees did not have full Medicare coverage because they had not worked in the private sector. Mr. Bibb asked the committee to address this issue.

Mr. Bibb expressed appreciation for the committee's efforts since the end of the 2003 Legislative Session and he looked forward to working with the committee and members of PEBP to arrive at some solutions.

Assemblywoman Parnell asked if there was a solution to the unevenness of retiree premium rates.

Mr. Bibb said that the rate schedule could be confusing and was compounded with the concern that participants who retired before 1994 had a different subsidy than those who retired after 1994. He said the $5 million put in to offset the Medicare retiree rates was specifically for Medicare retiree and spouse. There were many others in that category who did not have rate relief; for example, the self-only Medicare retiree. The out-of-pocket limit prior to this year for a person with a full career was about $14 per month; that amount went up to $133. Although the amount was somewhat offset by the monthly checks for 80 percent of Medicare Part B, those affected were older retirees on smaller pensions who saw a significant increase ($133 less $62 for 80 percent of Medicare Part B). Mr. Bibb said that researching what other plans were doing and looking at pooling within the confines and constraints of union-negotiated benefits was a valid approach.

Assemblyman Goicoechea clarified that Mr. Bibb was referring to the state retirees because the non-state Medicare rate was significantly higher.

Mr. Bibb agreed and said that was because there were a larger number of retirees on a ratio basis in the non-state pool than in the state pool.

Assemblyman Goicoechea said the ratio was about 5:1.

Mr. Bibb said the rates would certainly change, but the subsidy would be the same under A.B. 286 of the 2003 Legislative Session. The rates were different because the retirees were in two separate pools.

IX. PUBLIC COMMENT.

Chairman Amodei moved to the public comment section of the meeting.

Mr. Danny Coyle, a retired state employee, suggested that the committee recommend to the Legislature that language be added to protect reserves and pre-funded fund balance. He admitted that he was cynical after having attended several sessions of the Legislature, because he knew many people wanted the reserves returned to the General Fund. For example, Washoe County Senate District 2 was looking for money for a pork barrel project. They saw the money in PEBP's reserves and tried to get it. There should be statutory protections against those using those funds for other purposes, whether funds were reserves or irrevocable trusts, and they should be immune from the "fiscal finagling" that he saw going on every session of the Legislature.

Chairman Amodei said the briefing on pre-funding indicated trust funds must be held for those purposes. The question would be whether the 2007 Legislature would set up such a fund.

X. SCHEDULING OF DATES AND LOCATIONS FOR FUTURE MEETINGS.

Chairman Amodei found that all committee members were available and scheduled a meeting on March 16, 2006 at 10 a.m. in Carson City.

Chairman Amodei broadly outlined the anticipated agenda for the February 7, 2006 meeting in Las Vegas.

- Mr. Atkinson would report on the funding issues regarding the budget amendment. Senator Amodei cautioned that the committee was not going back to the 2005 Legislative Session to beat a dead horse. Rather, it was an effort to establish parameters for the committee's recommendations regarding future excess premium in the context of the applicable federal rules. In that context, it would be relevant to see what happened with the money last session when determining what to do in the future.
- The committee would like to hear about whether stop loss was viable and economical, whether it had been evaluated by PEBP before, and why the plan did not currently have it. This discussion would be contingent on whether or not excess reserves were available to fund stop loss, with the understanding that excess reserves would not be available every year.
- The committee would like a report on the advantages and disadvantages of rating by regions.

- Senator Amodei asked staff to prepare rough draft BDRs to include language on the issues of 1) future non-state retirees indicating that if non-state retirees were sent to the plan, non-state actives must also be sent to the plan. The BDR should include languages to provide "teeth" to the edict that local governments provide retiree health insurance, and 2) a definition of commingling in the context of Medicare-eligible retirees. That discussion would include what was known about A-87 and GASB.
- The committee would like a brief presentation by the three or four entities mentioned in Ms. Eissmann's memo regarding PEBP discussions with insurance companies interested in providing a bid to administer the plan (page 95 of Exhibit A).
- Chairman Amodei asked PEBP to respond to the pros and cons of a biennial budget plan that would be adopted in July or August of odd-numbered years. The budget would be presented to the health care committee or the money committee. The purpose would be to provide stability. A biennium budget plan would also provide automatic participation in the process by the Legislature, keeping open formal lines of communication, which has been a shortcoming the Legislature experienced over the last few years.
- Chairman Amodei said he would like another discussion of pooling in the context of catastrophic claims and the inclusion of members of bargaining units. He specifically asked if it would be possible to have a pool containing members of bargaining and non-bargaining units, at a different level of benefits, with the same plan options.
- Chairman Amodei asked for a briefing on the state of Pennsylvania plan mentioned in Mr. MacKenzie's presentation.

Mr. Goicoechea said, in a perfect world, the plan would offer a basic level of health care coverage and allow for enhancements that could be bargained for by the groups.

XI. ADJOURNMENT.

There being no further comments, the meeting was adjourned at 12:34 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.