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*)

November 21, 2005

The first 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 9:30 a.m. on November 21, 2005, at the Legislative Building, 401 South Carson Street, Room 4100, Carson City, Nevada. The meeting was videoconferenced to the Grant Sawyer State Office Building, 555 East Washington Avenue, Room 4401, Las Vegas, Nevada.

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

COMMITTEE MEMBERS PRESENT IN LAS VEGAS:
Assemblywoman Chris Giunchigliani, Vice-Chair
Senator Bob Coffin

COMMITTEE MEMBERS ABSENT:
None

STAFF MEMBERS PRESENT:
Mark Stevens, Fiscal Analyst, LCB Fiscal Analysis Division
Gary Ghiggeri, Fiscal Analyst, LCB Fiscal Analysis Division
Bob Atkinson, Senior Program Analyst, LCB Fiscal Analysis Division
Linda Eissmann, Senior Research Analyst, LCB Research Division
Brenda Erdoes, Legislative Counsel, LCB Legal 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: Memo from the Public Employees' Benefits Program (PEBP) to the Legislative Commission dated September 7, 2005, on the subject of PEBP Status.
Exhibit D: Memo from PEBP to the Legislative Commission dated November 16, 2005, on the subject of PEBP Status.
Exhibit E: PEBP report titled Demographic and Financial Overview dated November 21, 2005.

Exhibit F: Memo from Linda J. Eissmann, Senior Research Analyst, Research Division, to Senator Mark E. Amodei on the subject of Comparison of Public Employee Insurance Plans dated November 15, 2005.
Exhibit G: *Coverage Conundrum*, State Legislatures magazine, July/August 2004.
Exhibit H: *New State Health Plan has Handle on Costs*, Minneapolis Star Tribune, August 12, 2005.
Exhibit I: Minnesota Advantage Health Plan 2005 table of cost levels.
Exhibit J: Minnesota Advantage Health Plan information, including 2004 table of cost levels.

I. CALL TO ORDER AND OPENING REMARKS.

Chairman Amodei called the meeting to order at 9:46 a.m. The Committee Chair established that all committee members were present. Assemblyman Tom Grady was in the audience at the Carson City location.

II. REVIEW OF THE PROVISIONS OF ASSEMBLY CONCURRENT RESOLUTION NO. 10 (2003 LEGISLATIVE SESSION).

Bob Atkinson, Senior Program Analyst, Fiscal Analysis Division, gave a brief overview on the items that were included in A.C.R. 10 of the 2003 Legislative Session. He referred the committee to page 4 of the meeting packet (Exhibit A) to the following list of items that the study must include according to the resolution:

1. An examination of the methods used for determining premiums, equitable employee contributions based upon actual costs to this state, and coverage for active and retired state and non-state public employees and their dependents;
2. A review of the administration and solvency of the Fund for the Public Employees' Benefits Program;
3. A review of any financial contribution non-state public employers made to assist their retired employees in maintaining health insurance coverage;
4. The feasibility of soliciting proposals for a contract that would take over the entire statewide operation or the regional operation of group health insurance funded by public employees and public employers;
5. An examination of relevant facts to determine whether all members of the Public Employees' Retirement System should be required to participate in a statewide program of health insurance funded by public employees and public employers;
6. The desirability of eliminating or changing the composition of the Board of the Public Employees' Benefits Program;
7. Consideration of whether it was feasible or desirable to allow voluntary participation of public employees and public employers in such a program;
8. The feasibility and desirability of establishing a program similar to the Federal Employees Health Benefits Program, which provides a choice through local and national carriers;
9. Consideration of how the non-state public employers should contribute to the costs of insurance for employees who retire from their service;

10. Consideration of requiring non-state public employers' benefit plans to include reinstatement rights for their retirees, as currently required by the Public Employees' Benefits Program;
11. Consideration of options for pre-funding retiree health benefits for all members of the Public Employees' Benefits Program;
12. Consideration of a state subsidy mechanism providing for a specific dollar amount or a specific percentage of the cost for employees and separately for their dependents, including an appropriate funding method;
13. A review of this state's retiree subsidy formula for past, present and future retirees and an appropriate funding method to address the current structural deficit;
14. Consideration of the feasibility, desirability and financial impact of authorizing large groups of participants to withdraw from the Public Employees' Benefits Program to obtain group insurance from other sources;
15. Consideration of the feasibility and financial impact of the State of Nevada forming one or more purchasing coalitions with surrounding states or private entities, or both; and
16. An analysis and review of issues related to:
    (a) Pharmaceutical programs designed to reduce the price of prescription drugs for:
        (1) Persons of low income in this state;
        (2) Enrollees in this state's health benefits plan; and
        (3) Participants in programs administered by this state that make available or provide prescription drugs;
    (b) Prescription drug buying clubs used in other states and the potential for such clubs to assist the residents of this state in reducing their expenses for prescription drugs;
    (c) Methods to access manufacturer rebates for prescription drugs to assist the residents of this state in reducing their expenses for prescription drugs;
    (d) Interagency bulk purchasing and interstate buying of prescription drugs to reduce the prices of prescription drugs for this state's programs and health benefits plan;
    (e) Methods to negotiate for lower prices on prescription drugs and a plan to carry out the methods; and
    (f) Methods to control the prices of prescription drugs for this state's programs that provide pharmaceutical assistance to persons of low income in this state and for enrollees in this state's health benefits plan.

Mr. Atkinson said that the committee would submit its final report to the 2007 Legislature. He noted that because A.C.R. 10 called for a three-year study, the committee would have met over two interims at its conclusion.

There being no questions from the committee on Mr. Atkinson's presentation, the Chairman continued to the next agenda item.

III. SUMMARY OF THE ACTIVITIES OF THE A.C.R. 10 COMMITTEE DURING THE 2003-2005 INTERIM.

Mr. Atkinson reported that during the 2003-05 Interim, the committee met three times, and the Advisory Committee and its subcommittees met seven times. He reported that the committees focused primarily on gathering information.

Mr. Atkinson reported that during the 2003-05 Interim the committee heard presentation on the following topics:

- The history and current status of PEBP;
- The CalPers program, where they learned there were many similarities between the two programs. For example, medical costs were much lower in the southern part of the state compared to the northern part of the state in both Nevada and California. CalPers representatives reported that they had no easy answers to the problems that the programs shared;
- PEBP plan design and rate methodology;
- Nationwide health care cost trends; and
- Health benefits programs offered by local governmental entities including the City of Henderson, Clark County Teacher's Health Trust, Washoe County School District, Nevada League of Cities and the City of Las Vegas.

The committee asked the PEBP Board to hire a consultant to perform two studies. The first was a study on the potential savings of establishing a statewide program of health insurance for all public employees. Mr. Atkinson referred the committee to the report on page 7 of the meeting packet (Exhibit A) showing the results of that study.

The second study related to the post-retirement health benefit costs and included analyses of 1) the liability created by the current state subsidy for health insurance for future and current retirees, and 2) how the liability could be funded as a percentage of payroll. The executive summary of that report was on page 53 of the meeting packet.

Mr. Atkinson said, if the committee requested it, he would arrange a meeting with the consultants who prepared the reports.

Vice Chairwoman Giunchigliani suggested that the committee discuss the recommendations after the committee addressed the other agenda items.

Chairman Amodei agreed and stated that the meeting would be opened for suggestions as to the content of the next three meetings after the other agenda items were discussed. He would then assign the topics to individual committee members, who would report to the committee at the next meeting.

IV. PRESENTATION ON THE FINANCIAL AND PREMIUM HISTORY, DEMOGRAPHICS AND STATUS OF THE PUBLIC EMPLOYEES' BENEFITS PROGRAM.

Chairman Amodei pointed out that materials had been provided to the committee (Exhibits B, C and D) to accompany the presentation. He introduced Woody Thorne, Executive Officer of the Public Employees' Benefits Program.

Mr. Thorne began the presentation by introducing Jim Wells, PEBP Financial Officer. Mr. Thorne said the PowerPoint presentation (Exhibit E) would cover participant demographics, plan design, self-funded contributions and plan finances.

Mr. Thorne referred the committee to page 3 of the handout titled Demographic and Financial Overview (Exhibit E). He said the program had experienced steady growth in overall participation. He pointed out that bar graphs for the years 2001-2004 showed a period when the program was unable to retain an HMO to serve northern Nevada; therefore, there was a significant decrease in HMO participation. Mr. Thorne reported that when the HMO returned as an option in 2005, the number of participants in the self-funded plan versus the HMO returned to a more normal distribution.

Mr. Thorne said the majority of participation in either plan was single coverage for the participant only (page four of Exhibit E). The next largest group for the self-funded plan was for the participant and spouse, followed by participant and children and participant and family. He said there was a slightly higher participation of children and family in the HMO plan.

Mr. Thorne noted the following changes in total enrollment numbers from 1998 to the current year:

- state actives declined from about 75 percent in 1998 to 71 percent;
- state retirees increased from 15 percent to approximately 18 percent;
- non-state actives decreased from 5 percent to approximately 2 percent; and
- non-state retirees increased from 5 percent to 9 percent.

Mr. Thorne continued, stating that because the non-state participant group was relatively small and the statute required that it be rated separately, it was difficult to recruit new members in that area. The ratio of actives to retirees for the non-state group was about even in 1998; at the time of the meeting, the ratio was more than 4.5:1 for retirees to actives.

Moving on to the topic of Plan Design History, Mr. Thorne said that from 1998-2006, PEBP had multiple deductible plan options. He referred to a graph (page 6 of Exhibit E) that showed the history of medical plan deductibles. He pointed out that there had been an increase in deductibles and co-payments in response to an increase in costs over the last 10 years. Mr. Thorne said there was a similar increase in the out-of-pocket maximums (page 7 of Exhibit E), but they have been level for the last three years. He said the plan was probably at the maximum amount of out-of-pocket expense that was reasonable for plan participants to bear.

Mr. Thorne said the history of co-payments and co-insurance was depicted on page 8 of Exhibit E, and showed no increase in co-insurance payments for out-of-network physician visits, with out-of-network co-insurance payments of 50 percent. He said that although the rise was steady in co-payments for PPO physicians, it remained a modest amount for a physician visit.

Mr. Thorne continued to the topic of Pharmacy Plan Design, stating that from 1998-2001 there was a generic retail plan, a generic mail order plan, a name brand retail plan and a name brand mail order plan. He recalled that in 2002 the plan expanded to three tiers, including generic formulary name brand and non-formulary name brand. He said every class of drug was covered under the formulary name brand plan. In addition, Mr. Thorne said if an individual's physician thought a name brand was necessary, it would be covered at the second tier co-payment level.

Mr. Thorne referred to the graphs on pages 10-15 (Exhibit E) showing the contributions for state actives and retirees and non-state actives and retirees. For the state actives (page 10), the fastest growing component was the state subsidy. There were modest increases in employee contributions. He reported that in 2005, the plan began using predictive modeling, which was the most reliable method to predict costs. As a result, PEBP discovered that they would have significantly higher costs for spouses in the "participant and spouse" category. Mr. Thorne said that group consisted of older "empty nesters" with more expensive medical issues. At the same time, those in the "spouses and children" category (particularly the children themselves) had significantly lower costs, thus PEBP lowered the contribution for that group.

Mr. Thorne directed the committee's attention to the graphs on pages 11-13 (Exhibit E). He noted that there was an increase in the cost for Medicare retirees reflecting the full commingling and that the contributions reflected the Medicare Part B premium that was paid-in-full by all Medicare retirees. At the time of the meeting, the Medicare Part B premium was reimbursed at 80 percent.

Mr. Thorne said that the graph on page 14 showed the effects of A.B. 286 from the 2003 Legislative Session, which required non-state public employers to provide a subsidy for their retirees participating in the PEBP program at the same levels as the subsidy for state retirees.

Mr. Thorne reminded the committee that the purpose of group insurance was for the many to pay for the few. He reported that 4 percent of PEBP participants incurred 65 percent of the costs. He said historically the split averaged a ratio of 30:70 industry-wide, but was now 17:83. One out of 27 participants incurred paid claims in excess of $10,000. He reported that the most common diseases experienced by plan participants were oncology (cancer); hypertension; diabetes; end-stage renal disease and coronary artery disease. PEPB paid medical claims totaling $63.5 million for 1,734 participants. Mr. Thorne stated that the average claim for those participants was $36,360, which amounts to $212 per month for every participant in the program.

On the topic of plan finances, Mr. Thorne said there were two instances where the plan needed an infusion of additional money from the Legislature. The 1999 Legislature made a $26 million appropriation to the program and created the PEBP Board. In August 2002, during the 18th Special Session, the Legislature made an $18 million augmentation of the subsidy assessment, which brought PEBP to the break-even point for fiscal year 2003. Since then, the plan experienced a downturn in overall claims expense. Mr. Thorne recalled that at the end of 2003 and beginning of 2004 there was a drop in the number of large claims. Mr. Thorne reported that the program recently experienced a normal number of large claims, and the gap between income and expenses was closing.

Mr. Thorne referred to a graph on page 18 (Exhibit E) showing the growth in the medical, dental and vision parts of the program, and the prescription portion relative to that total. The graph showed a decrease in 2003. Mr. Thorne explained that the apparent decrease was due to a transition from a calendar year plan to a fiscal year plan, making a six-month plan year during that transition. He said that when expenses were annualized and divided per member, per month, the expense history was as follows:

FY 2003	$475.30
FY 2004	$396.25
FY 2005	$453.64

Mr. Thorne observed that while the experience was better than in the past few years, claims expenses were on an upward trend.

Mr. Thorne reported that in 1998 the actual versus recommended reserves were negative in funded versus recommended reserve. Reserve amounts were steady until 2002 when there was a drop in the funded reserve due to an abnormally high number of large claims, in addition to a high rate of utilization across the board. He said that the combination of those two factors turned the plan, “upside down.” Mr. Thorne said that the plan has since recovered fully and exceeded the recommended reserve in 2004 and 2005 (page 20 of Exhibit E).

Continuing, Mr. Thorne said that the two key performance indicators were claims loss ratio and expense ratio. For fiscal year 2005 the plan expense ratio was at a level that was comparable to 2004, which was a little more than half of what was expected of a plan of its size (page 21 of Exhibit E). The claims loss ratio was very low in 2004 (69 percent); the projected claims loss ratio had been 91 percent. Mr. Thorne said for an ideal balance, the sum of the of claims loss and expense ratio percentages would equal 100, which was the break-even point. Mr. Thorne said changes were made to encourage generic drug utilization to reduce the cost of generic drugs to participants. Generic drug utilization was 52 percent in fiscal year 2004, 56 percent in fiscal year 2005 and was recently in the 56-57 percent ratio. He said anything over 48 percent was considered an excellent generic drug utilization pattern.

Mr. Thorne said the plan worked to improve and maintain a high level of medical network utilization. Medical network utilization was 92 percent in fiscal year 2004. The plan attempted to raise the level to 93 percent in 2005, but actual fiscal year 2005 medical network utilization was 89 percent (page 21 of Exhibit E).

Mr. Thorne explained that the plan did not have an opportunity to maintain a high ratio for dental network utilization, but was consistently meeting its goal of 71-72 percent.

Mr. Thorne said that to ensure that claims were processed properly, the ratio of appeals to the number of plan participants was monitored. There were 0.65 appeals per 1,000 participants in fiscal year 2004, the projected ratio for fiscal year 2005 was 0.72, and the actual fiscal year 2005 ratio was 0.52. Based on those ratios, PEBP was satisfied that claims were being paid properly.

In conclusion, Mr. Thorne directed committee members to a graph on page 22 of Exhibit E showing expense ratio and claims loss ratio over the past four years. In fiscal year 2002 claims alone were 112.73 percent of revenue; in addition, there was a 9.44 percent expense ratio. He recalled that in fiscal year 2005 the claims loss ratio was about 82 percent and the expense ratio was 7.4 percent. The fiscal year 2004 amounts were well below the 100 percent threshold.

Mr. Thorne asked the committee if there were any questions on the presentation.

Senator Coffin asked Mr. Thorne for his thoughts on the equity of premiums for the non-Medicare versus Medicare retirees.

Mr. Thorne said the issue generated a lot of discussion during and following the 2005 Legislative Session. He said the PEBP Board frequently heard from Medicare retirees on the issue. PEBP was gathering information for a number of alternatives for plan design for Medicare retirees in fiscal year 2007, including a Medigap policy. He expressed concern with the Medigap idea because of the potential for catastrophic loss. Mr. Thorne said PEBP was looking for ways to blend Medicare/Medigap coverage and still provide catastrophic protection. Mr. Thorne would present those options to the PEBP Board at their February 2006 meeting. The board will make a decision on the final plan design at the February 2006 meeting, and final rates would be set at the March 2006 meeting. He said that it was an important issue to participants, particularly those on Medicare. Mr. Thorne said that since there was a requirement in the statute that required claims experience of actives and retirees to be commingled, there would be no difference between a non-Medicare retiree and a Medicare retiree. Continuing, Mr. Thorne said there would be no differentiation between retirees due to primary coverage. Mr. Thorne said that PEBP had no choice in as far as commingling of claims. He said as an offset they were providing 80 percent reimbursement for the Medicare Part B premium so the entire premium that the Medicare retiree paid would be subject to the subsidy formulas applied to all participants. He reported that the recommended plan for the next fiscal year would be to increase reimbursement from 80 percent to 100 percent for the Medicare Part B premium, which was entirely out-of-pocket on the part of the Medicare retirees prior to the current year. Mr. Thorne said there was no ability for PEBP to apply the subsidy to that portion of the cost.

Chairman Amodei said the PEBP Board interpreted NRS 287.043 to mean that rates and claims experience should be commingled. Chairman Amodei stated that while the regulation clearly required the commingling of claims experience, he saw nothing in the statute stating that rates must also be commingled. Chairman Amodei said that regardless of whether the plan was the primary or secondary health insurance of the participant, the Medicare-eligible population should not be placed in a separate rating category because the rates would increase.

Chairman Amodei asked that staff provide a copy of the statute to all committee members so committee members could devise an amendment to require that, when establishing premiums, it should be considered whether the insurance was the member's primary or secondary provider. He asked that staff add the issue to the agenda as an action item for the next committee meeting.

Mr. Thorne explained that the rates for the program were set by claims experience. If claims expenses were commingled, the rates would be based on combined claims expense and the operating expense. He did not think they had any other option based on the language of the statute. He reported that PEBP struggled with this issue since the statute became effective in January 2002. One of the inequities they struggled with was the Medicare Part B premium that Medicare retirees had to pay. PEBP saw that as an expense over and above the other active or non-Medicare retirees. Therefore, PEBP commingled on the basis that anything that was covered the same would be commingled and anything that was covered under Medicare would be treated as a separate group. Any attempt to provide a refund or credit for the Medicare Part B premium created an implied income that incurred an additional tax liability for the Medicare participant. Mr. Thorne explained that the payment was then treated as a reimbursement of a medical expense, which eliminated the tax implication and allowed PEBP to go forward with a fully commingled rate and a reimbursement of the Medicare Part B premium. Mr. Thorne said PEBP was aware of the problems and were trying to devise a plan that would meet both the requirements of the statute and the needs of the participants.

Senator Coffin suggested there was a danger in using professional industry "terms of art" in the statutes. *Commingling* was an insurance industry term rather than a legal term, and it may not have been properly defined in the statutes. He recalled that, in the insurance industry, commingling was a term used regarding claims rather than premiums. Senator Coffin asked staff to review whether the term was being used properly in the statute.

Assemblywoman Giunchigliani said Chairman Amodei accurately captured the debate towards the end of the 2005 Legislative Session regarding Medicare eligible participants. She agreed that they should have an agenda item at the next meeting to define what was intended in the statute. She said the PEBP Board over-interpreted legislative intent and took the more negative approach. She recalled that Chairman Amodei, Assemblywoman Parnell and Assemblyman Pierce were working on language at the end of session to clarify what was intended statutorily, but they ran out of time. Instead, the one-time supplemental subsidy was devised. Ms. Giunchigliani said she thought it was clear that commingling did not mean the same rates had to be charged to both Medicare-eligible and non-Medicare individuals. She agreed with Senator Coffin

that if they had used their own definitions, rather than industry terminology, they would have more flexibility within the statute. Assemblywoman Giunchigliani said she had other concerns but would wait until the end of the meeting.

Assemblyman Amodei said that at the end of the meeting all committee members would be given the opportunity to indicate their priorities.

Chairman Amodei asked that LCB staff provide the proposed regulation of the PEBP Board (LCB File No. R164-05) to the committee for their comments at the next meeting. He planned to report to Assemblywoman Buckley, Chair of the Legislative Commission, that the committee reviewed the regulation that defined the term commingling. In addition, he asked that LCB File No. R089-05 also be given to the committee members before the next meeting. Chairman Amodei said the Legislative Commission and its Subcommittee to Review Regulations put both files on hold pending his request to allow the committee to review and comment.

Assemblywoman Parnell said that in addition to the issue of premium rates for Medicare-retirees, there should be a discussion about the difference in rates between state and non-state employees.

There being no more discussion, the committee moved on to the next agenda item.

V. UPDATE ON THE EXECUTIVE BRANCH STUDY OF ALTERNATIVE METHODS OF PROVIDING INSURANCE TO PARTICIPANTS IN THE PROGRAM FOR WHOM MEDICARE PROVIDES PRIMARY COVERAGE AND OTHER INFORMATION CONCERNING THE PROGRAM REQUESTED BY OR PRESENTED TO THE LEGISLATIVE COMMISSION.

Woody Thorne, Executive Officer of the Public Employees' Benefits Program, reported that they have not had any further communication from the Executive Branch as to when the study would start, the scope, or who was to be involved.

Chairman Amodei responded that the legislators were assured that the Executive Branch would study the issue and present alternatives. He recalled that he appeared at a PEBP public hearing to request that the PEBP board wait for the PEBP A.C.R. 10 Committee's review of the anticipated Executive Branch study of the issue; now, several months after the session, nothing has been provided. Chairman Amodei stated that there was an unequivocal indication that the study would be complete; but that was not fulfilled. He said it was bothersome as a credibility issue because many legislators told concerned individuals with material stakes in the issue that the Executive Branch, the A.C.R. 10 Committee and the Legislative Commission were studying the issue; now that effort has been reduced by a third. Chairman Amodei expressed disappointment that the study of the issue was not followed through by the Executive Branch. He emphasized that the criticism was not directed at Mr. Thorne or his staff personally. However, after four years of work that will have been done at the end of the committee's charge, there would be no input on the topic from the Executive Branch. Chairman Amodei said that the study would have allowed a full and fair voice from the Executive Branch perspective; and the fact that it was promised but not given was troubling.

Vice Chair Assemblywoman Giunchigliani asked if the Executive Branch study of alternative methods of providing insurance to participants in the program for whom Medicare provided primary coverage and the actuarial study were the same. She recalled that the Governor's office and SNEA both thought money was appropriated for that report.

Mr. Thorne responded that the actuarial study was a separate issue. The actuarial study was requested by the A.C.R. 10 Committee during the 2003-04 Interim. The PEBP Board funded the study. He referred to a copy of the study on page 53 of the meeting packet (Exhibit A). Mr. Thorne also referred to the Feasibility Study on page 7 of the meeting packet (Exhibit A) and reported there was some potential for overall savings. He said that he and SNEA were in support of consideration of a full public employee program, so if an individual participated in PERS or in one of the university-approved retirement programs, he or she would be included in the Public Employee Benefits Program. As noted by the PEBP A.C.R. 10 Advisory Committee in the 2003-2004 Interim, there were a number of hurdles to overcome before that was possible. Mr. Thorne said there was a question of whether it made sense to proceed in that direction. He opined that if they did not, the non-state group would not be a viable pool, as it was in a "death spiral." Mr. Thorne said the alternative would be to grandfather those already in the program into a single pool and then allow no further non-state participation in the program. The local entities would be responsible for their active and retired employees, as has been required by statute since 1967. Mr. Thorne reiterated that he did not think the hybrid model of the current program was viable.

Ms. Giunchigliani said one point addressed by Mr. Thorne that the committee struggled with was whether everyone in PERS should be in a single, statewide public employee pool. If they were, the risk would be distributed among a larger number of participants and PEBP would have more negotiating power. Alternatively, the committee could devise a lower cost model without jeopardizing quality. She suggested the federal "cafeteria" model might be appropriate. She noted that they had new committee members that had not participated in past discussions.

Senator Beers asked if there was actuarial justification for having the non-state employees in a separate pool.

Mr. Thorne explained that A.B. 286 of the 2003 Legislative Session intended to bring state and non-state participants into a single pool. He said the financial impact to the state was over $5 million per year. At that time, the non-state group was small and was made up of more retirees than active employees, so it created a higher loss ratio for the entire pool. Assembly Bill 286 was changed so that local government retirees who came into PEBP would be subsidized by their employer at the same level as state retirees were subsidized by the state. Mr. Thorne said that approach resulted in a higher expense to the state because, under the formula for the Distributive School Account (DSA), there was a reimbursement to the school districts for the cost of paying the subsidies for the retirees. He commented that the non-school district local entities were responsible for paying the entire amount of the subsidy.

Senator Beers asked if the non-state group had a greater percentage of retirees in a high-cost caseload.

Mr. Thorne affirmed that the non-state caseload was high cost.

In response to a question from Senator Beers, Mr. Thorne said that the state active and retired employees were in one risk pool and the non-state active and retired employees were in a separate risk pool.

Senator Beers asked if there was any actuarial reason to have the groups in separate pools.

Mr. Thorne said, from an actuarial standpoint, the claims data was combined to figure the cost to provide coverage. He said the state and local entities needed to decide whether they wanted to have separate or combined pools.

Mr. Goicoechea asked if there was information on the number of non-state retirees from the school districts versus the number retired from other local government entities.

Mr. Thorne said that although he did not have those numbers on hand, he recalled that there were a high percentage of retired school district employees and the largest group of non-state retirees was from the Clark County School District.

Reading from page 12 of the Public Employees' Benefits Program Demographic and Financial Overview (Exhibit E), Assemblywoman Parnell noted that the state Medicare retirees were paying $80.96 and that the non-state retirees paid $392.91 in fiscal year 2005. She asked if the local governments added a subsidy to the $392.91 that the non-state retirees were paying.

Mr. Thorne replied that the amount paid by non-state retirees was $392.91, minus the subsidy.

Senator Beers asked whether any other non-state entities subsidized their retirees.

Mr. Thorne replied that many of the non-state local entities did provide a subsidy, but some did not.

Mr. Goicoechea asked why the local entities were not providing a subsidy as mandated under A.B. 286.

Mr. Thorne responded that they were mandated to subsidize their retirees who were in the PEBP plan, but not their retirees under their local plan.

Mr. Goicoechea said that was why premium amounts were $800 to $1,200 per month. Mr. Goicoechea commented that many of the retirees had been part-time employees or did not have many years of service, so the premium could consume their total pension check. He asked that the committee devise a plan that was more affordable.

Mr. Thorne agreed that it was a problem and said that, unfortunately, a number of local entities took advantage of A.B. 286 by encouraging their retirees to move into the PEBP plan because it was cheaper for the local government entity to pay the subsidy than to have the retirees in their own local plan. He commented that the Clark County School District plan was an HMO available only in Clark County, and if the retirees lived elsewhere, they would not be able to use the plan.

Mr. Goicoechea said that some plans offered by the local governments would not accept retirees.

Mr. Thorne said that situation illustrated the vagaries of the insurance industry. The insurance companies had a choice as private businesses whether or not to accept a risk, and if they did, under what conditions. He observed that the same situation occurred in Florida for property and casualty insurance because of the hurricanes over the past decade. He said there was a significant reduction in the number of carriers writing policies and those that did were charging extremely high premiums. He said a similar situation happened in the Gulf Coast and in New Orleans in particular. Mr. Thorne said businesses were having trouble returning to New Orleans because there were very few insurance carriers willing to provide insurance for businesses and the costs were so high that the businesses could not afford it.

VI. OVERVIEW OF RECENT NATIONAL SURVEYS ON TRENDS IN STATE EMPLOYEE HEALTH INSURANCE PROGRAMS, AND REVIEW OF INFORMATION FROM OTHER STATES CONCERNING THEIR STATE EMPLOYEE HEALTH INSURANCE PROGRAMS, INCLUDING PLAN DESIGN, PRESCRIPTION DRUG PLAN, COMMUNICATION WITH MEMBERS, AND REGULATORY OVERSIGHT.

Chairman Amodei told the committee that he asked Linda Eissmann, Senior Research Analyst in the Research Division of the Legislative Counsel Bureau, to compare public employee insurance and retiree benefits plans of other western states with the Public Employees' Benefits Program.

Ms. Eissmann referred to a memo distributed to the committee members entitled Comparison of Public Employee Insurance Plans (Exhibit F). Ms. Eissmann said that her role was to provide information at the request of the Chairman. She said that in her position as staff, she did not support, defend, advocate or oppose any program or policy, but rather she provided research and policy analysis. She said that her focus was to address specific questions, and she was not otherwise an expert in insurance matters.

Ms. Eissmann said that the information in the memo (Exhibit F) came from a number of reputable references, both print sources and conversations with experts in the field.

Ms. Eissmann said that Chairman Amodei asked the following questions:

1. How do other states provide insurance to employees, and do they insure both active employees and retirees?

2. Do states insure other public employees (like county or school districts)?

3. What were the typical premiums paid by state employees in other states?

4. Do other state employee insurance systems answer to an Insurance Commissioner, and if so, to what degree?

5. How do other states communicate changes in the insurance plan with their employees?

6. Was there another state in which the state employee insurance program was widely considered a unique approach or an example that might be worthy of further study?

Ms. Eissmann said that she consulted with a number of references identified on page 13 of the memo (Exhibit F). She said that the references included several national surveys on employee benefit programs. The references included information from relevant national associations like the National Conference of State Legislatures (NCSL), Council of State Governments, the National Governor's Association, the National Association of Insurance Commissioners and the National Association of State Personnel Executives. She reported that she also spoke to representatives of public employee benefits programs in the other western states and consulted a number of specific professional journals.

Ms. Eissmann then went on to address the specific questions.

1. How do other states provide insurance to employees, and do they insure both active employees and retirees?

Ms. Eissmann reported that all 50 states provide health insurance coverage for their active state employees and early retirees under age 65 (early retirees were often pooled with active employees; retirees might have been required to pay a higher premium amount than their active employee counterparts). When retirees reached age 65 and became eligible for Medicare, two states (Indiana and Nebraska) no longer offered benefits. The remaining states offered some coverage, although it could consist only of a supplemental Medicare plan or might be consistent with coverage they had as active employees. Although Wisconsin offered retiree insurance, the benefits consisted of a program that converted accumulated sick leave to retiree health insurance credits.

Ms. Eissmann reported that for active employees, the amount of coverage, eligibility, and portions paid by the state and employee varied greatly from state to state. On average, states paid approximately 82 percent of the premium costs, and the employee paid the rest. That amount varied upon the coverage. States generally paid a higher portion of those costs for single coverage and the employee paid less, or states paid less for family coverage, and the employee paid more. A few states continued to provide the full premium for single coverage with no cost to the employee.

Ms. Eissmann said that retiree benefits also varied greatly by state. Some states continued to pay a portion of the premium although often at a lesser percentage than for active employees. Many states required the retiree to pay the full premium, but because the retiree participated in group coverage, the premium was generally less than if the retiree had to find independent coverage.

Programs were administered by an executive branch department or by a separate board or commission whose members were appointed by the governor. Retiree insurance programs might be administered by the same entity that managed the active employee insurance program, or by a different entity (such as through the retirement system).

2. Do other states insure other public employees (like county or school districts)?

Ms. Eissmann reported that approximately one-half of states provided for some non-state active employees to be covered under the same or a parallel health benefit plan. They usually included city or county workers, public school teachers and employees, and/or public higher education faculty and employees. At least two states experimented with including specific segments of the general population in their state plans, such as employees of small businesses.

Similarly, many retiree health insurance programs included non-state retirees such as local government, school district, and higher education retirees.

3. What were the typical premiums paid by state employees in other states?

Ms. Eissmann said, as previously noted, the states paid an average of 82 percent of the premium cost; therefore, the employees paid an average of 18 percent of the premium costs.

She said that in 2002, a national survey of public employee benefit programs by the Kaiser Family Foundation/Heath Research and Education Trust found that total premiums (state plus employee contributions) were, on average, $276 per month for single coverage and $643 per month for family coverage. For single coverage, the lowest premium was Pennsylvania at $170 per month; the highest was Alaska at $635 per month. For family coverage, the lowest was Montana at $429 per month; the highest was Maine at $1,110 per month.

Ms. Eissmann stated that the employee share paid by employees was on average, $29 per month for single premiums and $145 per month for family coverage in 2002. For comparison purposes, Nevada state employees under the PPO plan paid nothing for single coverage and $256 for family coverage in 2002.

4. Do other state employee insurance systems answer to an Insurance Commissioner?

Ms. Eissmann found that national surveys did not specifically address this question. Therefore, in an effort to address this question, she surveyed the other 12 western states and received responses from nine of them (Alaska, Arizona, Colorado, Idaho, Montana, New Mexico, Utah, Washington, and Wyoming). She discovered none of the nine states reported to an Insurance Commissioner. Most explained that this was because their plans were self-funded. She understood that if the state plan was not self-funded but relied instead on private insurance carriers, those private insurance providers would be subject to review by the Insurance Commissioner.

Ms. Eissmann reported that in Wyoming, the state's Department of Insurance audited the benefits program every other year, even though the plan was not otherwise subject to jurisdiction by the Insurance Commissioner.

5. How do other states communicate changes in the insurance plan with their employees?

Ms. Eissmann reported that, national surveys did not specifically address this question, so the information was queried from the nine western states noted above.

She found that all of the states communicated open enrollment information with their plan participants through mailings, although to varying degrees. Increasingly, the states were moving to electronic communication to communicate with active employees, either by e-mail or by information posted on a website. All of the states reported that regular mail was the most reliable and widely-used method to communicate with retirees.

According to Ms. Eissmann enrollment packets were mailed in all states except Washington, where the state mailed a postcard notifying the employee that there was an open enrollment period and they should use the website to enroll online. The state of Colorado indicated that they were moving towards electronic mail as its primary means of communication. Additionally, all states offered enrollment and informational meetings where they provided information about the various plans, providers, and other benefits available to employees. New Mexico and Wyoming indicated that they relied heavily on meetings with the human resources/benefits personnel in each agency. Those employees then communicated directly with the agency employees. The reason for this was because there were few employee benefit program staff, which limited their ability to conduct meetings statewide.

Ms. Eissmann said the following notes might be of interest to the committee:

Alaska – Alaska experimented with broadcast e-mails and voice mails to active employees. However, some employees accused the state of "spamming."

Utah – The state benefit plan included coverage for employees of the City of Provo, although the city communicated directly with its employees. Provo experimented with the use of digital video discs (DVDs) and was pleased with its response.

Washington – Washington had an extensive, centralized Internet system called "Access Washington," where employees knew information was available on various subjects. Each agency had its own website on this system, and oftentimes employees were referred there for information and notices. Staff also reported that board members (representing various stakeholder groups) were very active in the process and helped to determine how best to contact the stakeholder groups they represented.

6. Was there another state in which the state employee insurance program was widely considered a unique approach or an example that might be worthy of further study?

Ms. Eissmann said each state faced its own unique set of circumstances; what worked in one state might not necessarily work in another. However, a program in Minnesota won an innovation award from the Council of State Governments in 2004. She cautioned that the program was new, so there was no long-term analysis of its overall success.

She reported that the Minnesota Advantage Plan came about in 2001 when 30,000 Minnesota state employees went on strike. At issue were the increasing costs of health insurance and the amount of costs that should be borne by the employees.

She said that negotiators and labor representatives eventually agreed to a plan with a three-tiered cost structure; a fourth tier for the most expensive providers was added later. Each tier had its own level of deductibles, co-pays and other out-of-pocket costs, but all required the same monthly premium.

Ms. Eissmann said that the cost of deductibles and co-pays increased from Level 1 to 4, but the same types of care was available at all levels. Participants could move among the tiers during the year without waiting for an open enrollment period. This allowed flexibility to match health care resources and specific needs. She gave an example that if someone had been diagnosed with a life-threatening illness, they could move from the lowest to highest tier during a year for the care they desired. She notes that in Minnesota, the fourth tier included the Mayo Clinic.

Ms. Eissmann noted that additional information was provided to the committee on the Minnesota Advantage Plan (*Coverage Conundrum*, State Legislatures magazine, July/August 2004 Exhibit G; *New State Health Plan has Handle on Costs*, Star Tribune, August 12, 2005, Exhibit H; Minnesota Advantage Health Plan 2005 table with cost levels, Exhibit I; and Minnesota Advantage Health Plan information and 2004 table with cost levels, Exhibit J).

Ms. Eissmann pointed out that employees who chose Level 1 paid $15 per office visit, while those at Levels 2 and 3 paid $20. At Level 4, enrollees paid 30 percent coinsurance for each visit. Yearly deductibles ranged from $30 for a single person at Level 1, to $1,000 for a family at Level 4. The maximum annual out-of-pocket amount was $3,300 per family.

Ms. Eissmann reported that critics said the plan shifted more costs to employees. Proponents argued that employees were given greater control of their health care costs and choices.

Finally, Ms. Eissmann said that since its inception in 2002, increases in claims have slowed, and in 2006, Minnesota expected a zero percent increase in claims.

Ms. Eissmann switched to the topic of prescription drug costs, explaining that in 2001 a group of states began working together to explore a multi-state purchasing project for prescription drugs. The group eventually formed the "Rx Issuing States," or RXIS program, comprised of five states: Delaware, Missouri, New Mexico, West Virginia and Ohio. Together they issued a Request for Proposal and selected a single pharmacy benefit manager. She reported that the RXIS program was designed to address the dramatic increase in prescription drug costs faced by states by consolidating negotiating power, achieving efficiencies, and capturing rebates through a multi-state purchasing collective (RXIS covered 700,000 people).

Ms. Eissmann said participant states reported significant cost savings as follows:

- Ohio anticipated savings averaging $5 million per year;
- West Virginia estimated savings of $25 million over three years, which represented savings of 5 percent over the previous prescription drug system;
- Missouri expected savings of $1.4 million, or 2 percent of the plan costs, in its first year;
- New Mexico expected to save $2 million; and
- Delaware reported $1.9 million in rebates.

Ms. Eissmann referred the committee to page 7 of Exhibit F to a general overview of employee benefits programs. She reported that in 2002, the Kaiser Family Foundation found that the average premium increased by 12.7 percent nationwide. However, by 2004 and 2005, the rate of growth declined to single digits, slowing to 9.2 percent in 2005. She said although that was good news, the increase continued to outpace inflation and average wage growth.

- Since 2000, health insurance premiums grew by 73 percent, compared to cumulative inflation of around 14 percent and cumulative wage growth of 15 percent.
- The average monthly cost for single and family coverage, including employer and employee contributions, was $335 and $907, respectively.
- On average, employees contributed $51 per month for single coverage and $226 for family coverage.
- Annually, premiums for single coverage cost more than $4,000, and the cost of family coverage was almost $11,000.

Ms. Eissmann reported that health insurance became less affordable every year, which might have explained the steady erosion in recent years of the number of private companies offering health benefits (from 2000 to 2005, the number of private firms offering health benefits decreased from 69 to 60 percent).

She said because of the trend, several sources reported that employee health benefits had been, and would remain, the most popular benefit employers could offer prospective workers. According to the Employee Benefit Research Institute, health insurance was rated as the first and second most important benefit by 75 percent of workers. The next closest benefit was a retirement savings plan, with 55 percent of workers rating it as very important.

Ms. Eissmann said that unlike the federal government or private employers, states must balance a commitment to provide comprehensive employee health benefits with pressures to balance budgets, especially during the recent economic downturn.

Ms. Eissmann said the NCSL attributed recent attention to state employee benefit programs to the following factors: 1) rapidly rising commercial premiums impacted state budgets; 2) state fiscal pressures were leading to more proposals to increase the employee's share of costs; and 3) co-payments and deductibles were on the rise nationwide. She said the cost of prescription drugs rose at an even higher rate in the past decade. Costs were driven by extensive direct consumer advertising, the proliferation of new drugs and an aging workforce that required maintenance drugs.

Ms. Eissmann explained that those factors were complicated by the new Government Accounting Standards Board (GASB) rules that would put pressure on states to manage costs differently in their retiree health systems. She recalled when similar rules were adopted by the Financial Accounting Standards Board (FASB) a decade ago in the private sector many companies stopped offering retiree insurance.

Ms. Eissmann referred the committee members to pages 9 and 10 of the memo (Exhibit F) which contained detailed information regarding the status of cost coverage and pharmaceuticals among the states.

She referred the committee to page 11 of the memo to the section titled Trends and Forecasts. Ms. Eissmann said that as each state evaluated its program costs and ability to meet the new GASB standards, the following were some of the common approaches considered to address the rising cost of employee health insurance:

- Increase the employee's contribution toward coverage for themselves or their dependents;
- Increase the employee's share of prescription drug costs;
- Increase the cost of co-payments and coinsurance; and/or
- Add disease management and wellness programs.

Ms. Eissmann said in recent years some states have implemented higher deductible health plans and consumer-driven health plans (including health savings accounts).

- As previously noted, High Deductible Health Plans typically had a deductible of at least $1,000 for single coverage and $2,000 for family coverage.
- Consumer-Driven Health Plans were plans in which a portion of the employer's dollars was earmarked for the employee to spend. The employee controlled the purchase and use of the health care services rather than the employer. This type of care provided financial incentives to consumers to reduce unnecessary health care utilization by increasing their financial risk. The Health Savings Accounts, one component of consumer-driven health care, allowed consumers to own and control their health care spending and save for future health care costs with tax-free interest until retirement.

Ms. Eissmann said that several states were experimenting with different premiums for different employee groups. Four states (Alabama, Georgia, Kentucky and West Virginia) charged lower premiums to nonsmoking employees and higher premiums to those who smoked.

For retirees, states expected to continue adjusting retiree benefits, including changes to eligibility requirements and increases in retiree contributions toward premiums. However, they did not anticipate making dramatic changes such as eliminating retiree benefits altogether, as was observed in the private sector following implementation of the FASB rules a decade ago. Most states see retiree health benefits as an important factor in their ability to hire and retain their workforce.

In conclusion, Ms. Eissmann said the prescription drug benefit was considered by many to be the largest area of cost pressure, and states reported that they were more likely to make changes in that area than in any other. She stated that new drug cost sharing requirements, new utilization management strategies, incentives to increase the use of generic drugs, and methods of negotiating lower prices for drugs (such as the RXIS program previously described) were the most likely changes expected in coming years.

Ms. Giunchigliani was interested in the multi-state purchasing project for prescription drugs mentioned on page 7 of Exhibit F; she suggested that the committee explore that idea further, particularly since five other states had experienced positive results.

Senator Coffin thanked Ms. Eissmann for the comprehensive digest of a large amount of material. He then asked what issues the states encountered when charging higher premiums for smokers. He asked if the decision was made with or without legislative intervention. In addition, he asked whether the states considered higher premiums for those with other risk factors, such as being overweight or underweight. He commented that it could be a "slippery slope" to make premium rate decisions based on personal lifestyles and habits, whether or not people put themselves at greater risk for health problems. He supposed the next step would be to base premiums on an individual's genetic history. He commented that the state could set examples to help guide private industry in these matters.

Ms. Eissmann replied that she did not have the answer to that question, but would research and report to Senator Coffin.

Senator Beers asked Ms. Eissmann what effect the new GASB regulations would have on employee health benefits.

Ms. Eissmann replied that she had summaries of the new rules and would provide that information to Senator Beers. She said that the changes to the GASB regulations would also have an effect on other post-employment benefits, and states would have to account for that liability.

Mr. Atkinson added that information on the recording of the liability for benefits accrued to current retirees and current employees for their future retiree health insurance was included in the AON executive summary on page 53 of the meeting packet (Exhibit A).

Ms. Eissmann replied that she had a survey of states to find out how many of them pre-fund for retiree costs versus using the pay-as-you-go approach. She commented that Nevada was a pay-as-you-go state. She said that although initial costs were higher for the states that pre-funded, over the long term they were in a better position to address the GASB standards.

Chairman Amodei asked that Ms. Eissmann work in conjunction with Fiscal staff to prepare a presentation for the next meeting on the issues of arbitrage in terms of history (excess premiums, premium reserves) and the potential for pre-funding. He asked that the presentation include information from the past two budget cycles and consider the relationship between developing the budget and the state's contribution to active employee and retiree costs. In addition, Senator Amodei requested a briefing on budget amendments made during the cycle that resulted in either 1) additional monies being put into the system or 2) monies being removed from anticipated premium contribution by the state, and 3) whether there were adjustments made to reduce the states contribution if there was a similar adjustment made in the participant's contribution. He asked if there was any prohibition for using excess reserves either in the context of pre-funding or "rainy day" benefits. He noted that the topic of arbitrage would be discussed among these issues, but he specifically requested that it be viewed in the context of employee health plans.

Ms. Parnell asked that the presentation include a detailed analysis of what happened to the surplus that existed during the 2005 Legislative Session.

Ms. Giunchigliani suggested that Fiscal Division staff compare the criteria used for the Judicial Retirement System when considering pre-funding for state employee health benefits. She said the potential savings to the state would be a rationale for considering pre-funding.

VII. PUBLIC COMMENT.

Chairman Amodei took Agenda Item VIII, Public Comment, out of order before Agenda Item VII, Scheduling of Dates and Locations for Future Meetings.

Mr. Leonard Gang, retiree, spoke on the topic of Medicare-eligible retirees stating that that both he and his wife were on Medicare. He thanked the committee for its attention to the issue. He then requested a comparison of claims paid versus premiums paid for retirees for whom Medicare was the primary insurance, and retirees for whom the state plan was the primary insurance. In addition, Mr. Gang asked what effect the 28 percent reimbursement to the states from the federal government for providing prescription coverage for retirees on Medicare would have on the plan.

Chairman Amodei asked Ms. Eissmann to be the primary contact for Mr. Gang's question about federal prescription coverage reimbursement. He then asked Mr. Atkinson to work with PEBP staff to find the number of Medicare-eligible individuals in the program and to perform a comparison of claims paid versus premiums paid for both retiree groups. He asked Mr. Atkinson to contact Mr. Gang by phone with the results.

Chairman Amodei stated that Scott McKenzie, Executive Director of State of Nevada Employee Association (SNEA), and Marty Bibb, Executive Director of the Retired Public Employees of Nevada (RPEN), would be on the agenda for the remaining committee meetings.

Chairman Amodei said that the committee would have four more meetings, which was the equivalent of a legislative week. He said that if anyone had specific ideas of areas to be evaluated, or ideas for change, they were welcome to give their comments.

Mr. Scott McKenzie, Executive Director for SNEA/AFSCME Local 4041 said that he was concerned that the AON actuarial study was not broad enough, and ought to be expanded.

Mr. McKenzie reported that he had spoken with NSEA Director, Ken Lange, about the possibility of pooling with SNEA. Mr. McKenzie said that health insurance costs would continue to rise, and if the pools did not expand, then the fund would become unstable.

Mr. McKenzie said that SNEA was also very interested in the idea of full or partial pre-funding for retirees, similar to the PERS model. He understood that the GASB laws limited unfunded liabilities. Therefore, funding the liabilities ought to be explored, as opposed to eliminating retiree benefits. He said that if the committee did not study these issues over the next decade, the state would reach a crisis in state employee insurance issues.

Regarding non-state retirees, Mr. McKenzie said that as long as collective bargaining did not address issues for retirees in the cities and counties, and the retirees were in a separate pool, there would be cost problems. He said that if the pool included both active and retired employees, the situation would be stabilized somewhat.

On another topic, Mr. McKenzie said that, the program should be allowed to maintain a reserve. He said that if the fund had a reserve there would be more stability and less fluctuation in the fund. In conclusion, he observed that the committee had an enormous amount of work to complete in a short time.

Chairman Amodei asked Mr. Atkinson to contact Mr. McKenzie for his input on the topics of pooling, pre-funding and protecting the fund by enabling a reserve, and report at the next meeting.

Chairman Amodei said that because the committee did not have much time to work on the issues, he would give specific assignments to individual committee members based on their interests.

Chairman Amodei asked Vice Chair Giunchigliani which stakeholders she thought should be involved in the issue of pooling. Vice Chair Giunchigliani replied that Mr. Bibb of RPEN might be interested. She would include a Medicare contributor. In addition, she would include a local government entity to uncover the reason some local governments cost-shifted its employees to the state rather than assuming the obligation at the local level. She suggested that members of last interim's Advisory Committee might give their expertise. Vice Chair Giunchigliani said she would work with Mr. Atkinson and Ms. Eissmann to coordinate and gather information on potential pooling partners.

In addition, Vice Chair Giunchigliani said that she hoped that when they discussed the pooling issue, they would also discuss whether the state should remain self-funded, versus changing the program to include a broader group of providers. She stated that Washoe County and the rural areas did not have access to a wide variety of insurance plans. She wanted to find out how the large insurance companies and HMOs could expand from southern Nevada. The northern and southern plans were not equal because many members in Washoe County and the rural areas had limited health care options. In addition, she said that there was discussion last interim about why the HMOs were subsidizing the PPOs. She asked whether self-funding was causing the problem, or if there was another mechanism to get more bids on the state health care plan. In conclusion, she stated that it would benefit the program participants and the taxpayers to have a broader group to provide services.

Chairman Amodei asked Ms. Giunchigliani to work with Mr. Atkinson and Ms. Eissmann to uncover reasons for the lack of competition for the state's request for proposals from the insurance industry, on a regional and statewide basis.

Chairman Amodei expressly requested that Mr. Thorne and PEBP staff provide any thoughts or information on any of the matters discussed in any of the meetings.

Senator Coffin cautioned that a larger program would not necessarily be a better program, nor would it guarantee lower premiums. He said a bigger program might make outcomes more predictable, but would not necessarily mean lower premiums. He said that public employees groups had flexibility in their work schedules, so they could schedule more operations. Senator Coffin agreed with Mr. McKenzie that there was much work for the committee to perform in a very short period, and the committee may

need to expand the number of meetings. He suggested that the committee consider coordinating its work with the Interim Retirement and Benefits Committee and the Interim Finance Committee because certain topics overlapped.

Chairman Amodei said that coordinating with the Interim Retirement and Benefits Committee was an excellent idea because that committee would exist for a longer period than the PEBP A.C.R. 10 Committee would.

Chairman Amodei said that over the next two meetings the committee would work to take some issues off the table, and then concentrate on the issues remaining. He said that the committee did a good job last interim reviewing a broad range of issues. He said that the objective this interim would be to stabilize benefits and rates in an atmosphere where health care costs were rising.

There was no further public comment. Chairman Amodei asked committee members for their priorities for the study.

Vice Chairperson Giunchigliani asked if the Insurance Commissioner should audit the program occasionally. She suggested that the committee investigate the federal employee health care plan that was "tiered" similar to the Minnesota Advantage plan Ms. Eissmann mentioned in Agenda Item VI.

On the issue of the AON report, Vice Chair Giunchigliani recalled that it was received mid-session and legislators and staff did not have adequate time to review it. She agreed that additional study and discussion of the issue would be required.

Chairman Amodei asked Mr. Thorne to review the Minnesota Advantage Plan and give a preliminary report at the next meeting.

Assemblywoman Parnell volunteered to work on any area, but she was particularly interested in the area of premium equity. She recalled that year after year, premiums for one group or another increased dramatically. She said that she had been working for years to find a balance so that premium rates were more predictable.

Chairman Amodei asked that Ms. Parnell work with Fiscal staff on pre-funding, arbitrage and budget amendment issues.

Assemblyman Goicoechea recalled that from 1999-2002 there was a $40 million shortfall, followed by a $70 million surplus. Premiums and benefits were reduced or increased accordingly. He predicted that pooling would reduce those fluctuations.

On another issue, Mr. Goicoechea asked that the committee examine the reasons some local governments were contributing more than others to the plan. He said that if all of the local government employees were added to the PEBP pool, membership would almost double, which would make a big difference in premiums and risk. He echoed Ms. Parnell's comment that they had been searching for answers to the premium equity issue for four or five years. He said that issue was what caused local governments not

to participate; pre-Medicare retirees were paying $1,500-$1,800 per month for themselves and their spouse. Mr. Goicoechea said that the committee had lots of information, and they now needed to put it together.

The Chairman asked Mr. Goicoechea to lead the charge on pooling and rural availability issues. On the pooling issue, Chairman Amodei asked Mr. Goicoechea to work with Mr. Thorne, Mr. McKenzie and LCB staff to define the barriers to pooling. For example, what would be required in terms of timing for a statewide program and what impact could it have on collective bargaining agreements? He asked Mr. Goicoechea to return to the committee with a list of obstacles to creating a pool, and a suggestion of which pools would be the least difficult to create.

Senator Beers said that he would like to know more about the implications of the GASB pronouncements. He said that, if the changes were big enough to eliminate retiree health benefits in the private sector, he was concerned for the implications to state employee health benefits for retirees. Chairman Amodei asked Senator Beers to concentrate on the GASB projections. In addition, Chairman Amodei asked Senator Beers to investigate the projected number of incoming Medicare-eligible retirees, examine the impact those numbers would have to the overall plan and how that would effect commingling the groups. Senator Beers said he would also look at forecasts.

Senator Beers recalled that the Medicare program began in 1987 and by the year 2017, 90 percent of the plan's retirees would have Medicare as the primary retirement health insurance. Chairman Amodei said that information would be needed for the existing group, and for making recommendations prospectively.

Chairman Amodei asked committee members to give a brief overview on their areas of concentration, or arrange for the appropriate staff person to present the information, at the next meeting.

VIII. SCHEDULING OF DATES AND LOCATIONS FOR FUTURE MEETINGS.

Chairman Amodei said that he would like to hold the next meeting soon after the holidays.

Vice Chairperson Giunchiliagni said that Senator Coffin suggested the meeting be scheduled to coordinate with the Interim Finance Committee meeting on January 26, 2005 and the Interim Retirement and Benefits Committee meets on January 25, 2005. She also suggested that the committee monitor the agendas for the Interim Retirement and Benefits Committee for related topics.

Chairman Amodei asked Ms. Eissmann to contact the staff of the Interim Retirement and Benefits Committee and PEBP to advise them of our agenda items. He suggested that they hold the last meeting jointly, or ask the Interim Retirement and Benefits Committee to send a committee member to the fourth meeting so that each committee could find out what the other was recommending to the 2007 Legislature.

Chairman Amodei scheduled meetings for January 11, 2006 at 9 a.m. in Carson City and February 7, 2006, 9 a.m. in Las Vegas.

IX. ADJOURNMENT.

Chairman Amodei adjourned the meeting at 12:01 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.