MINUTES OF THE
LEGISLATIVE COMMISSION'S COMMITTEE TO STUDY
THE PUBLIC EMPLOYEES' BENEFITS PROGRAM
(ACR 10, 2003 LEGISLATIVE SESSION)
March 19, 2004

A meeting of the Legislative Commission's Committee to Study the Public Employees' Benefits Program (PEBP) (created as a result of Assembly Concurrent Resolution 10 – 2003 Legislative Session) was held at 1:00 p.m. on March 19, 2004 in Room 4401 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. The meeting was video-conferenced to Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. Exhibit A is the Agenda and Exhibit B is the Attendance Roster.

COMMITTEE MEMBERS PRESENT IN LAS VEGAS:
Assemblywoman Chris Giunchigliani, Chairwoman
Assemblyman Pete Goicoechea
Senator Bob Coffin
Senator Dean Rhoads

COMMITTEE MEMBERS PRESENT IN CARSON CITY:
Senator Mark Amodei

COMMITTEE MEMBERS ABSENT:
Assemblywoman Barbara Buckley (Excused)

STAFF MEMBERS PRESENT:
Mark Stevens, Assembly Fiscal Analyst
Bob Atkinson, Senior Program Analyst, LCB Fiscal Analysis Division
Eileen O'Grady, Principal Deputy Legislative Counsel, LCB Legal Division
Mary Alice McGreevy, Senior Deputy Legislative Counsel, LCB Legal Division
Becky Lowe, Secretary, LCB Fiscal Analysis Division
Sherie Silva, Secretary, LCB Fiscal Analysis Division

EXHIBITS:
Exhibit A - Agenda and Meeting Packet
Exhibit B - Attendance Roster
Exhibit C - Memorandum from Woody Thorne, Executive Officer, Public Employees' Benefits Program regarding ACR 10 Interim Study Information Requests.
Exhibit D - State of Nevada Employees' Benefits Program – Utilization Review and Rate Development for Plan Year July 1, 2004 through June 30, 2005 - Power Point Slide Presentation Made by Lew Emanuelson and Nancy Faville, AON Consulting
Exhibit E - CalPERS Health Benefits Program – Power Point Slide Presentation Made by Joyce Vermeersch, CalPERS
Exhibit F - City of Henderson Health Insurance Plans – Power Point Slide Presentation Made by Daryl Moore, Human Resources Director
Exhibit G - Teachers Health Trust Presentation – Peter Alpert, Chief Executive Officer

I. CALL TO ORDER AND OPENING REMARKS.

Chairwoman Giunchigliani called the meeting to order at 1:10 p.m. and asked the secretary to call the roll.

Senator Amodei was present in Carson City; Assemblywoman Buckley was excused.

Chairwoman Giunchigliani announced that this was the second meeting of the ACR 10 Committee, and the agenda would include presentations from various entities, which would provide information that would be helpful to the Advisory Committee's two working groups scheduled to meet the following day. She explained the Committee was charged with reviewing approximately fifteen issues concerning health care for state employees, as well as other public employees in the state. The Legislative Committee had been created for a period of four years in order that some recommendations could be presented to the 2005 Legislature, and others could be moved forward to the following session. Chairwoman Giunchigliani said the four-year period should allow the Committee to make the right choices and right decisions regarding health care, its increasing costs, and the impacts on the various employee groups around the state.

Chairwoman Giunchigliani pointed out that a study had been done in 1990 by the Public Employees' Retirement System (PERS) concerning whether PERS should handle group health insurance for all public employees who were participants in PERS. A copy of the study was included on page 95 of the meeting packet (Exhibit A). She had asked that it be included as informational material for members' review; she thought it was important for the members to know the thought process in 1990. She noted that staff had also distributed information provided by the Public Employees' Benefits Program (PEBP) responding to questions from the last Committee meeting regarding 1) historical regulations relative to non-state entity participation in the plan, 2) breakdown of participants in the program, 3) information on the number of participants in the Clark County and Washoe County plans, and 4) a breakdown of the state contribution amount for active employees (Exhibit C).

II. APPROVAL OF MINUTES OF NOVEMBER 17, 2003 MEETING.

ASSEMBLYMAN GOICOECHEA MOVED FOR APPROVAL OF THE NOVEMBER 17, 2003 MINUTES. THE MOTION WAS SECONDED BY SENATOR COFFIN AND UNANIMOUSLY CARRIED.

III. APPOINTMENTS TO ADVISORY COMMITTEE AND DIRECTIONS, DISCUSSION AND METHODOLOGY FOR THE ADVISORY COMMITTEE MEETINGS.

Chairwoman Giunchigliani explained some individuals had been appointed during the November meeting of the Committee, and she now had to make recommendations for additional members. She asked Bob Atkinson, Senior Program Analyst, Fiscal Analysis Division, to review the list of those previously appointed.

Mr. Atkinson read the names of those who had been appointed at the November 17, 2003 meeting:

Peter Alpert, Teachers' Health Trust
Kirk Brower, Humboldt County School District
Janel Carlos, Mineral County School District
Stephen Cook, Mineral County School District
Laura Dancer, Washoe County School District
David Fraser, League of Cities and Municipalities
Robert Hadfield, Nevada Association of Counties
Nancy Howard, League of Cities and Municipalities
Ralph Jaeck, City of Reno
Bob Johnston, Retired Public Employees of Nevada
Hal Keaton, Lincoln County Commissioners
Scott MacKenzie, State of Nevada Employees' Association
Terrence Marrin, City of Mesquite

Tom Marshall, Washoe County School District
Rusty McAllister, Professional Firefighters of Nevada
Walt Rulffes, Clark County School District
Woody Thorne, Public Employees' Benefits Program
Randy Waterman, City of Sparks

Chairwoman Giunchigliani announced the addition of George Stevens from Clark County and Ann Hoskin, a retired teacher.

Assemblyman Goicoechea asked if there would be an opportunity for additional appointees; he had received requests from rural Nevada. He nominated James Ithurralde, Eureka County Assessor.

Other members that had been appointed by Chairwoman Giunchigliani since the November meeting were:

Doug Bierman, Intertech Services Corp.
Al Bellister, Nevada State Education Association
Sue Brand, Retired Educator
Allin Chandler, Clark County Association of School Administrators
Sam Connally, University of Nevada, Las Vegas
Don Giancursio, Sierra Health
Rick Kester, Douglas County School District
Daryl Moore, City of Henderson
Linda Nichols, University of Nevada, Reno
Geof Stark, Churchill County
Ali Tognoni, Eureka County School District
Ty Windfelt, Hometown Health
Gary Wolff, Teamsters Local #14

ASSEMBLYMAN GOICOECHEA MOVED TO APPROVE THE LIST OF ADVISORY COMMITTEE MEMBERS WITH THE ADDITIONAL NAMES NOTED. THE MOTION WAS SECONDED BY SENATOR RHOADS. THE MOTION WAS UNANIMOUSLY APPROVED.

Senator Coffin expressed concern with the fact that there were no insurance brokers on the Advisory Committee. He suggested Don Giancursio from Sierra Health might be of assistance in nominating a representative from that field. Senator Coffin also thought a representative from a major self-insured employer should also be considered.

Chairwoman Giunchigliani remarked members could still be added, and she would welcome the addition of an insurance broker. Senator Coffin noted that Mr. Atkinson had been trying to reach the Association of Health Underwriters but had received no response.

With regard to the working groups that would be meeting on the following day, Chairwoman Giunchigliani explained that Senator Coffin would facilitate the Fiscal Issues work group, and she would facilitate the Policy and Benefits work group. She indicated that Advisory Committee members were free to choose the group which interested them. Fiscal staff would be available to assist each group. She added that it was important to receive input from Advisory Committee members, both short-term and long-term.

Chairwoman Giunchigliani thought the working groups should meet to hear testimony and receive some suggestions and then submit recommendations to the Advisory Committee. The agenda for the Legislative Commission's Committee included presentations and testimony that hopefully would provide information for

discussion by the working groups. Two major issues to be considered were how to serve the northern part of the state better and how to entice other carriers to bid on health care coverage. Another issue was the segregation of retirees from active employees, both in the state health plan and local health plans. What should be done to ensure that everyone who had given their years of service to public employment were not restricted or impacted negatively with out-of-pocket costs once they retired?

Continuing, Chairwoman Giunchigliani said she had talked with police and fire groups that had been financially healthy and then became inverted because their population included more retirees than active participants. Many of these employee groups would be facing a similar situation, and it was her opinion that the state had an obligation to ensure that the public taxpayer dollar was being used wisely, while also ensuring that proper coverage was being provided.

Senator Coffin asked if the staff had decided which group they would participate in and where each group would meet. Mark Stevens, Assembly Fiscal Analyst, replied he would be providing staff support for the Policy and Benefits work group, and Bob Atkinson would be providing support for the Fiscal Issues group. Chairwoman Giunchigliani noted the Advisory Committee would meet first in room 4412, and then the groups would divide into two separate rooms.

Assemblyman Goicoechea noted that nearly every local government and entity in rural Nevada had a different insurance provider. Although there appeared to be an adequate number of providers, he constantly received calls from individuals who were dissatisfied with their coverage, whether it was the state self-funded program or county individual coverage.

Chairwoman Giunchigliani announced that Agenda Item V, Discussion Regarding the Federal Employees' Health Benefits Program, would be deferred until a later meeting. In order to give representatives from CalPERS an opportunity to organize their presentation (Agenda Item IV), Agenda Item VI would be taken out of order.

VI. PRESENTATION BY AON CONSULTING REGARDING PLAN DESIGN AND METHODOLOGY USED BY THE PUBLIC EMPLOYEES' BENEFITS PROGRAM.

Mr. Lew Emanuelson with AON Consulting introduced Nancy Faville, also with AON; he noted that his presentation was an adaptation of a presentation given to the Public Employees' Benefits Program (PEBP) Board at its last meeting.

Mr. Emanuelson explained that as of July 1, 2003, AON Consulting was hired by the PEBP Board to provide consulting and actuarial services. He was the co-consultant for PEBP and served on AON's State and Local Government Practice Council. Ms. Faville was AON's Western Region Public Sector Senior Advisor and also served on AON's State and Local Government Practice Council. She had extensive background with California CalPERS and other governmental and university benefit programs. Mr. Emanuelson went on to say the role of AON at this meeting would be to present general historical information and perspective rating analysis and respond to any questions from the Committee.

Mr. Emanuelson said the PEBP Board had asked AON to use predictive modeling, an industry-recognized state-of-the-art modeling methodology, to help set the rates for July 2004. The method being used was an actuarially and clinically based statistical model that would take the historical claims and health history of participants within the program, extrapolate the information, and then project it forward to determine if those people would be likely to use health care services and to what extent. For example, an individual who had a heart bypass six months ago would not be likely to have very serious health issues going forward.

Chairwoman Giunchigliani asked how the model was different from what had been done in the past. Mr.

Emanuelson said historically, an underwriter would take historical claim data, adjust the aggregate amount paid, and apply a trend factor to it. That factor would be multiplied times the historical claim data, which then would become the projected claim cost. He said this method was always looking at historical data as opposed to trying to look forward to what might happen in the group. Predictive modeling was considered the state-of-the-art; the federal government had mandated it on all Medicare Plus Choice programs effective January 2000, as well as all Medicare changes effective January 2004 and beyond. Mr. Emanuelson said carriers such as Aetna, Kaiser, United Health Care, Great West, and Cigna were also using the model, although mostly for their book of business and not necessarily on a group-specific basis. He said as an actuarial consulting firm, AON had chosen to use the model, as predictive modeling was a prospective predictor of what would be emerging and not a retrospective model.

Mr. Emanuelson referred the Committee to Page 5 of Exhibit D, which contained the actual results for the claim year July 2002 through June 2003. The first column of the chart reflected actual claims for the period by plan funding, plan costs, reserve funding, and total plan surplus or shortfall. He reviewed the plan funding and costs for the year, which reflected a net surplus of $5,694,816 at June 30, 2003, with a reserve funding shortfall of $21,100,000, resulting in a net shortfall of $15,405,186.

Mr. Emanuelson reminded Committee members that there had been changes made to the plan as of July 1, 2003. He then explained if no plan changes had been made, there would have been a $54.5 million shortfall as of June 2004. Turning to Page 6 of Exhibit D, Mr. Emanuelson noted that the budgeted cost of the plan for the claim period ending June 30, 2003 was $170,490,694, and the actual cost was $164,795,880. For the year ending June 2004, there was a budgeted expense of $197,600,000, with actual projected costs at approximately $218,100,000, which would have resulted in a $20.5 million shortfall as of June 2004 if plan changes had not been implemented.

Mr. Emanuelson reviewed specific information as to how $149 million in claim expenses was incurred during the 2002-03 plan year:

- $ 110,747,834 spent on medical claims (excluding drugs)
- $ 22,513,906 spent on drugs
- $ 15,877,915 spent on dental

A further breakdown of the $149 million in claim expenses indicated that:

- $ 100,601,848 spent by employees only
- $ 31,668,384 spent by spouses
- $ 16,869,423 spent by children

Mr. Emanuelson reviewed the breakdown of the figures by age and gender:

- Male – under 40 years $13,856,968
- Male – 40 to 64 years $44,694,128
- Male – 65 and over $ 9,018,192

- Female – under 40 years $21,712,498
- Female – 40-64 years $55,401,530
- Female – 65 and over $ 7,456,337

Senator Coffin asked what population was included in the age and gender statistics. Mr. Emanuelson replied they included approximately 27,200 state and non-state employees, of which 2,500 were non-state employees.

Senator Coffin noted that the female claims were higher, and he asked if it was because there were more women in the plan. Mr. Emanuelson replied the bulk of the population was female, and the average age of the state employees was in the mid-40s. He said he would provide specific information to the Committee members.

Continuing with his Power Point presentation, Mr. Emanuelson listed the top five major diagnostic categories (MDC) for the plan year ending June 2003:

- $20,044,144 MDC 8 Musculoskeletal System and Connective Tissue
- $14,460,259 MDC 5 Circulatory System
- $11,048,390 MDC 6 Digestive System
- $ 7,315,564 MDC 23 Factors Influencing Status & Other Contacts with Health Services (physician and office encounters)
- $ 5,986,492 MDC 1 Nervous System

There were 104 claims in excess of $100,000 during the year, and the top five were:

- $741,021 Gastric Ulcer
- $609,590 Obstruction of the Blood Supply
- $595,286 Congenital Heart Anomaly
- $515,977 Failure of the Bone Marrow
- $466,769 Obesity

Mr. Emanuelson noted that the large claims were quite high for a plan population of this size.

Senator Coffin asked if the claims being reflected were from both the preferred provider and the HMO. Mr. Emanuelson responded that the HMO claims were not included, since no claims breakdowns were received from Sierra Health Plan, which covered nearly 4,000 participants in southern Nevada.

Senator Coffin asked that the additional information be provided, and Mr. Emanuelson said he would attempt to obtain it, but that data had never been provided. Senator Coffin said he would be interested to know the differences in utilization between the HMO and the other plans, as well as what ultimately had happened to those participants with the large claims.

Mr. Emanuelson said AON received claim tapes from Benefit Planners, Catalyst Rx, and the dental provider. The tapes were loaded on a claim system called Acclaim, which produced specific utilization data that would break the claims data down by the various categories. The information was used in preparing information for the PEBP Board. He said AON would like very much to receive the claim data from the HPN plan in order to prepare a comparable benchmark to identify specific utilization.

Chairwoman Giunchigliani remarked that Jack Kim of Sierra Health Services had made a note to pursue a request for the information. She suggested other providers and groups might provide their experience history for consideration by the Committee when making decisions about the state plan.

Assemblyman Goicoechea asked if there was a further breakdown of how many participants were in the plan as employee-only and how many carried spousal and dependent coverage. Mr. Emanuelson said that AON did in fact gather that information, and he would provide it to the Committee.

Mr. Emanuelson provided the following data concerning utilization during plan year July 2002 – June 2003, explaining that the figures included inpatient and outpatient payments:

Top Three Hospitals:

$9,142,903	Carson-Tahoe Hospital
$8,409,613	Washoe Medical Center
$4,335,796	St. Mary's Regional Hospital

Mr. Emanuelson pointed out that there were 18,000+ participants in northern Nevada, whereas there were only 6,000 southern Nevada participants in PEBP.

Chairwoman Giunchigliani asked if the three hospitals had PEBP contracts. Mr. Emanuelson replied that St. Mary's was contracted on an outpatient basis but not on an inpatient basis; the other two hospitals were contracted for both.

Chairwoman Giunchigliani asked if there was a reason St. Mary's was not contracted for inpatient services. Mr. Emanuelson replied that the state issued PPO contracts last year and St. Mary's was not included in the northern Nevada PPO network for inpatient services; he did not know the exact reason.

Chairwoman Giunchigliani asked Mr. Thorne to comment. Mr. Thorne, Executive Officer, Public Employees' Benefits Program, testified that the PEBP Board went to bid for a statewide PPO that went into effect July 1, 2003. St. Mary's was a contracted inpatient and outpatient provider with the multiple PPOs in the plan prior to that time. In the selection the Board made for a single statewide PPO, St. Mary's was not a contracted hospital with the selected new vendor. He clarified that St. Mary's was contracted during the claim period being discussed, but not for all employees. On July 1, 2003, the Board went to a single statewide PPO, and all of the northern Nevada employees and retirees were in a single PPO. St. Mary's was no longer on the contracted list.

Senator Coffin asked how northern Nevada hospital per-diem rates compared with those in southern Nevada. Mr. Thorne replied the PPO contracted rates ran about 50 percent higher in northern Nevada than in southern Nevada, which was typical for all medical expenses. He said that a request for proposal (RFP) for an HMO had just been concluded, and there would again be an HMO for northern Nevada. However, the rates would be more than 100 percent higher than the HMO rates in southern Nevada.

Senator Coffin said individuals in the private marketplace had the same difficulty trying to contract with doctors and hospitals in southern Nevada due to the competition; northern Nevada did not have the issue of competition. Sierra Health Services had tried to provide services to northern Nevada, but it was also unable to obtain decent rates. Senator Coffin expressed concern that there might be coercion. He did not understand how the rates could vary that much from southern Nevada.

Mr. Thorne said the Committee would later hear testimony that the same kinds of problems were being faced by CalPERS in northern California, as well as in the eastern portions of Oregon and Washington.

Mr. Emanuelson said in speaking with the new HMO that had been selected for northern Nevada, the question was asked why they had not submitted a southern Nevada proposal, and the response was that they could not get good contract rates in order to effectively compete with the existing HMO in southern Nevada.

Returning to Page 9 of Exhibit D, Mr. Emanuelson reviewed the following 2002-03 expenditures:

Primary Care Physicians vs. Specialists:

$10,996,821	Primary Care Physicians
$41,521,538	Specialists

Prescription Drug Breakdown:

$ 3,931,871 Generic – 43 percent of prescriptions (national average)
$18,582,036 Brand – 57 percent of prescriptions
$ 2,948,962 Dollars spent based on top 5 prescriptions: Lipitor, Prilosec, Paxil, Oxycontin, and Advair
563,424 Total number of prescriptions filled

Mr. Emanuelson pointed out that during the first six months of the current plan year, generic drug use had grown to 50 percent, which was a result of the plan design changes implemented on July 1, 2003. The large impact of the generic drug use was slowing the increase in drug costs.

Ms. Faville remarked the high use of Oxycontin should be of concern. It was a very addictive painkiller, and its recreational resale value was $1 per milligram.

Moving to the next slide (Page 10 of Exhibit D), Mr. Emanuelson reviewed the changes that had been made to the plan effective July 1, 2003:

- Medical Benefits: Increased deductible to $500; offered $1,000 and $2,500 deductible options.
- New medical management/UR vendor.
- Rx Drug Benefits: Implemented a $50 annual deductible and increased co-payments.
- New statewide PPO network.
- New national PPO network.
- Individual out-of-pocket maximum increased from $2,400 to $3,500; family out-of-pocket increased from $4,800 to $7,000.
- Primary care physician co-payment increased from $15 to $20.
- Specialist physician co-payment increased from $20 to $30.
- Urgent care co-payment increased from $30 to $45.
- Emergency room visits changed to $70 co-payment with 80-20 coinsurance.
- Individual wellness benefit increased from $300 to $600.
- Vision benefit changed to allow annual eye examination only with a maximum benefit of $40.
- Active employee life insurance reduced to $20,000; retiree life insurance reduced to $10,000.

Finally, with regard to funding, the state subsidy was increased and employee contributions were also increased.

Senator Coffin requested a breakdown of the choices made by participants for their deductibles, cross-tabbed by age and retiree versus active employee. Mr. Emanuelson said only a small number of people enrolled in the $2,500 deductible plan.

Senator Rhoads asked what the life insurance had been previous to July 2003. Mr. Emanuelson replied it was $40,000 for actives and $20,000 for retirees.

Chairwoman Giunchigliani remarked vision coverage of only a $40 exam was not of much benefit. She wondered if there were any statistics with regard to the vision and dental plans.

Mr. Thorne replied the change made by the PEBP Board on the vision plan was to retain the vision exam benefit, which had a lot of value as a predictor of other medical problems. Chairwoman Giunchigliani agreed, but added there were no benefits after the exam, so she did not understand the benefit.

Mr. Thorne said an eye examination could reveal problems such as high blood pressure, but Chairwoman

Giunchigliani responded that the examination could also reveal glaucoma, but the plan no longer covered the medicine for glaucoma. Mr. Thorne replied all of the eye diseases would be covered, but glasses were no longer covered.

Chairwoman Giunchigliani remarked that parents would now have to pay out-of-pocket for glasses for their children. She was concerned that some parents would not even bother to take their children for an eye exam since they would not be able to pay for the glasses.

With regard to eye diseases, Chairwoman Giunchigliani affirmed that even though the prescriptions would be covered, there were no generic brands, so the out-of-pocket expenses would be higher. Mr. Thorne replied that all eye diseases would be covered under the medical program just as any other disease. Chairwoman Giunchigliani disagreed with Mr. Thorne, adding that she knew of individuals who were paying out-of-pocket for their eye problems.

Continuing with his presentation, Mr. Emanuelson referred to the chart on Page 11 of Exhibit D, which displayed a chart indicating where the plan's funding and costs were as of the first six months of the plan year. As of December 31, 2003, there was a positive surplus of $25,022,923. He said much of the surplus was attributable to lower utilization and higher deductibles and out-of-pocket expenses, which were typically satisfied within the first six months of the plan. Projecting through June 30, 2004, Mr. Emanuelson said it was calculated there would be about a $24 million surplus.

Chairwoman Giunchigliani asked what the standard reserve was for claims incurred but not reported (IBNR). Mr. Emanuelson said the typical reserve was 60-90 days worth of claims, depending upon the volume of claims and the backlog that might have accumulated. An IBNR as of June 30, 2004 was estimated to be $18 million, based on current utilization and actual claim lag reports developed by AON.

Chairwoman Giunchigliani asked if the $24 million surplus was in addition to the $18 million IBNR. Mr. Emanuelson said the $18 million reserve requirement would have to come from the surplus, leaving a surplus balance of about $6 million.

Chairwoman Giunchigliani noted that the $18 million did not comply with the previous stated reserve requirement of 20-25 percent. Mr. Emanuelson replied the original reserve estimates were provided by the prior actuary; AON had taken the actual claim tapes and identified the claims by the date incurred versus the date paid, which provided a more accurate projection.

Chairwoman Giunchigliani asked if the change meant a switch in policy from the 20-25 percent reserve requirement to a reserve based upon actual incurred expenses based upon claims tracked. Mr. Emanuelson said she was correct.

Mr. Emanuelson continued his slide presentation (Page 12, Exhibit D), saying that the actuary had recommended to the PEBP Board that contingency reserves be set aside in addition to the IBNR reserve. A contingency fund should be created to provide for catastrophic situations. He explained the actuary recommended contingency reserves for two reasons: First, there was no stop/loss reinsurance on the program; the plan was fully self-funded and the PEBP plan would bear the risk for all liabilities. There was a potential for large claims to emerge, as there were in the 2002-03 plan year when there were 105 large claims in excess of $100,000, which would exceed the typical expectation of large claims. Secondly, there was a growth in drug costs, especially in specialty drugs, which were typically injectibles.

In response to a question from Senator Rhoads, Mr. Emanuelson explained specialty drugs were non-formulary as well as injectible drugs, e.g., growth hormone, hemophilia, HIV, and cancer drugs.

Mr. Thorne added that specialty drugs also included bio-engineered drugs, which were the newest drugs coming out on the market. There were currently approximately 100 specialty drugs on the market, and it was projected that by the year 2005 there would be in excess of 300, and 800 by 2006.

Senator Rhoads asked if the specialty drugs were all approved, and Mr. Thorne answered they were all in the process of being approved. He added that the market was growing, the research was growing, and that was where the new drugs would be coming from; however, they were also very expensive.

Senator Coffin asked if the plan participants utilizing these drugs had to pay higher co-pays. Mr. Thorne replied specialty drugs required a $40 co-pay; however, the plan's prescription manager typically would wait four to six months, sometimes longer, to approve coverage of a new drug in case there was a recall. Once the drug was approved and it was added to the formulary, it would be subject to the same brand co-pay as any other drug. Mr. Thorne said the PEBP Board had approved a specialty drug program, which would narrow the purchasing power through a single source with higher discounts and eliminate purchase of some through the mail order system and limit purchase to retail only. The main focus would be on overnight availability, even in the rural areas, and a single provider to maximize the discounts.

Senator Coffin noted there was a consolidation occurring in the medical equipment industry; he thought there were only two companies left in the country willing to offer the needed services. He wondered if the plan would be impacted in the future by increased pricing in this field. Ms. Faville replied that the increases were included in the prospective trends in the medical programs.

Senator Coffin added the mark-ups in the medical equipment field were huge, and there was less and less competition. Mr. Emanuelson said medical equipment and specialty drugs were being prescribed for patients, but instead of realizing discounts, they were actually seeing mark-ups, oftentimes as high as 100 to 200 percent, particularly on specialty drugs. Oftentimes the mark-up was actually a substantial portion of the physician's income, i.e., it would become part of his compensation. Mr. Emanuelson said this concern was being addressed through the new specialty drug program to be implemented by PEBP on July 1, 2004, which should help to mitigate the costs of some expensive drugs.

Chairwoman Giunchigliani asked if the PEBP Board had set its new rates based on the new contingency reserve figures. Mr. Thorne said that concurrent with the recommendation to establish a contingency reserve and IBNR, the Board had asked AON to submit three potential scenarios for moving toward full predictive modeling and how it would be assessed against the different tiers. For example, the spouses in the husband and wife tier were driving the costs, as opposed to the full family tier, in which the spouse was younger and healthier. Because there was a high percentage of older active employees, the spouses were actually driving the costs. He noted there was a large percentage of female employees, so it was the male spouses who were in the acute illness time of their lives. Consequently, there were distortions such as the higher cost to insure a husband and wife than to insure a full family. The Board was looking to make a gradual transition to what the predictive modeling was revealing.

Chairwoman Giunchigliani noted that there would be $24 million in a contingency reserve, while there were individuals with no coverage or minimal coverage. She personally would prefer to see coverage provided to more employees rather than holding funds in reserve, especially since the IBNR was in place.

Mr. Thorne said if there had been a contingency reserve in 2002, it would not have been necessary for the Special Session to provide $18 million in supplemental funding. There would have been sufficient reserve to cover the shortage; as it was, the $18 million boost held the plan through the end of fiscal year, just as it was designed to do. He said that in the last couple of years, the plan had experienced an extremely large number of high claims, whereas the plan was currently experiencing an abnormally low number of large claims. Mr. Thorne said there was evidence of an increased trend in the March claims, but the plan was still on track to

fund the IBNR reserve out of surplus this year, which was basically three years earlier than what had been built into the rates.

Mr. Thorne reiterated that the surplus was being driven by the reduction in large claims. The plan changes made by the PEBP Board effective July 1, 2003 resulted in an increase of $683,000 in out-of-pocket expense, i.e., deductibles, co-pays, and co-insurance, for the participants in the self-funded plan. At the same time, there was a $14 million reduction in net claims paid, which demonstrated that the claim drop was due entirely to the large claims. Mr. Thorne said there had not been a large increase in what the participant was paying out-of-pocket, but there was a huge drop in both the number and the dollars involved in large claims.

Chairwoman Giunchigliani said she appreciated Mr. Thorne's remarks, but she was still concerned that there were retirees with no insurance or with large out-of-pocket expenses, and she thought it was irresponsible to have $24 million built into the plan for savings when that money could be diverted to providing coverage for those without. She asked Mr. Thorne if the budget had been adopted by the PEBP Board, or if it was just considering the action.

Mr. Thorne replied that at its March meeting, the Board approved the concept of applying the rates and accumulating a contingency reserve at the rate of $5 million per year. Consequently, as of June 30, 2004, if $5 million were applied to the contingency reserve, the additional $19 million would be accumulated over the next three-plus years and would be set in reserve to prepare for the upswing that eventually would come. He said the stop/loss reinsurance market would also be considered again; it had eased up somewhat in the past six to nine months, but it was unaffordable prior to that time.

Senator Coffin suggested that one way to implement a predictive model and predict costs would be to place a stop/loss on individuals or aggregate claims. The necessity for contingency reserves might be less if there were a predictable stop/loss. He asked if AON had submitted any such options to the PEBP Board.

Mr. Emanuelson said AON had not yet been requested to do anything concerning the stop/loss, although he and Mr. Thorne had discussed the potential for stop/loss. It was Mr. Emanuelson's personal feeling that stop/loss was a good idea, and he did not know if a group was ever too big to have some sort of reinsurance to cover large claims. As Mr. Thorne had noted, it was large claims that had hurt the plan in 2002.

Chairwoman Giunchigliani recalled that at one time the shortage was blamed on the small pool of non-state retirees. Mr. Thorne disagreed; he said the non-state actives and retirees were a much smaller pool, and there was greater volatility. He thought it was a utilization issue in the fact that it was a small group as opposed to a stop/loss issue.

Chairwoman Giunchigliani said she thought the point of a risk pool in the first place was to not segregate small pools and thereby increase costs. She asked for a breakdown of non-state retiree actual costs compared to the rates.

Addressing Senator Coffin, Ms. Faville said it was not typical for insured populations the size of the state's plan to obtain stop/loss. Generally there was some predictability, but the purpose of the contingency reserve was in fact to carry the state employees through periods of adversely high claims experience.

Chairwoman Giunchigliani said she appreciated that fact, but the intent was a four-year payout. Now with the rate changes being accomplished in one year, it appeared the plan was funded three years ahead of schedule, which was an advantage. However, she still believed the money should be used to pay costs of insurance rather than be held in reserve.

Mr. Thorne said on July 1, 2004, the active and retiree rates and claims experience for the non-state group would be pooled into a single pool. Instead of three pools, there would be two; the state actives and retirees would be commingled and the non-state actives and retirees would be pooled as well.

Chairwoman Giunchigliani asked what the premiums would be. Mr. Thorne said AON would be presenting the rate options to the PEBP Board at the next meeting.

Mr. Emanuelson said he would be hinting at what the rates might look like later in the meeting. Referring back to his Power Point presentation, he reviewed the Board Strategy for Rate Setting (Page 12, Exhibit D):

- Prudent levels for contingency reserves and IBNR - $24.5 million for contingency reserves and $18.3 million for IBNR.

- Period over which to build reserves – typically over a three- to four-year period. The state would need to accumulate approximately $5 million per year over the next four years. Approximately $5 million had been built into the proposed rates for the 2004-05 plan year.

Mr. Emanuelson again pointed out that the actuary had indicated to hold less than $24.5 million in contingency reserves would put the state plan at risk of having to increase state contributions to cover a shortfall as had happened in prior years.

Moving to Page 14 of Exhibit D, Mr. Emanuelson explained that using the predictive model, projections had been made for medical, dental, Rx, vision, and administrative costs for July 2004–June 2005. The total projected cost was $182,623,721, which when combined with the fully insured costs for life, long-term disability (LTD), accidental death and dismemberment (AD&D), and business travel accident (BTA) of approximately $5 million, would come to a total PPO plan cost of $187,595,664.

Mr. Emanuelson summarized the projected plan figures for the year ending June 2005:

Total Cost	$187,595,664
Total Subsidy	$155,135,992
Remaining Cost to be Funded	$ 32,459,672
Contributions:	
Actives	$ 26,483,928
Retirees	$ 14,440,811
Total Contributions	$ 40,924,739
Surplus Fiscal Year 2005	$ 8,465,067

Mr. Emanuelson pointed out that the figures did not include an amount for non-state subsidies, since it was not known. He stated the decisions made by the PEBP Board during the next month would determine what the actual participant contributions would be. At this time, it was not anticipated that the actives or retirees would be contributing more than they were under the current plan year. Once the rates for the 2004-05 plan year were known, the non-state contribution could then be determined.

Chairwoman Giunchigliani asked how many non-state retirees were still in the state plan. Mr. Emanuelson replied there were less than 2,000 non-state active and retired participants in the plan. He explained that for its April meeting, the PEBP Board had instructed AON to:

- Adopt funding of contingency reserves with phase-in over three years;

- Use predictive modeling analysis to gradually redesign rates for each coverage tier and correct

disparity among the tiers;

- Produce several employee contribution scenarios for Board consideration; and

- No plan changes be made other than an HMO in Northern Nevada effective July 1, 2004 at open enrollment.

Upon conclusion of his presentation, Mr. Emanuelson asked for questions from the Committee.

Assemblyman Goicoechea noted the AON chart reflected nearly $3 million in non-state retiree subsidies, and he asked if there was a way to project what the subsidy would be for non-state actives if they were brought into the pool. Mr. Emanuelson said he would try to quantify that amount and report back to the Committee.

Mr. Thorne stated that currently there were 2,514 non-state participants in the plan, not including dependents, with 1,141 being actives and the remainder retirees.

Assemblyman Goicoechea asked if the active number of participants had declined. Mr. Thorne replied he did not have those numbers on hand, but he recalled that at one point in the past few years there were in excess of 2,500 non-state actives. The number could have been higher in prior years.

Chairwoman Giunchigliani thanked Mr. Emanuelson for his presentation, saying it was very informative and worthwhile.

Following a short break, the Committee moved to Item IV, Presentation by CalPERS, which had been deferred earlier in the meeting.

IV. PRESENTATION BY CalPERS ON THE HEALTH BENEFITS PROGRAM FOR CALIFORNIA PUBLIC EMPLOYEES.

Joyce Vermeersch, Office of Policy and Plan Administration, CalPERS, explained her specific job was to manage the HMO contracts. She said the purpose of her presentation was to provide an overview of the CalPERS health benefit program. She had read ACR 10 and tried to choose topics from the CalPERS program that might be of interest to the Committee, given the charges of the Committee in the bill. Ms. Vermeersch stressed that she was not present to provide any solutions or magic cure to Nevada's problems; in fact, she understood how difficult the issues confronted by all purchasers of health care were, particularly those purchasers whose premiums were funded with public funds.

Ms. Vermeersch was prepared to give a Power Point presentation (Exhibit E), but she noted she had also distributed a packet to the Committee members which included the various benefit designs and structures of the CalPERS health benefit program.

Moving to her presentation, Ms. Vermeersch explained CalPERS was a program that covered both active and retired public employees throughout the state of California. She profiled the plan as follows:

- The plan currently consisted of 1.2 million active and retired members;
- The plan covered all state departments in California, the state university system, and 1,100 contracting public agencies, including various cities, counties, school districts, and special districts. Since the various entities could join the plan by bargaining unit, the membership actually represented the total number of "units" as opposed to public entities;
- State members comprised 62 percent of the membership, and contracting agencies represented 38

percent;
- 79 percent of the participants were actives and 21 percent were retirees;
- State agencies were not segregated from public agencies; they were in a combined pool;
- All programs currently had statewide premiums; the same premium would be paid whether in a PPO in Redding or San Diego; and
- The estimated expenditures for plan year 2004 were $3.9 billion.

Ms. Vermeersch said that contracting agencies made up a significant proportion of enrollment in CalPERS. The major requirement for a contracting agency to participate in CalPERS was to have a retirement program; it did not have to be the CalPERS retirement program – it could be a county-based or other program. Each bargaining unit must cover its retirees – it was not an option – and a current minimum contribution of $32.20 per month must be made to retiree coverage. A new statute was enacted in 2003 that would raise the amount to about $97 over a period of five years; she noted this was a very controversial development with regard to how to keep agencies in the program.

Ms. Vermeersch went on to say that if a contracting agency joined CalPERS, it could have no other option besides the plans offered by CalPERS. Previously, that was not the case, but it was found that as HMO offerings were consolidated, those that had been eliminated were directly recruiting public agencies with low risk. In order to maintain the integrity of the CalPERS program, a regulation was adopted two years before that mandated those agencies joining CalPERS to offer those benefits and no others. Ms. Vermeersch said some agencies offered cafeteria plans that would not preclude a union trust type of design, and some were grandfathered in. If an agency chose to drop out of CalPERS, it must wait five years to rejoin. She noted that public agencies were not required to participate in CalPERS; joining was totally voluntary. There were approximately 4,000 eligible agencies in the state, and obviously there were many that had chosen not to join.

Continuing, Ms. Vermeersch said an administration fee was charged, both to the state employers as well as to the contracting public agencies, which was placed into a contingency reserve account to pay for the administration of the program, as well as any unusual contingencies of premium. The statute allowed an administration fee of up to 4 percent of the premium, but the Legislature dictated the amount each year, which was currently .44 percent of the premium.

Ms. Vermeersch said that 75 percent of the enrollees were in three HMOs, 22 percent were in two self-funded PPO plans, and 3 percent were enrolled in three association plans, which were plans operated by the Highway Patrol for its members, the California Correctional Peace Officers Association, and local law enforcement agencies.

Ms. Vermeersch reviewed the premiums for the basic plan for actives and retirees who were not eligible for Medicare. Once a retiree reached age 65 and was eligible, there was a Medicare supplement, or coordinated plan, they were required to join. Western Health Advantage (WHA) was a small plan primarily serving the Sacramento area that covered about six counties and had an enrollment of 10,000. The two large HMOs were Blue Shield and Kaiser, both of which had close to 450,000 members. PERSCare and PERS Choice combined had approximately 223,000 members. She noted that the HMO premiums were gradually approaching the premiums of the PERS Choice PPO, which was an 80-20 plan. The premiums for employee only were as follows:

- Blue Shield $315.22
- Kaiser $305.42
- WHA $280.41
- PERSCare $544.77
- PERS Choice $349.41

For coverage of two individuals, the premium would be multiplied by 2, and for a family of three or more, the premium would be multiplied by 2.6.

Ms. Vermeersch explained the employers had various rules for contributions, depending on whether they were a state or public agency. All state actives were covered by collective bargaining arrangements, so CalPERS did not control the state contribution or the employer contribution. The largest bargaining group was the California State Employees' Association, which currently had a formula wherein 80 percent of the weighted average of the premium was covered for the four largest plans.

California state retirees were covered under the 100/90 rule, which was a similar program in which the average of the four largest plans was weighted; this plan covered 100 percent for the retired employee members and 90 percent for their dependents. Ms. Vermeersch further explained that a vesting schedule was adopted in 1985; people hired before 1985 were able to vest in two years. In order to be vested now, an employee would have to work 10 years for 50 percent of the 100/90 rule, and then it would gradually rise 5 percent per year up to 20 years.

In the counties without HMOs, there was a program that subsidized the premium in the PPO and/or the deductible requirements. This program was funded from the general fund by the state legislature and was only available to state active and retired members. The cost was only about $500 a year per participant, and bills were submitted to the State Department of Personnel Administration, which administered the program. This program was not available to contracting agencies or to members located out of state.

For public agency active employees, Ms. Vermeersch said that the governing body of the local entity would determine whether or not to participate. The governing body board would have to pass a resolution and file it with CalPERS. There were no rules governing retiree participation, except that the employer contribution must be equal to actives or the CalPERS' minimum contribution.

Continuing, Ms. Vermeersch said that CalPERS had experienced double-digit rate increases in the last several years, and the HMO rate increases had been substantially larger than those for the PPO. She noted that CalPERS had previously had problems with its PPO, which required a mid-year increase in premiums; however, the plan had stabilized and a premium reduction was possible this year. CalPERS did not have a reinsurance program for either its HMO or PPO plans.

Ms. Vermeersch further explained the major cost drivers in California:

- Hospital Pricing – Major increase area; over the last two years, hospital trends had increased by about 50 percent due to seismic retrofits, nurse staffing ratios, and system consolidation in the northern part of the state.

- Medical Group/IPA Behavior – Withdrawal of medical groups from capitation and therefore from HMOs; re-pricing off of the capitated rate to a fee-for-service discounted rate with PPO carrier.

- Cost Shifting – Medi-Cal, Medicare, and uninsured.

With regard to demographic trends, Ms. Vermeersch remarked that CalPERS' age trend was getting older; the average age of its population was in the mid-30s, but CalPERS was aging at a faster pace than the rest of the country, which was a big factor in utilization and costs.

For the 2002-03 plan year, CalPERS' average health care dollar was spent as follows:

- 35% Physician
- 34% Institutional
- 18% Pharmacy
- 11% Operations and Profit
- 3% Ancillary and Other

Ms. Vermeersch said the 2003-04 figures would probably reflect a shift upward in institutional costs to about 38 percent and a shift downward in the physician costs. Pharmacy costs would remain the same. She went on to say that the largest percentage of the population had small claims, and the largest percentage of the costs was driven by a small portion of the population, with the high-cost utilizers being the retirees.

CalPERS had experienced a dramatic withdrawal of HMOs from the rural areas, even though more than a million members still had access to an HMO.

CalPERS had adopted a number of cost-containment strategies for the 2003-05 period:

- HMO Consolidation – 2003
- Disease Management – 2003 (required in all plans)
- Three-Year Contract with Blue Shield – 2004
- Hospital Networks – Proposed - 2005
- Regional Pricing – Proposed 2005
- Rx Initiatives – Proposed 2005

Ms. Vermeersch explained that in 2003, CalPERS adopted a policy limiting the number of HMO plans to be allowed in the program in order to contain the cost increases, but also to eliminate the higher-cost HMOs. Seven HMO plans were reduced to three, and the strategy was to develop a closer partnership with the HMOs in order to control pharmacy expenditures and institutional costs. CalPERS was able to develop an on-line data warehouse from which cost and utilization data could be obtained for the PPO plan, Blue Shield, and Kaiser.

Up until 2004, CalPERS had one-year only contracts with its HMOs. Ms. Vermeersch said the contract with Blue Shield was now three years, and in return, Blue Shield was the exclusive statewide network HMO. Part of the contract was that Blue Shield would have to stay in the 40 counties in which they were currently located; it could no longer withdraw from the rural areas. The rates would be set based on a three-year pricing model. In an effort to obtain greater transparency on how premiums were set, each year's premiums would be based on the target cost of health care, rollovers, cap on administrative costs, and cap on retention (i.e., profit). She noted that nationwide, plans were becoming more sophisticated and rates were being set based on utilization.

Ms. Vermeersch said that consolidation in northern California, primarily in the three large hospital chains – Tenet, Catholic Healthcare West (CHW), and Sutter – had been a major cost driver in determining the difference in the costs of health care between the north and south. Across all of the plans in CalPERS, the average premium cost difference between the southern part of the state and the northern part of the state was about 40 percent, primarily due to the lack of competition among the major hospital chains.

Referring to charts on Pages 17 and 18 of Exhibit E, Ms. Vermeersch remarked the data indicated that cost did not necessarily relate to quality. The charts had been prepared by Blue Shield and reflected no relationship whatsoever between cost and quality. Consequently, CalPERS was now working with Blue Shield on the possibility of developing an exclusive hospital network that would exclude high-cost hospitals based on their cost and quality scores. The network proposal had been presented to the CalPERS Board and was still evolving; it would save CalPERS an estimated $54 million in 2005. Another option being

considered was the tiered network, in which all of the hospitals would be retained, but a co-pay would be implemented; this option was estimated to save $34 million. Finally, for the first time, CalPERS was negotiating with Sutter, Tenet, and CHW as they negotiated their contracts with Blue Shield. Ms. Vermeersch said CalPERS was not so concerned with the billed charges, but more so with the stop/loss provisions and charges for high-cost cases.

CalPERS was also considering regional pricing for the contracting agencies only. Ms. Vermeersch said the state members were strongly opposed to regional pricing because they saw themselves in one large pool and no one should have to pay more for insurance than anyone else. However, she added, contracted agencies were local regionalized entities, and if something was not done to provide parity with what could be obtained in the open market, those entities would leave CalPERS. About 37,000 members were lost last year, primarily in southern California, which would result in a 1.1 percent increase in premiums for 2005 because the members that were lost were low-cost members. Through a risk adjustment methodology, CalPERS was able to know the age, sex, and disease burden of its participants, but these were not the reasons that many of the 37,000 members were low-cost in nature. They were low-cost because they were from the southern part of the state. Therefore, the CalPERS Board had approved moving forward with regional pricing for the contracting agencies.

Ms. Vermeersch then reviewed the goals of CalPERS for 2005:

- Align premiums with regional costs;
- Retain public agency participation;
- Make CalPERS more competitive; and
- Stabilize the risk pool.

With regard to pharmacies, Ms. Vermeersch reiterated that pharmacy costs were approximately 17-18 percent of the cost of health care. CalPERS had several kinds of pharmacy arrangements:

- PPO: Caremark PBM;
- Blue Shield: Did its own purchasing except for Express Scripts (mail only);
- WHA: Medco PBM; and
- Kaiser: Self-managed.

Several different options were being considered in pursuit of better pharmacy drug prices:

- Purchasing coalitions;
- Carve-out study (carving out from the HMOs);
- Drug formulary;
- Ingredient costs vs. rebates; and
- Generic substitution.

Ms. Vermeersch said decisions on the options would be made by the CalPERS Board in June 2004.

Ms. Vermeersch reviewed some things that were **not** being considered by CalPERS:

- Members were very much dedicated to the defined benefit plan, as was the Board. The goal was to try to preserve the benefits and co-payment structure and not reduce premiums by shifting costs to participants through higher co-payments. There had been no major co-payment change since 2002.

- Committed to not reduce benefits; the PPO plan must maintain benefits similar to the HMOs, which were required to provide a rather “rich” benefit per state statute.

- Not considering consumer-driven plans, although some believe that should be done; however, potential alternative benefit design for public agencies is being considered, along with regional pricing.

- No reduction of retiree coverage.

Ms. Vermeersch added one of the problems CalPERS was having with retention of contracting agencies was not only the statewide rate, but the retiree contribution. Because the public agencies were now required to make a defined statutorily-required contribution, they were now contemplating leaving CalPERS. Many brokers were promoting alternative plans and recruiting those agencies.

Upon completion of her presentation, Ms. Vermeersch remarked that it appeared to her Nevada was attempting to deal with similar underlying issues as CalPERS. She noted again that the highest-cost areas in California were primarily in the northern non-urban areas. CalPERS had many members in the Lake Tahoe/Truckee area, and many of them had suggested exploring the possibility of a regional plan with Nevada, as well as Oregon. Because of the challenges being faced, CalPERS was now taking a proactive approach to finding solutions to the many problems. She offered to answer questions from the Committee.

Chairwoman Giunchigliani thanked Ms. Vermeersch, adding that her presentation was extremely informative. She remarked that the regional concept sounded interesting, and it might be something worth the Committee's attention.

Senator Coffin observed that CalPERS might have more money at its disposal than Nevada. He asked if California's prison inmates were covered under CalPERS. Ms. Vermeersch replied they were not; inmate medical care was provided by the state. Hearings were being conducted by the state legislature on ways to provide more efficient health care to the prison population. Prisoners often had to be transported for hospitalization or specialty care. CalPERS was working with the district hospitals to try to develop some type of an arrangement with the peace officers' union, the prisons, and the California State University System entities in the northern part of the state to develop an innovative new health care delivery system. A rural task force had just been formed to discuss collaboration with bordering states. Ms. Vermeersch was not sure if that would be feasible, but it was certainly worth considering.

Senator Coffin asked what would have happened to CalPERS if the California debt management ballot question had not passed. Ms. Vermeersch explained CalPERS was a totally separate entity from the executive branch and the legislature; therefore, neither the legislature nor the governor's approval was required for development of the health benefits program. She noted that CalPERS did not control the state contribution; theoretically, CalPERS could have continued with high benefits, high payments, and high premiums and then be told it was responsible for paying for them. One of the reasons CalPERS had become so active was that it realized the state would not have had the money to pay the premiums if the ballot question had not passed. It was the Board's goal now to reduce the premiums as much as possible, which was a change in attitude of the Board. When a state budget was not passed for three months last year, CalPERS was not sure what it would do; the state would not have had the money to pay the state contribution or the annuitant contribution for the state members.

Referring back to Page 19 of Exhibit E, Chairwoman Giunchigliani asked if she had understood correctly that CalPERS would be excluding hospitals based on a quality versus cost issues. Ms. Vermeersch replied she was correct, but it was only being done in the Blue Shield network at the present time. The big issue was what type of disruption these actions would cause the members. The consolidation would not only involve the hospitals, but the medical groups affiliated with them as well. She reiterated the Board would not be acting on this matter until June 2004.

Chairwoman Giunchigliani asked if part of the criteria for quality was staffing levels for nurses. Ms.

Vermeersch replied she did not believe that measurement was among the quality issues used by Blue Shield. The criteria were based more on standardized surveys and outcome measures than on processes or staffing levels.

Chairwoman Giunchigliani affirmed that the CalPERS Board consisted of 13 members, some appointed, some statutory, and some elected. She asked if certain qualifications or background were stipulated in statute. Ms. Vermeersch said the members represented their constituencies as defined in the statute, e.g., retirees, teachers, local agencies.

There being no further questions, Chairwoman Giunchigliani again thanked Ms. Vermeersch for her presentation.

Chairwoman Giunchigliani reiterated that the representatives of the federal plan were not able to attend; therefore, Agenda Item V would be scheduled at a later date. However, the meeting packet included a guide to the federal plan for members' review.

VII. PRESENTATIONS FROM LOCAL GOVERNMENTS ON THE HEALTH BENEFIT PLANS OFFERED BY THOSE ENTITIES.

A. City of Henderson – Daryl Moore, Human Resources Director.

Daryl Moore, City of Henderson Human Resources Director, also had prepared a Power Point presentation outlining Henderson's health insurance plan (Exhibit F). She explained that the city only offered health insurance to its 1,467 full-time employees. The self-insured plan had 860 participants and included non-represented employees, the police and fire union employees, and retirees. There were 630 employees represented by the Teamsters' Local 14 union who participated in the Taft-Hartley Trust Plan.

Ms. Moore reviewed the teamster rates, which were the subject of collective bargaining. The city of Henderson's contribution was $460 per employee per month, and the per-employee contribution was $108.34 per month. The teamster plan included a self-insured plan with dental and vision coverage, as well as an HMO option with dental and vision, and a $9,000 life insurance benefit. The plan also offered an employee assistance plan; however, there was no long-term disability plan.

Ms. Moore went on to explain that Henderson's self-funded plan design and oversight was provided by a committee of nine employees appointed by the city manager. Some standing positions in attendance at the meetings were the president of the police union, the president of the fire union, the chief financial officer, the risk manager, and a representative of the retirees; the chairperson was the Director of Human Resources. Ms. Moore said essentially the committee approved contracts with all providers, including the insurance consultant, third-party administrators, and all other vendors. The committee also determined plan design and set the rates on an annual basis.

Continuing, Ms. Moore said there were currently 843 employees in the city's self-insured plan, and 37 in the HMO option (currently HPN). She reviewed the chart on Page 7 of Exhibit F, which displayed the self-insured HPN rates for three different categories of employees, i.e., non-represented, police, and fire. She explained the rates differed because the amount of the city's contribution was a subject of collective bargaining with the different groups.

There were also differences in the rates for non-represented employees, which Ms. Moore explained were broken into three categories: employee only; employee plus one dependent; and employee plus two or more dependents. She reviewed the rates for all groups of employees in the self-insured plan as shown on Pages 8 through 11 of Exhibit F. She explained that the city did not subsidize any retirees participating in the self-

funded plan; the retirees had to pay 100 percent of the premium themselves. The rates for actives and retirees had always been commingled; there had never been different rates for the two. She added that only about 5 percent of the plan's participants were retirees, so it did not seem fair to segregate them from the actives. Retirees were required to have Medicare when they turned 65, although there were about 50 employees who would be retiring without Medicare because they had worked exclusively for the state and/or the city.

Ms. Moore went on to explain that the self-insured premium did not include just health insurance; it also included:

- Dental
- Vision
- Life Insurance
  - Equal to the annual salary for managerial and professional employees
  - $50,000 for administrative employees and police and fire
- Accidental Death and Dismemberment - $50,000 for all employees
- Long-term Disability of 60 percent of salary up to $6,000 per month
- Employee Assistance Program
- Retirees:
  - $50,000 Life ($25,000 after age 65)
  - $50,000 Accidental Death and Dismemberment ($25,000 after age 65)

The city of Henderson plan had specific and aggregate stop/loss provisions. The specific excess loss was set at $75,000 per individual per year, and the aggregate excess loss was a capitated pricing structure, which would basically be set at 125 percent of anticipated claims. Ms. Moore said she had only seen an attachment one time in her career; it did not happen often.

Continuing, Ms. Moore said there were some retirees who had elected to participate in the state plan. There were seven single retirees and six retiree participants with one dependent. The subsidy for those employees was currently $4,050 per month.

Ms. Moore explained that Henderson had recently undergone a substantial change in its benefits structure, similar to what had occurred in the state plan. The city's finance director had done an analysis in 2003, and it was determined that premiums would have had to be increased by 38 percent in order to maintain projected claims for calendar year 2004. It was decided that benefits would have to be cut substantially; benefits that were previously paid at 100 percent would no longer be paid at that level. Ms. Moore said the changes were designed with the philosophy that those individuals who were a higher cost to the plan should share more of that cost than those individuals who were healthy. In addition, she was working closely with the fire and police groups in looking at some wellness programs.

Pages 15 through 24 of Exhibit F included details of the city's new plan design. Ms. Moore said it was not known what impact the design would have on premiums, due to the magnitude of the changes. She pointed out the biggest change was that deductible and co-pay amounts would no longer come from the out-of-pocket maximum as had been the case previously. Even if an individual had met his deductible, he would still have to pay the $100 deductible for admission to a hospital. She reiterated that when benefits were cut, the plan was designed so that those individuals using the benefit the most would be paying a larger portion of what they utilized.

Referring to the hospital benefits outlined on Page 17 of Exhibit F, Ms. Moore noted that a substantial penalty was assessed for use of out-of-network hospitals. A co-pay amount of $500 would be required, and the plan

would pay only 70 percent. The penalties were designed to encourage participants to stay in the PPO and not use hospitals outside of the network.

Ms. Moore added that the city's plan was part of the Sierra Network, which had some centers of excellence throughout the country. Years before when Sierra Network had not contracted with the Valley systems and St. Rose, the city of Henderson had contracted with those hospitals on its own in order to provide employees with in-network hospitals at a lower rate.

Ms. Moore noted that the mental health and home health care provisions were basically standard. However, two other benefits were offered that were somewhat unique: a Temporomandibular Joint Syndrome (TMJ) benefit and laser eye correction (employee only). She said the theory behind the laser eye coverage was that a large percent of the plan's participants were police officers and firefighters, and the coverage was considered to be an employee safety issue.

Ms. Moore called the committee's attention to some of the changes made to the plan:

- $10 co-pay for a doctor's visit was increased to $15;
- Specialist visits were increased from $15 to $25;
- A $100 co-pay for each injection for certain chronic incurable diseases was implemented; and
- A $300 limitation was placed on preventative care for well-child and well-adult care.

Concluding her presentation, Ms. Moore asked for questions from the Committee.
Senator Coffin asked if the city of Henderson had worked with Sierra Network to negotiate better rates from St. Rose. He wondered how the city was able to hold its costs down while offering good benefits. Ms. Moore said until this year, the city had contracted with St. Rose independently and had a better contract than Sierra could provide. This year Sierra was able to provide an excellent discount for St. Rose.

Senator Coffin asked what other hospitals were included in the network. Ms. Moore replied every hospital in the Las Vegas valley was included in Sierra's PPO network. Senator Coffin complimented Ms. Moore on the city's plan.

B. Clark County Teachers Health Trust – Peter Alpert, Chief Executive Officer.

Peter Alpert introduced himself as the Chief Executive Officer of the Teachers Health Trust; he would give the Committee a brief overview of the Trust as outlined in Exhibit G.

Mr. Alpert explained that the Teachers Health Trust was formed in 1983, and Assemblywoman Giunchigliani was an integral part of that formation. The population of the Trust was unique; all of the employees were college graduates, which made the group rather educated and sometimes very demanding. Women comprised 72 percent of the population, and the average age was 35.

The Teachers Trust was a self-administered self-funded trust. Mr. Alpert explained that being self-administered meant that the Trust did everything itself; there was no third-party administrator. The Trust had its own claims administrator, as well as its own claims service, information technology, and accounting departments.

Mr. Alpert said the population of the group at the present time was approximately 30,000 – about 15,000 teachers and an equal number of dependents. The Trust included two PPO plans; about 80 percent of the participants were in the PPO plans. The HPN plan included about 12 percent of the population. In addition, the Trust had a hospital supplement plan, which basically provided a cash payment to those who did not want insurance because they had coverage elsewhere. The plan provided a lifetime maximum of $2 million

in benefits, and there were no annual deductibles.

Continuing, Mr. Alpert said the Trust belonged to the Health Services Purchasing Coalition in Las Vegas, which was a coalition of culinary unions, teachers, most of the major hotels, Clark County, firefighters, police, and various other organizations, for a total of about 150,000 employees in addition to 150,000 dependents. Negotiations with all of the hospitals in Clark County were done through the contract with the coalition. He added that the Trust had been very successful in keeping rates down through the contract; it was a three-year contract that would come up for renewal in 2005. He remarked that the rates were confidential, but they were extremely low in comparison with other entities.

Chairwoman Giunchigliani asked if there was a restriction on how many private sector and public sector entities could legally be part of the coalition. Mr. Alpert thought she was referring to a recent anti-trust issue, and a legal opinion had indicated that it could not include more than 150,000 employees, dependent upon the size of the community. The culinary union was the largest member of the coalition, and the Teachers Health Trust was either the second or third largest.

Chairwoman Giunchigliani asked who had issued the legal opinion, and Mr. Alpert replied it had been obtained from a private attorney. She asked if the membership limit would rise with the increase in population, and Mr. Alpert indicated that was true, but he did not know what the numbers were.

Continuing, Mr. Alpert stated the Trust operated with a budget of about $100 million per year, with 50 full-time employees. Premiums were collectively bargained with the Clark County School District, and at the present time the Trust was receiving $382.18 per month per licensed teacher.

Mr. Alpert referred Committee members to Exhibit G, which contained a chart reflecting a summary of the most frequently used services in the Trust's two PPO plans. He explained the basic PPO plan was available to every employee at no additional cost, and the PPO Plus Plan included additional benefits at a cost of $34.00 per month.

The IBNR of the Trust was fully funded, and there was a contingency reserve fund of about 1-1/2 months' costs. Mr. Alpert recalled that in August 2003, the Trust was not sure whether it would be receiving any funds from Clark County in September due to the uncertain funding of schools by the 2003 Legislature. The contingency fund would have been exhausted within 1-1/2 months. Although Mr. Alpert agreed that the contingency fund should not overshadow or overwhelm the mission to pay benefits to people, but he believed a prudent plan should have a contingency fund.

Assemblyman Goicoechea asked what coverage was provided to non-classified employees. Mr. Alpert replied the Clark County School District was comprised of three groups: the non-classified, teachers, and administrators. The Trust only covered the teachers.

Assemblyman Goicoechea asked if the same subsidy was provided for members of all three groups. Mr. Alpert indicated each group received different amounts.

Mr. Alpert said the Trust had taken several steps to manage its costs, and it had been very successful. Administrative costs amounted to 6.5 percent of the Trust's revenues, which was one of the lowest ratios on the west coast. The plan included disease management programs, a diabetes program, and a coronary heart disease program. Mr. Alpert added that the programs not only existed, they were also supported and encouraged by the Trust staff. A scale and blood pressure monitor were provided to coronary patients for home testing and monitoring by a central office through a phone line. If a problem occurred, the patient's provider would be contacted for possible intervention. Mr. Alpert stressed the importance of these types of programs in order to avoid future claims.

In addition to the programs previously cited, Mr. Alpert said the plan included breast cancer awareness programs, osteoporosis programs, free mammograms in the month of October with no co-pay, a full-time wellness director, walking and running competitions among schools, and weight management programs.

One of the most important services to the participants was the care coordination program. A department headed by a registered nurse reviewed all of the large and unusual cases, and phone calls were made to the participants to encourage them to discuss their care. Visits were made to hospitals and skilled nursing facilities to make sure that all questions were being answered and that correct choices were being made. The plan was very proactive with its large cases, and as a result, out-of-pocket costs had been tremendously reduced.

On page 2 of Exhibit G, Mr. Alpert noted there was no co-pay amount if lab work was performed by a network lab, and there was a generic mail order program with no co-pay; generic usage was now exceeding 55 percent of the Trust's total drug program. About 250,000 prescriptions were filled each year, and drug costs were about 14 percent of the plan's total expenditures.

Chairwoman Giunchigliani asked if the Trust tracked its highest use drugs. Mr. Alpert replied it did, but he did not have that information with him. However, he recalled that Paxil was number one in use.

Finally, Mr. Alpert noted that dental and vision programs were also offered. He asked for questions from the committee.

Chairwoman Giunchigliani asked if mental health services were included in the plan's actual medical coverage. Mr. Alpert said the plan included a full mental health network. The plan provided for 24 visits to a mental health professional per year without any prior authorization.

Chairwoman Giunchigliani asked if retired teachers were covered. Mr. Alpert replied that retirees were covered, but effective July 1, 2004, the only coverage available to them would be the HMO plan. No funds were received from the school district for retirees; the retiree plan was entirely self-funded. The retiree premium had always been higher than the actives, and the retiree program had lost money over the past four years. There were only about 800 retired teachers in the pool, and it was difficult to manage a plan that small.

Chairwoman Giunchigliani asked what plan the rest of the retirees had; Mr. Alpert replied about 400 were in the state plan and several hundred were in the HMO. He did not know where the balance of retired teachers were, but he assumed many had moved from Nevada. Chairwoman Giunchigliani asked Mr. Alpert to provide the Committee with the premium amounts being paid for each level in the Teachers Health Trust plan.

Senator Coffin asked what portion of the Trust's benefits were purchased through the coalition. Mr. Alpert said the only benefit purchased by the coalition at the present time was hospital care. Consideration had been given to purchasing prescription drugs, disease management, and other benefits, but the groups were so diverse – there were many different plans and needs – that the coalition had not been successful in bringing the various programs under one umbrella, other than the hospital program, which was extremely successful.

Chairwoman Giunchigliani asked how passage of AB 286 would impact the Teachers Trust. Mr. Alpert said that matter was still being explored; numerous conversations had been held with the school district, and there were many uncertainties regarding the bill. The Trust had obtained a legal opinion that contradicted the Legislative Counsel Bureau and Attorney General's legal opinions. He said the Trust was presently in a state

of flux, but the matter was being actively pursued with the school district.

Chairwoman Giunchigliani asked from whom the legal opinion had been obtained, and Mr. Alpert replied James Wadhams. She asked Mr. Alpert to provide the Committee with a copy of the opinion.

Assemblyman Goicoechea affirmed that the 800 retirees in the Teachers Trust and the 400 employees in the state plan were paying 100 percent of their own premiums; Mr. Alpert confirmed that was correct. The Health Trust was not receiving any employer subsidy funds for its retirees. Assemblyman Goicoechea remarked that under AB 286, the school district was supposed to be paying the subsidy to the Trust for its 800 retirees.

Mr. Alpert stated that the only subsidy the school district was required to pay was to the Public Employees' Benefits Program. Assemblyman Goicoechea questioned if AB 286 mandated that all retirees were to be treated the same as active employees, and the school district was responsible for paying the subsidy to the Trust. Mr. Alpert stated that the wording of the LCB opinion, the Attorney General's opinion, and Mr. Wadhams' opinion was that funding of the subsidy was supposed to come from the local municipality, whether it was the school district, city, or county, to the state plan, but not to the Teachers' Health Trust, and therein was the crux of the problem.

Assemblyman Goicoechea stated the intent of AB 286 was that the subsidy would come from the school district, and he assumed it should be paid to the Teachers Health Trust for those retirees in that plan. Mr. Alpert respectfully disagreed; he wished that were the case. Assemblyman Goicoechea remarked that was the reason the issue was being discussed by the Committee, and if the matter was not resolved before, it would be resolved during the 2005 Legislative Session.

X. PUBLIC COMMENT.

Judith Hamblin, a retired teacher and a member of the Teachers Health Trust, testified she would soon be joining the state plan. She cited the premium amounts for retirees in the Teachers Health Trust:

- Retiree only in Sierra Choice: $455 + $50 for dental and $15 for vision
- Retiree only in HPN: $410 + $50 for dental and $15 for vision
- Retiree + 1 dependent (Sierra Clinic) $800 + $50 for dental and $15 for vision
- Retiree + 1 dependent – HMO (HPN) $725

Ms. Hamblin said she was a retired teacher who had been paid by state tax funds for 30 years, but she was insured by the Teachers Health Trust, which seemed to feel it had no obligation to her as a retired member. Referring to Mr. Alpert's statement that there were two PPO plans, Ms. Hamblin said one of them and the Medicare Supplement Plan would be discontinued effective June 30, 2004, according to a flyer she just received from the Trust. She said she was aware the plans were going to be discontinued, and she and others were fighting against it because of the stipulation in AB 286 that retirees were supposed to have the same plans as the actives at the same cost. She explained the costs were not the same; for herself and her husband, who also had a Medicare supplement, she was currently paying $1,055 per month to the Teachers Health Trust, which amounted to 38 percent of her income. By moving to PEBP, she would be paying $643.75, and she would be eligible for a subsidy of $386.07, which would mean a savings of approximately $800 per month.

Assemblyman Goicoechea asked if the subsidy was being paid by Clark County School District. Ms. Hamblin replied it would be as of July 1, 2004. He asked her when she had received the information that the subsidy would be available, and she said she had not received any information until just recently. Ms. Hamblin said part of the problem had been lack of or conflicting information from the Teachers Health Trust. Members were informed that as of December 31, 2003, coverage of retirees in the PPO plan would be

discontinued unless they lived in Bullhead City, Pahrump, or Clark County. She added that the plans would be changing July 1 to Sierra Choice POS and HPN HMO plans, but retirees on social security would only be offered Senior Dimensions.

Ms. Hamblin said she was a native of Nevada and was aware of the legislative process. Once legislative funding was provided to Clark County School District, the district would begin negotiations with the Clark County Education Association (CCEA) in an attempt to determine a subsidy to the Teachers Health Trust. Ms. Hamblin's concern was that the Legislature would have to mandate complete compliance with AB 286, and secondly, if the Teachers Health Trust received any subsidy funding from the Legislature, those funds must be used to provide the same subsidy to retirees who elected to remain with the Health Trust as would be provided to retired members entering PEBP.
Assemblyman Goicoechea noted that information from the Teachers Health Trust indicated it received a subsidy of $382.18. Ms. Hamblin remarked that was the amount subsidized for active teachers; that was the amount she received prior to retirement. She believed if an active employee was receiving $382.18, a retired teacher should receive the same amount, whether in PEBP or the Teachers Health Trust. Her point was that the subsidy amounts should be granted to the employees rather than put into general funds, which might require some type of action to control the Trust. Ms. Hamblin said members had been told that the Trust was in "delicate negotiations with the district." It was rumored that the district would keep a portion of the funds and the remainder would go to the Health Trust. Ms. Hamblin said that it seemed that according to Mr. Alpert, the Health Trust was comprised of active employees only, not the retirees.

Assemblyman Goicoechea clarified that AB 286 did not mandate that all local jurisdictions provide health care benefits to retirees. However, if a local jurisdiction provided coverage to an employee under the group health insurance plan before retirement, it was the LCB Legal Counsel's opinion that the local jurisdiction must provide the employee, upon retirement, with the option of continuing coverage under that health benefit plan or join PEBP to the extent that such coverage was not provided. Assemblyman Goicoechea said he had voted for AB 286, and it was his opinion that if an employee stayed in the same health care plan after retirement, the employer must subsidize that employee at the same rate as the active employees were subsidized.

Ms. Hamblin added that retirees who moved out-of-state should also be guaranteed coverage; withdrawing benefits from them was not fair. Assemblyman Goicoechea agreed with Ms. Hamblin.

Senator Rhoads said he voted for AB 286 with the understanding that the intent was as Assemblyman Goicoechea had stated. If that was not the case, then the statute needed to be amended in 2005.

Ms. Hamblin again agreed, adding that all teachers in the state should receive equal treatment. Referring to Mr. Alpert's statement that he did not know where the balance of the retired teachers were if they were not in the Teachers Trust or PEBP, Ms. Hamblin said many had gone to Banker's Life, Blue Shield, and other carriers. She had been trying to help others re-enter the state program because they had left the Teachers Trust because they could not afford it.

Chairwoman Giunchigliani noted there were many spouses who were school administrators, and it would be interesting to see how they would be impacted by AB 286. She recalled that the original version of AB 286 had a $5 million fiscal note that was removed when the bill was sent to the Senate. She said part of the Committee's intent would be to determine what should be done for retirees in public service to ensure that they were properly covered at an affordable rate.

Ms. Hamblin remarked that partly because Nevada was a windfall state, there were problems with Medicare; in order to get any part of a Medicare supplement, it was necessary to have Parts A and B of Medicare, for which many public employees did not qualify. In addition, public employees could not draw Social Security in

addition to their state pension because of its status as a windfall state.

Chairwoman Giunchigliani said the Legislature had passed a resolution in the 2003 Session to call on Congress to change the Social Security issue; public employees should not be penalized for receiving retirement benefits from the Public Employees' Retirement System.

Chairwoman Giunchigliani thanked Ms. Hamblin for her testimony. There were no others wishing to testify. She then asked Allin Chandler, former Executive Director of the Clark County Association of School Administrators (CCASA), to comment.

Mr. Chandler explained he was no longer the Executive Director, but he continued to work for CCASA on a part-time basis and he had been involved in insurance for a very long time. He had been a teacher and administrator in the Clark County School District, and originally everyone in the district had insurance coverage under one plan administered by Aetna. In 1983, the teachers started their own trust, and then in 1984 the district administrators became participants in the state plan. The administrators stayed in the state plan until 1999, when they withdrew and secured their own plan, selected their own broker, and approached the school district for collective bargaining. Mr. Chandler explained that a collectively bargained health plan was different than a health plan covered under AB 286. Assembly Bill 286 specifically addressed plans that had been formed under NRS 287.010, 287.015, and 287.020; those plans were specifically provided by the employer for its employees. CCASA obtained its own insurance plan and presented it to the school district for negotiation. The title of the plan was the CCASA/CCSD Health Insurance Plan.

Mr. Chandler said for the administrators' purposes, the CCASA/CCSD plan had worked well. Active employees and retirees paid exactly the same premiums. All retirees were offered the opportunity to join the plan at the time it was created. He said that even though the costs were high, they were nothing compared to what had been revealed at this meeting. The premium for an employee only was $356.57 for complete coverage, including medical, dental, vision, and a $50,000 life insurance policy. The plan consisted of four tiers: retiree only, retiree and spouse, retiree and children, and family. The family rate was the highest at $972.91.

Continuing, Mr. Chandler explained the retirees paid 100 percent of their health insurance premiums. For those retirees who had retired prior to 1984 before the administrators had joined the state plan, or those who were in the state plan as actives and then transferred to CCASA as retirees, it was believed at this point that they were entitled to receive the subsidy from the state. Mr. Chandler was not of the opinion that the subsidy should be received from the state; he wished that were true, but he believed the law only applied to those plans developed and administered by the school district itself as the employer. Since CCASA was not the employer, he did not think those employees were eligible for the subsidy. He noted that since creation of the CCASA plan, 100 percent of those who had joined had stayed in the plan; none had moved to the state plan.

Mr. Chandler remarked that CCASA had also secured a legal opinion, which was still in draft form and confidential. He said he would share it with the Committee once it was ready for publication. He added that the policemen and firemen working with CCASA did not believe AB 286 applied to their plan because they had a trust, and trusts were covered separately under the Nevada Revised Statutes.

Assemblyman Goicoechea said some agencies in his district were complying and some were not. The Truckee-Carson Irrigation District (TCID) in Fallon was assessed $38,000, and TCID had no employees; however, it complied with what it perceived to be the letter of the law. Other entities had other legal opinions or just were not paying. He hoped the issue could be resolved quickly.

Mr. Chandler thought that Clark County School District's belief was that it was responsible for providing a stipend for those people who were in PEBP, and the district's obligation was $2.18 million per year.

Chairwoman Giunchigliani agreed that some groups had complied with what was thought to be legislative intent and others had not. She asked Mr. Chandler if it was the intent of Clark County School District to not pass stipend funds on to CCASA. He replied it was his understanding the district did not believe the retirees insured under CCASA or the Teachers Trust were entitled to a subsidy; he thought the district felt the subsidy was only required for those employees who retired under PEBP.

Walt Rulffes, Deputy Superintendent and Chief Financial Officer for the Clark County School District, noted that there had been discussion regarding an allocation from AB 286, and he wanted to make it clear that school districts did not receive an allocation. The district was currently funding any subsidies paid, and it was following the legal opinion of the Legislative Counsel Bureau and Attorney General, which indicated the district was required to subsidize those employees in the state plan, but made no provision for subsidizing those in other plans. From what he had heard in earlier testimony, Mr. Rulffes thought that, for equity purposes, there should be the same subsidy for retirees in other plans as in the state plan.

Mr. Alpert said the one crystal clear intent in AB 286 was that Clark County School District had to pay the subsidy for teachers in the state plan only – not in the Teachers Health Trust. If that stipulation were modified, the issue would be different and the Health Trust would have sufficient funding. However, the district was not obligated to provide funding of the subsidy for those retirees in the Teachers Health Trust.

Assemblyman Goicoechea said in reviewing AB 286, he understood that what the school district was following might be implied, but it was his opinion that was not the intent of the Legislature. He said there was no intention on the part of the Legislature to force retirees to enter the PEBP program. His understanding of the intent was for retirees to have an option and receive a subsidy regardless.

Mr. Chandler remarked that the school district administrators certainly wished the subsidy applied, regardless of which insurance plan the retirees were in. Unfortunately, that was not the district's understanding of the bill. Secondly, in contradiction to Mr. Alpert's comments, Mr. Chandler did not believe it was crystal clear that the district had to pay the subsidy for teachers in PEBP; he wished it were.

Chairwoman Giunchigliani asked what the dollar amount would be to fund the subsidy for all retirees from the district. Mr. Rulffes replied it was known the minimum cost would be $2.5 million this year; using Mr. Alpert's figures, the amount would increase to between $4 and $6 million next year. It was the district's hope that the Legislature would provide funding so that it would not be necessary to take dollars away from children for other purposes.

Chairwoman Giunchigliani recalled that $5.8 million was set aside for increases in health insurance costs for active employees that had been unanticipated. Mr. Rulffes remarked that the school district had been specifically told by the Department of Education that none of those dollars would be available for the consequences of AB 286.

Mark Stevens, Assembly Fiscal Analyst, explained that at the April 8 Interim Finance Committee (IFC) meeting, the agenda included a request from the IFC Contingency Fund for $2.3 million related to AB 286 costs. The Department of Education and the State Budget Office were currently reviewing applications that had been sent forward by the school districts for funding of unanticipated health insurance costs for active employees; that request would not be submitted to the Interim Finance Committee until the June meeting.

Chairwoman Giunchigliani clarified that the $2.3 million for AB 286 was projected by the State Department of Education. Mr. Stevens concurred, adding that the request was then sent to the State Board of Examiners for approval prior to submission to IFC. Chairwoman Giunchigliani asked if the $2.3 million was to be used only for retirees going back into the state plan.

Mr. Rulffes replied the $2.3 million was for the current membership in the state plan; it did not take into account any transition that might occur from the Teachers Trust to the state plan in order for participants to access the subsidy.

Chairwoman Giunchigliani asked if the Department of Education had asked the school district for the number of retirees, regardless of which plan they were in, or if the department had just asked how many were in the state plan. Mr. Rulffes replied the district was not consulted at all; it was not aware of the subsidy requirement until after passage of AB 286 when notices were sent out by PEBP.
Assemblyman Goicoechea remarked that the way AB 286 was drafted, everyone was being forced into PEBP if they wanted the subsidy. However, that was never the intent of the Legislature. Some of the local jurisdictions could have far cheaper plans that would require a smaller subsidy.

Mr. Rulffes disagreed, saying there were many retirees in the support plan, and they would stay there because it was cheaper, even taking the subsidy into account. Assemblyman Goicoechea understood that, but he did not believe it was fair that they did not receive any subsidy at all. Mr. Rulffes said that had been one of the major issues of AB 286; it did not provide a subsidy to the participants in any plan other than PEBP.

Assemblyman Goicoechea reiterated that he did not believe that the intent was to send participants to PEBP, since at that point PEBP was so high no one could afford it. Mr. Rulffes said the problem was broader than just the Teachers Trust and the administrators union – it affected people in all other plans and retirees in other states.

Chairwoman Giunchigliani said if the intent had been to cover everyone, the Department of Education should have requested more than $2.3 million from IFC.

Bob Hadfield, Executive Director of the Nevada Association of Counties (NACO) introduced Nancy Howard of the Nevada League of Cities and Municipalities. Mr. Hadfield said that AB 286 was an interesting and important topic for local governments as well. Unfortunately, local governments could not request an appropriation and increased funding from the Legislature. As with the school districts, local governments were required to pay a subsidy, but they had one additional burden. Some local entities were at the statutory tax cap, and money for the subsidy would have to be taken from other programs. Mr. Hadfield said NACO was still trying to quantify the amount; the impact of AB 286 would not be known until the Public Employees Retirement System (PERS) calculated the numbers. He pointed out that PERS would know the location of every retired school teacher receiving benefits.

Mr. Hadfield said there were many small local entities that had long-time employees. The demographics of Nevada were changing rapidly, and many people would be eligible for retirement within the next five years. The dollar amount today may not seem significant, but it would escalate substantially over time. In looking at the financial implications and considering ways to deal with the problem, Mr. Hadfield urged the Committee to also understand that local governments would need a form of relief as well. They must be given the ability to generate the funds to pay for a benefit that was rightfully deserved. Mr. Hadfield emphasized that NACO's only concern was the fiscal issue.

Nancy Howard, Assistant Director of the League of Cities and Municipalities, echoed Mr. Hadfield's remarks. The League would not argue what was morally right or wrong with providing retired employee subsidies, but AB 286 did come with a very significant fiscal impact to cities, counties, and school districts. She suggested that in the course of the Committee's discussion, the source of funding be explored. As Mr. Hadfield had commented, the costs would continue to spiral out of control.

Chairwoman Giunchigliani remarked that part of the intent of ACR 10 was to not only deal with the current situation, but also to project future needs and funding streams.

Assemblyman Goicoechea said although he was from local government and was well aware of the impacts, he had supported AB 286 because something had to be done – the situation could not continue for another ten years. He was committed to addressing the issues through ACR 10.

Mr. Kirk Brower, an administrator with Humboldt County School District, testified from Carson City. He said he would reiterate most of what had been said concerning the retirees. He served on the insurance committee for the district, and the self-insured insurance plan costs had become so exorbitantly expensive, the contingency fund went from $.5 million to minus $.5 million. As a result, many rates had to be increased, and the retirees were seriously impacted. Mr. Brower wanted the Committee to also consider the impacts on families. He had always been able to interview potential employees and tell them the benefits of the health plan; however, many of the district's employees with families had found it necessary to drop their children from their insurance because of the expense. It had always been difficult to recruit teachers to the rural areas, but the impact of the insurance issue was making it even more difficult.

Marty Bibb, Retired Public Employees of Nevada, commended the Committee for taking on the challenges of ACR 10. He said that Ms. Hamblin had very effectively described the many concerns of those retirees who were in a situation of not knowing what their choices were with regard to insurance. Others in attendance had made several legitimate points, and that was all part and parcel of a lengthy, broad-ranging challenge of the ACR 10 Committee. Mr. Bibb expressed his appreciation for the Committee's efforts.

John Cahill, a retired Clark County government employee, said he had worked for 30 years as a juvenile officer at the juvenile court services. Mr. Cahill was the president of the collective bargaining unit when Clark County became self-funded under its group insurance in the early 1980s. He said he had been receiving calls for advice from some of his previous co-workers who were now retiring. Many asked why they should not sign up for PEBP in order to get the subsidy, which they would not receive if they stayed with the county. Mr. Cahill said he had advised them if they were healthy and currently in the HMO plan, it made sense to join the state plan, receive the same benefits, and save approximately $350 a month. He did not understand why the law had been passed and why the state would want more retirees in the state plan. However, he advised them to stay with the county plan if they were not very healthy or wanted freedom of choice and could afford it, since he did not know what was going to transpire in the future. Mr. Cahill also had conversations with the Clark County risk manager concerning the issue; he was curious what her thoughts were concerning the trend for retirees to join the state plan for the subsidy that was not available through the county plan. The risk manager said if more retirees moved to the state plan, the advantage for the county plan would be that long-range costs would be more stable and easier to project. However, Mr. Cahill asked what would happen if the contribution rates were increased in the future, and the risk manager agreed that would be a problem. Mr. Cahill said there were currently employees retiring and joining the state plan simply in order to get the subsidy; that was the way the law was being interpreted.

Chairwoman Giunchigliani remarked that errors were occasionally made in drafting and passing legislation, which unfortunately could not be corrected for another two years. She thought the discussion throughout the meeting had been very beneficial. The Committee would have to determine what action could be taken between now and the 2005 Legislative Session, during the session, and after session for the long term. She encouraged other groups who might wish to make a presentation to the Committee to contact her or Bob Atkinson.

VIII. SCHEDULING OF DATES AND LOCATIONS FOR FUTURE MEETINGS.

Chairwoman Giunchigliani apologized for scheduling a meeting on a weekend and indicated that would not

occur again. After some discussion, it was decided the next meeting of the Committee would be held on Thursday, May 13, 2004 in Carson City, at 9:30 a.m. The meeting would be video-conferenced to Las Vegas.

Chairwoman Giunchigliani reminded members that the Advisory Committee to the Legislative Committee to Study the Public Employees Benefits Program would be meeting on the following day, Saturday, March 20, beginning at 9:30 a.m. in room 4412.

There being no further business to come before the Committee, the meeting was adjourned at 5:15 p.m.

Respectfully submitted,

_____
Sherie Silva, Transcribing Secretary

APPROVED:

_____
Assemblywoman Chris Giunchigliani
Chairwoman

Date:_____

Copies of the 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.