

**MINUTES OF THE
LEGISLATIVE COMMISSION'S COMMITTEE TO STUDY
THE PUBLIC EMPLOYEES' BENEFITS PROGRAM
(ACR 10, 2003 LEGISLATIVE SESSION)
June 10, 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 June 10, 2004 in Room 4100 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was video-conferenced to Room 4401 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Exhibit A is the Agenda and Meeting Packet and Exhibit B is the Attendance Roster.

COMMITTEE MEMBERS PRESENT IN CARSON CITY:

Assemblyman Pete Goicoechea

COMMITTEE MEMBERS PRESENT IN LAS VEGAS:

Assemblywoman Chris Giunchigliani, Chairwoman

Assemblywoman Barbara Buckley

Senator Bob Coffin

COMMITTEE MEMBERS ABSENT:

Senator Mark Amodei

Senator Dean Rhoads

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

Sherie Silva, Secretary, LCB Fiscal Analysis Division

EXHIBITS:

Exhibit A - Agenda and Meeting Packet

Exhibit B - Attendance Roster

Exhibit C - Letter from Senator Amodei to the PEBP Board Concerning New Vendor
Contracts and Extension Schedule for 2004

Exhibit D - Health Care Purchasing Coalitions

Exhibit E - Letter from Michael Tobey – AB 286

Exhibit F - Letter from Bill Richards – AB 286

Exhibit G - Letter from Val Judd – AB 286

Exhibit H - Letter from Carolyn McLeod – AB 286

I. CALL TO ORDER AND OPENING REMARKS.

Chairwoman Giunchigliani called the meeting to order at 1:15 p.m. and asked the secretary to call the roll. She noted that Senator Amodei was excused.

II. APPROVAL OF MINUTES OF THE MARCH 19, 2004 MEETING.

SENATOR COFFIN MOVED FOR APPROVAL OF THE MINUTES OF THE MARCH 19, 2004 MEETING. THE MOTION WAS SECONDED BY ASSEMBLYMAN GOICOECHEA AND CARRIED.

III. DISCUSSION AND RECOMMENDATIONS TO THE PUBLIC EMPLOYEES' BENEFITS PROGRAM (PEBP) BOARD ON PROPOSED CONTRACT EXTENSIONS FOR CERTAIN VENDORS OF THE PUBLIC EMPLOYEES' BENEFITS PROGRAM.

Chairwoman Giunchigliani said she and Senator Amodei had expressed concern regarding PEBP contract extensions (Exhibit C) and requested that the matter be put on the agenda in order to receive further clarification. It was their initial understanding that contract extensions had been granted in order to lock the PEBP Board into agreements prior to the ACR 10 Committee making recommendations concerning potential privatization, requests for proposal, etc. She asked Mr. Thorne to address the issue.

Woody Thorne, Executive Officer of the Public Employees' Benefits Program, explained that the contract extensions had been granted to organize the major contracts that the PEBP Board had gone out to bid for into logical groupings based on the type of contract. During the previous 18 months, the Board had gone out to bid on 13 major contracts, which was extremely stressful on staff and resources at the State Purchasing Division. Mr. Thorne said all of the contracts were reviewed in conjunction with staff from State Purchasing and a representative from the Attorney General's Office, and a request for proposal (RFP) schedule was developed that placed similar contracts into the same bidding cycles, as well as spread the bids out over a longer period of time.

Mr. Thorne reviewed the PEBP New Vendor Contracts and Contract Extension Schedule for 2004 (Exhibit C – page 2):

Administrative Contracts

- Third-Party Administrator for Claims Payment
- Eligibility System Vendor
- Prescription Drug Vendor
- Large-Case Management and Disease Management Vendor

Mr. Thorne said efforts had been made to get the eligibility vendor and the third-party administrator into the same bidding cycle (June 30, 2006), and the Catalyst Rx and CBCA Case Manager to June 30, 2007. The fact that Catalyst Rx was getting a longer term contract enabled Catalyst to negotiate additional discounts with their major providers. In doing so, PEBP would be looking at an additional savings estimated at \$1.2 million over the next three years.

Mr. Thorne said if the long-term contracts were not in place, the companies would have difficulty negotiating with their vendors for future contracts due to the unsettled nature of the marketplace itself, the rising interest rates, and the cost of doing business. The existing contracts would be honored, but if they were terminated or shortened, they would have to be renegotiated.

Moving to the case management program, Mr. Thorne said that a disease management program was being initiated beginning in July 2004. That contract would be extended an additional year to not only get it into a reasonable RFP cycle, but also to provide an opportunity to see the results from the program.

Leased Provider Networks

- National Network with Beech Street
- Diversified Dental Services, Inc.
- Statewide PPO-SHO

Mr. Thorne explained it was hoped to obtain a common expiration date of June 30, 2008, offering a request for proposal in November 2007.

Insured Products

- Life Insurance
- Accidental Death and Dismemberment
- Group Long-Term Disability

Mr. Thorne said the insured products were the most stable element of the state's coverages and could be underwritten for a longer period of time. These products would be extended to the next cycle, which was 2009.

Working with the State Purchasing Division, PEBP hoped that all contracts could ultimately be on a four-year cycle in order to go to bid on all products every four years. Mr. Thorne said the goal was to provide nominal increases in fees or savings to the plans as part of the contract extensions and get into a rational and stable cycle so that PEBP would be going out to bid for certain types of contracts on a regular basis. Mr. Thorne said that regardless of the outcomes of the ACR 10 Committee, all contracts had a termination provision of 60 days with no cause required. He added that while the decision-making and deliberation were being undertaken by the ACR 10 Committee, PEBP still had a plan to administer and an obligation to maximize the benefits and establish strong relationships and partnerships with those providing services to the plan and its participants.

Chairwoman Giunchigliani asked if all products had been competitively bid and, if so, when. Mr. Thorne referred her to the Effective Date column on the chart in Exhibit C. He noted that no bids were received in 2002 for an insured product, and in 2003 no bids were received for an insured product on the PPO side. PEBP was looking for a statewide HMO or PPO and there were no competitive bids for a statewide HMO in 2002 or 2003. As of July 1, 2004, there was an HMO in the north and an HMO in the south.

Chairwoman Giunchigliani asked if the request for proposal had been written in such a way that no one wanted to competitively bid, or if the market was dictating something at that

point. Mr. Thorne replied it was a combination of the market and the terrible claims experience of the program. When any of the potential insurers looked at the claims experience, they did not feel they could offer an insured product at anything close to a reasonable cost, neither an HMO nor a PPO. The experience had improved, and bids were received for both the north and south this last year. Mr. Thorne reiterated the lack of competition was driven as much by the market as the claims experience of the program.

Chairwoman Giunchigliani asked if the 60-day out clause in the contracts applied to all of the contracts; Mr. Thorne said she was correct. She asked if there were any penalties, and he replied there were not. She asked what was hoped to be accomplished by getting all of the contracts on a four-year cycle, and he explained the contracts had traditionally been written for a three-year period with an option for a one-year extension. A major investment in time and effort was required to prepare the RFP and to make a transition to a new vendor. A longer contract term would be of benefit to both the plan and the vendor.

Chairwoman Giunchigliani referred to Senator Amodei's letter (Exhibit C), which stated that the purpose of bidding was to secure competition. She asked if PEBP had the in-house expertise to write RFPs that were truly competitive.

Mr. Thorne said PEBP's expertise in writing RFPs had been improving over the past three years. PEBP was also working with State Purchasing and consultants on ways to improve the RFP process and implement electronic RFP distribution and response, which would enable an easier and timelier analysis of the competition among the vendors. Mr. Thorne said there would be issues with regard to electronic responses to Purchasing and revisions to statutes for implementation; PEBP was working to streamline the process as much as possible.

Chairwoman Giunchigliani asked if an investigation was ever conducted when no bids were received in response to an RFP. Mr. Thorne said some informal inquiries had been made after the fact to find out what had caused the reluctance to bid, and a number of carriers indicated that they would provide administrative services only to their larger clients, and they considered the state to be in that classification. He said many had looked at the state's claims experience and determined the state had a very unhealthy group; until they saw some improvement, they were not willing to take the risk that was involved.

Assemblyman Goicoechea asked if the vendors had the same 60-day escape clause with no cause as the state; Mr. Thorne replied they did.

Chairwoman Giunchigliani agreed with Senator Amodei's observation that the Committee did not want to be restricted from making certain recommendations. Members were surprised to learn of contract extensions in the midst of the Committee's request for information and deliberations concerning possible privatization and/or new coverages. She wanted to make sure that the Committee's concerns were noted, and she was glad to know there was a 60-day escape clause.

Mr. Thorne said it had not been the intent of the PEBP Board or staff to provide any type of roadblocks to the Committee, and therefore the standard opt-out clause was included to allow flexibility. At the same time, it was PEBP's desire to organize the RFP process into a rational timetable to balance out the use of available resources.

Senator Coffin asked if PEBP had prepared the schedule of administrative and leased provider contracts (Exhibit C). He found the numbers difficult to understand without annual figures; he asked if Mr. Thorne had the annual figures and if annual inflation was built in. Mr. Thorne said the contracts for the HMOs and insured products were estimates of the number of participants times the premium and the vendor's estimate of what potential experience increases would be over the next two years. The fees for administrative contracts were based on an estimate of how many participants; the prescription drug coverage included the administrative fee and actual claims costs. He said there were no inflationary clauses in the contracts. In the case of items like Catalyst Rx, attempts were being made to develop a mechanism that would separate the claims from the fee elements.

Senator Coffin was most interested in the Catalyst contract. Mr. Thorne said the costs for Catalyst were running just under \$2 million per month. Senator Coffin remarked the market for pharmaceuticals was very unstable; he asked if the plan was being audited closely. Mr. Thorne said in the past the prescription providers had conducted self-audits; they were reluctant to allow a review by outside auditors. PEBP would be conducting an independent audit for the plan year closing out June 30, 2004. Independent quarterly claims audits were conducted on the third-party administrator.

Senator Coffin reiterated his concern with the pharmacy plan, noting that it seemed to be consuming a larger portion of the claims every month. Mr. Thorne agreed, explaining that the experience had been stable on the prescription drug plan changes made and costs of the plan had not increased anywhere near the levels they had two years ago.

Chairwoman Giunchigliani asked what percentage Catalyst Rx charged the state for administrative costs. Mr. Thorne replied there was a network cost of \$0.24 per employee per month starting in July 2005. Dispensing fees from the pharmacies were part of the claims cost, whether it was mail order or retail. Access to the program for administration was a flat \$.24 per employee per month. In fiscal year 2004, the fee was \$.25 per employee per month, and the dispensing fee at the retail level was \$2.25 for generic and \$2.00 for brand. Beginning in July 2005, that fee would be reduced to \$1.95 for brand and \$2.00 for generic.

Mr. Thorne clarified that the \$.24 per employee per month fee was assessed on approximately 24,000 employees and retirees in the PPO plan; there was no assessment on dependents. The goal of the new pharmacy plan was to shift usage to generic drugs. Generic usage had been increased to 52 percent of the total prescriptions dispensed, which had reduced the overall cost increases in the prescription drug program. In January 2002, generic utilization was under 30 percent.

Chairwoman Giunchigliani recalled that the state contributed \$495 per person for health insurance. Mr. Thorne said the current state subsidy was actually \$560, which went toward the total cost of coverage for state employees and their dependents. When the rate setting was switched over to AON and predictive modeling, the health status of participants in each tier was evaluated, and it was found that the husband and wife group was a greater health risk than the husband and wife in a family grouping, basically due to the fact that the husband and wife group included older participants with more health

problems. However, to reflect the more traditional pricing, the subsidy was adjusted and it would gradually move to the actual costs.

Chairwoman Giunchigliani agreed that the premiums must eventually reflect the actual cost of coverage; the fact that subsidization of dependents still existed needed to be recognized and dealt with policy-wise. Mr. Thorne said there had always been an unstated policy that the state subsidy not only covered the cost for the employee, but also provided some subsidy for dependents, even though it had never been stated clearly in statute or legislative policy. When building its budget for the next biennium, PEBP would try to clarify the policy; instead of looking at a fixed dollar amount, PEBP would look at what percentage of the cost the state would subsidize for the employee and dependents. The state subsidy level had been consistent overall on a percentage basis over the years.

IV. PRESENTATION ON THE COST AND TIMEFRAME FOR CONDUCTING A STUDY ON THE FEASIBILITY OF ESTABLISHING A STATEWIDE PROGRAM OF HEALTH INSURANCE AND OF PRE-FUNDING RETIREE HEALTH INSURANCE COSTS.

Mr. Thorne remarked there were two elements to be discussed under this agenda item: 1) the feasibility of establishing a statewide plan, and 2) the pre-funding of retiree health insurance benefits.

Mr. Thorne referred Committee members to page 49 of Exhibit A, a letter from AON Consulting regarding the ACR 10 Feasibility and Savings Analysis, which outlined the steps that would be beneficial and the timelines involved. Mr. Thorne said the estimated cost of \$71,000 to \$97,000, plus travel and meeting expenses, would provide the following:

- Overview of other statewide programs around the country;
- Benefit plan benchmark analysis – PEBP versus larger Nevada governmental versus other states with statewide programs;
- Nevada demographic analysis - PEBP versus larger Nevada governmental employer groups;
- Analysis of savings due to statewide consolidation, i.e., margins, risk charge, etc.;
- Identification of issues to ensure success of a statewide consolidation; and
- Recommendation report on plan design and plan provisions with funding strategy.

AON had indicated concern with two other issues. A new Governmental Accounting Standards Board (GASB) standard required a declaration of future liability stated on a present value basis for the subsidization or provision of non-pension retiree benefits. Mr. Thorne said he had met with the State Controller's Office and State Budget Office to begin discussions on this matter. AON had submitted a proposal for conducting an analysis and making a projection for the state, but a GASB declaration had to be in place by the beginning of 2006. By the end of 2006, there had to be an acknowledgement of the liability for plan years beginning after fiscal year 2006. Mr. Thorne said this item had the potential of being very costly, and it would relate to how the state wished to deal with what was currently an unfunded liability.

Continuing, Mr. Thorne said the second issue related to pre-funding. In a June 7, 2004 memorandum from AON to Bob Atkinson (Exhibit A, page 53), AON discussed four phases of an assessment and evaluation of the financial liability and funding implications:

- I. Prepare and submit a data request for information that would be presented to:
 - Benefit Planners – PEBP current health plan administrator;
 - Iowa Foundation for Medical Care Information Systems (IFMC) – current Information system;
 - State of Nevada PEBP; and
 - State of Nevada PERS.Review all data for general reasonableness.

- II. Review demographic and economic assumptions and provide written assumptions to ACR Committee for confirmation.

- III. Process all gathered data, run valuation and projections, and prepare the actuarial report.

- IV. Present AON's report to the ACR 10 Committee.

The estimated cost of the four-phase study ranged from \$36,000 to \$47,000.

Mr. Thorne added that both studies would have to rely on or would create some piece of the GASB analysis that would have to be done, so PEBP would continue to work with AON. Depending upon how the Committee wanted to proceed with either proposal, a determination would be made as to what portion of the expense could be offset by GASB requirements.

Chairwoman Giunchigliani observed that the Feasibility and Savings Analysis was probably necessary, but that the State Subsidy Analysis/Pre-Funding of Retiree Medical Benefits was essential. She asked Mr. Thorne if he knew how AON's proposal differed from the Segal study that was done earlier; he replied he did not know. She wondered if an update of the Segal report would provide the information currently needed. Mr. Thorne believed some elements of the Segal report would apply, but because of the new standard under GASB, it made sense to have the same actuary working on both issues.

Chairwoman Giunchigliani asked for Committee members' thoughts concerning the two study proposals. She asked if PEBP would be able to fund the State Subsidy Analysis/Pre-Funding of Retiree Medical Benefits until other funding could be obtained, and he replied he would make the recommendation to the PEBP Board to cover the expense of the analysis. He agreed that given the GASB liability potential and the fact that it would be a sizeable unfunded liability, the state subsidy analysis was essential.

Chairwoman Giunchigliani remarked that the information would be necessary to make a proper decision and it would benefit PEBP, as well as the other entities. Both studies would be beneficial, but she reiterated that the state subsidy analysis appeared to be the most pressing.

Assemblyman Goicoechea asked Chairwoman Giunchigliani if she was proposing to fund the pre-funding study rather than the feasibility and savings analysis. She replied she would prefer to do both, but funding was an issue. Assemblyman Goicoechea agreed, adding that it would be necessary to develop a mechanism for pre-funding, but he would like to hear the Advisory Committee's recommendation. He was concerned about extending the contracts; although AB 286 had defined who would pay, what would be paid was the real issue.

Chairwoman Giunchigliani asked Mr. Thorne his thoughts concerning the feasibility and savings analysis. Mr. Thorne replied the analysis was not something PEBP would do on its own; it would only be done on behalf of the ACR 10 Committee. He believed it made sense for the PEBP Board, the state, and the ACR 10 Committee to do the pre-funding analysis for retiree benefits first, given that the GASB analysis would be necessary to determine the potential unfunded liability.

Senator Coffin said he was torn on the issue of the studies, because the unfunded liability number would be huge, and medical costs were increasing each year. Even the best analysis would not provide a guarantee of future costs. He wondered if performing the analysis earlier than needed would possibly cause a black mark on the state's bond rating.

Mr. Thorne replied the bond rating was not a problem. All states were struggling with the GASB standard, and even though there was no official declaration that the analysis be done until 2006, the process would have to be completed in any event. In addition, there could be discussion during the 2005 Session, since implementation would be required in the next biennium, and the information would be required.

Senator Coffin speculated the number would be similar to the amount of the PERS' calculation of what would be needed to be fully funded. He believed the medical bills would also amount to a huge unfunded liability. He asked if the bond rating for all states would drop, and Mr. Thorne replied that probably would be an issue, depending on how the states recognized the number and what action they took to offset the potential cost. The same thing would apply to the Financial Accounting Standards Board (FASB) for the private sector, which went into effect a number of years ago and resulted in a dramatic change in the way the private sector was or was not providing retiree health benefits.

Referring to page 55 of Exhibit A, Chairwoman Giunchigliani asked if demographic and economic assumptions from local jurisdictions would be included in the analysis. She wondered if an assumption was being made that all public employees were automatically in PERS, which would not include University System and groups with other options. Mr. Thorne replied PEBP would provide guidance to AON in the review of demographic data, but a determination would have to be made whether the study was just for the state component or if the goal was to project future funding costs for all groups. It was possible that the actuary could take the state data and project it out for the local entities as well. The state would be required to report its liability for what it had promised its state employees and retirees.

Chairwoman Giunchigliani suggested that the information be captured for all groups statewide, not just state employees. Mr. Thorne agreed that was a reasonable request.

Chairwoman Giunchigliani suggested that the Committee move forward with both studies. It would not be possible for the Committee to make proper recommendations without all of the information. Since the ACR 10 Committee had been created for a four-year period, a request could be made to the 2005 Legislature to reimburse PEBP for unanticipated costs. Mr. Thorne said he would request the PEBP Board to proceed with both studies.

ASSEMBLYWOMAN BUCKLEY MOVED THAT THE COMMITTEE REQUEST THAT THE PEBP BOARD ADVANCE ON AON'S PROPOSALS FOR THE ACR 10 FEASIBILITY AND SAVINGS ANALYSIS AND A STATE SUBSIDY ANALYSIS/PRE-FUNDING OF RETIREE MEDICAL BENEFITS STUDY, AND THAT THE PEBP BOARD BE ABLE TO REQUEST FUNDING FROM THE 2005 LEGISLATURE FOR UNANTICIPATED COSTS.

THE MOTION WAS SECONDED BY SENATOR COFFIN AND CARRIED.

V. REPORT ON RECOMMENDATIONS FROM THE ADVISORY COMMITTEE TO THE LEGISLATIVE COMMISSION'S COMMITTEE TO STUDY THE PUBLIC EMPLOYEES' BENEFITS PROGRAM

Nancy Howard, Chairperson of the Advisory Committee, reported that the Advisory Committee had met three times and had engaged in lively discussions. In the long-term, she said that the Committee as a whole agreed that a mechanism needed to be found to pre-fund retiree benefits in the future.

In the short-term, the Advisory Committee had agreed to distribute a survey to collect census and demographic information from the state, cities, counties, and school districts. The League of Cities, the Nevada Association of Counties, and the Fiscal Analysis Division would be working together to pull the information together. Ms. Howard said that discussion had been held in the morning session concerning the ultimate goal of the Advisory Committee: Was a statewide plan feasible and what everyone wanted? Should the state be looking at creating a benefit for state employees only? If local governments provided their own benefits, what would the rules, terms and conditions be?

A small work group of six members had been appointed to analyze some of the data being gathered and report to the Advisory Committee on July 21. The group would consider proposals and recommendations for issuing a request for proposals or request for information for a statewide plan. Chairwoman Howard said once the information was obtained, the Advisory Committee would be better able to determine whether the plan should be state or state and local. She offered to answer any questions.

Chairwoman Giunchigliani affirmed that the issue was still whether to create one statewide pool or maintain a state plan that would be responsible for state employees from active to retired status and local governments would be responsible for their employees, but would have to adopt a policy to pay for their retirees.

Ms. Howard concurred, adding that it was decided to move forward with the presumption that it would be one plan, gather the information, and analyze the data, which hopefully would assist in answering the questions.

Assemblyman Goicoechea did not understand how the plan could be anything other than one combined large group because of the mix of the employees and their work experience. Personnel transitioned from local government to state and back; it would be difficult to separate them out. The issue had been further complicated as a result of AB 286.

VI. PRESENTATION ON NATIONWIDE TRENDS IN HEALTH CARE

Ginny Cady, American Federation of State, County, and Municipal Employees (AFSCME), the parent organization of the State of Nevada Employees' Association, with headquarters in Washington. Ms. Cady specialized in health benefits, and she had been asked to address the Committee regarding what other states were experiencing with pooling and purchasing coalitions. A lot of activity was also taking place in two other areas, i.e., prescription drug re-importation and implementation of quality measures in health plans and disease management programs.

Purchasing Coalitions

Ms. Cady explained purchasing coalitions were established by purchasers who wanted to use their joint purchasing power and leverage to gain lower health benefit costs and hopefully higher quality of care. A larger pool would give more negotiating power and would spread the risk out in order to obtain more predictable premium costs. Most of the pools were self-governing and obviously not for profit, since most were in the public sector. Ms. Cady had seen state plans that had allowed local government participation; they were self-insured and therefore did not purchase insurance products. While pricing control was the primary short-term focus of the coalitions, they also tended to share information about best practices in an attempt to improve quality and subsequently maintain costs.

Ms. Cady said there were major concerns that needed to be considered when looking at coalitions, the largest being adverse selection. One of the major problems was local governments joining the plan to save money, and when they didn't save money, they dropped out, because they were voluntary coalitions. To prevent this from happening, a mandatory pool requiring that local governments participate would have to be created.

Another difficulty, Ms. Cady continued, was benefit design. Some local governments claimed their benefit design was better and their cost-sharing was better, and therefore they did not want to join the state plan and pay more. Methods had to be found to standardize the benefits so they were fair to everyone.

Ms. Cady said both obstacles, the sharing of the risk and benefit design, could be overcome; it had been found that when everything was the same, the savings were greater. If the risks were similar, it was easier to charge a community rate; however, if the claims were significantly different, the groups with better risk would not want a community rate. One option would be to assess a community rate to everyone up-front, but then issue rebates based upon the risk factors and claims experience of the actual group. A second alternative would be to experience rate claims and then share other costs, such as administrative costs. A third option was to pay all the claims to a certain pooling point, either an aggregate amount for the entire covered group or per individual, and then the group could either buy stop/loss insurance to cover claims above the pooling amount or self-insure that as well.

An example of a public sector coalition of which Ms. Cady was aware was New York State, which allowed local governments to opt into its self-insured plan, and most of the local governments in the state participated. Ms. Cady said the state had experienced the problem of adverse selection in the early years of the coalition; participating local governments would opt out when the cost of the state plan went up, thinking they could do better. However, a year or two later they would go back into the state plan because they found they could not do better. To resolve the issue, New York required governments that chose to leave the state plan to pay a penalty to return at a later date. Ms. Cady believed the penalty was based on the actuarial value of the state's loss on that particular part of the group. The state of New York had a huge network of providers, with some located nationwide to accommodate retirees who left the state.

Ms. Cady was also familiar with the coalition in Kentucky, which she understood was experiencing the same problems as Nevada. Kentucky allowed local governments to cover their active employees and/or their retirees. Most of the local governments had put their retirees in the state plan and kept their active employees in a separate plan. Because of the adverse selection, the state plan had experienced huge increases. The state was trying to resolve the problem by requiring that participating local governments either cover their actives under the state plan if they wanted their retirees covered under that plan, or pay the actuarial difference if they covered only their retirees. Ms. Cady added that the issue had not yet been resolved.

Ms. Cady said that Alaska was a new state employee union-run coalition that allowed some local governments to opt-in. Alaska's big problem was the lack of hospitals, making it difficult to negotiate rates. In order to try to resolve the problem, the state had negotiated rates with states in the lower 48; it was less expensive to send people having expensive surgery to hospitals in other states, including paying lodging expenses for patients' families.

Continuing, Ms. Cady remarked that more recently states had been looking at prescription drug coalitions, since prescription drugs were driving a lot of the health care costs. If drug costs continued to rise at the current rate, in five years they would be double what they were currently. One coalition called Raxis, which purchased prescription drugs for state employee programs, was driven by the West Virginia public employee health plan. Six states participated in the coalition, and a request for proposal was issued in 2001 to select a pharmacy benefit manager. The coalition's goals were:

- Pricing transparency – It was not always known what deals were made between the pharmacy benefit manager (PBM) and drug manufacturers; oftentimes they negotiated rebates unknown to the purchaser. One of the requirements of the West Virginia coalition was that everything would be revealed, i.e., transparency in the contract. Ms. Cady said that the goal had nearly been achieved; the PBM had contracted to disclose and pass through all of the rebates and what they paid for the drugs, except for mail order, which they had not yet agreed to; and the PBM was subject to an outside independent audit. Ms. Cady explained that an independent audit was very expensive, sometimes too expensive for one state to have conducted as frequently as necessary. Sharing the cost as a coalition made the audits much more affordable.

- Pricing Guarantees
- Aligned Incentives Between the PBM and the Purchaser – A lot of PBMs negotiated with the drug manufacturers for rebates, and oftentimes rebates were given on more expensive brand-name drugs that would not otherwise be prescribed; in essence, they were driving up the costs. Ms. Cady said that some PBMs made 50 to 70 percent of their money on rebates that should be going to the purchaser.
- Flexibility in their Ability to Use their Current Formulary – They did not want to change the medications their employees were currently on, and they negotiated a deal whereby their current prior authorization programs and current co-pay amounts would be honored.

Ms. Cady said several states had attended the meetings before the six states finalized their request for proposal. Not all of the states signed up, but some did utilize the processes they had learned to negotiate lower rates and some transparency with their current PBMs.

The agreement also allowed for deeper discounts based on more partners joining the coalition in the future. Ms. Cady said she had several contact names she would be willing to share if Nevada wished to pursue a coalition. Ohio had just joined the coalition, and some problems were encountered with the acquisition rules that were in place in the state; it was a very big issue politically. The state hired a consulting firm to test claims data of the current vendor against the rebates and pricing guarantees that were offered through the coalition to determine how much money would be saved. The initial results indicated the state would save substantially over the three-year contract. Ms. Cady cautioned that drug pricing was so complicated that it was not something that the state, union, or anyone should try to resolve alone without expertise.

The National Legislative Association on Prescription Drug Prices was another coalition consisting of representatives from nine states and the District of Columbia. They could not get a PBM to agree to the transparency issue, so they planned to form their own PBM and offer a mail order product from Canada.

Referring to page 6 of Exhibit E, Ms. Cady explained that drugs cost 30 to 80 percent less in Canada than in the United States. The drugs were the same, and most of them were developed in the U.S. She said that U.S. drug prices were expected to increase by at least 15 percent again in 2004; Canadian prices were expected to increase by 2 percent. Twenty states had introduced some sort of drug import measures in their 2004 legislative sessions. Only one, Louisiana, was in opposition to importing medications from Canada or other countries. A lot of the states had passed resolutions asking Congress to legalize importation, and a few had asked for permission to run a trial program. Several states had set up websites directing their citizens to Canadian pharmacies that had been found to be safe and reliable. Ms. Cady went on to say that a few cities had importation programs in place, the first being Springfield, Massachusetts. Springfield had the choice of laying off police and firemen or reducing their medical costs, so the city started an importation program in violation of the Food and Drug Administration (FDA). The plan had been in place nearly a year and had saved the city about 40 percent on its total drug bill. The only

drugs being imported were maintenance medications, which was a good piece of the drug program but not all of it. The city saved 40 percent in spite of the fact it gave up its rebates on the drugs being imported because it was no longer working with its PBM; the city paid the shipping costs of the drugs; and the employee co-payments were waived. Ms. Cady remarked it was incredible that a savings of 40 percent was still being realized. Technically, it was not legal to import drugs, but the program was channeled through a Canadian PBM. Employees sent their prescriptions to the Canadian PBM, which sent the prescriptions back to the employees and billed the city at the end of the month. The FDA had threatened the city, but nothing had been done.

Continuing, Ms. Cady stated that another county, Schenectady, had negotiated an agreement with ACFSME to re-import medications from Canada; the county spent about \$2 million per year on medications and expected to save hundreds of thousands of dollars. Worchestershire, Massachusetts, had begun a similar program in April and expected to save about \$1.2 million of its \$13 million annual drug costs in the first year. Employees were also being encouraged to use generics. Ms. Cady noted that Nevada was doing a good job in that area, as the percentage of generic substitutions was very high. Other measures being taken were educating employees on the proper use of prescription drugs to prevent additional health care costs and offering employees incentives to participate in the program.

Many other cities were looking into optional programs. Ms. Cady remarked that although they may not be the final answer, at least Congress had finally begun to act. The House of Representatives had approved legislation to re-import from Canada and a number of other countries in July 2003, and there had been several bills introduced in the Senate. She noted that the pharmaceutical lobby was huge – it was even larger than defense, which was one of the reasons nothing had changed on prescription drugs so far.

Pharmaceutical companies want the public to believe that if costs were lower in the United States, they would not have funding to conduct research and development. Ms. Cady said the facts were that pharmaceutical companies spent about 11 percent of their earnings on research and development and 17 percent on marketing, which included television commercials, lobbyists, and detailing (samples). The last statistics she had seen showed that the pharmaceutical companies' profits were about 18.5 percent per year, which was eight times the median for all other Fortune 500 companies. Every dollar spent on consumer advertising yielded \$4.20 in additional pharmaceutical sales of the expensive brand names. Therefore, Ms. Cady concluded, it was not a valid argument that prices could not be lowered because of lack of funding for research and development.

Another aspect that seemed to be prevalent in many plans was the quality of health care received through the plans. Ms. Cady remarked there was a lot of under-use, over-use, and misuse in the U.S., which not only cost money to pay for that use, but also cost money for complications that resulted from having unnecessary surgeries and procedures, e.g., 30 percent of hysterectomies were not necessary and 25 percent of insertions in children's ears were not necessary. Insurance companies were paying for procedures that were not necessary and probably quite frequently resulted in complications. She cited examples of under-use: 50 percent of people needing some sort of preventive screening, such as for breast cancer and prostate cancer, did not receive it, which was very costly in the end. Thirty percent of individuals with acute care problems did not receive medication, and

40 percent of people with chronic conditions, such as diabetes, failed to get eye and foot examinations. With regard to mis-use, one statistic was that 6.3 million seniors had a total of 7.9 million prescription errors.

Ms. Cady remarked that quality was not only life-threatening, but a huge cost factor as well. Disease management was becoming a prevalent program, and she said it was important to keep in mind that generally 15 percent of the population in a health plan used nearly 75 percent of the health care resources, which clearly emphasized that the focus should be on the portion of people who were really ill, because they were driving the costs. Imposing higher co-payments would create lower premiums for a year or so, but in the long run, it would not affect the people who were really driving the costs. Ms. Cady said that disease management had emerged as a relatively new tool to help reign in spiraling costs for people with high health care needs, such as heart disease, asthma, and Aids.

Continuing, Ms. Cady said health plans now looked at utilization data to determine which group participants had conditions for which there were well established evidence-based treatment guidelines, such as asthma and diabetes. Programs could range from mailing information to the participants to full-fledged monitoring and follow-up. Many programs offered a financial incentive to encourage participation. Ms. Cady noted the savings were hard to quantify, but one study had recently found that after implementation of disease management programs, the costs were reduced by 24 percent.

Another new approach being pursued was intensive care management, which was a program to help a patient through the process of getting appropriate treatment. Some states had contracted with centers of excellence for such treatments as organ transplants.

Ms. Cady explained that the National Committee for Quality Assurance (NCQA) was the accreditation agency for HMOs and PPOs to ensure they were providing high-quality care. Another group making progress was called the Leapfrog Group, a Washington-based coalition of over 100 public and private organizations that provided health care benefits to their employees. Leapfrog was using its collective purchasing power to motivate hospitals to implement measures designed to improve patient safety and quality of care. To date the group had three standards in place:

- Computer Prescription Order Entry (CPOE) – Required physicians to write their prescriptions through a computer and send them to the pharmacies – had drastically decreased medication errors.
- Referral of patients in need of certain high-risk surgeries to centers of excellence where they would receive the best care, have better outcomes, and lower costs.
- Contracted hospitals were staffed ICU units with doctors trained in intensive care medicine, which was apparently not always the case.

In summary, Ms. Cady said there was no “silver bullet” that would fix health care in the United States. What might work for one group might not work for another. It was necessary to look at the demographics, how they compared with other groups, and where

the costs were going to determine what combination of programs could be put in place to help contain costs. Ms. Cady offered to answer questions from the Committee.

Chairwoman Giunchigliani noted there was a hospital coalition in southern Nevada. She asked Ms. Cady if she was aware of any legal requirements as to who could participate in a coalition to avoid a monopoly issue. Ms. Cady replied she was not aware of that being an issue; she observed it could be a possibility, but it would occur more on the state level, and different states had different acquisition regulations.

Regarding the re-importation plans for prescriptions, Chairwoman Giunchigliani asked if the participating cities had implemented those plans through ordinances or statutes. Ms. Cady said in some cases they did, and in others they had just implemented the plan by resolution or other means. The cities feared action by the FDA, but so far the FDA had just shut down U.S. storefronts.

Senator Coffin thanked Ms. Cady for her excellent remarks; he requested that she forward her remarks in writing, and she agreed to do so. He noted that the northeastern states were re-importing prescriptions from Canada, but Nevada was closer to Mexico, and he understood there were reliable pharmacies there. Ms. Cady said she was only familiar with pharmacies in Canada; she had not heard much about Mexico. The medications being purchased from Canada were sold as packaged by the manufacturer, which it was felt alleviated the tampering issue.

Chairwoman Giunchigliani remarked that many senior citizens from the western states purchased drugs in Mexico because they were cheaper. She suggested that option should be pursued.

Assemblyman Goicoechea asked if most of the coalitions provided health care coverage for retirees. Ms. Cady said she did not know the answer, but it was her understanding that provision of retiree health care coverage was based upon whether it was promised.

Chairwoman Giunchigliani thanked Ms. Cady for her presentation, adding that she had peaked the interest of the Committee and had provided some interesting ideas.

VIII. SCHEDULING OF DATES AND LOCATIONS OF FUTURE MEETINGS.

Chairwoman Giunchigliani suggested that another meeting not be scheduled until after the Advisory Committee met in July, and hopefully a presentation from Kaiser could be scheduled in August or September.

IX. PUBLIC COMMENT.

Chairwoman Giunchigliani said she had received a letter concerning AB 286 from Michael Tobey (Exhibit E) that would be entered into the record.

Mr. Wilbert Brown, Retired Battalion Chief from the Sparks Fire Department, testified that in 2003 he received a letter asking him to complete a questionnaire if he was interested in joining PEBP. He had rejected the plan earlier because of the cost, but because the city of Sparks' insurance was getting more expensive, he completed and returned the

questionnaire. However, he was unaware that the city was obligated to pay a subsidy for his insurance. He later received additional paperwork, which included the subsidy notice. Several of his friends were then told they were ineligible because they had not returned the questionnaire, even though they were present during the open enrollment meeting.

Mr. Brown said that when he retired from the city of Sparks in 1993, he was promised that his insurance would never increase beyond its existing rate unless he received an increase in his retirement from PERS. He had been retired several years when he received notice of a drastic increase in his insurance and was informed that the Legislature had passed a law that retroactively nullified the promise from the city of Sparks. He said he had planned his retirement based upon the promise of no increased premiums, but he and many of his friends were forced to pay 40 to 50 percent of their pension to pay health insurance premiums. Mr. Brown noted he had not seen any notice of the subsidy until he received a notice to appear in Carson City to sign up for PEBP.

Now that he had switched to the state insurance, Mr. Brown wondered if the Legislature could decide at a later date to no longer require the subsidy from the city of Sparks. He was concerned he would find himself with the rug pulled out from him again. He had been told that he could not enroll in the city's plan again; he hoped that the state subsidy would continue as promised.

Chairwoman Giunchigliani asked if Mr. Brown was currently paying into the state insurance plan. Mr. Brown replied he was, and the amount was approximately \$250 more per month than he had been paying with the city. He could not understand why a short open enrollment period was scheduled and then there would never be another opportunity to enroll.

Chairwoman Giunchigliani replied part of the reason was to prevent participants from shopping around and changing plans frequently. The standard had always been that employees who opted out of a local government plan could not return. However, notice of the enrollment period should be longer than one or two months. She thanked Mr. Brown for his testimony.

Assemblyman Goicoechea asked Mr. Thorne if it was true that Mr. Brown's fellow retirees would not have the ability to shift from the city to PEBP because they had not opted to make the change in 2003. Mr. Thorne replied that for those who had retired prior to 1994, the buy-in open enrollment was conducted from September 2003 through the end of January 2004, and it was their last opportunity to do so. Local governments were required by statute to allow reinstatement to their programs in even-numbered years; however, those who retired prior to 1994 would not be allowed reinstatement in PEBP. Mr. Thorne added that there were no provisions in AB 286 relating to reinstatement rights for retirees into their former employer's plan, which was verified in the opinions from the Attorney General and the Legislative Counsel Bureau.

Assemblyman Goicoechea asked if adequate notice had been provided to the retirees. Mr. Thorne said the mailing had been sent from the Public Employees' Retirement Program to the few thousand retirees in that particular situation. PEBP received in excess of 900 inquiries and responded by sending packets out for potential biannual reenrollment, and a substantial number of retirees did enroll. Mr. Thorne said there was definitely an

awareness among the retirees; RPEN had conducted an extensive education campaign as well.

Assemblyman Goicoechea asked if the letter had stated they would be eligible for a subsidy from their respective local government or other agency if they were not state retirees. Mr. Thorne did not recall.

Mr. Bill Richards, Retired Fire Captain from the city of Sparks, testified that he had served 37 years with the fire service. He was a member of the city of Sparks' health committee for over eight years after his retirement, and he had received several calls from retirees concerning this issue. Mr. Richards said he did not recall receiving the letter from PERS; having been a member of the health committee, he would have examined it carefully. In his examination of previous letters concerning the state insurance, he had found the coverage not to be equal to that provided by the city as to either the cost or the benefits. Mr. Richards said the situation had changed drastically since the city had reneged on its obligation and promise that his insurance would not increase by any greater percentage than his PERS check.

Mr. Richards said he had received nine PERS' increases, and in twelve years he had gained \$17 in take-home pay due to the failure of the city to keep its promise concerning health insurance increases. He had sent a letter to Susan Scholley of the LCB Research Division in early May (Exhibit E), but he noted the figures in the letter were out of date. The cost of his health insurance had increased from \$712 per month by \$127. He had realized a \$1,527 total annual decrease in take-home pay since 2002.

Mr. Richards said he was not testifying only on his own behalf. He read a letter from Captain Val Judd (Exhibit G), a retired fireman who had moved to Idaho. Mr. Judd had made a trip to Carson City in 2003 to attend the open enrollment meeting, but he did not receive any further notices or correspondence; his phone calls were not returned.

In summary, Mr. Richards asked why there was a sunset on the open enrollment to change to the state health program for those who had retired prior to 1994. He did not recall any notification of the sunset date. He did not believe the notifications were timely or adequate, adding that many retirees left the area for the winter and might not have received the notice until after the deadline. He thanked Committee members for their time and indulgence.

Chairwoman Giunchigliani replied that staff would investigate the sunset question. She hoped the issues of notification and open enrollment periods would be revisited in the 2005 Legislative Session.

Chairwoman Giunchigliani asked if there was anyone else wishing to testify. Bob Atkinson reported that Carolyn McLeod had been present to testify but had to leave the meeting; she had submitted a letter for the record regarding A.B. 286 (Exhibit H).

Chairwoman Giunchigliani recalled that the Committee was to receive a ruling from the Attorney General concerning AB 286, but the opinion had not yet been received. It would be mailed to Committee members and Advisory Committee members upon receipt.

There being no further business to come before the Committee, the meeting was adjourned at 3:25 p.m.

Respectfully submitted,

Sherie Silva, Committee 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.