MINUTES OF THE
ADVISORY COMMITTEE TO THE
LEGISLATIVE COMMISSION'S COMMITTEE TO STUDY
THE PUBLIC EMPLOYEES' BENEFITS PROGRAM
(ACR 10, 2003 LEGISLATIVE SESSION)
April 21, 2004

The second meeting of the Advisory Committee to 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 9:30 a.m. on April 21, 2004, in Room 4412 of the Grant Sawyer Office Building, 555 East Washington Street, Las Vegas, Nevada. The meeting was videoconferenced to the Legislative Building, Room 4100, 401 South Carson Street, Carson City, Nevada. Exhibit A is the Agenda Packet and Exhibit B is the Attendance Roster.

ADVISORY COMMITTEE MEMBERS IN ATTENDANCE IN LAS VEGAS:
Nancy Howard, Chairwoman
Tim DeRosa, Vice Chairman
Peter Alpert, Teachers' Health Trust
Sue Brand, Retired Representative
Allin Chandler, Clark County Association of School Administrators (CCASA)
Sam Connally, University of Nevada-Las Vegas
Don Giancursio, Sierra Health Services
Robert Hadfield, Nevada Association of Counties (NACO)
Ann Hoskin, Retired Representative
James Ithurralde, Eureka County
Hal Keaton, Lincoln County
Scott MacKenzie, State of Nevada Employees Association
Rusty McAllister, Professional Firefighters of Nevada
Linda Nichols, University of Nevada-Reno
Walt Rulffes, Clark County School District
Woody Thorne, Public Employees' Benefits Program (PEBP)
Ty Windfelt, Hometown Health
Ben Zunino, Eureka County School District

ADVISORY COMMITTEE MEMBERS IN ATTENDANCE IN CARSON CITY:
Al Bellister, Nevada State Education Association (NSEA)
Doug Bierman, Intertech Services, Inc.
Kirk Brower, Humboldt County School District
Rick Kester, Douglas County School District
Tom Marshall, Washoe County School District
Geof Stark, Churchill County
Gary Wolff, Teamsters Local #14

ADVISORY COMMITTEE MEMBERS ABSENT:
Janell Carlos, Mineral County School District
Steven Cook, Mineral County School District
Laura Dancer, Washoe County School District
J. David Fraser, Nevada League of Cities & Municipalities

Ralph Jaeck, City of Reno
Bob Johnston, Retired Public Employees of Nevada
Terrance Marren, City of Mesquite
Daryl Moore, City of Henderson
Randy Waterman, City of Sparks
George Stevens, Clark County

LEGISLATORS PRESENT:
Senator Mark Amodei (Carson City)
Assemblywoman Chris Giunchigliani (Las Vegas)
Assemblyman Pete Goicoechea (Las Vegas)

STAFF PRESENT:
Mark Stevens, Assembly Fiscal Analyst, Fiscal Analysis Division (Las Vegas)
Bob Atkinson, Senior Program Analyst, Fiscal Analysis Division (Carson City)
Eileen O'Grady, Principal Deputy Legislative Counsel, Legal Division (Carson City)
Mary Alice McGreevy, Senior Deputy Legislative Counsel, Legal Division (Carson City)
Sherie Silva, Secretary, Fiscal Division (Las Vegas)

EXHIBITS:
Exhibit A – Meeting Packet and Agenda
Exhibit B – Attendance Roster
Exhibit C – Power Point Presentation – "Welcome to Enlightened Health Care – The City of Las Vegas Consumer Driven Health Plan" – Vickie Robinson, City of Las Vegas
Exhibit D – Power Point Presentation – "Employee Benefit Trends" – Robert Moore, ABD Insurance and Financial Services
Exhibit E – Letter from Robert Moore, ABD Financial Services

I. CALL TO ORDER AND OPENING REMARKS.

Chairwoman Nancy Howard called the meeting to order at 9:35 a.m. She thanked everyone for their attendance, noting that some members were located in Las Vegas and some in Carson City.

II. APPROVAL OF MINUTES OF THE MARCH 20, 2004 ADVISORY COMMITTEE MEETING.

ASSEMBLYWOMAN GIUNCHIGLIANI MOVED FOR APPROVAL OF THE MARCH 20 ADVISORY COMMITTEE MINUTES; MOTION SECONDED BY ASSEMBLYMAN GOICOECHEA AND PASSED UNANIMOUSLY.

III. APPROVAL OF MINUTES OF THE MARCH 20, 2004 MEETING OF THE FISCAL ISSUES WORK GROUP OF THE ADVISORY COMMITTEE.

BOB HADFIELD MOVED TO APPROVE THE MARCH 20, 2004 FISCAL ISSUES WORK GROUP MEETING MINUTES WITH TWO MINOR CHANGES; MOTION SECONDED BY WOODY THORNE AND PASSED UNANIMOUSLY.

IV. APPROVAL OF MINUTES OF THE MARCH 20, 2004 MEETING OF THE POLICY AND BENEFITS WORK GROUP OF THE ADVISORY COMMITTEE.

APPROVAL OF THE MARCH 20, 2004 POLICY AND BENEFITS WORK GROUP MEETING MINUTES WAS MOVED, SECONDED, AND CARRIED UNANIMOUSLY.

V. PRESENTATION BY CITY OF LAS VEGAS ON HEALTH BENEFITS PLAN OFFERED BY THE CITY OF LAS VEGAS.

Vicki Robinson, Manager of Insurance Services for the city of Las Vegas, proceeded to give a Power Point presentation entitled, "Welcome to Enlightened Health Care – The City of Las Vegas Consumer Driven Health Plan" (Exhibit C).

Ms. Robinson explained that, like every other county and municipality in the country, over the last few years the city of Las Vegas had faced increasing costs for its self-insured health plan. It was decided by the city's insurance committee, which was made up of three management and three union representatives, to pursue other options, e.g., buying a fully insured plan. One of the committee's concerns was that employees did not understand the actual costs of health care, and after the committee looked at several different vendors, it was decided to choose a consumer-driven health plan, Lumenos, Inc., which was a very different kind of plan.

Ms. Robinson defined a consumer-driven health plan as a plan in which employees spent money from an employer-funded Health Reimbursement Account (HRA) to pay for routine health care expenses, but were covered for serious injury or illness by a high-deductible insurance plan. It was the city's goal to have employees become conscientious consumers and to understand the actual costs of medical care; consumer-driven plans were currently the fastest growing market segment in health care.
Ms. Robinson described the city's plan:

- The city paid the initial portion of the deductible.
- Employees were provided with a Health Savings Account (HSA), from which they would purchase medical care until a designated cap was reached. The employees would then pay a deductible, then coinsurance of 90/10, up to a maximum out-of-pocket amount.
- Monies in the HRA that were not spent could be rolled over into the following year's account and added to that year's allocation. Monies left in the account at the time of retirement could be used for retiree health care.

Continuing, Ms. Robinson cited the benefits of the plan:

- Employees had a **choice** of any doctor – no referrals or pre-approvals;
- Employees and their doctor **controlled** what services were received;
- Employees could **save** because there were no out-of-pocket costs when using the HSA, plus what didn't get used, rolled over for future health needs;
- Employees had **protection** for all the health care needs that were covered under other plans – from minor illnesses to major medical conditions; and
- Employees had access to **personalized tools and resources** that promoted "well" behaviors and helped them to make wise health care decisions.

Before this plan was chosen and a vendor selected, Ms. Robinson talked to six different corporations that

had implemented the plan, and all indicated that their employees were very satisfied with the plan, the provider, and the third-party administrator. To date, 60 to 70 percent of enrollees in consumer-driven health plans have had money left in their Health Savings Accounts to roll over into the next year.

Ms. Robinson conceded that it could not yet be stated that the plan would save the city money, but a study released by Aetna in February revealed the company had seen dramatic drops in increases in medical care costs, as well as increases in preventive care visits.

Referring to page 6 of Exhibit C, Ms. Robinson reviewed the structure of the Lumenos Program:

- Health Savings Account (HSA):
  - Annual allocation from city of Las Vegas;
  - Pays 100 percent when funds are available;
  - Use it on HSA extras.
- Bridge:
  - Employee's responsibility if expenses exceed the annual HSA allocation;
  - Paid only as expenses are incurred;
  - Can be reduced or eliminated by HSA rollover.

- Traditional Health Coverage:
  - Additional protection covers the services allowed by the city;
  - 90% discount;
  - 70% non-discount;
  - 100% coverage after out-of-pocket max.

Ms. Robinson went on to say that preventive care was covered 100 percent; every employee and dependent was provided with $500 worth of Lumenos benefit that could be spent on annual physicals, baby well check-ups, shots, etc. This benefit was an incentive for employees to practice preventive health care.

Assemblywoman Giunchigliani asked if the preventive care allowance was in addition to the Health Savings Account, and Ms. Robinson replied it was.

Continuing, Ms. Robinson explained that the city of Las Vegas had always provided free health coverage to its employees, which did not provide any employee incentives; however, under the Lumenos plan, incentives for good behavior were provided through payments to the employee's HSA account, i.e., $100 for completing My e-Checkup, $50 for each employee or dependent accepted to the Personal Health Coach program, and $100 for each employee or dependent graduating from the Personal Health Coach program.

There were no limits on the amounts that could be rolled over into the employee's Health Savings Account, and the savings could be used to reduce or eliminate the employee's bridge for the next year; cover coinsurance up to the out-of-pocket maximum; or purchase HSA extras, e.g., smoking cessation or weight loss programs.

The network used by Lumenos and chosen by the city of Las Vegas was called PHCS, which was a national network that allowed the city employees to receive services throughout the country. Ms. Robinson encouraged Committee members to visit the Lumenos provider network website: www.info.Lumenos.com (User Name: lasvegas; Password: lasvegas.321) or www.PHCS.com. She detailed the services offered by the website (pages 14-18, Exhibit C):

- Personalized Health Resources
- Health Tools

- Doctors Plus Directory – Doctor and Hospital Information
- Doctors Plus Directory – Prescription Drug Costs
- Tracking Your Account

Ms. Robinson then reviewed two employee coverage scenarios (pages 11 and 12 of Exhibit C), and the last portion of her presentation consisted of answers to commonly-asked questions. She noted that since adopting the consumer-driven health plan, the city of Las Vegas had seen a surge in employee education. Employees were genuinely understanding the actual costs of medical care and were questioning the need for tests and seeking lower-cost alternatives. She added that the plan was complex and required a substantial amount of training, but once that was completed, the transition was seamless. Over 60 percent of the city's employees had selected the consumer-driven plan.

Ms. Robinson thanked the Committee for the opportunity to speak, and she offered to answer any questions.

Chairwoman Howard thanked Ms. Robinson, and said she would like to personally applaud the city of Las Vegas for taking a risk. There were very few government entities in the country that had taken such a large step. Ms. Robinson remarked that the city of Las Vegas was the second governmental entity in the country to adopt a consumer-driven health plan; Anchorage, Alaska, was the first.

Chairwoman Howard said the Nevada League of Cities had had an insurance plan for over 30 years that involved multiple local entities, and the League was considering a consumer-driven plan for the future. The group, though on a smaller scale, was not too different from the state as far as demographics. She wondered how employees scattered throughout the state would be educated in such a complex plan.

Ms. Robinson replied it would involve a tremendous education process. However, once some employees grasped the concept, they then would become the trainers for other employees. Consumer-driven plans had only been in existence since 1999, but the city's third-party administrator (TPA) had indicated that enrollment was increasing each year. She said although the website was a wonderful teaching tool, it was important to have one individual explain how it worked.

Tim DeRosa, Business Benefits, Inc., said he had been in the insurance business for 24 years and had spent some time studying consumer-driven plans, and he noted there had been limited experience nationally with this type of delivery system. He asked if there was any evidence from Lumenos suggesting that there were potential issues in the future concerning employees making wrong decisions on the care and testing they received and the potential liability to the provider.

Ms. Robinson replied that since the city of Las Vegas had been self-insured, it had contracted with an on-site nurse case manager for the PPO plan, and that manager was also being utilized for the Lumenos plan. She explained the only pre-authorizations needed were for hospitalization or gastric bypass surgery, and both situations were an immediate trigger for services of the nurse case manager. The manager was also available for any large cases that were identified when the city moved to the Lumenos plan, and Lumenos had agreed that future cases identified through large billings would also be referred to her. Ms. Robinson concurred that employees could probably make bad decisions, but the city's intent was for the case manager to assist them in good decision-making. She pointed out that employees could also make bad decisions under the general PPO plan.

Mr. DeRosa asked if the difference in the decision-making process in the current PPO and the Lumenos plan was that the employee was faced with a potential significantly greater amount of out-of-pocket expense. Ms. Robinson replied that was not true; the out-of-pocket provisions for the two plans were virtually identical.

Mr. DeRosa clarified he did not mean in the aggregate; he meant on a case-by-case basis. For instance, he

said that Ms. Robinson had cited a case when an employee had indicated he would not have any tests done until he knew how much it would cost him. In the PPO plan, Mr. DeRosa surmised that would have not been a factor, and the tests would have been done.

Ms. Robinson replied the cost of the tests would have come from the employee's HSA account and therefore would not have been out-of-pocket. She asked if Mr. DeRosa's concern was that people would not receive the care that they needed. Mr. DeRosa replied that was his question; he wondered if it would be possible that liability would come back, particularly since the nurse case manager was employed by the city, and the nurse may or may not have been of help. Would the city be responsible for the fact that a decision was made to not have the test and the person now had significantly greater medical bills?

Ms. Robinson responded that an employee in the city's PPO plan could also make the decision to not have a test done. It was just a matter of making good choices.

Mr. DeRosa asked if there was anything that the consumer-driven plan had that a fully-insured plan could not do. Ms. Robinson reiterated that selection of the plan was an insurance committee decision, and she did not serve on the committee. However, the insurance committee had looked at the city's insurance plan and determined that the employees were not making good choices; they did not seem to care about using generic drugs versus brand name drugs; and they genuinely believed that it cost $10 to go to the doctor. The committee believed the best way to combat these issues was to look at an alternative plan that would educate employees to be good consumers. Ms. Robinson said the city was not claiming the plan would save a substantial amount of money or would be the end-all be-all of insurance plans. It was an alternative decided upon because it seemed to be the next logical step.

Assemblywoman Giunchigliani asked if the major difference between the consumer-driven plan and a fully-insured plan was that the employee would make more decisions in the process. Ms. Robinson replied that other entities with the consumer-driven plan had indicated the major difference was they were not seeing the rises in costs that they had experienced when they were self-insured. The city's goal was to either reduce costs or slow escalation of the costs and to educate employees and make them happier and more satisfied.

Assemblywoman Giunchigliani asked if the plan had a built-in cost-of-living adjustment (COLA). Ms. Robinson replied that the insurance committee would review the plan annually; a COLA was not presently in the plan. Obviously, five years from now, it might be necessary to make adjustments.

Assemblywoman Giunchigliani asked how the city dealt with the collective bargaining agreements. Ms. Robinson said half of the members of the city's insurance committee were collective bargaining members; nothing was done without the encouragement of the union. It was a partnership effort.

Assemblywoman Giunchigliani asked if the benefits were taxed or if there was any prospect of them being taxed in the near future. Ms. Robinson replied benefits were not presently taxable, and she had not seen any indications of changes in the future.

In response to a question from Assemblywoman Giunchigliani, Ms. Robinson said all of the hospitals in Nevada were on the PHCS network, as well as clinics in southern Nevada and St. George, Utah. The city's plan did not have a need for many services in rural Nevada, but the PHCS network had been good about adding providers.

Assemblywoman Giunchigliani asked if an employee could retire from the city, work five years for another entity, and still collect his accrued HSA rollover for retirement. Ms. Robinson replied the only time an employee could use the rollover would be upon permanent retirement.

Assemblywoman Giunchigliani asked if the city had a plan for retirees. Ms. Robinson explained the retirees could continue to participate in the Lumenos program, but they would be paying the full premium. If a retiree chose to participate in PEBP, the city would pay the retiree's subsidy, in compliance with AB 286.

In response to another question from Assemblywoman Giunchigliani, Ms. Robinson explained that Sierra HPN was an HMO option fully funded by the city as a separate plan. The third-party administrator for the consumer-driven health plan was Lumenos; Southwest Administrators was the third-party administrator for the other PPO plan.

Sue Brand asked if the city was keeping statistics on employee wellness programs. Ms. Robinson replied the plan had only been in existence since March 1, 2004, but statistics were being kept on the number of employees who had accessed the nurse coaches and taken the e-Checkup. She explained the wellness program was a separate program to be handled by the wellness coordinator. She hoped that good statistics would be available within a year or two.

Ms. Brand asked if the contract with Lumenos was a multi-year agreement, and Ms. Robinson replied the contract was for two years.

Ann Hoskin, retired teacher, asked if previously retired city employees had access to the Lumenos plan. Ms. Robinson replied the plan was not offered to current retirees because of the extensive education that was required. The decision was made at the last insurance committee meeting that Lumenos would be offered to retirees during the next open enrollment in October 2004.

Ms. Hoskin asked if the plan would be offered to those retirees who had moved out of state. Ms. Robinson replied it would.

Rusty McAllister, Professional Firefighters Association, asked if the city made a per-member per-month contribution to Lumenos. Ms. Robinson replied the city paid Lumenos as a third-party administrator per-member per-month – the same as Southwest Administrators.

Mr. McAllister asked if each employee in the City Health Insurance Plan (CHIP), the PPO plan, paid a certain amount. Ms. Robinson answered that the employees did not pay anything for any health plan – Lumenos, HPN, or CHIP. They paid 50 percent of their dependents' coverage.

Mr. McAllister clarified that even though the employee did not pay a premium, participation in the CHIP program was considered a benefit, and he wondered how the cost per month compared with the Lumenos plan. Ms. Robinson explained the cost of administration of the Lumenos plan was significantly higher than the cost of administration of the PPO plan due to the additional services provided, e.g., website, nurses, health coaches. In addition, at the time the city was considering a new plan, the selection of consumer-driven health plans was limited, but it was her understanding that by 2006, there would be local agencies providing this type of coverage.

Mr. DeRosa affirmed that the Lumenos plan was still a self-funded plan, as was the PPO, so the city's risk remained the same with either plan. Ms. Robinson said the actuaries advised that the premiums paid by dependents and the premium-equivalents were almost identical for both plans, based on projected losses.

Mr. DeRosa asked if the cost for dependents, on a payroll-deducted basis, was more or less for the Lumenos plan than for the PPO or the HMO HPN plans. Ms. Robinson replied Lumenos was slightly less than the PPO plan, and significantly more than the HMO cost.

Mr. McAllister asked if a person retired, started collecting from PERS, then engaged in other employment

with health insurance, whether he could lock up the benefits he had accrued with the city of Las Vegas and return to that plan after a period of time. Ms. Robinson did not know; she had never been asked that question. Mr. McAllister said it appeared one of the concerns of the Committee was the ability for an employee to return to the plan after an absence. Ms. Robinson replied the employee would certainly be able to return; however, if he had accumulated an amount in his Health Savings Account, she was not certain whether that amount could be banked. She would consult with the insurance committee and the finance director.

Mr. McAllister noted the city's CHIP program had a dental and vision provision; he asked if the Lumenos plan included those plans. Ms. Robinson replied the dental and vision plans were separate from the CHIP plan; the same dental and vision plans were available to participants in all three health plans, i.e., Lumenos, HPN, or CHIP. The premium equivalents were identical.

From Carson City, Gary Wolff, Teamsters Local #14, asked how many employees were insured by the city of Las Vegas. Ms. Robinson replied approximately 2,200 employees were in the three different insurance plans. Mr. Wolff asked how many were insured, including dependents, and Ms. Robinson indicated that the total was about 4,400.

Mr. Wolff asked what the cost per employee was to the city of Las Vegas. Ms. Robinson explained that since the city was self-insured, the amount fluctuated from month to month, but would average between $600 and $700 per month. Mr. Wolff asked if that included the 50 percent contribution for dependents, and Ms. Robinson replied it did not. The net would be less because premiums were collected from employees for dependent coverage.

Mr. Wolff asked what a city employee's monthly cost would be to retain the Lumenos plan upon retirement. Ms. Robinson replied the current premium for the retiree only would be $409.49 per month, and the premium for the retiree and spouse would be $790.31. The CHIP plan would be slightly more expensive. The premiums were reduced significantly for Medicare-eligible retirees.

Don Giancursio, Sierra Health Services, commented that the city of Las Vegas had taken a progressive approach in trying to empower employees. It was still a new program, and he didn't think it was a panacea in terms of overall cost reduction, but he believed it was a positive step. He asked if the two-year commitment from Lumenos applied only to the third-party administrator portion of the contract, and Ms. Robinson replied it did. She reiterated that in January 2005, an actuary would look at the expenses and make a determination as to what the premium equivalents should be.

Mr. Giancursio affirmed that retirees paid the full cost of their coverage, as opposed to an active employee who paid nothing, and Ms. Robinson replied he was correct.

Assemblyman Goicoechea said he understood that under AB 286, local governments would be allowed to subsidize any plan as long as it did not exceed the amount paid to PEBP. It seemed to him that it would be less expensive for the city of Las Vegas to allow retirees to stay in the city's plan rather than to subsidize the retirees under PEBP. Ms. Robinson said when the city first learned that AB 286 was a reality, it was determined that it would cost the city less money if retirees elected coverage under the PEBP plan, even with the subsidy. If a retiree elected coverage under PEBP, the city paid the subsidy; if an employee chose to stay with the city's plan, there was no subsidy and the retiree paid the premium, but the city's self-funded plan was responsible for the health care costs.

Assemblyman Goicoechea still maintained that it could be less expensive if the city paid a portion of the subsidy and allowed retirees to stay in the city plan. Ms. Robinson replied that was true, but then it would be much more expensive to the taxpayers of the city of Las Vegas and the state in general because the city's

self-funded plan would be absorbing the cost. She stressed that AB 286 was very expensive.

Assemblywoman Giunchigliani said she thought Assemblyman Goicoechea was saying that it would not be necessary to shift the retirees to the state plan; it would actually be less expensive to retain them in the city's plan and provide the subsidy.

Ms. Robinson replied if the city paid a subsidy, it only paid the required subsidy, and the retiree was fully insured under PEBP. Any time the retirees remained in the city's self-insured program, it would be more expensive to the city; even if the city subsidized retiree participation, it would cost the city more. She said the city would encourage the retirees to shift to PEBP.

Assemblyman Goicoechea affirmed that it would actually cost the city more to cover retirees under its self-funded plan. Ms. Robinson explained that until passage of AB 286, the city's retirees were charged a different premium than the active employees, which reflected their actual usage of the plan, and thus the premiums were significantly higher than for active employees. Under AB 286, the rates for actives and retirees were pooled together.

Allin Chandler, Clark County Association of School Administrators, questioned the statement that when a local government paid a subsidy, it could not exceed the PEBP subsidy. It was his understanding that it could not exceed what was being paid to employees of the local entity; the subsidy was not tied to PEBP. Secondly, the PEBP subsidy was $280 for those who retired prior to 1994, and it could be greater for those people who had 20 years of service, up to $386.

Chairwoman Howard remarked that under the structure of AB 286, it was her understanding that a subsidy was being paid, even if the retiree stayed in his current plan, because actives and retirees would have to be pooled together. Ms. Robinson agreed, adding that one of the reasons the premium equivalent rates for employee dependent coverage had increased in the current year was that the past experience was pooled, and the retirees saw a significant reduction in their CHIP premiums, based on the fact they were now being subsidized by all of the active employees paying dependent premiums. The city of Las Vegas was paying more as well.

Chairwoman Howard asked what the rate increases were, and Ms. Robinson said she did not have the exact numbers, but they were considerably more. Mr. DeRosa requested that she provide that information to the Committee, and she agreed to do so.

Addressing Assemblyman Goicoechea, Peter Alpert, Teachers Health Trust, observed that the conversation seemed to always revert to AB 286. He believed focus needed to be placed on two words: (1) mandatory wording of AB 286, which said that all local government employers must contribute to PEBP if the employee elected that plan, and (2) local government employers may contribute to their own plan, which was not mandatory. In either event, Mr. Alpert pointed out, both stipulations were unfunded, which he felt was the crux of the problem.

Assemblywoman Giunchigliani added that AB 286 mandated commingling active employees and retirees, which had an impact on the costs for active employees. During the 2003 Legislative Session, one of the issues was that service in public employment was service, regardless of whether it was as a teacher, an administrator, etc., and that those years of service should equate into some funding for insurance coverage – not anticipating the full cost, but some offset for those years of experience. She explained the state provided retiree insurance based on years of service; not all of the local governments did. She suggested the Committee may want to consider that issue when making final recommendations.

Continuing, Assemblywoman Giunchigliani recalled another issue during the session was that many of the local governments were putting their retirees into the state plan and paying no subsidy at all. It was felt there

should be a mutual responsibility with the local government entities. She said the Committee should consider how funding should be provided for all retirees in acknowledgement of the years dedicated to public service.

Assemblywoman Giunchigliani noted that the state had one public employment retirement system, and it might be desirable to consider one statewide health plan to be funded mutually by all the various groups. However, she cautioned that the design of a statewide program would need to be studied to insure it would include the components necessary to accommodate the state's diversity. A statewide plan would need to consider the differing needs of the rural areas, as well as the differences between the northern and southern parts of the state.

Woody Thorne, Executive Officer, Public Employees Benefits Program, commented that there was an initial $5 million per year fiscal note on AB 286, which was for the additional state cost due to commingling of the state and non-state participants into a single pool. The commingling would lower the retiree costs and increase costs for the active group. He recalled the fiscal note was removed when the bill continued the separation of the pools into a state pool and a non-state pool. Mr. Thorne said that who paid for it was a funding issue, but the intent of AB 286 was still to provide affordable coverage for retirees. There was a requirement in the law that the local entities should provide coverage for their retirees, which they should have been doing since 1967. That provision was mandated but was being ignored, and now it had come to light as a result of legal opinions issued on AB 286.

Mr. Thorne said the PEBP Board had heard presentations on the consumer-driven health care plans early in 2003 and had conducted continuing conversations with Lumenos. The biggest concern in this arena was that in order to be effective consumers of health care, participants must have information, and that was a resource that had been relatively lacking until the last 18 months or so. Mr. Thorne suggested that there be a mandatory reporting of outcomes and the state should provide a mechanism for collecting that information. The state of Pennsylvania had implemented such a program, which had been very successful, with some surprising results.

One of the PEBP Board's concerns with the consumer-driven health care plan was the cost issue. Mr. Thorne had attended a consumer-driven health care conference, and there was general agreement that 2005 would be a threshold year for gaining critical mass for these products and also critical mass for the information delivery that people needed to have in order to make effective use of consumer-driven health care plans. He said that conceptually, the plans were very attractive; he received only positive responses from employers who had adopted them, and they all experienced growth in participation in the second year of the plan. Since the plan was an employer-sponsored plan, the question would be how to administer it as a multi-employer group. To his knowledge, there had been no Governmental Accounting Standards Board (GASB) rules developed as to how to account for the growing liability of the rollover and accumulation, particularly if the rollover was allowed for retirement benefits. He asked Ms. Robinson if she had received any feedback on that aspect of the plan.

Ms. Robinson replied the city finance director was pursuing that question, but she did not know the status.

Chairwoman Howard suggested the Committee schedule presentations from other consumer-driven health plans that had been in existence for longer periods in order to receive more information. Ms. Robinson said that Lumenos and Definity were the two niche markets; Aetna was also in the market and there were other insurers pursuing similar plans.

Don Giancursio, Sierra Health Services, said a consumer-drive health care program had been developed which emulated this model and was an HRA on top of a high deductible health plan. There were other companies marketing similar programs, Aetna and Humana being two, but Definity and Lumenos were the

pioneers in terms of breaking ground in this product area.

Kirk Brower, Humboldt County School District, asked for clarification regarding the Lumenos personal health care website; he wondered if it was the employee's obligation to input the information and keep the site up-to-date. Ms. Robinson replied that would be the employee's option; it was just a tool that was available.

Mr. Brower asked if feedback had been received concerning the site, and Ms. Robinson said that she was surprised that employees in the field were actively using these websites. Mr. Brower asked if Lumenos used the information, and she answered that the information was accessible by the employee only.

Senator Amodei remarked that two other issues needed to be focused upon:

1. To the extent that the state would become the provider of last resort for retirees, there could be a serious impact on premiums. He believed that the Legislature recognized that the state pool was weighted with the influx of non-state retirees and policy decisions would need to be made to address the issue. How do you build a system that is weighted in a reasonable fashion instead of being the primary repository for retirees in the state?

2. The policy decision had been made that the state would do everything possible to provide retirees with some value of health care insurance. Senator Amodei suggested that the 2005 Legislature would not seriously evaluate how to maintain the status quo of the past in terms of allowing retirees to enter the PEBP plan and worry about the cost later. The focus would need to be where to go from here and what would be the responsible way to go. He hoped there would be some forward thinking rather than dwelling on mistakes of the past. The objective should be how to get the plan where it needed to be.

Ms. Robinson remarked that she had not yet heard mention of other instruments that would allow employees to save money tax free for their retirement health care, i.e., retiree health savings accounts. The city of Las Vegas was currently setting up a system to allow employees to funnel excess funds from sick-leave buyout or annual leave when they retired to a retirement Health Savings Account, which would be treated similar to a flex plan, i.e., the employee would pay for his health care and get reimbursed from tax-free money. Ms. Robinson said there were many creative innovations that could be considered to assist employees in funding their own health care. They needed to understand how much health care really cost and that it was something they should save for. She emphasized that health care was not going to get any cheaper, so employees needed to be encouraged to participate and save on their own.

There being no further questions of Ms. Robinson, Chairwoman Howard thanked her for her presentation and moved to the next item on the agenda.

VI. PRESENTATION ON CURRENT TRENDS IN HEALTH BENEFIT PROGRAMS OFFERED BY EMPLOYERS.

Mr. Bob Moore, Vice President of ABD Insurance and Financial Services, explained that his company handled employee benefits consulting and brokering for 23 public employee organizations in the state of Nevada, representing approximately 12,000 employees. (See Exhibit D for his Power Point presentation.)

Before discussing employee benefit trends, Mr. Moore said he would like to talk about cost drivers and what employers were doing to react to them. Many things were driving costs in the health care system, but Mr. Moore cited the five principal drivers:

- Legislative and Regulatory Issues;
- Aging Population;

- Medical Technology;
- Health Care Utilization; and
- Governmental Cost Shifting.

Mr. Moore said the last 20 years had seen a flurry of activity in the legislative regulatory area (listed on Page 4, Exhibit D). One of the most profound changes had been the enactment of the Health Insurance Portability and Accountability Act (HIPAA). HIPAA had done a lot of good things from a public standpoint, but they were all expensive, e.g., the mental health parity act, the elimination of pre-existing conditions. In addition, Mr. Moore continued, the new privacy rules had a huge economic impact, requiring dissemination of much information and forms. Mandated benefits had been very costly, and tort reform had been a very contentious issue in Nevada.

Aging of the population had created a greater preponderance of aged workers in the workforce and a greater preponderance of retired workers. Forty percent of state workers were eligible to retire within the next five years, which was a staggering statistic. Along with aging would come increased morbidity, Mr. Moore remarked all of these issues were driving costs, along with medical technology, which was also very expensive.

Mr. Moore characterized medical technology in two terms:

- Hard Technology – Example: Stereo Tactic Radio Surgery (non-invasive).
- Soft Technology – Revolved around new pharmaceuticals and new therapies.

With new technology and new therapies would come high utilization. Mr. Moore noted that the stereo tactic radio surgery was previously made available to an estimated 8 out of 1,000 people, but now that it was more available, an additional 40 people would utilize it.

Continuing, Mr. Moore remarked Nevada had its own unique lifestyles, i.e., smoking, epidemic of obesity, and general state of unhealthiness. These characteristics were also substantial cost drivers.

With regard to governmental cost shifting, i.e., Medicare and Medicaid, Mr. Moore said that hospitals received about 30 percent on the dollar; the other 70 percent was passed on to insurance companies and private employers through self-funded plans. Since Medicare and Medicaid were not paying the bills, those costs were being shifted to the private plans, whether they were fully-insured or self-insured.

Mr. Moore reviewed employer reactions, both in the private and public sector, to the cost drivers:

- Cost Shifting
- Wellness Programs
- More Plan Flexibility
- Consumer Driven Health Plans
- Deeper Utilization Management
- Irrational Benefit Behavior

Cost Shifting: Employers were requiring employees to make greater contributions, not only for their own coverage, but for their dependent coverage as well. They were reducing benefits, implementing higher deductibles and higher co-insurance limits, cutting back on benefits, increasing the waiting periods for new hires, adopting defined benefit strategies, adopting buy-up options, FSAs, and offering voluntary benefits, e.g., dental and vision.

Wellness Programs: A lot of plans were spending time and money looking at wellness programs within the constraints imposed by ADA and HIPAA. Wellness programs included incentives and disincentives, smoking cessation programs, hypertension management programs, cholesterol management programs, weight loss programs, and specific disease management programs. Mr. Moore said the most aggressive, creative, and innovative wellness program in Nevada had been adopted by the Washoe County School District. The district's wellness program was a national award winner, which he suggested the Committee might want to consider.

Increased Plan Flexibility: Multi-option options, i.e., HMO, PPO, and POS, in combination with an array of cafeteria plan approaches; pre-tax voluntary benefits; and FSAs.

Consumer-Driven Plans: Innovative new approach.

Deeper Utilization Management: People were looking at the data harder and deeper. Where the costs and what were could be done to deal with them? Programs were adopting more aggressive disease management programs and predictive modeling.

Irrational Benefit Behavior: A lot of small employers were beginning to self-insure their accounts with absolutely no knowledge of the implications. They were unable to get a good fully-insured proposal because of their poor claims experience, so their solution was to be self-insuring. Some small employers were self-insuring their plans with complete disregard for the financial implications of doing so, and some were completely terminating their benefit plans, which was a real problem for the state because those employees eventually would end up on the Medicaid rolls.

In conclusion, Mr. Moore remarked that his presentation was a brief overview of what was going on in the health care insurance industry, and it was not a pretty picture.

Chairwoman Howard said she had received a letter from Mr. Moore (Exhibit E), in which he had discussed different trends and potential solutions. She asked him to address the contents of his letter.

Mr. Moore said the letter contained his rambling thoughts on solutions to what he perceived to be an impending "train wreck." The population was getting older and the retiree group was exploding. In 1980, the typical public entity group had about 11-12 percent retired members, and now that number was 20-25 percent. If it was true that 40 percent of the state employees were going to retire within the next five years, the situation was alarming. Mr. Moore stressed the time to address the issue was absolutely and positively right now, but there were social issues that the policymakers would need to deal with:

- Should a public employer provide a health benefit to a retired employee? The answer was probably yes, in some fashion.

- How would it be paid for? Currently, the system was on a pay-as-you-go basis, which in his judgment did not have much of a future.

- A proposal was made in 1991 to prefund retiree health benefits through a PERS contribution, which Mr. Moore believed made sense. A one percent PERS contribution on the state's payroll would provide a substantial fund to create a retiree program in which all public employees, upon retirement, would be part of a special prefunded retiree program. He remarked that it was obvious to him that the pay-as-you-go system that had worked adequately for the past 40 years was not going to work in the future.

Mr. Moore stressed that unless action was taken fairly quickly, coverage for retirees was going to be

absolutely unaffordable.

Assemblywoman Giunchigliani noted that discussion had been held during the 2003 Legislative Session about reviewing the 1991 study. It seemed to make sense that the Committee should study the possibility of prefunding retiree health insurance for PERS members. She asked Mr. Moore to explain funding of post-retirement benefits as a liability under GASB.

Noting that he was not an expert on GASB, Mr. Moore replied that AB 286 mandated that claims experience for actives and retirees must be blended. Under GASB, the employer would not report the implicit cost liability, but would instead report the explicit cost, which would be an astronomical sum.

Bob Hadfield, Nevada Association of Counties (NACO), commented that it was critical to understand the cost transfer on what Medicaid and Medicare paid physicians and hospitals. It was often overlooked. When the federal government said it was reducing costs in the Medicare and Medicaid programs, that cost reduction would have to be made up somewhere else for the hospitals to recover the real costs. To this extent, the state and counties must also look at what they paid for the medically indigent. Doctors' education was more expensive, drugs cost more, the nursing shortage was a problem, and salaries were rising; these costs would have to be made up somewhere. Mr. Hadfield stressed that these issues must be considered when trying to fix any of the problems.

There being no further comments or questions for Mr. Moore, Chairwoman Howard thanked him. She then declared a ten-minute break.

VII. DISCUSSION OF METHODOLOGY FOR STUDYING AND MAKING RECOMMENDATIONS ON THE ITEMS ENUMERATED IN ACR 10 (2003 LEGISLATIVE SESSION), INCLUDING THE ESTABLISHMENT OF TIMELINES FOR EACH ITEM.

Chairwoman Howard opened Agenda Item VII for discussion. The first charge of the Advisory Committee in ACR 10 was as follows.

> *An examination of the methods used for determining premiums, equitable employee contributions based on actual costs to the state and coverage for active and retired state and non-state public employees and their dependents.*

Assemblyman Goicoechea asked if Mr. Thorne could discuss the surplus in the PEBP plan and its impact on future premiums. He had heard that the state rates would be reduced.

Mr. Thorne said the plan was currently in the low end of the cycle for large claims, with a minimum 20 percent drop in the number and amount, which had generated a significant surplus in the current year. Large claims over the past two years had run much higher than was typical for a group the state's size, and now they were running much lower than was expected. Mr. Thorne said that overall, based on the predictive modeling used by AON Consulting, a 3.5 percent increase was projected for the plan year beginning July 1, 2004, which amounted to 6.5 percent of the state portion and a reduction on the non-state group. Also, for the first time, the commingling of the non-state, retiree, and active employees was causing a reduction in the rates for the retirees. The combination of a significant increase in the number of retirees as a result of AB 286, in conjunction with the commingling, had resulted in a substantial reduction in the cost of a non-state retiree to participate in the plan.

Mr. Thorne said it had been projected it would take four years to restore the Incurred But Not Reported (IBNR) reserves; however, that was accomplished in one year. The PEBP Board was working to establish a four-year plan to fund a contingency reserve. If the plan year 2004 contribution levels had been

maintained, the plan would have generated another $19 million in surplus. However, the Board adjusted the required contribution levels downward in order to bring the surplus down and tie in with building a contingency reserve over the next several years.

Continuing, Mr. Thorne explained the PEBP Board and staff wanted to generate a contingency reserve, which would provide a method of leveling out the cost increases such as had been experienced the last two years. It was the Board's desire to be able to ride out cost fluctuations for a biennium and deal with them in the normal budgetary process, as opposed to what was required in the 2002 Special Session.

Mr. Thorne said it was unknown how long the lull in large claims would last – it was the most unpredictable part of the insurance business. He reiterated the Board was attempting to implement a mechanism to deal with rises in the future. He anticipated that increases would continue to be in the double digits over the next biennium, probably in the 12-16 percent range.

Ms. Brand remarked that she was confused; even though Mr. Thorne's comments were important, she thought the Committee was discussing methodology.

Chairwoman Howard replied the information related by Mr. Thorne provided a background of where the PEBP Board was at the present time. The Committee's task was to establish future methodology and timelines for implementation.

Ms. Brand questioned the procedures to be followed by the Advisory Committee. Chairwoman Howard explained the Advisory Committee had broken into two work groups at the last meeting and had gone through the process of discussing the various tasks of the Committee. Each group had developed suggested priorities, but no timelines or methods for reaching those goals were established, which was the goal of the Advisory Committee at this meeting. She asked for suggestions from the members with regard to the first item in ACR 10.

Ms. Brand agreed the items needed to be broken down into components and timelines needed to be determined. However, she wondered if there was a more expedient manner in which to accomplish those tasks.

Assemblywoman Giunchigliani suggested that timelines be established for the items for which there were not yet answers. For example, it had been suggested that some form of prefunded retiree premiums should be pursued. She requested that an actuarial study be completed to determine what percentage of payroll would have to be committed, possibly a certain percentage for retirees currently in the plan and the remainder for prefunding of future retiree premiums. Assemblywoman Giunchigliani pointed out that a decision could not yet be made due to the lack of information, but she thought it was time to recognize that this option might be a possible method to deal with retiree cost increases. The Legislature would then have to make a policy decision. In summary, it was necessary for the Committee to obtain more information before making solid decisions and recommendations.

With regard to the first item, Assemblywoman Giunchigliani said she did not have enough knowledge about how the methodology worked to establish a premium. She asked Don Giancursio to explain how a premium was developed.

Don Giancursio, Sierra Health Services, replied that the basic elements of building a premium were dependent upon the company, its contracting methodology, and whether it was an experienced-rated program or a pooled program. Sierra Health's model was a community-rated model entirely based upon a concept of pooled coverage. Plans were filed with the state that had base rates, and the variables within the group varied from group to group, e.g., the age and sex composition, the demographic make-up,

number of families, etc. Mr. Giancursio further explained that once the calculation was completed, a manual rate to be quoted to a prospective buyer would be developed. The rates would include the cost of delivering coverage and a retention component - a component to cover the administrative cost of the program. Mr. Giancursio said the basic mechanics were probably the same, whether for an insured or self-insured plan. A self-insured plan would include the fixed expenses to operate the plan and projected claim costs. The same approach would be employed by the carrier community, i.e., expected claim costs attached to the fixed expenses. He said the best way to differentiate how Sierra Health approached pricing as opposed to most of its competitors was that the company used a community-rated product, i.e., an experience-rated product where the actual claims of the particular population were used to determine future costs based on the benefits selected, etc.

Mr. DeRosa said he would submit that there was a lot of material to be covered and discussed over a lengthy period of time, but if the goal was to look at alternatives and compare them to what was in place, the first step in the process should be to build a relatively straight-forward design model. The model could be as simple as that which was already in place for public employees, and a request for proposal (RFP) could be created and sent to the various insurance companies that would be interested in looking at fully insured plan designs and ask them to submit proposals. The proposals and plan design could be compared to the existing plan and modified as necessary.

Mr. DeRosa said designing a plan could be lengthy, but the process for getting under way would not have to consume an enormous amount of time. It would only require that an RFP be drafted and prepared in such a way that it would be possible for private insurance companies to bid.

Chairwoman Howard said she did not disagree with Mr. DeRosa. However, she did not feel the Committee was at the point of discussion of an RFP if the plan design was still unknown. Plan design would need to be the first step, along with the other items in ACR 10, such as whether local governments would be required to participate in the plan. What pool would we be looking at? Were we just looking at state employees? Would we be looking at one large group or different groups? She believed those issues needed to be decided upon before considering an RFP.

Mr. DeRosa said he did not disagree. However, he suggested that at least as part and parcel of Item 8 in ACR 10, the first step in that process would be to determine whether there was a desire to consider the model. He believed the federal government model was an outstanding model and would be well worth exploring. A hypothetical census that would incorporate all state and non-state employees, municipalities, etc. could be created that would not obligate anyone in advance whatsoever. It would simply be an exploration, and by virtue of that, a significant amount of information could be received back in the way of proposals from many private insurers that could be reviewed and compared with the plan that is in place and other self-funded plans that exist. It might be possible, once the process was over, to be able to offer multiple models to state and non-state, active and retiree, employees, which would be a great first step.

Assemblywoman Giunchigliani said she was hopeful that the federal government would be making a presentation at the next meeting. She suggested that the Committee must determine who would comprise the pool before proceeding any further.

Mr. Thorne agreed; it was not possible to even conceive of an RFP until the population demographics were determined. Who should be in the pool? If it was to be an all-employee pool, then collective bargaining issues must be considered, some of which were very broad and some very detailed. He said the federal plan worked very well; the majority of that plan's population had two choices. He noted that Nevada was a small state with a small population, with one large population area in Clark County and then the rest of the state. The question was how to support the required services with that kind of population distribution. He believed the opportunities would be better with a single pool, but that would involve several questions: Do

we do regional rating? Do we do experience rating and down to what level? The peer pool concept of HPN product could be used and risk adjustment factors could be used for the populations. That may be a mechanism that could be used, but the first determination would be whether participation would be voluntary.

Mr. DeRosa said that for purposes of exploration, the best method would be to anticipate that it was a single pool and create an all-inclusive plan for the Committee to consider. Again, he noted it would not be obligatory, but it would be the beginning of something to either add to or take away from.

Mr. Alpert said he was concerned with the RFP process; he thought the insurance carriers would be spending a lot of time and effort for an informational item only. Perhaps the correct vehicle would be a request for information (RFI). He believed getting the unions to agree to one pool would be a problem.

Mr. DeRosa said it was a question of semantics. He intended the process to be a request for information that would incorporate all of the entities, none of which would have any obligation to participate in any informational proposals presented by any insurance companies. However, it would provide something for everyone to review and consider. As far as the insurance companies were concerned, Mr. DeRosa noted they were in the business of taking risk and they were in the business of presenting proposals and information on a consistent basis with only the hope of gaining more business. He suspected that most of the insurance companies would be happy to assist in the exploratory process.

Mr. Giancursio replied that generally speaking, he believed the insurance companies would cooperate. However, before going through a formal process, he suggested that the population be identified and parameters be set for the insurance companies to understand. The funding obligation should also be identified so they would know the economics of the offer. Mr. Giancursio said the basic federal government model included many plans, not just a few; he would be bringing the plans available to Nevada employees to the next meeting. He thought the concept Mr. DeRosa was talking about was a mixture of programs, e.g., HMOs, PPOs, consumer-driven health plans, which would create an opportunity for national and larger organizations to participate in the program. A complete plan could not be appropriately addressed by any one company; there might even be a self-insured plan component. However, Mr. Giancursio reiterated, it would first be necessary to identify the population and define the funding mechanism.

Ms. Brand agreed with Mr. Giancursio's comments. She cautioned against using the term "mandate," as it often made people nervous. Exploring for information should be the key focus.

Mr. Chandler said at this point it would be necessary to look at what the law currently required. All state employees were required to participate in the plan, but there were groups of 300 or more who by law had the mechanism to opt out. Non-state agencies were also allowed to come into the plan. He wondered if the Committee would want to expand the group of people who could participate in the plan. Mr. Chandler thought the charge of the Committee was to look at the current Public Employees' Benefits Program and try to make the program better for whatever population to be served. If the plan should serve all local governmental entities, he wondered if the Committee should continue with the idea that the local entities could opt in at their choice, or if at some point local government employers should be required to participate. If participation was mandated, then the plan must be attractive; it could not be a plan that did not match the entities' current plan. Mr. Chandler said the local entities could not be asked to give up plans they had worked on for years to become part of a plan that did not meet that group's needs. He reiterated that before the Committee could discuss what the benefit plan would look like, it would be necessary to first identify who would participate. Referring to ACR 10, he observed that Items 1, 2, and 3 were simply informational items; there were no decisions to be made until Item 4.

Mr. Chandler recalled that prior to 1991, everyone in PEBP paid one rate, and then the population was

broken into state and non-state; at one point there were non-state groups of over 100, under 100, etc. One of the fundamental decisions to be made would be if the state would want to create a single pool and rate everybody the same. In 1991, it was calculated what it would cost to go to a single premium, and it would have required $1.93 increase to the premium being charged to the state. During the 2003 Session, there was testimony that it would cost $4.5 million to go to a single set of rates, which would translate to $4.50 per person, and if the benefits were reduced, it could be done for $3.50 per person.

Continuing, Mr. Chandler stated that regional coverage would create the same kinds of problems that would be associated with state and non-state. When the groups were broken out, then the risk would not be spread over the group. If a regional plan was to be instituted, the employees in Carson City or Washoe County may benefit, but it was his opinion that if the state was going to go to a single plan, then the risk should be spread and a single cost charged to all participants. Southern Nevada participants might have to pay a little more to cover the additional costs in northern Nevada, but that would be the whole reason for having a group plan. He added that when a group was segregated or rated individually, insurance became impossible for other people in the group. He was a strong believer in one plan that would meet the needs of all participants.

Chairwoman Howard agreed with the comments made, adding that the focus should be on who the participants in the plan would be before moving on to anything else.

Sam Connally, University of Nevada-Las Vegas, agreed the plan population should be the first decision made. It should be recognized that, intuitively, larger groups spread risk over a larger population and should reduce costs. He thought the logical place to begin would be with the entire active population of public employees in the state, whether they were state, local government or city employees.

Mr. Connally said that to tackle any of the ACR 10 issues, defining the group was really the focal question. He believed all public employees needed to be hypothetically profiled into a group and then the insurance companies could be asked to rate that group with a standard basic portfolio of packages.

Continuing, Mr. Connally stated that another issue of concern was whether the risk would be commingled between the active and retired population and how it would be funded in the future. The state of North Carolina had a prefunding mechanism for retiree health coverage by which 2 percent of the state salaries was paid into the retirement system. North Carolina had had more than 20 years of experience, and it was still paying out about $150 million more per year than it was taking in, but theoretically, the state paid 2 percent of salaries to the retirement system to invest to generate enough money to purchase the health insurance for retirees. He said one of the commonly recognized flaws of the program at present was separating the risk and the cost between retiree health and active employee health, and this had never been addressed, so there were still commingled risk issues and the state was paying the same premiums for retirees as for active employees. Obviously, the cost was much larger for the retiree population, so cost shifting, to the extent that it occurred, resulted in the reality that the 2 percent was not sufficient to fund the entire cost of retiree health. The cost shifting was effectively from the state to the active employees, which had a significant impact on the dependent coverage cost. Mr. Connally remarked this could be a substantial issue the Committee would need to consider.

Mr. Connally noted that Nevada was a relatively young state, with 23,000 active employees and 5,000 retired employees. The state of North Carolina had 80,000 active participants and 240,000 in the retired population. At some point, the demographics in Nevada would shift and the pay-as-you-go process would not be viable. In anticipation of reaching the point where it would have to be determined what the state would have to pay to fully fund health insurance for retirees, he suggested the Committee look for information that would compare the actual cost of the active population with the actual cost of the retired population. That information would then be available in determining what contribution rate would be required to fully fund the actual cost of retiree health. Two key pieces of information were essential: What

would it cost to insure all of the active employees today compared to all the retirees today, and what would be the cost of the entire project?

Mr. Wolff said he was somewhat confused regarding one group and the size of the pool. Addressing Mr. Thorne, he asked if the fact that the state allowed people to enter the HMO program had any effect on the rest of the employees. If the program was to be pooled into one program, what was the point of offering other programs?

Mr. Thorne replied that the federal plan consisted of multiple plans that competed for pieces of that market. The concept of a much larger pool to compete for plans through one venue made sense. However, giving local entities the option to come in and out of the plan was self-defeating. Mr. Thorne noted that was exactly the situation now, and there was practically no participation in southern Nevada where the market was more competitive. The population in northern and rural Nevada was interested because a better price was not available. Mr. Thorne suggested that a single pool with options within that pool would be the best mechanism to try to accommodate the union and negotiated collective bargaining issues at the local levels and still provide a larger pool that would be more attractive, whether that was self-funded or insured.

Assemblywoman Giunchigliani added that she believed competition should drive the market. There were few companies that would bid for the state contract; HMOs would always have a role. She would like to see other groups compete for a certain portion of the market share, because in the long run it would be the only way to drive down some of the costs. Also, a program should be tailored that would meet the different needs of employees.

Assemblywoman Giunchigliani said that she believed the Committee had the following major issues:

- Define the pool – Consider gathering information on the number of participants if all employees were in one health care system. It was not realistic to think this could be done by the 2005 Legislative Session; however, the Committee should now be looking at the potential for the following session.

- Mandate that everyone would participate – It would not be possible to have the choice to opt-in and opt-out.

- Make the decision whether to fully fund retirees, or whether it should be a match or percentage based on years of experience.

Assemblywoman Giunchigliani noted that the Committee did not have a budget, and she asked Mr. Thorne if PEBP would have the resources to hire an actuary. Mr. Thorne replied PEBP could approach AON and ask what it would cost to provide those findings and work out a funding mechanism to reimburse AON for doing the work. The scope of PEBP's contract with AON should be broad enough to request the additional information. He agreed that gathering the information from all of the public employers in the state would involve a major effort. The Public Employees' Retirement System (PERS) would be a major resource for the number of retirees, and the University System should be able to provide information concerning the participants in TIAA-CREF and other plans for the professional employees.

Assemblywoman Giunchigliani asked that a timeframe and cost estimate be prepared for the next Committee meeting. She would request that a representative from PERS be available to assist the Committee with obtaining the information. She asked if the members agreed that, at least for information purposes, one pool with all public employees would be envisioned.

Chairwoman Howard replied she did not think it was a bad idea to pursue what the costs would be; however, she wondered how the collective bargaining agreements would be handled. If participation and plan were

mandated, benefits would be taken off the table.

Assemblyman Goicoechea disagreed. He believed it would be possible to have a plan in place that would allow collective bargaining for different components of the plan.

Chairwoman Howard remarked she was not an expert on collective bargaining, but she was aware that local governments had to deal with it, and the state did not. She wondered if the state would be forced to bargain with local government employees.

Assemblywoman Giunchigliani stated she was an absolute proponent of collective bargaining and would not support anything that would eliminate it. However, she added, the matter of intent must be considered because the issue would become salaries versus benefits, regardless of which public employee group was involved. She thought the federal plan might suggest some organizational options to provide competition, but at the same time allow the groups to bargain for the benefits they chose to have. Assemblywoman Giunchigliani said it was obvious the problem could not be resolved in two years; it would be necessary to gather the information, the numbers, and the projections in order to make a wiser decision two to four years in the future.

With regard to collective bargaining, Mr. Connally believed there were two issues. One issue would be the demographics of the group. If there was logic in the marketplace that larger groups would be more stable over a period of time and would give a more effective array at a lower cost, then even for an entity such as the city of Las Vegas with a great plan, the demographics would shift and a lower-cost plan would no longer exist. It would then be necessary to appeal to employees or union representatives' long-term interest by saying that stability in the pricing of health care over a period of time should outweigh the short-term gain of a subgroup from the state population.

The second approach would be if a plan were priced with all public employees, both state and local, collective bargaining could still be engaged at the local level in terms of the percentage of the total cost the local government entity would be willing to pay. There would still be opportunities for bargaining, but they would be on the price differential or price break.

Mr. McAllister concurred with Mr. Connally's remarks, adding that he agreed there would be an opportunity to incorporate the collective bargaining process with governmental entities. Currently in the retirement system, each local governmental entity was collective bargained on the percentage that the local government entity would contribute for employees; some paid full, some paid 50-50; some paid full up to a certain amount. Mr. McAllister pointed out there were health care plans established that had been nurtured into very successful trusts over an extremely long period of time. The firefighters had better benefits than the state plan and sums of money had been accumulated in the trust. He wondered what would be done with those funds if the members became part of the state plan. Outside of that, he noted that other benefits had been negotiated through the collective bargaining process that helped to offset insurance premiums upon retirement. A separate trust fund was created in lieu of salary increases to which the city contributed each month to pay a monthly stipend for retirees to help subsidize the cost of health insurance premiums, as long as they stayed in the trust. He asked again what would happen to those funds. The county firefighters and the metro police department had similar trust funds.

Assemblyman Goicoechea remarked the trusts would still exist and be maintained by the respective jurisdictions. A trust fund created to offset health insurance premiums would continue to be used for that purpose. He maintained that one large pool would be more affordable to everyone.

Mr. Thorne said the presentation from the federal government would help in the discussion. There were a number of different union plans listed in the federal government's options for federal employees, and he

speculated that some of those plans were among the options offered.

Mr. McAllister noted again that the city contributed a certain amount each month to the firefighters' trust in lieu of salary increases. If a statewide pool of health insurance was created and the premiums were less than the amount being contributed to the trust fund on behalf of the trust members, what would become of the city's contribution to the trust since it was an in-lieu-of-salary benefit?

Mr. Hadfield said Mr. McAllister had expressed some of the issues that had been brought to his attention by various local governments. There was a great deal of fear that everyone would be thrown into one plan. However, the costs and various scenarios must be identified in order to develop comparable information. It was clear that legal commitments that had been made and negotiated under law would need to be taken seriously. Those rights and those monies would have to be protected. However, at this point, Mr. Hadfield did not believe them to be mutually exclusive. Once all of the information was compiled, then the various issues could be addressed, not only by the ACR 10 Committee and its Advisory Committee, but by the Legislature as well.

Ms. Brand agreed that the numbers needed to be pulled together before the Committee could take any action. Mr. Thorne said he would follow-up with AON before the next meeting to get a quote on what it would cost to gather the information. He recalled that North Carolina's retiree population was substantially larger than its active population, and in looking at prefunding premiums for retirees, he suggested the actuary should look at separating rather than commingling the actives and retirees, recognizing the cost of providing health coverage for retirees and basing the prefunding plan on the actual costs. Mr. Thorne stated this would significantly reduce the costs for the active participants and provide an offset for the retirees.

Mr. Zunino commented that the system consisted of the actives, the retirees, and the combined populations, and information on the three groups would provide better information to compare globally and make decisions about the requirements of mandating any entity to be part of the system.

Chairwoman Howard added that in pulling the information together, stability would be a huge factor to consider. However, if local governments were not mandated to participate, those impacts would need to be known as well.

Assemblywoman Giunchigliani remarked that the Committee was in the situation of not knowing the numbers. She suggested the Committee needed to know how many groups actually had trust funds.

Mr. Hadfield said NACO would be able to gather the needed information from the local government entities and school districts, and the Public Employees Retirement System should have the demographics on the active employees. NACO would work with the League of Cities and Municipalities to obtain the statistics needed.

From Carson City, Mr. Wolff remarked that one of the issues was that two systems currently existed under PERS, the police/fire and regular members. If a medical program was to be prefunded for retirees, he hoped the formula would apply to the early retirees versus the normal retirees, since a prefunded plan for the early retirees would cost substantially more; policemen and firefighters could retire as young as 46 years old and would not be eligible for Medicare for several years.

Chairwoman Howard recessed the meeting for lunch at 12:52 p.m.

The meeting was called back to order by Chairwoman Howard at 1:48 p.m. Since the Committee would not be able to take action on Agenda Item VII until the requested information was received, she asked the Committee to move to Item VIII.

VIII. DISCUSSION OF POTENTIAL ENHANCEMENTS TO THE PUBLIC EMPLOYEES' BENEFITS PROGRAM THAT MIGHT BE DESIRED BY LOCAL GOVERNMENTAL ENTITIES.

Chairwoman Howard said that Item VIII would be difficult to discuss based on the lack of information as well. She recommended that the discussion of potential enhancements to PEBP be deferred until the required information was gathered.

IX. DISCUSSION OF HOW NON-STATE PUBLIC EMPLOYERS SHOULD CONTRIBUTE TO THE COST OF INSURANCE FOR EMPLOYEES WHO RETIRE FROM THEIR SERVICE.

Chairwoman Howard pointed out this was a very important issue, especially to local governments. The outcome of AB 286 in the 2003 Legislative Session created a tremendous impact on local governments. She was aware that some local governments were providing a subsidy, but she did not which ones or the amounts. However, the result of commingling the actives and retirees created larger premiums, and having to pay a subsidy for employees in the PEBP plan created another financial impact. Chairwoman Howard noted that since the Committee had started its deliberations, it had become obvious that the intent of the Legislature was to create the subsidy for all retirees. She recommended the Committee discuss the issue in an effort to determine what the subsidy should be, who it should apply to, and how it would be funded.

Mr. Chandler was of the opinion that the intent of providing a subsidy for retirees, regardless of their employer or where they obtained their insurance, was a good idea. It would be costly, but it was a fairness issue. Currently, governmental entities that provided health insurance for actives also had retirees who had joined the state plan and were receiving a subsidy. However, the retirees who stayed with the local agency's plan were not receiving a subsidy. Mr. Chandler felt an obligation to say that there was still a lingering misunderstanding of AB 286. According to his interpretation, AB 286 applied to retirees who were insured through an employer-sponsored plan – not a collectively bargained plan and not a trust plan that was in existence prior to October 2003. He said based on AB 286, many people were allowed to enter the PEBP plan who might possibly have not been legally allowed to do so because they were not coming from an employer-sponsored plan. Mr. Chandler believed the only retirees entitled to receive a subsidy were those coming from an employer-sponsored plan. Therefore, there were some governmental entities being billed by PEBP in accordance with the LCB and Attorney General's legal opinions, but there were some conflicting legal opinions as well. He reiterated the bill stated the retiree must come from an "employer-sponsored plan." He requested that the discrepancy be clarified.

Chairwoman Howard replied that opinions on AB 286 were indeed just "opinions." That was all they were until a court ruling was issued.

Ms. Brand asked if it was agreed that the Committee was operating under the assumption that it would follow the opinions of the Legislative Counsel Bureau and the Attorney General. It would not be possible to proceed without a consensus.

Mr. Stevens remarked that Mr. Thorne and PEBP would have to follow the opinion of the Attorney General, since that office was PEBP's legal counsel. Until a court decision indicated otherwise, Mr. Thorne had no other option.

Ms. Brand agreed with Mr. Chandler that there were different opinions, which would have a bearing on cost factors, either for the entities or for the state plan itself. She asked if a court case was pending. Mr. Stevens replied he did not know of any. Ms. Brand asked if there would be a challenge, and again Mr. Stevens replied he did not know.

Mr. Chandler recalled that PEBP had recently distributed information concerning the calculation of the subsidy. Originally there was a subsidy amount identified and sent to the employers to distribute to members of PEBP. However, he thought there had been a change in the methodology used in calculating the years of service with each agency, and the calculation of the subsidy provided for that individual. Mr. Chandler said notice of the change had indicated it was based on AB 286, but he did not see anything in the bill that described the change. He asked Mr. Thorne to explain the reason for the most recent letter.

Mr. Thorne said the reason was a combination of the impact of AB 286, which went into effect October 1, 2003, where the local entity from which the retiree retired was responsible for the entire subsidy. In addition, AB 249, which was sponsored by PEBP, was intended to address an inequity as to who received a subsidy from the state. The law currently required that the retiree had to retire from the state in order to receive a state subsidy, regardless of where the retiree had spent the majority of his career. The methodology was changed to require that if the employee had state service, the subsidy would be calculated based on the state service, regardless of the entity from which the employee retired. In bringing AB 286 and AB 249 together, Mr. Thorne said it was necessary to identify where the retirees had spent their careers and identify those years of service. The Board went through a regulation process at the beginning of the year to establish a mechanism on how the subsidy would be calculated, which was basically to apportion it among the retiree's former employers based on the years of service with each employer. He added the vesting would be the same as under PERS, i.e., at least five years of service to qualify.

In response to a question from Ms. Brand, Mr. Thorne said purchase of prior service would be calculated according to PERS rules.

Mr. Chandler said the letter he was referring to had stated that the change was based on the legal interpretation of AB 286. He asked if it actually had to do with another bill and the calculation practices the PEBP Board was using. Mr. Thorne reiterated it was a combination of the two bills: AB 286 required the initial subsidy be paid in the same manner as the state, and AB 249 altered how the state paid the subsidy for its retirees, which required the local entities paying a subsidy for their retirees to pay in the same manner.

Chairwoman Howard asked Mr. Thorne if he would share the information he had concerning the retirees, particularly those from the local governments, and the subsidy to be paid. Mr. Thorne said that information was not yet available; the forms were not required until the end of May, and the data would not be compiled until mid-June at the earliest.

Assemblyman Goicoechea asked if AB 249 included specific language mandating that PEBP follow PERS regulations, or if it simply included a five-year service requirement. Mr. Thorne replied the policy would follow the same rules as in PERS, and that was referenced in the statute. The PEBP Board set the regulation to follow those rules, even for retirees of the University System; determining length of service was calculated according to PERS rules.

Assemblyman Goicoechea asked if the procedures to be followed were in the PERS regulations, or if they were in statute. He was concerned if the PERS regulation was subject to change without a change in statute. Mr. Thorne explained the PERS rules for service were in the PERS section of the statutes.

Mr. Zunino expressed concern that an unfunded mandate not be created for any of the entities, however that may be interpreted. He was fearful the subsidy matter could easily become an unfunded mandate for Eureka and Esmeralda Counties, and he strongly recommended against it.

Mr. Zunino further recommended a system be developed that would deduct insurance premiums prior to deduction of federal taxes. When he was an active employee, he was able to sign a form to have his health premiums deducted from his paycheck prior to any income taxes. Once he became retired, however, he was

advised he could no longer do that because he was not an employee of the employer paying the premium. Mr. Zunino thought there should be a procedure whereby retirees could have their health insurance premiums deducted prior to taxes, which would be a great benefit to retirees.

Chairwoman Howard indicated that Mark Stevens would pursue the matter and bring information back to the Committee at the next meeting.

Referring back to the issue of prefunding retiree insurance costs and the concern that it not be an unfunded mandate, Mr. Thorne said he would leave the funding issue to the policy makers, but he thought the Committee should develop the mechanism of the subsidy itself and apply it to current retirees. He suggested a "defined-benefit" type subsidy where retirees would receive a flat amount of subsidy or a graduated scale benefit based on years of service. If a PERS-type assessment was initiated and that funding was allowed to accumulate for 10 years, the subsidy mechanism would then already be in place.

Chairwoman Howard remarked the subsidy was a two-pronged issue. There definitely was a short-term problem, as well as another long-term problem as to how to prefund it. She thought the long-term solution might be easier than the short-term.

Ms. Brand asked if ACR 10 mandated the Advisory Committee to develop a solution. Chairwoman Howard said she was not sure if the bill contained a mandate, but part of the discussion of the Advisory Committee was to be how non-state employers should be contributing to their retirees' insurance benefits. It obviously was not a simple answer; it was both a short-term and long-term issue. She cited two items in ACR 10 dealing with funding a subsidy:

- Consideration of options for prefunding retiree health benefits for all members of the Public Employees' Benefits Program, and

- Consideration of a state subsidy mechanism for a specific dollar amount or a specific percentage of cost for employees and separately for their dependents and including an appropriate funding method.

Ms. Brand remarked the two items appeared to be long-term in nature; it would be necessary to address the short-term issues first.

Assemblyman Goicoechea asked Mr. Thorne if all of the local governments were participating in the subsidy program. Mr. Thorne said approximately 77 local governmental entities were being billed for a subsidy. Only three or four were reluctant to pay their share, and the PEBP Board had approved collection procedures to be implemented in order to collect the required subsidy. Once the local entities were notified of the collection procedures, compliance increased. He estimated the entities were at about 95 percent in compliance.

Chairwoman Howard suggested the Advisory Committee discuss recommendations to take back to the full committee. Should local government entities be mandated to pay the subsidy? Should the subsidy be eliminated? If not, how much should the subsidy be and who should it be applicable to?

Mr. Connally said it appeared to him that the spirit of the ACR 10 legislation dealt with recommending to the Legislature what constituted good public policy for the state of Nevada. The question was where the money would come from, which was really secondary to the Committee at the present. In looking at what would be good public policy for the state of Nevada, every employee participated in the same retirement system because it was in the state's interest for public employees, whether they were state employees or city, county, or local government employees, to have a secure retirement. In similar fashion, Mr. Connally believed it would be good public policy for the state for all public employee retirees, be they state, county, or local government employees, to be secure in funding of health insurance during retirement and to be

self-supporting, to the extent that they would have a predictable income stream for retirement health insurance so they would not be dependent upon the social network of the state for a subsidy.

Mr. Angus MacEachern identified himself as a person who had been involved in public sector bargaining and labor relations in Nevada since 1971, and he had been on both sides of the table. He said he could not disagree more with Mr. Connally's comments. The first issue was public policy: It was not necessarily good public policy that public employees have benefits much greater than any private sector employee. The second issue was what funding local governments should contribute to retirees, and what the public policy was. Mr. MacEachern believed the public policy was settled in 1969, 1971, and 1973 when the Legislature resolved the mandatory subjects of bargaining for public employees at the local government level. One of the mandatory subjects of bargaining was insurance. Since that timeframe, local government employers had been bargaining insurance. Some employees and employers adopted plans similar to what the firefighters proposed earlier in the meeting. They set up trust funds and they provided for retiree insurance. Other local governments and unions negotiated different plans in which they wanted all the money immediately; they didn't want to put any money aside for the future for retiree insurance, i.e., the unions took the money then and the employers paid the money then. That was the deal that was made and the deal that was still to be honored.

Continuing, Mr. MacEachern said there were public employers, particularly in southern Nevada, who had their insurance funded through the Taft-Hartley Insurance Trust, which was a federal statute with federal rules. There were employers who did not provide any insurance for their employees; they gave them $500 a month to do with as they wished; there were no subsidy requirements.

In his mind, Mr. MacEachern thought the issue was whether there was a problem; he believed there was a problem, and the problem was the passage of AB 286, which required unfunded mandate payments to local government employers. The issue of what employers should pay had been decided years before. In the local government sector, it was a bargainable issue between the employee and employer; it should be left there, and it should not be touched any further.

Mr. DeRosa disagreed, saying that from a public policy standpoint, the result would be uninsured or underinsured populations, and the impact of not supporting the retiree population and medical benefits would translate into additional taxation on the public at large by virtue of the fact that those populations would be entering into providers, hospitals, etc., with no coverage. The issue was still money, although he could clearly see the point of the issue of workers making deals many years ago and now they were subjected to the consequences, unintended as they may have been. Mr. DeRosa added the situation would not go away simply by identifying the fact that it clearly was not fair. The issue was worth exploration.

Mr. Wolff concurred with Mr. MacEachern's comments on the Taft-Hartley issues. However, as a representative of the state, law enforcement, and Teamsters, he had followed AB 286 very closely, and he had voiced his opinions. The single largest issue for him was that passage of AB 286 not be on the backs of state employees. Traditionally, Clark County's wages were higher than those of state employees, but he had always pointed out to the state employees that the county employees did not have subsidies when they retired unless they were part of a union. Mr. Wolff said his group had been very adamant that if cities and counties were going to be required to fund their retirees when they entered the state system, it not be done at the expense of state employees. Now, it appeared to him, that was exactly what was going to happen. The cities and counties now realized the financial impact of AB 286, and if the legislative intent of AB 286 was upheld and cities and counties were required to pay a subsidy for all of their retirees, it would be a matter of time before the Legislature ruled they would have to pay for it. That amount would come from state money, which would result in less funds for comparable wages for state employees. Mr. Wolff said during the discussion of AB 286, he had been assured it would not have an impact on the state, but that was not true. He agreed with Mr. MacEachern that the cities and counties had negotiated their benefits under collective

bargaining agreements years ago, and now the state was being asked to bail them out by providing the subsidy.

Chairwoman Howard asked if Mr. Wolff was making a recommendation, and he responded that for years he had recommended prefunding of retiree health premiums. One way or another, the state would have to pay health care costs for retirees, but he believed seed money would be required to provide subsidies up-front. He recommended that the Committee pursue a way for the cities, counties and state to finance a prefunding program through PERS to satisfy the needs of future retirees.

Chairwoman Howard remarked she was not sure the Committee had an answer as to how local governments should be contributing. She asked if the item should be put on hold until more information was available.

Mr. Chandler asked why the local entities were being asked to pay a subsidy to begin with. As he understood it, the subsidy was not to make up the additional costs to the state plan; the subsidy came about as a way to offset the high costs of non-state agencies. The local agencies were not paying any subsidy, and the retirees were having to pay the full premiums from their pockets. It was the intent that rates for non-state participants would be based on what it would cost to insure that population. He also agreed with Mr. MacEachern's assessment of the situation; some time ago, the local governments had chosen to negotiate funding of the programs that they wanted to fund. Again, he asked, what was the purpose of the subsidy?
Assemblyman Goicoechea explained that the 2003 Legislature had not started with AB 286; there were a total of four bills. He agreed with Mr. Chandler, adding that what drove action on AB 286 was that non-state actives and non-state retirees were faced with premiums of $711 for the employee, $1,422 for an employee and spouse, and $1,800 to $1,900 for a family plan. A number of local governments that were with PEBP had been hit with a tremendous bill, and as they began to search for less expensive coverage, they found most carriers would not take retirees. The result was the non-state actives could shift to other plans at less cost than the state self-funded plan, but retirees could not. The legislators had been inundated by retirees claiming they had been abandoned by local jurisdictions across the state.

Ann Hoskin, a retired teacher, agreed with Assemblyman Goicoechea. She was one of the retirees who was very upset because her insurance premiums with Teachers Health Trust were about half of her retirement check. Over the years, the active teachers had given up salary increases three times in her 32 years with the school district in order to help fund the Teachers Health Trust for retirees, under the assumption that they would be taken care of too, only to find out that when she got to retirement, she was no longer accepted into the Health Trust. She was in favor of AB 286, even though she realized the intent of the bill was different than how it had been proposed. Speaking for a number of Clark County School District employees, she said they were in favor of the intent of AB 286.

Mr. Alpert said the Legislature's action was admirable; it had addressed the retirees' problem, which needed to be addressed. It was his understanding that the charge of the Advisory Committee was to make recommendations to the Legislative ACR 10 Committee. He said a tremendous inequity in the bill was being overlooked. When the subsidy went into effect, the retirees shifted to the state plan, leaving the Teachers Trust with a few people who needed the most care and were the highest cost. The school district would not provide a subsidy to the Trust because there was no mandatory requirement to do so. Mr. Alpert believed a subsidy and its funding source should be designated for everyone, or no one should receive a subsidy. With the present inequity, the problem would never be solved.

Assemblyman Goicoechea responded that a resolution was probably nine months away, at least until the 2005 Legislature convened.

Ms. Robinson said she recognized that, as a public employee, she was not only paid very well, she had

some extraordinary benefits, including a great pension. However, she asked: What made public employees better and more worthy of having subsidized health care when they were retirees? How many people working in private industry in the state of Nevada had subsidized health care? She agreed there was no question an inequity existed; those with subsidized health care were so much better off than the average general employee. She wondered if there was a public appetite for giving public employees more benefits. Ms. Robinson believed the state had a duty to its retirees to help them fund their retirement, and she understood that retiree health care was very expensive. However, the question was not necessarily how much should be subsidized; the question was whether the state should be subsidizing in the first place.

Ms. Brand remarked she was a Clark County School District employee for over 30 years, starting out as a classified employee, then a teacher, and then an administrator. Over the years, she had observed people pouring into Nevada. When she became an administrator, she was placed on a recruiting team for teachers, but it was extremely difficult to recruit from anywhere else in the country. She noted the salaries were not the best, the conditions were not the best, and the future was at stake. Nevada had one of the lowest college and high school graduation rates in the country. She wanted to make the point that the human technology aspect of the state would have to be improved upon before good teachers could be recruited.

Ms. Robinson said she could not argue with Ms. Brand's point; however, money was finite, and if it was spent in one direction, it would not be spent in another.

Mr. DeRosa referred to his earlier comment that the situation was unique when it came to medical care, but under all circumstances, no matter who or where a person was, he would get medical care. The real question was who would paid for it, when it would be paid for, and how much would it cost. If populations were not insured or were underinsured, regardless of who they were, they would require services from various facilities and the taxpayers would pay the tab at a much higher cost.

Mr. McAllister said he understood Ms. Robinson's comments regarding private employees, but he believed the problem was statewide. Las Vegas was not reflective of the rest of the state, particularly relating to salaries and benefits. Assemblyman Goicoechea agreed.

Mr. Connally remarked that the state already had made a commitment that it would provide some retiree health coverage, and it was a graduated benefit that maxed out at 20 years. Local governments had not necessarily made the same commitment; they were all participants in PERS with respect to the defined retirement benefit plan, but local governments did not have the same up-front graduated commitment to fund retiree health. Some counties may have elected to do so, and some had not; some may have negotiated benefits in the past, but some may have not. Since retiree health care was not guaranteed, it had become a structural issue. Mr. Connally said the issue was not what had to be paid to state employees in order to recruit them; there was a market-based competitive compensation package in the state, but the Committee's task was not to determine increasing benefits or compensation levels for state employees. Its task was to determine how the current commitments could best approach the marketplace to get the best deal for state, county, and local employees to meet the obligations that had been made.

Mr. DeRosa suggested the Committee could determine whether a recommendation could be made on Agenda Item IX. If it was decided that a recommendation could not be made until additional information was received, then at that point the Committee would have an opportunity to consider whether a subsidy should be applied across the board, if it should be modified, or if it should be eliminated altogether. Mr. DeRosa did not think the Committee currently had enough information to make any of those recommendations. He added that the matter did not seem to require immediate urgency since nothing could be done for nine months anyway.

Scott MacKenzie, State of Nevada Employees Association, believed the intent of ACR 10 was to determine

how to create efficiencies in order to develop better buying power for all public employees in Nevada. In discovering what the efficiencies were, the Committee could also consider what could be done for non-state retirees. However, any contemplation of creating a new benefit that could add a huge fiscal impact would not be beneficial. Mr. MacKenzie suggested the Committee first decide what efficiencies could be created, and then determine how to address the problems.

Chairwoman Howard asked if there were any further questions or comments regarding Agenda Item IX. It appeared to her that there was a fundamental question of whether the state should be mandating that local government subsidize retirees, since collective bargaining had been in existence for many years. She noted that the Committee did not have nine months to make recommendations because recommended changes would require legislative action, and Committee bill draft requests would have to be submitted to the LCB Legal Division by September 1, 2004.

X. DISCUSSION OF THE FEASIBILITY OF SOLICITING PROPOSALS FOR A CONTRACT THAT WOULD TAKE OVER THE ENTIRE STATEWIDE OPERATION OR THE REGIONAL OPERATION OF GROUP HEALTH INSURANCE FUNDED BY PUBLIC EMPLOYEES AND PUBLIC EMPLOYERS.

Chairwoman Howard suggested this item should also be deferred until further information was received.

XI. SCHEDULING OF DATES AND LOCATIONS FOR FUTURE MEETINGS.

Chairwoman Howard noted that the Legislative ACR 10 Committee was scheduled to meet on May 13, 2004, and it would be receiving further information from PEBP, as well as information from local governments regarding various trust plans.

The Committee determined the next Advisory Committee meeting would be held on June 10, 2004 in Carson City beginning at 9:30 a.m. The meeting would be videoconferenced to Las Vegas.

XII. COMMENTS OF ADVISORY COMMITTEE MEMBERS REGARDING THE INTERIM STUDY AND THE PUBLIC EMPLOYEES' BENEFITS PROGRAM.

There were no further comments from Advisory Committee members.

XIII. PUBLIC COMMENT.

There was no further public comment.

XIV. ADJOURNMENT.

There being no further business to come before the Advisory Committee, the meeting was adjourned at 3:05 p.m.

Respectfully submitted,

_____
Sherie Silva, Committee Secretary

APPROVED:

_____
Nancy Howard, 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.