MINUTES OF THE
POLICY AND BENEFITS WORK GROUP OF THE
ADVISORY COMMITTEE TO THE
LEGISLATIVE COMMISSION'S COMMITTEE TO STUDY
THE PUBLIC EMPLOYEES' BENEFITS PROGRAM
(ACR 10, 2003 LEGISLATIVE SESSION)
March 20, 2004

Advisory Committee Members Present:
Tim DeRosa, Business Benefits Incorporated, Vice Chair
Doug Bierman, Intertech Services Corp.
Sue Brand, Retired Representative
Allin Chandler, Clark County School Administrators Association
Sam Connally, University of Nevada-Las Vegas
Laura Dancer, Washoe County School District
Hal Keaton, Lincoln County
Jack Kim, representing Don Giancursio, Sierra Health Services
Rusty McAllister, Professional Firefighters of Nevada
Daryl Moore, City of Henderson
Randy Waterman, City of Sparks

Legislators Present:
Senator Mark Amodei
Assemblywoman Chris Giunchigliani
Assemblyman Pete Goicoechea

Staff Present:
Mark Stevens, Fiscal Analyst, Fiscal Analysis Division, LCB
Sherie Silva, Secretary, Fiscal Analysis Division

Exhibits:
Exhibit "A" – Policy and Benefits Work Group Agenda
Exhibit "B" – Agenda and Meeting Packet – Advisory Committee to the Legislative Commission's Committee to Study the Public Employees' Benefits Program (Original on File with Fiscal Analysis Division)

Legislative Committee Chairwoman Chris Giunchigliani served as facilitator for the meeting. After call to order and opening remarks, she proceeded to review the items on the agenda:

A. Scope of contract for group health insurance.
B. Participation of members of the Public Employees' Retirement System in statewide program of health insurance.
C. Composition of the PEBP Board.
D. Voluntary participation in PEBP by public employers and public employees.
E. Establishment of program similar to Federal Employees' Health Benefits Program. (Assemblywoman Giunchigliani noted a copy of the federal plan was included in the Legislative Committee's meeting packet (Exhibit B), but representatives were not able to attend the meeting to discuss the plan; they have agreed to appear at a later date.)
F. Reinstatement rights of non-state retirees in non-state benefit plans.

G. Prescription drugs.

Assemblywoman Giunchigliani referred to a copy of ACR 10 on page 10 of the Advisory Committee packet (Exhibit B), and reviewed how the items were divided between the two work groups. The Policy and Benefits work group was to consider Items 4, 5, 6, 7, 8, 10, and 16 (Policy and Benefits Work Group Agenda Items A-G, respectively) and rank them in order of priority. She asked for input from the work group participants.

Sue Brand, a retiree representative to the Advisory Committee, remarked that in listening to the discussion which had taken place during the previous day's meeting of the Legislative Commission's Committee to Study the Public Employees' Benefits Program, there appeared to be some confusion with regard to the spirit of intent and the actual application of Assembly Bill (AB) 286 (2003 Legislative Session). She suggested the legislative members needed to clarify the meaning of the law. Ms. Brand said the state and non-state retiree issue should not necessarily be the first priority, but she would like to know the true intent of the bill.

Assemblywoman Giunchigliani agreed that was a problem; there were many different legal opinions regarding AB 286. She explained that in the 2003 Legislative Session, she, Assemblyman Goicoechea, and Assemblywoman Koivisto had each sponsored separate bills. Assemblyman Goicoechea had sponsored AB 165, which had been proposed by the Nevada Association of Counties (NACO) for Eureka County. AB 165 had required that local governments not be separated out of the risk pool and that there be one major state plan risk pool.

Ms. Brand asked if that was done in order to not have different rates for different people, or if the spirit of intent was to just get people involved in the system.

Assemblyman Goicoechea replied the intent of AB 165 had been if there was a pool of 60,000 consisting of retirees and actives across the board, it would be possible to obtain coverage that was more affordable than the existing PEBP program.

Ms. Brand asked if Eureka County's group was being rated differently, and Assemblyman Goicoechea replied it was. The county retirees were all separate. Historically, their actuary had actually been lower in the past, and there did not appear to be any benefit in changing. Prior to the 2003 Session, there were a number of retirees across the state who were having to pay between $1,400 and $1,700 per month in premiums. He said it was not his intent to segregate groups so that the only way to receive a subsidy would have been to join PEBP. The intent was to combine the pool and provide some kind of subsidy to the retirees, whether it was in the existing plan of the local government or school district, or in PEBP if that was the best option.

Assemblyman Goicoechea believed that some local governments had turned their backs on their retirees. However, Eureka County had always paid $130 of the retiree's monthly premium, regardless of the retiree's plan. Now the retirees were required to pay nearly triple what they had been paying. He was of the opinion that the subsidy would be less if the retiree had the option to enter the local government plan; there were some better deals available. A teacher in Churchill County was able to get private insurance with cheaper and better coverage than under PEBP, but he couldn't get out of PEBP until July; he would realize a $300 per month savings.

Ms. Brand affirmed that it was not Assemblyman Goicoechea's intent to require participation in PEBP. Assemblyman Goicoechea said that was correct; however, it was his intention that there would be affordable health care coverage available to retirees. He reiterated PEBP was not the best current plan available from a cost standpoint.

Assemblywoman Giunchigliani explained she had sponsored a bill in the 2001 Session which,

unintentionally, allowed groups in PEBP to segregate and pool with non-state retirees in an exclusive group. She said the school district administrators had been segregated out, and then there was a subsequent segregation of non-state retirees. The result was smaller and smaller pools; she did not believe that was ever the Legislature's intent. It was her understanding that the intent of AB 286 in 2003 was to first end the segregation, and then to provide some sort of subsidy. It should not matter whether the retiree was from state or local government.

Continuing, Assemblywoman Giunchigliani said the third issue was that local governments had never paid into the state system. Fourth, if there was to be a subsidy, who was responsible for paying it? She said in the Legislature's desire to end the segregation and provide a subsidy, consideration was not given to the issue of local governments paying for their retirees.

Assemblyman Goicoechea said Eureka County had paid a portion of the retiree's premium to PEBP, but the county had to separate from PEBP because the premiums were too high.

Assemblywoman Giunchigliani pointed out that some local governments paid almost nothing for retirees; there was a handful that paid some contribution. She asked if any local governments paid the full premium for their retirees; no one was aware of any.

Assemblywoman Giunchigliani noted that Senator Amodei's district (Carson City) probably had the largest group of state employees, but there was still the issue of active and retiree subsidy.

Senator Amodei remarked that one of the aspects that made the issue truly statewide was school district retirees. Over the past few legislative sessions, the PEBP Board had been reconstituted, there had been many problems, and now there was the state retiree issue. Senator Amodei said most the calls he received were from retired school teachers from throughout the northern part of the state, not just his district. The thinking was if a group of retirees was segregated out, they could access benefits at a greater rate, the group would be smaller, which would make it more expensive; the priority at the time was to give relief to the active participants by not including the retirees in the underwriting. The result was the creation of a very small group of people who accessed health care benefits predictably and fairly often, and they were getting rated based upon what they actually did. The socialistic nature of the issue was to make the groups bigger; in his discussions with fellow legislators, Senator Amodei said the consensus was that people should not be treated separately, because as long as they were rated separately, the premiums would be outrageous.

Senator Amodei stated he had requested assignment to the PEBP interim committee because it was clear that the insurance coverage was no longer a great benefit, active or retired. Segregating participants out of the plan was a recipe for disaster; smaller numbers did not make sense. The Carson City School District had been complaining about the cost, but at some point in time, that would be part of the cost of doing business, which some people might think was a fiscally reckless thing to say, but they would need to start paying.

Continuing, Senator Amodei indicated that one of the reasons the state workforce was getting older was because the state was not perceived as the great career track that it used to be. One of the reasons it was a great career track in the past was the benefits. People he talked to have indicated that an improvement in health care coverage would be preferred over a pay raise. It was his hope that something could be done faster and that the group could be made larger.

Assemblywoman Giunchigliani agreed with Senator Amodei, adding that what was being done had not been working. The state plan benefits were terrible; the city of Henderson had better benefits and a smaller group. She said it was imperative to be sensitive to the tax dollar being collected to pay for these benefits.

Senator Amodei recalled that group insurance was also an issue during the 2001 Special Session that dealt

with the issue of medical malpractice. The Governor and PEBP had requested additional funds to cover the overriding costs of the plan. The question was asked at that time if the amount would cover the whole cost, which it would not, and what this would do to the average employee in the plan. The Budget Director, Perry Comeaux, did not have an answer at the time, and PEBP provided information that the premiums would go up as much as $350 a month. Senator Amodei said that was when the Legislature made the decision to provide a complete bail-out. At that time, there was an appetite to provide more money than was asked for to send a message, pending a committee like this, to say that the Legislature understood that the system had problems and needed to be fixed.

Ms. Brand said she was encouraged at Friday's meeting when she saw a different method of calculating and forecasting insurance data; so many other models were available. She did not realize that the state was so far behind in its thinking that it was not even using current accepted practices for actuarial calculations. She was pleased to learn a new model was being implemented. Addressing Senator Amodei, she said she was not surprised that Mr. Comeaux did not have the information, since the information being provided was from an old model.

Allin Chandler, Clark County School Administrators Association, said he first joined the state plan in 1984, and from then until 1991, the program seemed to work well for all participants, both state and non-state. In 1991 there was a piece of legislation which allowed the state insurance group to break into the state and non-state groups. When that occurred, there seemed to be a fair amount of flexibility, but very little information. Essentially, the non-state agencies were hit with a rather significant increase in their premiums – large enough that most were going to have difficulty paying them. Although it was nothing compared to what the agencies were currently facing, back then it looked pretty serious. Mr. Chandler explained that in subsequent legislative sessions, legislation was passed that said if a non-state agency stayed within 5 percent of the state agencies, they would go back to a single set of premiums as opposed to multiple premiums for state and non-state agencies. The goal for all those years was to return to a single set of rates because the segregation had created so many problems. His calculations at the time indicated the plan could have gone back to a single set of premiums for about $1.93 per person per month.

Mr. Chandler said he had followed AB 165, AB 286, and ACR 10 during the 2003 Session, and all three of the bills had one thing in common: they all wanted to return to a single set of premiums and eliminate the state versus non-state premiums. He recalled that AB 286 included that provision until two days before the session ended, when it was amended out without a hearing. In the discussion of AB 286, it was obvious that in order to return to a single set of premiums, $4.5 million would be needed, either by increasing premiums for the state employees, which would result in a decrease to the non-state employees, or the state could pick up the full $4.5 million and return to a single set of premiums. Mr. Chandler believed that for $4.5 million, a continuing problem was created wherein families from non-state agencies were being asked to pay up to $1,900 a month for their insurance. Very few retirees in the state of Nevada could afford to pay $1,900 for insurance. Therefore, there were now many people who could not afford insurance.

At one time, Mr. Chandler continued, AB 286 would have commingled the actives and the retirees, younger and healthier employees with older and less healthy retirees, which would have resulted in a more reasonable rate. But that was not the situation. Once his group pulled out of the plan as actives and created its own plan, the only people remaining in the plan were the retirees, which meant there was no one to commingle them with except other retirees. When retirees were commingled with retirees, the rate was still higher. That was the problem with the result of AB 286; most of the active employees in non-state agencies have had to move to another plan because they could not afford the rates that were being passed on by the plan to the non-state agencies.

Assemblyman Goicoechea remarked that there were some local governments caught in the situation of not being able to find other coverage and had no other options. They were paying exorbitant premiums.

Mr. Chandler agreed, adding that was what happened to his group. Fortunately, they were large enough to look for private insurance at a lesser premium, and they did. They were not paying as much now as they were paying in the state plan in 1999, and the benefits were better. The state plan had $500, $1,000 and $2,500 deductibles; the City of Henderson was at $250, with significantly lower premiums and significantly better benefits.

Assemblywoman Giunchigliani exclaimed that the question was “Why? Why does that situation exist?”

Assemblyman Goicoechea asked if the City of Henderson had retirees in its pool, and Mr. Chandler replied that it absolutely did.

Tim DeRosa, Advisory Committee Vice Chairman, identified himself as a broker for the Clark County Association of School Administrators (CCASA). He said much of the reason CCASA was able to create better benefits for less money related to the notion that market competition could be used among the insurance companies to drive pricing down and benefits up. The group’s original intent was to create the largest risk pool possible, but CCASA was much smaller than the groups being discussed at these meetings. The potential risk pool for state participants was enormous and could create a lot of leverage if there was willingness on the part of the Legislature and others to consider commercially available products from the private sector and to embrace the possibility that a better level of benefits could be created for actives and retirees utilizing that delivery system. Mr. DeRosa said his knowledge of the state plan’s history was limited, but there was a desire on the part of many to retain the state system because at one time, years ago, that delivery method was a good choice. He said Nevada was unique in a lot of respects, not the least of which was, especially in Las Vegas, the state was an island so-to-speak; there were both pluses and minuses attached to that fact. One plus and minus was that Health Plan of Nevada had enormous market share; its capacity to generate significantly lower pricing at the root of the business was extraordinary. Health Plan of Nevada paid less money for all of Clark County to utilize a hospital system and related medical services it contracted with than anyone else.

Mr. DeRosa said the premise was to look at the private sector delivery system and see if it could be improved upon and get CCASA out of the insurance business. Getting out of the insurance business meant using and looking at companies in the business for profit. By shifting all the risk to the private companies, the only problem would be whether to shift the risk for short periods of time or long periods of time. If the risk could be shifted indefinitely, it would be, and if it could be shifted contractually for multiple use, that was what they did. By doing that, the group created safety in terms of pricing stability on a long-term basis and got multiple-year contracts, always a minimum of two years with a cap in the third year.

Mr. DeRosa said with a large risk pool such as the state, there would certainly be opportunities to create even longer multiple-year contracts with insurance companies. There would also be methods by which other insurance companies could be incorporated within the pool. The effect would be a model much more similar to a federal delivery system, which had two, three or four insurance companies delivering benefits and competing with each other. Once that occurred, it would make no difference what the claims were. It wouldn’t matter what the utilization was and it would not matter to consumers how utilization impacted pricing, except to the extent that the competitive nature of the insurance companies would cause them to carve up that block. Therefore, if there were 140,000 persons available to be insured and there were four insurance companies wanting a piece of the pie, then they would do, from a pricing and benefit standpoint, what was necessary to effectively carve into that block. Would they base their pricing and their benefits on utilization and on the age/sex demographics? Absolutely, they would; but the reliance would be solid.

Mark Stevens, Assembly Fiscal Analyst, said the Legislature had instructed the PEBP to issue a request for proposal (RFP) for insurers for the PPO, although not for the full insurance product. Mr. Stevens said it was his understanding that the health insurance market was much different in northern Nevada than in southern

Nevada. There were differences in plan design and demographics, and if an insurance company were to bid and then have bad claims experience, it would base its subsequent premiums on making up part of its loss. He said he agreed with what Mr. DeRosa was saying, but claims experience, in some fashion, would enter into the premium determination. It was possible to use the marketplace to drive down cost if the group was large enough, but apples must be compared to apples. If the state plan was to be compared to Mr. DeRosa's plan, then consideration must be given to plan design, geography, and available services. He noted there was not even an HMO in the northern part of the state that would bid on the plan.

Assemblywoman Giunchigliani said the HMOs would not bid because the plan was so volatile, and the request for proposal was not written to draw any competition. She said she had received phone calls from major statewide companies that said they would have bid if the RFP had been written differently. She asked Mr. DeRosa if his group was self-insured.

Mr. DeRosa replied it was not; the group was a fully insured plan design and its stability came from its ability to negotiate for multiple-year contracts. They had seven years of average annual increases of less than 6 percent per year; the plan had started with premiums at 21 percent less than when CCASA left the state plan. He reiterated that the benefits were far superior to any other plan being considered by the state.

Continuing, Mr. DeRosa noted that there had been discussion about what could be done by the PEBP Legislative Committee, which was created for a four-year period, to accelerate action. He suggested the way to accelerate would be to create an RFP that would reach the private-sector carriers and, in exchange for acceleration of the process, the companies would demonstrate that they would consume large segments of the public sector population and deliver benefits on long-term guarantees. Mr. DeRosa said he could assure that the companies would compete, and they would compete relentlessly to consume even their perceived piece of the business, assuming that there were at least two or three insurance companies delivering benefits from which participants could choose, based upon location, physicians and hospitals, and premiums. He said this process could certainly be done within a six- to twelve-month period.

Allin Chandler remarked that one thing that would need to precede issuing a request for proposal would be to eliminate the segregation of groups.

Sam Connally from the University of Nevada, Las Vegas, said he was a newcomer to the state of Nevada; he had moved here about six months ago from North Carolina, which had about 80,000 state employees. He was surprised to hear that the total insureds under the state plan in Nevada was about 45,000, compared to over 800,000 insureds in the state of North Carolina. The North Carolina state health plan had a $1.5 billion annual budget; it included all state employees, active and retired, all local governments, county governments, and public school teachers. From his perspective, the more historical issue to deal with was the issue of small groups as opposed to looking for prospective strategies to enlarge the pool. In the state of North Carolina, with comparable coverage, the sheer size of the pool would drive rates down. North Carolina was paying an employer contribution of $325 per month compared to $500 in Nevada for comparable coverage. The rate was fixed and the same for county and local governments, public school teachers, state employees, and retirees. The structural issue was one needing to be dealt with, as well as some policy and social issues. The issue last year was whether to treat actives and retirees the same actuarially and have a fixed rate premium. It was his impression that no one had set aside money for the retirees, so it was not a prefunded plan – it was the same as Social Security, i.e., pay-as-you-go. The debate for North Carolina, because it was a larger group and had larger consumption, was having an adverse impact on active employees because they were combined, but that was in the context of a plan design where theoretically retiree health was being prefunded through a percent of payroll contribution during active years. There was some cost-shifting going on where the retirement system, which picked up the cost for retirees, wasn't really paying its fair share in relationship to the general fund for active employees, and it was distorting some of the actuarial issues.

Mr. Connally thought as a policy and program committee, the biggest issue to address was what the state's obligation to its employees should be, whether at the state level or at the local government level. One of the chief tools to recruit and retain employees was not cradle-to-grave socialism, but the stability of employment in the benefits structure. From that vantage point, the obligation to individuals needed to be considered, not only during their period of active employment, but also during their retirement. The structural issue should be dealt with first, followed by market models, self-insured, and reinsured kinds of approaches.

Senator Amodei said he was open-minded to the possibility of privatization in the context of what the state had historically experienced. In 1999, the state decided to remove itself from the industrial insurance business, so the precedent had been set, even though the comparison was not apples and apples. However, in 2002, the medical malpractice industry decided it wanted out of Nevada. Senator Amodei agreed with Mr. Connally that the market would respond to a combined pool; the only thing that would give him pause would be the private industry's refusal to continue to contract with the state. He said the state had demonstrated consistently how incompetent it was in the health care insurance business, and that alternatives needed to be considered. He cautioned that the market was a good place except when it decided it didn't want to participate any more. Nevada was a state of only 2.2 million people, and the large insurance companies could decide not to do business here if they didn't want to.

Assemblywoman Giunchigliani agreed that the state would have to be sensitive to that issue.

Jack Kim, Sierra Health Services, said he was representing Don Giancursio, who was unable to attend. He stated that all health care, unlike some other kinds of insurance, was local, i.e., it was provided in Nevada by local plans to a large extent. Health Plan of Nevada started as Southwest Medical and grew up in Nevada from 1980; northern Nevada had St. Mary's and Hometown Health, which were local plans. Mr. Kim emphasized that the local plans would not be going anywhere; they originated in Nevada and would stay in Nevada.

Mr. Kim said if a statewide request for proposal were sent out, bids would be submitted, including coverage for the rural areas. However, the costs in the rural areas would always be higher than in the urban areas. He pointed out that in the Washoe County area, state employees had no choice but to participate in the self-funded plan. A number of years ago, they had the choice of HMOs, St. Mary's and Washoe Medical. However, the previous PEBP Board had added a surcharge to every employee who joined an HMO, thereby forcing the agencies out of the system. People who were very ill and needed a lot of medical care stayed in the health plans and all of the healthy people left, forcing the HMOs to withdraw due to rising costs. For the record, Mr. Kim emphasized that the reason there was no choice of providers in northern Nevada was because of actions of the PEBP Board, not because of the health plans.

From Mr. Kim's point of view, it looked like the state was looking for predictability – for the state fiscally, for employees so they would know how much they had to pay, and for the retirees. The state was also looking for costs of benefits and how much each party would be liable for. He also thought the state was trying to reduce its risk and eliminate the necessity of providing supplemental appropriations to its plan every few years. Mr. Kim noted that the insurance industry would take on the risk for a cost, and he thought that was where the state would like to be. Employees would like to have choices: a self-funded plan, an HMO, or a PPO.

Continuing, Mr. Kim remarked that Sierra Health Services' model was probably different than any other health insurer in Nevada, in that it had a staff model plan similar to Kaiser, as well as network contracts. Southwest Medical, which was the grandfather of Health Plan of Nevada, had its own clinics (15-16), 150 doctors, 18 OB/GYNs, and digital radiology, all of which helped to reduce costs. Kaiser's model was similar, which was the reason their costs were so much lower.

Daryl Moore, City of Henderson, said she appreciated the discussion on AB 286 and that it had been very helpful. She did not think there was any resistance to the concept that everyone was interested in providing affordable health care to all public employees, and that it be continued through retirement. However, a lot of groups were asking what was driving the state's costs when the groups could hold premiums to $800 a month and have better benefits. If she was told she had to participate, she would not have a comfort level until she knew what was driving the costs. Ms. Moore said she was a very active participant in how the health care plan was administered in the City of Henderson. She asked that the state not ask the city to continue to pay for something that it felt was not of value. There were a lot of things that could be done, such as consider joint purchasing options for self-insureds or pooling risks within organizations. Ms. Moore said there was no disagreement that a larger pool of people would certainly be able to leverage much more efficiently statewide if the plan were put to bid for a PPO or HMO or other options. Total compensation issues also needed to be looked at; there were also federal tax changes that allowed individuals to put pretax money away or hold pretax money out after retirement. The pricing structure between the north and the south was very significant. Because the City of Henderson employees participated in the Teamster Trust, a mixed Taft-Hartley Trust which was both public and private sector, those structures would have the most difficulty if the PPO was the one designated as the state. In considering structure, Ms. Moore would recommend the state look at things that could be effective and not necessarily roll everyone directly into the state plan.

Assemblywoman Giunchigliani asked if structural issues should be discussed, e.g., pre-paid/pre-funding ideas, or if that should be something initiated in the state system itself. Everyone participated in PERS, so maybe it was time to consider placing a percentage of the PERS contribution into an insurance pool (pre-funding concept). The issue of medical costs being higher in different parts of the state should also be reviewed. In education funding, a wealth equalization formula was utilized because of location. Should the state be looking at that?

Allin Chandler said it appeared to him that at some point the Committee would have to look at the plan and how it was funded. However, unless the problem of state versus non-state employees was resolved and a single pool was created, the problem would continue. A single pool was the basis for all three bills during the 2003 Legislative Session. It must be decided whether the state plan should have a single set of premiums which would cover state, non-state, actives, and retirees as one risk pool. That was the fundamental problem that had to be resolved initially. If it was not, any plan design would still have unacceptable and unachievable rates to certain groups of people. The same thing that drove the three bills would always be there until the problem was resolved.

Mr. Thorne stated that the issue came down to cost, and it didn't matter what the policy was as far as how much coverage, how little coverage, where or how much; it still came down to dollars. How much was the state willing to spend and how much were the local entities going to spend? Until that determination was made, a decision could not be made on other issues as far as coverage. With regard to a statewide HMO and PPO, the regional issues were a cost driver. He said the same plan in northern Nevada with the same coverage and same population demographics would cost at least 100 percent more than it would cost in Las Vegas. He said that was a fact of life with medical care on the provider side in Nevada. The PEBP Board had gone out for statewide PPOs and statewide HMOs. The fact was there were no licensed HMOs in the rural counties. There were southern HMOs and northern HMOs whose focus was in the metro areas in both places. The southern HMOs might be licensed in four counties in the south, but the northern HMO was licensed only in Washoe County. On the bids that were received, the cost of the HMO premium across the board was over 100 percent higher in the north.

Senator Amodei asked Mr. Thorne what he attributed that to; he asked If there were infrastructural problems in the north in terms of physicians' associations or key players in the hospitals dealing with Medicaid. If there

were structural problems that could be addressed by the Legislature, then they needed to be discussed. Senator Amodei said he did not expect an immediate response; he was aware that some of the reason was that the population in the north was about one-third of the south. “Beyond that,” he asked Mr. Thorne, “what do you attribute the 100 percent cost differential to?”

Mr. Thorne replied he thought that scale was a large part of the driver. He had received off-the-record comments from the provider community in northern Nevada about the high cost of providing services and why the charges were so high. The off-the-record comment was “because we can.”

Senator Amodei said he thought Mr. Thorne was being diplomatic; however, he was hearing physicians’ associations and hospital contracting practices were the reason for high costs.

Mr. Thorne said he had just come from the Fiscal work group, which was having the same discussion. Washoe County was facing the same dilemma. There were basically only two hospitals and there was not much competition. To obtain better per diem rates at one or the other would require an exclusive arrangement, and then some valuable services on one side or the other would be eliminated. There were many more hospitals and much more competition in the Las Vegas area. Mr. Thorne said Nevada was facing the same problem as CalPERS. Part of the other work group discussion was whether the state should be considering regional rating, which would go back to the issue of equalization. Regional rating would base premiums on costs in particular regions, with costs in southern Nevada being lower than in northern or rural areas. There was also the question of the state versus the local governments; how would the locals continue to pay? Those in the southern part of the state would have an opportunity to obtain better coverage for a lower price. The local governments in the northern and rural parts of the state would not be able to obtain a better product for a lower rate because the state would be taking the risk for the whole state and pooling it into a single rate. The northern part of the state was getting the advantage of the southern participation, but the southern local entity would have to pay a premium over what it could get on its own in order to take care of that pooling.

Senator Amodei said he did not doubt what Mr. Thorne was saying, and he appreciated his remarks. However, it was a fair question to ask why the costs were what they were. He noted that the Carson City hospital was very profitable on the scale within which it operated, and if there was some way to make it more competitive for the retirees and state employees who used it, then it should be done. However, Senator Amodei continued, he doubted that would be possible if it was a fact that the economies of scale made it cheaper for someone in Henderson to get public employee insurance than for someone in Dayton. Maybe it was less expensive for the City of Henderson because it had all young employees, but everyone was entitled to an answer to the question of why the northern part of the state was so much more costly. Senator Amodei said if the answer was “it costs more because they can,” then he felt it was time to start looking at the statutes. He stated that people worked for the state because there was stability and a benefits structure; the state still had stability and it still had a decent benefits structure for retirement, but the retirement structure for health benefits was a problem. Senator Amodei again emphasized that something had to be done. Before one risk pool was created, everyone deserved an answer as to why it would cost more to belong to the state than it would for plans currently provided by southern local governments. He understood part of the answer was regional, but the other aspect was there were 130,000 people living outside of western Nevada and Clark County. Where were the walls that needed to be broken down or where were the bridges that needed to be built? What was driving the costs?

Mr. Thorne replied there was one non-profit hospital left in the state, University Medical Center, and it was the only hospital in the state that was losing money. Until Carson-Tahoe Hospital went non-profit, there was little or no surplus, and now a surplus had appeared. He said the extreme would be to declare that the only services to be provided in the rural areas would be primary care physicians and emergency care; all others would be transported to Las Vegas. At the very high level, for items such as transplants, there were centers

of experts around the country, and it would actually be cheaper to send the patients there, as well as their families, because the plan would be paying a single-case rate due to the volume of that particular procedure, and end up with better outcomes than if the patients went to any hospital in the state of Nevada. He emphasized that less than two percent of the population was driving over 60 percent of the costs; that was a demographic issue that was not going to change. In fact, he added, it would get worse, since 40 percent of the state active employees were eligible to retire in the next five years. Once they retired, there would be a need for young people to replace them to provide some balance.

Senator Amodei said it appeared that retirees would have to move to Clark County in order to get decent health care. Mr. Thorne replied that was what some of the southern local plans were facing; in order to maintain their benefits structure and to retain employees, their focus was on a plan that would keep the employees in the area, such as an HMO in Clark County only.

Senator Amodei asked if Mr. Thorne had an opinion as to how the plan had been funded over the past five years. Senator Amodei had heard that for budgeting purposes, the plan had been funded on a very optimistic basis over the past bienniums.

Mr. Thorne replied there needed to be a fully funded reserve for Incurred but Not Reported (IBNR) and it would make sense to have a contingency reserve, particularly for a public entity on a biennial budget in a volatile industry. If there had been a contingency reserve in place coming out of the 2001 Session, it would not have been necessary for the 2002 Special Session to provide $18 million in supplemental funding. Without a reserve, it would be necessary to return to the Legislature to request funding to make up any shortages. Mr. Thorne would prefer funding of a contingency reserve, and the PEBP Board concurred with the actuary's recommendation to create a reserve.

Senator Amodei remarked one of the first things he had confronted as a legislator in 1999 was a premium increase, and part of that increase was clearly to rebuild the reserve, which had been depleted because of the claims history prior to 1999.

Mr. Thorne said every plan – private insurance, self-funded, reserve mechanism, or pay-as-you-go – would have ups and downs, particularly in large claims, and the problem was how to pay for them. He believed funding a reserve should be done over time. His opinion on a fully insured versus a fully self-funded plan was that the economics were identical; the difference was for a fully insured plan, a profit would be paid, as well as the margin for reserve.

Senator Amodei repeated his question to Mr. Thorne: "Do you think we have been actuarially optimistic over the past five years?" Mr. Thorne replied that he did.

Assemblyman Goicoechea said he understood there was a difference doing business in southern Nevada compared to northern Nevada, but the bottom line was that most of the local governments opted out and went to the private sector because it was cheaper; most of them were able to reduce their rates by 30 percent from what the state was costing. He wondered if the state really was better off being self-insured or if it should pursue the private sector, particularly from a northern Nevada perspective. It appeared it would be cheaper to be in the private sector.

Mr. Thorne responded it would be cheaper to be in the private sector based on the demographics of the particular case. The fire protection district in the Carson City region could not get insurance coverage from any carrier. In 1984 when the self-funded plan was created, the state had gone to bid for an insurance carrier and received one bid, which constituted a 40 percent rate increase; that was the reason the state shifted to self-funded. He explained it was the ebb and flow of the insurance companies' market that would make a difference on pricing at any given time. Two years after the fire protection district had joined the state

plan, it was able to get cheaper coverage in the local market; however, the retirees who stayed in the state plan were glad to be there since it was cheaper than the current private plan.

Assemblyman Goicoechea disagreed with Mr. Thorne, saying that in 1985-86 the state plan actively solicited the local governments to join the state plan. It was not a case of the local jurisdictions looking to get out of the plan; they were priced out. The state changed the program and separated the pool to the extent that most local jurisdictions were priced out.

Mr. Thorne said he was not with the system when this occurred, but he understood that by law the pool had to be rated separately. If the Legislature would like to change the law and shift to a single risk pool, from an administration standpoint, the process would be the same. There were now more retirees in the non-state pool than there were actives, resulting in commingling and a lower rate for retirees and a higher rate for actives. The same situation would exist in one large risk pool; 20 years from now there would be more retirees in the plan than actives. The larger the pool, the more leverage, and the larger the pool, the more smoothing over time.

Assemblyman Goicoechea remarked that even a good risk pool would ultimately end up costing more as the pool aged.

Mr. Thorne said the question that still remained was what the participants were willing and able to pay. If the coverage was poor or unaffordable, the state would end up paying for it anyway because it paid for indigent care. The plan could be created to fit the available dollars.

Ms. Brand said if that were the case, the CCASA plan would be in trouble now because it had always pooled its retirees, and there had always been a significant number of retirees in that program. If the retirees were not pooled and attention was not paid to this issue, there would not be any young people coming to work for the state in the first place. If the state was not a desirable or appealing career opportunity, the plan would not get better. She said Mr. Thorne's logic did not make sense to her.

Allin Chandler said the CCASA rates had gone up only slightly, and the group had been pooled from the very beginning.

Mr. Thorne said he was not blaming the cost increases on the retirees; he was saying that the costs for all participants would rise because of the aging of the population, both active and retiree. The average age of active employees was over 45 years old, and those people would begin facing acute and chronic illnesses, e.g., diabetes and strokes. He reiterated it was not a question of actives versus retirees; he apologized if that was the impression he had given.

Assemblywoman Giunchigliani summarized, noting that the problem was a national one, and Nevada was only reflecting what the rest of the country was experiencing, including at the national level. She cautioned against pitting one group against another, state versus non-state or actives versus retirees. The PEBP Board would have to react to what the Legislature did in terms of funding. She reviewed the important issues that had been brought forth:

1. The hospitals in the north apparently charged more just because "they can."

2. Licensing of HMOs in the north; why were more hospitals are not licensed?

3. Who wrote the requests for proposals. Were there groups more

experienced to assist the state in preparing a better RFP?

Mr. Thorne interjected that PEBP prepared its own RFPs in conjunction with State Purchasing as required by law, and they were being refined each time. Every RFP had asked for an HMO in each of the regions, as well as statewide and outside of the state, because 3-1/2 percent of the covered population lived outside of the state of Nevada. Mr. Thorne said none of the entities licensed in the north or south provided a statewide bid, based on the fact that they felt they were not competitive and, in fact, they were not competitive in light of the regional rate. Mr. Thorne added this would be the same situation if a single state risk pool were created.

Assemblywoman Giunchigliani continued with her review of the issues:

4. Consider statutory changes to deal with non-profit hospitals and how the RFPs are driven and how they should be written.

5. Self-insurance versus full insurance models.

6. Recommendations for risk pooling.

7. Coverage expectations.

8. Pre-payment or pre-funding of retiree premiums in anticipation of those costs; how would that be structured; would it be mandated?

9. Rural equalization model or formula.

10. Should coverage be shifted to private insurance?

11. Exploration of joint purchasing agreements and networks.

12. Intent of AB 286; end of segregation.

13. What does a subsidy mean?

14. Local governments not paying into the system; make the plan more attractive to local governments.

15. The state must end its volatility.

16. Predictive modeling.

17. Claims experience.

18. Market competition.

Senator Amodei stressed that it would not be the intent of the Committee to mandate members of a successful smaller group to join a more volatile larger group.

Assemblywoman Giunchigliani agreed; she said the hope would be the plan would become attractive to those groups four or six years in the future and that the mechanism would be in place for them to join at that

time.

The work group adjourned at 11:10 a.m. to reconvene as the Advisory Committee to the Legislative Commission's Committee to Study the Public Employees' Benefits Program.

Respectfully submitted,

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Sherie Silva, Secretary

APPROVED:

_____
Nancy Howard, Chairwoman

Date:_____