MINUTES OF THE
NEVADA LEGISLATURE'S
INTERIM RETIREMENT AND BENEFITS COMMITTEE
(*Nevada Revised Statutes* 218E.420)
March 26, 2014

The second meeting of the Nevada Legislature's Interim Retirement and Benefits Committee (IRBC) was held at 8:30 a.m. on March 26, 2014, at the Nevada Legislative Building, 401 South Carson Street, Room 3138, Carson City, with videoconference to the Grant Sawyer State Office Building, 555 East Washington Avenue, Room 4412, Las Vegas, Nevada.

COMMITTEE MEMBERS PRESENT IN CARSON CITY:
Assemblywoman Maggie Carlton, Chair
Senator Debbie Smith, Vice Chair
Assemblyman Randall Kirner

COMMITTEE MEMBERS PRESENT IN LAS VEGAS:
Senator David Parks
Assemblywoman Heidi Swank

COMMITTEE MEMBERS ABSENT:
Senator Joyce Woodhouse (Excused)

STAFF MEMBERS PRESENT IN LAS VEGAS:
None

STAFF MEMBERS PRESENT IN CARSON CITY:
Mark Krmpotic, Senate Fiscal Analyst, Fiscal Analysis Division
Cindy Jones, Assembly Fiscal Analyst, Fiscal Analysis Division
Laura Freed, Senior Program Analyst, Fiscal Analysis Division
Eileen O'Grady, Chief Deputy Legislative Counsel, Legal Division
Carla Ulrych, Committee Secretary, Fiscal Analysis Division
Becky Lowe, Committee Secretary, Fiscal Analysis Division

EXHIBITS:

Exhibit A: Agenda and Meeting Packet
Exhibit B: PEBP 2015 Rates and Plan Design
Exhibit C: PEBP 2015 Base Rates Comparison

I. ROLL CALL.

Chairwoman Maggie Carlton called the meeting to order at 8:39 a.m. The secretary called roll; all members were present, except Senator Woodhouse who was excused.

Chair Carlton thanked members and staff for their attendance. In an effort to establish a more collaborative relationship with PEBP, she thought it was beneficial for the IRBC to meet prior to the PEBP Board (Board) meeting on April 3, 2014, when the Board was expected to move forward with its strategic plan.

II. PUBLIC COMMENT.

Vicki Cameron said, as a non-state, early retiree who did not qualify for Medicare, she was concerned about her health insurance. She was offended by threatening notices from PEBP requiring non-state retirees to return to their original employer's health insurance plan. Ms. Cameron was hopeful the Committee would prevent non-state retirees from being penalized.

Peggy Lear Bowen said she was also a non-state retiree and would never qualify for Medicare because she had not earned 40 quarters. She said to qualify for the $50 premium discount, she was required to complete forms and pass a quiz. Additionally, as a second year wellness plan participant she was required to complete several physical activity challenges, and she was unsure how that would affect her as a disabled person.

Ms. Bowen said there was concern that the state subsidy would decrease and insurance rates would increase. She said Nevada created a system to keep money in state to allow more control over rates and expenses. However, she thought PEBP had created a negative impact on Nevada's economy by sending money out-of-state to the Medicare exchange provider.

Ms. Bowen said a recent PEBP Board meeting was held in a location not easily accessible by the public. She thought the Nevada Open Meeting Law should be changed to require videoconference or teleconference for people who were unable to physically attend a meeting.

III. APPROVAL OF THE MINUTES OF THE JANUARY 16, 2014, MEETING.

> ASSEMBLYMAN KIRNER MOVED TO APPROVE THE MINUTES OF THE JANUARY 16, 2014, MEETING OF THE INTERIM RETIREMENT AND BENEFITS COMMITTEE. SENATOR SMITH SECONDED THE MOTION.
>
> THE MOTION CARRIED UNANIMOUSLY.

There was no public comment on this item.

IV. PUBLIC EMPLOYEES' BENEFITS PROGRAM (PEBP).

A. Presentation by PEBP's actuary of claims experience and trend for the first two years of the Consumer Driven Health Plan (Plan Years 2012 and 2013).

Justin Kindy, Actuary, Aon Hewitt, said PEBP requested a review of historical claims experience to understand the reason for the excess reserves. He said that the reserves that accumulated over the last two years were due to a combination of things, some driven by national trends, and others by PEBP-specific decisions. Surpluses accumulated over the past two years were due to an overall lower medical trend nationally; changes to consumerism and the behavior of the plan population, specifically a reduction in certain aspects of utilization; better contract negotiations and savings due to a change in Third Party Administrator (TPA); and reduction in "unnecessary care," or "inefficient care."

Chair Carlton asked how "unnecessary care" would be quantified. She said issues were often identified at a regular check-up that may not have been found otherwise; therefore, people should not be discouraged from obtaining medical care.

Mr. Kindy explained that while most employers would like to cover 100 percent of employees' medical care, it was not realistic. He said the demand and cost of health care was larger than what plan sponsors or employers could afford. Aon Hewitt thought it was best to move to a plan that would get the highest utility of every state dollar spent on PEBP. He said there was a health care term called, "value-based design," which was a concept applied to a plan on a micro level that incentivized care that was effective and prevented long-term downside risk. For example, there were plans that covered 100 percent of diabetic drugs, which encouraged utilization of medication to prevent a non-compliant patient from future issues that would lead to more costly care. Mr. Kindy said the concept of value-based design allowed plans to utilize each dollar efficiently and effectively. Based on the newest data, PEBP members were receiving more efficient care than in the past.

Continuing, Mr. Kindy said data indicated the Consumer Driven Health Plan (CDHP) was a better option for high-cost patients. Furthermore, based on current utilization, and from a purely out-of-pocket perspective, the CDHP was a better option than the prior PPO plan for over 92 percent of the population.

With regard to excess reserves, Mr. Kindy said the trend on a national level was lower than expected. He provided the following quote from a report given on the Affordable Care Act (ACA), "Health care price inflation is at its lowest in 50 years…health care inflation is currently running at just one percent on a year-over-year basis, the lowest level since January 1962," and noted the Standard & Poor's claims index supported that. Aon Hewitt believed PEBP experienced lower than expected trend. Mr. Kindy said some ACA provisions, such as elimination of plan maximums and dependent coverage to age 26, had a direct impact on the plan. Other components were not as direct, and the impact was still unknown. Mr. Kindy said additional costs were built into the rates over the past few years to account for the ACA, and those costs may still come to fruition.

Mr. Kindy said Aon Hewitt believed the lower trends experienced by PEBP were tied to plan design changes that resulted in the behavior changes typically seen with a move to a consumer driven plan. PEBP experienced a greater than normal reduction in utilization. Mr. Kindy said the state exchanges had several levels of healthcare plans, such as bronze, silver, gold and platinum. He noted the CDHP, after taking into consideration the Health Savings Account (HSA) contribution from PEBP, was similar to a low level "gold" plan through the state exchanges. With the additional HSA contribution from excess reserves, the CDHP was comparable to a "platinum" level plan.

Mr. Kindy said Aon Hewitt and U.S. Preventative Medicine (USPM) noted a decrease in disease burden within PEBP's population, which reduced the cost of care, though Mr. Kindy noted that this might be incidental.

Debbie Donaldson, Actuary, Aon Hewitt, said with the change in the CDHP, there was also a change of TPA to HealthScope Benefits. Some unexpected results of the new TPA were changes in contracts, network savings and better management of the plan. Aon Hewitt noted a 3 percent reduction in rates associated with the changes made by the TPA, which was about $3.4 million over a two-year period (PY 2011 through PY 2013). Upon further review, it was determined the CDHP paid about 94 percent of average inpatient costs, compared to 91 percent with the former plan. Additionally, the out-of-pocket maximum with the CDHP was lower than on the previous plan, therefore, the CDHP was helping protect against catastrophic loss. Ms. Donaldson said Aon Hewitt also looked for indicators of care avoidance, and they did not find an increase in large claim amounts typical with care avoidance. Also, "well visits" saw a 19 percent increase for actives and a 5 percent increase for retirees in PY 2013.

Ms. Donaldson noted the HSA was provided by PEBP to help pay for first dollar claims. The deductible for an individual was $1,900, but with HSA enhancements over and above the basic contribution, the employee received about $1,400 in contributions payable with the HSA. Aon Hewitt indicated HSA balances totaled approximately $12.5 million and Health Retirement Account (HRA) balances around $9.4 million. She noted the HSA balances were allowed to grow, similar to a savings account; therefore, active employees could contribute additional funds to help pay for coverage after they retired.

Ms. Donaldson said Aon Hewitt compared projected trend versus actual trend. In PY 2012 there was an underlying trend of 10 percent before plan design and utilization changes. The net trend after utilization and plan design changes was 1.2 percent for medical and -4.8 percent for prescription drugs. The actual trend was -18.6 percent. For PY 2013 there was a projected trend of 7.2 percent and the actual trend was -5.9 percent. Ms. Donaldson clarified that inpatient utilization was 40 percent of medical costs. The percentage of cost paid by the plan for inpatient costs increased from PY 2011 to PY 2013. The conclusion was that those obtaining high-cost care were

receiving greater financial support from PEBP, by the fact that expenses paid by PEBP increased three percentage points.

Ms. Donaldson noted outpatient care, which was about 60 percent of cost, was where the effect of consumerism could be seen. The cost of outpatient care, such as doctor visits, shifted to members, which resulted in approximately $8 million savings over the two-year period. Although there was an increase of 12 percent in PY 2012, there was a decrease of 5 percent in PY 2013. She said the decrease was probably because out-of-pocket expenses, before deductible was met, was seen in outpatient care. However, that did not reflect employees who used HSA or HRA funds to pay for first dollar coverage. She said doctor visits declined from PY 2011 to PY 2012, but increased in PY 2013. Additionally, well visits increased from PY 2012 to PY 2013. One thing to note was that the number of mammograms decreased in both years, because in PY 2011 coverage permitted more than one mammogram per year.

Senator Smith asked if there was a decrease in the actual number of visits made by members as compared to a decrease in the cost. Ms. Donaldson replied that the number of patients per thousand declined minimally for actives, but there was a noticeable decrease for retirees.

Ms. Donaldson explained that typically, ER visits increased when there was care avoidance. She noted that, although ER visits per thousand did increase, the number of admittances also increased from PY 2011 to PY 2012.

Turning to the topic of prescription drugs, Ms. Donaldson said there was a decrease of 25 percent in total number of prescriptions from PY 2011 to PY 2013. In PY 2013 there were 38 percent fewer members taking prescription drugs compared to PY 2011. She said there was an overall shift toward generic medications and a cost shift to participants, because prescription drugs were subject to deductible and coinsurance on the CDHP.

Ms. Donaldson said generic drugs made up about 18 percent of the overall prescription drug spend, but represented 78 percent of prescriptions. The average cost for generic drugs was about $26, which reflected no change over a three-year period. There was an increase of about 5 percent for the percentage of generic drug utilization from PY 2011 to PY 2013, which meant there was a shift from brand names to generics. Ms. Donaldson said the average cost of non-specialty brand drugs was approximately $128, which represented 30 percent of total costs, but 20 percent of overall prescriptions. She said there was a decrease in non-specialty brands, however, and an increase in generics. There was a 1 percent increase in the dollar spend of non-specialty drugs from PY 2011 to PY 2013; however, the average cost of generic drugs remained relatively stable. Ms. Donaldson said, specialty drugs were about 2 percent of overall prescriptions, but represented 52 percent of the costs. She noted there was an increase of less than 1 percent in the percentage of prescriptions from PY 2011 to PY 2013, and an average cost increase of 8 percent from PY 2011 to PY 2013. Aon Hewitt predicted specialty drugs would comprise a larger percentage of

the overall prescription drug spend in future years; therefore, it would need to be monitored. Ms. Donaldson said the prescription drug cost trend had a noticeable increase during the previous plan year. She thought that was because a high percentage of prescription drugs had migrated to generics. The associated savings would be less significant going forward, because the shift to generic drugs had leveled out; however, cost increases for specialty drugs would be likely.

Chair Carlton remarked that often specialty drug manufacturers provided coupons so patients could try the drug at a lower cost for six months or a year. She said it was common with certain heart medications and blood thinners, which were usually long-term medications. Chair Carlton hoped the increased cost could be factored in to avoid exorbitant pharmacy increases.

Ms. Donaldson said in the prior plan, approximately 2.3 percent of participants did not file a claim. She said this was significant, because typically 15-18 percent of participants filed no claims on average. That meant most employees were utilizing the plan in PY 2011; whereas, in PY 2013, 30 percent of participants did not file a claim.

Senator Smith noted that if 2.3 percent was an outlier, 30 percent was double the average. Ms. Donaldson replied that typically the range for a CDHP was 20-25 percent; therefore, 30 percent was high.

Senator Smith asked why the percentage of participants not filing claims was so much higher for the CDHP. Ms. Donaldson replied that patients in a PPO plan had a tendency to obtain medical care more liberally, because they were only responsible for a copay. However, patients in a CDHP were more likely to take a conservative approach to care, because they were responsible for the entire cost of the visit until the deductible was met.

Senator Smith remarked that it was a red flag that the percentage was so high, and it should be monitored.

Mr. Kindy noted many pharmacies offered generic drug programs. He thought perhaps members were paying out-of-pocket for those lower dollar items, as opposed to filing a claim.

Chair Carlton noted that 30 percent of participants filed no claims in PY 2013, yet the amount of hospital admittances as a result of ER visits increased. Further, 65 percent of participants either filed no claims, or filed claims that were before deductible. Therefore, she said, almost two-thirds of participants were impacted in some way. Chair Carlton remarked that was a red flag that raised concerns that there would be cases of care avoidance that would lead to more serious illness. She remarked that it seemed as though people were paying a premium, but not accessing the health care they should be receiving.

Ms. Donaldson replied that participants may have received the required care, but paid with HSA funds, because the deductible had not been met.

Mr. Kindy noted that individuals who did not file claims, or who did not have benefits paid by the plan, still benefitted from the accumulation of HSA funds that could be used in the future.

Senator Smith said even if the plan did not pay, a claim made against the deductible was still a claim, which was utilization. Mr. Wells clarified that the 30 percent represented the amount of participants who did not file claims. He said there was another number in the 30 percent range that reflected claims that were filed, but not paid out by the plan, because the deductible had not been met.

Mr. Wells noted that non-claim filers did not even take advantage of the annual wellness check-up that was covered 100 percent. He said HealthScope provided PEBP with a population distribution indicating which groups were not filing claims, and he would provide that information to staff.

Senator Smith asked if patient history was taken into consideration. She said historical perspective could be helpful to determine if lack of doctor visits was due to a different health care plan, or because people were healthier, or a combination of both.

In response to a question by Senator Smith, Mr. Wells confirmed that prescriptions were included in the percentage of no claims filed.

Senator Smith said that meant that people taking maintenance drugs were not filing prescription claims. She noted that could be because patients were paying out-of-pocket, because it was cheaper in the long run. Mr. Wells added that there was a slight shift in the area of maintenance prescriptions due to many pharmacies offering "4/10" programs. He explained that these programs allowed patients to purchase a 30-day prescription of certain medications for $4, or a 90-day supply for $10. He said not all the pharmacy programs were set up to file a claim toward the plan deductible.

Ms. Donaldson said out-of-network negotiations by the TPA saved PEBP about $5.1 million over a two-year period. In addition, the TPA created centers of excellence for transplants and bariatric surgeries that saved the plan about $1.8 million in PY 2013.

Senator Smith asked if the trend on bariatric surgeries was still increasing, or had it plateaued. Mr. Wells replied that the number of bariatric surgeries had leveled off, but there were still quite a few. He noted that, along with the centers of excellence, additional criteria was required before surgery could occur. He said the goal of the pre-surgical requirements was to help people change habits before surgery, so they would be successful after surgery. Mr. Wells noted that according to HealthScope, the number of transplants had increased. He said at any given time there were 20-30 patients either on the waiting list, prepping for surgery, or in post-surgery follow-up.

Chair Carlton remarked that the issue of excess reserves arose multiple times. She asked what had been discussed with respect to projected claims cost, future trends and how adjustments would be made. Mr. Wells replied that agenda item IV. B explained part of the reason as to why the FY 2014 rates were missed. Also, agenda item IV. D included some additional information concerning the trends for the CDHP and HMO plans.

Chair Carlton recalled that there was some discussion at the previous IRBC meeting regarding excess reserves. She said certain information provided at today's meeting was new, and although it was helpful, there needed to be a more thorough discussion about the issue of excess reserves. Chair Carlton said it was important to know why and how the reserves accumulated, because it was a large sum of money that could have been used elsewhere.

In response to a question from Mr. Kirner, Mr. Kindy replied that historically rates were set at a 95 percent confidence interval. That meant there was a 95 percent confidence level that the funding the rates represented would cover the cost of the plan in that year. He said Aon Hewitt reduced the confidence interval to 50 percent, because of the existing reserves; however, if the cost of the plan was over 50 percent, the reserve would be used to pay the claims. Mr. Kindy said, the question moving forward was whether the confidence interval should be more aggressive than 50 percent.

In response to a question from Mr. Kirner, Mr. Kindy replied that the 95 percent rate would have additional margin built into the rate to cover the 50-95 percent part of the curve in terms of claims. Because of the additional reserves, if rates were set at a 95 percent confidence interval, 45 percent of the time additional reserves would be expected to build. A 95 percent confidence interval would insulate the rates, as well as create excess reserves, which would be a conservative approach.

Mr. Kirner asked if the confidence interval could be set at 95 percent and then mitigated with the reserves. Ms. Donaldson replied that reserves were budgeted at a 95 percent confidence interval level. Additionally, Aon Hewitt had been incorporating a 95 percent confidence interval into rates to ensure rates would be covered. That margin was removed to avoid being overly conservative. The confidence interval was currently set at 50 percent, but a 95 percent confidence interval reserve was established in the likelihood it was needed in addition to the excess reserves.

Chair Carlton said, overall, the reserves were too high, and if reserves were being built into future calculations, there needed to be discussion about how to best utilize them. She remarked that part of the reserves were contribution dollars from the General Fund that could have been used for other purposes within the state. Chair Carlton thought it was important to remember the goal was to avoid continuously missing the mark.

Mr. Kirner added that the reserves were made up of state contributions and individual's premiums; therefore, it impacted participants as well.

Mr. Wells said PEBP had received loss ratio information from the two HMO plans. Federal law mandated that 85 percent of every dollar received for premiums must be spent on claims, or provided as a rebate to the plan population. Mr. Wells noted, the loophole was that the percentage applied toward a collective group. For example, one employer could be at 80 percent and another 90 percent; therefore, the cumulative was 85 percent. He said while the reserves had been building over the last couple of years, the population for the state HMO plans experienced dramatically low loss ratios; therefore, the HMO premiums missed the mark too. Mr. Wells noted that if the HMO plans had been self-funded, additional reserves would have been generated instead of subsidizing other employers or providing a profit to the HMO carriers. He said that would be taken into consideration when rates were set.

B. Presentation by PEBP's actuary regarding recent refinements in the method of projecting trend for future plan years.

Ms. Donaldson said the first step when updating rates was to gather claims and enrollment data from HealthScope. During the most recent process, Aon Hewitt discovered that claims did not compare to information previously provided by HealthScope. After multiple discussions, Aon Hewitt learned that HealthScope had changed its method of reporting incurred data, and factors used to complete the incurred data were materially different than actual. Additionally, prescription drug claims provided by the pharmacy benefit manager were truncated at $9,999, which meant claims over $10,000 were not reported to HealthScope. She said this explained the increase in prescription drug claims, and decrease in medical claims (page 57, Exhibit A). Ms. Donaldson indicated that because of the two data discrepancies, FY 2014 rates were set about 6.2 percent higher than they should have been for the state plan. For the non-state plan, the prescription drug discrepancy essentially offset the medical claim discrepancy.

In response to questions from Chair Carlton, Ms. Donaldson confirmed that this was a one-time occurrence that resulted in approximately $20 million in excess reserves.

C. Update by PEBP staff regarding projected excess reserve on June 30, 2014.

Mr. Wells said the cash balance of $175.1 million covered several things that were built into the program (Exhibit B). The first item, Incurred But Not Reported (IBNR) liability, included claims incurred prior to the fiscal year end that were submitted to the administrator for payment, or were not paid until after July 1. The current projection for IBNR was approximately $40.7 million. The next item, Catastrophic Reserve, was $28.1 million. It was set at 95 percent confidence to account for, and cover, any year in which rates did not cover the claims. The HRA Reserve was the amount contributed to the HRA accounts of Medicare exchange retirees and CDHP participants who do not qualify for a Health Savings Account. The current liability for the HRA Reserve was projected at $22 million. Mr. Wells said the Board approved carrying the HRA amounts

over in perpetuity with no cap on the amount; therefore, HRA account balances would continue to build.

Mr. Wells said the ACA imposed two new taxes on self-funded and fully insured plans scheduled to begin in FY 2014. The first tax was $1 per member (primary participant and all dependents) to the Patient-Centered Outcomes Research Institute. The payment, due in July, would be roughly $70,000. Mr. Wells said the tax per member would double to $2 in FY 2015, and would be indexed after that. The second tax was for the Transitional Reinsurance Program and would cost $63 per member, per year. He said the revenue would provide assistance to plans that were under the Silver State Health Insurance Exchange to offset the cost of the more expensive participants they believed would join the program first. The fee, which equated to $5.25 per month, per employee, was provided to carriers to offset losses. The liability of $1.3 million (page 13, Exhibit B), was for the first six months, with the same liability again from July-December. Mr. Wells said the cost decreased to approximately $3.67 per member for calendar year 2015 and would be due in two installments. The first payment, due January 2015 for calendar year 2014, was 90 percent. The balance of the payment would be due in December 2015. The Transitional Reinsurance Program fee was intended for three years only. He said the amount would decrease in calendar year 2016 and then dissipate completely. Mr. Wells said, for the time being, it was included as a liability, because it was a cash amount to be paid after the close of the fiscal year.

Mr. Wells said the end result was approximately $82.9 million in reserves over and above those required for liabilities at the end of the plan year. The Board committed to using some of the excess reserves for items such as HSA and HRA contributions and wellness incentives. He said the HRA contributions included those for the Medicare exchange retirees who would receive an additional $2 per month, per year of service in July 2014. For example, 20 years of service would result in an additional HRA contribution of $420. He said it was anticipated to cost approximately $4.4 million. The Board also agreed to contribute an additional $400 to HSA and HRA accounts for each primary participant on the CDHP, and $100 for each dependent up to a maximum of three. The cost of those contributions was $7.6 million for primary participants and $1.4 million for dependents.

Mr. Wells said the amount for wellness incentives was reduced for two reasons. First, PEBP was taking a more conservative approach based on participation in the previous year. Second, it was originally thought that premiums would continue to increase; however, premiums for the self-funded plan decreased which was reflective of the lower single-person premium being covered at 100 percent. He explained that the wellness incentive for a participant only on the CDHP would cover 100 percent of the participant's cost if the participant earned enough wellness points.

Mr. Wells said the Board approved coverage of the Part B premium credits provided to retirees who were not eligible for Medicare. He explained that non-Medicare eligible were individuals who had not paid into Part A, because they did not have enough

quarters, or because the participant covered a non-Medicare eligible dependent. Those participants were permitted to remain on the CDHP or HMO, and would receive a credit equal to the Part B premium paid to Medicare when they enrolled in Part B. The cost of the premium credits was estimated at about $1.1 million.

Mr. Wells said the Board also approved four benefit enhancements to the plans.

Enhancements specific to the CDHP:

- Increased coinsurance from 75 percent to 80 percent after deductible, with a projected cost of $1.5 million;
- Decreased deductibles from $1,900 to $1,500 for individuals, and from $3,800 to $3,000 for a family, with a cost of approximately $2.1 million;
- Annual vision exam covered at 100 percent with a projected cost of approximately $1.3 million.

Enhancement for all plans:

- Increased dental maximum from $1,000 to $1,500. The cost of the increased dental maximum was estimated at $3.2 million.

In response to a question from Chair Carlton, Mr. Wells confirmed that the benefit enhancements were effective July 1, 2014.

Mr. Wells said there was $54.5 million in excess reserves remaining for the 2015-17 biennium. He said on April 3, 2014, the Board would discuss how to allocate the remaining $54.5 million in PY 2015. Most likely a portion would be used to mitigate rate increases; however, Mr. Wells thought mitigating rate increases was shielding participants from an impending increase in monthly premiums and out-of-pocket costs. He said PEBP was trying to gradually increase premiums and out-of-pockets costs over the next biennium to avoid “rate shock” in the future.

Chair Carlton said before there was talk about rate shock, there needed to be a deeper discussion about excess reserves. She recalled hearing about rate shock in 2011 and since then the reserves had been sizeable.

Mr. Kirner asked if the enhancements were funded by the excess reserves, and if they applied equally to state and non-state participants. Mr. Wells clarified that three of the enhancements applied to the CDHP specifically. The increased dental maximum applied to all participants and dependents on all plans. He also confirmed the enhancements would apply to state and non-state participants alike.

In response to Mr. Kirner, Mr. Wells confirmed that there would not be a negative impact on the rate setting process for FY 2015; however, the enhancements increased the underlying cost of the benefits which would increase premiums when reserves were depleted.

Mr. Kirner noted the benefits structure could be changed in lieu of premium increases.

Chair Carlton said she was especially interested in the Board's actions pertaining to the $54 million in excess reserves. She was aware there had been some discussion at the PEBP Board meeting on February 27, 2014.

With regard to certain proposed Board actions, Chair Carlton thought it was good that participants were receiving additional support. She suggested that a premium rate holiday would be a sensible use of excess reserves. Although it might be challenging to implement, she thought it warranted discussion by the Board.

Mr. Wells replied there had been internal discussions about a premium holiday as a potential option for the Board to consider. He said there were possible complications related to premium holidays, specifically for the state. He explained that there was some question as to whether agencies would actually experience a savings based on the way money was deposited into the PEBP budget account, and the way the monthly Active Employee Group Insurance (AEGIS) and Retired Employee Group Insurance (REGI) assessments were withdrawn from employee paychecks and placed into separate pass-through budget accounts. It was unclear whether a premium holiday would be legally feasible from the perspective of the AEGIS and REGI. State agencies might have to continue to fund the two pass-through budget accounts; therefore changing where the excess reserves lie. Mr. Wells said a premium holiday would affect the majority of participants; however, a participant-only, with the wellness incentive, would not benefit from a premium holiday, because their premium was already at zero. He noted that a premium holiday would be a topic of discussion at the Board meeting on April 3, 2014.

Chair Carlton thought it was important to determine possible barriers pertaining to a premium holiday, and move forward from there.

Mr. Wells said he would discuss the situation with PEBP's Deputy Attorney General. He thought it would be helpful to receive input from the LCB Legal Division staff as well. Mr. Wells noted that a premium rate holiday in the month of January would be easier to manage. Additionally, it would allow time to determine the legal status, and time to pass legislation if necessary.

Public Comment:

Marty Bibb, RPEN, understood the Committee was dedicated to managing the situation with the excess reserves. He hoped the Committee would consider the Medicare exchange and HMO non-state retiree participants when determining the best use of excess reserves.

Peggy Lear Bowen asked for clarification regarding the allowable number of mammograms per year. She thought many people avoided follow-up mammograms because they would be responsible for the cost.

With regard to ER visits, Ms. Bowen said after a recent head injury she was hesitant to go to ER due to the cost; however, two doctors recommended an MRI scan. When she went to ER to request the test she was told she did not appear to have a life-threatening situation; therefore, a CT scan was recommended rather than an MRI due to cost. She said, to date, she still had not undergone an MRI to determine the extent of the damage.

With regard to the dental benefit, Ms. Bowen said she was grateful for the increased benefit. She noted that the limits on coverage, such as 50 percent for a crown and 80 percent for a filling, made it difficult to utilize the HSA in the way she preferred.

Marlene Lockard, RPEN, said during the 2013 Legislative Session, S.B. 34 endeavored to provide $400 per person to non-state retirees by using excess reserves. Although the bill did not pass, she wanted to remind the Committee of its intention to address the non-state retiree issue.

With regard to Ms. Bowen's comments, Chair Carlton asked Mr. Wells to clarify the allowable number of mammograms per plan year. Mr. Wells confirmed that in PY 2012 the number of preventative mammogram screenings, covered at 100 percent, was reduced to one. He said if an initial mammogram had a potential finding, follow-up tests and/or additional mammograms were covered, but subject to deductible and coinsurance.

Mr. Kirner said traditional x-rays were an ineffective screening method for certain breast densities. He asked if an annual sonogram was covered under the same benefit. Mr. Wells indicated that he would research the question.

With regard to S.B. 34, Mr. Wells said $400 for non-state retirees was included as part of the excess reserve use for PY 2015 (page 13, Exhibit B). Chair Carlton thanked the Board for keeping the Legislature's intention in mind.

D. Presentation by PEBP staff regarding proposed Plan Year 2015 rates to be presented to the PEBP Board at its meeting on April 3, 2014.

Mr. Wells provided an overview of potential plan design changes and rates for FY 2015 (Exhibit B) that would be discussed by the Board on April 3, 2014.

Chair Carlton and Assemblyman Kirner sought clarity on whether the figures reflected the state's portion only. Mr. Wells replied that the numbers reflected the base HMO rate, which included the employee and employer share; however, it did not include administrative costs, life insurance or long-term disability. He further clarified the dollar amounts were the amounts billed to PEBP by the carrier for one month for each specific plan.

In response to Chair Carlton, Mr. Wells said the participant's portion would be included as part of the rate setting discussion.

Mr. Kirner asked why there was a difference between state and non-state if Health Plan of Nevada (HPN) was charging a flat rate to provide coverage. Mr. Wells replied that the state and non-state participants were rated separately per statute.

Mr. Wells provided an overview of possible changes to HMO copayments (Exhibit B). He explained the goal was to make Southern and Northern Nevada HMO plans more reflective of one another, because the premiums were the same. The benefit structure of the Southern Nevada plan was traditionally more rich. However, the Northern Nevada plan allowed self-referral to specialists, unlike the Southern Nevada plan.

Mr. Wells said the HPN rates were scheduled to increase between 8-9 percent without any benefit changes. With plan changes the HPN rates would increase by 5 percent. The Northern Nevada HMO agreed that if the current plan design options were maintained, the rates would not increase. However, to enhance the benefits in order to lower the two copayments, the cost would be between 4-5 percent.

Mr. Wells said PEBP was currently using HMO "rate blending" to determine rates. This involved taking individual premiums and weighting them by enrollment in the two HMO plans to establish a single rate for each tier. He said that resulted in "rate variance," which was the difference between projected and actual enrollment. To date, the rates should have been higher given actual enrollment compared to projected enrollment. Mr. Wells said over the past two years the cost of the rate variances were about $14 million, which was absorbed by reserves instead of affecting rates.

Mr. Wells said there was an alternate method of rate blending, which would involve determining a blended contribution amount and applying it to the actual rate from different carriers. The difference would be offset by the amount that came from subsidy accounts. Mr. Wells said a consequence of the alternate method would be a large increase to the Northern Nevada non-state retiree HMO and Cobra rates. Additionally, the subsidy would go further in Southern Nevada than in Northern Nevada. The alternate method was intended for state active and retiree populations only.

Mr. Wells noted the Board had three options: continue with the existing rate blending methodology for HMOs, switch to the alternate method, or eliminate blending altogether and revert to the individual plan offset by the percentage the state pays.

Moving to the topic of trend, Mr. Wells provided an overview of the three options to be presented to the Board. He said the actuaries thought the underlying trend for PY 2015 would be 6 percent for medical and prescription drugs, and 4 percent for dental. PEBP asked the actuaries to provide two other alternatives; reduce by half and remain at zero. Mr. Wells thought the 6 percent trend option was overly conservative. He suggested 3 percent medical trend and 2 percent dental trend would be a better starting point. He noted that if the Board approved a zero percent trend level, it was likely that the excess reserves would be consumed. Mr. Wells also pointed out that the rates shown in Exhibit B were not "loaded" with all the administrative costs.

Mr. Wells stated the Board would also discuss whether to increase the life insurance benefit. He said in 2011 the life insurance benefit was reduced by 50 percent as part of the benefit reduction package. Life insurance coverage for active employees was reduced to $10,000 and to $5,000 for retirees. He noted the cost to fully reinstate the benefit would be $2.2 million, which could be paid with excess reserves.

Mr. Wells said the available excess reserve amount was $54.6 million. If the Board chose a zero percent trend level for the CDHP, the cost would be about $5.8 million. He said the Board would have the option to mitigate rate increases. If the Board wanted to keep the rates fixed, the cost would be up to $9.6 million depending on the copayment option package selected by the Board. Mr. Wells said, for the most part, excess reserves were primarily driven by state active employees in the CDHP. The other plans did not generate excess reserves, but instead consumed them. He said at some point there should be discussion about how much one group should subsidize another.

Chair Carlton asked Mr. Wells to provide the cash flow documents to staff that would help provide a better understanding of the formulas. She wanted to understand how the dollars were siloed, and the strength of those silos.

In response to a question from Mr. Kirner, Mr. Wells said in order to determine which plans generated or consumed excess reserves, the revenue, claims, and administrative costs were apportioned.

Mr. Kirner asked if both state and non-state employees would benefit when PEBP applied the excess reserves. Mr. Wells confirmed the excess reserves would benefit all the various participants. Mr. Wells also briefly discussed PEBP's methodology for determining which participant groups generated excess reserves and which groups "consumed" excess reserves.

With regard to contribution amounts, Mr. Wells explained the method for establishing contribution amounts for state active employees and state retirees was different than non-state participants. He said the state's portion of the total premium for CDHP was 93 percent and the employee's portion was 7 percent. For the HMO plan, the state's portion was 78 percent and the employee's portion was 22 percent. Mr. Wells said that in 2011, PEBP examined out-of-pocket costs in an effort to align the plans. At that time, the CDHP had a $1,900 deductible offset by $700 in HSA contributions for active employees, so a model was designed to determine the appropriate state contribution percentage, which was 78 percent. He said, for those with dependents, the state's portion for the CDHP was 73 percent of the incremental costs of dependent coverage, and 58 percent for the HMO. For retirees, the state's portion was 64 percent for the CDHP and 49 percent for HMO. The state's portion for retirees who cover dependents was 44 percent for CDHP and 29 percent for HMO. Mr. Wells clarified the percentage for retirees was for the "base" subsidy, based on 15 years of service credit. Subsidies were then adjusted up or down based on actual years of service. He said, in PY 2014 the Board maintained participant contributions for the HMO plans, and instead, drew the

balance from the AEGIS. Mr. Wells said the base rates that the Board would review reflected the original contributions; however, the Board would have the option to adjust the contributions.

E. Presentation by PEBP Board Chair regarding Board consensus on updates to PEBP's Strategic Plan, any plan design modifications anticipated for the 2015-2017 biennium, Board meeting protocols discussed by the PEBP Board on February 27, 2014, and strategies to improve communication with PEBP participants.

Leo Drozdoff, PEBP Board Chair, said the Board wanted to avoid significant changes over the next several years. He noted the current healthcare plans were good, and the decisions made at the April 3, 2014, meeting would place them in the platinum range, based on the Affordable Care Act's "metal ratings" for health plans.

Mr. Drozdoff said the excess reserves afforded the opportunity to reinstate certain benefits to the plans.

Regarding a middle-tier PPO or corporate exchange, Mr. Drozdoff said the Board was not ready to consider the idea yet. He said that although a middle-tier PPO or corporate exchange might be reexamined at some point, the current focus was to ensure that the HMO, CDHP and Medicare exchange plans ran smoothly. Additionally, the Board was concerned with utilizing reserves effectively and avoiding excessive accumulations in the future.

Mr. Drozdoff recalled a discussion at a previous IRBC meeting concerning non-state retirees, and he thought there were three choices to consider. The first option was to combine state and non-state into one rating pool, which would require a statutory change. It also meant that state employees and retirees would augment the non-state retiree group's costs. Mr. Drozdoff estimated this cost at approximately $10 million. The second option was to find funds elsewhere to continue funding the non-state retiree group's costs. The final option was to find another mechanism, such as returning non-state retirees to their former employers' healthcare plan. Mr. Drozdoff said historically the Board was not in favor of comingling the groups, because it would have a negative impact on the state group; however, the Board would be receptive to the best option for non-state retirees.

Chair Carlton said at the next IRBC meeting there would be a more thorough discussion concerning the non-state retiree group. Chair Carlton felt that it was an ongoing issue that would not be resolved for quite some time. Chair Carlton commended the Board for addressing the issue in the short-term; but she noted the issue required a long-term solution.

For the next IRBC meeting, Senator Smith requested a count of the non-state retirees that would not transition to the Medicare exchange.

Chair Carlton agreed, but noted it could be difficult and time-consuming to determine who was and was not on Medicare. She hoped there would be enough time before the next legislative session to obtain the information.

Mr. Drozdoff said PEBP would assemble information for the next IRBC meeting that would provide direction leading up to the 2015 Legislative Session.

Mr. Drozdoff said PEBP was updating its strategic plan because the current version did not reflect the CDHP or Medicare exchange. The subcommittee appointed to review and update the strategic plan was provided specific items for inclusion to ensure an effective document.

Mr. Drozdoff reassured Chair Carlton and the Committee that future Board meetings would be held in an accessible location.

Mr. Kirner said the Committee was told the healthcare plans were good, but the reserves would be used to enhance the plans to make them better. When the reserves were consumed, the rates would increase to compensate for the enhanced plans. He asked if the Board considered leaving the plans as-is, and using the reserves to lower rates instead.

Mr. Drozdoff said, with regard to the CDHP there were some added benefits and HSA contributions, which would likely occur again in the future. Regarding the HMO, the rates increased 5 percent, because it would cost almost $10 million to keep the rates the same. He said the danger in using reserves to keep rates static was that eventually the reserves would be exhausted and there would be a large rate increase. Raising the rates by 5 percent now was a more gradual approach. He said another option would be a rate holiday.

Mr. Kirner said he would argue that the reason for excess reserves was that current rates were artificially high. Instead of reinstating certain benefits, he asked if the Board considered using the reserves to lower rates to a more realistic level, to avoid a large increase in the future.

Mr. Drozdoff replied that the reserves were used to lower rates to a certain degree, such as the decreased deductibles for the CDHP. He said between the decreased deductibles and the HSA contributions, the CDHP was similar to a low deductible plan. Mr. Drozdoff said, although it still needed adjustment, the CDHP was generating savings as originally intended.

Mr. Kirner commended the Board for increasing the subsidy for the Medicare exchange participants in an effort to combat rising rates.

F. Presentation by PEBP staff regarding latest audit results for Towers Watson (formerly Extend Health), PEBP's Medicare Market Exchange provider, PEBP's response to the audit, and Towers Watson's communication with Medicare retirees.

Mr. Wells provided an overview of the audit results for Towers Watson. He said the audit was the third audit of the Medicare exchange. The first audit resulted in a series of strong recommendations from PEBP. Towers Watson addressed and corrected the issues; however, additional issues were found in the second audit. Towers Watson was notified of the findings and the corrective actions that PEBP expected (page 141, Exhibit A).

Mr. Wells noted that Towers Watson made some changes requested by PEBP, as well as some of their own volition. As a result, the communication to participants and PEBP was not always aligned, or was overlooked. In an effort to close the communication gaps and improve recurring customer service issues, PEBP and Towers Watson were scheduled meet to address some larger issues.

Chair Carlton said she had received comments from constituents concerning Towers Watson's communication issues. She thought it could be helpful to have an ombudsman located within the state to help with questions concerning basic logistics. Chair Carlton noted many businesses, particularly insurance companies, provided that type of service. Chair Carlton encouraged PEBP to discuss the possibility of an in-state advocate at their upcoming meeting with Towers Watson.

Mr. Wells noted in June 2014 there would be meetings throughout the state for Towers Watson to explain to the participants the process of Medicare exchange transition and post-transition. The meetings would be held in several locations and a recording of the meeting would be available on the PEBP website for individuals who could not attend a live meeting. Mr. Wells said PEBP was preparing a Request for Proposal (RFP) for the contract, and now had a better understanding regarding what to include and what to look for in the responses. He noted that although Nevada was the first state to mandate a Medicare exchange for retirees, Rhode Island was now mandating it as well. Several larger states were also considering Medicare exchange groups, which meant it was undoubtedly a growing trend.

Chair Carlton noted she had the opportunity at a recent national conference to communicate some of the challenges that Nevada encountered concerning Medicare exchange groups. Out of consideration for retirees, she thought it was important to correct the problems soon, or rethink the program.

G. Presentation on current demographics of PEBP participants from non-state entities, and discussion of alternatives for non-state participants' plan design for the 2015-2017 biennium.

Mr. Wells said approximately 350 non-state participants over age 65 remained enrolled in the CDHP or HMO plans, because they did not have Medicare Part A, or because they were covering a non-Medicare dependent (page 145, Exhibit A). He said individuals were not required to transition to the Medicare exchange plan until the youngest individual (either participant or dependent) turned 65.

Mr. Wells said there were a series of options affecting the non-state retirees to discuss before the next IRBC meeting. He said a non-state retiree participant had received correspondence from the Clark County Teachers Health and Welfare Trust concerning coverage reinstatement. Mr. Wells said there was a statutory requirement that allowed a non-state retiree to reenroll in retiree coverage with their non-state employer; however, the letter attempted to deny that fact.

Mr. Wells noted that another letter, issued by PEBP to non-state retirees, was not meant to be threatening, it was meant to be factual. He explained that communication lapses occurred as a result of the addition of non-state retirees beginning in 2003, and elimination of the ability for new non-state retirees to join the plan, effective in 2008. He stated there were thousands of retirees who joined before the cutoff. Mr. Wells did not think there was clear communication to the non-state retirees about the impact of joining PEBP. There were only six active non-state employees remaining in the non-state pool, making it literally a non-state retiree-only rating pool. Mr. Wells said the pool was becoming more volatile as it was shrinking. A million dollar claim had a much bigger impact on a small group, as opposed to a group of 30,000. Mr. Wells thought it was important to explore all options to determine which would be in the best overall interest of all parties involved, while recognizing that the non-state retirees needed relief.

Chair Carlton recalled Assembly Commerce and Labor Committee meetings where requests were made to establish insurance pools for 300 people or less; however, the insurance commissioners were of the opinion that was not a large enough pool to support itself.

Mr. Wells responded that PEBP's actuaries now thought 750 people did not create a large enough pool to support itself. He indicated that the non-state pool was quickly approaching that number on the CDHP, and both HMOs were also very close. He remarked that the state was rapidly approaching a non-sustainable, non-ratable pool of participants.

V. PUBLIC COMMENT.

Marlene Lockard, RPEN, noted the $400 mentioned by Mr. Wells was provided to all participants; however, the intent of S.B. 34 was to provide additional relief specifically for the non-state retiree group. Additionally, the $400 appeared to be for CDHP participants only, not for non-state retirees on the HMO. Ms. Lockard said RPEN was encouraged to hear that all options would be discussed and considered by the PEBP Board.

Ms. Lockard said she strongly supported the idea of an in-state ombudsman to assist the Medicare exchange retirees, because it was a complicated issue.

Peggy Lear Bowen asked if statute required the state and non-state groups to remain separate when obtaining bids. She thought by combining pools, the strength in

numbers could lower rates, especially for the non-state retiree group who were paying higher rates due to the low volume.

Ms. Bowen noted that the rates for non-state retirees appeared to show an increase based on Appendix A (Exhibit C). Due to the technical nature of Ms. Bowen's question, Chair Carlton asked Program Analyst, Laura Freed, to speak with Ms. Bowen after the meeting adjourned.

Jack Harris, RPEN, noted that PEBP has had many of the same ongoing difficulties with Towers Watson. He noted that issues such as communication and penalty phases were included in the original contract. He noted Towers Watson had several large clients, yet seemed to have more problems with the State of Nevada, in spite of its small size. He wondered, if the programs were the same across the board, why there were more problems with the state's program?

Mr. Harris appreciated the suggestion for an in-state ombudsman, because many members did not know who to contact for assistance.

VI. ADJOURNMENT.

The meeting was adjourned at 11:45 a.m.

Respectfully submitted,

_____
Carla Ulrych, Committee Secretary

APPROVED:

_____
Assemblywoman Maggie Carlton, Chair

Date:_____

Copies of exhibits mentioned in these minutes are on file in the Fiscal Analysis Division at the Legislative Counsel Bureau, Carson City, Nevada. The division may be contacted at (775) 684-6821.