STUDY OF STATE PROGRAM OF GROUP INSURANCE

Bulletin No. 83-15

COMMITTEE TO STUDY THE STATE PROGRAM
OF GROUP INSURANCE

STATE OF NEVADA

March 1983

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Committee to Study the State Program

of Group Insurance

State of Nevada

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SENATE CONCURRENT RESOLUTION—Creating a committee to study the state's program of group insurance and report back to the 62nd session of the legislature.

WHEREAS, Many state employees and employees retired from state service participate in the state's program of group insurance; and

WHEREAS, Changes in the program may be required to maintain the stability and ensure the efficient management of the program; and

WHEREAS, A study of the program would aid the legislature in determining any necessary changes; now, therefore, be it

Resolved by the Senate of the State of Nevada, the Assembly concurring, That a committee of five members be formed as soon as possible to study the state's program of group insurance; and be it further

Resolved, That the majority leader of the senate appoint one member of the senate, one person who is retired from state service and one person who has specialized knowledge of insurance to serve on the committee and that the majority leader of the assembly appoint one member of the assembly and one state employee to serve on the committee; and be it further

Resolved, That the committee investigate and prepare a report concerning:

1. The method of appointment and the qualifications of the committee on group insurance;
2. The method for determining premiums and benefits for the program of group insurance;
3. The procedure for soliciting bids from insurers to provide coverage;
4. The adequacy of the program;
5. The procedure for determining the legitimacy of claims;
6. The insurers currently providing coverage; and
7. The advisability of self-insurance by the state and the advisability of providing coverage for public agencies;

and be it further

Resolved, That the committee is directed to submit its report to the 62nd session of the legislature within 45 days after the members of the committee are appointed.

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REPORT OF THE COMMITTEE TO STUDY THE STATE PROGRAM OF GROUP INSURANCE

To the Members of the 62nd Session of the Nevada Legislature:

This report is submitted in compliance with Senate Concurrent Resolution No. 5 of the 1983 legislative session (File No. 13) which creates a five-member committee to study the state program of group insurance and requires the committee to report its findings within 45 days after its members are appointed. The resolution requires the committee to investigate and prepare a report concerning:

1. The method of appointment and the qualifications of the committee on group insurance;

2. The method for determining premiums and benefits for the program of group insurance;

3. The procedures for soliciting bids from insurers to provide coverage;

4. The adequacy of the program;

5. The procedure for determining the legitimacy of claims;

6. The insurers currently providing coverage; and

7. The advisability of self-insurance by the state and the advisability of providing coverage for public agencies.

The committee has attempted, in this report, to present its findings and recommendations briefly and concisely. A great deal of information was gathered in the course of the study. The data which bear directly upon recommendations in the report are included, either in the narrative or appendices. The report is intended as a useful guide to busy legislators. All supporting documents and minutes are on file with the legislative counsel bureau and are available to any member.

This report is transmitted to the members of the 1983 legislature for their consideration and appropriate action.

Respectfully submitted,

Committeee to Study the State Program of Group Insurance

Carson City, Nevada
March 25, 1983

COMMITTEE MEMBERS

Assemblyman James J. Banner, Chairman
Senator Randolph J. Townsend
Mr. Robert Gagnier
Mr. Clarence Hecksthorn
Mr. Ben Dasher

SUMMARY OF RECOMMENDATIONS

This summary represents the major conclusions reached by the committee. These conclusions are based upon (1) suggestions which were made to the committee at public hearings; (2) written responses to the committee's questions to the committee on group insurance, the broker of the state's group health insurance plan and the administrator of the plan; (3) other correspondence to the members and staff of the committee; and (4) the experience and knowledge of the committee members.

The committee suggests that those recommendations requiring legislation be drafted into appropriate form and be considered by the 62nd session of the legislature.

The committee recommends:

POWERS AND DUTIES OF THE STATE RISK MANAGER AND THE COMMITTEE ON GROUP INSURANCE

1. The statutes be amended to give the responsibility for purchasing group life, accident or health insurance, or for establishing state self-insured programs of life, accident or health insurance for state officers, employees or persons retired from state service, to the state risk manager. The committee recommends further that the committee on group insurance provide advice and assistance to the state risk manager and, in its advisory capacity:

   (a) Advise the state risk manager on matters relating to group life, accident or health insurance, or any combination thereof, for the benefit of all state officers, employees or persons retired from state service;

   (b) Review and make recommendations to the state risk manager on the following topics:

      (1) Cost containment programs including, but not limited to, mandatory second opinions for surgery, medical screening of claims, discounts for outpatient care, and the use of peer review boards;

(2) Prepaid plans or preferred providers plans;

(3) Complaint handling procedures;

(4) Direct benefit and capitation programs;

(5) Appropriate group life, accident and health insurance bidding practices;

(6) The use of health maintenance organizations;

(7) Deductibles, coinsurance levels, coverage maximums, and schedules of benefits for reimbursement;

(8) Requirements and special needs of state officers, employees and persons retired from state service for life, accident or health group insurance coverage;

(9) Legislation needed to strengthen, improve or modify the state's group life, accident or health insurance programs;

(10) The feasibility of the state establishing state self-insured programs of life, accident or health insurance coverage for state officers, employees or persons retired from state service;

(11) The feasibility of mental health benefit coverage by the private sector;

(12) The purchase of policies of life, accident or health insurance, or any combination thereof, from any company qualified to do business in this state for the benefit of all state officers, employees and persons retired from state service who elect to participate in the state's group insurance program; and

(13) The purchase of Part B of Medicare for retired state employees.

(c) Recommend to the state risk manager such regulations and perform such duties as may be assigned by the state risk manager to carry out the applicable provisions of the Nevada Revised Statutes.

2. The state risk manager provide for the establishment of orientation and continuing education programs relating to benefits, changes in benefits, and cost-saving techniques which will cause (a) life, accident or health insurance premium cost savings for the state and state officers, employees and persons retired from state service who participate in the state group insurance program and (b) reduce abuse or overuse of the group insurance plan.

3. The statutes be amended to require the legislative auditor to conduct periodic financial and operational audits, which determine compliance with the law, of the state's activities relating to the program of group life, accident or health insurance.

   The committee recommends further that the statutes require the legislative commission to establish a schedule for those audits.

COMPOSITION OF THE COMMITTEE ON GROUP INSURANCE

4. The statutes be amended to provide that the committee on group insurance be composed of five members appointed by the governor from the following categories: one member selected from a list of five names recommended by the Nevada State Employees' Association; one member selected from a list of five names recommended by the retired public employees of Nevada; two members who have not been employees of the State of Nevada for 5 years preceding their appointment and who are not retired state employees; and one representative of the University of Nevada System selected from a list of five names recommended by the board of regents of the University of Nevada System.

   The committee recommends further that the members of the committee on group insurance serve 3-year staggered terms. To accomplish the staggering of terms, the initial appointments for the representatives from the Nevada State Employees' Association and the retired public employees of Nevada should be for 1 year. One public member should be initially appointed for 2 years and the other for 3 years. The initial appointment of the representative of the University of Nevada System should be for 2 years. No member should serve more than two terms and the governor should be permitted to remove any member for cause.

PREMIUMS AND BENEFITS

5. The state risk manager attempt to stabilize premium costs and improve coverages through negotiating long-term contracts with appropriate providers.

6. The statutes be amended to require that premium costs for group life, accident or health insurance for persons retired from state service be computed as part of the total group insurance plan costs and not as a separate cost entity in the group plan.

7. The statutes be amended to clarify that the surviving spouse of a person retired from state service, who is covered under the state plan for group life, accident or health insurance, is entitled to remain covered under that plan after the retired employee's death.

8. The statutes be amended to prohibit political subdivisions of the state from joining the state plan for group life, accident or health insurance coverage.

9. The statutes be amended to permit the state to establish state self-insured programs of life, accident or health for state officers, employees or persons retired from state service.

10. The statutes be amended to eliminate the premium tax on the state's policy of group insurance.

REPORT TO THE 62ND SESSION OF THE NEVADA LEGISLATURE FROM THE COMMITTEE TO STUDY THE STATE PROGRAM OF GROUP INSURANCE

I. INTRODUCTION

The study of the state program of group insurance had its genesis in retired state employees' concerns about the program. Representatives of retired state employees expressed the belief that the program does not provide adequate health insurance coverage at reasonable premium cost for the state's retired officers and employees. The belief has also been expressed that changes need to be made in the composition of the committee on group insurance, and many of the committee's practices need to be modified to maintain the stability of the program of group insurance and to ensure its efficient management.

Retired state employees believe, it has been noted, that actions of the committee on group insurance tend to discriminate against retired state employees and taint the state's moral obligation to properly consider the medical well-being of those persons who have devoted a lifetime of work to state service.

The members of the 62nd session of the Nevada legislature agreed that sufficient grounds exist for a study of the state's health insurance program and adopted Senate Concurrent Resolution No. 5 (File No. 13) which provides for the creation of a committee to study the state's program of group insurance and requires that the committee report back to the 62nd session of the legislature within 45 days after the committee's formation.

The 62nd session of the legislature realizes that the state's program of group insurance affects more than those persons who have retired from state service. The administrator of the program advises that of the 12,051 persons covered by the plan, 11,169 are active state employees. In passing S.C.R. 5, therefore, the 1983 legislature sought a balanced appraisal of the state's program of group insurance by requiring that the committee be composed of one senator, one assemblyman, one state employee representative, one person who is retired from state service and one person who has specialized knowledge of insurance.

The members of the committee were appointed on February 9, 1983, and the report was due by March 26, 1983. It should be noted that a study of this nature, conducted while the legislature is in session, is unique and offers the same legislature which adopts a study resolution the opportunity of considering the recommendations emanating from the study.

The committee, within the limited time frame allowed for its study, attempted to perform a comprehensive review of the state program of group insurance. It held public meetings in Carson City on February 18, February 25, and March 4, 1983. A listing of those persons who appeared before the committee and signed the witness rosters is contained in the credits section of this report. The committee held a work session on March 17 and chose the recommendations contained within this report.

The committee prepared a list of questions for the chairman of the committee on group insurance, the agent-broker of the state's group health insurance plan and the administrator of the plan. Those questions and responses to them are contained in appendices A through C of this report. As can be seen, the questions cover most aspects of the state program of group health insurance including such areas as premiums and coverages, cost containment, self-insurance by the state, bidding practices, the composition of the committee on group insurance, the activities of the committee and its agent and program administrator, insurance carrier turnover, insurance need analyses of state employees and retirees, supplemental coverages, claims administration, complaint handling and several other matters. In an effort to keep this narrative short, those questions and answers will not be reiterated or summarized.

Recommendations made by representatives of retired state employees are contained as appendix D to this report. Other committee working papers, including correspondence to the committee, are contained with the committee's minutes which are on file in the research division library of the legislative counsel bureau.

Technical assistance to the committee was provided by a staff member of the insurance division of the department of commerce and by the state risk manager.

II. FINDINGS AND RECOMMENDATIONS

The following sections of this report represent the committee's recommendations and legislative proposals for changes needed to improve the state's group health insurance program and to ensure adequate and appropriate medical insurance coverage for those persons electing to participate in the program.

A. POWERS AND DUTIES OF THE STATE RISK MANAGER AND THE COMMITTEE ON GROUP INSURANCE

1. Risk Manager Given Responsibility for Purchasing Employee Group Insurance.

Under existing law, the committee on group insurance is charged with the responsibility of purchasing policies of life, accident or health insurance for the benefit of all eligible public officers and employees who elect to participate in the state group health insurance program. The committee is also responsible for advising state employees about group insurance matters, negotiating and contracting with political subdivisions that wish to join the state's program and adopting regulations for the conduct of the program. The committee is required to consult the state risk manager in performing its duties.

The state risk manager is required by law to act as an adviser to the committee on group insurance. The risk manager is, however, restricted from determining the nature and extent of requirements for employee group insurance or from negotiating for or purchasing employee group life, accident or health insurance.

The committee on group insurance is not statutorily accountable to a higher authority, nor does it fit into a "chain of command" which ultimately reports to the governor or an elected governing body. Moreover, as discussed later in this report in the section entitled "Composition of the Committee on Group Insurance," two of the five members of the group are selected by the employees' association and need not be directly concerned with the governor's favor for continued membership on the committee.

The committee studying the state program of group insurance believes that there needs to be more accountability in the state program of employee group insurance. There is strong precedent for accountability in employee group health insurance programs in other states, political subdivisions in Nevada and the private sector. According to the program administrator, the total annual premium for the state program is $18,758,028. No group should, the study committee feels, be free to spend over $18.7 million without being accountable to a higher authority. Furthermore, it is questionable whether a lay group should be directly involved in the highly technical endeavor of purchasing insurance. A full-time state official should be charged with that activity. Employees need a person with whom to communicate about the program, other than an outside administrator. An amorphous committee cannot answer the day-to-day questions of persons concerned about how their group insurance is being handled or give advice on group insurance matters.

The committee studying the state program of group insurance believes that the state risk manager should be assigned the primary responsibility for carrying out the functions associated with the employee group insurance program. The risk manager is involved in a direct chain of command which leads to the governor's office. The risk manager is also accessible for complaint handling and has the knowledge and experience to deal efficiently and effectively with insurance matters. It could be argued that the director of the department of administration, who is an ex officio member of the committee on group insurance, reports to the governor and that this gives the governor some degree of control over the committee. The director, however, is only one member of the committee which is highly factioned and whose membership has diverse views.

The committee to study the state program of group insurance therefore recommends:

The statutes be amended to give the responsibility for purchasing group life, accident or health insurance, or for establishing state self-insured programs of life, accident or

health insurance for state officers, employees or persons retired from state service, to the state risk manager. The committee recommends further that the committee on group insurance provide advice and assistance to the state risk manager and, in its advisory capacity:

(a) Advise the state risk manager on matters relating to group life, accident or health insurance, or any combination thereof, for the benefit of all state officers, employees or persons retired from state service;

(b) Review and make recommendations to the state risk manager on the following topics:

(1) Cost containment programs including, but not limited to, mandatory second opinions for surgery, medical screening of claims, discounts for outpatient care, and the use of peer review boards;

(2) Prepaid plans or preferred providers plans;

(3) Complaint handling procedures;

(4) Direct benefit and capitation programs;

(5) Appropriate group life, accident and health insurance bidding practices;

(6) The use of health maintenance organizations;

(7) Deductibles, coinsurance levels, coverage maximums, and schedules of benefits for reimbursement;

(8) Requirements and special needs of state officers, employees and persons retired from state service for life, accident or health group insurance coverage;

(9) Legislation needed to strengthen, improve or modify the state's group life, accident or health insurance programs;

(10) The feasibility of the state establishing state self-insured programs of life, accident or health insurance coverage for state officers, employees or persons retired from state service;

(11) The feasibility of mental health benefit coverage by the private sector;

(12) The purchase of policies of life, accident or health insurance, or any combination thereof, from any company qualified to do business in this state for the benefit of all state officers, employees and persons retired from state service who elect to participate in the state's group insurance program; and

(13) The purchase of Part B of Medicare for retired state employees.

(c) Recommend to the state risk manager such regulations and perform such duties as may be assigned by the state risk manager to carry out the applicable provisions of the Nevada Revised Statutes.

2. Risk Manager Charged With Establishing Health Insurance Orientation Program.

It was noted to the committee studying the state program of group insurance that employee orientation programs on the proper use of medical insurance can result in substantial premium cost reductions. For example, certain minor surgery can be safely performed on an outpatient basis thereby eliminating the expense associated with overnight hospital stays. An orientation program could help employees to understand and realize potential medical cost savings for both themselves and the state.

In these difficult economic times of rising medical costs, it is well-advised to effect medical cost reduction whenever possible. Education in the proper use of medical care and medical insurance is an important aspect of such cost-saving techniques.

Employees also need to be oriented on changes in benefits or premiums in their group insurance program. The committee therefore recommends:

> **The state risk manager provide for the establishment of orientation and continuing education programs relating to benefits, changes in benefits, and cost-saving techniques which will cause life, accident or health insurance premium cost savings for the state and state officers, employees and persons retired from state service who participate in the state group insurance program and also reduce abuse or overuse of the group insurance plan.**

3. Financial and Operational Audits of Program of Group Insurance.

The legislative auditor advises that the committee on group insurance has never been subject to an operational audit. This is disheartening if one considers how the operation of the committee can affect state funds. The committee's bidding procedures, selection of brokers, selection of administrators, use of prepaid plans or preferred provider plans and cost containment programs can all affect group health insurance premiums and the quality of medical care for state employees.

The committee studying the state program of group insurance found no indication of mischief. It feels, however, that the program of group insurance should be subject to financial and operational audits which also determine compliance with the law. This is just good business practice. The committee therefore recommends:

> **The statutes be amended to require the legislative auditor to conduct periodic financial and operational audits, which determine compliance with the law, of the state's activities relating to the program of group life, accident or health insurance.**

B. COMPOSITION OF THE COMMITTEE ON GROUP INSURANCE

The designated membership of the committee on group insurance has undergone three changes since reference to the committee was added to the Nevada Revised Statutes by Assembly Bill 345 (chapter 470, Statutes of Nevada 1963). The original committee consisted of seven members composed of: one member selected by the president of the Nevada State Employees' Association; one member designated by the state controller from his staff to carry out administrative functions; one member designated by the director of the budget from his staff; one member designated by the chief of the personnel division of the department of administration from his staff; one member designated by the executive director of the employment security department from his staff; one member designated by the chief administrative officer of the department of highways from his staff; and one member designated by the president of the University of Nevada from his staff.

In 1967, Senate Bill 34 (chapter 528, Statutes of Nevada 1967) reduced the committee's size from seven to five members and changed its composition to: two members selected by the board of directors of the Nevada State Employees' Association, the director of the department of administration, and two members appointed by the governor. Senate Bill 41 (chapter 63, Statutes of Nevada 1977) added the requirement that one of the two members appointed by the governor be an employee retired from state service.

The committee studying the state program of group insurance heard presentations indicating that the committee on group insurance, as presently comprised, is unresponsive to the group insurance needs or desires of state employees and retirees. As noted earlier, the committee on group insurance is not accountable to a higher state government entity. Furthermore, the method by which members are appointed creates factionalism on the committee.

The committee studying the state program of insurance agrees that the composition and method of selection and appointment of the committee on group insurance needs to be changed to cause the committee to be responsive to all those persons who participate in the state's group health insurance program. It is appropriate that different interest groups recommend members to serve on the committee on group insurance. The governor, however, who is responsible for

all state employees, retired state employees and to the citizens of Nevada, should have the power to appoint the members of the committee on group insurance. Specific terms of office should also be stated in the law.

The committee studying the state program of group insurance therefore recommends:

The statutes be amended to provide that the committee on group insurance be composed of five members appointed by the governor from the following categories: one member selected from a list of five names recommended by the Nevada State Employees' Association; one member selected from a list of five names recommended by the retired public employees of Nevada; two members who have not been employees of the State of Nevada for 5 years preceding their appointment and who are not retired state employees; and one representative of the University of Nevada System selected from a list of five names recommended by the board of regents of the University of Nevada System.

The committee recommends further that the members of the committee on group insurance serve 3-year staggered terms. To accomplish the staggering of terms, the initial appointments for the representatives from the Nevada State Employees' Association and the retired public employees of Nevada should be for 1 year. One public member should be initially appointed for 2 years and the other for 3 years. The initial appointment of the representative of the University of Nevada System should be for 2 years. No member should serve more than two terms, and the governor should be permitted to remove any member for cause.

C. PREMIUMS AND BENEFITS

The committee studying the state program of group insurance spent considerable time reviewing the premium cost and benefits provided under the state's group health insurance plan. Most of the questions the committee asked relate to benefits and premiums, and the answers to those questions are contained in appendices A through C to this report.

Topics receiving special attention included: longer term contracts for group insurance; computing premium costs for retired state employees by including retirees in the total group instead of as subgroup; continuing coverage for spouses of retired state employees; political subdivisions

joining the state plan; the state self-insuring its group insurance program; and the premium tax being waived on the state's policy of group insurance.

1. Longer Term Contracts for Group Insurance.

Since 1975, the committee on group insurance has entered into contracts with four insurance carriers to provide medical coverage for the state program of group insurance. Representatives of the committee advise that this turnover has been caused by the low amount of funds appropriated by the legislature for premium cost payments and by escalating medical costs.

These may be legitimate reasons for certain of the turnover in the state's group health insurance providers. The committee studying the state program of group insurance notes, however, that the scope of coverages has expanded under the program without a needs analysis being conducted of persons enrolled in the program. Bidding practices have also been questioned.

The committee on group insurance says it has reviewed all potential carriers in its bidding process. It appears, however, that certain additional insurance carriers might be interested in contracting with the state for group medical insurance. Medical providers have also communicated with the committee about contracting for direct medical and dental services at reduced cost to the state.

A more stable plan would reduce the ever-changing premiums, benefits, deductible levels and use requirements associated with annual changes in group health insurance providers. The committee therefore recommends:

The state risk manager attempt to stabilize premium costs and improve coverages through negotiating long-term contracts with appropriate providers.

2. Computing Premium Costs for Retired State Employees As Part of the Total Group

Under existing practice, the entire cost of the premium for active state employees' group health insurance is paid by the state.

Retired state employees receive only a partial payment for their group health insurance premiums. Also, retired state employees are placed in a separate rating group which includes disabled former employees. The payment of benefits under the group plan to retired state employees has also been predicated on the assumption that the retired employees are enrolled in Part B of Medicare. This assumption is not currently being made but will resume after July 1, 1983.

Retired state employees appearing before the committee studying the state program of group insurance and those who provided written materials to the committee advise that these actions, taken together, have caused retired employees to pay costly group insurance premiums without receiving concomitant medical insurance benefits. The committee to study the state program of group insurance agrees with the retired state employees and recommends:

> **The statutes be amended to require that premium costs for group life, accident or health insurance for persons retired from state service be computed as part of the total group insurance plan costs and not as a separate cost entity in the group plan.**

3. Continued Coverage for Spouses of Retired State Employees

Under existing practice which has been in effect since 1970, the surviving spouse of a retired state employee who is covered under the state plan for group insurance is permitted to continue coverage under the plan after the employee's death. The committee on group insurance accepts this practice. It also indicates that it is possible, in part, because the retirement check provides a convenient vehicle for the deduction of group health insurance premiums.

The committee on group insurance indicates that the continuation of a surviving spouse's group health insurance coverage is not provided for in any statute. It says, however, that the attorney general's office has indicated that the committee has the discretion to carry out the practice.

The committee studying the state program of group insurance believes that permitting the surviving spouses of retired state employees to continue under the state

plan of group insurance is an appropriate and desirable practice. It feels, however, that the practice should be spelled out in the statutes. It therefore recommends:

The statutes be amended to clarify that the surviving spouse of a person retired from state service, who is covered under the state plan for group life, accident or health insurance, is entitled to remain covered under that plan after the retired employee's death.

4. Political Subdivisions Prohibited From Joining the State Plan for Group Insurance

Under subsection 2 of NRS 287.043, the committee on group insurance is required to negotiate and contract with the governing bodies of political subdivisions desirous of obtaining group insurance for their officers and employees by participating in the state group insurance program. At the present time, the following political subdivisions have employees enrolled in the state group plan:

(a) The City of Henderson
(b) Mineral County School District
(c) Lyon County Health Center
(d) Lyon County
(e) Truckee-Carson Irrigation District (effective April 1, 1983)
(f) Mt. Grant General Hospital, Hawthorne
(g) Washoe County Conservation Center
(h) State Board of Pharmacy
(i) Sun Valley Water District
(j) Walker River Irrigation District
(k) Nevada State Board of Accountancy
(l) State Board of Nursing
(m) Nevada Liquefied Petroleum Gas Board
(n) Lincoln County Power District
(o) Clark County District Health Department
(p) Lincoln County

The chairman of the committee on group insurance advises that the committee has established guidelines to ensure that political subdivisions requesting admission to the state group insurance program meet certain minimum requirements. He indicates that political subdivisions

with over 100 employees must have their most recent 3-year claims, premiums and benefit histories reviewed for compliance with the requirements before being permitted to join the state group insurance program.

The committee studying the state program of group insurance was advised by persons appearing before it that only those political subdivisions which have difficulty in obtaining their own group health insurance coverage at reasonable costs because of the high medical cost experience of their employees attempt to join the state program. The state group health insurance plan, the committee was told, has become, in effect, a "dumping ground" for the medical coverage of poor risk public employee groups in Nevada.

The committee feels that it is disadvantageous to the state plan to admit political subdivisions which cause premium costs to increase or which dilute the level of medical insurance benefits for state employees or persons retired from state service. It therefore recommends:

The statutes be amended to prohibit political subdivisions of the state from joining the state plan for group life, accident or health insurance coverage.

5. Self-Insurance By the State

There may be certain financial advantages if the state chose to establish a self-insurance program for life, accident or medical coverage for its employees and persons retired from state service. These advantages include the lack of a premium tax, control over reserves and the cash flow that would be generated to offset future costs. There are, however, also potential disadvantages including administrative costs, the lack of outside parties to handle claim disputes, increased auditing costs and the potential for funds being used for other purposes in times of economic difficulties.

The committee studying the state program of insurance took no position on the state being self-insured for life, accident or medical coverage for its employees. It does believe, however, that the state risk manager

should study the possibility of self-insurance by the state. It also believes that the statutes relating to group insurance for state officers and employees should contain a provision authorizing self-insurance, if feasible. Chapter 331 of the Nevada Revised Statutes now contains such a provision for other forms of risks. The committee believes a similar provision could be provided for group insurance coverage and recommends:

The statutes be amended to permit the state to establish state self-insured programs of life, accident or health for state officers, employees or persons retired from state service.

6. Premium Tax Waived on the State Policy of Group Insurance

Under existing law, insurance companies doing business in the State of Nevada are subject to a "net direct" written premium tax of 2 percent. Net direct written premium means "direct gross premiums written in Nevada on insurance policies less return premiums and dividends paid or credited to policyholders."

It is estimated by the state risk manager that if the statutes were amended to eliminate the premium tax on the state's group health insurance plan, a savings of approximately $372,000 would be generated. This, in turn, would reduce premium costs to the state and employees who cover their dependents under the state program of group insurance.

Persons appearing before the committee suggested that the premium tax be eliminated on the state's program. The committee believed this recommendation has merit and therefore recommends:

The statutes be amended to waive the premium tax on the state's policy of group insurance.

III. CREDITS

Dr. Charles Ashman
Ashman Dental Group, Ltd.
Las Vegas, Nevada

Ingrid Barbash
Assistant Actuary
Insurance Division
Department of Commerce
Carson City, Nevada

Lillian Bergevian
Retired member of the Committee on Group Insurance

Julie Bossard
Consultant
William M. Mercer Incorporated
Las Vegas, Nevada

Dave Byington
Life Underwriters Association

Dr. Katheryn Duffy
Retired Public Employees of Nevada

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Department of Administration
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William M. Mercer Incorporated
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Zaven K. Kazazian
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CNA Insurance Companies

Barbara Mighles
Retired State Employee

E. Edward Oquist
Manager, Group Sales
CNA Insurance Company

Anthony Palazzolo
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Michael D. Phillips
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Sandy Porter
Associated Service Corporation of Nevada

Charles Ritter
Retired State Employee

Ray Rothwell
President of Blue Shield of Nevada

Leonard Saye
President
Continental Group Agency and
Central Administrators

Bob Shaw
Life Insurance Agent and
Member of the Northern Nevada Life Underwriters Assn.

Dr. Al Stoess
Chairman
State Committee on Group Insurance

IV. APPENDICES

March 9, 1983

Ms. Mary E. Finnell
State Risk Manager
209 E. Musser Street
Room 205
Carson City, NV 89701

SCR 5 RESPONSES

Dear Mary:

Al Stoess and I collaberated on the responses to the questions you drafted for him. Therefore, the responses to the common questions given to Mercer will be similar. I am enclosing Al's answers at his request.

Any questions should be directed to Al Stoess.

Sincerely,

JULIE BOSSARD

Enclosure

cc: Dr. Al Stoess
Mr. Roy Gonella

A Marsh & McLennan Company
1818 Industrial Road • Las Vegas, Nevada 89102 • Telephone (702) 384-9382

OVERVIEW QUESTIONS

1. Q Does the Committee have any regulations?

   A. Yes. The Committee has approved broker selection regulations and has draft administrator selection regulations.

2. Q. Does the Insurance Committee consult with the Risk Manager?

   A. The Risk Manager attends all meetings of the Group Insurance Committee. During the meetings, the Risk Manager gives advice and asks questions concerning the group insurance program. Her input is considered in committee discussions. The Risk Manager was also permitted to participate in the broker selection meeting.

3. Q. Would you recommend any improvements in the statute which would provide better controls or checks in the administration of the program?

   A. The statute which creates the committee provides for adequate representation of the various interest groups within the plan, including the administration. Making the Committee accountable to someone within the administration such as the Risk Manager may create a conflict of interest. Because of the organizational structure of the Department of Administration, the Risk Manager could find herself in a potential political position. A similar analysis would apply to having a benefit manager in the Personnel Department.

SECTION 1 QUESTIONS

1. Q. What would be the disadvantages or benefits of having the group insurance handled by one person or a few persons, as opposed to the current committee system?

   A. The person or persons would have to be mutually agreed upon by all parties. Once an appointment is made, the benefit of such an arrangement could be the elimination of special interests in decisions regarding the plan. However, there is no way to eliminate the interests of any special groups.

2. Q. If there was going to be an in-between route, for example between the Risk Manager, or someone in personnel handling this in conjunction with a committee, what would be the ideal in-between ground?

   A. Refer to the answer to question 3, Overview Questions.

3. Q. Are there any people with insurance backgrounds on the committee?

   A. Yes. In my experience with the committee, I have found all the members to be knowledgeable of various aspects of group insurance. At least some of the members have had formal training in insurance and employee compensation.

4. Q. Why is a lay committee delegated full responsibility for committing the large amount of money involved in the State Group Health Insurance Program? Why shouldn't this be handled by a Professional Benefits Manager responsible to the Legislature or some other responsible entity?

   A. The committee is formed and authorized by statute to perform this function. This is a public policy question that was decided by the Legislature. Any changes would have to be considered by the Legislature.

5. Q. Who is the Committee on Group Insurance responsible to?

   A. The Committee on Group Insurance has final authority as provided in the law. However, the Committee on Group Insurance is responsible to the State of Nevada, its people and the State employees.

6. Q. Why does SNEA have two representatives on the Committee and only one retiree?

   A. The statute determines the composition of the committee. This is a public policy decision that was determined by the Legislature.

7. Q. Should some type of rotation be used within the Committee on Group Insurance?

   A. Because a lay committee is appointed, involving a rotation would put an unnecessary burden on the remaining committee members and others involved in the plan who would be required to re-educate new members continually. The existing committee has become quite sophisticated on the general understanding of group insurance and their specific knowledge of the State plan. However, this is a public policy decision that was determined by the Legislature.

8. Q. Why couldn't the Insurance Division act as advisor or broker to the Committee?

   A. Because the Insurance Division is a regulatory body, there is a possibility of a conflict of interest. This is also the view of a former Insurance Commissioner, who for this reason declined to act in this position.

9. Q. What is the term of appointment to the Committee?

   A. The term of appointment is not specified in the statute. However, the members appointed by the Governor serve for three years, as specified in NRS 232A.020.

10. Q. What is the reason for appointment of two of the five members by a non-governmental group?

    A. The two members who are appointed by the State of Nevada Employees Association are active State employees representing SNEA membership. SNEA represents approximately 50% of active State employees. The composition of the Committee is a public policy decision that was determined by the Legislature.

11. Q. What are the qualifications for membership on the Committee?

    A. The law does not specify member qualifications, however 232A.020 specifies the qualification of such members, who must have an interest in and knowledge of the business conducted by the Committee.

12. Q. Has the Committee ever been audited, either for financial or operational responsibility?

    A. No, not to my knowledge. However, information of this nature should be obtained from the auditing division.

13. Q. Why are all the members of the Committee active employees of the State except one who is a former employee?

    A. The law requires that one committee member shall be an employee retired from State service. The law is specific as to the composition of the Committee.

14. Q. Should there be a broader representation of State employees, including representatives from the Senate/Assembly, representatives from State employees and retired State employees, representatives from Risk Management and Budget Office, and the Tax Payer Association, with rotating two year terms?

    A. Increasing the size and composition of the Committee would create organizational problems. The existing Committee is broad based and it is difficult to coordinate the schedules of the members without enlarging the Committee.

SECTION 2 QUESTIONS

1. Q. Who determined the benefit schedule?

   A. The Committee on Group Insurance.

2. Q. Whose decision would it have been to change coverages for retirees?

   A. The Committee on Group Insurance

3. Q. Do you consider the retirees to be part of the group?

   A. Yes, but they are also one of three subgroups.

4. Q. Do you consider one person on the Committee from the retirees adequate representation from that group?

   A. Yes. Retirees comprise slightly over 10% of the total insured group.

5. Q. Do some companies provide insurance on a long term basis? (e.g. rates guaranteed for more than one year). What if we went to a longer term contract than what the State has now?

   A. It would not be possible to secure a contract of group insurance for longer than a 12 month period. In these days of escalating medical inflation, insurance companies are not willing to write long term contracts.

6. Q. In as far as changes in coverage are concerned, have there been any actuarial studies or surveys to find the type of coverages needed or wanted by the different age groups involved, etc. Do you study the future cost impact when benefits are added?

   A. With respect to the existing group insurance plan, employees have not been surveyed to find the type of coverages needed or desired. However, when benefit changes are considered, the State's insurance carrier performs actuarial calculations to determine the cost and future impact of these changes. The Committee has recently completed a survey of State employees for the purpose of determining their needs and desires in this area. Although the survey was directed to employee paid programs, the information gained from it could be used in the future for State funded benefits.

7. Q. Retired employees over 65 years of age pay $6.50 for $5,000 life insurance. Active employees over 65 pay $5.00. Why is it that retirees pay 30 percent more than active employees for the same benefits?

   A. At the July 1, 1981 group insurance renewal, the Legislature had appropriated 15% additional premium for the cost of employee group insurance coverage. In order to continue coverage for active employees with no plan modification, it was necessary to increase the subsidized retiree premium in an amount greater than the increase that was applied to active employee premium. In addition, employees over 65 (who range in age from 65 to 70) are part of the active group while retired employees over 65 range in age from 65 to 100 and represent greater risk to the carrier.

8. Q. Is the Committee discriminating against those retirees who have Part "A" of Medicare and purchase Part "B" of Medicare and then have the State plan offset all Medicare payments instead of coordinating the two programs?

   A. No

9. Q. On the carve-out plan, does the State plan pay a negligible amount for hospital and doctor bills? What are the liabilities of the State plan under carve-out?

   A. The amount paid under the State of Nevada carve-out plan depends upon the claim submitted. The liabilities of the State plan are the difference between normal State plan benefits regardless of other coverage and what Medicare pays on the total bill. State plan liability can be quite large if the claim involves charges that Medicare limits extensively or does not pay, for example, a hospital confinement lasting longer than 60 days. For the first six months under the carve-out plan, the carrier has paid $918,965 in claims, a significant amount.

10. Q. Is the wife/husband of a retired employee, and carried as a dependent, entitled to be carried on the insurance coverage in the event of the retired employee's death? Under what statute provision?

A. The dependent wife/husband of a retired employee who is covered under the State plan is entitled to be carried on the plan as a surviving spouse in the event of the employee's death. This has been the practice since 1970. Coverage is extended to survivors of retirees because the retirement check deduction provides a convenient vehicle for payment of premiums. This practice is not outlined in any statute. It should be noted that an opinion has been given by the Attorney General's office (June 10, 1980) with respect to the Committee's authority in this area.

11. Q. How can the insurance carrier and its agent assume that all retired persons have Medicare coverage? Do they actually make this assumption in determining the amount of the claim to be paid?

A. In the carve-out plan, Medicare Part "B" is assumed since it is available to all persons. Since the carve-out plan was implemented prior to an open enrollment period under Medicare, the plan is not now assuming that all retired persons have Part "B" coverage. However, effective July 1, 1983, the effective date of Part "B" coverage for late enrollees, the plan will begin to assume coverage under Part "B" of Medicare. It should be noted that normal plan benefits are paid for persons who are not eligible for Part "A" of Medicare.

12. Q. Are all of the various types of insurance coverage provided under the plan actually authorized under provisions of NRS 287.043?

A. Yes. The Committee sought an Attorney General's opinion on this matter.

13. Q. Has the Committee in the past provided additional lines of coverages excluding changes to existing benefits when the premium cost for the in force plan was less than the amount appropriated by the Legislature? Was the same coverage provided for all persons covered by the plan? Have these additional coverages resulted in higher premiums to continue providing the coverage?

A. At the renewal in 1980, the Committee added dental benefits for dependents and vision care benefits for employees. This coverage was extended to all persons covered under the plan. Dental insurance costs have resulted in higher premiums in subsequent years. Vision care premiums have been lowered to pre-implementation levels.

14. Q. Why are benefits constantly being adjusted, sometimes more liberal, sometimes more restrictive, to fit the premium structure? Shouldn't a benefit package be negotiated every two or three years and then funding be provided?

A. Because funding levels are set by the Legislature and are typically less than recommended by the insurance committee, it has been necessary in the past to restrict benefits to fit the premium structure. As long as the Legislature continues to underfund the plan, pre-setting the benefit package will have no effect. Theoretically, however, it would be preferable to negotiate the benefits. This may require annual sessions of the Legislature to fund the plan.

15. Q. Does the present method of determining premium payments truly follow the principles of Group Insurance?

A. Yes.

16. Q. Are the present costs for supplemental coverage to Medicare comparable with other similar policies?

A. The present cost for supplemental coverage to Medicare is comparable with other group policies. However, a review of individual supplemental policies shows that an adequate supplement to Medicare can be purchased on an individual basis at less premium. An example of this would be the plan offer through the American Association of Retired Persons (AARP). However, Life, Accidental Death and Dismemberment, Dental, and Vision Care cannot be purchased on an individual basis.

17. Q. Why did the Carson-Tahoe Hospital withdraw from the plan?

A. It is believed that Carson-Tahoe Hospital withdrew from the State of Nevada plan because it desired to cover independent contractors who did not qualify as employees under the definition of the State of Nevada plan.

18. Q. Why did Storey County, after inquiry, choose another carrier?

A. Storey County requested that the Committee waive the statutory service waiting period on a new employee. When their request was declined, they withdrew from the State plan. The Group Insurance Committee is constantly approached by political subdivisions of all sizes who request information about the State plan for inclusion in their own marketing surveys. In some cases, the State plan appears to be more attractive than plans offered by other carriers. In other cases, the State plan may be more costly and therefore not competitive for a particular entity.

19. Q. Is it possible to equitably offer the opportunity for premium payments to be made by the State for coverage for an employee and one dependent when some employees do not have a dependent? Will this option also be offered to retired persons in the plan?

A. This is an area of public policy that was determined by the Legislature and not by the Committee. This question should be directed to the Legislative Committee which is responsible for its introduction and passage.

20. Q. Was there a provision for a premium stabilization fund? If so, please explain.

A. Yes. The premium stabilization fund was estabilished by the Committee in 1979 when the State plan experienced a surplus. The fund was created rather than purchase more benefits which would have to be eliminated in the future. However, the plan has deteriorated to the point that at the 1982 renewal, the fund was used up. The plan is now in a deficit position. In the future should the plan experience a surplus, a premium stabilization fund will likely be established.

21. Q. Are the disabled former employees included with the retirees for rating purposes? Why?

A. All retired employees are included in the retired group. This includes disability as well as normal retirees. The retired group is as reported by the Public Employees Retirement System.

22. Q. Is the experience of disabled retirees charged to the retiree group? Why?

A. See the answer to question 21.

23. Q. Why does the State pay the entire premium for employees and only a partial amount for the retiree?

A. In 1980, the Legislature provided for a State appropriation on behalf of retired employees for group insurance. The amount paid by the State is set by the Legislature. This is a public policy question that was determined by the Legislature.

24. Q. Why do premiums have to be set by law?

A. The Legislature directs the amount of public monies to be spent.

25. Q. When the Legislature appropriated funds for retired employees insurance, was it the intent to place retirees in a separate status? What was the intent?

A. Based on past actions by the Legislature, the Committee on Group Insurance determined that the Legislature intended the group of retired employees to be self supporting. It was not intended that the active employees or dependents subsidize the retired group and vice versa.

26. Q. Why did the Insurance Committee assume the authority to interpret Legislative intent and split up the group and experience-rate the retirees as a separate group? If the retirees are part of the group, should they be rated with the group?

A. Refer to question 25. It is believed that the intent of the Legislature is quite clear.

27. Q. Could the State waive the premium tax if the plan remains fully insured?

A. Yes, the State could waive the premium tax.

28. Q. Is it economically advantageous to allow other political subdivisions into the State's plan?

A. The Committee has established certain guidelines which provide that an entity requesting admission to the State group insurance program satisfy certain requirements. In addition, if the entity employes 100 or more employees, the past three years claim, premium, and benefit history are reviewed prior to admitting the group to the plan. These procedures safeguard the plan. It could be advantageous to the State plan to admit groups with good experience. It is also beneficial to the plan to increase the number of participants over which the risk is spread, and thus increase total premium.

29. Q. How does the Committee on Group Insurance "negotiate" with other public agencies when they wish to join the State plan? During negotiations, is the public agency's prior experience considered?

A. Please see answer to question 28.

SECTION 3 QUESTIONS

1. Q. What procedures are used for soliciting bids from insurance companies?

A. When the Committee decides to go to bid, the broker is directed to prepare specifications about the plan. The specifications are mailed by the broker to all licensed insurance companies doing business in the State of Nevada. The last time the State went to bid, specifications were sent to over 120 carriers.

2. Q. What procedures are used in determining a broker of record both before and after 1976? Is it open for full public bid?

A. Before 1976 - To my knowledge, there was no broker of record prior to 1976. Shortly before the bid process which occurred in 1976, the Committee was informed that it was required to name a broker of record.

After 1976 - In 1981 the Insurance Committee established a regulation governing the selection of a broker of record. The selection process is open for full public bid. The procedures used from 1976 to 1981 were incorporated in the regulations.

3. Q. Has there been an investigation into the methods and procedures of the Committees bidding procedures? When was the Committee investigated? What was the result of that investigation?

A. There has been no investigation into the methods and procedures of the Committee's bidding process. The Committee requested guidelines from the State Attorney General's office with respect to broker and administrator selection. The broker selection regulations referred to in the answer to question 2 were developed from the Attorney General's recommendation. From time to time, individuals with complaints about the Committee's actions had been referred to the Attorney General's office. How many complaints were actually investigated is unknown. I do not recall that the Committee has ever been informed that it has engaged in any unfair or illegal practice. For greater detail, contact the Attorney General's office.

4. Q. How have the cliams administrators been selected in the past, both before and after 1976?

A. Before 1976 - Although I am not sure, there was no separate claims administered prior to 1976.

After 1976 - The Committee has drafted regulations for selection of an administrator which have met with the approval of the Legislative Council Bureau. However, due to lack of funds, the Committee has not engaged in the advertising for holding of hearings at this time. The Committee intends to do so as soon as funds are appropriated.

5. Q. When selecting administrators, do you take into consideration that there were other administrators in the State that have experience in medical claims administration for large groups in the State of Nevada?

   A. Yes.

6. Q. Does the Committee insist on a third party administrator? Are all carriers willing to submit bids under this condition? Have some carriers refused to bid because of conditions in the bid proposal? Is it necessary that the plan be administered by a third party administrator or would the insurance be less expensive if administered by the insurer?

   A. The Committee has determined that the major duties involved in the program-consulting, claims administration, and insuring - should be separated and contracted for separately. This determination was made to avoid conflicts of interest and to provide a system of checks and balances among the three contractors. Some carriers have indicated an unwillingness to allow a third party administrator to pay claims on their behalf. However, this has not prohibited carriers from bidding. Administration by a third party administrator is not necessary. However, it is commonly known that a third party administrator can often provide claims administration services at less cost than an insurer. The Committee would consider using an insurer to pay claims if one had indicated a willingness to provide local service.

7. Q. Has the Committee ever received offers from other companies to administer the plan? Were these proposals above or below the cost for the present administration? Why were the bids not accepted?

   A. Insurance services are an intangible product which cannot be exclusively measured in dollars. The Committee receives numerous offers from insurance carriers and other insurance related providers to perform services of many different kinds. In some cases, these offers are very attractive financially, however, the Committee does not feel that any of these offers should be arbitrarily accepted without going through a bidding process. The offer from a local third party administrator which is receiving much attention was made on an arbitrary basis to the Committee. This administrator was informed that the Committee was in the process of drafting regulations for the selection of an administrator and was invited to bid again when these services were put to open bid.

8. Q. Has the Committee considered dropping some of the coverages to reduce the premium cost?

   A. Yes.

9. Q. Why is it that we, the State, have so much turn over in carriers?

   A. In years when the funding appropriated by the Legislature has not been sufficient to cover the cost of the plan, the Committee has been forced to go to bid to seek a lower premium. For this reason, the history of the plan indicates frequent carrier changes.

10. Q. Do you feel that the agent/broker exercises too much power?

A. The Committee's broker is in an advisory position only. The Committee utulizes the broker for his expertise in the group insurance area. Often, the Committee accepts the recommendation of the broker. However, the Committee has the final authority. There have been numerous occasions where the advice of the broker has not been taken.

11. Q. Why hasn't the Committee on Group Insurance taken the opportunity to have experienced group insurance people assist them free of charge? (e.g. The Life Underwriters Association).

A. To the best of my knowledge, the Committee has not received an offer of assistance from the Life Underwriters Association or any other experienced group insurance people for free assistance.

12. Q. In 1976 when Prudential was awarded the contract, were one of the plans accepted as written in the specifications? If not, did all bidders have a chance to resubmit bids that were adjusted for the change in benefits?

A. In all cases when the plan is out to bid, all bidders have the opportunity to present a better program than that called for in the specifications. The package offered by Prudential which included Mercer as broker and Mutual Administrators as third party administrator was an improvement on the specifications at the most competitive price.

13. Q. Why was Doyal Boring and William Mercer Company selected in 1976?

A. To my recollection, Mr. Boring was not the Mercer representative at the time of selection.

14. Q. In the recent selection of a broker of record, Leonard Saye and Lee Cranmer of Western Group Agency submitted a bid with a lower cost than that which was being charged by William Mercer Company. Why were they not selected to be the broker of record?

A. The Committee requires a number of services from its broker which must meet certain standards of professionalism. The bid submitted by Western Group Agency was not significantly lower than the current fee charged by William Mercer, Inc. The Committee is and has been pleased with the performance of its broker and could not justify changing brokers merely for a small cost differential. In addition, Mercer's experience with the State groups was superior to that of Western Group Agency.

15. Q. Why was a California broker selected instead of a resident Nevada broker?

A. William M. Mercer, Incorporated maintains an office in Las Vegas, Nevada. They are now and have been a licensed resident Nevada broker.

16. Q. Was William Mercer, Incorporated licensed with the Division of Insurance of the State of Nevada at the time he presented a proposal, or at the time of his selection or afterwards?

A. William M. Mercer is now and has been properly licensed with the Division of Insurance.

17. Q. Do some brokers and administrators feel it is closed to open bidding and there is no opportunity to become the broker of record or the administrator under the present system?

A. Since the Committee has established regulations with respect to broker selection and has performed a broker selection in 1981, it is difficult to understand why some brokers would feel the State plan is closed to open bidding. As I have indicated before, an administrator selection will be forthcoming.

18. Q. Should any other administrator receive specifications, when the minutes of the Group Insurance Committee show motions concerning the bidding that the existing broker and administrator will continue to provide services? (see minutes of 5/19/79 page #4, paragraph (a) of Doyal Boring's recommendation and page #5 Tony Palazzolo's motion. Also the recent bid specifications indicate a strong preference for the present administrator).

A. As described in my answer to the bidding process, specifications are mailed directly to insurance companies and not to other administrators. Since the specifications are a matter of public record, any broker or administrator can request a copy of the specifications from the chairman of the Group Insurance Committee.

SECTION 4 QUESTIONS

1. Q. What studies on utilization and cost containment, especially for in-patient hospital care have been done, if any?

A. The Committee's consultant is currently involved in a cost containment study, the basis of which is an analysis of in-patient hospital expenses. The study will provide the Committee with previously unavailable data, as well as an analysis which will pinpoint areas of unnecessary hospitalization and privider overcharges. This study was requested by the Committee on Group Insurance and its results will be presented to the Committee shortly.

2. Q. Has the Committee looked at a program of mandatory second opinions for surgery?

A. Prior to the 1982 renewal, the Committee conducted several workshop meetings during which numerous cost containment mechanisms were discussed. Included in the discussion was a program of mandatory second opinions for surgery.

3. Q. Has the Committee reviewed pre-paid plans, preferred providers or provider panels?

A. The group insurance package currently utilizes a pre-paid panel plan through Nevada Vision Service Plan.

4. Q. Has an alternative delivery system for dental care been considered which would make it more cost effective?

A. The Committee considered a proposal from Delta Dental plan which is a panel arrangement at the last renewal. The rates quoted by Delta plan were higher than those quoted by the State's current carrier.

5. Q. Will an effort be made to establish a utilization control board?

   A. Not at this time. However, the Committee does not preclude the possibility of moving in this direction in the future.

6. Q. Has the Group Insurance Committee looked into direct benefit and capitation programs?

   A. See the response to question 3.

7. Q. Has the Committee looked at HMO's?

   A. The Committee will hear a presentation from Health Plan of Nevada, a federally qualified Health Maintenance Organization, at its meeting on March 16. However, the law does not allow the Committee to deal with certain types of providers.

8. Q. What is carve-out and why have this program?

   A. Carve-out is a commonly used method to supplement Medicare used by group insurance plans. The program was implemented on July 1, 1982 to control the cost of the retiree experience. Carve-out also resulted in less premium cost than the prior coordination of benefits approach.

9. Q. What are the ramifications of the so-called "Carve-out" policy?

   A. The purpose of the carve-out program is to lower the retiree claims experience and to ultimately hold down future costs for the retiree group. In addition, it has the effect of equalizing total benefits received by retirees to the benefits received by active employees.

10. Q. Should the State consider inside limits in the plan vs. UCR limits?

    A. The Committee considered using inside limits in place of the current usual customary and reasonable charges during its workshop meetings prior to the last renewal. Inside limits were not implemented because this method is viewed as transference of costs rather than cost containment.

11. Q. Should a variety of deductibles be available in the interest of economy?

    A. The Committee has considered using several deductible options. However, the savings has not been significant enough to enter into such a flexible benefit plan. In addition, administrative procedures will be increased substantially. An argument against offering different benefit plans is that adverse selection may result, thus increasing plan cost. Current plan design includes the use of a variety of deductibles for hospital confinement, basic dental care, major dental care and Vision care.

12. Q. What is the approximate turnaround time for medical claims?

    A. Current turnaround time is three days.

13. Q. Do you consider vision coverage one of the types of benefits that should be included in the group policy, or should that be an optional coverage paid by employee?

A. Vision coverage is currently included in the benefit package. Allowing employees to choose whether or not they want vision care would result in adverse selection against the plan, thus increasing cost.

14. Q. Does the Committee feel claims payments by the carrier to retirees as a supplement to Medicare are in keeping with the premium cost as compared to the claims payment return per premium cost of the active employee?

A. Yes. According to the claims experience, retirees are receiving 50% more benefits than the carrier is receiving in premium. Conversely, active employees are receiving 20.5% less benefits than premiums through the first six months of this plan year.

15. Q. Could the present policy regarding premium determination eventually lead to an "adverse selection" condition in relation to the retired employee portion of the plan?

A. It is certainly possible.

16. Q. How does the Committee handle complaints on claims? Do you believe claimants receive the proper forum for their complaints?

A. An employee with a claim complaint has similar rights to those provided under the Employee Retirement Income Security Act of 1974 (ERISA). Under this system, the employee requests an appeal on the decision made by Mutual Administrators. Mutual reviews the claim and sends ti to CNA, the State's insurance carrier, for review. If CNA upholds Mutual Administrator's decision, the employee may take his case to the Committee on Group Insurance. The Committee will hear the case and make an interpretation where the contract is silent. If the employee still is not pleased with the decision, he has the right of litigation, or can appeal to the Insurance Division.

17. Q. What communication programs are in effect to advise employees of their benefits or changes in benefits?

A. Historically, the Committee on Group Insurance has not been sufficiently funded to provide a communications program to State employees. We believe this has caused much of the dissatisfaction with the Committee and the plan. The Committee must rely on the carrier, administrator and broker to compose, print, and distribute communication pieces., The various payroll centers are responsible for seeing that employees receive these communications. It would be helpful to involve the Personnel Department and the Public Employees Retirement System in this responsibility.

SECTION 5 QUESTIONS

1. Q. How can the State control costs on behalf of retirees, so that the plan doesn't have runaway costs?

   A. The carve-out plan which was implemented on July 1, 1982 is an attempt to control costs on behalf of retirees.

2. Q. What action is taken by the claims administrator when htere is a dispute over a claim?

   A. The procedure which is followed in the event of a claims dispute is outlined in my answer to Section 4, question 16.

SECTION 6 QUESTIONS

1. Q. We are experiencing increases of 35-50 percent in premiums--

   a. What other cost containment procedures are you implementing?
   b. How much are we going to save on these procedures?

   A. With the renewal on July 1, 1982 the plan was changed to include the followin cost containment methods:

   1. An additional $50 hospital confinement deductible is applied to each hospital confinement in addition to the calendar year deductible of $250. This is meant to discourage unnecessary hospitalization.
   2. Expenses for surgery which is performed on an out-patient basis are reimbursed at 90% after the deductible. This is meant to encourage out-patient surgery when the option is available.
   3. Testing that is normally done while hospital confined is reimbursed 90% if performed on an out-patient basis. This feature is meant to take advantage of the 60% reduced cost available for out-patient laboratory work.
   4. In August of 1982, the Committee established a Patient Management Program. Under this program, each person covered under the State plan who becomes hospital confined is monitored by a registered nurse who has been hired by the State's insurance carrier. The nurse's responsibilities are to encourage prompt discharge from the hospital and to arrange home health care or alternative care if possible.

   The actual dollar amount to be saved as a result of these methods will not be known until the financial analysis is completed at year end.

2. Q. It is understood that registered nurses are used to monitor hospital utilization. Is this a program of Mutual Administrators? Do they review the claims paid by Mutual Administrators?

   A. The Patient Management Program was arranged by teh Committee on Group Insurance. It is a program of the State's carrier, CNA. The program is defined in the answer to question 1. The Patient Management Program does not include a review of paid claims.

3. Q. Why is an out-of-state insurance company sleected to provide coverage?

   A. Prior to the beginning of the July 1, 1982 policy year, the State group insurance plan was put out to bid. Every licensed company in the State of Nevada had anopportunity to submit a proposal. No in-state insurance

company submitted a proposal. In the past, proposals have been received from in-state insurance companies, however, they have not been competitive. For this reason, an out-of-state insurance company is currently providing coverage.

4. Q. What is the percentage premium or amount paid to the Broker?

   A. The Broker receives .2% of life, medical and dental premium.

5. Q. What was the percentage premium or amount retained by the carrier? Does this include premium tax? How is this broken down?

   A. The total retention (amount retained by the carrier) for the policy year July 1, 1981 through June 30, 1982 was 7% of premium. The breakdown is as follows:

Premium tases	2.0%
Claims administration	2.6%
Commission	0.2%
Other expenses (including the cost of forms, envelopes, supplies, etc)	2.2%
	7.0%

6. Q. Which percentage reflects the cost of forms, envelopes, supplies, etc.?

   A. See answer to question 5

SECTION 7 QUESTIONS

1. Q. Is there an advantage for the State to become self-insured? What are the advantages? What are the disadvantages?

   A. There is a financial advantage for the State to become self-insured. This advantage stems from a number of factors; premium taxes would not be included in the cost of the plan, the State would have control over the reserves, and significant cash flow would develop in the first year of a self funded plan. The disadvantages of self funding include the backup of a large insurance carrier on decisions regarding disputed claims, the lack of an automatic audit of the third party administrator which the carrier performs, and the lack of a maximum guaranteed liability (rate). This latter disadvantage can be overcome through the purchase of stop loss insurance. In addition, there would be no guarantee that the insurance fund would not be tapped by other State agencies or the Legislature.

2. Q. Could past claim experience be reviewed to determine the savings had the plan been self insured?

   A. Analysis of past claim experience would not reveal any savings had the plan been self insured. On a plan the size of the State of Nevada, actual premiums are used to fund claim cost. Since self funding will not affect the amount of cost incurred, a claims experience analysis would not be useful. The savings occurs in the retention portion of premium and the availability of reserves to the State.

3. Q. In your opinion, could the State benefit by going self-funded with "specific" and "aggregate" re-insurance?

   A. It is generally felt that a case the size of the State would benefit by going self-funded. However, specific stop loss insurance may not be necessary. Should the State decide to prusue this option,proposals from stop loss insurance carriers would be solicited.

4. Q. If the State would self-fund the group insurance benefits, what changes would be involved and what would be the impact?

   A. With the elimination of an insurance carrier, the State would be required to accept additional responsibility concerning the plan in the following areas:

      1. In order to effectively make use of cost containment devices, it would be necessary to communicate these devices and their meaning to State employees.
      2. Since the State would be directly funding their own claims, certain financial aspects now being handled by an insurance carrier would be the State's responsibility.
      3. It would be necessary to arrange for a consulting firm to perform the necessary actuarial calculations and to create a booklet and plan document. The current broker can provide these services.

5. Q. Has the Insurance Committee considered self-insuring the dental, vision, or prescription drug benefits?

   A. The Committee has been prevented from exploring any form of alternate funding since the law is silent of this point.

March 9, 1983

Ms. Mary E. Finnell
State Risk Manager
209 E. Musser Street, Room 205
Carson City, NV 89701

SCR-5 QUESTIONS

Dear Mary:

Enclosed is our response to the questionnaire prepared for Mercer. We will be happy to address any further questions you, the subcommittee or the Legislative Council Bureau may have. When the subcommittee has presented its report to the Legislature, we would appreciate receiving a copy.

Best Regards,

JULIE BOSSARD

JB/jo

cc: Mr. Roy Gonella

A Marsh & McLennan Company
1818 Industrial Road • Las Vegas, Nevada 89102 • Telephone (702) 384-9382

OVERVIEW QUESTIONS

1. Q. What is the total annual premium involved in the entire State program?

   A. $14,310,000 for the 1981-82 plan year.

2. Q. How much does the State of Nevada spend on employees premiums?

   A. For the 1982-83 plan year, the State will spend approximately $11,523,690.

3. Q. How much is spent by the State for retire premiums?

   A. For the 1982-83 plan year, the State will spend approximately $1,355,760.

4. Q. What is the total number of employees?

   A. Number of active employees is 11,134.

5. Q. What is the total number of dependents?

   A. The total number of dependent units of active employees is 3,711.

6. Q. What is the total number of retirees?

   A. The total number of retirees is 1,468.

7. Q. Does the Insurance Committee consult with the Risk Manager?

   A. The Risk Manager is present at Committee meetings and has given advice to the Committee on several occasions.

8. Q. Would you recommend any improvements in the statute which would provide better controls or checks in the administration of the program?

   A. We have no recommendations to offer in this area.

SECTION 1 QUESTIONS

1. Q. What would be the disadvantages or benefits of having the group insurance handled by one person or a few persons, as opposed to the current Committee system?

   A. Labor and management would have to agree on an individual or agency to manage the benefit plan. Input from both labor and management would have to be considered by this individual or agency in a non-partial manner. Under the current system, this would not appear feasible.

2. Q. If there was going to be an in-between route, for example between the Risk Manager, or someone in personnel handling this in conjunction with a committee, what would be the ideal in-between ground?

   A. See above answer.

3. Q. Are there any people with insurance backgrounds on the Committee?

   A. All current Committee members have much experience with the State plan due to long term involvement.

4. Q. Why couldn't the Insurance Division act as advisor or broker to the Committee?

   A. The function of the Insurance Division is that of a regulatory body, and not as an advisor.

5. Q. Has the Committee ever been audited, either for financial or operational responsibility?

   A. Not to our knowledge. However, the Committee should be consulted to determine the answer to this question.

6. Q. Should there be a broader representation of State employees, including representatives from the Senate/Assembly, representatives from State employees and retired State employees, representatives from Risk Management and Budget Office, and the Tax Payer Association, with rotating two year terms?

   A. From our point of view, a larger Committee with rotating terms would involve constant re-education of the various members.

SECTION 2 QUESTIONS

1. Q. Who determines the benefit schedule?

   A. The Committee on Group Insurance

2. Q. Whose decision would it have been to change coverages for retirees?

   A. The Committee on Group Insurance

3. Q. Do you consider the retirees to be part of the group?

   A. Yes.

4. Q. Do you consider one person on the Committee from the retirees adequate representation from that group?

   A. Yes. The retirees represent a little over 10% of the total group.

5. Q. Do some companies provide insurance on a long term basis? (e.g. rates guaranteed for more than one year). What if we went to a longer term contract than what the State has now?

   A. Companies do not provide longer term contracts for health insurance.

6. Q. In as far as changes in coverage are concerned, have there been any actuarial studies or surveys to find the type of coverages needed or wanted by the different age groups involved, etc.? Do you study the future cost impact when benefits are added?

   A. The carrier determines the cost of different coverage options using actuarial assumptions. The future impact of additional benefits is considered. State employees have been recently surveyed to determine their benefit needs and desires.

7. Q. Retired employees over 65 years of age pay $6.50 for $5,000 life insurance. Active employees over 65 pay $5.00. Why is it that retirees pay 30 percent more than active employees for the same benefits?

   A. At the July 1, 1981 group insurance renewal, the Legislature had appropriated 15% additional premium for the cost of employee group insurance coverage. In order to continue coverage for active employees with no plan modification, it was necessary to increase the subsidized retiree premium in an amount greater than the increase that was applied to active employee premium. In addition, employees over 65 (who range in age from 65 to 70) are part of the active group while retired employees over 65 range in age from 65 to 100 and represent greater risk to the plan.

8. Q. Is the Committee discriminating against those retirees who have Part"A" of Medicare and purchase Part"B" of Medicare and then have the State plan offset all Medicare payments instead of coordinating the two programs?

   A. No. As far as group insurance benefits are concerned, the law provides no protection for persons in other than an employee status. Therefore, the Committee has not discriminated against this group.

9. Q. On the carve-out plan, does the State plan pay a negligible amount for hospital and doctor bills? What are the liabilities of the State plan under carve-out?

A. The amount paid under the State of Nevada carve-out plan depends upon the claim submitted. The liabilities of the State plan are the difference between normal State plan benefits regardless of other coverage and what Medicare pays on the total bill. State plan liability can be quite large if the claim involves charges that Medicare limits extensively or does not pay, for example, a hospital confinement lasting longer than 60 days.

10. Q. Is the wife/husband of a retired employee, and carried as a dependent, entitled to be carried on the insurance coverage in the event of the retired employee's death? Under what statute provision?

A. Yes. This is a practice which has been in force since 1976. It is not outlined in the law.

11. Q. How can the insurance carrier and its agent assume that all retired persons have Medicare coverage? Do they actually make this assumption in determining the amount of the claim to be paid?

A. In the carve-out plan, Part "B" is assumed since it is available to all persons over age 65. Since the carve-out plan was implemented prior to an open enrollment period under Medicare, the plan is not now assuming that all retired persons have Part "B" coverage. However, effective July 1, 1983, the effective date of Part "B" coverage for late enrollees, the plan will begin to assume coverage under Part "B" of Medicare. It should be noted that normal plan benefits are paid for persons who are not eligible for Part "A" of Medicare.

12. Q. Are all of the various types of insurance coverage provided under the plan actually authorized under provisions of NRS 287.043?

A. Yes. The Committee sought an Attorney General's opinion on this matter.

13. Q. Has the Committee in the past provided additional lines of coverages excluding changes to existing benefits when the premium cost for the in force plan was less than the amount appropriated by the Legislature? Was the same coverage provided for all persons covered by the plan? Have these additional coverages resulted in higher premiums to continue providing the coverage?

A. At the renewal in 1980, the Committee added dental benefits for dependents and vision care benefits for employees. This coverage was extended to all persons covered under the plan. Dental insurance costs have resulted in higher premiums in subsequent years. However the plan was modified at the last renewal to curb rising costs. Vision care premiums have been lowered to pre-implementation levels.

14. Q. Why are benefits constantly being adjusted, sometimes more liberal, sometimes more restrictive, to fit the premium structure? Shouldn't a benefit package be negotiated every two or three years and then funding be provided?

A. Because funding levels are set by the Legislature and are typically less than recommended by the insurance committee, it has been necessary in the past to restrict benefits to fit the premium structure. As long as the Legislature continues to underfund the plan, pre-setting the benefit package will have no effect.

15. Q. Does the present method of determining premium payments truly follow the principles of Group Insurance?

A. Yes.

16. Q. Are the present costs for supplemental coverage to Medicare comparable with other similar policies?

A. The present cost for supplemental coverage to Medicare is comparable with other group policies. However, a review of individual supplemental policies shows that an adequate supplement to Medicare can be purchased on an individual basis at less premium. An example of this would be the plan offered through the American Association of Retired Persons (AARP). However, Term Life, Accidental Death and Dismemberment, Dental, and Vision Care cannot be purchased on an individual basis.

17. Q. Why did Carson-Tahoe Hospital withdraw from the plan?

A. Carson-Tahoe Hospital withdrew from the State plan in favor of self-funding its benefits.

18. Q. Why did Storey County, after inquiry, choose another carrier?

A. Storey County requested that the Committee waive the statutory service waiting period on a new employee. When their request was declined, they withdrew from the State plan.

19. Q. Is it possible to equitably offer the opportunity for premium payments to be made by the State for coverage for an employee and one dependent when some employees do not have a dependent? Will this option also be offered to retired persons in the plan?

A. This provision is part of the law. The Legislature would determine whether it is to be extended to retired employees.

20. Q. Was there a provision for a premium stabilization fund? If so, please explain.

A. Yes. The premium stabilization fund was established by the Committee in 1979 when the State plan experienced a surplus. Its purpose was to offset future rate increases in years when the appropriation was less than needed. The plan has deteriorated to the point that at the 1982 renewal, the fund was used up. The plan is now in a deficit position. In the future should the plan experience a surplus, a premium stabilization fund will likely be established.

21. Q. Do you have experience figures on retirees who have both Part "A" and "B" of Medicare since July 1982?

A. Our records include claims experience for the retired group as a whole. Experience for retirees with Parts "A" and "B" of Medicare is not available.

22. Q. Are the disabled former employees included with the retirees for rating purposes? Why?

A. All retired employees are included in the retired group. This includes disability as well as normal retirees. The retired group is as reported by the Public Employees Retirement System.

23. Q. Is the experience of disabled retirees charged to the retiree group? Why?

A. Yes. See answer to question 22.

24. Q. Could the State waive the premium tax if the plan remains fully insured?

A. Yes.

25. Q. Is it economically advantageous to allow other political subdivisions into the State's plan?

A. The Committee has established certain guidelines which provide that an entity requesting admission to the State group insurance program satisfy certain requirements. In addition, if the entity employs 100 or more employees, the past three years claim, premium, and benefit history are reviewed prior to admitting the group to the plan. These procedures safeguard the plan. It could be advantageous to the State plan to admit groups with good experience. It is also beneficial to the plan to increase the number of participants over which the risk is spread, and thus increase total premiums.

26. Q. How does the Committee on Group Insurance "negotiate" with other public agencies when they wish to join the State Plan? Duging negotiations, is the public agency's prior experience considered?

A. See answer to question 25.

SECTION 3 QUESTIONS

1. Q. What procedures are used for soliciting bids from insurance companies?

   A. When the Committee decides to go to bid, the broker is directed to perpare specifications about the plan. The specifications are mailed by Mercer to all licensed insurance companies doing business in the State of Nevada.

2. Q. What procedures are used in determining a broker of record both before and after 1976? Is it open for full public bid?

   A. Mercer's involvement with the Committee began July 1, 1976. We are not familiar with procedures used prior to that time. The Committee has established a regulation governing the selection of a broker of record. The selection process is open for full public bid.

3. Q. Has there been an investigation into the methods and procedures of the Committee's bidding procedures? When was the Committee investigated? What was the result of that investigation?

   A. There has been no investigation to our knowledge. However, the Committee should be consulted for verification.

4. Q. How have the claims administrators been selected in the past, both before and after 1976?

   A. We have no knowledge of pre-1976 procedures. Since Mercer became involved, the Committee has considered other proposals and has chosen to remain with the current administrator who has provided competitively priced, quality service.

5. Q. When selecting administrators, do you take into consideration that there were other administrators in the State that have experience in medical claims administration for large groups in the State of Nevada?

   A. The Committee has considered other administrators' bids.

6. Q. Does the Committee insist on a third party administrator? Are all carriers willing to submit bids under this condition? Have some carriers refused to bid because of conditions in the bid proposal? Is it necessary that the plan be administered by a third party administrator or would the insurance be less expensive if administered by the insurer?

   A. The Committee has determined that the major duties involved in the program - consulting, claims administration, and insuring - should be separated and contracted for searately. This determination was made to avoid conflicts of interest and to provide a system of checks and balances among the three contractors. Some carriers have indicated an unwillingness to allow a third party administrator to pay claims on their behalf. However, this has not prohibited carriers from bidding. Administration by a third party administrator is not necessary. However, a third party administrator can often provide claims administration services at less cost than an insurer.

7. Q. Has the Committee ever received offers from other companies to administer the plan? Were these proposals above or below the cost for the present administration? Why were the bids not accepted?

A. The Committee received a lower cost offer to provide claims administration. However, based on our experience, the administrator priced his proposal so low that it was doubtful whether the required services could be performed without the possibility of a request for more funds at some future date. Also, the bid was not solicited by the Committee. The Committee felt it could not act on the proposal without going to public bid. At the time, administrator selection regulations were being drafted and the administrator was invited to bid again during the formal selection process.

8. Q. Has the Committee considered dropping some of the coverages to reduce the premium cost?

A. Yes.

9. Q. Why is it that the State has so much turn over in carriers?

A. In years when the funding appropriated by the Legislature has not been sufficient to cover the cost of the plan, the Committee has been forced to go to bid to seek a lower premium. For this reason, the history of the plan indicates frequent carrier changes.

10. Q. Why hasn't the Committee on Group Insurance taken the opportunity to have experienced group insurance people assist them free of charge? (e.g. The Life Underwriters Association).

A. During the time of Mercer's involvement, we know of no free offers of assistance extended to the Committee.

11. Q. In 1976 when Prudential was awarded the contract, were one of the plans accepted as written in the specifications? If not, did all bidders have a chance to resubmit bids that were adjusted for the change in benefits?

A. The package offered by Prudential which included Mercer as broker and Mutual Administrators as third party administrator was an improvement on the specifications at the most competitive price.

12. Q. Was William Mercer, Inc. licensed with the Division of Insurance of the State of Nevada at the time he presented a proposal, or at the time of his selection, or afterwards?

A. William M. Mercer is now and has been properly licensed with the Division of Insurance.

13. Q. Do some brokers and administrators feel it is closed to open bidding and there is no opportunity to become the broker of record or the administrator under the present system?

A. We are not aware of the attitudes of other brokers and administrators.

14. Q. Should any other administrator receive specifications, when the minutes of the Group Insurance Committee show motions concerning the bidding that the existing broker and administrator will continue to provide services? (see minutes of 5/19/80 page #4, paragraph (a) of Doyal Boring's recommendation and page #5 Tony Palazzolo's motion. Also the recent bid specifications indicate a strong preference for the present administrator.)

A. Specifications are mailed directly to insurance companies and not to other administrators. Any broker or administrator can request a copy of the specifications from the Group Insurance Committee.

SECTION 4 QUESTIONS

1. Q. What studies on utilization and cost containment, especially for in-patient hospital care have been done, if any?

A. Mercer is currently involved in a cost containment study, the basis of which is an analysis of in-patient hospital expenses. The study will provide the Committee with previously unavailable data, as well as an analysis which will pinpoint areas of unnecessary hospitalization and provider overcharges. This study was requested by the Committee on Group Insurance.

2. Q. Has the Committee looked at a program of mandatory second opinions for surgery?

A. Yes.

3. Q. Has the Committee reviewed pre-paid plans, preferred providers or provider panels?

A. The group insurance package currently includes a pre-paid panel plan for vision care through Nevada Vision Service Plan.

4. Q. Has an alternative delivery system for dental care been considered which would make it more cost effective?

A. A proposal was received from Delta Dental Plan which is a panel arrangement at the last renewal. However, the rates quoted by Delta Plan were higher than those quoted by the State's current carrier.

5. Q. Will an effort be made to establish a utilization control board?

A. This is a future possibility.

6. Q. Has the Group Insurance Committee looked into direct benefit and capitation programs?

A. See the answer to question 3.

7. Q. Has the Committee looked at HMO's?

A. The Committee will hear a presentation from Health Plan of Nevada, a federally qualified Health Maintenance Organization, at its upcoming meeting.

8. Q. What is carve-out and why have this program?

A. Carve-out is a method commonly used by group insurance plans to supplement Medicare. The program was implemented on July 1, 1982 to control the cost of the retiree experience. Carve-out also resulted in less premium cost than the prior coordination of benefits approach.

9. Q. What are the ramifications of the so-called "Carve-out" policy?

A. The purpose of the carve-out program is to lower the retiree claims experience and to ultimately hold down future costs for the retiree group.

10. Q. Should the State consider inside limits in the plan vs. UCR limits?

A. Inside limits were considered but not implemented because this method tends to transfer costs rather than contain costs.

11. Q. Should a variety of deductibles be available in the interest of economy?

A. Deductible options have been considered, however, the savings has not been significant enough to enter into such a plan. In addition, administrative procedures will be increased substantially. An argument against offering different benefit plans is that adverse selection may result, thus increasing plan cost.

12. Q. What is the approximate turnaround time for medical claims?

A. Three working days.

13. Q. What type of claims history is maintained for each claimant?

A. This question has been addressed by Mutual Administrators

14. Q. How many claims examiners are assigned to the State claims?

A. See answer to question 13.

15. Q. What is the average number of years experience of the claims examiners?

A. See answer to question 13

16. Q. What is the longevity of the claims personnel?

A. See answer to question 13

17. Q. How many claims were processed last year?

A. See answer to question 13

18. Q. How often are the claims audited by the Carrier to determine if they were paid accurately?

A. It is our understanding that CNA performs an audit of the Administrator approximately twice each year. This should be verified with the administrator In addition, Mercer recently performed a special audit of the administrator at the Committee's request.

19. Q. When the carrier audits the claims, do they recalculate the benefits paid?

A. See answer to question 13.

20. Q. How many claims were audited by the carrier last year?

A. See answer to question 13.

21. Q. Based on claims dollars paid, what percentage of accuracy was achieved on those claims audited?

A. See answer to question 13.

22. Q. Do you consider vision coverage one of the types of benefits that should be included in the group policy, or should that be an optional coverage paid by the employee?

A. Vision coverage is currently included in the benefit package. Allowing employees to choose whether or not they want vision care could result in adverse selection against the plan, thus increasing cost.

23. Q. Does the Committee feel claims payments by the carrier to retirees as a supplement to Medicare are in keeping with the premium cost as compared to the claims payment return per premium cost of the active employee?

A. Yes. The claims experience shows that retirees are receiving 50% more benefits than the carrier is receiving in premium. Conversely, active employees are receiving 20.5% less benefits than premiums through the first six months of this plan year.

24. Q. Could the present policy regarding premium determination eventually lead to an "adverse selection" condition in relation to the retired employee portion of the plan?

A. It is possible.

25. Q. How does the Committee handle complaints on claims? Do you believe claimants receive the proper forum for their complaints?

A. An employee with a claim complaint has similar rights to those provided under the Employee Retirement Income Security Act of 1974 (ERISA). Under this system, the employee requests an appeal on the decision made by Mutual Administrators. Mutual reviews the claim and sends it to the insurance carrier for review. If the carrier upholds Mutual Administrator's decision, the employee may take his case to the Committee on Group Insurance. The Committee will hear the case and make an interpretation where the contract is silent. If the employee still is not pleased with the decision, he has the right of litigation, or can appeal to the Insurance Division.

26. Q. What communication programs are in effect to advise employees of their benefits or changes in benefits?

A. Historically, the Committee on Group Insurance has not been sufficiently funded to provide a communications program to State employees. The Committee must rely on the carrier, administrator and broker to compose, print, and distribute communication pieces. The various payroll centers are responsible for seeing that employees receive these communications. It would be helpful to involve the Personnel Department and the Public Employees Retirement System in this responsibility.

SECTION 5 QUESTIONS

1. Q. Who signs the claim vouchers?

A. This question should be referred to Mutual Administrators.

2. Q. How are charges excluded from coverage and what method is used to determine what is and is not covered?

A. Charges specifically excluded in the plan and those over usual, customary and reasonable fees are not covered. There are several methods used to determine the usual, customary and reasonable fee. These include schedules published by the Health Insurance Association of America and Relative Value Schedules. Mutual Administrators can provide an in depth discussion of methods.

3. Q. How can the State control costs on behalf of retirees, so that the plan doesn' have runaway costs?

A. The carve-out plan is an attempt to control costs on behalf of retirees.

4. Q. What action is taken by the claims administrator when there is a dispute over a claim?

A. See the answer to Section 5, question 25.

SECTION 6 QUESTIONS

1. Q. What kind of programs does Mutual Administrators have to control costs?

A. It is our understanding that Mutual Administrators utilizes internal auditing procedures and orders external audits of hospital bills regularly. A more complete discussion of internal controls can be provided by Mutual Administrat

2. Q. How much is saved on coordination of benefits? How much are you saving on "carve-out" or "offset" of Medicare for retirees?

A. Coordination of benefits savings is not now recorded. Savings on carve-out cannot be specifically determined due to the content of the retiree group. However, the year end financial analysis will reveal the effects of carve-out.

3. Q. We are experiencing increases of 35-50 percent in premiums---
a. What other cost containment procedures are you implementing?
b. How much are we going to save on these procedures?

A. With the renewal on July 1, 1982 the plan was changed to include the following cost containment methods:

1. An additional $50 hospital confinement deductible is applied to each hospital confinement in addition to the calendar year deductible of $250. This is meant to discourage unnecessary hospitalization.
2. Expenses for surgery which is performed on an out-patient basis are reimbursed at 90% after the deductible. This is meant to encourage out-patient surgery when the option is available.
3. Testing that is normally done while hospital confined is reimbursed at 90% if performed on an out-patient basis. This feature is meant to take advantage of the 60% reduced cost available for out-patient laboratory work.
4. In August of 1982, the Committee established a Patient Management Program. Under this program, each person covered under the State plan who becomes hospital confined is monitored by a registered nurse who has been hired by the State's insurance carrier. The nurse's responsibilities are to encourage prompt discharge from the hospital and to arrange home health care or alternative care if possible.

The actual dollar amount to be saved as a result of these methods will not be known until the financial analysis is completed at year end.

4. Q. What is Mutual Administrator's fee based upon: percent of premiums, number of claims paid or fee per enrollee? How much is the fee?

A. The administrator now receives 3.0% of premium not to exceed $39,672 per month.

5. Q. It is understood that registered nurses are used to monitor hospital utilizatio Is this a program of Mutual Administrators? Do they review the claims paid by Mutual Administrators?

A. The Patient Management Program was arranged by the Committee on Group Insurance. It is a program of the State's carrier, CNA. The program is defined in the answer to question 1. The Patient Management Program does not include a review of paid claims.

6. Q. Has the Insurance Division ever made an examination of the claims administrator operation since awarded the State contract?

A. This question should be referred to Mutual Administrators.

7. Q. Why is an out-of-state insurance company selected to provide coverage?

A. Prior to the beginning of the July 1, 1982 policy year, the State group insurance plan was put out to bid. Every licensed company in the State of Nevada had an opportunity to submit a proposal. No in-state insurance company submitted a proposal.

8. Q. What is the percentage premium or amount paid to the broker?

A. Mercer receives .2% of Life and health premium.

9. Q. What was the percentage premium or amount retained by the carrier? Does this include premium tax? How is this broken down?

A. The total retention (amount retained by the carrier) for the policy year July 1, 1981 through June 30, 1982 was 7% premium. The breakdown is as follows:

Premium taxes	2.0%
Claims administration	2.6%
Commission	0.2%
Other expenses (including the cost of forms, envelopes, supplies, etc.)	2.2%
	7.0%

10. Q. Which percentage reflects the cost of forms, envelopes, supplies, etc.?

A. See answer to question 9.

SECTION 7 QUESTIONS

1. Q. Is there an advantage for the State to become self-insured? What are the advantages? What are the disadvantages?

A. The advantages of self funding are financial. Premium taxes would not be a cost factor, the State would control the reserves, and significant cash flow would develop in the first year. The disadvantages of self funding include the State's role as legal fiduciary in claim disputes and the lack of a guaranteed cost for budget purposes.

2. Q. Could past claim experience be reviewed to determine the savings had the plan been self insured?

A. Yes. Although the paid claims amount would not change,it would be easy to pinpoint such savings as reserves, risk and profit charges, and premium taxes. In addition, other administrative services could have been provided at less cost than that charged by the insurance carrier.

3. Q. In your opinion, could the State benefit by going self-funded with "specific" and "aggregate" re-insurance?

A. We believe there are advantages to be gained by performing a detailed study of self-funding for the State. In our annual report (which will be presented to the Committee at its upcoming meeting) we have offered to perform the feasibility study.

4. Q. If the State would self-fund the group insurance benefits, what changes would involved and what would be the impact?

A. Enabling legislation would be necessary to allow this form of funding. The State may desire to contract for stop loss insurance. It would be necessary to contract with a consultant such as Mercer to provide actuarial projections and prepare a plan document contract and booklet. The State would have to fund for the cost of booklet printing and other administrative costs.

5. Q. Has the Insurance Committee considered self-insuring the dental, vision, or prescription drug benefits.

A. Alternate funding is not available to the Committee at this time.

APPENDIX C

mutual administrators

ROBERT HUFFMAN
president

March 8, 1983

Ms. Mary E. Finnell, State Risk Manager
State of Nevada
Risk Management Division
Capitol Complex
Carson City, NV

Dear Mary,

Attached is Mutual Administrators' response to questions from the Legislative Sub-Committee studying the State's program of group insurance. If you have any questions or require further information please contact Mike Phillips or myself at your earliest convenience.

Sincerely,

R Huffman

Attachments

RH/dcp

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OVERVIEW QUESTIONS

What is the total annual premium involved in the entire state program?

How much does the State of Nevada spend on employees' premiums?

How much is spent by the State for retiree premiums?

What is the total number of employees?

What is the total number of dependents?

What is the total number of retirees?

OVERVIEW QUESTIONS

1. $18,758,028.00

2. $11,559,915.00

3. $313,977.60

4. 12,051 employees covered. Of this number, 11,169 are State employees.

5. 4,071 employees with dependent coverage.

6. 1,475 retired employees. 523 have dependent coverage.

Section 2 questions

Do you have experience figures on retirees who have both Part "A" and "B" of Medicare since July 1982?

Is the experience of disabled retirees charged to the retiree group? Why?

1. No, but all carve-out claims are now coded and those figures are available from CNA.

2. Yes, because anyone, without exception who is receiving retirement benefits is included in this group.

Section 4 questions

What are the ramifications of the so-called "Carve Out" policy.

Should the State consider inside limits in the plan vs. UCR limits?

What type of claims history is maintained for each claimant?

How many claims examiners are assigned to the state claims?

What is the average number of years experience of the claims examiners?

What is the longevity of the claims personnel?

How many claims were processed last year?

How often are the claims audited by the Carrier to determine if they were paid accurately?

When the Carrier audits the claims, do they recalculate the benefits paid?

How many claims were audited by the Carrier last year?

Based on claims dollars paid, what percentage of accuracy was achieved on those claims audited?

How does the committee handle complaints on claims? Do you believe claimants receive the proper forum for their complaints?

What communication programs are in effect to advise employees of their benefits or changes in benefits?

SECTION IV

1. Carve-out policy was established in order to provide equal benefits to all claim receipients, whether active or retired.

2. It is felt this is inadvisable since it would create more ill will with the employees than the savings will justify. Additionally, fixed limits would be "dated" almost immediately upon implementation and over a period of time employees would receive fewer benefits due to the current escalation of health costs.

3. A seperate file folder is maintained for each individual or family, and contains a complete cronological claims history.

4. Corporate Staff - Allocated for time devoted to account
   Office Superivsor - Reno Office (50%)
   Unit Supervisor - Las Vegas Office
   Unit Supervisor - Reno Office
   Administrative Assistant - Reno Office (65%)
   10 Examiners
   8 Clerks

5. 5.25 years

6. Average 3.5 years

7. 125,000

8. Continental Assurance Company claims audits are conducted twice yearly in both the Reno and Las Vegas Offices. From the Chicago Office a computer print-out of all medical, dental, and life drafts issued, is supplied the regional audit staff who choose approximately 300 random payments for sampling prior to coming into Mutual Administrators, Inc. Further, any payment exceeding $10,000.00 must be audited by CNA prior to the release of benefits as well as any file which exceeds an aggregate payment total of $25,000.00 for the year.

9. During a claims audit, the eligibllity, deductible amounts, stop-loss provisions and claims payment sampling are verified for accuracy of benefits as well as Contract provisions.

10. Between 1,500 and 2,000

11. 98.8% Accuracy

12. The committee acts as a forum to review claims where there is an impasse between the administrator and/or Company and/or the claimant. Historically, over a period of years this system of claims review has proven to be successful. To our knowledge, there have been no claims taken past this point of review into litigation.

13. Employees are furnished on a timely basis with booklets outlining current coverages. When changes in Plan Design are effected, the administrator and broker prepare and distribute notices of such changes in advance of the effective date.

Section 5 questions

Who signs the claim vouchers?

How are charges excluded from coverage and what method is used to determine what is and is not covered?

How can the State control costs on behalf of retirees, so that the plan doesn't have runaway costs?

What action is taken by the claims administrator when there is a dispute over a claim?

SECTION V

1. Robert Huffman, President - Mutual Administrators, Inc. through a facsimile signature plate.

2. The State of Nevada Contract provides explicit criteria for Covered Expense. Extensive guidelines; along with updates on new services and procedures are provided by CNA regularly. The Contract guidelines and the CNA Claims Manual to make routine decisions. Claims requiring a more complex review are referred to the CNA Regional Medical Department to either the Medical Consultants Peer Review Association, or legal department as necessary.

3. First, by implementing the "carve-out" approach, which has already been done; and secondly, by requiring all retirees to subscribe to Part B and/or Part A of Medicare.

4. Each complaint is given a thourough review by the Unit Supervisor and the Office Claims Manager. If the claimant is still not satisfied after a local review, claim is referred to the Regional Claims Office of CNA for further review and determination. At this point should the claimant remain dissatisfied with the Company's determination then he or she may refer the claim to the Insurance Division and/or the Statutory Committee for Group Insurance. A final avenue of appeal would be litigation, but again, to the best of our knowledge there has been no such accurance over the past 6½ years.

Section 6 questions

What kind of programs does Mutual Administrators have to control costs?

How much is saved on coordination of benefits? How much are you saving on "carve out" or "offset" of Medicare for retirees?

What is Mutual Administrator's fee based upon; percent of premiums, number of claims paid or fee per enrollee? How much is the fee?

It is understood that registered nurses are used to monitor hopsital utilization. Is this a program of Mutual Administrators? Do they review the claims paid by Mutual Administrators?

Has the insurance division ever made an examination of the claims administrator's operation since awarded the State contract?

SECTION VI

1. The most important part of the program to control costs is the recruitment and retention of quality claim examiners, in addition, regular claims reviews are conducted on each individual's claim that exceeds $5,000.00 and re-examined at each $5,000.00 interval. The Unit Supervisor also conducts routine audits on each individual examiner. Three of our claims examiners have come to us with extensive background in the nursing profession.

2. Approximately, 9% which compares favorably to the National Average of 5%.

3. Reliable statistics are not available at this point since carve-out has been established only since July 1, 1982. Mutual Administrators' fee is based on 2.5% of premium for claims ajudication and .5% of premium for ancilliary administrative duties, currently, "capped" at $39,672.00. This level of compensation was projected to allow an annual profit for Mutual Acministrators during the current policy year of $20,856.96 (4.4% net profit).

4. No
   Yes

5. No, however, each company office is audited by CNA twice yearly, and we received a favorable audit from the in-house claims specialists of William Mercer Co.

Section 7 questions

If the state would self-fund the group insurance benefits, what changes would be involved and what would be the impact?

1. Superficially, the savings would be in premium tax and the use of reserve funds for investment purposes. A stronger impact would be derived from the employee's knowledge that the program was being funded by his employer and fellow employees. While there is no way to measure this impact, we do know that fraud under self-insured programs drops almost to the zero level and employees tend not to submit frivilous claims for payment.

REPORT AND RECOMMENDATIONS TO THE COMMITTEE TO STUDY THE STATE INSURANCE PLAN

The Retired Public Employees of Nevada, after hearing testimony before your Committee, and based on their experience with the problem, would like to offer this report of our position and recommend solutions to the problem.

First, it is our contention that the State Insurance Plan, as it relates to retired persons, was intended to be used as a supplement to Medicare or Medicaid and was used to pay, at least partially, those medical costs not paid by Medicare or Medicaid. Up to the present insurance contract this has been true. Under the existing contract what we really have is two prime insurers and the State Plan, as the second payer, has repeatedly claimed they have no obligation to the insured as the other insurance has already paid the maximum allowed. As a result the retired person is paying, with some State assistance, a very sizeable premium for practically non-existant insurance.

Secondly, the experience rating of the retirees has been greatly inflated by arbitratily including in their section of the plan those persons retired for reasons of disability. We have no desire tc create a hardship for the disabled persons, rather, it seems incumbent that everything possible should be done to make their circumstances as comfortable as possible. However, we do feel the medical costs of these persons, at least during the normal extended benefit period, normal in all such insurance, should be assessed against the active employee sector of the plan where they can be spread over a larger number of insured.

Lastly, we feel the method of selection of the Statutory Committee members, the lack of specific terms, the fact they are not responsible to any State Government entity, and absence of any auditing, has made the Committee unresponsive to the insurance needs and capabilities of the group as a whole.

To correct these problems we would like to offer the followins Suggestions:

I. NRS 287.041 should be amended as follows:

287.041. Committee on group insurance. Creation; composition. There is hereby created the committee on group insurance to be composed of five members (to be appointed by the Governor) as follows:

NRS 287.041 continued.

(1. One member shall be selected from a list of five names recommended by the Nevada State Employees Association.

2. One member shall be selected from a list of five names recommended by the Retired Public Employees of Nevada.

3. The Insurance Commissioner of the State of Nevada.

4. Two members shall be appointed who have not been employees of the State of Nevada during the past five years, and are not retired from service with the State of Nevada, and have not represented either group above.

5. The terms of office for members, other than the Insurance Commissioner, shall be for three years. The initial appointment for the representative from the Nevada State Employees Association and the Retired Public Employees of Nevada shall be for one year, one public representative shall be appointed for two years and one public representative shall be appointed for three years.

6. No person shall be appointed for more than two terms on the Committee.

7. Members of the Committee may be removed for just cause by the Governor.)

II. NRS 287.043 should be amended as follows:

287.043. Committee on group insurance: Powers and duties. The Committee on group insurance shall:

1. Act as an advisory body (to the State risk manager) on matters relating to group life, accident or health insurance, or any combination thereof, for the benefit of all state officers, employees or persons retired from state service.

NRS 287.043 continued.

2. Negotiate (and recommend to the state risk manager) contracts with the governing body of any public agengy enumerated in N.R.S. 287.010 which is desirous of obtaining group insurance for its officers, employees and retired employees by participation in the State Insurance Program.
3. (Recommend to the State risk manager) the purchase of policies of life, accident or health insurance, or any combination thereof, from any company qualified to do business in this state for the benefit of all public officers, employees and retired employees who elect to participate in the State's group insurance program, (except nothing in this section shall prohibit the State from insuring itself in all, or part, of the program of health, accident or life insurance).
4. Carry out the directions of the State risk manager as to the duties set forth in this section.
5. (Recommend to the State risk manager the) adoption of such regulations and perform such duties as may be necessary to carry out provisions of NRS 287.041 to 287.049 inclusive.

III. NRS 287.044 should be amended as follows:

Add the following:

Paragraph 3.

No additional insurance coverage may be provided after the appropriation has been made by the State Legislature to cover premium cost unless specifically authorized by the Legislature.

Paragraph 4.

Any excess of appropriation amount over premium cost shall be held in account for premium adjustment in future insurance contracts.

IV. NRS 287.047 should be amended as follows:

Add the following:

Paragraph 3.

3. For purposes of determining premium cost the costs of the retired section of the plan shall not be computed separately, but as a part of the total group.

Paragraph 4.

4. The State Insurance Plan shall be considered as a supplement to coverage by Medicare or Medicaid and as such may pay up to, but shall not exceed, the total medical expense of persons covered under this statute.