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LETTER OF CONCERN IN REGARD TO EXCESSIVE FEES CHARGED TO NON-STATE RETIRED MEMBERS WITH CONTINUOUS PARTICIPATION IN THE STATE OF NEVADA'S PUBLIC EMPLOYEES' BENEFIT PROGRAM FOR MEDICAL, PHARMACY, DENTAL, AND VISION COVERAGE

Presented before
ASSEMBLY COMMITTEE
ON
GOVERNMENT AFFAIRS

March 10, 2003

ASSEMBLY GOVERNMENT AFFAIRS G1-4
DATE: 3/10/03 ROOM: 3143 EXHIBIT G
SUBMITTED BY: Jim Weishaupt

LETTER OF CONCERN

This Letter of Concern is presented to the Assembly Committee on Government Affairs in response to AB~~165~~ 222, this 10th day of March, 2003 by James L. Weishaupt who resides at 424 S. California Street, City of Yerington, County of Lyon, State of Nevada, zip code 89447. I am a native Nevadan, born in Fallon, Nevada on April 4, 1943 (59 years ago). Retired under the disability provisions of the Public Employees Retirement Act, Chapter 286, in 1996 following 28 years of combined service as an employee of the Truckee-Carson Irrigation District and Walker River Irrigation District, both as political subdivisions of the State of Nevada organized under Nevada Irrigation Act, Chapter 539. I have been an active and continuous participant in the Nevada Public Employees Benefits Program during this entire work period and without participating in any other private benefits program.

As for the basis for this letter of concern, I state as follows:

Statement 1. Participant premiums (rates) effective January 1, 2003 thru June 30, 2003 are excessive in amount and personally prohibitive to fund.

Statement 2. Determination by PEBP (staff?) appear to have been calculated on a false interpretation of intent of directive statutes.

Statement 3. Notice was not provided throughout work period (throughout last 28 years while a participant) to participant of possible or future changes in 'insurance group' classification.

Statement 4. Rates set forth should be based on the commingling of claims experienced by all participants in the Program.

SUPPORT MATERIAL
FOR EACH OF THE ABOVE STATEMENTS

Statement No. 1

According to the January 28th, 2003 electronic funds transfer notice from PERS, $711.67 was deducted for Medical Plan premium from my retirement check. That equates to $4,270.02 for the January 1 thru June 30 period, or $8540.04 for a single year; $42,700 for 5 years; $85,400 for 10 years, and so forth. If one amortizes the above amount, for each of the time frames the amounts become greater. In comparison, I have determined from my actual medical records for the year 2002 gross expenditure totals (see Attachment A) from doctors, hospitals, clinics, dentists, optometrists and prescriptions. (I need to explain that this total reflects medical requirement needs for the maintenance of a patient with heart disease, having had open heart surgery in 1996.), that the total eligible charge against my claims to the Program was slightly less than $3,000. Adjust the $3,000 amount by $257 in co-payments, $300 in deductible, the actual payout by the Program becomes $2,450. It appears that for this particular year there is a large discrepancy between the amount of paid in premiums and the amount paid out of the Self-Fund, therefore the annual premiums are deemed excessive in amount.

Statement No. 2

NRS 287.045, in part, states, in line 4,"....and was not participating in the program at the time of his retirement is eligible to participate in the program 60 days after notice of the selection to participate is given pursuant to NRS 287.023 or 287.0235. The Board shall make a separate accounting for these retired persons". It continues in line 10, "The claims experience of these retired persons must not be commingled with the retired persons who were members of the program before their retirement, nor with active employees of the state".

I was a member of the program before I retired, when I retired, and continue in the program as retired. Therefore, it appears to me as I interpret this wording in the statute, it was the intent of the legislature to commingle active and retired members of the Program, and to not commingle those active and retired members in the program with those that were not in the program at the time they elected to participate. The statute does not differentiate from State and Non-State Retirees, it states, "An officer or employee .... or other political subdivision. Based on this interpretation, I should not be included in the classification 'Non-State Active Employees and Non-State Retirees. Again, a Non-State Retiree participating in the Program at the time of his retirement would not be included in the category presently set forth under the heading of Premiums: Non-State Active Employees and Non-State Retirees. In conclusion, the interpretation by PEBP staff may be misinterpreted and not according to the legislative intent.

Statement No. 3

At no point in time, during my 28 years in the Program, was I notified that as a non-state active employee or non-state retiree, that I would be classified, or commingled in such a small segregated, isolated group. I wasn't aware that the premiums or fees to provide medical coverage would be treated differently. The inequity of the present program was never anticipated. The younger generation in today's program should be funding the program as I did when I began my career, and my generation funded the program through our years of service. As manager of an irrigation district, I was party in the decisions concerning the payment of premiums for all employees. If we had been notified that the program would consider us as a separate group after being commingled with all other employees, paying the premiums as did all other employees, we certainly would have made different provisions for insurance that would provide affordable coverage before and after retirement.

Statement No. 4

By definition, the Self-Funded (Insurance) Medical Plan is an act of insuring each of its members where, by contract, the State of Nevada undertakes to indemnify or guarantee the participants against loss by a contingent event .

As an employee of a political subdivision of the State of Nevada since 1971, it was my understanding that I paid the required premiums as a participant in the Program, and that said premiums were in turn used to indemnify those current members, active or retired, against loss by a medical event; thus all members, or participants, were commingled uniformly. Therefore I feel that I am a vested annuitant in the program, have not relinquished my status as a participant in the program, and should be treated equally as any member, active, state or non-state, or retired.