MINUTES OF THE MEETING
OF THE
ASSEMBLY COMMITTEE ON GOVERNMENT AFFAIRS

Seventy-Fourth Session
February 12, 2007

The Committee on Government Affairs was called to order by Chair Marilyn K. Kirkpatrick at 9:00 a.m., on Monday, February 12, 2007, in Room 3143 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/74th/committees/. In addition, copies of the audio record may be purchased through the Legislative Counsel Bureau's Publications Office (email: publications@lcb.state.nv.us; telephone: 775-684-6835).

COMMITTEE MEMBERS PRESENT:

Assemblywoman Marilyn Kirkpatrick, Chair
Assemblywoman Peggy Pierce, Vice Chair
Assemblyman Kelvin Atkinson
Assemblyman Bob Beers
Assemblyman David Bobzien
Assemblyman Chad Christensen
Assemblyman Jerry D. Claborn
Assemblyman Pete Goicoechea
Assemblyman Ruben Kihuen
Assemblyman Harvey J. Munford
Assemblywoman Bonnie Parnell
Assemblyman James Settelmeyer
Assemblyman Lynn D. Stewart
Assemblywoman RoseMary Womack

STAFF MEMBERS PRESENT:

Amber Joiner, Committee Policy Analyst
Scott McKenna, Committee Counsel
Cheryl Williams, Committee Secretary

OTHERS PRESENT:

Leslie A. Johnstone, Executive Officer, Public Employees' Benefits Program
Jon M. Hager, Chief Financial Officer, Public Employees' Benefits Program

Chair Kirkpatrick:
[Meeting called to order. Roll called.]

This morning we have a presentation on the Public Employees' Benefits Program (PEBP).

Leslie Johnstone, Executive Officer, Public Employees' Benefits Program:
The Chair has asked that we provide an overview of the PEBP Program and Operations. I have broken this down into a basic discussion about insurance economics and how PEBP relates to those factors. We will then talk a little bit about the demographics and the financial history of the program. We will then cover some of the operational improvements that have been made over the last several years. Finally we will have a very brief overview of the Governor's Recommended Budget for the upcoming biennium.

The Public Employees' Benefits Program (PEBP) serves as your insurance program. It covers State employees, State retirees, and non-state jurisdictions that choose to participate in the program with their active employees. Non-state retirees can also decide to join the plan upon retirement, or in each even-numbered year. It is a self-funded part of the program that experiences the same risk as any private insurance company. Obviously, the administrative costs are lower for PEBP than in the private sector because of the lack of a profit factor. The health benefits are offered under two different models. There is a self-funded program, otherwise known as a Preferred Provider Organization (PPO). This is how we have implemented the self-funded aspect. We also offer fully-insured products that participants can enroll in through the Health Maintenance Organizations, (HMO). PEBP is fully funded for several other lines of benefits, including life insurance, a long-term disability program, business travel accident, and the HMO products are fully insured. The vendors that we procure those benefits from are bearing the financial risk. PEBP has a known premium that it has to pay each year. PEBP also offers some voluntary products to most of its participants. Individuals can buy life insurance either for themselves or their dependents. We have arrangements for discounted property and casualty insurance for home, auto, and boat coverage that participants can enroll in. The program for active State employees, other than the University, includes flexible spending accounts or Section 125. This is for pre-tax dollars for

medical reimbursement and for dependent care reimbursement. There is also a voluntary product that participants can buy for short-term disability and long-term care insurance. Under these voluntary products, PEBP serves to facilitate the procurement of these policies, and then the individuals decide whether or not to enroll. They interact directly with the vendors that PEBP has selected to obtain the discounted rates.

We have included in the material that we handed out a Benefits Summary Document (Exhibit C), which is the shorthand version of what is referred to as our Master Plan Document. It will give you an idea of the benefits themselves, as well as the rate schedules that are in place for the current year. This is for your information. The self-funded plans as I mentioned are exposed to all the same financial risks of all the claims, which most insurance companies are. This is about the law of large numbers. The statistic that I want to emphasize for the Committee is that, in the medical area in the self-funded plan, 60 percent of those costs last year were incurred by 4 percent of the individuals. As we talk about the program and rates that are assessed, we always need to remember that we have individuals who are relatively healthy and low users of the plan, but it is the catastrophic cases that drive most of our economics. The self-funded plan offsets some of this risk and tries to mitigate some of the risks several different ways. One I mentioned is the law of large numbers. The larger the enrollment, the smoother the impact of this risk is from one year to the next. The cost can be spread over a larger number of individuals. Some plans are able to purchase—or it is cost effective to purchase—a reinsurance or stop-loss insurance. PEBP has chosen not to do this for a number of years, primarily because of the way the insurance policies are priced. It seems to us that the benefit that you receive out of those polices lasts for about a year, and then the policy can be re-priced to cover the insurance company's financial amount that is at risk. They can see our claims numbers just as well as we can, and they are not offering these policies to lose money. Another area is to fund a reserve that can be used to absorb any spike in claims, and PEBP has that in place. For the last several years it has been referred to as Catastrophic Loss Reserve or Reserve for Rate Stabilization, and we will refer to it by either name. The idea is that if you do have a high cycle of large claims, some of the costs can be absorbed through a reduction in that reserve, and does not necessarily have to be passed on in the following year's participant rates.

Cost increases in the self-funded plan are the result of several different things that can be going on simultaneously. Some individuals will refer to this as "trend." I want to indicate what some of the components that go into that "trend" are. The most basic element is the medical inflation, so the cost of service "X" will cost 5 percent more next year than it did this year. There are also deductible and co-payment leveraging so that if you increase or decrease

the share that is passed on to the participant, costs are affected. If the deductibles or the co-insurance is increased for the participants of the plan, it will lower the "trend" of the overall cost increase. There are other forms of cost-shifting through plan design, different tiers that are structured for prescription drug coverage, or different co-payment levels that are established for different levels of medical service whether it is the primary physician, specialty, or emergency room. Another component that goes into the overall trend is utilization. More visits to the doctor per person or more prescriptions per person will result in a utilization cost increase component. On occasion there are governmental mandates that impact "trend." If a particular type of screening is required to be covered by the plan, which previously had not been, those can go towards the increase of the overall cost for the plan. Then probably the biggest component that we are facing in the upcoming years is the increased cost associated with medical technology, new procedures, and new treatments that had not been previously available. That and our aging population are probably the two main areas where cost increases will have pressure. The medical "trend" is outpacing general inflation. Individuals will hear numbers advertised about medical trend: 10 percent sometimes down to 8 percent, and those are a function of all of the components that I talked about previously. PEBP has been running at about an 11—12 percent trend for medical and prescription overall, so we frequently get asked why our trend is not closer to the national number of 8 percent growth in most recent years. Our actuary will say that the 8 percent trend reflects plan design changes. PEBP has not cut back on its plan design and the scope of the benefits since claim year 2003, so the net number that we often hear about is 8 percent, including the changes in benefit structure. As I mentioned, we use Aon's national trends for our actuarial report. They are based out of Denver, but they are an international company, so they will report national trends without any plan design changes in the neighborhood of 11—13 percent. I need to correct the 8 percent figure on the national trends after benefit changes; this does not include increases due to utilization. I will stop here and see if there are any questions.

Chair Kirkpatrick:
Do we have any questions?

Assemblywoman Parnell:
I was not even aware of the voluntary products. When you become a member of the program, do you have to actually opt into something to purchase the life insurance, the short-term disability, or the long-term health benefits?

Leslie Johnstone:
The life insurance has two different components; there is what we refer to as the basic life insurance which is the $20,000 for active employees and $10,000 for retirees, and there is a voluntary component with additional coverage for life insurance that you can buy.

Assemblywoman Parnell:
What if you were to do the additional life insurance? Do you have a cost break?

Leslie Johnston:
I do not have that with me, but we can certainly get that for the Committee. I will say that the retiree buy-out cost is relatively expensive because it is age rated, but because the voluntary product it is not commingled with the actives, it does tend to be expensive for the retirees. We can get the information on the premiums as well as what the enrollment has been.

Assemblywoman Parnell:
Long-term care insurance is becoming so important. Are your costs for that comparable to the market in general?

Leslie Johnstone:
We are in the process of going out to bid, so I might be a little premature. Right now, through the end of June, we have a very favorable rate, which has not been adjusted for a number of years. We will see what the new vendors bring because this is getting to be a more popular policy.

Assemblywoman Pierce:
Where you talk about the two models—the fully-insured and the self-funded—is that self-funded entirely or partially by the employee?

Leslie Johnstone:
It is entirely self-funded by the program so that cost is shared between the employer and the employees or the retirees. That covers medical benefits, prescription, and dental.

Assemblywoman Pierce:
Did you give us numbers on how many people are in the program?

Leslie Johnstone:
I have those in the demographics section.

Assemblyman Goicoechea:
Is the voluntary expansion of the insurance, for example, the life [insurance] or the vehicle [insurance], extended to non-state also?

Leslie Johnstone:
It is extended to non-state.

Assemblyman Goicoechea:
We do not see a lot of that, especially in local government. It is typically health care, and I was just curious.

Leslie Johnstone:
Yes, it is available to the non-states as well.

Assemblyman Goicoechea:
Apparently it has not been marketed, because I am not aware of any local governments accessing it.

Assemblyman Settelmeyer:
I was told a long time ago that when PEBP originally began, it was brought forward due to the fact that there was no Medicare allowed to state employees. I was going to clarify that in the beginning when it first started out; a person who was not allowed to also have Medicare now has that ability. What percentage of increase in liabilities are we seeing because of the increase in benefits that the State has decided—or by court orders has decided—to extend overall benefits over the last five or ten years? Do you have any idea what percentage of increase in liabilities we have seen due to that increase, even if it is a marginal increase in benefits due to a court order or anything?

Leslie Johnstone:
The state employees hired before 1986 were not covered by Medicare. Now we have several participants who were from that era who have Medicare coverage on their own. I will show in the demographic information the number of non-Medicare retirees that we have. Those tend to be due to age and not to eligibility. In the over-65 age group, we have about 300 who do not have Medicare Part A coverage. In looking at the central payroll demographic, which covers most of the state employees, it looks that we will have a tail of about 150 to 300 for several years who will be over 65 who do not have Medicare coverage. That makes sense because the people who started prior to 1986 are just now entering into retirement planning and potentially retirement age. We do find that most of the participants end up having coverage from other employers, so it is a relatively small component. The actuaries will tell us that

because it is such a small component of 300, it is not really a credible group to evaluate plan design changes just based upon those 300 individuals.

I do not currently have a way to respond to the other component. We can talk with the actuary about how we might quantify that. In their plan year 2003, because of the plan's dire financial situation, we made many significant plan design reductions and shifted cost benefits to the participants as a result. We can talk with an actuary to try to quantify those reductions, determine the effects, and note recent changes. We have not changed the plan a great deal since 2003. I do not have a direct answer to your question. We will try to get that information.

Mr. Christensen:
I know that different states have their systems that may operate exactly the same, similarly, or maybe very differently. Can you think of two or three states that you would be familiar with, with systems that are very similar to ours or that would be the most similar to ours?

Leslie Johnstone:
The state of Utah is probably pretty comparable to our plan as to who it covers. That is the one that comes to mind, but there are several, and we could get the information out of our plan design comparison—which we do every year—and provide that to the Committee as well. I did not bring that with me.

Mr. Christensen:
That would be great if you would. I would really appreciate it

Chair Kirkpatrick:
That would be great Ms. Johnstone, if you would make sure that everyone on the Committee has a copy of that as well. We will go forward because it sounds like most of our questions are moving into the next portion of your presentation.

Leslie Johnstone:
In the next section, I want to give the Committee some demographic and financial history information. I will start with one way we look at our population, which is the breakdown between state and non-state participants. I will focus on non-state because it has been the most affected over the last several years. In plan year 2002, the non-state participant had a bad year when it came to claims. This relatively small group had a spike in large claims and cost increases. Without a large group to pass that onto, the rates went up considerably for plan year 2003. With that, we had quite an exodus of the employers that covered their active employees, and so the population of

non-state actives declined dramatically in Fiscal Year (FY) 2004 and then again in 2005. That left a non-state population that is heavily weighted towards the retiree group. The same rate increase that caused the non-state actives and the employers to leave the plan caused dramatic retiree premium increases. This was all happening during the 2003 Legislative Session. The advent was when Assembly Bill 286 of the 72nd Session was adopted in the 2003 Legislative Session that required non-state employers to subsidize their retirees at the same level as the State subsidizes its retirees. In the subsequent years, we have a late enrollment period in each even numbered year. In 2004 and then again in 2006, retirees who were not on the plan had an opportunity to join the plan. Then, of course, we have on-going retirements that occur on a daily basis. With A.B. 286 of the 72nd Session we have had a dramatic percentage increase in non-state retirees to the point that we have gone from 1,500 non-state retirees in 2004 to almost 5,000 in January 2007. The employer has an incentive to have retirees on PEBP since it costs the employer less than their current plan. In some cases, there have been plan design or subsidy changes at the employer level that may result in PEBP being one of the few options for retirees. Because of those two factors or dynamics, we have seen a dramatic increase in the non-state retiree group.

The non-state group is rated separately from the State participants. With the kind of demographics in the non-state group, it is hard to imagine active participation increasing because of the high cost due to the heavily weighted retiree population. We envision a disproportionate increase in state retirees in the next five to ten years, as we hear about the bubble of state employees who are retiring, and assume that they are backfilled with the active. Time will tell on that projection.

The other way that we look at our population is the percentage of people who are enrolled in the self-funded plan versus the percentage who are enrolled in the Health Maintenance Organizations (HMO). In FY 2004, we only had one HMO plan available, and it was available only in the south. When we were able to procure Anthem Blue Cross Blue Shield in 2005, we had some shift away from the self-funded plan to Anthem. Anthem offers the HMO product in the northern counties for us. The percentages have remained relatively stable since that time. So we are very heavily weighted toward the self-funded plan.

The benefit designs are similar. In the HMO product in the south through HPN (Health Plan of Nevada), there are significant premium savings for the participants. In the north, the Anthem product rates are about the same as the self-funded, so there is not as much price difference in the north. Another way to look at our plan is by age demographics. We have a large population of children; obviously, they are covered by the plan. I will say that children are one

of the lowest cost groups for the plan, so these large numbers are not a concern for us based upon several years of history. Children are not large cost drivers, and because of our age group for the actives and the retirees, we do not have a high percentage of maternity costs, compared to plans that cover only active for different businesses. We had a run on complicated pregnancies this last year, but, compared to our plan size, it has not had a significant impact. I did not update the average demographic. The active employee covered under PEBP a couple of years ago was about 47-48 years old. It is an older group as plans go, and it is a group that is starting to enter the age of needing more medical benefits. That is one of the drivers for our overall cost as well.

I want to include a little bit of financial information. When we look at self-funded claims, we do not focus as much on the total cost as we do on the cost per participant. Because of our change in enrollment, it is most meaningful for us to look at the per person cost. The jump from FY 2004 to FY 2005 is a little deceiving because, in FY 2003, we made large benefit reductions. If I had taken this back two more years, you would have seen quite a dip from FY 2002 to 2003, and then it starts to go back up again. I wanted to note that the growth between 2004 and 2005 is largely due to utilization. There was a reaction from the participants not to utilize services as much while they were adjusting to the new benefit design, and then we went back to the previous utilization patterns.

To give you an example of where we spend our self-funded dollars, our top four diagnostics groups are consistent year to year. Many diagnostic groups coincide with the age group of our population. Musculoskeletal ranks number one. We are starting to see arthritis and joint issues, as well as other types of musculoskeletal situations. Circulatory problems cover high blood pressure. Digestive is third and respiratory is fourth. Taken together, those four diagnoses are almost half of our claims expenses.

The next slide will show you the income and expenses for PEBP each year since FY 1999. I take it back that far to show you the two very tough financial years for the plan and the legislative reaction to each of those. In 1999 we were recovering from problems with the third-party administrator, and the legislature was required to add an infusion of $26 million as a supplemental. That was also the year that the program was administratively changed from the Committee on Benefits to the Public Employees Benefits Program (PEBP). A lot of adjustments were going on at once. Then the plan went through some very tenuous years. In 2000 and 2001, we had a different third-party administrator who was still trying to get a handle on what the actual claims were. In FY 2002 we intentionally strove to be current on claim payments. At the same

time, we had a spike in large claims, which resulted in a significant loss in FY 2002. The claims spike is not attributable to only that one year, but it was a clean-up year for the claims. As a result, during the 19th Special Session, the Legislature gave the program another infusion with the intent that the plan be stable at the end of that year and break even, which it accomplished. Now, in FY 2004 through the present time, we have had relatively stable benefits. We have had more accurate projections primarily due to stability with the third-party administrator, oversight of the third-party administrator, and a more refined method for funding the State subsidy. We have actually generated a surplus as a result of FY 2004-2006, so that in FY 2007 we are budgeted to lose $21 million, and bleed off some of that excess reserve.

Speaking of reserves, I want to show the same history going back two years further to 1997. I picked that year because that was the last year, probably the only year on record that the plan had a reserve for catastrophic losses or rate stabilization. When problems with the third-party administrator went into a negative reserve situation in FY 1998, it recovered somewhat in 1999 after the infusion from the Legislature. In 2001, it appeared that there was a fully funded reserve. After we got all the claims paid in 2002, it turned out not to be the case, and so we went again into an under-funded situation of 36 percent funded in 2002. We have been growing out of that situation so that in 2004 and 2005 we had significantly more funds than were required for the "Incurred But Not Reported" (IBNR) reserves. Then we added a catastrophic reserve in 2006 and 2007. I might take a moment to explain "Incurred But Not Reported." This is a reserve which accounts for the time lag on claims yet to be submitted for payment. For example, if you go to the doctor on June 25, we may not get that claim for 15 or 30 days. When we close the books on June 30, we estimate what claims have been incurred that we have not seen yet. That is not routine, but it is a mechanical process to estimate the reserve. The reserve for catastrophic losses is intended to be there for a spike in large claims. We can draw from that reserve and not have to pass the costs on directly to the rates. Over time the reserve should be built up again. It is not free money, but it allows you to get through a session, for instance, so that we would not have to incur any more Special Sessions or supplemental requests during the session for the current year. We are putting the budget together so that we can, at the end of this upcoming biennium, get back down to a 100 percent funded level. We have concerns from some of the federal agencies if we hold too much money, because many of our positions are funded through the federal government, and they do not like being charged more than they need to be charged for health insurance. We are cognizant of that. I will stop here and ask for questions.

Assemblyman Goicoechea:
Is Anthem now available in all northern counties? I know there was a time when they were not available.

Leslie Johnstone:
That is correct.

Assemblyman Goicoechea:
Can you explain to me why we had such a dramatic turn around from 2003 until 2006 when the reserves sky-rocketed? I realize that we were adjusting, but clearly we are talking about premiums back to claims.

Leslie Johnstone:
The plan design changes that we made in 2003 had a dramatic effect. We also shored up some of the contract arrangements with the largest providers—hospitals, for instance. We have made a concerted effort not to have any more contracts that have stock loss coverages for hospitals. That lowers our exposure. I would like to think that our utilization management company dealing with large claims has also had an effect. They are making sure that, on the catastrophic cases, our costs are minimized to the degree that they can be, either through what provider the individuals are receiving care, or the level of services that are being provided. At the same time, we have had more reliable information from the third-party administrator and the pharmacy company about what claims are being incurred. We probably have been conservative in estimating the trend increases; it will be a long time before we will forget about 2003 and 1999 and meeting those infusions. We will probably err on the side of caution for those trend assumptions. The utilization has gotten back to a normal level, or a more stable level, from one year to the next. It is a combination of the previously mentioned factors, and we are trying to refine the projection process so that we can get our reserves back down to the 100 percent, which we have been inching towards since FY 2005.

Assemblyman Goicoechea:
Clearly, we have seen non-state retirees double again, actually quadruple if we go clear back to 2003 with A.B. 286 of the 72nd Session and that non-state subsidy. Did that have a critical part in this dramatic turn around?

Leslie Johnstone:
It definitely seems to have stabilized the cost for the non-state retiree group. It is a larger group now than it was, and it also has not experienced the spike in large claims. It is a much more stable area, and with the plan design changes we realize the same benefits from the non-state group as we did from the state

group. This increase in funded reserves is from both the state and the non-state groups, definitely.

Assemblywoman Womack:
We are on the Anthem Blue Cross through the federal government, and we have had to change doctors three times because of the slow pay from Anthem Blue Cross. Now, that Anthem Blue Cross is in the northern part of the State, are you experiencing slow payments also?

Leslie Johnstone:
We have had an increase in complaints about lack of providers, and I assume that means that people have had to change providers as individuals have dropped out. We are addressing that with the Anthem management. That is one of the issues we have passed on to the Insurance Commissioner to see if their office could provide any assistance.

Chair Kirkpatrick:
What do mean by, "you are going to bleed off $21 million"?

Leslie Johnstone:
The amount of reserves projected for FY 2007, when the budget was originally put together, was $21 million more than could be justified through an IBNR Reserve, and a reserve for catastrophic losses. So it is considered excess, especially in the eyes of the federal government and the allowable overhead allocations or calculations. We used various methods. The State subsidy for its portion was lowered, so it went up less than it would have otherwise. In order for the State to pay in less than the plan by itself would justify, the participant share was accomplished through what we called a Premium Holiday in July of 2006, so that no participant had to pay a premium.

Chair Kirkpatrick:
Can you, at a later date, get us the different groups that participate in PEBP, the non-state versus the state, and the different numbers that you and I had talked about? Lastly, how long do these contracts stay in place? If you have a new provider—Anthem, up north, and a HPN down south—how long do those typically stay in place?

Leslie Johnstone:
Typically, we have four year contracts. We are providing the count by jurisdiction for the Interim Retirement Benefits Committee, so we will simply ask that a copy of that be provided to this Committee.

Chair Kirkpatrick:
Does anyone have any other questions? [There were none.]

Leslie Johnstone:
I want to take the opportunity to present some of the operational milestones or changes that have been put in place by PEBP over the last several years. The first one is the wellness component. Prior to FY 2006, PEBP offered a $600 per participant wellness benefit. We wanted to increase participation in screenings. That resulted in increasing the wellness benefit to $2,500 per participant, per year. It was increased as much as it was in order to cover the cost of colonoscopies, which is an expensive screening. It would not have been absorbed in the $600. Unfortunately, we have had very low utilization of the program; fewer people took advantage of the wellness program in 2006 than in 2005. So the board is focusing on how to reduce the barriers for both the participants as well as the providers for allowing the wellness benefit to be more heavily utilized. One of the decision units in our budget is related to a cardiac wellness pilot project, which I will talk about in a few minutes.

We also started focus groups in the fall of each year in 2005 and 2006, and provided the information there. We randomly selected participants for informal meetings to try to get feedback and discussion going about the good and bad things about the plan. We plan to expand these to twice a year throughout the State with one of the decision units in our upcoming budget, if that is approved.

We sent a customer satisfaction survey to all plan participants in 2005. We had a 19 percent response rate that year, but in the second year the rate was down to 15 percent. Others will tell us that 15 [percent] is still good, but we were disappointed that it was a lower number. So, we are looking for different ways to communicate, and to generate some interest in submitting those surveys to us. The surveys were largely alike between 2005 and 2007. In the area specific to customer satisfaction, there was an increase in the overall satisfaction with PEBP customer service.

We also started a quarterly newsletter. We have provided a sample of the newsletter to each of the Committee members.

We instituted a Health Assessment Questionnaire, which allows us to send targeted mailings to individuals about weight loss and smoking cessation programs available through the program. We offered an incentive for individuals to complete the questionnaire by lowering their deductible 50 percent if they were in the self-funded plan, and increasing the dental benefits covered by the plan for all participants. I did not talk about this in the plan design, but even the

participants in the HMO plan receive their dental benefits through the self-funded programs. So everybody has the same dental benefits.

This is an evolving process. There are many Health Assessment Questionnaires and/or Health Risk Assessments that are available. We will look for other tools so that we can get this information. We are changing our utilization management company effective July 1. They offer a Health Assessment Questionnaire that we might take advantage of. Many assessments are geared towards internet access. We struggle with how to make the questionnaires available to all the participants because we have a significant portion without internet access.

Medicare Part D, as you know, was implemented at the federal level in January of 2006. The plan gave several options about how to respond to Medicare Part D, one of which was to retain the current benefits. Medicare encouraged us to do that with a 28 percent subsidy paid to PEBP for prescriptions that we continue to offer to Medicare retirees. They said that they were trying not to have all the plans turn their Medicare retirees over to Part D coverage, and this was their way of encouraging employers to retain their current plans.

We have about 4 percent utilization on our flexible spending account, and that is low for a group our size. Trying to encourage the participants to take further advantage of this benefit, we increased medical reimbursement to $6,000 per year, and we implemented a grace period. You are probably aware that Section 125 had a use it or lose it rule, and one way to address that was added in 2004. If an individual had a balance at the end of the plan year, he had 90 more days to incur expenses and draw down on that old balance. That is referred to as the grace period and was implemented for our plan as well.

We have had several significant vendor selections in the last year. One is the statewide Preferred Provider Organization (PPO). We selected a joint arrangement between Sierra Health Care Options and Hometown Health so that, to our participants, it looks like one plan, and it offers them transparency between the north and the south. At the time that we were considering the different vendors, the Hometown and Sierra Health Care option was the low cost claims projection as well for us. We have a new contract going into place with Catalyst RX who will be our pharmacy benefit manager in July of 2007, and that will carry forward some amendments that we made in January of 2007 that offer full transparency to the arrangement. This means, as drug prices change and as Catalyst gets bigger and acquires better discounts, those discounts will be passed immediately on to this plan. Rebate revenue is not as significant for Catalyst as it is for some other pharmacy benefit managers, but the pharmacy rebate monies would be passed on 100 percent to the plan. In

exchange for that benefit we pay a higher administrative cost to Catalyst than we did in the past. Overall, this is a multi-million dollar savings for the plan per year. We are also changing to a new utilization management vendor in July. This vendor was selected in large part because it had some very innovative and interesting ideas on how to maximize the utilization of the wellness program, as well as implement disease management programs beyond what the plan currently does.

The board is in the process of updating its strategic plan. We initially adopted one in October of 2005, and we had several comments from the most recent LCB (Legislative Counsel Bureau) audit about that strategic plan. Those comments are being taken into consideration as we update this new version of the plan. It will include emphases in three areas: provider quality and access, how to measure it, and how to reward for improved quality and access; the wellness benefits itself, which will probably focus on cardiac wellness; and participant communication and education, which we continually strive for.

The rates, obviously, are subject to the plan design and the benefits that are offered. We look at the most recent 12 to 18 months claim experience, so the actuaries will use our claim experience, as well as the claim and trend information for the regional plans that are in the area. The PEBP selection of the PPO networks has a large effect on what those claims projects will be. We also have the HMO renewal rates, which tend to change every year. We tend to see changes every year in the other fully insured products: the life insurance, the long term disability, and so forth. Then we have the share divided between the employer and the employee that affects the actual rates.

The PEBP rates are structured so that we rate the state participants separately from the non-state participants. Within each of those groups, there are actives and retirees that are commingled. We structure the rates in four participant tiers as follows: participant only; participant plus spouse; participant plus children; and then participant plus family, which means a spouse and children.

The State Active Subsidy is calculated based upon the plan selection, so each year the plan designates one of its offerings as the base plan. What I did not mention on the self-funded plan description is that we have two structures, referred to as high and low deductible. The low deductible is $500 for the individual. If you complete the Health Assessment Questionnaire your deductible is cut in half to $250. The high deductible is $2,000, cut in half to $1,000 if you complete the Health Assessment Questionnaire. That is designated as the base plan. The subsidy is allocated to pay 100 percent of the employee cost if they select the high deductible plan, and 85 percent of the dependent's cost. If they select either the low deductible self-funded plan or

either of the HMO plans, then the employee cost is covered 95 percent by the subsidy, and the dependent cost is covered 75 percent by the subsidy. Overall, with our plan year 2006 enrollment by plan, and enrollment by tier, the overall State share for active employees was 90 percent of the overall cost.

The State retiree subsidy is allotted in a similar fashion but with different percentages, so for those individuals that are part of the base plan, the base subsidy, which is targeted at the 15 years of service level, is 73 percent of the retirees cost, and 51 percent of the dependents cost. If a retiree enrolls in the low deductible or either of the HMOs, the retiree cost is covered 67 percent and the dependent's cost is covered 45 percent. Now, with the actual enrollment in the individual plans and tiers that we had in FY 2006, the overall State share was 59 percent for retirees.

For the new members on the Committee, I will briefly explain the State subsidy. There is a Session bill that will establish the dollar amount for the base retiree subsidy, which is used for all retirees that retired prior to 1994. If they retired after 1994, that date is earmarked as the 15 years of service level. If they have less than 15 years of service it declines 7.5 percent per year to a minimum of 25 percent with five years of service. Put another way, someone who retires after 1994 is eligible for some subsidy if he has at least five years of service. It starts at 25 percent and goes to 100 percent if they have 15 years of service and caps out at 137.5 percent of that base dollar amount with 20 years of service. The PEBP program bills the employers for the full cost of any active non-state participant. We do not know about the cost share between that employer and that active employee. Therefore, I am not able offer information about what kind of variety there is, but it is billed entirely to the employer. The non-state retiree receives a subsidy that is similar to what the State pays per A.B. 286 of the 72nd Session. As a practical matter we have many retirees who work for more than one employer—for example, both Humboldt County and White Pine County. The plan bills both of those employers a proportionate amount of the overall subsidy. It can get rather complicated if you have many employers. The only real requirement is that one must have at least five years of service with an employer in order for that employer to be subject to any subsidy.

The plan changes that the board has approved for the upcoming year include improving the coordination of benefit method used for individuals with other primary coverage, and for the PEBP program regarding Medicare retirees. The change is to go to a standard coordination or full coordination of benefits. What this means is that the plan will cover costs that Medicare does not cover, after the retiree meets the PEBP deductible—either $250 or $500, depending on what plan they selected. We have prescription drug savings. The largest piece

here was not a plan change but the benefits from the new contact terms with our pharmacy benefit manager. We have made some changes to the benefit program itself, and one of the positive ones is that the $50 annual deductible will not apply to generic drugs starting July 1. So there is no deductible to meet with generic drugs; however, you will still have the $50 deductible for any formulary drugs. The other change is with mail order prescriptions, we had been offering a 90-day supply for a co-payment equal to a 60 day supply, so it encouraged people to use the mail order method of filling their maintenance drugs. The market place has changed such that the cost of mail order drugs is not as cheap as it originally was. So, we are removing that change in the co-payments. Now for a 90-day supply by mail order, you would still pay the 90-day co-payment. Your co-payment would be the same, retail or mail order.

The Medicare Part B Reimbursement, for the last two plan years, has issued a separate check through its third-party administrator in an amount equal to 80 percent of the Part B premium for Medicare retirees. We changed the mechanics behind that so that, instead of issuing a separate check, we will be lowering the Medicare contribution rates by the same amount. This will affect about 1,300 people, who in the current year do not pay a large enough contribution to PEBP to reduce the full amount of the Part B Reimbursement. They will no longer have the benefit of a separate check. Their premium will be brought down to zero, and there is some cost savings on the plan by changing that mechanism.

There is a minor change in the out-of-network dentistry reimbursement that brings the payment level for an out-of-network dentist to the same as the in-network dentist. That has a very small impact on the plan, but I wanted to mention it because it is one change in the dental benefit. It will not affect the participant as much as it will the providers. The purpose is to motivate participants to use in-network dentists.

We have been considering these plan design changes since our August meeting last summer. As the board meets almost every month, it has considered one or more plan design changes. At the January meeting we reaffirmed what the list of plan design changes would be. Next month we will consider how the actuaries may be incorporated into the rates. I will stop for questions.

Assemblyman Goicoechea:
How is the board going to address the actuary for the non-state side? Clearly, when we are talking about 700 active versus 7,000 retirees, it will not work. Has the board discussed where we are headed?

Leslie Johnstone:
No, that kind of thing is a policy discussion here about eligibility for the plan. That will be one of the things considered in Assembly Concurrent Resolution 10, the eligibility of non-state participants into the plan. So, the short answer to your question is that the board has not proposed any changes.

Assemblyman Goicoechea:
In other words, you are going to let us deal with it.

Assemblywoman Parnell:
The A.C.R. 10 Interim Committee looked closely at this issue and recognized that it is a critical problem because we have huge non-state groups that keep their actives, but many move to PEBP on retirement, which has thrown the risk off because it has increased the number of retirees in the system. One of the recommendations that you will see in bill form, maybe a year from now, is that local governments will no longer have the option to send their retirees. If they want to send all of their employee base and retiree base, fine. Active retirees together as a block would be great because that would allow the program to stay stable, but that will no longer be if that is approved by this body. They will be approved to send only their retirees. So that is one of the policy discussions that we will all have resulting from the A.C.R. 10 Interim Study.

Assemblyman Beers:
Earlier on, a question was asked regarding one of the complaints of slow pay. Some other client complaints have been about a very narrow scope of providers and unsympathetic customer service. Are you planning to introduce a standard mechanism to address the causes of these?

Leslie Johnstone:
This is in reference to Anthem Blue Cross. The provider issue continues, both with the access as well as the reasons for it. The complaints that we had been getting previously about unsympathetic customer service was due to a long, protracted process for obtaining authorization for services. Anthem has recently brought in a Regional Manager, and we have seen an improvement in recent months since his arrival. We are hopeful that he has taken our concerns to heart and has addressed that issue and those forms of complaints. We are seeing an overall reduction in the complaints, and, the majority that we get now have to do with access.

Chair Kirkpatrick:
Does anyone else have any questions? [There were none.]

I would like to know how many people are decreasing their deductibles from $500 to $250 by filling out the paperwork. Who pays the difference? Since any time you have something for free, it is really not for free. Either the manufacturer has to pay it or the insurance folks have to pay. So who eats that cost?

Leslie Johnstone:
The number who actually completes the questionnaire is about 60 percent of the overall population. Who pays for it? It is re-spread out to all of the participants. I could find out from the actuaries what the overall effect is. We have a certain number of individuals who do not use their deductible. We will try to have it quantified from the actuaries what that incremental change has been.

Chair Kirkpatrick:
Do you want to continue?

Leslie Johnstone:
The last section is a very brief overview of the Governor's Recommended Budget for PEBP. We have three budget accounts in a relatively straight-forward budget structure. Budget Account 1338 is all of our operating costs. The claim expenses run through this account, as well. The Budget Accounts 1390 and 1368 operate as "pass through accounts" for the state employer subsidy; 1390 is for the actives and 1368 is for the state retirees. The only change here is that 1368 is where any pre-funding would occur for the GASB (Governmental Accounting Standards Board) liability.

The total budget request in the current biennium—$220 million—was approved in 2006 and increased to $254 million. We are always hesitant to give projections through the end of the year, but it looks like our overall expenses will be close here. We have had enrollment that exceeded the original projection, but the claims expenses have been lower per individual than what we had included in the adopted budget. The enrollment in the HMO has been higher than what we originally projected. We always will be hesitant until about May or after June 30 to project what the year turned out to be. At this point we will say it looks pretty close.

We have adjusted how we project the participant enrollment for the Governor's Recommended Budget, since it has a large impact on the growth from one biennium to the next. It assumes no changes in the non-state retiree enrollment or eligibility. If A.C.R. 10 proposals were approved, it would have an impact on these budget projections, but it reflects quicker absolute numbers and state employees going into retiree status, as well as the growth we have had in the

non-state retiree population. The allocation of expenses, mostly in category eight, which is the fully insured product, that is where the HMO, life insurance, and accidental death and dismemberment types of products are paid out. Category ten pays for our network fees for the self-funded plan, so access to the network contracts is where those network fees are charged. Category 12 is by far our largest and where the claims expense are incurred for medical, dental, vision, and prescription for the self-funded plan. We have reserves, which are a function of where we think we will end each year. In the FY 2009 budget there is a reserve of $58.2 million between the IBNR and the catastrophic reserve that has no excess reserve that I referred to earlier.

Our operating budget is relatively small at $5.2 million each year. For sources of revenue we have the AEGIS (Active Employees Group Insurance Subsidy) Assessment, which is the state subsidy for active employees, and that is our largest component. The REGI (Retired Employee Group Insurance) assessment is the state subsidy for retirees. All other premium income is from the employers of retirees and actives, non-state employers, as well as all of the participant shares, both state and non-state. All other revenue is made up mostly of interest and pharmacy rebate income. For the assumptions that went into the budget, we have enrollment inflation at 5 percent for FY 2008 and 7 percent for FY 2009. This is a function of that biennial late enrollment that I referred to for retirees who can elect to come back into the plan or join the plan for the time. For instance, enrollment for 2006 gained about 1,100 non-state retirees, and that was primarily from Washoe and Clark County Schools. This will be a function of whether there are any large changes at the employer level that motivate people to join our plan or not join.

Medical and prescription claims increased. The "trend" was included at 11.4 percent overall, but dental holds pretty steady at about 7 percent per year. We have increased the IBNR trend to 11.4 percent per year to track with the medical and prescription claim increases. And we have included 10 percent inflation for the insured products. The next slide shows the enrollment projections broken down by state and non-state and within each of those, the number of actives, early retirees, or those who are retired but not yet eligible for Medicare, and the Medicare retiree population itself. This will give you another view of the different characteristics that we have between the non-state and the state populations and the ratio between actives and retirees.

We have used the same basic performance indicators in this budget as we had in previous years. Expense ratio is largely a function of the population growth because our operating expenses do not change dramatically. With the growth we are projecting a slight decrease in the expense ratio, which are our operating expenses as a percentage of our premium income. The claims loss ratio is our

claim expense as a percentage of the income from the self-funded plan. We are very pleased with the growth that we have had in generic drug utilization. We are at the 60 percent mark now, and we project that to go to 63 percent, even without any plan design changes. We think that eliminating the annual deductible for generic drugs will motivate even more people to use the generic drug option.

The medical network and dental network use remain pretty stagnant. There are certain circumstances in which people will avail themselves of a non-network provider. We are not going to change that. The only thing that we have done that might change this is to contract with all of the hospitals in the south, both the HCA (Hospital Corporation of America) and the Valley Health Systems, in addition to the Saint Rose facilities. We had a fair number of utilization at the Valley Systems that will now be considered in-network

Ignore the FY 2006 and 2007 budget figures for Appeals Ratio. Those were projected several years ago using an archaic form of tracking these complaints. This figure is higher than it actually should be, and we are confident now with the 0.15 complaints per 1,000 participants. We are very pleased with that.

We currently have the Rate Stabilization Reserve at $24 million, and we recommend in the Governor's Budget that that figure be increased to $28.5 million, which is trended to mid-point in the biennium, and we will adjust it once each biennium.

The IBNR Reserve was $21.5 million at the end of last year, which was actuarially valid. We have trended that at 11.4 percent per year, so that it would end the biennium at almost $30 million. Any excess reserve beyond these two amounts would be eliminated by the end of the biennium.

The next chart tries to show you how that would happen. Our projection is that we would start the next biennium at $72.6 million in reserve. At the end of the biennium we would retain or save $28.5 million in the Rate Stabilization Reserve and the $30 million in the IBNR. During the biennium we have two decision units that we are proposing be funded out of the reserve. One is a pilot project for the cardiac wellness program. What we have in mind is that we would have 1,250 participants go through a new kind of medical protocol for screening and then treatment for any cardiac disease that might be identified. We would evaluate this program at the end of 12 months and again at the end of 24 months to determine whether it is cost effective for the plan and beneficial from a health perspective for the participant to expand it to the entire population. If it continued over the long term, it should pay for itself, but, in the meantime, the pilot project would be funded out of the reserve program.

We have a small item in our Communications Enhancement Decision Unit. It is a professional video production of what the PEBP program offers. The idea is that we would be able to give this to pay center representatives and human resource folks, show it at our open enrollment meetings, and it would provide a recap of what the benefit program offers.

That would leave excess reserves of approximately $8.3 million. The Governor's Budget proposes to reduce the growth in the subsidy and the participant contributions by that amount, and we have split it 50 percent each year of the biennium. The growth in each of those figures is lower that it would have been otherwise.

Maintenance Decision Units are relatively straight forward, and I will not go through these in much detail. Our biggest changes include the enrollment growth, as well as the inflation for the claims expense itself.

We have one Enhancement Decision Units, E251 (Quarterly Audits) of $19,000 per year where we propose that we audit ourselves, or have an audit done of ourselves on our enrollment and eligibility records. We have several different kinds of audits that are done for a financial perceptive. This is an enrollment and eligibility audit to make sure that the individuals that we have in the plan are being recorded correctly. As a result, our claims expenses are being paid properly and our subsidies are being collected properly.

The Enhancement Decision Units on Communications expands on a theme that we had in the current year biennium, which was to allocate additional funding for communications with participants through mailings and meetings throughout the State.

The Enhancement Decision Units on Wellness is the large one. That is based upon 1,250 participants—1,000 would be active participants, and 250 of them would be retired individuals. We have some expenses incurred for a utilization management firm to look at the claims expenses that are incurred before and after individuals go through this program and to help us with the economic analysis on whether or not it should be rolled out to the rest of the population. We have funding set aside in the Governor's Budget for doing the actual evaluation of the program, and these costs were estimated by the University of Nevada, Reno Business Center. We are in the process now of refining exactly how we would like to approach that study, and we may come up with a lower cost option than what was available through this economic study with the University.

We are proposing that this be funded through the excess reserves, which amounts to about $3.1 million in each year of the biennium.

We have the usual Enhancement Decision Units, with equipment replacement, and new equipment. PEBP is heavily reliant on technology; we scan all of the documents and use optical character recognition software to record all of the information that is provided for enrollment and eligibility. We are in the process of implementing a new enrollment and eligibility system that will allow more transactions to be done via the web. We will always be reliant on individuals filling out forms to give us their enrollment changes, and the technology that the state has invested in has allowed us to forego staffing increases to accommodate the growth in the program itself. We think it has been worthwhile.

We have some Statewide Enhancement Decision Units on the Unclassified Step Adjustment and the Information Technology Contract Unit, which I will not go into.

I want to provide at least a four-year history of where the Active Subsidy figure has gone. The current biennium started at $481 per participant, and this is the amount that goes into the AEGIS budget account. We draw it out into our operating budget based upon percentages of cost share. The low growth between FY 2006 and FY 2007 at 4 percent is due to the intentional loss where the growth and the subsidy increased less than it would have otherwise if we had not budgeted to lose $21 million. It steps up at a more normal pace in FY 2008 and FY 2009 to $557 and $626 respectively.

The Retiree Subsidy shows a similar type of pattern where we have a lower growth in what would have otherwise happened in FY 2007, and then it steps up 8.4 percent and 12.4 percent per year, so that we have $365 in FY 2008 and $410 in FY 2009.

We will talk more about GASB (Governmental Accounting Standards Board) tomorrow, but in the REGI budget account, there is an Enhancement Decision Unit that records $25 million. That is recommended by the Governor to go towards pre-funding the GASB liability for the retiree benefits. This money would be collected as the normal REGI assessments are now, as a percentage of payroll. The budget proposes to establish an irrevocable trust fund that these monies would be deposited into, and we are working with the administration to draft legislation that would be required to implement this. I will talk more about GASB tomorrow.

Assemblyman Settelmeyer:
Legal has indicated to us that before a vote, or a possible introduction to a Committee of a BDR, that we should have disclosure on any matter when discussed. In that desire for transparency and disclosure in elected officials, I want to inform everyone that my sister is a State employee and is a member of PERS and PEBP. This does not affect me directly, or differently, than anyone else with a sibling; therefore, I feel I am capable of voting on these matters.

Chair Kirkpatrick:
Just so everybody is clear on this because I think there are probably a few more people that have to make some kind of disclosure. This is just an overview; it is not a hearing. We are trying to make sure that the Committee is comfortable with the subjects. If anyone else has disclosures to make, you can do it at a later time.

Assemblyman Goicoechea:
Since I sat on the A.C.R. 10 Committee, I wanted to see how hard the Board had looked at what would happen if legislation came forward that required all actives to come with retirees. I mean, we could well see 10 to 15,000 members enrolled in PEBP if non-state agencies decided that was the only way they had to go with their retirees. As I look at those numbers and how that drives enrollment costs, IBNR would also be affected because there would be a big movement. There would be a lot more demands on the system again if we expect another 15,000 members or so. That could happen overnight.

Leslie Johnstone:
We have talked internally from an administrative perspective, especially with GASB liability, that if the non-state eligibility remains as it is, it might behoove us to separate our operating budget between state and non-state, so that it is very clear what amount of that reserve, and all of our other components, are attributable to state or non-state because the state will need to record the liability just for the state retirees. We would have to think about that some more, but that is one possibility.

Assemblyman Goicoechea:
My real concern comes when you talk about bleeding off the reserve. Again, how do you earmark what created that reserve? Given that kind of influx, I would prefer to err on the side of caution and not see a lot of costs. Let us see if we can stop bleeding some place.

Chair Kirkpatrick:
Does anybody else have any questions? [There were none.]

I think that you have done a nice job with the overview. I appreciate you putting extra work into it, and I look forward to you finishing the presentation tomorrow.

Meeting adjourned at [10:31 a.m.]

RESPECTFULLY SUBMITTED:

_____
Cheryl Williams
Committee Secretary

APPROVED BY:

_____
Assemblywoman Marilyn K. Kirkpatrick, Chair

DATE: _____

EXHIBITS

Committee Name: Committee on Government Affairs

Date: February 12, 2007 Time of Meeting: 9:00 a.m.

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Guest List
	C	Leslie Johnstone, PEBP	Health Benefits Summary