MINUTES OF THE MEETING
OF THE
ASSEMBLY COMMITTEE ON GOVERNMENT AFFAIRS

Seventy-Sixth Session
March 18, 2011

The Committee on Government Affairs was called to order by Chair Marilyn K. Kirkpatrick at 8:02 a.m. on Friday, March 18, 2011, 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/76th2011/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 K. Kirkpatrick, Chair
Assemblywoman Irene Bustamante Adams, Vice Chair
Assemblyman Elliot T. Anderson
Assemblywoman Teresa Benitez-Thompson
Assemblyman John Ellison
Assemblywoman Lucy Flores
Assemblyman Ed A. Goedhart
Assemblyman Pete Livermore
Assemblywoman Dina Neal
Assemblywoman Peggy Pierce
Assemblyman Lynn D. Stewart
Assemblywoman Melissa Woodbury

COMMITTEE MEMBERS ABSENT:

Assemblyman Harvey J. Munford (excused)

GUEST LEGISLATORS PRESENT:

None

STAFF MEMBERS PRESENT:

Susan Scholley, Committee Policy Analyst
Cynthia Carter, Committee Manager
Jenny McMenomy, Committee Secretary
Olivia Lloyd, Committee Assistant

OTHERS PRESENT:

James R. Wells, Executive Officer, State of Nevada Public Employees' Benefits Program
Jon M. Hager, Chief Financial Officer, State of Nevada Public Employees' Benefits Program
James T. Richardson, representing Nevada Faculty Alliance
Martin Bibb, Executive Director, Retired Public Employees of Nevada
Barry Smith, Executive Director, Nevada Press Association, Inc.
P. Michael Murphy, representing Clark County
Rusty McAllister, President, Professional Fire Fighters of Nevada

Chair Kirkpatrick:
[Roll was called.] We will now have a review of the Public Employees' Benefits Program (PEBP). This is the health care program for our state workers.

James R. Wells, Executive Officer, State of Nevada Public Employees' Benefits Program:
There is a presentation that we have provided (Exhibit C). Many of you have received phone calls that PEBP is dumping its retirees or abandoning them, that we are no longer covering prescription drugs, that we are no longer providing dental benefits, that costs for PEBP participants are just too high. I hope that this presentation will address some of those concerns.

I would like to start with some of the statistics and some of the underlying causes behind the increases in our premiums and why they continue at such alarming rates. Americans make up 6 percent of the world's population, but consume 60 percent of the world's manufactured prescription drugs and over 90 percent of the world's painkiller Vicodin. Directed consumer advertising has been a boon to pharmaceutical companies. It has greatly increased the cost to health plans as patients insist on trying the latest and greatest drug for their condition. Advances in the treatment of specific diseases with new medications account for part of the increase in prescription drug costs. Too many people feel that if they leave their doctor without a prescription, they have not been properly treated. They might look for a new provider; they believe that there is a pill for what ails them. This has led prescription drugs to be the fastest

growing component of our program. From fiscal year (FY) 2006 to FY 2010, the total amount that PEBP spent on prescription drugs grew 81 percent. That is from $26 million to $47 million. While our population has increased by almost 27 percent since July of 2005, the per participant per month prescription drug cost has risen 52 percent. That is from $84 to $128.

In the first quarter of FY 2011, over 47 percent of our self-funded participants filled a prescription. On average, they filled 1.5 prescriptions per month. Eighty-four percent of the participants in our care management program have the preventable form of type 2 diabetes. Seventy-one percent of those people have two or more comorbid conditions in addition to their diabetes. Thirty-one percent of the people who are on the wellness program and took the blood test had a fasting blood sugar level which would indicate diabetes, yet these people did not identify themselves as being diabetic. That means that they are potentially undiagnosed and untreated. Eleven percent of the participants on our wellness program are identified as being at-risk for their weight or body mass index (BMI) and say that they are not ready to take the necessary actions to improve their health. The total per participant, per month cost for PEBP has increased 32 percent for medical, dental, and prescription coverage. This is from $489 in 2006 to $645 in 2010.

We are a self-funded plan. Costs are driven by claims and not by profits. In FY 2010, the PEBP claims loss ratio was 99.6 percent. That means that we spent all of the money we received from our premiums on claims. There were 300 individual claims where over $40,000 was spent. The average claim of over $40,000 was $77,107. It takes the premiums of ten people without any claims for an entire year to cover the cost of just one of those claims. That means that 3,000 of our 30,000 participants, or ten percent, had to have no claims for an entire year in order to cover just those 300 major claims. Please keep in mind that those are single claims. They are not necessarily the only claims associated with that particular treatment.

On slide 2 of the presentation (Exhibit C), you will see an agenda. We are going to hit on governance, who is eligible to participate in our plan, what the current benefit structure is, funding, benefit changes for July 1, 2011, performance indicators, other post-employment benefits liability, and then the two bills that are on the agenda. Slide 3 discusses the governance of PEBP. It is governed under Chapter 287 of the *Nevada Revised Statutes* (NRS). We are governed by a nine-member board. They are appointed by the Governor. We have one vacancy currently. The other eight members are listed on slide 3.

Chair Kirkpatrick:
How many of the board members have medical experience? What is the selection process for the members? Are there certain guidelines for these board members? I have never understood why there are not more people with medical experience on the board.

James Wells:
The statute, which is NRS 287.041, dictates the composition of the membership of our board. Of the nine members, one is to be a professional employee of the Nevada System of Higher Education (NSHE); that is Jacque Ewing-Taylor, she is our vice chair. One of the members has to be retired from public employment; our retiree representative is George Campbell. Subsection (c) states that there must be two members that are employed by the state; those are Leo Drozdoff and Teresa Thienhaus. One member has to be from local governments; that is Dawn Stout. One member has to be in a managerial capacity; Karen Caterino is that member. Two members have to have demonstrated substantial experience in risk management, portfolio investment strategies, or employee benefit programs. One of those positions is vacant; the other is Jeff Garofalo. The last person is the Director of the Department of Administration or his designee. The designee currently is Julia Teska. There are no medical providers on our board. There is a section that says that in order to be appointed to the board, the member cannot be a vendor or provider to the PEBP program.

Chair Kirkpatrick:
When the board was set up originally, there were more people with medical experience on it and it has been changed over time. When these people are making the decisions based on our plans, is most of it personal, or are they a representative of their membership? How does that work?

James Wells:
The decision-making body meets in public meetings. All meetings are noticed and have an agenda. They are all public. We, as staff, make recommendations and present information to the board. The board takes that into consideration and makes those decisions regarding the plan designs.

Chair Kirkpatrick:
My understanding is that there is a list of appointments that are given to the Governor, and he decides from there. Is that correct?

James Wells:
For certain areas, like the NSHE or retiree board members, they are supposed to get recommendations from the groups that are represented by those. For

instance, the Nevada Faculty Alliance (NFA) would provide information on a list of people that they would consider for the NSHE position.

Chair Kirkpatrick:
That is where I hear the most complaints from my constituents. They have no idea how the person representing them was even selected. There is not an open discussion. Is there anything in statute that says that there must be a discussion on the selection of board members?

James Wells:
No, the appointments are all made by the Governor.

Chair Kirkpatrick:
For instance, is there a process for selection for the representative from NSHE? Does everyone just submit names? I am not sure how that works.

James Wells:
Dr. James Richardson is here from NFA. He may have a better insight into how it works for the selection of the NSHE member. I do not know what the process is for those people to submit lists for the various groups. For the current vacancy on the board, we put a notice on our website that there was a board vacancy and asked for applications. We forwarded those applications onto the Governor's Office for appointment to that position.

Chair Kirkpatrick:
I will let Dr. Richardson explain later. I want to have an idea of how these appointments are made.

Assemblywoman Bustamante Adams:
Is the process similar for the private sector board members? How long has the private sector representative position been vacant?

James Wells:
The process I was describing is for the vacancy. The current vacancy is a private sector member. We posted that vacancy on our website to solicit applicants, and we then forwarded those applications on to the Governor's Office for consideration. The vacancy occurred on Election Day. The last person to fill that position was Assemblyman Kirner. Elected officials cannot sit on our board. As soon as he was elected, he had to resign from our board.

Continuing on with the presentation (Exhibit C), NRS 287.043 states some of the requirements of the board. The board is there to establish and carry out a program of group life, accident, and health insurance. The board can purchase

policies, set rates, and contract with local Nevada governments to provide health insurance for the employees of those local governments. We have about 15 local governments who participate in PEBP. The City of Elko is the largest remaining one. The rest of them are very small. They are mostly general improvement districts, charter schools, and other relatively small organizations.

On slide 5, the board appoints an independent certified public accountant (CPA) to provide an annual audit of the program. They also appoint an attorney to perform a biennial review of our compliance with federal and state laws and regulations relating to taxes and employee benefits. The board is also able to adopt regulations and make recommendations to the Legislature concerning the program. On an annual basis, the board submits a report regarding the administration and operations of the program to the Legislature. That includes the financial results, an assessment of the actuarial accuracy of the reserves for the previous and current plan year, a summary of the plan design, a description of any written communications that are provided to our members, and a discussion on the activities concerning purchasing coalitions.

Chair Kirkpatrick:
Does this go out to a request for proposal (RFP) process? How do we determine this?

James Wells:
There are many different purchasing coalitions that we work with. For example, there are hospital coalitions both in northern and southern Nevada. These relate to concerns with whether or not we would want to join in with other local government plans to do a larger RFP. This is not how we do our contracts with our specific vendors, necessarily. These are coalitions of multiple parties getting together to do a contract. We have not had any of the activities with purchasing coalitions; almost all of the purchasing that we do, we do on our own.

Chair Kirkpatrick:
What is the reasoning for that? I just find it ironic that we have so many employees and they have the costliest health care in the state. I will use myself as an example. My husband is a retired plumber. We pay $116 a month for two children and ourselves on the plan. It baffles me that these state employees pay a substantial amount more for just themselves. I have been asking this question since 2005. I will get an answer someday. I do not understand how we have so many people on our health care system. I do not understand why we are not leveraging 25,000 employees to get us better rates.

James Wells:
Our program has about 30,500 self-funded members. The rest of them are on the two health maintenance organization (HMO) plans. We have one in northern Nevada and one in southern Nevada. The southern Nevada market is significantly less expensive than northern Nevada or the rural markets. Much of that is competition. The volume of doctors and hospitals in the south is more than it is in the north and rural areas. There is little or no competition in those places. That is one of the reasons why the cost in the north and rural areas are so much higher. For the self-funded plan, we blend all of our participants together from both the north and the south. That is how we come up with the rates that we have now. We are blending rates with our northern Nevada participants who are more expensive and our southern Nevada participants who are less expensive. The other part of this is that we are one of the few that comingle our retirees with our active people. When we comingle the more expensive non-Medicare retirees with the lower-cost active employees, it costs more money.

Assemblywoman Pierce:
How many local governments are participants?

James Wells:
We have about a dozen local governments. There are only 200 employees covered from all those local governments. They are all very small local governments.

Assemblywoman Pierce:
How many are in the plan altogether?

James Wells:
We have a little over 43,000 participants, plus dependents.

Assemblywoman Bustamante Adams:
On slide number 5, do you have a policy to change the CPA every few years? When was the last time the CPA was changed?

James Wells:
The contract for our CPA firm is four years long. We go out to bid for our CPA every four years. This CPA firm has been there for eight years.

Assemblyman Ellison:
You said that the north has got a higher rate than the south, as far as doctors and health care costs. Do you have a breakdown on that? What is the difference in the numbers?

James Wells:
We do not have a specific breakdown of our providers. The best that we could do is to give you an idea of when we look at the HMO rates for the north. For our northern HMO, our employee only rate is $718. For the southern HMO, it is $365. It is almost half.

Assemblyman Ellison:
I would like to see a breakdown on this. I do not know where you are looking. Are you looking at Battle Mountain? Are you looking at Elko?

James Wells:
For the HMOs, the north is considered everything with the exception of Clark, Nye, Lincoln, and Esmeralda Counties. The other 13 counties for the HMO are considered the northern counties. The four counties that I mentioned are considered the southern HMO area. The preferred provider network that we use for our self-funded plan is basically the same companies and the same geographic distribution. The four counties are incorporated into the southern Nevada market. The other 13 are in the northern market.

Assemblyman Ellison:
So Washoe County and north would be considered northern?

James Wells:
It would be Washoe to Elko and south down to Nye.

Assemblywoman Neal:
When you comingle the two groups, it sounds like rate sharing. What is the process of negotiation with the HMOs in the north? To me, it would be like if you grouped me with my father, who is a retiree. I have completely different health issues, concerns, and costs than my dad. His could be less or more than mine. If he was not healthy, his would be higher. I do not see how that is an efficient way to go about this.

James Wells:
Statute requires that PEBP comingle everyone for whom we pay for primary care. We are a primary insurer for active employees and non-Medicare retirees. We are a secondary provider for Medicare retirees. When it comes to medical care, active employees and non-Medicare retirees are comingled into a single pool and rated as a group. Medicare retirees, for medical costs only, are rated by themselves because Medicare is their primary provider. When we look at prescription drugs, we are primary for Medicare retirees, non-Medicare retirees, and active employees. In this way, all three groups are comingled into a single pool. Therefore, there is the much higher drug utilization of the Medicare-aged

population, which is then comingled with the much lower prescription drug costs of active employees. They are then blended to get an average rate. It is statutorily required that we comingle our participants.

Assemblywoman Neal:
Are prescriptions driving up the costs? My sister is a pharmacist. She says that there is an overprescribing of drugs. Do you get into that at all? Do you try to examine whether the cost is being driven by the overprescribing of drugs to certain populations? There may be waste or abuse going on.

James Wells:
We do not give medical advice. We rely on the physicians and patients to manage their medical care. There is an overprescribing of drugs. That is what some of the statistics that I reviewed at the beginning of this presentation state. It is difficult for us to manage that. That is a decision between the provider and the patient.

Assemblywoman Pierce:
The $600 a month that was referenced, who pays that money? Is that the active employees or the retirees?

James Wells:
I am not sure what number you are referring to.

Chair Kirkpatrick:
I do not know what your regular premium is, but did you not say it was $648 a month?

James Wells:
The cost of the medical on our end is about $648. That is blended between active employees and retirees. That is our self-funded population.

Chair Kirkpatrick:
Are both the retirees and active employees paying that per month?

James Wells:
Yes.

Assemblywoman Pierce:
So the retirees are paying this out-of-pocket?

James Wells:
No, that is the total cost. There is a subsidization of both active employees and retirees. There is a difference in the subsidization policy. We will get into the subsidization policy later on.

Assemblywoman Pierce:
So, for Medicare retirees, Medicare is primary for hospitals, and PEBP is primary for prescription drugs?

James Wells:
Yes, and dental.

Chair Kirkpatrick:
When you say the cost in the north and rural areas is extremely high, do the rural areas and the north have an 80/20 plan as opposed to an HMO? Do they have an HMO that is ridiculously priced? How does that work?

James Wells:
We will talk about the plan design later. We will go into what the plan design does. The rural areas have the same plan designs as the rest of the state for the self-funded plan. It is one plan that is statewide. The HMO plan that is available in the north is for all 13 counties that are in the market.

Chair Kirkpatrick:
If someone wants the 80/20, then they have to pay the difference. I like paying $5 or $15 as opposed to paying the 20 percent difference. Will you make sure to cover that?

James Wells:
We will talk about that as we get into the plan designs. Going back to the presentation (Exhibit C), slide 7 speaks to who is eligible to join our plan. We have active employees from the state, as well as state retirees. They can join at the time of their retirement or during late enrollment, which occurs in even-numbered years. We have about 12 nonstate active employers who participate in our program. We have nonstate retirees. They can be nonstate retirees from those organizations that participate in our plan. Up until 2008, they could be a retiree from any local government. In 2007, Senate Bill 544 of the 74th Session stated that all people had to be in the plan or that PEBP could only cover the retirees. The PEBP plan will only cover the retirees of those local governments who are participating with their active employees. That froze our population of nonstate retirees.

On slide 8 is the actual number of people enrolled for FY 2010 and projections for FY 2011, FY 2012, and FY 2013. There are 25,800 active state employees. There are about 8,000 state retirees. On the nonstate side, there were 459 nonstate employees last year with about 9,000 nonstate retirees. There was a decrease from 459 people to 222 people. We lost two large employers in 2010. Those were the Clark County Health District and the White Pine County School District. Both were able to find cheaper alternatives and left our plan. There are two rating pools. There is a rating pool for state employees and retirees, and there is a rating pool for nonstate active employees and retirees. There are three state employees for every one state retiree. The active employees are generally less expensive. That helps control the cost. On the nonstate side we have 220 active employees and 9,000 retirees. That pool will continue to get more expensive as time goes on.

We have increased our population by about 26 percent since July of 2005. State employee enrollment peaked at 26,530 in 2008. It has then decreased to 25,570 as of July 2010. In that same period of time, the staffing level for PEBP has remained flat at 32 full-time equivalents (FTE).

Assemblyman Livermore:
Will you give me a definition of early retirees? Will the Medicare retiree rates change in July of this year? Will they be ousted from the plan and have to find other means of insurance? Will we see some changes of those numbers as a result of these changes?

James Wells:
We define an early retiree as a retiree who is under the age of 65 and not eligible for Medicare. That means anyone who retires before age 65 and is on our plan, as a retiree, is listed as an early retiree. A Medicare retiree is anyone who is 65 years of age or older who has Part A or Part B Medicare insurance. Those are the populations.

As for the changes for July 1, 2011, the Medicare retirees will be transitioned to the individual market and covered through a health reimbursement arrangement. We will provide money for them to select a plan through the private market. That will not change the numbers on the state side, except for as people age into Medicare; they will not be in our self-funded plan. On the nonstate side, you will continue to see the non-Medicare or early retirement population decline because no new nonstate retirees can join unless the active population is insured by us. That is only 200 people. That will not be a very big pool. As the early retirees age into Medicare, they will become Medicare retirees. You will see the Medicare retiree population increase and the non-Medicare or early retirement population decrease on the nonstate side.

Assemblyman Livermore:
How many Medicare retirees will be affected on July 1, 2011?

James Wells:
There are about 9,400.

Assemblyman Livermore:
So, 9,400 will be transitioned out to the private sector?

James Wells:
That is correct. Continuing on slide 9 (Exhibit C), it shows what our current benefit options are. We have two different options for the medical side. We have a self-funded preferred provider organization (PPO) option, or we have HMO plans. On the HMO plans, we have one that covers the northern 13 counties and one that covers the southern 4 counties. We also have a couple of Medicare Advantage plans that are only open to Medicare-eligible retirees. We have about 900 people on those Medicare Advantage plans today. We also offer a dental program, basic life insurance, accidental death and dismemberment, and long-term disability. On slide 10, there is a list of voluntary options that we provide to our membership.

On slide 11 is the current funding for 2011. It shows where our money comes from and where it goes. About 52 percent of our funds come from the state subsidy for active employees and retirees. About 30 percent is received in contributions. That means contributions from state employees, state retirees, nonstate retirees, as well as the nonstate employers. About 1 percent of our income is from "other." That is mostly drug rebates and investment income. About 17 percent of our money was carried forward from the previous year. That relates to the amount that we have in our reserves. We keep money in our reserve, and it is carried forward from one year to the next. On the usage side, about 51 percent of our money is paid for self-funded claims. About 22 percent is used for fully insured products, which includes both HMOs and life insurance and long-term disability. About 23 percent of our expenditures for 2011 will be for our reserves and 3 percent will be for self-funded administration. That is the cost for the networks of doctors for our self-funded plan. The cost to run our office is about 1 percent of the money that we spend.

Slide 12 talks about why we started down the path of making some significant changes to the plan. If we were to continue the exact same program and the same subsidization level that we provide through our employees and retirees, we would need $579 million. When we started our budget process last summer, the Department of Administration said that they were going to keep our revenues flat. The money that we were going to get for our retirees'

subsidy was going to be the amount that we received in FY 2011. The dollar amount per employee was going to remain flat at $680.84. Those revenues combined gave us about $493 million and left us with about $85 million that we had to shift to participants. We had to determine how to shift that to participants, either by increasing their premiums or decreasing their benefits.

Slide 13 details how we divided up the money for the upcoming biennium. We are still going to see over 50 percent of our money come in through state subsidies.

Chair Kirkpatrick:
We have 25,000 active employees. It is $418 million that we have. We have a little over 10,000 retirees, and it is $75 million. I am confused. I am going back to where you told us who was enrolled within PEBP.

James Wells:
There are about 8,000 state retirees.

Chair Kirkpatrick:
Is it $75 million for them?

James Wells:
Yes, we get $75 million for the biennium for those retirees. There are about 25,500 active employees and, for the biennium, we get $418 million from them.

Chair Kirkpatrick:
So out of these 8,000 retirees, how many of them are from the north and how many are from the south? If you do not have that, will you get it to us?

James Wells:
I will get that to you. I do not have it broken down.

Assemblywoman Pierce:
What is that active subsidy? Is that what the state and the employee both contribute? How does that work?

James Wells:
The state provides a subsidy. That would be a dollar amount per employee, per month. We put that into a pool, and the board allocates that money as a percentage of the premiums for our program. That is for the primary participant and dependents.

Assemblywoman Pierce:
So the subsidy would be the employer contribution?

James Wells:
That is correct. The other thing with the north versus the south is that we have about 15 percent of our retirees who live out of state. There are graphs on slide 13 (Exhibit C). On the right, PEBP projects that we will expend 48 percent of our resources on self-funded claims for the upcoming biennium, as well as 7 percent in health reimbursement arrangements (HRA) or health savings account (HSA) contributions. Those are the first dollar amounts that will be provided to our employees. We will talk about that as we go through the plan design changes. The fully insured products, such as HMOs and life insurance, will consume about 25 percent of our biennial expenditures. Our reserves at the end of the biennium will be about 17 percent. The administration and operations of our office are at about 3 percent.

On the revenue side, about 51 percent is projected to come from the state subsidy or employer share for both active employees and retirees. About 27 percent will be from contributions from either employees, retirees, or nonstate employees and retirees and their employers. The 2 percent is primarily drug rebates and interest earnings. On slide 14, we show the reserves for the last decade. We have had a fully-funded incurred but not reported (IBNR) liability for the last seven years. Those liabilities are basically claims that have not been submitted at the end of any fiscal year. At the end of a fiscal year, patients have seen doctors, gone to hospitals, et cetera, but we have not received that bill. We always project what that cost is going to be. That has been fully funded for the last seven years. The catastrophic reserve was created in the 2005 Legislative Session. The catastrophic reserve was created to allow us to set aside some money for events that were beyond our control. That would be things like large claims. If you look at the 2002-2003 time frame, we were well into our IBNR reserves. We had the Legislature provide an infusion of cash on two different occasions. Once was in the late 1990s and once in 2002. They put General Fund dollars into our program to keep it solvent. In 2005, the Legislature approved the catastrophic reserve to prevent that from having to occur in future years. The catastrophic reserve has been fully funded for the last five years.

Chair Kirkpatrick:
Is there a certain amount that you have to keep within the reserves?

James Wells:
We typically have the actuaries give us an estimate of what the IBNR is, as well as what would be a catastrophic reserve sufficient to ensure that we have a

95 percent probability that we would maintain our plan solvency under the worst-case scenario.

On slide 15 is a summary of the plan design changes for the plan year that starts July 1, 2011. Our plan year is on a fiscal year, not a calendar year. Our plan year starts July 1 and runs through June 30. The changes that are projected, and have been approved by the board, for implementation on July 1 are changing our current PPO structured plan to a high-deductible health plan. We have changed coverage for various medical components. We eliminated coverage for spouses or domestic partners who have access to other employer-based coverage. We did some reductions to the dental program. We changed some of the fully insured supplementary products. We are implementing a transition of our Medicare retirees to the exchange. Lastly, we did a shift of premiums from the state subsidy to the employees. That hits those who are on the HMO plan.

We did this in two steps. For the self-funded plan, we tried to do most of the changes to cover that shortfall through plan design. On the HMO side, we have the same exact plan design that we have today. It is even better in the north. Those people will now pay a higher monthly premium.

Assemblyman Anderson:
My question is in regards to the retirees moving to the exchange. Do you anticipate that stretching the state subsidies and making it go farther? Would it bring in more money?

James Wells:
Yes, part of the savings from our plan was transitioning the Medicare retirees into the private market. The savings that were associated with that were about $22 million for the biennium. We put that money toward the benefits for the active employees and the non-Medicare retirees who are staying on our plans.

Assemblyman Livermore:
On the summary of plan design changes effective on July 1, you say that PPOs will be replaced with a consumer-driven, high-deductible health plan. In my district, there are many state employees. They have communicated to me as a catastrophic plan, the deductibles and copayments are useless. They may not have health insurance if this is the type of health insurance that they have.

James Wells:
We will talk about the actual changes to the health plan next. How much the deductible is increased, how HSA and HRA will work. I am sure that several of you are getting those types of complaints. It is a different plan. There is no

doubt about that. It is not catastrophic coverage. There are still some first-dollar coverage. There is also preventive coverage for mammograms, colonoscopies, cholesterol checks, Prostate-Specific Antigen tests, et cetera. Those are all still covered first-dollar without any deductible or copayment by the participant.

Assemblyman Livermore:
I have met with an individual; she explained what her issues were. She and her husband both work for the state. They have a son who is diabetic. Now, because of the new program going into place, his insulin medication is going to be at such cost to them that they have to make decisions on whether they fund medicine for their family or pay other bills. She described it as a catastrophic plan that is useless to her because of the out-of-pocket expenses.

James Wells:
I am familiar with the person you are talking about. That person has met with someone who is on my staff as well as a representative of the HMO to discuss her options. They are working with her to figure out the best alternatives.

Chair Kirkpatrick:
As you go through the changes, there may be some questions from the Committee members. It is unfortunate that some of these people are insurance poor. I do not know how else to say that. They are paying high premiums. As an example, some of my constituents in southern Nevada pay $150 a paycheck a month to have insurance. Their deductible is $2,000. They are insurance poor, in my opinion. They are not going to the doctor. It is getting bad. My boss made some changes in his insurance. I understand why. It is $35,000 a month. It is expensive. He has found that when he gives them the ability to go to the doctor for $10, it is saving him on everyone waiting until their conditions have gotten worse. Going for your common cold instead of waiting until it becomes pneumonia is what we want to encourage. My boss found this out because he lost productivity from the employees when they were that sick for a longer period of time. It also cost him twice as much. I would be curious to know how we ensure that people do not wait to go to the doctor. If you have a sick person showing up to work all the time because they cannot afford the deductibles, the productivity of the state will eventually go down.

James Wells:
I will now go into how the high-deductible plan works. I will compare it to how the current plan works. On our current plan, our participants pay $20 to see a primary care physician. They pay $30 to see a specialist. There is an $800 deductible for labs and hospitalization. This is how the plan works currently. There are copays associated with the various aspects of our plan. It is the

same situation with prescription drugs. If a prescription drug is generic, there is a $5 copay. If it is a brand name drug there is a $50 deductible and $40 copay. Our plan is peppered with deductibles and copayments the way it is set up today.

The plan design that will go into effect on July 1 will change that structure significantly. It will eliminate all copayments. It will have a deductible of $1,900. That deductible will be for the medical and prescription drug coverage. The plan will not pay out until the participant has paid $1,900 for an individual and $3,800 for a family. There is also an individual family deductible of $2,400. The second piece of that are the HSA and the HRA. We are providing $700 to an HSA or HRA. That money can be used for first-dollar coverage. That money can be used to get primary care physician visits, prescription drugs, et cetera. The difference between that $1,900 and $700 is really a $1,200 deductible. There is a little bit of hole there. We are providing $700 coverage up front. There is then a $1,200 gap where we have provided all of the first-dollar coverage and where that deductible ends. If employees want no deductible, they can then put money into their HSA on a pretax basis from every check. If they want to put in $100 a month, they have a zero-dollar deductible plan. After the deductible, the plan pays a coinsurance amount. After someone hits $1,900, the plan pays 75 percent until an additional $2,000 has been paid. Once you have paid $3,900 out of pocket there is no more cost as a single person for the remainder of that plan year.

Chair Kirkpatrick:
Why does it have to be so complicated? Is the HSA something they can use for something other than their primary doctor visits? Is this money that they can reinvest? Are we going to have worse productivity because people are going to avoid going to the doctor? State workers are now on furlough. They may use that $700 for groceries. How does that work? It seems very complicated. I am not going to think about how much it costs if my child is sick and I want to take him to the doctor. Someone has to pick that up. It is going to be the rest of the state. Are we setting ourselves up for more costs? It is something we have to look at.

James Wells:
Indiana is one of the states that have over 70 percent of their employees on high-deductible health plans with HSAs.

Chair Kirkpatrick:
How long have they been on that?

James Wells:
They started in 2006.

Chair Kirkpatrick:
How long have most of their employees been with them?

James Wells:
I do not know that. I know that 70 percent of the 30,000 people that they have insured are on the high-deductible health plans. Mercer consulting did a study on the experiences of the high-deductible health plans. It was published last year. It was through 2009. It was a four-year study. They found that the copay structure leaves people unaware and insensitive to the actual cost of medical care. People do not understand that the plan is paying out a significant amount of money in addition to that copayment. When the study implemented the high-deductible health plans and people saw how much the medical care was costing, they started making smarter decisions. They continued to go when it was necessary; they started asking the right questions. Do I need to have this test done? Do I need to go? Do I need to take this prescription drug?

Assemblyman Livermore:
I understand about the HSA. That is great. It is probably the right way to go for young and healthy individuals. When you change that plan for people with preexisting conditions and make that deductible that high, it is a problem. The example that I used earlier where the person has to buy insulin for her son, there is no generic prescription for insulin. Her prescription is going to cost something like $350 every time she has to buy insulin for her child. With a $1,900 deductible, you can see where that leads. It would take her maybe five or six months to reach that deductible. In the meantime, all of that money is coming out of her living expenses. She is now also paying the insurance rate. Compound that with the high-deductible plan, and it is not a good deal for her. She has over 20 years with the State of Nevada. The plan has changed for her and she feels taken advantage of. In the middle of her employment history the plan changes are significant for her. She now questions whether she can continue to work.

Chair Kirkpatrick:
There is no easy answer.

James Wells:
It is important to keep in mind that the $85 million was going to get passed on to participants in some way, shape, or form. That was going to happen. We could have increased premiums. That was one of the options that was presented to the board. We could increase everyone's premiums and then

everyone would pay a significantly higher monthly premium amount. They would then keep that $20 copay and $800 deductible. The deductible was indexed under the current plan. The deductible was going to go to $900. We could have kept that plan and increased everyone's premium. Going to the HSA allows people to set their own deductible. If they want a zero-dollar deductible health plan, then they can put $100 a month extra aside or however much it takes. If they have family coverage, they can put aside additional money to cover that deductible. The flexibility of the HSA was one of the things that drove us to propose this plan and the board to adopt it. It allows for individual families and single employees to make the decision of how much they are going to pay for a deductible. If they want a zero-dollar deductible plan, then they can put more money into their HSA. The other beauty of the HSA is that it carries over. At the end of the year, if you have not used that, you have $1,900 deductible and you do not have any claims this year, that $700 gets rolled over. We will put another $700 in that plan next year. There is now $1,400 of your $1,900 deductible that has been put in by the state. That is assuming that you have not put in any of your own money. The beauty in it is the flexibility in it and the high-deductibility coupled with the HSA.

Assemblywoman Neal:
I understand that the dynamic was that either benefits were lost or participants would pay a higher premium. Assemblyman Livermore and Chair Kirkpatrick's statements resonate with me. The reality is when you have a preexisting condition or you are focusing on preventing illnesses, you are somehow locked in this financial bind under this program. As stated, the income that these participants are receiving is flat. It is not going to adjust or get higher. This is true for retirees. Going back to work is not an option for them. Within this solution, and I understand you were mandated to find a solution, why did we not create some kind of temporary catch-all for this preexisting group that was stuck with the high cost where they are not going to be able to cover it? They are not financially able to cover it. It is a small minority, but was that discussed or considered?

My mother had cancer twice. She did not go to the doctor because it was expensive. Cancer drugs were ridiculously expensive. She was on my father's plan. She did not go and take care of herself because she was worried about the cost. She was worried about the impact on the family household. Those are very real considerations. By the time she got to the doctor, it had already festered. I know what the state mandated from you, but when you get into life and reality, those are the kind of frames that people are analyzing their choices through. Did we have that discussion? Did you bring that to the table when you were mandated to fix this?

James Wells:
We did bring those discussions to the board. There is an option for those people. They can go on an HMO plan. If they want to keep the copay, they can go to the HMO plan. There is an HMO plan available to every one of our in state active employees and retirees. The HMO is not available to out-of-state retirees.

Chair Kirkpatrick:
Then the high-deductible plan is only for the out-of-state people? Or is it for people who do not want to be in the HMO plan?

James Wells:
The high-deductible plan is available to all of our participants. Those who live in state, those who live out of state, active employees, retirees, that plan is available to everyone. The HMOs are restrictive. The HMOs have geographic areas that they are limited to. The 13 counties for the northern HMO and the 4 counties for the southern HMO is the availability we offer. There is no HMO availability outside of Nevada, with the exception of the individual market, for the Medicare retirees. They will have access to HMOs outside of Nevada.

Chair Kirkpatrick:
I just wanted to clarify that. That is not what I have been hearing. I have been hearing that there is only the high-deductible option.

James Wells:
In all fairness, we had to do something. This was the plan we chose. We have two plan designs. For those that are in state, you can go to the PPO, which is a high-deductible plan. You can pay more out of pocket when you go to use services, but the premium is lower. You can also go the HMO route and pay a higher monthly premium and when you go to the doctor, you will spend less. It is a choice. We have the two alternatives.

Chair Kirkpatrick:
What is the premium for the HMO then?

James Wells:
If you look at slide 29 (Exhibit C), this is for state active employees. For the plan year that goes into effect July 1, for employees only, they will pay $43.90 per month for the PPO, which is the high-deductible health plan. If they want to be on an HMO, they will pay $116.57 out of pocket. This is the employee contribution shares. This is not the state subsidy amount or the total premium. This is the amount that would come out of the employee's paycheck.

We have talked a lot about how the HSAs and HRAs will work. We can skip to slide 20 which talks about the other changes to the plan. These are some minor changes. They are not significant. We eliminated testing that is performed at hospitals unless it is related to urgent care, emergency room care, or inpatient admission. That was for cost savings. We found that we were paying a significantly higher dollar amount if people were getting their routine lab work done at a hospital, as opposed to a stand-alone lab. We reduced coverage for temporomandibular joint syndrome (TMJ) from 80 percent to 50 percent. One of the enhancements to the plan was allowing a 90-day prescription supply of certain maintenance drugs at the retail pharmacy. Currently, you can only get a 90-day supply through mail order. This will allow you to get a 90-day supply through a retail pharmacy. We have been able to secure some additional discounts through some of the providers to make that a manageable and less expensive alternative. We eliminated the coverage for hardware for vision. That means contacts and glasses. We still allow for the annual vision exam subject to your deductible. We eliminate the "or as needed" from the preventive and wellness guidelines. We are adopting the Centers for Disease Control and Prevention's preventive guidelines. The requirements under the Affordable Care Act, or federal health care reform, expand our liability for preventive care. This is important to remember for those that are on the PPO plan; preventive care is paid at first-dollar. It is not subject to a deductible. If you go get a colonoscopy, mammogram, blood work, cholesterol checked, et cetera, that is all covered first-dollar. There is no out-of-pocket cost to the participant. We did eliminate coverage for spouses and domestic partners who have access to other employer-based coverage.

Slide 21 talks about the changes that we made to the dental plan. We increased the deductibles from $50 to $100 for individuals and from $150 to $300 for families. We decreased the annual maximum benefit that we would provide, from $1,500 to $1,000 per person. We maintained the four routine cleanings and annual examination each year. We also maintained our existing dental network and discounts.

On Slide 22, we reduced the life insurance payouts by 50 percent. For active employees, we reduced it from $20,000 to $10,000, and for retirees from $10,000 to $5,000. We also eliminated dependent life insurance. We had a $2,000 dependent life insurance policy. We have eliminated that. We have eliminated accidental death and dismemberment. It is important to remember that any voluntary policies or additional amounts that were purchased by employees or retirees are still in effect at the same premium rate, as long as they continue to make those premium payments. There is no impact to the voluntary portion.

Chair Kirkpatrick:
Who is being forced into the high-deductible plan? I understood that a lot of people were being forced into it. You are saying that these people have the opportunity to get the HMO plan.

James Wells:
There is a small percentage of our population that will be forced into it. Those would be people that live outside of the boundaries of the state of Nevada. We do have a handful of state employees—most of them are Department of Taxation auditors—that live out of the state, who will have to go to the high-deductible health plan. The non-Medicare retirees who live out of state will have to go to the high-deductible health plan. Everyone who lives in state will have a choice between the high-deductible health plan and one of the HMOs.

Chair Kirkpatrick:
Okay. So it is just for the out-of-state people. I understand.

Assemblyman Ellison:
Are the life insurance plan changes only for out-of-state people as well?

James Wells:
The life insurance is effective for all of our participants.

Assemblyman Ellison:
If we have a senior that has been on this for many years and their spouse has never worked, they are eliminated from the life insurance plan completely. Is that correct?

James Wells:
If they had a $2,000 plan paid, that $2,000 plan has been eliminated. If they have purchased additional voluntary life insurance for that dependent, that would still stay in effect.

Chair Kirkpatrick:
That is consistent with what is happening in the private industry. Even union insurance people are doing this. The life insurance was just an extra perk that was given. It was just a guaranteed benefit. I know several people that have lost that perk. They still have the option to have that choice if they want to pay for it.

James Wells:
That is correct. I believe that the voluntary pieces are age-rated. You would pick if you wanted an additional $10,000 policy, you would just pay the monthly amount.

Chair Kirkpatrick:
It is still less expensive than trying to get life insurance on your own. My husband is overinsured.

James Wells:
That is correct. We still get group rates. Starting on slide 23, we are going to talk about the plan changes for the Medicare retirees.

Chair Kirkpatrick:
On the HSA, that is only for the high-deductible plan?

James Wells:
That is correct. The HSA is only available to plans that are considered high-deductible by the Internal Revenue Service (IRS). That is a minimum of a $1,200 deductible for a single person and a minimum of a $2,400 deductible for a family. Unless you have a deductible that is higher than that, you are not eligible for an HSA, even if that is secondary. If you are a state employee who has the PPO plan and your spouse covers you under a plan that is not high-deductible then you cannot have that HSA. The HSA is not allowable for plans that have copayments. The HSA and high-deductible health plan are married. It has to be that the participant pays out of pocket that first-dollar amount in order to be eligible for an HSA.

Chair Kirkpatrick:
On the retail pharmacy part, it is ironic that you said that we are going in that direction now. Our insurance company told us that having the 90-day supply was where some of the abuse came in. We are now back to a month-to-month.

James Wells:
We have been at month-to-month, with the exception of the mail order requirement. Please keep in mind that this is only for maintenance-type drugs. It is not for just any drug. It is for people who are on a standing prescription where they have to take the medication consistently. It is just an opportunity for them to not have to go every month to the pharmacy.

Chair Kirkpatrick:
It does not help our rates one way or the other for state employees.

James Wells:
Catalyst, our pharmacy benefit manager, brought this to our attention as a cost-saving tool. They were able to negotiate some bigger discounts with participating pharmacies. It is not every pharmacy, but those who have opted to provide this 90-day retail benefit collaborated with us. The big retail pharmacies have all done it. An example of a maintenance drug would be something like a thyroid drug. It has to be taken. That would be an example of a drug that would be available under this 90-day supply. It would not be a painkiller.

Chair Kirkpatrick:
So it would be high blood pressure and such. They have probably secured their product so that they are not switching from pharmacy to pharmacy.

Assemblywoman Flores:
I am hearing that because of these cuts that are coming, a decision had to be made on where you were going to achieve the cost savings. I went to a conference a couple of weeks ago on diabetes. We learned a lot of different things that other states are doing in terms of reforming their health care delivery system. Did you also take into consideration the changes that are being made to the delivery of services and working with doctors? One of the things that I found out is that pharmacists are not considered health care providers. Some of the states have been moving in to bringing pharmacists into the health care delivery teams. Also they are focusing more on preventative services, the delivery of information, and getting patients that are covered under the insurance programs into a managed care system. All of these things that states are doing in order to drive down the costs are interesting. You mentioned earlier that some of the people with the high-deductible plan are using their health care in a different way because they are now conscious of some of the costs associated. Was any of that taken into consideration in addition to spreading cost?

James Wells:
That is something I did not include in the presentation today. Last July, the plan implemented a wellness program for the PPO participants. It is an incentive-driven plan. So if participants joined, they would answer a 100-question health risk assessment questionnaire and have a biometric screening, which consists of a blood draw and measurements. The company took that information and put a plan together to improve health based on age, the response to the questions, and the outcome of the biometric screening. At the same time, we implemented a different plan. We have had a diabetes management plan. We implemented a new plan effective as of last July that provided that if you were engaged in the care management program, which

consisted of telephonic interventions with a nurse or provider, we would provide benefits for decreasing drug costs and provide for doctor visits associated with diabetes as preventive care, not subject to deductible or co-pay. We only had 26 percent of our diabetics engaged in that program. Even though it was incentive-driven, we did not get that population. The vast majority of that population are some of the people that I referred to at the beginning of our presentation. Most of them have type 2 diabetes, and 11 percent of overweight people said that they were not going to take any action. We have to figure out a better strategy. There is a fine line between the stick and carrot approach. We are looking at providing some information to the board in May and changing the incentive policies so that we can drive participation.

Assemblywoman Flores:
Being that you have already implemented some of these programs, have you tracked to see whether or not this has achieved any kind of cost savings? You are saying that it was not a very effective program. There was very little participation. That was one of the things that we talked about at the conference. We discussed ways in which they were able to increase the participation in some of those programs. The costs are still going up. Have you managed to see any kind of a decrease?

James Wells:
We are in our first year. The answer to that is obviously no. However, the company that started this program guaranteed that we would start to see a return on our investment for these wellness programs at the end of the third year.

On slide 23, (Exhibit C) we will talk about the changes for the Medicare retirees. The proposal that the board adopted for Medicare retirees is that they will be transitioned to the individual market effective July 1, 2011. We will eliminate the premium subsidy that we currently have for that group of people, and we will replace that with a health reimbursement arrangement that will be put into an account, based on their number of years of service, that they can use to pay for their premiums or their out-of-pocket costs when they go to see the doctor.

On slide 24, the Medicare exchange offers both Medicare Advantage and Medicare supplement, or Medigap plans that are provided by recognizable insurance company names. They have guaranteed issue and pricing, regardless of the health status. They also have multiple plans available in every zip code where we have Medicare retirees living. This will allow people to pick a plan that meets their needs. They will compile information on the drugs that they take, the doctors they see, the conditions that they have, where they live, and whether or not they travel. That will be built into the questions that the benefit

advisors will ask them in helping them to select a plan that will work best for their specific needs. The reason that this can save money is that the individual market is between 40 and 50 million subscribers. We have 94,000. We cannot compete with 40 million people to spread cost over. The individual market ends up providing a cheaper alternative for the participants and the plan.

Chair Kirkpatrick:
When you had this discussion with the board, did you have some individual markets come to the retirees and give them an idea of what some of the costs might have been?

James Wells:
We did. We had presentations starting in October. They wrapped up in early February. These presentations showed what the plan is currently and the cost and compared it with the costs under the new plan if you want to go with the Medicare supplement plan. We found, in most cases, that the cost for the participants was going to go down by a significant amount over the course of the year. It is important to keep in mind that this is the only group of people who are going to have an option to keep coverage somewhat similar to what they have today, at somewhat similar of a premium amount.

Chair Kirkpatrick:
Can you tell us how many individuals this affects?

Assemblywoman Pierce:
There are 94,000 people affected. How many retirees are there altogether? How many are Medicare retirees? How many are not? People who are not Medicare retirees are state employees and they did not contribute to Social Security. Is that correct?

James Wells:
There are about 8,000 early retirees or non-Medicare retirees on our plan. There are about 9,400 Medicare retirees on our plan. Those are a combination of people in state and out of state. That is our total population. There are about 300 of our retirees who are not eligible for Part A currently. They were state employees hired before a certain date. Those people will stay on the PPO plan or the HMO plan. They cannot get coverage through Medicare. We have about 1,000 of those. We have a maximum of 1,000 retirees that have not yet aged into Medicare eligibility. You have to be 65, so they have not turned 65 yet. There are rules on eligibility for Part A that allow you to obtain it through a spouse. Even though we may think that there are several hundred more, they may actually be available through their spouse. They would actually get Part A and go into the exchange.

Assemblywoman Pierce:
So, state employees now pay into Social Security?

James Wells:
Yes, starting in 1986. The numbers that I gave you are primary participants. Some of them have spouses and cover their spouses under our plan. The exchange will allow spouses to pick different plans. Currently, they pick one plan and both the participant and the spouse have to be on the same plan. Under the exchange, they will be able to pick completely separate plans. If one of the people in the couple is healthy, they can pick a low deductible with higher out-of-pocket costs because they are not going to utilize services that much. If the other person has chronic conditions, they can pick a higher premium product that has no cost when they go to see the doctor. It allows that flexibility. The contract that we have entered into provides licensed benefit advisers. These are people that are licensed by the department of insurance in the state where our retirees live. We will be able to help them manage through this process and become a lifetime advocate for them. That is a person that they can call if they have problems with their insurer. Those Medicare retirees that go to this plan are still eligible for the life insurance and to participate in our dental program on a voluntary basis.

Slide 26 talks a little about those people that are not eligible for Part A. That includes those that have dependents who are not yet eligible for Part A. If you are not eligible for Part A, you will remain on the PPO or HMO plan of your choice. If you have dependents, you have an option. You can stay in one plan on the PPO, or you can split the family. The part that is eligible for Medicare can go into the individual market exchange, and the part that is not eligible for Medicare can stay on the PPO or HMO plans.

On slide 28, it shows the subsidization percentages that the state provides for active employees and retirees. In the current plan year, we have provided 93 percent of the subsidies where the premium is paid by the state. That employer share is 93 percent for an individual. The PPO plan is considered our base plan. For the HMO plans it is 85 percent. That changes to 92.8 percent and 77.8 percent. It is a 15 percent differential. On the dependent side, it is currently 73 percent. For the dependent coverage, the state's share is 73 percent of the differential for the coverage of the dependents. That decreases to 72.8 percent for the PPO plan. For all other plans, it is currently 67 percent. That decreases to 57.8 percent. On the retiree side, the state subsidy is 64 percent of the premium today. That goes down to 63.8 percent for the primary insured on the base plan. There is then a 15 percent differential between the PPO plan and the HMO plans. On the retiree side, that amount is adjusted by your years of service.

Slides 29 and 30 show the employee contributions or retiree contributions. That is the amount that the employee or retiree pays out of their pocket on a monthly basis for the plan. You can see that there is the amount that is paid for FY 2011, which is the current plan year. You can also see the rates that we set for FY 2012. The plan that goes into effect in July and the difference between the two is shown here. The state active employee rate went up by $0.17.

Chair Kirkpatrick:
How long are these rates good for? Can we lock these in for three or four years?

James Wells:
Our rates are set on an annual basis. These rates are good for FY 2012. We will set the rates based on experience for July 1, 2013.

Chair Kirkpatrick:
Do other programs do it that way? I thought that they tried to lock it in, at least for a couple of years so that we could have a stabilized market.

James Wells:
As far as I am aware, most plans set rates on an annual basis. There are some contract guarantees on the HMOs to limit the amount that they can increase. We do have some of that contractual obligation, but as far as rate setting, we still set rates once a year.

Slide 31 has the performance indicators for PEBP. We use six primary performance indicators. The first two are the expense ratio and the claims loss ratio. The expense ratio is the percentages of our premiums that are spent on expenses other than claims. The claims loss ratio is the percentage of our premiums that are spent on claims. In FY 2010 that was at 99.7 percent. I mentioned that earlier. In FY 2011, we are trending downward. It looks like we will only be going to spend about 93 percent. In FY 2012 and 2013, those are over 100 percent. That is reflective of the fact that we would spend down any excess that came out of only spending 93 percent in the current year. We are proposing to spend that down over the next couple of years and get back to that excess being zero. We try to smooth the rates using that excess reserve. The generic drug utilization, which is 71.6 percent, is one of the highest rates that we are aware of. We are within a couple of percentage points of the maximum available generic drug utilization. It is the same thing with the medical and dental in network utilization. We have discounts through our in-network providers and because we do, it is important for us to have our participants see in-network providers. You can see on the medical side about

94.5 percent of our utilization is basically in our network. On the dental side, it was 93.2 percent for FY 2010. We are projecting that those trends will continue. We will continue to see more people utilize in-network providers because of the discounts. The last point is the appeals ratio. While our budgeted number was 1.5 percent per 1,000, we have been trying to get between 0.06 percent and 0.07 percent for a couple of years now.

On slide 32 are the other postemployment benefits (OPEB) liability. This is a liability to the state that recognizes the cost of providing retiree health care. It is composed of the cash subsidy and the benefit that the retirees get from comingling their experience with the active employees. It is considered earned during the working career. It is based on a years-of-service amount. It is considered earned each year during your active employment. The Governmental Accounting Standards Board requires recognition of the cost when it is incurred but not paid. That is why there is so much talk about the liability going on about the state's financial statements. The OPEB liability is actuarially calculated based on the current plan design as well as the number of employees and retirees who are eligible for retiree health insurance, the amount of the benefit that has already been earned, the life expectancy of those employees, the estimate of how long they will receive the benefit, the investment earnings of any fund balance that is set aside, and the estimated medical trend that is associated with a medical plan in future years. The last bullet is the one that makes that number so high. The differential between medical inflation and consumer price index (CPI) has long been the driver of the total liability costs. It continues in double digits while CPI is in the low single digits. It is that differential that drives the liability up.

On slide 33, you can see the liability. We are always a calendar year behind. As of July 1, 2009 the total benefit that is expected to be paid in the future for all employees including time that they have not yet accrued is estimated at $3.3 billion. The $1.9 billion that you see in the middle is the amount that would be paid if there was no more service earned after July 1, 2009. There is a bill draft that will come out that will freeze years of service. That is basically what you get. The differential between those two numbers is the impact of freezing the years of service. In order for us to be able to stay afloat, we would have to put aside about $220 million on an annual basis. That is over a 30-year period. These numbers are all down significantly from two years ago. Two years ago the $3.3 billion was $4 billion. The $1.9 billion was $2.2 billion. The annual required contribution (ARC) was $287 million. The numbers are falling. That is due to the changes that have occurred in the plan design in subsidization that the state has done.

Chair Kirkpatrick:
It seems as if we are making painful strides compared to where we were in 2007. Our intention has always been to put a minimum of $50 million aside every year. We have had to use that. Do you foresee us dropping our rates? This is as of July 1, 2010. As we make changes, do you foresee these numbers dropping?

James Wells:
Based on the plan design changes that the board approved, these numbers will have a significant decrease in the coming years. The movement of the Medicare retirees to the individual market will have a significant impact on that. It caps some of our costs related to the Medicare retirees. Those caps in costs are what drive down these numbers. We do anticipate that these numbers will drop significantly.

Chair Kirkpatrick:
Is this only if every single employee took their benefits today?

James Wells:
That is correct.

Chair Kirkpatrick:
Thank you for going through this with us. It has taken me a few sessions to get it. Are there any other questions?

Assemblyman Ellison:
I have become confused by slide 30 (Exhibit C). If a senior is on the PPO plan, then his rate would only increase 1.4 percent. Is that correct?

James Wells:
Yes. If you are a retiree who stayed on the PPO plan, your premium is going up by $2.99.

Assemblyman Ellison:
So it does not matter whether he is in the north or the south. If a retiree goes to an HMO, then that increase is going to be about $100 a month in the south. Is that correct?

James Wells:
Correct, if you are looking at the southern HMO for a retiree only. There are two factors driving into this. The first is that we changed the subsidization percentage for retirees because we did not change their plan design. They were always going to pay a higher premium. That was the trade-off. Someone either

pays more in their premium or more when they utilize services. The premiums were always going to go up. The second part of that is that we blended the north and south rates for the HMO. It is the only area in the state where there was a differential in compensation for our participants. The Public Employees Retirement System (PERS) check, service, et cetera, was all the same unless they were on the HMO plan. If they were on the PPO plan, they would pay the same premium in the north and the south. The board made a decision last September to blend the rates for the northern and southern HMOs so that they are paying one rate.

Chair Kirkpatrick:
So, it is cheaper for someone to be on a PPO than to go on the HMO. Is that correct?

James Wells:
That is correct. The monthly premium is cheaper.

Chair Kirkpatrick:
But the deductibles are higher.

James Wells:
The deductible and out-of-pocket costs are higher.

Assemblyman Ellison:
They can still pay into the cap to go into that? Is that correct? For instance, if they did not have any claims whatsoever that goes into a fund. Is that correct? What does that cap go to?

James Wells:
On the PPO plan, they would have money put into their HRA, and if they did not use it that would roll over into the next year. There is no cap currently on the HRA or the HSA. It is an unlimited cap at this time.

Assemblyman Ellison:
So they can bank whatever they want?

James Wells:
Yes.

Assemblyman Ellison:
That is important.

Chair Kirkpatrick:
At the same time, the PPO plan has the much higher deductible. Is that correct?

James Wells:
Yes.

Chair Kirkpatrick:
What is the deductible?

James Wells:
The PPO deductible is $1,900 for a single person, $3,800 for a family, or $2,400 for a single member of a family unit.

Chair Kirkpatrick:
Southern Nevada's rates would be lower for the HMO if we were not subsidizing the other 13 counties. Is that correct?

James Wells:
Correct. One of the things that we saw in southern Nevada was that the participant plus spouse was cheaper in the south on the HMO than the PPO for a better plan. You see adverse selection because they have recognized that they are paying a cheaper premium and paying less out of pocket.

Assemblyman Stewart:
You have done a very good job. I understand that in April there will be individual meetings with advisors to help individuals select their plans. Is that correct?

James Wells:
Our open enrollment period is starting April 1, 2011. It is starting early this year because of the significant plan design changes. Starting April 1 we will have open enrollment meetings throughout the state. April 1 is also the first day that people can have appointments to contact the benefit advisor if they are Medicare-eligible. Over 55,000 of our 94,000 Medicare retirees have already made appointments with benefit advisors to select their Medicare plan.

Chair Kirkpatrick:
We will now open the hearing on Assembly Bill 76.

Assembly Bill 76: Makes various changes concerning the Public Employees' Benefits Program. (BDR 23-497)

James R. Wells, Executive Officer, State of Nevada Public Employees' Benefits Program:
Assembly Bill 76 has two provisions in it. Sections 1 and 3 eliminate the statutory provision for a retiree who has declined health insurance coverage under the Public Employees' Benefits Program (PEBP) to reinstate the currently available health insurance benefits. This provision, which is known as the biennial reinstatement, currently occurs every even-numbered year. The retiree can decline and reinstate insurance as many times during their lifetime as they choose to do so. Sections 1 and 3 replace that biennial reinstatement provision with a one-time only reinstatement which would occur during our normal open enrollment process. Section 2 of the bill creates an exemption to the open meeting law and authorizes the PEBP to conduct an annual review of performance of the Executive Officer in closed session. It also allows an advisory committee, appointed to evaluate applicants for the Executive Officer, to meet and deliberate on the applicants and select finalists to be presented to the full board in closed session. The finalist interviews and the selection of the finalists would still occur during open session of a properly noticed public meeting. Allowing the evaluation to occur in closed session will provide for a more honest and open feedback and dialogue between board and the executive officer that may not occur in a public meeting setting. Allowing the advisory committee to evaluate and select finalists will allow for a larger pool of more qualified candidates. Some candidates are uncomfortable with their current employer becoming aware that they are applying for another job. There is one proposed amendment to A.B. 76 that we have submitted (Exhibit D). It relates to section 3 and is at the top of page 4 of the mock-up. It changes the sentence to read that the employee "Did not have more than one period during which the retired public officer or employee was not covered by insurance under the Program on the later of October 1, 2011, or the date of retirement of the public officer or employee."

This amendment addresses a scenario in which an employee quits and works somewhere else while still eligible for retirement. They have basically retired from state service, but they are not eligible and want to go out and work in another job. Someone who is 40 years old and has worked for the state for ten years is not eligible to retire yet. If they quit and go to work in the private sector, when they become 60 years old and are now eligible for retirement under the Public Employees Retirement System (PERS), this amendment would allow that person to come back onto the plan during the open enrollment process. They would otherwise be excluded from doing so.

Assemblywoman Pierce:
What you just described is part of the amendment or part of the bill?

James Wells:
That is part of the amendment that was provided as part of the mock-up proposed amendment to A.B. 76.

Chair Kirkpatrick:
It is hard for the Committee members to navigate the amendment and the bill at the same time.

James Wells:
In the amendment, look at section 3, subsection 1, paragraph (b). It says "Did not have more than one period during which the retired public officer or employee was not covered by insurance under the program on or after October 1, 2011." That "on or after" was the problem for that person who had worked for ten years and then had gone to the private sector. We wanted to make sure that it was on the later of October 1, 2011, or the date of retirement. When that person becomes eligible for retirement, then they can join as a retiree on that plan.

Assemblywoman Benitez-Thompson:
In section 3, about how many people do we have in the system right now who cycle off of the insurance, go somewhere else, and then come back?

James Wells:
The last biennial reinstatement would have been in early 2010. We had about 30 people. It is one of the reasons we are looking at getting rid of that biennial reinstatement. There are not very many people who are taking advantage of that biennial reinstatement.

Assemblywoman Benitez-Thompson:
So, the assumption is that those people have access to some other type of insurance coverage in another way?

James Wells:
They can still come back to our plan. We would just do it during our annual open enrollment process instead of having a special reinstatement cycle. They would be able to come back on a one-time basis through our normal open enrollment process.

Assemblyman Anderson:
My question is in regards to the requirement of the bill to allow an annual review for an executive officer outside of the open meeting law. Is there any other agency or state body that does this currently?

James Wells:
To my knowledge, there are no other people who have an exception to the open meeting law for that purpose.

Chair Kirkpatrick:
Can you explain why you would want to do this? I am sure there are some Health Insurance Portability and Protection Act (HIPAA) regulations.

James Wells:
The Public Employees' Benefit Program already has exceptions to the open meeting law for certain discussions of medical-related issues with our participants. If there is a participant appeal and it goes to board, it is done in closed session. The board cannot discuss things that are related to people's medical care. This is an exception for the annual evaluation. The thought behind it was that there would be more open and honest feedback. You would not see that between the executive officer and the board in an open meeting.

Chair Kirkpatrick:
Is this something that you have discussed with the Attorney General's Office? They have an open meeting bill for this session.

James Wells:
The Attorney General's Office has told PEBP that we cannot do the evaluation in a closed session without this exception.

Assemblyman Ellison:
When you get into a closed meeting, you would be talking about financial issues like prior bankruptcies and such. It should be open to the public. This could be a deal breaker if this is left in. I do not believe that the public should be excluded from anything.

Assemblywoman Pierce:
Can you explain to me what section 3, subsection 4 means?

James Wells:
Subsection 4 of section 3 was language that was added by the legal department when we submitted this bill draft request (BDR) that will exclude those who are collectively bargained.

Assemblywoman Pierce:
Excluded from what?

James Wells:
This deals with an entity that has union retirees that is not participating in our group plan. Those retirees of a union local government whose active employees are not covered by our plan cannot join our plan during the reinstatement process.

Chair Kirkpatrick:
In 2007, we made some changes that you had to opt in to or opt out of the program. I thought this issue was clear. What is the difference?

Jon M. Hager, Chief Financial Officer, State of Nevada Public Employees' Benefits Program:
Senate Bill 544 of the 74th Session stated that if you were part of a local government that is not participating in PEBP, you cannot join as a retiree. For instance, if Clark County joined PEBP, they have several unionized groups. A portion of them are covered under PEBP, but some of the unions are not. If that group does not join PEBP, then their retirees cannot join PEBP. However the people that are part of PEBP as active employees can join. This bill states that if the group that someone retires from is covered by PEBP, he can be reinstated. However, if the group that someone retires from is not covered by PEBP, then he cannot be reinstated with PEBP.

Chair Kirkpatrick:
How many cases have we had that that has happened? I thought it was clear in 2007. In my district, it was a big deal because people were given a month and a half to choose which way they were going to go.

James Wells:
You are right. In 2007 the bill gave those people the in or out option. What it did not anticipate is that an entity may join PEBP, but only for a segment of its population. For example, Clark County School District may join; however, only administrators join and the teachers keep the health trust that they have. This provision will state that just because you are a retiree of the Clark County School District does not mean that you can automatically join PEBP during the reinstatement process. You have to be a member of the administrators' group that is participating in PEBP in order to join. You cannot be a member of the health trust piece and reinstate PEBP coverage. The active employees are not covered under PEBP.

Assemblyman Livermore:
You are looking at a closed session to evaluate the executive officer and for the advisory committee to look at potential replacements. Is that correct?

James Wells:
That is correct.

Assemblyman Livermore:
I am sorry. I will tell you what my position is going to be. Open meeting laws are important to this state. This is a deal breaker for me.

Chair Kirkpatrick:
Apparently this was a loophole for people to circumvent the system. How many cases have we had? Are we just making sure that there are none?

James Wells:
We have had no one use this section for a loophole. Most of the employers are relatively small. We do have a couple of charter schools where we only cover a certain segment of the population of that school. This could happen, but most of them are not collectively bargained.

Assemblywoman Pierce:
Just so I am clear, the three parts of this bill are the open meeting part, the part about collective bargaining employees, and the part about closing the special enrollment period.

James Wells:
That is correct.

Chair Kirkpatrick:
Is there anyone who would like to testify in support of A.B. 76?

James T. Richardson, representing Nevada Faculty Alliance:
I appreciated the long discussion and was glad to see this Committee dealing with these important matters. This is where these matters belong. I am going to testify in favor of this bill and its provisions. It is a cleanup bill. It does have the provision about the open meeting law exception. Some of you who have been around have seen me testify in favor of an exception for the Nevada System of Higher Education (NSHE) because I do not think the selection and evaluation processes are nearly as effective as they could be if those meetings could be held in some confidence, as long as a decision is made in public. I realize that is a reasonably unpopular position to espouse. I have espoused it before and noted that reaction.

The other provisions of the bill that are set up are simply cleanup provisions. They do not involve a lot of people. You might decide that it is okay to let people shift back and forth on the insurance system. There is some comment

that some had played a game with the system. Every two years some people make a choice and move back and forth. This is an efficiency measure. There are a few people involved.

As far as the cleanup in section 4, there is a lack of clarity that needs to be stated. We need to make it clear what this body meant when Senate Bill 544 of the 74th Session was passed. If you want comments on how board members are selected, I can make a comment about that.

Chair Kirkpatrick:
I will save that for public comment.

Martin Bibb, Executive Director, Retired Public Employees of Nevada:
We represent 97,000 dues-paying members and 40,000 retired public employees in this state. I will not be redundant, but something that Dr. Richardson said was of our concern. This affects a very small number of people. Had there been a rush of people that are affected by this, we would have had a different take. Relative to the selection process, we would be most concerned that the selection of an actual executive officer be done in anything but an open environment. We would strongly oppose that. We realize this is as candidates are being considered. Our members support the open meeting law, but the largest concern is that the executive officer selection is done publicly.

Chair Kirkpatrick:
Is there anyone who would like to testify in support of A.B. 76? [There was no one.] Is there anyone who is in opposition of A.B. 76?

Barry Smith, Executive Director, Nevada Press Association, Inc.:
I am testifying today in opposition to A.B. 76. I am speaking specifically to the open meeting exemptions. This has come up several times. The policy decision has been to keep these meetings open. [Read from prepared text (Exhibit E).]

Chair Kirkpatrick:
Is there anyone else who would like to testify in opposition of A.B. 76? [There was no one.] Is there anyone who is neutral on A.B. 76? [There was none.] Mr. Wells, would you like to come up for final comment? I can see that the open meeting law part is a point of contention. If that portion were to come out, is that something that you are willing to make an amendment for? Is it what is most important to you?

James Wells:
I was appointed in June after this bill had been submitted to the Department of Administration on the May 1 deadline. I did not architect this bill. I am neutral

on it. I went through the evaluation process and one of the things that occurred during my interview was that my boss read about me making the finalist selection in the newspaper before I was told. I was not able to tell him about it. That is one of the concerns I have on the whole process being out in the open. I had already told my former boss that I had applied. If I had worried about losing my job, I would not have applied or would have withdrawn my application had the whole process been in public. That is the only concern that I have. We do not get qualified candidates because those people are afraid. I would rather have the other sections in and the exception left alone. If that is the will of the Committee, I would be supportive of amending those sections out.

Assemblywoman Flores:
The request to be exempted from the open meeting law is just for applicants submitting themselves for consideration for the position of executive officer. This is not for a subsequent evaluation once this person has been hired and is now performing their job duties. Is that correct?

James Wells:
There are two exemptions that are listed in that section. The first is for the advisory committee that would review applicants and select finalists. That would be done in a closed session. The actual interviews of the finalists and the selection of the executive officer would still be done in an open session. The other part of the exemption is to put into closed session, actual annual employee executive officer evaluations. There are two pieces of it here for the exception.

Chair Kirkpatrick:
That is for the annual review as well? That is a problem for me particularly.

James Wells:
There are two exemptions in A.B. 76.

Chair Kirkpatrick:
I shepherded a bill in 2005. Every session they have asked me to get rid of it. People have figured out how to discreetly give an annual review but, as a constituent, it became an issue close to my heart. I tried to watch how these evaluations were done when I had to shepherd the bill. I do not want to switch that around. I would like to watch some of those evaluations. It is amazing how you really do not get a real evaluation. They are in the public, but I can imagine what is said behind closed doors. That is a sticker. The other piece is the Committee's choice, but the annual review is not up for discussion.

James Wells:
Section 2, subsection 4, paragraph (e) is the annual evaluation part of the bill. Subsection 6 is the advisory committee to evaluate applicants for the position of the executive officer. There are two components in that section. The first deals with the annual evaluation of the executive officer. Subsection 6 allows for the closed section only for the purpose of reviewing applications and selecting finalists.

Assemblywoman Flores:
I agree with Chair Kirkpatrick in terms of the evaluations. That is taxpayer money. The person is doing a job at the expense of the taxpayer and serving the public. In my mind, there is no argument to be made why that evaluation should occur behind closed doors. There is a solid argument to be made for keeping the selection process private because of all of the concerns that you listed in terms of people's privacy. There is a chilling effect in terms of finding some qualified people that are willing to put their names out there to be considered for the position. I am definitely more sold on that. As far as the evaluations after the person has been hired, that is absolutely a no.

Assemblyman Livermore:
Even an application should be subjected to the public awareness. All of the information eventually becomes public. I would suggest that you keep that in mind. As a county elected official, when we hired the city manager it was generally the press's right to know who is applying. I support that public information right. I do not know how you can eliminate it entirely. You may be better pressed to embrace it and figure out how to deal with it. If you are unemployed and looking for a job, then that is easy. If you have a position, then you have to make sure you cover your bases before you do that application. It puts the elected body in a tough position when they have to defend the closing of a public meeting.

Chair Kirkpatrick:
I will now close the hearing on A.B. 76. I will now open the hearing on Assembly Bill 80.

Assembly Bill 80: Makes various changes relating to the Public Employees' Benefits Program. (BDR 23-496)

James R. Wells, Executive Officer, State of Nevada Public Employees' Benefits Program:
Assembly Bill 80 is another bill that was proposed by the Public Employees' Benefits Program (PEBP). This one is much more of a cleanup bill. I will start with sections 3, 8, and 14. The changes to those three sections will

consolidate the reporting requirements that are currently contained in *Nevada Revised Statutes* 287.043 and 287.04366 into a single section and recognize that it is the executive officer, not the PEBP Board, who is responsible for compiling and submitting these reports on behalf of the board. It is not the intent of these sections to change any of the information currently required under statute. Sections 4 and 12 of this bill eliminate preexisting conditions exclusion for reinstated retirees. Under the Patient Protection and Affordable Care Act or federal health care reform, plans must provide coverage for persons with preexisting conditions. There is an exception to this requirement. That is when a plan is considered grandfathered under the health care reform bill. While PEBP's plans will not be grandfathered, including for any participating local governments, there may be local governments who are intending to have grandfathered plans.

Clark County is going to offer an amendment allowing exclusions for preexisting conditions for those plans that are grandfathered in. This exception under the health care reform bill is only available until 2014. After 2014, no plans may exclude coverage of preexisting conditions even if they are grandfathered. The Public Employees' Benefits Program is neutral on the amendment as long as there is sunset language in accordance with the federal health care reform.

Sections 5 and 13 of the bill are intended to provide that a domestic partner of a police officer or firefighter killed in the line of duty is eligible to participate in a group insurance plan that was provided to the police officer or firefighter. It was also intended that the local government agency not be required to subsidize that domestic partner's health insurance if they elect to continue it. It allows eligibility of a domestic partner of a police officer or firefighter killed in the line of duty to continue on the health plan.

Section 6 eliminates duplicate language that is already included in NRS 287.046. Senate Bill 544 of the 74th Session closed this program to all local governments that do not currently participate in PEBP. Removal of this language does not have any impact on that restriction. Section 9 revises language in NRS 287.044 to conform to actual agency practice. As currently written, employees would be responsible for paying 100 percent of the costs of their dependent coverage. For many years, the PEBP Board has allocated the state subsidy that is provided to cover portions of both the primary participant and the dependents. This change will clarify that board allocates that monthly single dollar amount contribution into a percentage of the participant and dependents.

Section 10 revises language that was added in 2009 by Senate Bill 427 of the 75th Session and clarifies the subsidy eligibility for a person initially hired after

January 1, 2010. No subsidy will be provided for retirees that are initially hired after January 1, 2010 who do not continuously participate in the program after retirement or do not have at least 15 years of service. This may include local government years of service. There is an exception to the 15-year rule. That is for disability retirees who only have to have five years of service. This change clarifies that any employee hired after 2010 will not be eligible to reinstate insurance coverage. We just talked about the reinstatement process. The intent of the original language is not to allow a break in coverage to those who are hired after January 1, 2010. Those people hired after January 1, 2010, can only stay on the plan if they are continuously on the plan after they leave state service. Section 11 clarifies that subrogation, which is the liability of someone other than the plan to pay for medical costs that were incurred, is applicable to all the members of our plan including retirees and dependents, not just employees.

We have several amendments to this bill which should have been provided to you in a separate mock-up (Exhibit F). Under section 3, which is the new reporting requirements for the executive officer, all these reports should go to the PEBP board as well as to the Legislature and Department of Administration. We are just asking that the PEBP board be added where the reports are delivered. We also wanted to clarify that audits should be done on a fiscal year. They currently say plan year. Right now, it does not make a difference because our fiscal year and plan year are the same. A couple of years ago we had a short plan year and a long plan year that did not coincide with the fiscal year. We want to make sure that the audits are listed for the fiscal year and not the plan year.

In sections 5, 12, and 13, there are a couple of places where we need to add the word “domestic partner” or “surviving domestic partner” to ensure that they are eligible. When PEBP submitted this bill, the intent was that they be eligible to continue that coverage. That was the important thing. Just putting it in the paragraphs that say that the state or the local government does not have to pay did not affect what we were trying to do. We were trying to say that they could join. We have a few places where we need to add that in there.

Chair Kirkpatrick:
That has already been the practice for the last couple of years. Is that correct?

James Wells:
Domestic partners started on July 1, 2010. This is the first year we have had domestic partners on PEBP’s plan. There may be another bill draft request (BDR) that deals with the coverage for children up to the age of 26. That is another provision in the federal health care reform. The only place where it

resides in statutes deals with these police or firefighters who are killed in the line of duty. There are specific provisions that limit it to the age of 18 or the age of 23 if they are a continuing student. Our plan, which is effective July 1, 2011, will cover children up to age 26. Under the health care reform, we have to cover children up to age 26. Either through this bill or the other BDR, these two sections that deal with the age 26 have to be amended to comply with federal health care reform.

Chair Kirkpatrick:
You only have to cover them up to the age of 26 if they do not have any insurance of their own. Is that correct?

Jon M. Hager, Chief Financial Officer, State of Nevada Public Employees' Benefits Program:
Federal health care reform requires that a plan provide coverage for children through their 26th birthday regardless of their coverage status, marital status, or employment status. If the participant wants to cover their child through their 26th birthday, they can. They have to be afforded the opportunity.

Chair Kirkpatrick:
I have seen a lot of other plans that have said that they will provide coverage as long as they can not get it somewhere else. I thought it was only if they could not obtain health care somewhere else. I want it to be clear. That is a big difference. What is the cost difference?

Jon Hager:
The law as it is written allows anyone to cover their children, regardless of their status, through the age of 26. That coverage does not take effect until the plan year beginning on or after October 23, 2010. For PEBP, that begins July 1, 2011. We could have had other coverage restrictions prior to that date. I do not know if that is what other plans are doing.

Chair Kirkpatrick:
We do not have any restrictions? We do not have a retiree restriction?

Jon Hager:
The law requires that if you cover children, you have to cover them through the age of 26.

Chair Kirkpatrick:
Do they have to live with you?

Jon Hager:
They do not.

Assemblyman Stewart:
Considering the litigation on the federal health care reform act, if parts of the plan including this were to be declared void, would it affect what you are doing here?

James Wells:
There are a couple of lawsuits regarding the health care reform and there have been mixed results of those lawsuits. As they work their way through the appellate process, we will find out. The biggest one is the one that Nevada is a party to with 25 other states. That was a Florida judge who ruled that the entire health care reform bill is unconstitutional. Unfortunately, he did not maintain that any of the provisions can be enforced going forward until such time as it has been resolved. This will eventually end up at the United States Supreme Court. If the United States Supreme Court does rule that the entire thing is unconstitutional, plans would then have the ability to put these restrictions back in. Currently, PEBP's plans cover children up to age 18, and up to age 23 if you are still a student. This provision requires us to cover them up to age 26 regardless of their status. We will have to cover them up to age 26 until the health care reform bill is declared unconstitutional.

Assemblyman Stewart:
If it is declared unconstitutional, then we go back to the old plan. Would it automatically go back, or would we have to do legislation to put it back into place?

James Wells:
This is only for children of a policeman or fireman killed in the line of duty. The rest of the children are covered under the individual plan descriptions. In section 10, subsection 2 we have asked for a couple of amendments. One is the addition of the word "base" to track language that is the annual session bill. The annual session bill that sets subsidies for our participants always refers to a base amount. That amount corresponds to an employee who is retired before 1994 or one who has 15 years. That is the base amount that we adjust from. We also wanted to ensure that the references to retirement after January 1, 1994, relating to differential treatment in subsidies, be maintained. We have asked that the base amount is for persons retired before

January 1, 1994, or for persons hired after January 1, 1994, as adjusted by the years of service. We wanted to make sure there is a clear delineation of the two groups.

In section 10, subsection 4 we wanted to make sure that we continued the language that was provided in Senate Bill 547 of the 74th Session. If they do not have at least 15 years of service, under subsection 4, paragraph (b) "which must include state service and may include local government service" we want to continue tracking that particular language. In subsection 6 of section 10, the paragraph that is referred to in the first line under subsection 6 has actually gotten out of sorts. It needs to be amended and corrected to go to the right section. It should be section 3 and not section 1. In section 6, paragraph (b), we need to remove the word "state" to clarify that how we currently practice the calculation of the subsidy is correct. We accumulate all the years of service and round down the total years of service. We do not round down individual employer years of service when we calculate the subsidy and the allocation to the various governments. That particular one was not included in the mock-up change.

Chair Kirkpatrick:
Will you restate that?

James Wells:
In section 10, subsection 6, paragraph (b) it says no proration may be made for a partial year of state service. We need to strike the word "state."

Chair Kirkpatrick:
Why?

James Wells:
There is a referral in NRS 287.023 that says we need to calculate the years of service subsidy the same way that the state does. When you have a retiree that has years of service from multiple employers, we add them together to determine the subsidy. We then allocate the subsidy to those employers. When we do that, we add the total years of service together into one number and round down to the next lowest year. We do not round down each individual employer's years of service. If you had two employers that had 5 years and 7 months of service you would get 11 years and 5 months. We would round that down to 11. With the state in there, we technically should round it down to ten because you round down each individual employer to five. That is not the way we currently operate.

Chair Kirkpatrick:
Is that existing language? It is just a cleanup?

James Wells:
Yes, just a cleanup. In section 13, subsection 4, this is cleaning up the language for the health care reform act and covering children up to the age of 26. This has to do with firefighters or police officers who are on the state's program.

Chair Kirkpatrick:
We may have questions for you at a later date. Is there anyone who would like to testify in support of A.B. 80? [There was no one.] Is there anyone who is in opposition? [There was no one.] Is there anyone who is neutral on A.B. 80?

P. Michael Murphy, representing Clark County:
We have proposed several amendments (Exhibit G) from Clark County including an original document under the right format and an additional paragraph that was attached to the back of that document. We have had detailed conversations with PEBP in reference to a change that was spoken of earlier in section 4, subsection 4. The easiest way to describe this is that sometimes when changes are made there are unintended consequences. As a result of that, we would like to propose the verbiage that PEBP Board came up with rather than ours. We would like to withdraw all of our amendments and make a conceptual amendment to section 4, subsection 4. It is my understanding that there are additional copies.

Chair Kirkpatrick:
Is this the one that is attached to your other amendments (Exhibit G)?

Michael Murphy:
It is not. The one that is attached to the back of the document is the one that Clark County was proposing. We were going through this up until the close of business yesterday. The conceptual amendment that you now have in front of you is what was proposed by the PEBP Board (Exhibit F). We think that has better language. We would like to use that amendment. I apologize that this was at the last minute.

Chair Kirkpatrick:
I will read it to the Committee: "If a plan is considered a grandfathered plan pursuant to the Patient Protection and Affordable Care Act, reinstatement of insurance pursuant to subsection 1 may exclude claims for expenses for any condition for which medical advice, treatment, or consultation was rendered within 12 months before reinstated insurance has been in effect for more than

12 consecutive months. The provisions of this subsection expires when the provisions allow an exclusion of preexisting conditions expire pursuant to the Patient Protection and Affordable Care Act." That may be all well and good but I need you to explain this to the Committee.

Michael Murphy:
I will let Mr. Wells explain.

James Wells:
We referred to this in our testimony. The existing subsection 4 requires exclusion of preexisting conditions for reinstatement for the first year. It is not allowed under the Patient Protection and Affordable Care Act unless you have a grandfathered plan. The revision that you just received is if the plan is grandfathered according to the Healthcare Reform Act. We may exclude preexisting conditions but we do not have to. This is where we wanted to include the sunset language at 2014. When that provision is no longer available to any plan, after 2014, no plan regardless of the grandfather status can exclude preexisting conditions. We would like to put a sunset clause in there for 2014.

Chair Kirkpatrick:
We do not move bills on the same day. This will not be on a work session on Friday. We will have plenty of time to digest it.

Assemblyman Ellison:
Is this if someone opts out of the plan and would like to reinstate?

James Wells:
Part of the health care reform act eliminated the ability to exclude preexisting conditions. If someone came to us who had a preexisting condition, we are required to cover that preexisting condition under the new legislation. There is one exception that is put in under health care reform for grandfathered plans. There are specific definitions of what a grandfathered plan is. There are specific criteria to meet in order to have a plan considered grandfathered and to be able to exclude preexisting conditions. The ability to exclude preexisting conditions expires in 2014. If you had a grandfathered plan, they gave us a window through 2014 under which we could still exclude preexisting conditions. After 2014, no insurance provider can exclude preexisting conditions.

Assemblywoman Pierce:
How does it work now? If I was hired by the state, my preexisting condition would not be covered?

James Wells:
There are a couple of parts to this; PEBP does not exclude preexisting conditions for our active employees. If someone comes to work for us and has a preexisting condition, we do not exclude them. The two sections that are impacted by this are specifically for reinstated retirees.

Assemblywoman Neal:
Will disabled persons be affected by this? Will their coverage be reduced?

James Wells:
There are two preexisting exclusions currently. There is one for children and one for adults. This is for adults. We are already not able to exclude preexisting conditions for children. If a disabled child is put on our plan, we are required to cover them even with preexisting conditions. This is for adults, and any adult. If they have a preexisting condition, currently we can exclude the coverage for the preexisting condition. Health care reform eliminated that ability unless your plan is grandfathered. That is not eliminated until 2014.

Rusty McAllister, President, Professional Fire Fighters of Nevada:
We have signed in as neutral to this bill. We do have a concern with this bill. Under the PEBP amendment (Exhibit F) on page four, section 5, subsection 3. That seems like a contradiction. It says that PEBP will cover them to age 26 if a child is not going to school but only until 23 if they are attending college. I do not understand that completely.

James Wells:
This is something I did not catch in the mock-up. We were supposed to strike out all of paragraph (b) of subsection 3 on that page.

Rusty McAllister:
It is obviously a policy decision for you to make. I am not advocating for or against adding the term "domestic partner" into the language of the bill. However, is the life of a firefighter or police officer that dies in the line of duty less valuable because he has a domestic partner than if he were married? The insurance will cover a spouse but not a domestic partner. That seems like a contradiction. It cheapens their service.

Assemblywoman Pierce:
What section were you just talking about?

Chair Kirkpatrick:
He was talking about the bill as a whole.

Rusty McAllister:
It would be in section 5 where they add in the language of "surviving domestic partner." They say that these people can stay on the plan. Under the current statute, if a police officer or firefighter passes away in the line of duty their surviving spouse or children will have insurance paid for by the employer. In this case, they are adding in "surviving spouse" and saying that they can still be on the insurance, but PEBP will not pay for it. They will pay for a spouse or children, but they will not pay for a domestic partner.

Chair Kirkpatrick:
Is there anyone else who would like to testify in neutral on A.B. 80? [There was no one.] Mr. Wells, do you have any final comments?

James Wells:
I have one comment related to the last testimony. The language for that is permissive. We anticipated that it would be. We did not feel that we could require it.

Chair Kirkpatrick:
I will close the hearing on A.B. 80. Is there any public comment?

Martin Bibb, Executive Director, Retired Public Employees of Nevada:
I would like to go over the overview of the Public Employees Benefits Program (PEBP) system for the Committee. In the last period of time prior to 2009 until now there has been about $100 million cut from PEBP in response to the economic crisis. With that in mind, there have been some serious changes in recent sessions. In 2008, the deductible in this plan was as low as $250 depending on whether you completed the wellness questionnaire. That has now changed; it has gone up to $725 and then $800. With the consumer-driven health plan that Mr. Wells outlined in his presentation, we are talking about either $1,900 individual or $3,800 family deductibles for those who remain in the plan. This year, though the plan did not receive a cut in its budget under the amount being requested by the administration, medical consumer price indexes (CPI) plus a couple of federal mandates have added some additional costs. An example of that is how long participants are allowed to keep their children on their plans. Although the funding has not been slashed for the program, there has been somewhere in the range of $100 million that had to be assumed by the plan because of medical CPI and those mandates.

There has been underutilization of the program for estimates. That means that the actual shortfall is about $85 million. Of that $85 million, $22 million or more will be attributed to privatizing and sending Medicare retirees from the preferred provider organization (PPO) plan into this private sector. It was

described as a Medicare exchange. It amounts to a private-sector insurance broker who handles a great amount of options including Medigap policies, Medicare Advantage plans, et cetera. Our organization has been involved in trying to publicize for our members the timetable for this enrollment period. As described, it will be between April 1 and May 31. That is a short time frame. They have had a number of people preregister. People from the Medicare exchange, which is headquartered in a suburb of Salt Lake City, will contact Medicare retirees by telephone and try to enroll them that way. Among our concerns are how effective that telephonic enrollment period is. We are hoping that through the publicity that it goes smoothly. That is a concern for people who traditionally have enrolled in health plans sitting across a desk from someone. That will be different. We are hoping it is smooth. We are also hoping that the dealings that the Medicare retirees have with the company representatives will go well. Instead of contacting someone at PEBP about an insurance problem, if they have an insurance problem they will be directing their inquires to the insurance company itself. It could be located in a number of places. Additionally, we are hoping that the money that is provided for these Medicare retirees will prove adequate, not only now but into the future, in terms of assisting them with those needs. There is a $344 to $473 a month range for a fully employed person prior to or after 1994 in the form of subsidy currently. That money will be changed for the pre-1994 retirees to $150 a month and for the post-1994 retirees to $200 a month. The adequacy of that funding, now and into the future, will be a concern of ours. I enjoy testifying in this Committee. If there were a problem, we could not only bring it to the agency but also to the legislators. For some people, dealing with people on the 55th floor of an insurance building is not going to be the same thing. We are hoping that the Legislature will keep its eye on the adequacy of this funding and operation for those who are sent into the private sector in a cost-cutting effort. We would like to ensure that those program options are viable now and in the future.

Chair Kirkpatrick:
We are working to get all of the corporate insurance company representatives here. United Healthcare has their corporate office here. We want people to be able to work with their insurance representative locally instead of going through extensions on a phone to resolve the issues.

Martin Bibb:
All of those things are very helpful.

James T. Richardson, representing Nevada Faculty Alliance:
We support Assembly Bill 80. I can also tell you how our member of the PEBP Board is selected.

Chair Kirkpatrick:
I will work with you on getting this information to the Committee. Is there any other public comment? [There was none.]

Meeting was adjourned [at 10:48 a.m.].

RESPECTFULLY SUBMITTED:

_____
Jenny McMenomy
Committee Secretary

APPROVED BY:

_____
Assemblywoman Marilyn K. Kirkpatrick, Chair

DATE: _____

EXHIBITS

Committee Name: Committee on Government Affairs

Date: March 18, 2011 Time of Meeting: 8:02 a.m.

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
	C	James Wells, Public Employees' Benefits Program	Presentation
A.B. 76	D	James Wells, Public Employees' Benefits Program	Amendment
A.B. 76	E	Barry Smith, Nevada Press Association	Prepared Testimony
A.B. 80	F	James Wells, Public Employees' Benefits Program	Amendment
A.B. 80	G	P. Michael Murphy, Clark County	Amendment