MINUTES OF THE MEETING
OF THE
ASSEMBLY COMMITTEE ON WAYS AND MEANS
AND THE
SENATE COMMITTEE ON FINANCE
JOINT SUBCOMMITTEE ON GENERAL GOVERNMENT

Seventy-Sixth Session
March 4, 2011

The Assembly Committee on Ways and Means and the Senate Committee on Finance, Joint Subcommittee on General Government was called to order by Chair Marcus Conklin at 8:01 a.m. on Friday, March 4, 2011, in Room 2134 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).

ASSEMBLY SUBCOMMITTEE MEMBERS PRESENT:

Assemblyman Marcus Conklin, Chair
Assemblyman Paul Aizley, Vice Chair
Assemblyman Kelvin Atkinson
Assemblyman Tom Grady
Assemblyman Randy Kirner
Assemblyman John Oceguera

SENATE SUBCOMMITTEE MEMBERS PRESENT:

Senator David R. Parks

SUBCOMMITTEE MEMBERS EXCUSED:

Senator Moises (Mo) Denis, Chair
Senator Ben Kieckhefer
Senator Dean A. Rhoads

STAFF MEMBERS PRESENT:

Rick Combs, Assembly Fiscal Analyst
Mark Krmpotic, Senate Fiscal Analyst
Laura Freed, Senior Program Analyst
Carol Thomsen, Committee Secretary
Sally Stoner, Committee Assistant

Chair Conklin stated that the Subcommittee would review the remaining budgets for the Public Employees' Benefits Program (PEBP). Chair Conklin pointed out that review of budget account (BA) 1338 had commenced at the February 23, 2011, meeting of the Subcommittee, and he would start the review today with the proposed coverage for Medicare-eligible retirees.

SPECIAL PURPOSE AGENCIES-PUBLIC EMPLOYEES BENEFITS PROGRAM
PEBP-PUBLIC EMPLOYEES BENEFITS PROGRAM (625-1338)
BUDGET PAGE PEBP-1

James Wells, Executive Officer, Public Employees' Benefits Program (PEBP), stated that the PEBP budget presentation (Exhibit C) was available on the Nevada Electronic Legislative Information System (NELIS). The section that pertained to Medicare-eligible retiree plan changes began on page 16 of Exhibit C.

Mr. Wells explained that during the February 23, 2011, meeting of the Joint Subcommittee on General Government there had been much discussion about the effect of the proposed plan changes for early, non-Medicare-eligible retirees and active employees. Some plan changes were also being proposed regarding how PEBP would provide coverage for Medicare-eligible retirees. Mr. Wells explained that effective July 1, 2011, those retirees over 65 years of age who were eligible for Medicare Part A would be transitioned to an Individual Medicare Market Exchange (IMME). That would eliminate the premium subsidy paid by PEBP under its existing preferred provider organization (PPO) plan and replace that subsidy with a contribution to a health reimbursement arrangement (HRA). Mr. Wells said the amount would be based upon $10 per month per year of service, with a minimum of 5 years and a maximum of 20 years of service. Commensurate with existing statutory requirements for payment of subsidies, that amount would be set aside in an HRA for retirees to use for premium payments or out-of-pocket costs incurred based upon the plan selected through the IMME.

Mr. Wells explained that the subsidy savings to PEBP for decision unit Enhancement (E) 660(E) was estimated at approximately $22 million over the biennium. The balance in individual HRAs could be used by retirees for premium payments, but if that amount did not cover the full cost of the monthly premium, the retiree would be responsible for the difference. Also, said Mr. Wells, any balance remaining in the HRA would roll forward month-to-month and at the end of the year, that amount would continue to roll forward into future plan years.

According to Mr. Wells, transitioning Medicare-eligible retirees to the IMME was a method of preserving healthcare benefits for retirees while lowering the cost, not only for the plan, but also for the participants. The exchange offered both Medicare Advantage and Medigap plans through recognizable insurance companies such as Aetna, Humana, CIGNA, and United Healthcare. Mr. Wells said the plans had guaranteed issue and pricing regardless of the health status of the applicant. He pointed out that there were multiple plans available for every zip code or county where retirees lived.

Mr. Wells explained that the reason PEBP could save money through transiting Medicare-eligible retirees to the IMME was that the individual market covered between 40 million and 50 million individuals, which provided a much broader pool of participants over which to spread risk. That provided for more competitive rates because of the size of the risk pool and the competition in each geographic location. Mr. Wells said that 15 percent of the state's Medicare-eligible retirees lived outside the State of Nevada and were currently offered only one plan option, and those retirees would now have multiple plan options based on the area in which they resided.

Under the IMME, Mr. Wells said many retirees would fare better that they would if they had remained on the existing PPO plan, particularly when that plan increased to a high deductible health plan (HDHP). Medicare-eligible retirees were the only group of PEBP participants who had the opportunity to obtain similar insurance coverage at a similar cost.

Mr. Wells stated that one major benefit of the IMME was that it allowed a participant and spouse to enroll in different plans, depending on their individual circumstances. For example, a healthy individual might select a low-premium plan and higher out-of-pocket costs, whereas an individual with existing medical conditions could select a plan covering more out-of-pocket costs. Mr. Wells indicated that the plans were based on an individual's prescription drug usage, their doctors, their health conditions, and their place of

residence, as well as whether or not the individual travelled. He noted that some retirees spent part of the year in northern Nevada and part of the year in southern Nevada and that was an issue that the plans would consider.

Basically, said Mr. Wells, the IMME would allow individuals to tailor their coverage to address different lifestyles. The company that would provide access to the IMME for retirees offered licensed benefit advisors to guide retirees through the plan evaluation and selection process. Those same benefit advisors would also provide advocacy to retirees in dealing with insurers should issues arise during coverage. Mr. Wells stated that in addition to medical insurance, retirees would have the option of adding prescription drug, dental, and vision coverage.

As of March 1, 2011, Mr. Wells stated that approximately 38 percent, or 4,241 retirees, had made appointments with Extend Health to select their IMME coverage. He pointed out that enrollment in the plans would not commence until April 1, 2011, or 90 days prior to termination of the coverage offered by PEBP on June 30, 2011.

Mr. Wells stated that there were approximately 300 retirees on the current PEBP plan who were not eligible for Medicare Part A. That number would increase because there were others who had been hired prior to 1986 and had not paid into Social Security throughout their working career and were not eligible for coverage through their spouse. Those retirees would have the option to remain with PEBP on either the high deductible health plan (HDHP) or the Health Maintenance Organization (HMO) plan, depending upon their place of residence. Mr. Wells indicated that would also be an option for Medicare-age retirees who had non-Medicare-age dependents. For couples where one individual was eligible for Medicare and one was not, PEBP would offer the option of one individual moving to the IMME and the other remaining on the HDHP or HMO plan, or both could remain under the PEBP plans.

Mr. Wells stated that individuals who were not eligible for Medicare Part A and who remained on one of the PEBP plans would continue to receive the same premium subsidy as early retirees toward their premium each month. Those retirees would also receive a credit for primary insured Medicare Part B premiums. He explained that if a retiree had purchased Part B, PEBP would reduce the retiree's premium by the amount the retiree paid to Medicare for Part B, which was approximately $115 per month. Mr. Wells indicated that PEBP would treat Medicare Part B as the primary insurance in those cases.

Mr. Wells indicated that Medicare-age retirees would be eligible to participate in the PEBP dental program on a voluntary basis, and retirees could select dental coverage either through PEBP or through the IMME. Also, said Mr. Wells, retirees would remain eligible for the basic life insurance coverage provided by PEBP.

Chair Conklin referenced the subsidy of $10 per month per year of service for retirees, and he asked whether that amount capped at $200 per month. Mr. Wells stated that was correct.

Chair Conklin asked about the capacity of Nevada's retirees to participate competitively in purchasing insurance through the IMME. Mr. Wells replied that PEBP had asked the vendor to provide examples of the programs available in different market places, primarily Las Vegas, Reno, and Carson City, where the bulk of retirees resided. Under the existing plan, the premium for an individual Medicare retiree was $283.55 per month, and the subsidy provided by PEBP for a retiree with 15 years of service was $182.35. Therefore, the current out-of-pocket cost for the retiree to participate in PEBP was $101.20 per month. By way of comparison, said Mr. Wells, the premium for the highest-rated IMME plan, one that included prescription drug, dental, and vision coverage, was $275.43. The retiree with 15 years of service would receive $150 per month, which would increase their out-of-pocket cost to $125 per month for as good or better coverage. Mr. Wells explained that coverage under Plan F on the IMME basically paid for everything that was not covered by Medicare.

Chair Conklin asked about the vendor that had been selected for the transition. Mr. Wells said that PEBP had selected Extend Health, a company based in Salt Lake City, Utah, to provide the benefit to Nevada's Medicare-age retirees. He pointed out that Extend Health was the largest Individual Medicare Market Exchange (IMME) provider in the country. Mr. Wells pointed out that the "exchange" currently under discussion was not the same as the "exchange" that would come about in 2014 because of the Patient Protection and Affordable Care Act. Mr. Wells emphasized that the "exchange" currently under discussion was specific to Medicare-eligible retirees and dealt only with Medigap and Medicare Advantage plans.

Mr. Wells stated that Extend Health had transitioned over 300,000 Medicare retirees into the IMME from major corporations such as Ford Motor Company, General Motors, Caterpillar Equipment, as well as local entities.

Chair Conklin asked whether the vendor had been selected through an open bid process. Mr. Wells explained that PEBP had selected the vendor through a solicitation-waiver process because research indicated that Extend Health was the only vendor who provided the service. Extend Health was also the only vendor that PEBP believed had the public sector experience and the experience in dealing with the type of retirees and the population to be served in Nevada. The other vendors were small and had no public sector experience. Mr. Wells explained that Extend Health was in a relatively new market and had been providing the service in the private sector since 2005. There were other companies entering the market, but none had been in existence as long, nor had attained the level of expertise, as Extend Health.

Chair Conklin asked about the size of the contract. Mr. Wells explained that the contract with Extend Health was for a period of four years. The contracted dollar amount paid by PEBP was approximately $1.3 million for the four years. That amount was primarily for the administration of the health reimbursement arrangement (HRA). Mr. Wells indicated that PEBP would pay Extend Health a monthly amount per Medicare retiree to manage the HRA. The other source of revenue for Extend Health was from commissions it received from insurance companies, which were set by the Centers for Medicare and Medicaid Services (CMS). However, Mr. Wells pointed out that the benefit advisors did not work on commissions and were salaried employees of Extend Health and had no stake in assigning Medicare retirees to any given plan. Benefit advisors were objective, and their goal was to advise retirees about the options that best suited their needs.

Mr. Wells stated that Extend Health had sent out a “getting started” guide that asked retirees to accumulate certain information, such as their prescription drug usage, doctors, and location of residence. Extend Health benefit advisors would use that information to determine the top three or four available options and would discuss those options with each retiree.

Chair Conklin asked for clarification regarding retirees who owned homes in both northern and southern Nevada. Mr. Wells explained that Medigap and Medicare Advantage plans were only available in the county in which a person resided. There would be a different set of plans available for a person who resided in Carson City from those available to persons in Washoe or Clark Counties. For example, said Mr. Wells, those persons who spent six months in Carson City and six months in Las Vegas should make that information available to their benefit advisor. The benefit advisor would then find a plan that allowed the person to access coverage in both locations.

Chair Conklin said he was concerned about retirees in the rural or smaller areas of the state. While retirees in Las Vegas would be offered multiple options, which would help control costs, he wondered whether retirees in other areas of the state would be afforded those same options. Mr. Wells said that every zip code in the state in which a Medicare participant resided had multiple options for coverage. There were some markets that included more options than others, but every locality where PEBP participants resided would have options available.

Assemblyman Grady voiced disappointment that PEBP had contracted with an out-of-state vendor to provide access for Nevada retirees to Medicare Advantage and Medigap plans, without giving local insurance agencies a chance to bid on the process. He noted that meant PEBP would pay a sizeable fee to an out-of-state vendor. Assemblyman Grady pointed out that PEBP and the Legislature currently provided oversight for the insurance program, but once retirees were transitioned to the Individual Medicare Market Exchange (IMME) via a company that was housed out-of-state, he wondered what control or oversight would be provided by the state.

Mr. Wells replied that no in-state vendor offered the services provided by Extend Health. He assured the Subcommittee that PEBP would have preferred to use a local vendor to provide the services, but none were available. Regarding oversight, Mr. Wells explained that the plans offered through the IMME were governed by two sources. The Medicare Advantage plans were governed by the Centers for Medicare and Medicaid Services (CMS), and the Medigap plans were governed by the Division of Insurance. While PEBP would not have direct oversight or control of the plans offered through the IMME, oversight would be provided via those two sources.

Mr. Wells further explained that there were several “alphabetized” plans—Plan A through Plan N—offered through the Medigap coverage, and the benefit levels within each plan had been established by the CMS. For example, if a retiree selected Plan A, the services provided by insurance coverage under that plan were fixed.

Currently, said Mr. Wells, 900 Medicare-eligible retirees were being served through Medicare Advantage plans. Those retirees would simply transition from PEBP’s group Medicare Advantage plan to an IMME Medicare Advantage plan. Mr. Wells pointed out that PEBP had no control over the benefits that were provided by Medicare Advantage plans.

Assemblyman Aizley noted that a number of retirees had already contacted Extend Health, and he wondered whether there had been a comparison of the cost for plans being offered through the IMME versus the cost of remaining on the PEBP plans.

Mr. Wells explained that enrollment through Extend Health in the IMME plans would not commence until April 1, 2011. However, approximately 4,500 retirees had contacted Extend Health to provide the necessary information and discuss available plans. Of those retirees, approximately 4,200 had actually made appointments to select their coverage after April 1, 2011. Mr. Wells stated that he had not compared the IMME plan rates, which would vary by individual counties, to the PEBP plan rates. He stated PEBP had completed a comparison in October 2010 between the existing PEBP plans and the existing plans offered through the IMME. However, he had not seen the rates for calendar year 2011 for the plans offered through the IMME.

Assemblyman Aizley said there appeared to be no evidence that plans offered through the IMME would be either better or worse than those offered through PEBP. Mr. Wells said it was important to keep in mind that the PEBP plan would change significantly on July 1, 2011, to a high deductible health plan (HDHP) with an increase in deductibles for individuals and families. The PEBP Board had recently approved the premiums for calendar year 2011, but Mr. Wells said he had not compared those to the IMME rates for calendar year 2011. Assemblyman Aizley stated that he would be very interested in that 2011 calendar year rate comparison.

Chair Conklin asked for information about the Live Well, Be Well Prevention Plan, decision unit Enhancement (E) 400. Chair Conklin realized it was a relatively new program and that PEBP had approached the Interim Finance Committee (IFC) in April 2010 requesting approval of the program; however, his concern was that enrollment in the program was well below projections.

Mr. Wells stated that page 29 of Exhibit C depicted the information regarding the Live Well, Be Well Prevention Plan (Wellness Program) and the Diabetes Care Management Program. He echoed Chair Conklin's concerns and stated he was also very disappointed with the participation rate in both programs. Mr. Wells said one factor was that Medicare-eligible retirees discovered they were not eligible to receive the benefits even if they remained in the Wellness Program. Also, information from the vendor about the persons participating in the Program indicated that the percentage was heavily skewed because

relatively healthy persons were participating in the Program. There had been less participation in the Program by persons who were not as healthy, and that was of great concern to Mr. Wells because those were the persons that PEBP wanted to reach to improve their health status and, thereby, lower the costs to PEBP.

In light of that fact, Mr. Wells said PEBP staff had reviewed the incentive program offered to participants in the Wellness Program, which was only available to primary participants of the preferred provider organization (PPO) plan. When a participant joined the Program and completed the requested blood panel and health risk questionnaire, the participant received a $25 gift card. When a participant entered into prevention activities, such as adding daily exercise, eating healthier, and researching conditions such as stress or high blood pressure, the participant earned points which resulted in a credit of up to $30 toward their premium for plan year 2012. Mr. Wells said PEBP believed that was a good incentive, but unfortunately that incentive had not driven additional participation in the Wellness Program.

The PEBP was currently in the process of redefining the incentives for the Wellness Program. Mr. Wells said PEBP had considered making the Program mandatory, but determined that would be difficult, and it was felt that the incentives should be changed. In Mr. Wells' opinion, the gift card incentive had been a failure because less than one-third of those cards had been redeemed. There were participants who had reached the $30 level, and Mr. Wells believed those were the participants who were already healthy when they joined the Program. Mr. Wells said PEBP was considering a higher premium for persons who did not participate in the Wellness Program, and/or changing the incentives for intervention activities to match the level of participation.

Mr. Wells indicated that approximately 46 percent of persons enrolled in the PPO plan had participated in the Wellness Program, and according to the vendor that was an average number for the first year of such a wellness program. The performance guarantees in the current vendor's contract were that 60 percent of PPO participants would be enrolled in the Wellness Program for the first year, so the vendor would actually be assessed a penalty on administration fees that would be returned to PEBP for failing to reach that guaranteed percentage.

Mr. Wells said the anticipated savings in claims starting in 2012 and increasing in 2013 were depicted on page 29 of the exhibit and were reflective of the improved health status of the participants in the Wellness Program.

The concept was that as the participant moved through the Program their health would improve, which theoretically would decrease the number of claims submitted by those participants. The question was whether or not those savings would come to fruition, and Mr. Wells had reservations about meeting the projections. He believed that changing the incentive program to greatly increase the percentage of participants would drive those numbers closer to the projections.

Chair Conklin asked whether PEBP had discussed the incentives and the Wellness Program with current PPO plan participants to determine what incentives would lead to higher participation. Mr. Wells stated that PEBP had not conducted any type of survey or focus group discussions to determine the incentives that would work best, but he believed that was a good idea. He indicated that the PEBP Board had created a Wellness Subcommittee many years ago that had become dormant in recent years. The PEBP was considering holding workshops through that Wellness Subcommittee to determine which incentives would increase participation in the Wellness Program.

Chair Conklin stated that the Wellness Program could not afford to fail, but if it was going to fail, it should be terminated immediately. He opined that if he were trying to get persons to participate in a program, the first thing he would do was ask those persons about the incentives needed to prompt participation in the program.

Chair Conklin noted that page 29 of the exhibit listed the total number of participants as 13,987, which he believed was approximately one-third of the estimated number. Mr. Wells stated that was correct. Chair Conklin said the chart indicated the number of participants as 46.3 percent of 30,210, and he asked whether the total number included both active and retired participants. Mr. Wells explained that 30,201 represented PEBP's entire active and retired population that was eligible for participation in the Wellness Program. He reiterated that participants had to be enrolled in the PPO plan and the number did not include PEBP's HMO participants. At one point, said Mr. Wells, PEBP had considered eliminating the Medicare retiree population from that total number because they would be transitioned to the Individual Medicare Market Exchange (IMME) program. However, PEBP did not want to penalize the vendor for a plan design decision made by the PEBP Board, and the number of 30,210 participants included the Medicare retiree population.

Mr. Wells indicated that page 29 of Exhibit C depicted the statistics for the Diabetes Care Management Program. He said that the number of participants enrolled in the Diabetes Program was of even more concern than the number for the Wellness Program because participants in the Diabetes Program had already been diagnosed with an illness. The Diabetes Care Management Program provided incentives, such as discounts for doctor visits, laboratory work, and insulin products, and yet only 26 percent of the 3,527 diabetic participants in the PPO plan had enrolled in the program. Mr. Wells said that presented a very real problem because those participants had already been diagnosed with an illness and were driving a significant number of PEBP claims. The PEBP was looking at additional incentives for the Diabetes Care Management Program and would work through the aforementioned Wellness Subcommittee to determine how to increase participation in the Diabetes Program, which Mr. Wells opined should be at 100 percent.

Chair Conklin noted that participation in the Live Well, Be Well Prevention Plan and the Diabetes Care Management Program was low, and the purpose of those programs was to reduce the cost of claims. The benefit of the reduced cost of claims was that people would become healthier through the preventative programs and would not require a higher level of care. Mr. Wells stated that was correct.

Chair Conklin said he was having difficultly understanding why more persons had not participated in the two wellness programs once they understood that the benefit to them would be through a reduced number of illnesses and reduced severity of illnesses. He asked that Mr. Wells keep the Subcommittee informed regarding PEBP's plan to drive up the number of participants in the two wellness programs. Mr. Wells said he would provide that information to the Subcommittee. The PEBP was working on the problem and anticipated reconstituting the Wellness Subcommittee to allow public input and comment about the programs.

Assemblyman Aizley referred to Mr. Wells' testimony that the contracted dollar amount that PEBP would pay Extend Health was approximately $1.3 million for the four-year total. He stated there was a rumor that the plan would cost PEBP $9 million, and he asked Mr. Wells to confirm the cost and confirm that there were no commissions or bonuses included for Extend Health.

Mr. Wells explained that $1.3 million was the amount that PEBP would pay to Extend Health for administration of the health reimbursement arrangements (HRAs) based on $3.50 per month for each Medicare-eligible retiree that

selected a plan through the Individual Medicare Market Exchange (IMME). He emphasized that $1.3 million would be the extent of PEBP payments to Extend Health.

However, said Mr. Wells, Extend Health also received revenue in the form of commissions from the individual insurance policies it sold through the IMME. The commission for premiums was set and capped by the Centers for Medicare and Medicaid Services (CMS) and differed for each insurance plan sold. Mr. Wells emphasized that the benefit advisors for Extend Health were salaried employees who did not receive commissions and, therefore, had no incentive to drive a participant into any given plan.

Mr. Wells indicated that the benefit advisors were not aware of the commission structure and were focused on determining which plan would benefit individual participants. The idea was that when a participant called Extend Health and provided his or her health status, the benefit advisor would determine what options were available for that participant. The goal was to narrow the options and select the best plan for each participant.

Chair Conklin said Extend Health would manage the HRAs for Medicare retirees, and the $1.3 million represented the fee that PEBP would pay to Extend Health for that management. Chair Conklin said it appeared that Extend Health would manage as assets an average of $150 per retiree per month, which would allow Extend Health to make money in the form of interest. Therefore, it appeared that the contract amount to Extend Health would be much larger than $1.3 million.

Mr. Wells informed the Subcommittee that the HRA assets described by Chair Conklin would remain under the control of PEBP and would be reimbursed to Extend Health on a monthly basis.

Chair Conklin said it appeared that Extend Health's option to make money would be based on the products sold, and while benefit advisors had no incentive to sell particular plans, the company was obviously in business to make money. The bottom line was that the PEBP contract was worth more than $1.3 million to Extend Health. That amount represented only the fees paid to Extend Health by PEBP to manage the HRAs for retirees. Mr. Wells stated that was correct.

Assemblyman Kirner said the $1.3 million represented the fees paid by PEBP to Extend Health to manage the health savings accounts (HSAs) and the health reimbursement arrangements (HRAs). Gains and losses based on investments that participants selected from the IMME remained in Extend Health's account and would not change the fee. Mr. Wells explained that HRAs were not an investable option. That money remained with PEBP and was reimbursed through Extend Health as participants expended the funds.

Assemblyman Kirner said he was asking about the HSAs. Mr. Wells explained that HSAs were not available for Medicare-eligible retirees, who would receive HRAs. Assemblyman Kirner asked whether HSAs were also managed through Extend Health. Mr. Wells indicated that PEBP would use a separate vendor to manage the HSAs. He noted that Assemblyman Kirner was correct that HSA investments were possible.

Assemblyman Kirner said it appeared that Extend Health would also make money based upon commissions that would be paid by the various insurance companies, and Mr. Wells said that was correct.

With no further questions from the Subcommittee regarding budget account (BA) 1338, Chair Conklin asked Mr. Wells to review BA 1368.

SPECIAL PURPOSE AGENCIES – PUBLIC EMPLOYEES BENEFITS PROGRAM
PEBP-RETIRED EMPLOYEE GROUP INSURANCE (680-1368)
BUDGET PAGE PEBP-11

James Wells, Executive Officer, Public Employees' Benefits Program (PEBP), stated that budget account (BA) 1368, Retired Employees Group Insurance (REGI) was depicted on page 23 of Exhibit C. The REGI provided a centralized collection mechanism for contributions that were made by the state for the benefit of all retired state employees. Those contributions were made through payroll assessments to state agencies to cover the costs of the state subsidy. The assessment applied to all state agencies, boards and commissions, the Legislative and Judicial Branches, the Public Employees' Retirement System (PERS), and the Nevada System of Higher Education (NSHE).

Mr. Wells explained that BA 1368 was a pass-through account and the assessment receipts funded the subsidy percentages as depicted on page 21 of the exhibit, "State PPPM Base Subsidy Levels," which showed the percentage of premiums paid by the state for participants and their dependent coverage.

According to Mr. Wells, page 23 of the exhibit depicted the Maintenance (M) decision units for BA 1368, which were the same as those in BA 1338 as follows:

- M100 – Statewide inflation
- M101 – Self-funded claim and fully insured product inflation (PEBP-specific inflation)
- M102 – Reserve adjustment
- M160 – Elimination of information technology (IT) position
- M200 – Enrollment changes
- M300 – Fringe benefit rate adjustment
- M501 – Federal health care reform mandates

Mr. Wells indicated that page 24 of Exhibit C depicted the Enhancement (E) decision units for BA 1368 as follows:

- E275 – DoIT (Department of Information Technology) facility hosting of servers
- E400 – Live Well, Be Well Prevention Plan
- E660 – PEBP Board plan design reductions
- E661 – Cost shifting
- E670 – 5 percent salary reduction
- E671 – Suspend merit salary
- E672 – Suspend longevity
- E673 – Change to subsidy—part-time employees
- E710 – Replacement equipment

Chair Conklin referenced the Other Post-Employment Benefits (OPEB) liability, and noted that the figure had decreased over past years, from $4 billion on June 30, 2008, to $3.6 billion on June 30, 2009, to $3.3 billion on June 30, 2010. Based on the proposed plan changes, Chair Conklin asked whether PEBP has instructed its actuary, Aon Consulting, to project a new OPEB valuation going forward.

Mr. Wells replied that PEBP had not asked Aon Consulting to run an additional OPEB valuation that included the particular plan design changes. He called the Subcommittee's attention to page 28 of Exhibit C, which contained the chart entitled, "GASB OPEB Valuation – July 1, 2009." Mr. Wells explained that the chart showed the valuation that had been conducted for fiscal year (FY) 2010, which had commenced on July 1, 2009. The PEBP had been decreasing those numbers across-the-board because of plan design changes that had been put

into place up to the present time. Mr. Wells indicated that the numbers in that chart did not reflect the new plan design changes that had recently been approved by the PEBP Board and that would take effect July 1, 2011.

Mr. Wells said that upon completion of the legislative session, the plan designs that had been fixed by the PEBP Board would be reflected in the OPEB valuation conducted by Aon Consulting during the summer of 2011. Mr. Wells believed that the current plan design changes would significantly decrease the OPEB liability.

Chair Conklin noted that the OPEB liability decreases had not come at the expense of paying forward, but rather had come at the expense of plan changes. Mr. Wells said that was correct. Chair Conklin said the current plan design changes represented the third year that PEBP had made plan changes that reduced the OPEB liability, which was good. However, he wanted to make it very clear that the reduction had come at a cost, not to the state, but to the state employees and retirees who participated in the plan. Mr. Wells stated that was correct and noted that the reduction in OPEB liability had come about through shifting higher costs to active and retired employees.

Chair Conklin asked at what point in time would cost-shifting become overly burdensome to participants and no longer be feasible. In other words, said Chair Conklin, when was PEBP going to stop shifting costs and burdens to the individuals who served the state and its communities.

Mr. Wells explained that the State of Nevada was not unique in its OPEB liability. That liability affected every entity that provided retiree health care. Mr. Wells stated that when OPEB liability first hit the private sector in the mid-1990s there was a shift away from providing retiree health care by corporations, and it was now very uncommon for corporations to provide retiree health care. In early 2000, the Governmental Accounting Standards Board (GASB) required that government entities that sponsored OPEB, including health insurance, account for those benefits. That caused a very dramatic shift because entities were very concerned about the liability.

Mr. Wells said, from his experience, the number one driver of OPEB liability was the differential between medical inflation and the Consumer Price Index (CPI). If medical inflation could be reduced to the same level as the CPI, it would become a much more manageable problem. Mr. Wells commented that OPEB was an out-of-control problem because it was difficult to control medical inflation, and it was his hope that the current PEBP plan design changes would

help provide some control of medical inflation. Without that control, said Mr. Wells, the problem would never be solved for active or retired employees.

Chair Conklin commented that just because other states or private businesses took certain actions did not make it right. He pointed out that the private sector operated under different demands, which fluctuated with market conditions, while the government always had to provide services to its citizens. As a result, providing good benefits to employees and continuing them upon retirement was important to maintain a quality workforce in state government to provide the services needed.

Chair Conklin noted that the PEBP proposals would continue the trend of reducing benefits for the employees and retirees, which was passing the burden for the state's financial woes onto them, and that policy needed to stop at some point. He reiterated that this was not right, and a different approach was needed.

With no further questions forthcoming regarding budget account (BA) 1368, the hearing was closed and Chair Conklin asked Mr. Wells to address BA 1390.

SPECIAL PURPOSE AGENCIES – PUBLIC EMPLOYEES BENEFITS PROGRAM
PEBP-ACTIVE EMPLOYEES GROUP INSURANCE (666-1390)
BUDGET PAGE PEBP-18

James Wells, Executive Officer, Public Employee's Benefits Program (PEBP), indicated that the information regarding the Active Employees' Group Insurance Subsidy (AEGIS) began on page 25 of Exhibit C. He indicated that the AEGIS account provided a centralized collection mechanism for the state contributions paid by state agencies based on the number of active employees in each budget account. The assessments were based on filled positions and were charged to all state agencies, boards and commissions, the Legislative and Judicial Branches, the Public Employees' Retirement System (PERS), and the Nevada System of Higher Education (NSHE).

Mr. Wells explained that the flat monthly amounts funded the subsidy percentages depicted by the chart entitled "State PPPM Base Subsidy Levels," on page 21 of the exhibit for active employees and their dependents.

Mr. Wells said page 25 of the exhibit depicted the same Maintenance (M) and Enhancement (E) decision units as previously delineated in budget account (BA) 1368, Retired Employee Group Insurance. The exception was decision unit

E250, which requested that BA 1390 be moved from the Self-Insurance Trust Fund to the Payroll Trust Fund effective July 1, 2011.

Mr. Wells said that move would reflect that BA 1390 was a state account that contained state funds until PEBP withdrew the premium subsidies from the account. Mr. Wells indicated that BA 1390 was not part of the PEBP program and, therefore, should not be accounted for within the Self-Insurance Trust Fund. Moving BA 1390 to the Payroll Trust Fund would eliminate the confusion regarding accounts receivable or accounts payable that resulted each year from having either excess funds or a shortage of funds in the AEGIS account.

Chair Conklin noted that one proposal in BA 1390 would decrease the AEGIS contribution for part-time employees. He noted that approximately 85 percent of all part-time employees worked either for the Nevada System of Higher Education (NSHE) or the Department of Health and Human Services (DHHS). One of the compensations offered to part-time employees by the state was full benefits. Chair Conklin said that there were many part-time instructor positions and administrative assistant positions. He wondered whether PEBP had discussed the effect of a reduction in benefits for part-time employees with NSHE or DHHS and the types of employment changes those agencies might experience as a result of the plan change.

Mr. Wells stated that decision unit Enhancement (E) 673 had been included in The Executive Budget as a Governor/Budget Division recommendation. He said he had not spoken to either DHHS or NSHE about the effect the reduction in subsidy would have on their recruitment and retention of part-time employees.

Chair Conklin asked that a representative from the Budget Division come forward and explain the request. Stephanie Day, Deputy Budget Director, Budget Division, explained that decision unit E673 had been placed in the budget for all state agencies. The full-time subsidy for medical insurance premiums for part-time employees was the only state benefit that was not prorated. She stated that annual leave and sick leave were prorated based on the amount for full-time equivalent (FTE) positions; for example, a half-time employee would receive only half the amounts of annual leave and sick leave accrued by a full-time employee. Retirement credits were also prorated, and Ms. Day reiterated that the AEGIS contribution was the only full-time benefit offered to part-time employees.

Chair Conklin asked whether the Budget Division had considered the potential effect on those part-time employees or whether the Budget Division understood the demographics of the part-time employee. Ms. Day said the Budget Division had considered the demographics, and positions for classified employees were based on the work that was performed within that position, rather than the amount of time that was spent. Therefore, the hourly rate for a part-time employee would be the same as that of a full-time employee.

Chair Conklin asked whether the Budget Division had contacted NSHE prior to proposing the decrease in the AEGIS contribution, since 57 percent of those affected by that change were employed by NSHE. Ms. Day did not think NSHE had been contacted. Chair Conklin believed that the two departments that employed the most part-time employees should have been contacted prior to initiating a decrease of AEGIS contributions. Ms. Day indicated that the decision was made for agencies on a statewide basis, and the Budget Division believed it was no different than the projected salary reduction or whether or not to include an inflationary amount in agency budgets.

Chair Conklin asked how much money would be saved because of the reduction in AEGIS contributions. Ms. Day replied that the savings would be $1.6 million. Chair Conklin asked about those part-time positions at the lower pay levels, such as administrative assistants or accounting assistants, who might not have access to benefits because they could not afford the additional premium costs. He noted that there would be some part-time employees who could afford to pay additional premiums but might approach their supervisors in an attempt to increase the number of hours they worked to qualify for full benefits. Chair Conklin said some part-time employees were already retirement age, and continued working to receive full medical benefits and agencies might eventually be forced to hire full-time employees to cover some of those positions, thereby increasing the number of full-time employees.

Ms. Day stated that in some cases throughout the state, full-time positions were filled by two part-time employees who job-shared, and employers might ultimately decide to hire one full-time employee for those positions. Chair Conklin asked whether that factor was depicted in the budgets through an increase in full-time employees because it appeared that the Budget Division expected part-time positions to become full-time. Chair Conklin asked whether the Budget Division realized that the decrease in AEGIS payments would change some employer/employee behavior regarding future hiring policies. Ms. Day agreed that it was possible that employer/employee behavior could change.

Assemblyman Kirner agreed with Chair Conklin and wondered whether the proposal would save $1.6 million or would cost an additional $1.6 million.

Chair Conklin asked whether there were further questions regarding BA 1390, and there being none, he closed the hearing regarding the PEBP budget accounts. Chair Conklin opened public comment.

Bernard (Bernie) Anderson informed the Subcommittee that he was a member of the Retired Public Employees of Nevada (RPEN), and it was thanks to RPEN that he was at today's Subcommittee hearing. Mr. Anderson indicated that Mr. Wells always presented a strong picture of the programs offered by the Public Employees' Benefits Program (PEBP). Mr. Anderson explained that he had been diagnosed with type 2 diabetes approximately 15 years ago, but his condition was well-controlled by medication. He had also suffered from hypertension for the past 20 years and had struggled with weight problems for most of his life.

Mr. Anderson believed that the way the Diabetes Care Management Program and the Live Well, Be Well Program Prevention Plan (Wellness Program) had been presented and explained to participants was part of the problem. He pointed out that there had been little reason or incentive for him to participate, and therefore, he had not joined either program. Mr. Anderson stated that there had been absolutely no outreach to the target population on the part of PEBP regarding the Diabetes Program.

Regarding the transition of Medicare-eligible retirees to the private sector, Mr. Anderson wondered what the cost would be to him at 69 years of age to purchase an Individual Medicare Market Exchange (IMME) plan that included Part D drug coverage. He believed that a larger percentage of his overall income would soon be spent on Medicare coverage.

Mr. Anderson said he had served the Legislature as an Assemblyman for 20 years and received a small state retirement, which he felt would completely disappear as a result of the transition to the IMME plan. Obviously, said Mr. Anderson, that was unacceptable, and as a former Assemblyman and school teacher, he was terribly concerned about attracting qualified persons into the public workforce. Without the benefits offered by the state, there would be no reason or incentive for individuals to seek public employment.

Also, said Mr. Anderson, retirees had called Extend Health to set up a date for enrollment because the transition was being forced upon them. Retirees had received a letter instructing them to contact Extend Health to provide information and set up a time to enroll. He did not believe that the response by retirees in contacting Extend Health should be used as an indicator of the acceptance of the transition to the IMME plans or whether retirees believed that the IMME plans would be better. Transitioning retirees to the IMME might be better for management, but Mr. Anderson did not believe it was better for Nevada's citizens and former public employees.

Testifying next before the Subcommittee was Martin Bibb, Executive Director, Retired Public Employees of Nevada (RPEN), who stated that as already pointed out, a significant number of changes were proposed in the PEBP budget, which would affect the 43,000 primary members and the 17,000 early and Medicare retirees and their dependents who participated in the plan. Mr. Bibb noted that there had been significant cuts to the PEBP program in recent years along with cost-shifting to participants.

Overall, said Mr. Bibb, more than $100 million had been cut from the PEBP budget since the 2009 Legislative Session, some in the form of the Governmental Accounting Standards Board (GASB) and PEBP Other Post-Employment Benefits (OPEB) prefunding. However, said Mr. Bibb, during the current difficult economic times, money for that prefunding had been swept by the Legislature to try and deal with budget shortfalls. A deductible that was as small as $250 prior to 2009 was now proposed by PEBP to be a $1,900 deductible per individual and twice that amount for families of active employees and early retirees.

Mr. Bibb said those cuts would dramatically and negatively affect the participants in the PEBP plan, and for that reason RPEN believed that additional funding was essential; however, at the same time RPEN recognized the painful and difficult economic times and the challenges facing the Legislature. Certainly, some adjustments had to be made. Mr. Bibb stated that the PEBP budget contained $85 million in cuts, largely in the form of medical inflation that had to be absorbed by the plan, which PEBP participants were being asked to shoulder.

However, said Mr. Bibb, no group's insurance coverage was set to look as dramatically different as that for Medicare-eligible retirees. The approximately 9,000 Medicare-eligible retirees in the PEBP plan would no longer have their insurance provided through PEBP, but rather it would be provided through the

Individual Medicare Market Exchange (IMME). In a nutshell, said Mr. Bibb, that would involve Medicare retirees being contacted by agents of the private-sector exchange who would survey the individuals then direct them into a specific option. Following that process, the individual would be enrolled in one of the private-sector insurance plans.

Mr. Bibb said that meant the problems retirees might experience with claims and coverage would not be routinely addressed by PEBP plan administrators and staff, but rather would be addressed by insurance companies, which represented a major change. Mr. Bibb stated that RPEN had devoted resources such as its email and newsletters to inform its 9,700 members, many of whom participated in the PEBP plan, of the informational opportunities, timetables, and resources available through the dramatically different health plan proposed by PEBP.

Mr. Bibb said in RPEN's view it was essential that the enrollment process be smooth, that the products remained effective and affordable, and that the program worked. The RPEN also believed that legislators, many of whose Medicare-eligible retiree constituents would be involved in the new program, should keep a close eye on how well the plan functioned now and in the future. Mr. Bibb reiterated that it would be a dramatic change for Medicare retirees to deal with out-of-state insurance company representatives and personnel, rather than airing their concerns to an agency and to lawmakers who had historically overseen PEBP.

According to Mr. Bibb, the fact was that despite the challenges it had faced in recent years, PEBP had improved services to its insured population, notwithstanding the challenges of the economy, and RPEN believed that progress needed to continue. The hundreds of phone calls and emails that RPEN had received on the subject of the transition spoke to the concerns of Medicare retirees and evidenced their desire to continue a viable PEBP program.

James Richardson, representing the Nevada Faculty Alliance, testified next before the Subcommittee. Mr. Richardson said he would also speak on behalf of the Public Service Workers' Benefit Coalition on PEBP (Benefit Coalition) that had been formed during the 2009 Legislative Session to address the major issues within PEBP. He noted that the Benefit Coalition had been meeting weekly, and he thanked Assemblyman Oceguera for assisting the Coalition with the rooms for its meetings.

Mr. Richardson said that several important points had been made at today's Subcommittee hearing and he would try not to be repetitious. It was a fact that because of the budget crisis that had engulfed the state in recent years, the subsidy levels for active and retired employees had remained basically level for four consecutive years in the face of medical inflation that probably averaged 10 percent per year. That had created a gulf between the cost of maintaining the plan that had been available over the past two years and the plan that was being offered by PEBP today, and that gulf would be absorbed by the participants in the plan.

Mr. Richardson stated that a study had been presented by the PEBP Board to the 2009 Legislative Session that indicated the plan was somewhere in the middle range of health plans for public employee groups throughout the nation, but it had since deteriorated and would continue to deteriorate, as was obvious by the current proposed plan changes.

Mr. Richardson said for those persons who kept "yammering" in the press that PEBP needed to be reformed—it had been desperately reformed. He opined that further cuts to PEBP should be taken off the table, and everyone should stop beating up on PEBP and the hardworking state employees and retirees who depended on the plans offered by PEBP. Mr. Richardson emphasized that PEBP had been significantly reformed under current budget pressures.

Mr. Richardson said he had been forced to become more expert in the area of Individual Medicare Market Exchange (IMME) plans because of the deluge of emails and phone calls he had received since PEBP developed the plan to transition Medicare-eligible retirees to the IMME. With some reluctance, he had recommended to the Nevada Faculty Alliance that it support the action taken by the PEBP Board regarding Medicare-eligible retirees.

Mr. Richardson said he pointed out to Alliance members that the previous Governor and organizations such as the Nevada Spending and Government Efficiency (SAGE) Commission had suggested that the best action to take regarding Medicare-eligible retirees would be to simply "dump" them off the PEBP plan and provide no further assistance. That would have been a travesty because those retirees had worked long and hard for Nevada, and the state had actually benefitted by not having to pay into Social Security for those employees over the years.

Mr. Richardson advised the Subcommittee that what the PEBP Board had devised in terms of transitioning Medicare-eligible retirees to the IMME, along with the proposed subsidy, had been the best choice. It had been a very difficult choice for the PEBP Board, and it had also been a difficult choice for Mr. Richardson and the Nevada Faculty Alliance, but it was hoped that the transition would be a positive experience. If the transition was not positive, Mr. Richardson pointed out that legislators would certainly hear about it from their constituents.

Mr. Richardson asked the Subcommittee to make sure that the subsidy for Medicare-eligible retirees was included in the Appropriations Act and, in fact, the Legislature could show its appreciation to retirees by increasing the amount of the subsidy from $10 per month per year of service to as high as $15 per month per year of service. Mr. Richardson also noted that the transition would greatly lower the GASB liability for the state.

Mr. Richardson emphasized that the record should reflect that PEBP had been reformed under the budget pressures brought by the Budget Division in trying to deal with the budget crisis. He opined that the PEBP Board had done as good a job as possible under the circumstances.

Mr. Richardson appreciated Chair Conklin's insightful analysis of the part-time employee issue. The proposed change in the AEGIS contribution was very bad public policy, and Mr. Richardson also believed there was an error in the number of current part-time employees. A representative from Nevada System of Higher Education (NSHE) had informed Mr. Richardson that approximately 60 percent of the anticipated $1.6 million savings was to come from the NSHE, but it appeared that the Budget Division failed to recognize that some employees worked part-time within two separate accounts, but were actually full-time employees. Mr. Richardson said the amount of miscalculation for the NSHE budget approached $600,000, and he did not believe there would be a savings of $1.6 million.

Mr. Richardson explained he had two part-time employees who worked for a low salary, given their credentials, to maintain their health insurance. He felt he might be forced to increase their salary from 51 percent to 75 percent to retain those employees. He reiterated that it was bad public policy for the state to discourage the efficient use of part-time employees in all state agencies and NSHE at a time when the state was trying to get the job done with fewer workers. Mr. Richardson encouraged the Subcommittee to reject that decision unit.

The Chair recognized Michael Greedy, and informed him that members of the Subcommittee were in receipt of a copy of his statement, Exhibit D, and it was also available electronically on the Nevada Electronic Legislative Information System (NELIS).

Mr. Greedy thanked the Chair and stated that he would like to offer some observations about the programs offered by PEBP. One incentive of the current Wellness Program was the possibility of a reduced annual deduction in premium if an individual participated in certain preventative activities. Mr. Greedy said that had given him the incentive to participate in the activities. He explained that he had received a customized 63-page health plan document, which he had downloaded to his computer, but had not read.

Mr. Greedy said he had been provided a checklist of items that he was to discuss with his doctor via email because he had been unable to download the list directly from the vendor's website. Mr. Greedy stated that the $25 gift card had not provided much incentive for him to participate in the program.

Mr. Greedy stated the reason he had stopped participating in the Wellness Program was because that program would not benefit Medicare-eligible retirees, and the credit against the yearly premium would not be available to him as a retiree.

Mr. Greedy had submitted the exhibit to address questions about the proposed transition of Medicare retirees. He noted that action taken by the 76th Legislative Session would have an effect on workers who commenced employment with the State of Nevada after July 1, 2011. Reduced retiree benefits offered to new employees might affect their decision to accept employment or later on whether to remain employed with the state. Mr. Greedy commented that the state was in a highly competitive labor market for skilled employees, and absent those employees, there would be no State of Nevada.

Peggy Lear Bowen testified next before the Subcommittee. She stated she was a member of the Retired Public Employees of Nevada (RPEN) and a nonstate retiree member of PEBP through the Washoe County School District.

Ms. Bowen stated that she would like to discuss the other side of the coin. She stated that the Public Employees' Retirement System (PERS) was an asset that Nevada could ill afford to lose. She asked that the publication entitled,

"NV PERS, Positive Impact for Nevada, December 2010," be made a part of the record (Exhibit E).

Chair Conklin asked Ms. Bowen to remain on task because the Subcommittee was not considering the budget for PERS. Ms. Bowen understood that the Subcommittee was considering the budget for PEBP.

Continuing, Ms. Bowen said when the State hired an employee, it promised a total package that covered the time the employee signed on with the state through the time when the employee either quit or retired from state service. Any changes to PERS or PEBP would totally affect state workers. She appreciated Chair Conklin's comment that just because other states took certain action did not mean it would be good for Nevada. Nevada had always protected and insulated itself from outside issues.

Ms. Bowen said the state was now informing employees that it would provide less for working for the state because of increased insurance premiums and reduced benefits. She did not think the plan presented to the PEBP Board regarding Medicare retirees was the best plan. Ms. Bowen believed that the PEBP Board should seek an in-state provider of insurance for retirees, rather than the current plan that would pay an out-of-state exchange to handle the insurance needs of Medicare retirees. Ms. Bowen commented that the proposed PEBP plan for Medicare retirees was a significant gamble on the part of the state because it could not control the cost for medical care.

Ms. Bowen opined that perhaps the wellness programs had failed because when she first joined PEBP it had offered wellness fairs that had been well attended by participants. Those fairs often ran out of such items as "flu" shots because so many plan participants attended. Ms. Bowen said that participants in the wellness fairs were offered direction and assistance in improving their health.

Ms. Bowen said she was not speaking as a PEBP participant who would be "shoved out into the cold" and placed with an out-of-state company to secure whatever insurance coverage possible. She did not have Medicare Part A and Part B because she had trusted the State of Nevada and the county where she had been a teacher for 35 years, and where she served as an elected member of the State Board of Education for 12 years, to provide the agreed-upon benefits when she retired. Ms. Bowen said those who came before her had ensured that there was a reason for her to enter the field of teaching beside her love of children and her love of the State of Nevada. They made sure that in her old age she would not be homeless, poverty-stricken, or without medical care.

Ms. Bowen commented that the benefits paid by PERS remained in Nevada. Over 80 percent of approximately $1 billion paid out in 2007 by PERS had remained in the state. She believed that the Subcommittee should look at retirement benefits as an asset to help retain high-level employees, and also to ensure that those employees continued to contribute to their communities after retirement.

Ms. Bowen said the current PEBP proposal would piecemeal out the monies that could be retained and help make the state more economically sound. She opined that standards of education should not be lowered because the state could not afford to have a quality of education that included hands-on classes.

Ms. Bowen said the state had to help its population remain well, and it should not place retirees on insurance plans that did not pay for such things as hearing aids, glasses, or dental work. For Nevada to withstand the current economic assault, it had to take care of its employees and ensure a good quality of life in its communities so that people would want to live in Nevada. Ms. Bowen believed that the attraction to Nevada was because it had taken care of its own over the years and had not "sold out" or placed program participants in other categories because of costs.

Ms. Bowen said she was speaking for employees yet to come, those the state would seek to hire to the benefit of the state. She asked that the Subcommittee continue to nurture that which was already in place. Nevada had one of the top five retirement systems in the nation, Ms. Bowen said, one that would not run out of future funding because it had been well established.

Ms. Bowen asked the Subcommittee not to undo the work of those who had made Nevada resilient, but to build upon the resilience and the formulas that were already in place. She said transitioning Medicare-eligible retirees to an insurance exchange rather than continuing to participate in the PEBP program would not help Nevada's workforce grow, and she asked that the Subcommittee look at the positive effect rather than the cost.

Testifying next before the Subcommittee was Judy Sheldrew, who stated that she was a state retiree. Ms. Sheldrew said the group insurance program for retirees and the subsidy had been established several years ago in statute. There was a provision in the *Nevada Constitution* that prohibited the law from impairing contracts.

Ms. Sheldrew stated that she had not conducted exhaustive research on the matter of whether or not the proposal by PEBP regarding Medicare retirees would constitute an impairment of contract. She suggested that the Subcommittee obtain a legal opinion to determine whether such a significant deviation from the contract agreement between the State of Nevada and its retirees constituted an impairment of that contract. If so, Ms. Sheldrew believed that the Legislature would have major issues to review.

Ms. Sheldrew said she was unaware whether an opinion had been requested from the Attorney General's Office to the PEBP Board approving the proposal. It also appeared that the continued changing of the subsidy would not result in additional savings to the General Fund.

According to Ms. Sheldrew, PEBP was mandating that Medicare-eligible retirees be moved into the private sector through a vendor from whom no request for proposal (RFP) had ever been sought. Ms. Sheldrew believed that constituted a significant change in the original contract between the state and its retirees.

Ms. Sheldrew wondered why PEBP was proposing to transition Medicare retirees to the private sector because their cost to the system was not significant since Medicare was the primary insurer. However, the reason had occurred to her during the earlier discussion about the Other Post-Employment Benefits (OPEB) liability, and whether there was a projection of what that liability would be after the plan changes had gone into effect. Ms. Sheldrew said she was astounded that PEBP had not asked Aon Consulting to conduct an OPEB liability valuation that included the proposed plan changes. She suggested that perhaps the main benefit to PEBP of transitioning Medicare retirees to the private sector was the reduction of OPEB liability. The need for a group insurance subsidy for Medicare retirees would not be eliminated, but it could be written off the books.

Ms. Sheldrew wondered why the proposed IMME program was mandated by PEBP rather than being offered as an option. If it was such a great deal that Medicare retirees would flock to sign up, perhaps it should be offered as an option, and if Medicare retirees migrated to that program, PEBP would have proven that it was, indeed, a fabulous new option that would provide better coverage. However, Ms. Sheldrew believed that those retirees who did not wish to migrate to the private sector should be allowed to remain on the PEBP plan. Ms. Sheldrew said those were simply suggestions for consideration by the Subcommittee.

Ms. Sheldrew echoed the comments made by Mr. Greedy about the two wellness programs offered by PEBP. She opined that the reason persons were not participating in those programs was because they were not user-friendly.

Testifying next before the Subcommittee was Roger Bremner, who stated he was a Medicare retiree from the State of Nevada. Mr. Bremner said he had real concerns about how PEBP would set up the subsidy arrangement via the health reimbursement arrangement (HRA). At the present time, a premium supplement was transferred from the retiree's insurance account to PEBP for the benefit of that retiree. Mr. Bremner said the proposal would separate Medicare-eligible retirees from non-Medicare-eligible retirees in a way that was very detrimental and, quite frankly, would discriminate against Medicare-eligible retirees.

Mr. Bremner stated that at the present time the allocation of those monies was predicated on the retiree's length of service. The PEBP had created an artificial plan for Medicare retirees to enter the open market and purchase insurance through Extend Health, which was a brokerage located in Salt Lake City, Utah, and the state would provide a subsidy of $150 to $200 per month to the retiree to purchase the coverage.

Mr. Bremner indicated that the money PEBP received from the State Retirees' Health and Welfare Benefits Fund was substantially more than the proposed subsidy amount, and PEBP would keep a substantial portion of the monies transferred from that Fund. He noted that the State Retirees' Health and Welfare Benefits Fund was an irrevocable Fund that transferred funds to PEBP for the benefit of Medicare retirees. In exchange, said Mr. Bremner, PEBP proposed to give up all responsibility and all accountability for Medicare retirees, and would pay no claims, which would be a great deal for PEBP.

Mr. Bremner commented that the proposal was very discriminatory against Medicare retirees. He stated that he had recently spoken with two insurance brokers in an attempt to discover the cost of similar coverage as that being offered by PEBP through Extend Health. Both brokers were very upset that they were not offered a chance to bid on the proposal and felt the process had been conducted in a very secretive fashion without the issuance of a request for proposal (RFP). Mr. Bremner opined that there were brokers and agents in the insurance industry in the State of Nevada who were upset about the proposal.

Mr. Bremner said after the two brokers determined a premium cost for his insurance, he realized that the premium cost in the open market was substantially more than he was currently paying through PEBP. As a Medicare retiree, Mr. Bremner was part of the most vulnerable group in PEBP because the participants were older, had more health needs, and often received lower retirement benefits. He believed there would be a number of retirees who would not be able to purchase coverage in the open market because it was more costly than the coverage currently offered through PEBP.

Mr. Bremner said the solicitation-waiver process indicated that the proposal was a four-year pilot project, which he said was not true. The proposal was a radical deviation from the plan currently offered by PEBP, and he did not believe that Medicare retirees would ever be allowed to return to PEBP coverage. The PEBP also stated that Extend Health would receive approximately $1.2 million in "commissions" over the term of the contract. However, Assemblyman Aizley had referred to a figure of $9 million, which Mr. Bremner believed was closer to the correct amount. He did not think that approximately 9,000 Medicare retirees would pay only $1.2 million in commissions to purchase insurance from the broker in Salt Lake City.

Mr. Bremner said it was estimated that PEBP would reduce state subsidies by approximately $17 million over the 2011-2013 biennium with the current proposal. He thought there might be an explanation regarding how the state would pay a reduced subsidy amount, but he simply could not figure it out. Mr. Bremner agreed with Assemblyman Grady's comments about the lack of assistance to Medicare retirees if the plan proved to be unacceptable, because apparently PEBP would be completely out of the picture.

Mr. Bremner said he had been on both sides of the table, having been a licensed agent/broker of insurance in the state for 46 years and having served in the Nevada Legislature as an Assemblyman for 6 terms. Mr. Bremner said during his legislative career, he had never seen a proposal such as that submitted by PEBP that removed a state agency from all responsibility and liability for a program that it was paid to provide.

Mr. Bremner believed that the PEBP proposal should be closely reviewed by the Subcommittee, and perhaps the proposal should be reviewed over the interim by an interim study committee prior to making an irrevocable change that would affect the most vulnerable group of retirees in the state.

Testifying next was Larry Hardy, who stated he represented the Nevada Association of Health Underwriters, Nevada Association of Insurance and Financial Advisors, and Nevada Independent Insurance Agents. Mr. Hardy referred to his ten-page informational email that had been sent to members of the Subcommittee. He asked that his email be made a part of the record, (Exhibit F).

Mr. Hardy commented that he had made several phone calls so that he could understand the situation with the PEBP Medicare retiree benefit. He commented that "phones had been ringing off the hook" around the State of Nevada because every Medicare retiree had an insurance agent, and when PEBP began presenting information about the proposed transition, retirees began contacting their agents. Mr. Hardy stated that he had reviewed the PEBP proposal and believed there would be some unintended consequences, even though PEBP had done a good job with the proposal and Extend Health was a reliable vendor.

Basically, said Mr. Hardy, the same service as that being provided by Extend Health was available on every corner in Nevada—insurance agents with brick-and-mortar offices that included employees and benefit advisors. Mr. Hardy said there were agents who specialized in the Medicare Advantage and Medigap plans for retirees in Nevada, and the associations and independent agents were somewhat disappointed that they had not been allowed to participate in the PEBP proposal.

Mr. Hardy stated that he would like to clarify the revenue issue. The contract to manage the HRAs had been awarded to Extend Health in the amount of approximately $1.5 million over a four-year period. Mr. Hardy said he was aware of many companies in Nevada that specialized in HRA management only, and he opined that the contract should have gone out to bid. The $9.4 million that was alluded to in Exhibit F was a combination of the $1.5 million and the projected commission from sales of the various plans. Mr. Hardy said the figure very conservatively estimated that retirees would be aged 65 and the revenue from sales of insurance plans would be about $7.8 million, providing that each retiree purchased individual plans without covering spouses or dependents.

Mr. Hardy said that Nevada brokers and agents lived and worked in local communities and yet PEBP had awarded the contract for Medicare-eligible retirees to an out-of-state company. That meant that benefit advisors would set up insurance plans for retirees via the telephone or computer, when local agents would have personally contacted seniors in their homes to explain the available plan options.

Chair Conklin commented that he was concerned about the contract with Extend Health, and he had heard comments from constituents in his District about the use of an out-of-state vendor. In an era when the state was trying to spend its tax money and revenues in Nevada to foster jobs, and given the fact that many agents and brokers would be happy to deal with PEBP, he wondered why PEBP had not considered the possibility of having a vendor on premise, had not considered offering the contract to a local vendor, or had not required Extend Health to establish an office in Nevada.

Chair Conklin said that 17,000 retirees spending approximately $200 a month on insurance premiums would amount to approximately $3.4 million in revenue per month, which would equate to just over $100,000 per month in insurance premium tax revenue, not to mention the local jobs and the commissions paid to local insurance agencies. There was also a great deal of revenue potential for the state through the contract to manage the HRAs, and while he was not admonishing the PEBP Board for not considering a local vendor, Chair Conklin said the beauty of having a vendor on premise would be the continued service to Medicare retirees through PEBP. Retirees could then continue to call PEBP, and those calls could be transferred to the vendor on site.

Chair Conklin believed that there were issues that could be fleshed-out in the PEBP proposal that would provide better choices for Medicare retirees and for the State of Nevada and which would keep more revenue within Nevada and actually generate tax dollars.

Testifying next before the Subcommittee was Betty Kelly, who stated she was a Medicare-eligible state retiree. She said she had not intended to testify today, but she felt senior citizens were being “railroaded” like cows being sent to the exchange in Fallon for slaughter. Ms. Kelly said as a senior citizen, she was not as sharp and did not have as much fight as she used to have, so she was literally at the mercy of PEBP and legislators. Senior citizens did not like to be picked on, said Ms. Kelly, and she felt the current PEBP proposal was a form of elder abuse because PEBP seemed to push plans on senior retirees who did not have the fight to deal with the proposals. Ms. Kelly asked the Subcommittee to keep those facts in mind when considering the proposed PEBP plan for Medicare retirees.

Ms. Kelly said her concern was the possibility that the services of Extend Health would be limited to four years, and she wondered what would happen after that four-year period. She believed that maybe four years later PEBP thought that

most Medicare-eligible retirees would be "six feet under," which would be a form of attrition and would save money over the long run. Ms. Kelly said she was somewhat confused about the four-year time frame for Extend Health, and she felt that the Subcommittee should look at the proposal carefully.

Ms. Kelly said she was more fortunate than other seniors because she could afford to sign up for "Plan F," which provided complete coverage, but there were many other seniors who could not afford that plan. She reiterated that she believed Medicare-eligible seniors were being "railroaded" into the proposed PEBP plan.

Chair Conklin thanked Ms. Kelly for her testimony and recognized Mr. Papaianni.

Frank Papaianni, Director-at-Large, American Federation of State, County and Municipal Employees (AFSCME), Local 4041, introduced himself to the Subcommittee.

Mr. Papaianni said he was somewhat confused about the PEBP proposal. It was his understanding that the PEBP Board would approve the proposed plan, and that legislators would approve the financial support for the plan. He asked whether that was correct.

Chair Conklin advised Mr. Papaianni that the Legislature would approve the budget for PEBP, but he pointed out that the Legislature could be very persuasive because it had control over the budget.

Mr. Papaianni stated that it appeared the only control and follow-up of the proposed PEBP plan for Medicare-eligible retirees would be through reports from the vendor to PEBP to receive payment of the fee for management of the Health Reimbursement Arrangements (HRAs). He wondered whether a state agency not connected to PEBP should receive a report from the participants themselves about their level of satisfaction with the plan, the financial effect of the plan on individual retirees, the level of service provided by the insurance companies, and how receptive their medical providers were of the insurance coverage. Mr. Papaianni said there were some Medicare Advantage plans and Medigap plans that would not be acceptable to local medical providers.

Chair Conklin indicated that the testimony heard by the Subcommittee today indicated that there were several plan options available for every zip code throughout the state where retirees resided. Based on that testimony, the

Subcommittee would assume that there was no issue regarding medical providers not accepting the insurance plans.

Mr. Papaianni asked whether it would be possible to survey the Medicare-eligible retirees in approximately six months to ascertain whether they were satisfied with the IMME plans.

Chair Conklin replied that, unfortunately, because of proposed budget cuts it was unlikely that such a survey could be conducted.

Chair Conklin said the Subcommittee would make it well known to Mr. Wells that if the current PEBP proposal for Medicare-eligible retirees was approved, the Legislature would like to see documentation about the success of the plan.

With no further business to come before the Subcommittee, Chair Conklin adjourned the hearing at 10:09 a.m.

RESPECTFULLY SUBMITTED:

_____
Carol Thomsen
Committee Secretary

APPROVED BY:

_____
Assemblyman Marcus Conklin, Chair

DATE: _____

Committee Name: Assembly Committee on Ways and Means/Senate Committee on Finance Joint Subcommittee on General Government

Date: March 4, 2011 **Time of Meeting: 8:01 a.m.**

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
	C	James Wells, PEBP	Budget Presentation
	D	Michael Greedy	Public Testimony
	E	Peggy Lear Bowen	Publication, "NV PERS, Positive Impact for Nevada"
	F	Larry Hardy	Informational email to Subcommittee members