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

Seventy-Seventh Session
February 8, 2013

The Joint Subcommittee on General Government of the Senate Committee on Finance and the Assembly Committee on Ways and Means was called to order by Chair Joyce Woodhouse at 8:06 a.m. on Friday, February 8, 2013, in Room 2134 of the Legislative Building, Carson City, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

SENATE SUBCOMMITTEE MEMBERS PRESENT:

Senator Joyce Woodhouse, Chair
Senator Moises (Mo) Denis
Senator Michael Roberson

ASSEMBLY SUBCOMMITTEE MEMBERS PRESENT:

Assemblywoman Lucy Flores, Chair
Assemblyman Paul Aizley, Vice Chair
Assemblyman Paul Anderson
Assemblyman Andy Eisen
Assemblyman Cresent Hardy

SUBCOMMITTEE MEMBERS ABSENT:

Assemblyman Joseph M. Hogan (Excused)

STAFF MEMBERS PRESENT:

Michael J. Chapman, Principal Deputy Fiscal Analyst
Laura Freed, Senior Program Analyst
Alex Haartz, Principal Deputy Fiscal Analyst
Sheri Fletcher, Committee Secretary

OTHERS PRESENT:

James R. Wells, Executive Officer, Board of the Public Employees' Benefits Program
Tim Nimmer, Chief Actuary and Chief Broking Officer, AON Hewitt
Debbie Donaldson, Vice President, AON Hewitt
Martin Bibb, Executive Director, Retired Public Employees of Nevada
James T. Richardson, Nevada Faculty Alliance
Ron Dreher, Peace Officers Research Association of Nevada, Washoe County Public Attorney's Association, Washoe School Principals' Association
Elaine B. Steiner
Roger Bremner
Rob Joiner, President, Carson City Chapter, Retired Public Employees of Nevada
Bernie Anderson, A Solution

Chair Woodhouse:
We will start with Public Employees' Benefits Program (PEBP) Budget Account (B/A) 625-1338.

SPECIAL PURPOSE AGENCIES

PUBLIC EMPLOYEES' BENEFITS PROGRAM

PEBP - Public Employees' Benefits Program — Budget Page PEBP-10 (Volume III)
Budget Account 625-1338

James R. Wells (Executive Officer, Board of the Public Employees' Benefits Program):
For the first time in a couple of biennia, we are not here to discuss major cuts to the Program. On page 2 of the Public Employees' Benefits Program (PEBP), Presentation to: Joint Ways & Means and Finance General Government Subcommittee (Exhibit C), you will find my presentation agenda.

Starting on page 4 of Exhibit C you will see the current fiscal year (FY) 2013-2014 budgeted funding for the PEBP. The pie chart on the left designates the sources of revenue that make up our funding. Fifty percent of our money in FY 2013-2014 is projected to come from State subsidies for active employees and retirees. The

contributions number of 25 percent in the upper right hand corner of the chart includes employee and retiree contributions, as well as contributions from non-State retirees and non-State employers.

The 1 percent "All Other" revenue is made up of retiree drug subsidies and their federal government refunds, or rebates for Medicare Part D Prescription Drug Plan participants, as well as rebates from our pharmacy benefit manager. The 24 percent "carryforward" category represents the amount of money that we carryforward to fund our incurred, but not reported, liability and our catastrophic liability, as well as any liability associated with the health reimbursement arrangements. If there are any extra funds, those monies are carried forward to the next year.

The pie chart on the right shows how we budgeted our spending. The majority was budgeted for self-funded claims, the Consumer Driven Health Plan (CDHP), as well as another 8 percent for Health Savings Account (HSA) and Health Reimbursement Arrangement account contributions (HRA). Those two components make up 52 percent of the spending for our budgeted FY 2013-2014. The chart category Fully Insured includes the Health Maintenance Organization (HMO), life insurance and long-term disability. Those pieces are fully insured by individual carriers. The 20 percent Reserves category represents our incurred but not reported reserve (IBNR), catastrophic reserve, HRA reserve, as well as any excess reserves. We spend about 2 percent of our funding to administer the self-funded plan which includes a third-party administrator, the pharmacy benefit manager for the leasing of our networks and infrastructure to run the self-funded plan. The 1 percent is the actual administration costs for the PEBP office.

On page 5 of Exhibit C are PEBP's projections for FY 2013-2014. You will notice PEBP budgeted revenue and expenditures of approximately $528.4 million. Projections indicate we will spend $461,038,659 and commensurately draw in $461,038,659 in revenue. The primary reason for the revenues and claims, and the fully insured products being lower than what was budgeted, is that we are about 3,400 enrollees lower than what we had projected last Session for the 2013-2015 biennium. We projected enrollment of approximately 43,700 individuals for FY 2013-2014. We will most likely average 40,200 individuals in FY 2013-2014. That is a reduction of approximately 8 percent from the projected enrollment to our actual enrollment.

You will see on the last line, the projected reserves are $108,719,638 which is made up of four different components. There is an IBNR for claims that have been incurred prior to the end of the plan year, and have not been submitted to PEBP for payment until after the plan year is over. Under our plan, participants have up to 1 year to submit their claims for payment. The reserve pays for the claims that are submitted in the subsequent year. The catastrophic reserve ensures that if we had a catastrophic claim, or a large number of claims in excess of what is considered normal, that Catastrophic fund is there to ensure there are sufficient resources to pay those claims. There is also a HRA component of the reserve. That portion of the reserve is a fund for our participants to pay their own claims. That is the liability associated with the HRA funds established, but not spent, by the participants. Lastly, we have excess reserves, or reserves in excess of the amount that is required for the previous three components. We are anticipating there will be approximately $30 million in excess reserves at the end of FY 2013-2014. Those reserves are budgeted to be spent down over the next biennium.

I would like to introduce our actuary, Tim Nimmer of AON Hewitt, who provides PEBP with actuarial services. AON Hewitt is responsible for assisting us with pricing our benefit changes, setting our reserves and creating our annual rates. Mr. Nimmer will to go through the next several pages of Exhibit C discussing the trend experience for PEBP and how PEBP compares on a national basis to other large governments. Additionally, he will discuss the calculation of our rates, the reserves and the benefit costs.

Tim Nimmer (Chief Actuary and Chief Broking Officer, AON Hewitt):
I spend a significant amount of my time reviewing similar information with other states and other governing bodies such as yourselves, and provide legislative testimony on a routine basis. There are two types of trends. The first would be trends before benefit changes. The second would be trends after benefit changes. The difference is referenced on page 6 of Exhibit C.

The average reduction for benefits typically runs in the 2 percent to 4 percent range. Our national trend surveys are before benefit changes. Over the last few years, we have been quoting in our press releases a range of 8 percent to 10 percent. You may have seen other publications identifying trends of 4 percent to 6 percent. That typically means it is after those benefit changes. Trends over the last few years have been affected by the mandated changes under the

Affordable Care Act (ACA). State and federal exchanges are getting up and running. Insurance companies and other entities are reacting to how those changes will perform over the coming years. There will be some disruption of the health care delivery system countrywide. Several questions have affected trends, such as how the employers will pay for health care and the expansion of Medicaid.

Page 7 of Exhibit C discusses medical trends over the past few years, especially in regard to the State of Nevada. When health care reform was first introduced, it came at a time of economic downturn. There was uncertainty Nationwide about employment and insecurity about whether individuals would maintain their employment. As a result, because people were unsure about health care reform, we saw trends rise very quickly. Trends across the country spiked during that time. Many plans across the country saw their reserves depleted or reduced. Over the past few years, we have seen the opposite occur. Now we are seeing trends coming in lower, because people understand how the health care system will work. As a result, we are beginning to see those reserves increase across state governments in just about every part of the Country. How that impacts Nevada in particular will be explained by Debbie Donaldson.

A few major milestones occurred in Nevada. The plan year from July 2008 through July 2009 was extended 4 months to October 2009 which we refer to as the long plan year. Then we had a short plan year from November 2009 through June 30, 2010. When you consider the multi-year trends observed during that same time period, they were consistent with other large public sector plans across the Country. When we make such dramatic changes with one particular claim, you will see that volatility.

On average, the prescription drug trends for Nevada have been higher than those nationally. The move to the CDHP and the Medicare exchanges, as of July 1, 2011, has had an impact. Nevada has been at the forefront of the consumer plans in the public sector. Many states are considering a CDHP. They are very interested in what the experiences were in Nevada and how the plan has operated over the last few years.

Page 8 of Exhibit C contains the overall trend summary. There are several components to our trend calculations. Most notable is the core health trend. That is how much costs are increasing from 1 year to the next. An example would be

a doctor visit last year which might have cost $100, but this year it costs $105. That represents a 5 percent difference. Another major contributing factor is utilization. As a population ages, they see the doctor more frequently. We are observing utilization increasing across the country. There are other areas that are actuarial in nature, such as deductible leveraging, where there is a higher deductible. The impact on the trend is greater because of the leveraging effect. We typically consider those areas under our trend calculation.

Assemblyman Eisen:
I would like to see more data to specify what kind of services are being utilized at higher rates or lower rates than they were previously.

Mr. Nimmer:
We are seeing increased utilization in a few key areas. We are seeing a decrease in utilization with inpatient costs as people shift from going to a hospital or an emergency room to an outpatient or urgent care facility. Also, with the aging population, general utilization increases. We incur more costs and more engagement with the medical system as we age. That is also occurring in populations across the country. Because it is a closed population, we have low turnover within state governments compared to the private sector. As a result, the average age continues to increase slightly over time.

Assemblywoman Flores:
Why is the largest decrease in utilization in the self-insured area? Is the largest inflationary line item in the self-insured medical costs? We have only projected a small decrease for the upcoming biennium. I am trying to understand how the whole utilization rate is being added to the core medical inflation rate to come up with your adjustment. Why are these different line items, with different utilization rates adding up to this number?

I am referring to decision unit M-101 in B/A 625-1338. If we are going to discuss that further, then let me know. I want to make sure we have a good explanation on how we are utilizing that number.

M-101 Agency Specific Inflation — Page PEBP-12

Chair Woodhouse:
We will hold this discussion until later in the meeting.

Debbie Donaldson (Vice President, AON Hewitt):
A trend is one of the initial components we start with when we are setting rates for Nevada. Therefore, we look at historical experience in addition to what is happening nationally. We project what trend we are going to use in setting rates. We are in the process of doing that right now for FY 2013-2014. On page 9 of Exhibit C is a historical depiction of what has happened to trends and a look ahead to see where trends are going in the future. As you can see there has been significant volatility in trends.

The green line is called a 12 over 12 trend. We take the most recent 12 months of experience on a per employee, per month basis and we compare that to the prior 12 months. This removes seasonality during a plan year because it is on a historical basis. The blue line is called a lognormal trend. We have experience back to 2004 for Nevada, although we have only graphed from January 2007 through January 2013. The lognormal trend is a historical perspective. It gives you a sense of where the trend has been. The red line represents national trend. We gather information on a national basis from several carriers. We look at S&P 500 trends and we come up with a national trend.

Historically, until July 2008, Nevada was relatively stable from an actuarial position. Then there was an extended health plan year that ran from July 1, 2008 through October 2009. There was no reset of the deductible, so with the extended plan year we saw a spike in the claim experience. Subsequently, Nevada had a short plan year from November 1, 2009, through July 2010 and a reset of the deductible. Therefore, the 12 over 12 line really spikes downward.

After the long- and short-plan year experience, Nevada had a plan year where, due to fiscal constraints, the high deductible health plan (HDHP) was discussed. During that time, we saw a spike in utilization. Typically, we will see a run on the plan or increased utilization when there are disruptions in a plan, or when there is a significant plan design change. After that plan year, we went to the HDHP, a consumerism type plan, where we saw a drop in utilization. We have not seen a plan design change for 2 years. We are anticipating a dampening of this volatility in the future.

On page 10 of Exhibit C a bar chart depicts what we assumed our trend to be, what the actual trend was, and the net expected trend. The net expected trend is what Mr. Nimmer was talking about. It is a trend after benefit design changes or adjustments because of changes we anticipate in utilization.

Assemblyman Aizley:
Do the trend lines on the graph on page 10 of Exhibit C depict usage or do they depict costs? Is this a per person claim or the dollars spent on the claims?

Ms. Donaldson:
These are actual claims paid from the plan.

Assemblyman Aizley:
So these are dollars?

Ms. Donaldson:
That is correct. Dollars divided by the number of people. It is per employee, per month claim, per person.

Mr. Nimmer:
This is the change in dollars from one year to the next. If you spent $100 this year, then $130 next year, the result would be the 30 percent as noted on this graph. Relative to our other experience across the Country, the experience is not abnormal. The volatility is a bit more exaggerated than what we typically observe. However, when you have a long plan year and you do not reset the deductible, it makes sense that trends will be higher. The plan is paying for that additional deductible where a participant would normally pay that amount. Therefore, we would expect plan costs to increase during that time period. The opposite phenomenon is also true when you have a short plan year. You have less time to accrue benefits after the deductible is paid. You would expect the plan to observe a lower experience, hence the green line falls very quickly. We expected volatility during this time period. However, the rate of the variance from one year to the next was greater than expected.

Assemblyman Eisen:
Is it the dollars per employee compared one year to the percentage of changes?

Mr. Nimmer:
That is correct. Two major calculations are being illustrated. The green line on the graph would be the scenario I mentioned earlier. The blue line which is the smoothing line, is a much more complicated mathematical formula. Nonetheless, it imparts a smoothing method within the calculation. The red line represents what national trends were illustrated over the same time period, what we are seeing on a nationwide basis with other state plans and other employers across the Country. You are correct; it is observing costs from the current year over the prior year on a per employee basis.

Ms. Donaldson:
When you take the long- and short-term years, it was a total of 2 years, and you compare them to 2 years' experience nationally, Nevada was right in line with what was expected over that 2-year period nationally. You just saw more fluctuation over that 2-year period.

Page 11 of Exhibit C has a bar chart showing prescription drug plan trends. As Mr. Nimmer noted, particularly in FY 2008-2009, the drug trend in Nevada was higher than anticipated nationally.

Senator Denis:
There is a large drop from 16.1 percent to 2.6 percent in FY 2009-2010. What is that attributed to?

Ms. Donaldson:
The drop is due to the long- and short-plan years. If you take an average of those 2 years, it was around 9 percent, that is what we were seeing nationally.

Ms. Donaldson:
On page 12 of Exhibit C we are depicting what the trend has been in this plan moving forward since the start of the CDHP. Because of the nature of the plan, we actually combined the prescription drug and medical costs together, then graphed that out. You can see in FY 2010-2011 we expected a trend after adjusting for plan design changes of around 1 percent. It was a much lower trend than expected. For FY 2012-2013 we are anticipating an 8.75 percent trend. We just recommended to the Board of PEBP the use of an 8 percent trend. Therefore, we are anticipating a 0.75 percent drop trend from this fiscal year.

On page 13 of Exhibit C we are graphing what we saw on the dental trend. From a historical perspective, dental trends tend to be more stable. Nevada has experienced more volatility than we anticipated. Some of that is due to the long- and short-plan year. We did see a spike in utilization, right before moving into the CDHP. As we went into the CDHP, we saw a drop in trend. The interesting part with the CDHP is that people can now use their HSA or HRA funds to pay for dental care. Even though the HSA or HRA are associated with medical, it affects the trend for your dental plan.

Page 14 of Exhibit C shows a historical depiction of where the trend has been for the dental plan. We are anticipating for FY 2012-2013 a trend of 4 percent and then we drop 0.5 percent for FY 2013-2014. We have recommended a 3.5 percent trend.

Page 15 of Exhibit C shows a combination of medical, dental and prescription drug trends; and for FY 2013-2014, a combination of an 8 percent trend for medical and prescription drugs and 3.5 percent for dental. The recommended trend is 7.9 percent on a combined basis.

Mr. Wells:
Page 16 of Exhibit C shows the reserves by fiscal year. The program was created in the 1999 Legislature after there were some problems with the plan. The former certified public accountant did not pay claims appropriately which resulted in cash infusions being necessary in 1999 and again in 2002 through a special session of the Legislature. Therefore, for FY 2002-2003 the light red bars on the graph are higher than the darker red bars. This reflects we did not have a solvent plan and were on the verge of insolvency. The 2005 Legislature allowed the creation of the Catastrophic Reserve to ensure that a cash infusion would never be necessary again. So far, it has not. We hope it never will. We also try not to gain too much in reserves.

The green bar showing FY 2006-2007 is where the excess reserves were higher than what we had anticipated, even with the Catastrophic Reserve. We plan to spend those down. Premium holidays started the decline in excess reserve trends that you see in FY 2008-2009. Then you get into the long and short plan years in 2009 and 2010, along with building rates for FY 2010-2011, without knowing the impact of the plan design changes coming out of the 2009 Legislature which

caused higher reserves than anticipated. Also, when working through the HDHP, we projected some costs that did not come out as high as we originally thought.

Page 17 describes a return of those excess reserves to the participants in FY 2012-2013. In March 2013, for the plan year that started in July 2012, the Board approved mitigating the rate. We did not increase the rates as much as was recommended by both actuaries for the self-funded plan, and the underwriters for the fully insured HMO products. We mitigated by 50 percent, the amount of the increase that was anticipated by those two or three entities. That used about $6.9 million of the excess reserves. For the CDHP, we added one-time contributions to the HSA and HRA accounts. Those contributions were as follows: $400 for each primary participant, $100 for each dependent up to a maximum of 3 dependents and $200 for each primary over the age of 45, if they were an active employee, or with over 20 years of service, if they were a retiree. The Board then set aside some money to provide a similar one-time contribution to the Medicare retirees. The way that portion of our Session bill was written, we could not infuse it directly, but we did set aside the money to include it in our budget for placing those funds into their accounts in July 2013. The Board also chose to subsidize domestic partners in the same manner that it does for a spouse. That was approximately another $500,000 in utilization of those excess reserves. Of the $29.4 million that was projected to be available as of June 30, 2012, the Board used $23.1 million. They retained $6.3 million of that to mitigate rates in the upcoming plan year.

Assemblyman Aizley:
For FY 2012-2013, is the contribution to active employees roughly $733 per person and for retirees is it roughly $472?

Mr. Wells:
Yes, those are the numbers and we will address those later in the presentation.

Page 19 of Exhibit C shows the projected 2 years for the Governor's recommended budget in a bar chart of total operating costs and total reserves. Our FY 2011-2012 actual costs were $422.6 million. Of that, $293.7 million was spent for operating costs. That includes claims, administration and agency operations, and we had $128.9 million in reserves at the end of the year. In FY 2012-2013, the approved budget was anticipated to be $420 million in

expenditures for operating and $108.4 in reserves. We are projecting $352.3 million in expenses and about $108.7 million in reserves for FY 2012-2013. Our reserves are in line with what we anticipated. The approved numbers for FY 2012-2013 included about 3,400 more enrollees anticipated than what we actually have. The reserves will become smaller over the 2014-2015 biennium which is a reflection of spending down the excess reserves.

Page 20 of Exhibit C is a pictorial view of how we establish our budget for the biennium. We start with projecting our costs based on our projected medical inflation, changes in enrollment, utilization projections and costs associated with health care reform. Some of these are from the last biennium, including the elimination of lifetime and wellness caps. The former $2 million lifetime cap is no longer allowable under health care reform. It includes covering adult children, up to age 26, with potential shifts as the rest of health care reform becomes implemented. Programs like the Medicaid expansion pass more costs on to plans such as ours. Based on those costs, the funding breakdown is calculated using the State versus non-State enrollment projections. The subsidy allocation is then broken down between employees and retirees based on projected enrollment. These subsidies are the amounts that are entered for active employee and retirees, and make up the State subsidy portion.

Also on page 20 are the employee and retiree contributions, the non-State employer payments, drug rebates and the reserves that we carryforward to the next year. That is how we fund the program. There is the retiree subsidy, and the active subsidy. The retiree subsidy, B/A 680-1368, is funded on an assessment of State employee payroll. A percentage of payroll goes into that account to make up the approximately $77.1 million. That percentage depends on the number of payroll deductions approved by the Legislature during this Session.

PEBP - Retired Employee Group Insurance — Budget Page PEBP-20 (Volume III)
Budget Account 680-1368

We divide fixed dollar amounts that we know we need into the State's salaries to find a percentage that is then assessed against payroll for all the State agencies including the Nevada System of Higher Education (NSHE), PERS, the Legislative Counsel Bureau staff, and others. Money comes out of that budget account on a per employee, per month basis. We estimate that amount for both

Medicare retirees, as well as for non-Medicare retirees, based on how our anticipated rates look to be for the plan and the tier selections of the enrollment.

The active employee subsidy of $435.8 million is put in on a per employee, per month basis. A flat dollar amount is assessed against each position that is filled. That money is put into the active employee group insurance budget account, B/A 666-1390. We then disburse money based on the plan and tier a participant selected.

Regarding Assemblyman Aizley's comments, in FY 2012-2013, the amount that is put into the active employee group insurance budget account is $733.64 per employee, per month. Approximately 2.69 percent of payroll is put into the retired employee group insurance account. The amounts coming out vary based on the plan and tier selection.

PEBP - Active Employees Group Insurance — Budget Page PEBP-24 (Volume III)
Budget Account 666-1390

Assemblyman Aizley:
I will make a full disclosure. I am a Medicare retiree. I worked for the University of Nevada, Las Vegas, for 40 years. I have the maximum rate of subsidy as a Medicare retiree, but there are probably 10,000 more retirees. I am not being treated any differently than those individuals. I am speaking on their behalf. If the average payment for Medicare retirees is $171 per person, where is the other $300 going?

Mr. Wells:
We will answer that later in the presentation.

Page 21 of Exhibit C shows the Governor's recommended funding by decision unit. The primary component of our funding is a 55 percent State subsidy. That is up from 50 percent last year. This does not reflect that we are asking for a significant increase in State funding because there are fewer non-State enrollees. The State subsidy is becoming a larger percentage of a smaller pool. It is not that we are asking for more money, it is that our pool has become smaller. You are seeing the State share is a larger share. The 24 percent "Contributions" category on that page reflects employee and retiree contributions, as well as non-State employer

contributions. The "All Other" component is comprised of the retiree drug subsidies and drug rebates. The "Carryforward" component is the amount we anticipate being carried forward to fund the liability for the reserves that were calculated as of the end of the year.

Page 22 of Exhibit C shows the expenditures by decision unit for the 2013-2015 biennium budget totaling $939.5 million for the biennium. Forty-two percent of that funding will be expended on claims, with another 9 percent for the HSA and HRA contributions, totaling 51 percent for the self-funded claims portions of our program.

Self-funded Administration, or the "S/F Admin" section, represents the third-party administrator, pharmacy benefit manager, our leasing of networks to obtain discounts, etc. The "Fully Insured" category represents the HMO, our life insurance, as well as our long-term disability plan. The "Reserves" section represents the IBNR Reserve, the Catastrophic Reserve to insure financial stability of the plan, and the HRA liability funds for amounts that we have promised to people but they have not yet spent. The excess reserves, by the end of the biennium, are expected to be reduced to zero.

Page 23 of Exhibit C shows a list of maintenance units for FY 2014-2015.

Page 24 of Exhibit C is a list of enhancement units. Enhancement unit E-225 is for a data analytics project we are working on to provide better reporting tools for us to manage our populations. We receive some reports now, however, this data analytics is intended to give us a much broader range of reporting and data manipulation ability. This is being done through our actuarial consultants, taking data that we have been compiling and producing reports that are scheduled to start sometime this spring or summer.

E-225 Efficient and Responsive State Government — Page PEBP-15

Enhancement unit E-227 will be used for training which is necessary due to the significant turnover in executive staff. Three of our six executive staff members have only been here since last January. This decision unit will provide some training to get staff up to speed in the benefits arena.

E-227 Efficient and Responsive State Government — Page PEBP-15

Enhancement unit E-670 represents the Governor's recommended payroll reductions.

E-670 Reduce Salary for 2013-2015 Biennium — Page PEBP-16

Enhancement unit E-710 replaces our information technology equipment on a normal rotation basis.

E-710 Equipment Replacement – Page PEBP 17

Enhancement unit E-804 funds cost allocations for services provided by the Division of Human Resource Management. This change became effective December 1, 2012. We will not pay any assessment for FY 2012-2013, because they are doing it for us. In FY 2014-2015, the PEBP will begin the reimbursement through this assessment.

E-804 Cost Allocation — Page PEBP-17

Page 25 of Exhibit C shows reserves that are recommended in the Executive Budget. The FY 2011-2012 actual and the FY 2012-2013 budget numbers are the latest budgetary figures. The original legislatively approved budget for the current biennium included significantly higher Catastrophic Reserve funds for both FY 2011-2012 and FY 2012-2013. In FY 2011-2012, our projected Catastrophic Reserve was $34.9 million. The final figure was actually $26.8 million. In FY 2012-2013, the Catastrophic Reserve was projected to be $37.9 million, but was actually $27.8 million. The original calculations for those reserves were based on some of the volatility that we previously discussed. As we collect better data, we have been able to lower those Catastrophic Reserve requirements to make sure that the plan is fully funded and fully solvent.

Chair Woodhouse:
Did you have large dollar claims that caused that volatility to happen, or was the previous estimate too conservative?

Mr. Wells:
It was primarily the result of some of the conservatism built in around the volatility.

Mr. Nimmer:
There are two major components that go into the calculations for the Catastrophic Reserve Fund. For review, the Catastrophic Reserve was created to ensure confidence that the plan can pay its costs in the coming year. As Mr. Wells pointed out earlier, 8 or 9 years ago the PEBP had to go back to the Legislature for additional State appropriations which is what the Board wanted to avoid in the future. As a result, the Catastrophic Reserve Fund was set aside. The reserves provided the confidence levels that the PEBP could cover our costs in the coming year.

The calculation has two major variables that are taken into consideration. One would be the prior year's claims costs. Any large claim would be taken into consideration. The second variable is volatility. The more volatile a plan, the greater that reserve must be to cover any spikes in claims experienced in future years. As the plan begins to stabilize itself and volatility decreases, that piece of the calculation also decreases. Hence, the smaller reserve.

Mr. Wells:
The excess is currently projected at $30.6 million for the end of June 30, 2013, which is reduced to $10.5 million in FY 2013-2014, and then reduced entirely in FY 2014-2015.

Page 26 of Exhibit C shows medical and prescription drug plan trend observations going forward that create decision unit M-101. We have had only minor plan design changes in FY 2012-2013 and FY 2013-2014, which is the result of a more steady increase in our medical trend. In addition, our population continues to age slightly as we move forward. We did see a significant reduction in the average age in 2011, when we implemented the Silver State Health Insurance Exchange (SSHIX). We also saw a big reduction in our average years of service at that time which is now starting to creep back up again. That will increase our trend. There is some small impact for the ACA that is built in for FY 2013-2014 and FY 2014-2015. There is the population makeup that is included in our non-State trend. The non-State pool is a retiree-only pool. There are about 65 non-State employees left in the non-State pool, and there are approximately 4,000 non-State retirees. That

population makeup affects the non-State pool specifically. Lower prescription drug claims associated with moving the Medicare retirees causes a significant decrease in our per enrollment, per month costs for drugs. Those claims have a mitigating trend as well because they are combined in the deductible with the medical.

Page 27 of Exhibit C describes the M-101 decision unit and shows the inflation estimates that were used in preparing the budget. The chart shows growth associated with inflation and utilization increases based on historical information and actuarial projections provided by AON Hewitt for the self-funded medical, prescription drug, and dental programs. The increases are based on actuarial trend projections, historical inflation and contract maximum increase provisions. The crossed out lines represent updated information.

AON Hewitt has adjusted some of their details downward. Originally, they provided us with a 9 percent inflation figure for FY 2013-2014 and an 8.75 percent figure for medical and prescription drugs. In FY 2014-2015, they adjusted both of those down to 8 percent. AON Hewitt originally projected 4.5 percent inflation for dental for the 2 years of the biennium and have subsequently decreased that to 3.5 percent. The calculations for the HMO premiums were originally 8 percent in FY 2013-2014. We have received most of the information we need for the HMO carriers to set rates for FY 2013-2014. We believe that this inflation number is going to be much closer to 7.25 percent rather than 8 percent.

The Life Insurance and Long-Term Disability (LTD) premiums went to bid. We have received responses for that particular contract which expires on June 30, 2013. We are nearly through the vendor selection process. Life Insurance went down from 10 percent to zero percent. Therefore, we are looking at flat Life Insurance costs for the next biennium.

The LTD, on the other hand, has gone up from 10 percent in FY 2013-2014 to 15 percent, and from 10 percent in FY 2014-2015 to 11.9 percent, an increase in the next biennium.

Chair Woodhouse:
In light of this, will you be providing an amendment to the Governor's recommended budget?

Mr. Wells:
Yes. After the rates are finalized, we will be working over the next month, or so, to put together rates for Board approval on March 21. As we finalize that rate information, we will be putting together a formal amendment to the Department of Administration, Budget Division to address the FY 2013-2014 actual costs, including the impact of the FY 2013-2014 actuals on the FY 2014-2015 projection numbers.

Assemblyman Aizley:
The terminology here is not clear. Why has PEBP's actuary projected only a small decrease in medical and prescription trend for the upcoming biennium, if the HDHP has driven down claims costs in the current biennium? Explain how utilization is added to the core medical inflation rate to come up with the recommended inflationary adjustments. Should these numbers be going in the other direction? There seem to be many factors involved and I do not understand how they all come together. Some of the terminology is not clear, including the word "trend." "Trend," to me, represents a change over time, yet you are showing it here as a number. I am not comfortable with what we are doing here. Could you explain this a little more clearly?

Mr. Wells:
I will attempt to explain "trend," which is an actuarial term. It has taken me awhile to understand the term as well. Trend means medical inflation, the cost increase of medical procedures as well as utilization. Utilization and rate make up trend. The numbers that you see here, especially for medical, prescription drug and dental, are more the "price inflation" component of trend. Over the next few weeks, the actuaries will be looking at our utilization to determine if the 8 percent "cost inflation" factor needs to be adjusted up or down based on utilization of our specific population. We anticipate that utilization changes will drive that 8 percent number down. That is one of the reasons that we have not yet submitted a budget amendment. We are waiting to get the utilization component to go along with the lower cost inflation component to give us the total trend increase for next year.

Chair Woodhouse:
That is a better explanation, but we may not be there yet.

Assemblyman Eisen:
The numbers on page 27 of Exhibit C are the changes in rates, combined with the changes in utilization, to come up with the total numbers. Are these numbers the same information represented in the graph on page 9 of Exhibit C?

Mr. Nimmer:
Let me attempt to translate how a rate is calculated. In order to calculate a rate, we take the current year rate and multiply that times a factor in order to get next year's rate. The trend rate is a combination of everything that goes into the medical costs from one year to the next. In a year when the reserves are increasing, mathematically that means we have more money than we need in premiums, and end up with reserves building up on the side. If trend were 10 percent and our reserves were increasing, the premium rate the following year would be less. Let us call it 8 percent for illustrative purposes. What we are illustrating on page 9, as well as on page 27 of Exhibit C, is the change of the medical costs from one year to the next, or the inflation. Similar to the Consumer Price Index (CPI) or another index. We are just categorizing this as medical, prescription drug, dental, etc.

Numerous variables go into trends. The first variable is utilization. The second variable is the unit costs, meaning the costs for an office visit. If it costs $100 one year, and $105 the next year, the unit cost for that service has changed by 5 percent. The next variable would be the component tied to technology, and new services that come online. An example would be medical costs tend to be fairly inelastic, meaning if there is a procedure that is available to make you healthy, you will pay a premium to get better. We view our health as an inelastic benefit. It is not like purchasing an option on a car, we want to be healthy, and we want to stay alive. As a result, when new drugs go on the market and your child is sick, you want the best possible treatment for that child or for yourself. This means the technology, or the ability to take a new option in terms of your health care, requires you to pay that additional premium. If you think about services that are available today that were not available 5, 10, or 20 years ago, they cost more. Research and development goes into new technology and additional costs in training doctors to teach them the new services which is another component. When you combine many of these variables together, that is the overall medical inflation. When you hear about medical inflation in the news, they are combining all of those elements together, aggregating them, and saying the cost of medical services are increasing by 8 percent or 10 percent a year. However, when you look

at our CPI, it is a fraction of that amount. Therefore, the overall budget for health care is increasing much faster than the rest of the goods and services across the Country.

Assemblyman Eisen:
Do we understand why your projections were so far off and have you fixed that?

Mr. Wells:
We will answer that when we talk about out enrollment projections.

Assemblywoman Flores:
All of this sounds scientific, precise, and complicated. Why were our numbers so far off, if this is so incredibly accurate and precise and we have all this data? In addition, we see a decrease in all of these items except for the HMO premium for FY 2014-2015. If we are looking at a decrease to 7.25 percent, why are we estimating 12.5 percent in FY 2014-2015? If we were going out to bid, would it not put us at a disadvantage to project 12.5 percent? What is the incentive for anyone to give us a lower rate?

Mr. Wells:
These projections are very complicated, but certainly not precise. We are always estimating and we are always going to be wrong. The only question is, which direction and by how much. There are a lot of moving parts in our plan that may, or may not, factor into what happens after a given Legislative Session closes. We now know that the calculations for FY 2010-2011 were inaccurate. We are never going to know exactly why the projections were inaccurate. We had the volatility that we talked about coming in FY 2009-2010 and FY 2010-2011; some of that was factored into our rate-setting process for the 2011 Legislative Session.

The long- and short-plan year had an impact. There is a misconception that the excess reserves we had in FY 2011-2012 were completely generated by the move to the CDHP. That is not a true statement. That the reserves were not used as quickly is a true statement. However, if you look back at some of the reserves, you will see that they were high for several years. The long-plan year resulted in costs that were in excess because there was no deductible reset. The plan paid out costs in that long-plan year that it would not have paid out ordinarily.

The long-plan year was a result of massive changes to the PEBP that were proposed in the Governor's recommended budget. The Board approved extending the plan year rather than trying to set rates during that volatile process, not knowing what the outcome of the 2009 Legislative Session would be. Therefore, they extended the plan year for that 4-month period from July 1 to October 31, 2009. That extension cost the plan nearly $20 million. The excess cost of $20 million had to be built into the rates for the short-plan year. We did not know what the loss was going to be at the time we were preparing the rate for the short-plan year, so there was an estimate as to what that loss would be. I believe that the estimated loss was closer to $25 million or $26 million. As such, they built in an extra $6 million into that short-plan year rate in 2009-2010 that they did not need after they found out the results of the long-plan year.

In addition, there were some plan design changes that were put in place in 2009 after the Legislative Session. Previously, we had two deductible self-funded plans: a high deductible and a low deductible which were merged together. We then had to set rates for FY 2010-2011, basically 2 months after that short-plan year started. We did not know the impact of the plan design changes on the utilization patterns of our participants and the overall costs to the plan. We were setting rates for FY 2010-2011 based on some assumptions. We now know the short-plan year FY 2009-2010 rates were set too high because we overestimated the costs of the long-plan year. Also, we underestimated the impact of the plan design changes on the utilization patterns of our participants going into FY 2010-2011. Our FY 2010-2011 rates ended up being set too high. Many of the reserves we have today were built during that period.

The Governor's Office told the Board to set rates with a flat subsidy amount for the next biennium and we were still working off data that ended up being inaccurate. We knew we were going to be short without significant increases in the contributions of our employees and retirees. We made some misassumptions as to what the HDHP would save us, and what putting our Medicare retirees into the SSHIX would save us as a plan. Now we know some of the utilization patterns. Page 12 of Exhibit C shows we were anticipating a 1.2 percent net trend for FY 2011-2012 after adjusting for the utilization patterns in our HDHP. The actual experience was minus 21.2 percent.

Overall, the utilization patterns were significantly off from what was projected. We are now working off a year and a half of the same plan design. We are seeing less volatility in the usage patterns of our participants. We are hoping that moving forward, our volatility and these percentage volatilities will get much closer. That 8 percent figure is the cost inflation. The technology component will be adjusted based on our utilization patterns. It will most likely be significantly less than the 8 percent.

Assemblywoman Flores:
Given everything you just said, which indicates to me we are trending down, why are you projecting 12.5 percent?

Mr. Wells:
The HMO premiums, life insurance and LTD are fully insured products. The other pieces are self-funded. The self-funded components come from that whole litany of things I just discussed. The HMOs and the life insurance and LTD are fully insured products and we acquire rates from the insurance companies that sell us those products. Each year they give us a rate renewal card and this is what it is. These are the rates for next year. We have 4-year contracts for our HMO and our life insurance and LTD carriers. We are currently in the middle of 4-year contracts with the HMOs. We require the HMOs to provide a maximum rate. They cannot exceed a threshold from their premium increases from one year to the next. The rates range from 10 to 12.5 percent. They are higher the further into that 4-year contract you go. It does not mean that the rates will come in at 12.5 percent inflation, but it allows them up to 12.5 percent. One of our HMOs, 3 years ago, came in with a significantly bad year and wanted a 29 percent increase from 1 year to the next. They ended up changing the plan design of that HMO and they did many things to get that inflation number down.

The 7.25 percent that you see in FY 2013-2014 may not be final, but we have at least initial proposals from the two HMO carriers for the rates for the plan year that starts July 1, 2013. The 12.5 percent in FY 2014-2015 is the maximum rate caps in those two contracts. We do not know what the FY 2014-2015 rates will be yet, but those are the contractual caps in the contracts with the two HMO carriers.

Assemblywoman Flores:
Do we set the maximum cap?

Mr. Wells:
The maximum is negotiated as part of the Request for Proposal (RFP) response process.

Assemblywoman Flores:
If the actual cost for HMO increased by 7.5 percent in FY 2011-2012, and we projected our growth at 6.4 percent in FY 2012-2013, why are we negotiating ourselves to this 12.5 percent maximum? There is no incentive for them to come in any lower than that. Perhaps I do not understand the process entirely. We have data from the last several fiscal cycles and we have declines in all of these other areas. We are putting ourselves at a disadvantage by budgeting that 12.5 percent.

Mr. Wells:
We are experience-rated at both the HMOs. Our HMOs set their rates for us based on their experience with our participants. We are not pooled with all the participants for their book of business. The budgeted maximum you see is not necessarily indicative of what we would accept. When they submit rate proposals, we also require them to provide information that backs up the increase they are requesting. If they wanted a 12 percent cap increase, they would need to provide documentation that supports a 12.5 percent-rate inflation on their HMO. We do not just automatically agree to a 12.5 percent increase.

This year, for the first time, we are having our actuaries look at the additional data that is provided to substantiate their 7.25 percent inflation rate to ensure the 7.25 percent is accurate given the utilization patterns of our participants. We budget at the cap only because we have had experience in the past with being at, or above, the cap. We do not just accept that cap automatically.

Senator Denis:
Our HMO rates are based on our usage, therefore, if we want to reduce this amount in the future, we need to get our participants to be healthier. Since we combined the two HMOs, the north and the south, how has that affected these rates?

Mr. Wells:
The first year we projected enrollment in the north and south to come up with that composite rate, we had an influx of people in the north, but not as many as we had

projected. In FY 2010-2011 we projected a relatively significant number would leave the CDHP, the HDHP and go to the HMOs. We saw that migration in the north; we did not see the same migration in the south. The rate blending was low in the first year. We have adjusted that for inflation. We saw more stability in the enrollment in plan year 2013. Now that we have a stable pattern of north versus south participants, the blending of premiums in the north and south is more accurate.

Senator Denis:
Did you lose many participants in the south due to the high rate increases?

Mr. Wells:
We did not lose as many people from the south, though we anticipated a migration from the south. We also had a positive enrollment in the 2011 plan year. If a person did not submit an enrollment form, he or she defaulted to the HDHP. A group of HMO participants defaulted in 2012, but those people almost all moved back. There was a migration pattern moving back into the HMO. We did not see a massive migration from the Health Plan of Nevada HMO in the south, despite the increase in the rates.

Senator Denis:
With the blending of the two rates, the rates have stabilized. Has it been a good thing for the participants or is there still a discrepancy between what they pay in the north versus what they pay in the south?

Mr. Wells:
The participant pays the same amount regardless of whether they are in the north or south. From an inflation perspective, that 7.25 percent is a combined inflation percentage based on the two renewal pieces. The north is slightly higher in its inflation percentage for the upcoming year. It is coming off a higher base, so the starting dollar amount in the north will be higher.

Senator Denis:
What have we seen since then by comparing rates they were paying previously to today? The concern we had back then was that the south was going to see an increase in rates. Have those rates dropped back to where they were or are they still at the higher level?

Mr. Wells:
Rates have not fallen to the original levels. They are staying flat. All of our HMO costs are continuing to go up. We have yet to see negative inflation in any of our fully insured products. Life insurance has the first flat fully insured premium change that we have seen in some time.

Assemblywoman Flores:
Are we giving a signal to our HMO vendor that they can increase our rates by providing this projection of 12.5 percent?

Mr. Wells:
I can guarantee you that they cannot increase their rates to 12.5 percent without justification to support it.

Page 28 of Exhibit C shows maintenance unit M-102 reserve adjustments in B/A 625-1338. These adjustments account for changes to the IBNR in Catastrophic Reserve amounts that are actuarially set.

M-102 Agency Specific Inflation — Page PEBP-12

Decision unit M-103 requires a proposed contribution increase of $1 per month, per year of service, in the next biennium for those Medicare retirees who are in the Medicare Exchange. It would increase their base amount to $11. That is based on inflation from projected increases in the Medicare Advantage, Medicare Supplement and Medicare prescription drug plans. The cost is about $2 million in each year of the next biennium.

M-103 Agency Specific Inflation — Page PEBP-13

It does not include the one-time $2 per-month charge that is in decision unit E-275.

E-275 Educated and Healthy Citizenry — Page PEBP-16

Page 29 of Exhibit C shows enrollment projections for FY 2013-2014 and FY 2014-2015 as well as the actual for FY 2011-2012 and projected FY 2012-2013. We have been projecting enrollment for a long time based on historical trends. We looked at the last 4 years and where we are moving over the

next biennium. April 2009 was our peak enrollment month, with 44,300 participants. We have declined by 9 percent since. State employment peaked at 26,530 in June 2008 and has decreased ever since. That trend has bottomed out. According to the Department of Administration, there could be slight increases in the number of State employees in the next biennium.

The State enrollee population also includes the NSHE. The NSHE has not hired as many full-time employees, resulting in a flattening of our enrollment. We do not anticipate an increase of NSHE employees in the next biennium. Our FY 2010-2011 projections were too high. Some have migrated out, some of the non-State population has left for other reasons. Their rates are getting expensive quickly. They are able to find other, less expensive, coverage either through their former employer or through some other means. The non-State reduction is about 1,800 people over the next biennium, whereas there is a slight increase on the State enrollment side. The non-State population has become a lot harder for us to gauge from one year to the next, due to the volatility and the increases in those rates.

Those numbers were used to calculate the decision unit M-200 on page 30 of Exhibit C. Our enrollment projections from the Base Budget indicate decreases of $10.2 million in FY 2013-2014 or $16 million in FY 2014-2015. That reflects that adjustment from what we thought we would have, down to what is actual. These numbers are better than they were 2 years ago. We do not know the impact of the non-State population, or whether they will stay. We might start seeing increases in our population again, but at this time that is unknown. We try to do the best we can with the enrollment population, adjusting things that we know are going to happen and anticipate what is going to happen.

M-200 Demographics/Caseload Changes — Page PEBP-13

Assemblyman Eisen:
What are we doing to communicate with those non-State entities whose employees or retirees may be part of this pool, and with State agencies about their projections for position changes, increases, or decreases, so that we can get a more accurate projection on the State side? I want to ensure that we are doing everything we can to make our projections as accurate as possible. I understand we had fewer State employees. That was a big piece of this, we had substantial

cuts, we had positions that were eliminated, and we had people that left the system. I am hoping things are going in the other direction, but those kinds of things may happen again. There will be substantial changes in those employment numbers, but those were happening at the time these budgets were being closed in the last Session. What are we doing to make sure that we do not miss those numbers again?

Mr. Wells:
We talked to the Department of Administration before we finalized our submission for the Governor's recommended budget to see what they were recommending as far as positions, and whether they identified increases or decreases. We were told there might be increases in some places, but they are not going to be significant. Therefore, we left the State employee projection flat. The non-State side is very complicated and I do not know if we should go into it in detail. In 2003, the Legislature allowed non-participating, non-State retirees to join the non-State pool. At the time, there were 2,400 non-State employees and about 2,400 non-State retirees in that non-State pool. Most non-State entities do not provide subsidized retiree health care. The 2003 Legislature directed that if a retiree joined the PEBP, the State would subsidize that retiree in the same manner the State subsidizes its current retirees. We started seeing an influx of retirees and it became expensive for the non-State employees because they were subsidizing the more expensive non-State, non-Medicare retirees. As their rates went up, they were able, as employers, to find less expensive insurance for their employees and they left the plan. Our enrollment of retirees kept going up and our enrollment of active employees started going down. Subsequently, in 2007, the Legislature closed the pool to new non-State retirees effective November 2008. In 2008, there was a spike in the number of people near retirement who took advantage of this subsidized retiree health care. It got very expensive. Those rates went up, in some cases, as much as 20 percent a year.

The *Nevada Revised Statutes* provides that every other year, in even years, a retiree can re-enroll in their prior employer's plan. We contacted all retirees at the end of 2011 advising them they might want to contact their previous employers to see if they qualified for a less expensive health care option. We anticipate that by 2018 the non-State, non-Medicare population will be nearly gone. We are seeing that slow matriculation. Those factors are built into our enrollment projections.

Page 30 of Exhibit C describes decision unit M-501. The first part of that is the cost of the Comparative Effectiveness Research Fee. It starts in FY 2012-2013 at $1 per person, per year. That includes every participant, including dependents. New information indicates payments might not be due until 2015 because health care reform regulations are not yet finalized. It also does not include the potential for a transitional re-insurance fee. The regulations are not finalized. While it has been initially set at $65 for the first plan year, it could be as much as another $60 to $80. That 3-year fee would decrease in each year. This was not built into decision unit M-501. When we have more solid information, we will submit a budget amendment to the Governor's Office.

M-501 Mandates — Page PEBP-14

Page 31 of Exhibit C describes decision unit E-225. The data analytics included in the decision unit will provide a mechanism to obtain reports, analysis and benchmarking capabilities, by having our vendors share data and allow the staff and its actuarial consultants to utilize that data and meet the number of requests for reporting. We also intend to use that data to change, or implement, a number of new performance measures that are centered on health care, as opposed to some of the current performance metrics that we use.

E-225 Efficient and Responsive State Government — Page PEBP-15

Assemblywoman Flores:
Is there a reason you did not go out to bid on this? Was it just time efficiency?

Mr. Wells:
There were two reasons: one was time efficiency; the second was that our actuarial consultants were used to working with this data already. So it was not a change in the scope of their contract, it was an increase. It is a service that we have not traditionally purchased from them. It was included in their RFP response and the contract negotiations. Their contract goes out to bid on a recurring cycle. It will be included in future RFPs.

Page 31 of Exhibit C describes the one-time HRA contribution in decision unit E-275. The request is to use excess reserves from FY 2011-2012 to pay

$2 per month, per year of service contribution, to the HRAs for Medicare retirees. The estimated cost of $3.9 million is for the first year of the biennium only.

E-275 Educated and Healthy Citizenry — Page PEBP-16

Decision unit E-710 on page 31 of Exhibit C is for replacement equipment and includes upgrading of our current servers, personal computers, switches, etc., on their normal rotation cycle.

E-710 Equipment Replacement — Page PEBP-17

Page 33 of Exhibit C is an overview of the CDHP for FY 2013-2014. The CDHP plan meets the IRS definition of an HDHP, meaning all medical, pharmacy and vision expenses are subject to, and accumulate toward, a single deductible. There is not a separate pharmacy deductible, and participants who are enrolled in the CDHP do not have copayments for doctors' visits or prescription drugs. They do receive discounts for utilizing preferred networks. The participants only coverage has a $1,900 deductible and a $3,900 out-of-pocket maximum. Participants with families have individual family member deductibles of $2,500 which is up from $2,400 in the current fiscal year.

The out-of-pocket maximum has been increased to $7,800 per family. These are now true out-of-pocket maximums, as opposed to the former PPO plan, where the out-of-pocket maximum did not include copayments, nor did it include drug copayments. Out-of-pocket on the former plan included a deductible with an out-of-pocket maximum, and copayments, so it was not necessarily a true out-of-pocket maximum. This is now a true out-of-pocket maximum. Once a participant reaches $3,900, or a family reaches $7,800, the plan covers 100 percent. Between the deductible and the out-of-pocket maximum, the plan covers 75 percent. The participant is responsible for 25 percent.

In order to help participants with some of the out-of-pocket costs, the Board voted to fund the HSAs and HRAs in the amount of $700 for each primary participant, as well as $200 for each dependent on family coverage up to a maximum of 3 dependents, or $1,300 for the family. This does not include the one-time additional contributions that were established by the Board for plan year 2013. This is the base amount anticipated in the current and future plan years.

The chart on page 34 shows a comparison of medical claims paid by age group. There are no comparisons for prescription drugs or dental in this chart. The average cost for our total participant base was $275 per member, per month. In 2012, a slight increase occurred to $283 per member, per month. The chart shows the FY 2010-2011 percent of average, and the FY 2011-2012 percent of average, or percentage of average dollar amount. For children under age 1, we pay $627 per member, per month. This is over twice what the average person was paid. Ages 1 through 49 are all negatives. We are paying out less than average for that population. For ages 50, and over, especially 50 to 64, the medical cost increases. For ages 65-plus, in FY 2010-2011, the medical cost was $197, or about 28 percent less than the $275 average for all of our participants. The reason for that was because in plan year 2011, we were still covering Medicare retirees on the PPO plan. That reflects Medicare Part A, hospitalization, which is the most expensive component of health care. The State and the participants pay for Part A, through deductions or payroll taxes throughout their working careers. When they obtain and start using Part A as a retiree over the age of 65, there is no charge to either the employer or the retiree.

In FY 2011-2012, they are now at 104.6 percent of average, or over twice the average participant's cost. That is the population of retirees who are not eligible for Part A because they started working for the State prior to 1986 and never paid into Medicare. Thus, a total of 1,000 individuals in total on our plan are not eligible for Part A through their employment with State government. As a result, they will stay on the PPO and they will have Part A as their primary insurer. There is a lower overall cost to the plan for those who have Medicare as their primary insurer, especially for hospitalization, where those claims are being paid by Medicare as a primary insurer and we are the secondary payer. That is the reason Medicare retirees have become significantly less expensive to insure.

Page 35 of Exhibit C contains a summary of plan costs and highly expensive claimants for plan years 2011 and 2012. Total costs decreased from $241.5 million in claims to $152.7 million. Overall, costs were decreased from an average of $646.07 per participant, per month, to $596.85 per participant, per month. If you look at the medical component, you will see it went up on a per participant, per month basis, from $452.84 to $485.74.

The prescription drug expense went down significantly from $141.48 to $69.49. This reflects that the Medicare retiree population has a significantly higher utilization of drugs. With those over age 65 participants being covered through the SSHIX, we are no longer paying for their prescription drugs. From a self-funded plan perspective, the per participant, per month fee decreased by over half.

We also included information on high-cost claimants. In plan year 2011, there were 260 claimants with individual claims over $40,000, totaling just over $23 million, for an average of $88,682 per claim. It takes 11.83 single participants with no claims for the entire year to pay for each one of those claims. In plan year 2012, there were 416 claims over $40,000 for a total of $54.5 million. The average claim went up to $131,083 in plan year 2012, thus requiring 17.92 individual participants with zero claims, including no dental, no medical, no office visits, and no wellness visits in order to pay for each one of those 416 claims. That we would have increased our large claim exposure by that much was an anomaly that I did not expect. That is a significant increase in the per-claim amount. Last year was the first year individuals could exceed the $2 million lifetime cap. A few people have exceeded the $2 million cap, and one exceeded $3 million. Therefore, you are seeing some significantly expensive claims. Most people who have costly claims like this have additional related claims that do not necessarily hit that $50,000 threshold.

Page 36 of Exhibit C explains the HSA. It is an interest bearing, or investment, account established by the employee. It is owned by the employee and it is portable if the employee leaves State employment. In addition to PEBPs contribution employees can have pretax payroll deductions deposited into their HSA. Unlike the flexible spending account, it does not have a use-or-lose provision and the entire amount can be carried over into perpetuity. An employee can deposit up to $3,250 or up to $6,450 for family coverage of two, or more, people.

This allows people to put aside money on a pretax basis to fund their out-of-pocket costs. If they put aside $100 per month on a pretax deduction from their paycheck it will cost less than $100 depending on his or her tax bracket. Then they can use those pretax funds to pay for out-of-pocket medical costs. Individuals with HSAs can use debit cards or checks can be written from the employees' personal accounts. The funds must be used for medical care, otherwise there will be

a penalty from the IRS, plus taxes paid on the amount the employee withdrew and did not use for paying medical-related claims.

Page 37 of Exhibit C shows the balances of our HSA accounts. As of December 31, 2012, there are 11,211 HSAs that have a total balance of $15.8 million, or an average of $1,411. Fifty-eight percent of our participants have over $1,000 in their HSAs.

Page 38 of Exhibit C shows withdrawals participants have made from their HSAs in FY 2011-2012 and for the first 6 months of FY 2012-2013. In FY 2011-2012, 29 participants withdrew over $1,000, yet 18 percent did not take out any money. Those individuals saved that money for future health care costs. In FY 2012-2013, 23 percent took out more than $1,000, but 24 percent did not withdraw any in that first 6-month period.

Page 39 of Exhibit C covers HRAs. These are slightly different from HSAs in that they are established on behalf of the individual, but they are owned by the plan. They can be used just like an HSA. The only thing it cannot be used for is to pay premiums, with the exception of Medicare retirees, where the HRAs can be used to pay for their premiums through the Medicare Exchange. The HSAs are regulated by the IRS. Participants cannot contribute to the HRA. They are not portable, so if individuals leave the plan that money reverts to the plan. However, they can be used for spouses, children or eligible dependents. The PEBP Board allows unlimited carryover of the HRA amounts for our participants who have HRA accounts. All of the payments, both our contributions to them, as well as their usage for medical related services, are tax exempt.

Page 40 of Exhibit C shows the average HRA balance information as of December 31, 2012, for individuals in the PPO plan or the CDHP. There are 99,045 accounts with total balances of $12 million, with an average balance of $1,211. Sixty-two percent of the accounts contain over $1,000 and 80 percent of them have over $500. These contributions to the HRA are the same contributions that we make to the HSA, which is $700 for the primary insured and $200 for each dependent up to a maximum of 3 dependents, plus the one-time contributions of $400 for the primary and an additional $100 for each dependent.

Page 41 of Exhibit C shows CDHP-HRA utilization information for FY 2011-2012 and FY 2012-2013. In FY 2011-2012, 21 percent of participants had greater than $500. In FY 2012, the maximum contribution to the HRA was $1,300. The 38 percent who did not spend any of their HRA funds in FY 2011-2012 carried those funds forward into FY 2013.

In FY 2012-2013 through December 31, 2012, 43 percent did not spend any of their HRA money and 1 percent spent over $2,000. That means they spent some of the money they carried over from the first year, because the maximum contributions in the second year do not exceed the $2,000.

Page 42 of Exhibit C shows the number of enrolled dependents from November 2009 to December 2012. A large drop occurred for plan year 2012. On July 1, 2011, the Board approved the removal of spouses and domestic partners who had other employer-based coverage. As a result of that provision, 2,700 spouses were removed. Those participants went to their employers for their health insurance coverage. A subsequent loss of employment was considered a qualifying event to come back to our plan. As long as they have other employer-based health care, they are not allowed to participate in our plan. If they are retirees, they can still be covered under our plan.

The ACA increased coverage for dependents up to age 26. We used to have a provision covering children up to age 24, as long as he or she was a full-time student. The ACA superseded that provision, so in July 2011, about 600 adult children were added back to our plan.

Page 43 of Exhibit C shows the enrollment of spouses and children. Total enrollment has been going down slightly over the same period. From November 2009 to December 2012, there was a decrease in ineligible spousal enrollment because they had other employer-based insurance. The Child category remained relatively stable, as we did not see a massive outflux of dependents as a result of implementing the HDHP and increasing premiums in FY 2011-2012.

Page 43 also shows dependents per primary participant. In plan year 2009, there were about 0.27 spouses for every primary participant. That number decreased in July 2011 to 0.22 and has remained between 0.20 and 0.22 since. The number of children per primary participant was 0.42 in FY 2008-2009 and has fluctuated

between 0.41 and 0.43, remaining relatively steady over that period. We saw a slight decline in our overall enrollment and a slight decline in our total dependent enrollment. As far as the percentage of children being on the plan, we are not seeing a massive shift of children being taken off our plan.

Page 44 of Exhibit C shows the move of retired eligible employees, who have Medicaid Part A, to the Medicare Exchange. The Medicare retirees have a variety of options through the exchange. The exchange offers Medicare Advantage and Medicare Supplemental Insurance (Medigap) plans. They are provided by recognized insurers, such as United Healthcare, Humana, AETNA, or Cigna. They are guaranteed issue and pricing when they move to the plan, regardless of their health status. The plan that they move to has the right to reset their rates annually. Some of them set rates on an age-rated basis, so premiums go up as participants get older. Some rates are set on an aggregate basis. Each plan rate goes up the same amount every year. It is a larger pool. Moving our Medicare retirees to the Medicare Exchange was a method of preserving health care for that population while reducing the costs for both our plan and the retirees. Many of the retirees that went to the Medicare Exchange probably were better off than they would have been under the CDHP or with the premium increases that they would have seen on the HMOs.

Page 45 of Exhibit C describes the Medicare Exchange. Medicare retirees are able to tailor their coverage to their lifestyle based on their health status, their provider preference, their geographic location, their prescription drug usage and their specific health needs. They can also tailor their coverage to different coverage for the primary insured versus the spouse. If you have a healthy participant and an unhealthy spouse, or vice versa, you can pick different plans that pay a higher percentage of your out-of-pocket costs to manage your costs. They also offer an HRA. There is unlimited rollover of unused HRA funds from one year to the next. There is a $50 per month, or $600 per year, minimum up to a maximum of $200 per month, or $2,400 per year. Those who retired prior to January 1, 1994, received a flat $150 per month to the Exchange HRA. They are also eligible to participate in our PEBP dental program on a voluntary basis. Approximately half of them chose the dental plan. They are also eligible for basic life insurance.

Page 46 of Exhibit C shows the initial transition group of retirees in July 2011 who went to the Medicare Exchange. There were 11,953 eligible members, including

both primary participants and dependents, of which 10,316 enrolled through the Medicare Exchange and 1,067 enrolled through the PEBP. For one reason or another, they were eligible to remain on the plan. Most of those had non-Medicare spouses who did not have Medicare and could not purchase coverage through the Exchange. Therefore, they had the option to stay on the PPO or HMO plan. There were 338 participants enrolled outside of the PEBP or the Extend Health plans of which 181 were found to be deceased and 51 were not located. Many of them had premium-free medical care, so there was no monthly payment coming in to us. Because they were not paying anything to us, we did not know that they were deceased, so those 51 people were removed from our rolls.

Approximately 3.3 percent were enrolled outside of the plan, or we were unable to locate. Many of those who enrolled outside of the plan were survivors who neither received a subsidy nor the HRA. There was no benefit to them to enroll directly through the Exchange. They could have enrolled through any option and would not have lost the life insurance, or their HRA, and so there was no impact to them not to enroll.

Page 47 of Exhibit C is a summary of the decisions and costs for retirees through September 30, 2012. To date, our participants have enrolled with 82 different carriers in 502 different plans. Approximately 28 percent of them enrolled in Medicare Advantage plans. A Medicare Advantage Plan is similar to an HMO plan in our scheme. The Medicare Supplement Plan is more aligned to the PPO plan and 72 percent enrolled in that plan. The average monthly premium for the Medicare Supplement is $152 and the average for the Medicare Advantage Plan is $21. Those are heavily subsidized by the federal government. For the Medicare Part D prescription drug program, the average premium was $30. Dental and vision coverage was optional and so you see much lower enrollment in those two components. If you look at the total costs for a Medicare participant enrolled in the Exchange with a Medicare supplement, approximately 85 percent of those participants enrolled in what is called a Plan F. Plan F covers everything that Medicare does not, including cost overages. There are almost no out-of-pocket costs for participants enrolled in Plan F. The average person pays approximately $316 a month to cover the Medicare Supplement, Medicare Advantage, Medicare Part B and Part D prescription drug and dental and vision premiums. Their HRA

contributions are about $170, on average. That is completely out-of-pocket. There is very little in the way of out-of-pocket costs, beyond the premiums for those supplemental plans.

Pages 48, 49, and 50 of Exhibit C show the top five carriers our participants selected, as well as the minimum, average, median and maximum rates for those particular products. On page 48, Medigap plans, the top five carriers are AARP, Anthem, United of Omaha, United World, and Humana. The average premium is $151.86, the minimum premium is $21.50, the maximum premium is $319 and the median is $148.32. You will see the same information for the Medicare prescription drug plans on page 49. Humana has the top enrollment for drug plan coverage at an average cost of $29.88. The minimum drug plan is $14.80 and the maximum on the prescription drug plan is $126.60. Not every person who enrolled in a Medigap plan enrolled in a drug plan, so there is about a 675-person difference. There is no requirement to enroll in a drug plan.

Page 50 of Exhibit C shows Medicare Advantage carrier decisions. Health Plan of Nevada, the Senior Dimensions; and Hometown Health, the Senior Care Plus, are the top providers on the Medicare Advantage side. The maximum cost is $205, with most people paying very little with an average premium of $21.20. The minimum is zero and the median is zero. There are several Medicare Advantage plans that do not have a premium. That is because they are subsidized by the federal government. Most Medicare Advantage plans include prescription drug coverage, or have an option to include a prescription plan.

Page 51 of Exhibit C shows Medicare HRA balances. As of December 31, 2012, there are 9,157 accounts with a total balance of $4.8 million and an average balance of $527. Fifty-seven percent have a balance greater than $1,000, but 21 percent have a balance less than $500. Because participants can use their HRA balances to pay for their Medicare Part B premium and dental premiums, they use it to pay their monthly premiums in many cases.

Page 52 of Exhibit C shows the usage for FY 2011-2012 and FY 2012-2013. In FY 2011-2012, 70 percent spent more than $1,000, 21 percent spent less than $500, and 11 percent spent zero. Twenty-eight percent of our population is enrolled in the Medicare Advantage plan. In FY 2012-2013, through December 31, 2012, 57 percent spent more than $1,000, while 7 percent spent

zero. The maximum contribution for the first 6 months of the plan year was $1,200, or $200 per month. Those who spent more than $1,200 were spending some of the money that they carried over from the previous year.

Page 53 of Exhibit C shows the other changes that were effective on July 1, 2011. The dental plan deductible was increased from $50 to $100 for an individual and from $150 to $300 for a family. The plan maximum was decreased from $1,500 to $1,000. We maintained four routine dental cleanings for FY 2011-2012. Those dental cleanings do not apply to the annual maximum benefit, so they are in addition to the $1,000. Initially in FY 2010-2011, they were included in the annual maximum benefit. Participants can also set aside money, in what is called a Limited Scope Flexible Spending Account, to pay for both dental and vision costs. Individuals can have that money in addition to their HSAs. There is an additional mechanism for setting aside some money in a flexible spending account, specifically for dental and vision. Effective July 1, 2011, the life insurance payout was reduced by 50 percent, from $20,000 to $10,000 for active employees, and from $10,000 to $5,000 for retirees. We eliminated the dependent life and the accidental death and dismemberment portions from the coverage.

Pages 54 and 55 of Exhibit C are an introduction to the NVision Health & Wellness Program, formerly known as the Live Well Be Well Program. When we entered into the agreement with the provider, the original projections were between 60 percent and 65 percent of our members would participate in the Wellness program during the biennium. Our numbers have been significantly below that. We started with 48 percent in FY 2010-2011, and dropped to 32 percent in FY 2011-2012. We will be at roughly the same percentage in FY 2012-2013.

In FY 2013-2014, the incentive to participate in NVision is a possible premium savings of up to $45 per month. For an individual, that meant they could have a zero dollar premium for their PPO plan. While we have some preliminary information indicating that our participants' health is improving, calculating a return on investment on the Wellness Program has proven elusive. It is difficult to attribute savings or reductions directly to participation in a Wellness Program. The NVision Program will increase incentives to participate in the program of up to a $50 premium savings per month. It also expands the availability to HMO participants effective July 1, 2013. The Board will take into account those incentives when it sets rates at the meeting on March 21, 2013.

We have two disease management programs. One is the diabetic care management program that offers a pre-annual check-up and lab work as well as copayments for drugs and supplies. This is an additional benefit not subject to the normal deductible of the HDHP. There are only about 721 of our members participating in the diabetic care management.

We also started an obesity care management program on July 1, 2012, for the current plan year. As of December 1, 2012, there are 152 people participating in that program. We will be providing a report to the Board this fall on the outcomes of that program for this fiscal year.

The NVision Health and Wellness Program is a 4-year program aimed at educating participants about their health and benefits. They will complete a health assessment questionnaire and obtain a biometric screening. There are also individual tutorials for each HMO and PPO describing how the plans operate. The tutorial contains information on how the HSAs, deductibles and coinsurance work. It is a comprehensive look at our benefit plan.

Year two of the 4-year program focuses on exercise and activity; year three focuses on nutrition; and year four focuses on understanding results of those first three years. We pay for the biometric screening which includes screening for body mass index, blood pressure, triglycerides, cholesterol, glucose and nicotine for tobacco users. Starting in year two and beyond, participants are required to satisfy certain reductions or work with a physician to improve their health. If they have high blood pressure, they can still get the incentive as long as they are working with a physician to lower their blood pressure. There is also a requirement to get preventive screenings in order to receive the maximum incentive. The preventive screenings are included and covered at 100 percent by the plan. Participants can see their doctors for their annual physicals, see their dentists for their teeth cleanings, and the plan pays 100 percent of those costs.

Assemblyman Aizley:
Is there evidence of claims savings attributed to the Wellness Program? If so, is it measured?

Mr. Wells:
We have some anecdotal evidence that participants for 3 years have lowered their blood pressure, lowered their triglycerides, and lowered their glucose. Tying this back to specific claims has been difficult, which is one of the reasons we redesigned the Program. By doing those things included in the NVision Program over 4 years, participants will be doing everything they can to reduce their medical expenses. Right now that is the best we can ask for. Even the experts have found return on investment of a wellness program to be elusive.

Chair Woodhouse:
Did you to say there is about 30 percent involvement in the Program and you expect that to stay flat for the next biennium?

Mr. Wells:
The Program has been redesigned. It now includes HMO participants for the first time, so they will be eligible for incentives. We anticipate getting back to 60 percent, which is where we thought we would be in this Program. The incentive will be particularly attractive to HMO participants who pay a higher monthly premium.

Page 57 of Exhibit C shows the average State per participant, per month costs for FY 2011-2012 and the FY 2012-2013 and FY 2013-2014 approved budgets and the FY 2014-2015 budget requests. The active employee and the non-Medicare retiree costs are commingled and so are relatively close to one another. The actual costs for the active employee participants are significantly lower than the retiree population. For the FY 2012-2014 budget request, the average State per participant, per month costs are $942.22 for retirees age 67 and in FY 2014-2015, $1,028.89 for active employees, and $942.83 for retirees.

Page 58 of Exhibit C shows the average subsidy for each of those same 4 years. FY 2011-2012 and FY 2012-2013 amounts were approved in the 2011 Legislative Session. The FY 2013-2014 and FY 2014-2015 amounts are based on the Governor's recommended budget. These adjustments will be part of the budget amendment we will be providing. The FY 2012-2013 approved and FY 2013-2014 requested amounts decreased. In FY 2011-2012 it increased from $644.81 to $733.64, then decreased to $679.41 in FY 2013-2014, before going back up to

$821.30 in FY 2014-2015. That is because the Active Employee Group Insurance System (AEGIS) budget account is projected to have a surplus of approximately $15 million at the end of June 30, 2013.

The reason for the surplus is that we significantly underestimated the number of spouses who would be removed from the plan when we projected the number of spouses who had other employer-based coverage. We had 2,700 removed and projected significantly less. The amount coming out of the AEGIS is significantly less for an active employee only, than one with a spouse. The same applies to those with a family. When you remove the spouse, leaving just the participant, plus children, the amount that we draw from the AEGIS budget account is significantly less for "plus children," than it is for "plus family." This caused the balance that has been growing in the AEGIS account. That account is not supposed to have a balance. The current Governor's recommended budget uses that balance in FY 2013-2014, hence you see the jump from $679.41 to $821.30 in FY 2014-2015. That indicates there will no longer be a surplus in that account.

Page 59 of Exhibit C shows subsidization policies established by the Board. The Board establishes standardized differentials between dependents and plans. A base plan consists of a PPO plan or a CDHP. We also subsidize the two HMOs that are blended, which are 15 percent less than what we subsidized the primary participant in the CDHP. The differential for dependents is $20. Through the subsidy, we fund 93 percent of the PPO plan for the active employee and 73 percent of the dependents costs through the plan. The percentages in this chart were approved by the Board on January 31. However, these percentages will be adjusted slightly during the Board rate setting process in March and possibly will be reflected to include the NVision Health & Wellness Program incentives. The differential in the subsidy indicates that the HMO participants did not see significant plan design changes in 2011. We have talked about the impact of the HDHP, explaining there were no changes to the HMO plan in plan year 2012. The participants' costs were borne by increasing their premiums. The individuals on the CDHP saw an increase in out-of-pocket costs when they used services.

Pages 60 and 61 of Exhibit C show what the rates would look like based on the information included in the Governor's recommended budget while using the subsidized rates that were shown on page 59 of Exhibit C. The final rates have not been calculated for FY 2013-2014. We are in the final data gathering stages and

will have them in time for approval by the Board on March 21. These are what the rates would look like if every decision unit in the Governor's recommended budget were to be the final amount used for the rate-setting process.

Assemblywoman Flores:
Do you anticipate at the March PEBP Board meeting you are going to drop from 93 percent down to the 89 percent of covering the premium because of having to account for the Wellness program on page 59 of Exhibit C?

Mr. Wells:
There will be a small decrease in the 93 percent figure that you see on page 59 of Exhibit C. Part of the decrease will depend on what the actual rates end up being and part of it will be what the Wellness Program incentives are projected to cost. We will adjust those to reflect the more accurate information that will be available to the Board on March 21.

Assemblywoman Flores:
So what are we going to do if they come back with different numbers at that March meeting?

Mr. Wells:
That is a portion of what will be submitted to the Governor's Office for the budget amendment. These rates have not been adjusted for the decrease the decision unit M-101 inflation factors. These inflationary adjustments continue to be 9 percent for medical and prescription drug costs. These were determined assuming the Governor's recommended budget was the same and the percentages that the Board approved in its duties, policies and procedures are carried out. These adjustments are what the participant contributions would look like for employee and non-Medicare retirees on the PPO and the HMO plans.

Assemblyman Eisen:
Will this predicted medical inflation rate cause employee contributions to increase, or go up less?

Mr. Wells:
The utilization will result in less inflation. For example, the $51.01 employee-only participant premium for FY 1999-2000 would decrease. Also if, a participant

receives a $50 per month incentive and pays a $51.01 premium, their monthly net premium is $1.01. That is a big incentive to participate in the Wellness Program.

Page 61 of Exhibit C shows that same information for the non-Medicare retirees who are on PPO and HMO plans. These rates are based on what we call the "base amount," rather than for a retiree with 15 years of service, or one who retired prior to January 1, 1994. Those who retired after January 1, 1994, will have a subsidy based on their years of service. This number is adjusted up or down depending on the number of years of service of the individual retiree.

Pages 62 to 67 of Exhibit C are examples only and not the actual costs of any individual participant. This is intended to provide the Subcommittee with an estimate of the total out-of-pocket costs that a hypothetical individual participant, or a hypothetical family, would incur based on three different scenarios.

One example is based on a healthy, low-utilization family or individual; one in the moderate-usage category; and one in the high-utilization category. These examples use the Hometown Health or the northern Nevada market. Page 62 of Exhibit C shows a participant who goes to a primary care provider six times throughout the course of a year. It could be for a cold, flu, or a routine check-up. There are a couple of specialist doctor visits, a couple of generic prescriptions, not necessarily on a recurring basis, one brand-name prescription, and what their copayment would be under the HMO. A primary care office visit in the north costs $25, a specialist costs $45, generic prescriptions cost $7 and a preferred brand prescription costs $40. There are no costs on the northern HMO for lab work, so their total copayment for this low-utilization person is $294.

Chair Woodhouse:
I am going to ask the Subcommittee to look at pages 62 through 67 of Exhibit C on their own so we can move ahead to the performance indicators.

Mr. Wells:
As these examples show, we tried to make the out-of-pocket costs, including premiums, comparable for families. It depends on the individual circumstances whether individuals are better off on the HMO or on the PPO.

Page 69 of Exhibit C shows the Priorities and Performance Based Budget Indicators for the PEBP. All of our activities fall under the Health Services Core Function. We have four primary activities: fiscal management and information technology; the Wellness Program; care management; and Medicare Exchange as well as the general administration activity. The group insurance program is our largest. That represents the HMO and PPO for our active employees and non-Medicare retiree population and is 85 percent of our total cost. The whole intent of the data analytics decision unit was for us to start to gather the information we need to create better performance indicators for those other activities.

Page 70 of Exhibit C shows the current performance indicators we have used for a decade. They have been in every budget and represent how the plan operates. The expense ratio indicator is the percentage of premium revenue that is spent on the Agency operations, as well as the administrative costs for the self-funded plan. That includes the third party administrator, the pharmacy benefit manager, the networks, etc., as well as the Agency office operations. We estimated that would be 4.2 percent of our costs in FY 2011-2012, but it was actually 4.01 percent. The FY 2012-2013 current budget is 3.72 percent and the Governor's recommended budget is 4.11 percent and 3.96 percent in FY 2014-2015. That fluctuates based on costs we incur in the first year versus the second year of the biennium, as well as other costs. Under the ACA, large insurers are required to spend 85 percent of their premiums on claims. We are spending 96 percent of our premiums toward paying claims.

The claims loss ratio indicator is the percentage of premiums that is actually spent on claims. The FY 2011-2012 budget was 106.7 percent and the, FY 2011-2012 actual was 87.15 percent. If we are over 100 percent, we are projecting that we will spend down reserves. If we are under 100 percent, we are estimating that we will build reserves. In FY 2011-2012, we were looking to spend down reserves; in actuality, however, we did not. We are anticipating 103.08 percent in FY 2012-2013. Again, we are drawing down some of the reserves in FY 2012-2013, then using more of them in FY 2013-2014. You see a smaller number in FY 2014-2015, recognizing that the amount of reserves left to spend down is less.

The next three performance indicators we have looked at for the last decade or so, are generic drug utilization, medical, and dental in network utilization. They reflect our participants' utilization patterns in efforts to save and control our costs. Our estimated generic drug utilization was 71.6 percent in FY 2011-2012; the actual was 78 percent. The medical in network utilization was 94.5 percent projected and we were actually slightly less at 92 percent. The dental network projections were 93.2 percent and we were at 89 percent. Our participants can go to the doctors of their choice. Those doctors may or may not be part of our network. The drugs that they use may, or may not, be generic. We do show these performance measures to gauge our participant utilization.

The final performance indicator is the number of second- and third-level appeals. Starting this year, those include external review appeals of our claims process. We anticipate there will be 0.15 appeals per 1,000 participants. We usually come in a little lower than that.

Assemblywoman Flores:
How are we accurately measuring performance if we are not taking into account, for example, member satisfaction, since there are financial incentives and penalties tied to the Wellness component? Additionally, a recent audit of the PEBP revealed that you were not making information available to consumers in order for them to make good choices regarding their health plans.

Not all of these new factors are reflected in your performance indicators because, as you stated, you have been using these same indicators for the last 10 years. With this new priorities and performance based budget in place, why have you not tried to include into these performance indicators all of these new factors on which the plan is now based to gauge a more accurate picture of how you are doing? More importantly, how do the PEBP members feel about this?

Mr. Wells:
We conducted a customer satisfaction survey last year, for both the active employee population and the Medicare retiree population. We will likely conduct the same survey this year. One of the factors that we did not include in the employee survey is that we were the only ones out there doing a survey. A number of comments were made in that survey such as, "In addition to pay cuts, furloughs, no longevity and increases to my retirement contributions, I have to deal with this."

It was not necessarily a true reflection of just our organization. That information has to be taken into consideration when we conduct that kind of a survey. It was a big change. We are working on the response that is due in mid-March. The response will reflect a portion which has already been completed and we are working on some of the other components. The online explanation of benefits has already been rebuilt. Procedure codes are reflected, so individual participants can verify that the procedure they had was the procedure that was paid for.

Assemblywoman Flores:
Are you adding current procedural terminology codes (CPT) to your explanation of benefits?

Mr. Wells:
The CPT codes have already been added, effective the first week of January. We are working on finalizing the costing tool based specifically on our participants' claims experience and network discounts for the network, and are looking at a March 31 period to roll it out.

Assemblywoman Flores:
Does that period include the entire State?

Mr. Wells:
It will be based on zip codes, allowing participants to find their average costs based on where they live. We are doing that in addition to the reporting tools that we have already put on our Website. These include some national reporting tools specific to our network discounts and contracted rate amounts. The first large group of the standard procedures will be put out in March.

Assemblywoman Flores:
Do you intend to work some of these into your performance indicators at some point?

Mr. Wells:
The performance indicators we have are reflective of some of the things we need to continue to track. We will continue tracking these five or six items. We will be adding some performance indicators, such as the wellness component and the

disease management component, which are more qualitative than some that are more quantitative. We hope the data analytics portion will give us some additional qualitative aspects for performance indicators, as well as the numerical ones.

Page 72 of Exhibit C is titled Other Post-Employment Benefits (OPEB). Liability refers to the liability to the State of the cost to provide subsidized retiree health care to its participants. It is comprised of two components: the cash subsidy, which is an explicit, or a true, subsidy, and the implicit subsidy, the benefit of commingling their experience with the lesser costly active employees population. The OPEB liability is earned during the working career, and is considered deferred compensation. The Governmental Accounting Standards Board (GASB) requires deferred compensation to be included on the financial statements, or in the footnotes, for the State government as it relates to the amount of the liability. The liability is actuarially calculated based on the current plan design, the number of employees and retirees eligible for health insurance, the amount of the benefit they earned, life expectancy and investment earnings of any of funds set aside to cover the estimated medical trend rate associated with future plan years.

Page 73 of Exhibit C reflects current eligibility for a cash subsidy. This has changed over the last few Legislative Sessions. Individuals who started employment after January 2010 are required to have 15 years of service, as opposed to 5 years of service for individuals who were hired prior to January 2010. Anyone hired after January 1, 2012, is not eligible for a cash subsidy, but will continue to receive the commingling implicit subsidy as well as guaranteed access to the plan. However, they will be required to pay 100 percent of the rate. The base amount is established by the Legislature every 2 years. The base amount is adjusted by the years of service for those retired after January 1, 1994. The subsidy is adjusted up or down from a minimum of 5 years to a maximum of 20 years of service. The base subsidy is 15 years of service.

Page 74 of Exhibit C shows the OPEB Valuation. The GASB only requires us to conduct a valuation every other year if there are no significant plan design changes, which there were not in FY 2011-2012. We will provide another valuation in FY 2012-2013. The benefit valuations are conducted after the end of the fiscal year, but they are dated as of the beginning of the fiscal year. The valuation dated July 1, 2010, was actually completed after FY 2011 closed. The present value of benefits as of that valuation, approximately $1.8 billion, is the number most

frequently seen in the newspaper regarding the "trillion-dollar liability." That is the total amount of expected benefits that will be paid in the future for amounts that are earned by existing employees, including amounts they have yet to earn in future years.

The actuarially accrued liability, which is a snapshot of the benefits earned as of July 1, 2010, is approximately $977 million or about half of the $1.8 billion. The annual required contribution of approximately $119.9 million is the cost of the benefits earned in the year, plus any amortization of previously unfunded liabilities. To give you an idea of where these plan design changes and the Legislative changes have taken us, the $1.8 billion figure is down from approximately $3.3 billion in FY 2009-2010 and from approximately $4 billion in FY 2007-2008. The $977 million figure is down from approximately $1.9 billion in FY 2009-2010 and from approximately $2.2 billion in FY 2007-2008. The annual required contribution is down by approximately $100 million from FY 2009-2010 and $167 million in FY 2007-2008. There is no impact from A.B. No. 553 of the 76th Session, the elimination of subsidized retiree health care for those hired after January 1, 2012, because no one was hired at that time who was not eligible for retiree health care. The elimination of that subsidy again will decrease this number over many years.

Page 76 of Exhibit C discusses Senate Bill (S. B.) 34. This bill was approved by the PEBP Board and submitted to the Governor's Office and the Legislature for consideration. The bill will revise the way we commingle our pool. Currently, we have one pool for State employees and State retirees and a separate pool for non-State employees and non-State retirees. We have talked about the non-State employers leaving because they have found less expensive insurance. This would change to a pool for participating governments and a pool for nonparticipating governments. The State active employees and local government actives would be commingled into a single pool with their retirees, in order to get the benefit of a larger pool. The nonparticipating employers would continue in the retiree-only pool. There are currently only about 65 participating active employees.

SENATE BILL 34: Makes various changes relating to group health insurance provided by the Public Employees' Benefits Program. (BDR 23-377)

Page 77 of Exhibit C discusses the ACA, including the implementation of the ACA, its impact on the PEBP, mandatory coverage of children to age 26, preventive care and elimination of lifetime maximums, is already in place as of July 1, 2011. The last piece of the mandatory coverage is women's reproductive health. Those benefits will be implemented on July 1, 2013, in accordance with ACA requirements. The Patient-Centered Outcome Research Institute funded by the comparative effectiveness research fee, described in M-501, is nearly finalized.

The other piece not included in decision unit M-501 is the transitional re-insurance program which is used to fund things like the Medicare Exchange. The carriers through the Medicare Exchange, and like exchanges around the country, are used to fund some of their start-up liabilities associated with potential catastrophic claims assessed against insurance carriers and self-funded plans.

Assemblyman Aizley:
There seems to be no way for an individual to help lower the expenses of these programs, because there appears to be no benefit to the individual to look for less-expensive medical coverage, because insurance just pays a fixed amount.

Mr. Wells:
On the PPO side, that is not true at all. It might apply to the HMOs, where you are paying the flat copayment. Catamaran, our pharmacy benefit manager, has a Website where a participant can type in a drug name and it will tell them the nearest pharmacies and how much that drug will cost at each of those pharmacies. Each pharmacy might be a little different. Because the participants are paying out-of-pocket, subject to the deductible, if they can purchase the medication for $5 at CVS, or $8 at Walgreens, they save the difference.

Some pharmacies have a program where participants can purchase a 30-day supply of medication for $4, or a 90-day supply for $10. In some cases, it is actually less costly than purchasing medication through the preferred provider network, and they receive deductible credit.

We are also working with Catamaran to improve the pricing tool, because there are some drugs that are very difficult to price, such as creams, eye drops, etc., where the dosage amounts are not a pill or in a standardized format. That pricing tool is a little harder to determine.

Assemblyman Eisen:
We will go through this more with S.B. 34. Is the expectation that this commingling of claims experience is going to help with the rapidly rising participant costs, particularly amongst non-State, non-Medicare retirees?

Mr. Wells:
The non-participating, non-Medicare retirees would stay. The vast bulk of our non-State retirees come from school districts. We do not insure any school district active employees; they will remain in the retiree-only pool. The school district retirees that were not insuring their active employees through us were costing the employer more money for the active employees, so they all left that plan.

Assemblyman Eisen:
If that retirees' prior employer is currently participating with their active employees, then they would be blended into this claims experience and the demographic would see some benefit in terms of their out-of-pocket costs. If their prior employer is not currently participating, then they will not see that.

Mr. Wells:
Correct.

Chair Woodhouse:
We will now invite public testimony.

Martin Bibb (Executive Director, Retired Public Employees of Nevada):
I will read my written testimony, (Exhibit D), giving the reason why the Retired Public Employees of Nevada supports decision unit E-225.

The need for approval is evident. Medicare retiree subsidies in PEBP have been cut drastically. Their premiums helped build $30 million in excess reserve in PEBP in recent years. Some $18 million of that excess reserve has already been returned or is still being returned to active workers and pre-Medicare age retirees in PEBP. However, due to the way the law was written creating the Medicare Exchange in 2011, it will take legislative action this Session for Medicare retirees to realize any relief from this plan windfall.

As a result, PEBP's auditor reaudited Extend Health's exchange and reported on them at last week's PEBP Board meeting. They pointed to the deficiency of their out-of-State based call-in service center program. Among the experience they reported was being put on hold for 4 to 5 hours, or having to drop out of the plan and lose the subsidy because limited choices offered for Medicare supplements did not include specific physicians that their medical conditions required. Outside the metropolitan areas in northern and southern Nevada, no Medicare Advantage plans are offered.

James T. Richardson (Nevada Faculty Alliance):
I have submitted my reasons for supporting decision unit M-275 (Exhibit E). There have been radical changes made to this program in recent years, forced upon the PEBP Board by budgetary considerations. Numerous reservations were expressed by me and others at the time, but we have to try to make the best of it and move forward.

I want to comment on what was just said. We strongly support the effort to improve the data capabilities of the PEBP. I am on a task force at the University of Nevada, Reno, that has been trying to collect more information about the experience of our people. It has been difficult because of the lack of availability of data. It is amazing that we have a State agency of this size, with this kind of budget, that is limited in its ability to gather and manage data when requested. We urge your consideration of that part of the budget.

We also support decision unit E-275. Last Session, the concept to move Medicare retirees out of the State plan was new. Legislation had to be written to facilitate that. The legislation written was too limiting on the PEBP Board. When PEBP has reserves, they ought to be able to allocate some of those reserves by vote of the Board to the Medicare retirees who were shifted off the plan. That is a good way to use funds and it is needed. Some of these Medicare retirees have seen dramatic increases in their rates since they went on the Medicare Exchange. They can use the help. I would urge you to approve that item, and even change the law made in the last Session, to allow the PEBP Board to make that decision in the future without coming to you with a separate budget item.

In addition, we need more cost information. The PEBP is working on that. It has been difficult for people on the CDHP to make wise decisions because they cannot find out the costs. If they do find out, it does not often match what they are billed. I strongly encourage the PEBP Board to keep moving forward to get that cost information available. Part of the dramatic changes that were made should have been done long ago. We should have established HSAs in this State. They are perhaps the most positive part of the changes that were forced on us. This is a very good policy change. It allows people to save for their own health care in the future and, at the same time, the State is making a modest contribution to encourage that. I opposed the decision made, effective January 1, 2012, to drop new hires from any possibility of subsidization after they retire. You might want to revisit that issue. It was done as part of an effort to, perhaps, placate some people and reform the PEBP. Instead, it put some entities at a competitive disadvantage in the national hiring market. That is not the rule in many university systems around the country where we have to compete to hire people. Now, when we bring in new hires, they are told if they spend their entire life here, contribute to the State and retire, they are on their own.

Ron Dreher (Peace Officers Research Association of Nevada, the Washoe County Public Attorney's Association and the Washoe School Principals Association):
We support decision unit M-275.

Elaine B. Steiner:
The Extend Health plan is very difficult for some people to navigate. Everything is done over the telephone. Nothing is done in writing. They tell the caller which plan is the best for them. I conducted my own research prior to my phone call and I knew exactly where I wanted to go when I started. It took me over 45 minutes to get to where I needed to be. They tried to get me to purchase other policies. I had to keep asking: "Do you have anything else?" Finally, they came to where I wanted to go. I had to ask them, "I am not going to tell you which insurance I have, but do you have insurance A?" The representative said they do. There seems to be a common situation with insurance A. I advise friends to not tell them what plan they want, but to see what the representative offers them. They seldom give Plan A any advertising. I think that is very bad. Also, it is difficult for people who have hearing problems. They refuse to conduct business other than over the phone.

It is a poor process. We were told the process would be better, but it is not. Some people are confused about their options. How much has the State put aside that pays us a maximum of $200?

Chair Woodhouse:
We will find out for you.

Roger Bremner:
I am a retired State employee, Medicare eligible and a former legislator. I would like to address the apparent discrimination against Medicare retirees by the PEBP when it comes to the allocation of the premium support provided by the State. A. B. No. 562 of the 76th Session provided $472 for every retiree in this year of the biennium. The bill also limited the amount of money that the PEBP could spend on Medicare retirees to no more than $200. When you see $472 provided for every retiree, and $200 allowed for Medicare retirees, it is a big difference. Part of the reason, and the Legislature went along with that, is that the PEBP, at the time, was claiming they did not have the funds and there were untold problems. Legislators told me that they were advised that as much as $84 million would be needed to keep the system solvent. Coincidentally, a few months after the passage of the legislation, surpluses were found.

Medicare retirees also pay a premium for Medicare Part B. You pay for Part A while you work, but Part B is an option that Medicare retirees have when they reach 65 years of age. The current base premium for that is $104.60, and it changes annually. The Committee should consider requesting that the PEBP pay that premium for Medicare retirees. That would still bring the amount of money allocated for Medicare retirees up to less than $300 out of the $472 that was allocated for premium support as an assessment against various payrolls.

The PEBP also should be brought back in to the service portion, when it comes to assisting Medicare retirees with Extend Health. Extend Health is not a good service. Wait times are horrible and many senior citizens and retirees do not understand health insurance. The PEBP should be helping them, but they are not doing it.

Rob Joiner (President, Retired Public Employees of Nevada):
We support decision unit M-275. I hear from my chapter members on a monthly basis. It is true what Ms. Steiner said, that a person must do their own research before talking with Extend Health. I have close family members who have gone through this and it is horrible.

Given the bad economy when you started with Extend Health, why would you go with a sole source and not get competitive bids? They have a lucrative contract for multiple years with little or no performance measures. Why would they provide good service when they do not have to? Go through the process, do not use a sole source, and get competitive bids. Get someone who will perform and get something in writing, not over the phone contracts. We have a great support system here for the retired public employee if you want more input. Do a survey of people affected, not across the whole book of business.

Bernie Anderson (A Solution):
The opportunity for our retired teachers to get into a health care program in some of the smaller counties does not exist, except through the State program. I am delighted to see that S.B. 34 finally may remove that barrier. In due time it will get to its proper point. I want to speak in support of that. What is going to happen in both Washoe and Clark Counties? Many retirees in the education profession used the State system when they retired because it was an option for them. Now, they have become dependent upon it. They are not yet 65 years old and, thus, not in the Medicare Exchange. I am in the Medicare Exchange. I hear an enormous number of complaints from people in Clark and Washoe Counties about how the cost has become so prohibitive to them.

Extend Health is terrible. Public employees who worked for the State, or for local governments, are not accustomed to making informed decisions relative to life insurance or health insurance programs. Extend Health gives no guidance in terms of offerings, and it is all conducted over the telephone by appointment.

I went to the meetings that were offered by the State, to make us aware of how to utilize the system. In terms of real offerings, that was not present. There are several national organizations, including the National Education Association, which has health care programs available, but were not one of their listed providers. The PEBP could have come up with a better insurance plan. The PEBP could have found

other programs, but they were not going to make any money off them. This is an actuarial insurance company and not a charity, but the salesperson is not looking out for our employees or former employees. There is not much point in staying in low-paying public employee jobs if there will not be adequate compensation at the end of our careers.

Assemblywoman Flores:
No one has testified in support of, or even been happy with, Extend Health. I agree with the statement made by Mr. Anderson that we have not historically done a good job of taking care of our people in Nevada, much less our seniors. This is at a time when they need extra service, not less. Please explain how we chose this provider, when their contract is up, and how much this is costing us. Was it approved in the last budget?

Mr. Wells:
I know people who are happy with this Program. They do not ever show up for Committee meetings. We have had some complaints. We have done an audit. We are working on a corrective action plan. We have agreed to, and signed-off on, performance indicators for this contract. We are taking steps to address the issues that have been brought forward today. We have addressed many of them already.

Regarding the contract, when we looked at the implementation of the Medicare Exchange, and there were some savings associated with doing it this way, we were looking forward to $85 million. That number was the difference between what the costs of our old program would be at the same subsidization rates.

There was no hiding of any of these estimates. Part of the savings of $85 million with the HDHP was the transition to the Medicare Exchange.

Assemblywoman Flores:
I want to talk specifically about Extend Health. How much did it cost in the last Legislative Session? What amount was approved? When does their contract expire?

Mr. Wells:
The exchange contract expires June 30, 2015. We pay $3.45 per month per HRA account, which is for the primary participants. There are 9,157 accounts, the balance of those are dependents. That is the extent of what we pay to Extend Health to manage that program.

Assemblywoman Flores:
These concerns have been legitimized because there has been an audit and there are some performance measures in place. We do not know what is going to happen in 2015, or how many of us are going to be here when this contract expires. If these issues are still in existence in 2015, we can say we knew about this during the 2013 Legislative Session. They have not improved, therefore, we are going to look at someone else. What often happens is that these things come to light and then the status quo continues and all of our retirees are here continuing to complain Session after Session.

Chair Woodhouse:
Mr. Wells, I am encouraging you over these next 2 years, before this contract is up, to find a way to get Extend Health to provide an expanded level of customer service for our people.

Mr. Wells:
I agree that the wait times are completely unacceptable. The process does take an average of 45 minutes to 1 hour. Part of that process is mandated by Medicare such as the statements they have to go through and read and have the participant affirm that they are making this selection of their own choice. We have talked with Extend Health about ways to reduce those call times and we continue to work with them on areas in which we can improve the customer service experience. When we go out to bid, we now know a lot of the additional factors that we will include as requirements in the Request for Bid.

Chair Woodhouse:
With no further business before the Subcommittee, this meeting is adjourned at 12:00 p.m.

RESPECTFULLY SUBMITTED:

Sheri Fletcher,
Committee Secretary

APPROVED BY:

Senator Joyce Woodhouse, Chair

DATE:

Assemblywoman Lucy Flores, Chair

DATE:

EXHIBITS				
Bill	**Exhibit**		**Witness / Agency**	**Description**
	A	1		Agenda
	B	6		Attendance Roster
	C	78	James R. Wells	PEBP
	D	2	Martin Bibb	Testimony
	E	1	James T. Richardson	Highlights from Testimony