WASHOE COUNTY

"Dedicated To Excellence in Public Service"
www.washoecounty.us

CM/ACM
Finance
DA approved
Risk Mgt.
HR
Other

STAFF REPORT
BOARD MEETING DATE: May 12, 2015

DATE: May 1, 2015

TO: Board of County Commissioners

FROM: John Listinsky, Director of Human Resources/Labor Relations
328-2089 jlistinsky@washoecounty.us

THROUGH: Joey Orduna Hastings, Assistant County Manager
328-2000 jhastings@washoecounty.us

SUBJECT: Review recommendation of Insurance Negotiating Committee (INC) to approve FY2015/16 Health Benefits Program for employees, dependents and retirees at an approximate annual cost of $52.9 million with direction in which to fund the $3.6 million additional cost to the County; change the Program from a fiscal to a calendar year basis effective January 1, 2016; authorize the Director of Human Resources/Labor Relations to execute all insurance contracts and service agreements pertinent to the Health Benefits Program; and direct staff to return to the Board of County Commission at a future date in calendar year 2015 with long-term sustainable options for health care benefits. (All Commission Districts)

SUMMARY

Review of recommendation of Insurance Negotiating Committee (INC) to approve FY 2015/16 Health Benefits Program for employees, dependents and retirees at an approximate annual cost of $52.9 million with direction in which to fund the $3.6 million additional cost to the County; change the Program from a fiscal to a calendar year basis effective January 1, 2016; authorize the Director of Human Resources/Labor Relations to execute all insurance contracts and service agreements pertinent to the Health Benefits Program; and direct staff to return to Board of County Commissioner at a future date in calendar year 2015 with long-term sustainable options for health care benefits.

Attached documents:

- Current overview of benefits structure
- Historical summary plan design changes
- Historical rate changes
- INC Bylaws

Washoe County Strategic Objective supported by this item: Valued, engaged employee workforce.

AGENDA ITEM # 16

PREVIOUS ACTION

On May 13, 2014, the Board approved the FY 2014/15 Program at an approximate annual cost of $47.0 million.

BACKGROUND

The Health Benefits Program consists of the choice of three (3) plans: a self-funded group health plan (PPO), a fully-insured Health Maintenance Organization (HMO) plan, and self-funded High Deductible Health Plan (HDHP) paired with a Health Savings Account (HSA) which was introduced as a voluntary third plan option in FY 2012/13. Current enrollment for active employees is approximately 33% in the PPO, 62% in the HMO and 5% in the HDHP. The Program also offers self-funded dental, vision and life insurance plans for all enrollees.

The INC was created pursuant to collective bargaining with the various employee associations and includes a member from each association, one member from management, and one non-voting retiree member.

The INC reviews the self-funded PPO and HMO health plan renewals each year to provide input into plan design and review premiums in an effort to help control costs while still providing a valuable benefit to employees. A list of historical summary plan design changes and premium changes is included with this Board report. Washoe County offers its employees three (3) plan options; the chart below compares Washoe County's options with other local public entities.

Organization	Self-funded PPO Plan*	Self-funded PPO HDHP* (high deductible)	Self-funded EPO Plan (exclusive provider network)	Fully Insured HMO Plan	Self-funded HMO Plan
Washoe County	x	x		x	
Washoe County School District**	x		x		x
City of Sparks	x				
City of Reno	x	x			x
State of Nevada***		x		x	

*Employer pays for claims and other administrative costs via a third party administrator.
**Offers two EPO options (one with Renown's network and one with St. Mary's network).
***State of Nevada employees pay a portion of their own health plan premium.

The Human Resource Benefits staff coordinated 11 meetings with the INC and received input from representatives in the Comptroller and Budget offices regarding the impact of the proposals. On April 30, 2015, the INC completed its annual review of the plan design options for the PPO, the HDHP and the HMO. The final INC majority vote was to accept the renewal with no plan design changes, as presented, based on actuary reports for the self-funded plans and the Hometown Health (HMO) renewal proposal.

Should the BCC not agree with the INC's recommendation the INC bylaws outline the following process:

"If the Committee recommendation is rejected by the County Commission, the Commission shall define their objections and parameters and the Insurance Committee shall, within fifteen (15) days of being notified of the Commission's objections and parameters, meet and attempt to redefine plan modifications which meet the Commission established parameters. If the Committee is successful, the plan modifications shall be resubmitted to the Commission for approval. If the Committee is unable to determine acceptable modifications for submission to the Commission, the County and the Insurance Committee agree to resolve any resulting differences by submitting the dispute to expedited final and binding interest resolution which shall be binding upon the County and the bargaining units." (Bylaws, February 17, 2011)

Suggested cost saving options for FY 2015/16 that were presented for consideration by INC and reviewed by the INC includes the following:

Self-Funded Group Health Plan (PPO)
The Comptroller's Office considered data received from the actuary, increased costs in administration of claims, and in supplemental plans such as life insurance, in recommending an overall rate increase to the departments for employees with PPO coverage of 15%. The following plan design options could have reduced the increase to 13%:

- Increase annual individual and family deductible from $350/$700 to $450/$900.
- Increase annual out-of-pocket individual and family maximum from $3,350/$6,700 to $5,450/$10,900.
- Establish a separate pharmacy out-of-pocket annual maximum of $1,150.

The INC voted to accept the renewal with no plan design changes.

Health Maintenance Organization (HMO)
The INC requested proposals from other providers in addition to the current provider, Hometown Health. Two bids from other organizations were received. The Anthem Blue Cross bid came in 38% higher than the current rates, so it was not considered a viable option. Health Plan of Nevada (HPN) provided competitive quotes of 23.8% and 16.10% that included significant plan design changes that would increase participant costs. The INC chose not to consider the HPN quote due to the smaller network of providers in Northern Nevada and the mandatory referral requirement for Specialist office visits.

Based on the previous year's claims experience, Hometown Health's actuarial analysis indicated a premium rate increase of 27.8%. Hometown Health indicated they had to increase the rates based on a high loss ratio resulting from a significant increase in claims and increased costs due to Affordable Care Act legislation, in addition to the fact that they did not increase their rates for two consecutive years. After considerable discussions with Hometown Health executives, they revised the renewal to 22.5% (medical coverage only) and provided several cost saving options to bring down the medical portion of the premium that ranged from 22.5% renewal to 7.5% renewal with design changes. From the original five options, the INC narrowed its review down to two options:

Renewal Option 2 (Reduced increase from 22.5% to 16.5%)

- Increase annual individual and family out-of-pocket maximum from $2,500/$5,000 to $4,500/$9,000.
- Increase Rx co-pay from $5/$25/$40 to $7/$30/$50.
- Add a $500 calendar year deductible.
- Other lab and diagnostic testing increases of approximately $25.

Renewal Option 5 (Reduced increase from 22.5% to 15.3%)

- Increase annual individual and family out-of-pocket maximum from $2,500/$5,000 to $4,500/$9,000.
- Increase Rx co-pay from $5/$25/$40 to $7/$30/$50.
- Increase hospital inpatient deductible from $1,000 to $2,000 (includes increased GAP plan coverage to reimburse up to $2,000).

The INC reviewed disruption reports of these changes and after discussing the impact to participants, a majority voted to renew the HMO plan with no plan design changes at the 22.5% increase.

In the final rate setting, the Comptroller's Office added the costs of supplemental plans such as life and vision insurance, in recommending an overall rate increase to the departments for employees with HMO coverage of 25.5%.

Calendar Year Health Plan Program

Following discussion in 2014, the INC agreed to change the health program from a fiscal year to a calendar year period in January 2016. This change will result in balancing the calendar year for health plan deductibles, health savings accounts and Section 125 medical reimbursement accounts and will enable employees to better plan for health care expenses, and better sync the health plans with the employees' federal income tax reporting. Additionally, it may help increase employee participation in the lower cost High Deductible/Health Savings Account plan that enables participants to save for future medical expenses similar to a pre-tax 401(k) plan but for health care. This will also improve cost forecasting for preparation of the County's budget.

FISCAL IMPACT

The renewal rates for all three (3) plans will be increased. Employees will see comparable increases in payroll deductions for their share of dependent insurance premiums. The INC voted to accept the rate increases, which will impact the County General Fund for employee premium costs for which the County pays 100%, as well as dependent cost for which the County pays 50%. If incorporated into the budget, the significant premium increase could impact departmental budgets, which possibly impacts planned staffing and capital improvements for special revenue and proprietary funds.

As was reported to the Board on March 24 and on April 28, 2015, as part of staff's status reports on the FY2015/16 budget, the recommended 2015/16 budget only provides for a 6% increase in health insurance costs charged to departments. This is the County's share of health insurance costs, which represents approximately 80% of total costs, and which is accounted for in the Health Benefits Fund, Fund 618. The 6% increase factored in

increased claims from the County's self-funded health plans and did not contemplate a 22.5% increase in the premium charged by Hometown Health. The estimated additional cost to the County of a 25.5% increase in premiums (not including the cost impact on employees) is $3.6 million. In addition, the estimated cost impact to OPEB contributions in future years is $1.1 million.

Over the last 10 years, the total cost of employee benefits, including health insurance, that the County has paid on behalf of employees has increased substantially, increasing from $55.9 million in FY 2004/05 to an estimated $97.1 million in FY 2014/15. As a percent of base salaries for full- and part-time staff, the cost of employee benefits has grown from 38.9% of base salaries in FY 2005 to an estimated 61.0% in FY 2014/15. Although the County remains committed to support its employees, the increased cost of health care is forcing the County to revisit the current benefit structure to identify a sustainable plan going into the future. Unfortunately, the revenue the County receives is not able to keep up with the demand for increased community services and increased costs of health care benefits.

Currently identified options available to cover the estimated cost increase in HMO premiums for FY2015/16 may include a combination of the following:

1) Maintaining the 6% internal rate charged to departments and allowing the fund balance of the Health Benefits Fund to cover the increase. This would result in the Health Benefits Fund's balance falling below the recommended 10% target fund balance, which was previously agreed to by the INC in the May 2014 Summary of Insurance Negotiating Committee Operating Principles memo.
2) Adjusting cost of living allowances for general county employees for FY 2015/16.
3) Utilizing ending General Fund balance from FY2015 if ending fund balance comes in higher than estimated.

Although none of these options are appealing, it is important to note that these options represent one-time solutions that do not address future years' costs. Moreover, there is a significant policy decision involved: "How does the Board choose to allocate its limited resources?" In essence, the decision to fund this level of health insurance costs is an opportunity cost – the $3.6 million needed to cover the County's share of higher HMO premium could instead be used to pay for employee salary increases, new programs, or approximately 40 new positions, just to name a few examples. An additional concern with funding a 22.5% increase this year and increases in future years in HMO health insurance premiums is the compounding effect on the County budget. The cost increase will result in an even greater allocation of the budget for employee benefits, raising the labor burden rate (the ratio of benefits to base salaries) above the current 61% and redirecting resources away from other needed areas, thus reducing the County's ability to increase staffing to respond to service demands of an increasing population and growing business sector.

In terms of policy options, the Board may wish staff to research long-term sustainability options to include:

1) Consideration of significant plan redesign options.

2) Offering a cafeteria-style benefits plan that would offer employees a flat dollar amount for benefits.
3) Removing the option for an HMO and only providing for self-funded plans and/or making the HMO plan a buy-up option available to employees who want to pay a portion of the premium to have the plan.
4) Consideration of Medicare eligibility options.
5) Include Prime Healthcare Services, the parent company of St. Mary's Regional Medical Center, in selection/bid process.

The County may also choose to exercise the process outlined above in the INC bylaws and direct the INC to revisit the various options presented by Hometown Health. Again, for future sustainability, the County may want to consider reviewing various policies and funding options that may balance the demands of increased needs in the community and increased health care costs.

RECOMMENDATION

It is recommended that the Board of County Commissioners approve the FY2015/16 Health Benefits Program for employees, dependents and retirees at an approximate annual cost of $52.9 million with direction in which to fund the $3.6 million additional cost to the County; change the Program from a fiscal to a calendar year basis effective January 1, 2016; authorize the Director of Human Resources/Labor Relations to execute all insurance contracts and service agreements pertinent to the Health Benefits Program; and direct staff to return to the Board of County Commission at a future date in calendar year 2015 with long-term sustainable options for health care benefits.

POSSIBLE MOTION

Should the Board agree with INC's recommendation, a possible motion would be: Move to approve FY2015/16 Health Benefits Program for employees, dependents and retirees at an approximate annual cost of $52.9 million with direction in which to fund the $3.6 million additional cost to the County; change the Program from a fiscal to a calendar year basis effective January 1, 2016; authorize the Director of Human Resources/Labor Relations to execute all insurance contracts and service agreements pertinent to the Health Benefits Program; and direct staff to return to the Board of County Commission at a future date in calendar year 2015 with long-term sustainable options for health care benefits.

Washoe County Health Benefits Comparison Sheet

This is a comparison summary of the group health plans offered through the Health Benefits Program.

	Self-funded PPO Plan	High Deductible PPO Plan	Hometown Health HMO Plan
Plan Year Deductible	$350 individual $700 family	$2,500 individual $2,500 family	None
Plan Year Out of Pocket Maximum	$3,350 individual $6,700 family	$5,000 individual $5,000 family	$2,500 individual $5,000 family
Co-insurance	80%	80%	None
Participating Hospitals:	Saint Mary's Northern Nevada	Saint Mary's Northern Nevada	Renown

Office Visits and Professional Services

Primary Care Physician	$20 co-pay (PPO) 80% (non-PPO)	100% after deductible	$25 co-pay
Specialist	80% after deductible	100% after deductible	$50 co-pay
Surgeon or Anesthesia	80% after deductible	80% after deductible	$50 co-pay
Preventative Care	100% no deductible	100% no deductible	$0 co-pay
Outpatient Lab	80% after deductible $5 co-pay (in office)	80% after deductible	$0 co-pay Renown Lab
Outpatient X-Ray	80% after deductible $10 co-pay (in office)	80% after deductible	$25 co-pay
Complex Imaging (MRI, CT, PET)	80% after deductible	80% after deductible	$225 co-pay
Physical Therapy	80% after deductible	80% after deductible	$25 co-pay
Chiropractic Limited to $1,000 Benefit per CY	80% after deductible	80% after deductible	$50 co-pay
Mental Health and Substance Abuse (Out-patient)	80% after deductible	80% after deductible	$25 co-pay

3/26/15

Surgical and Hospital Services

	Self-funded PPO Plan	High Deductible PPO Plan	Hometown Health HMO Plan
Inpatient Hospital	80% (PPO) 60% (non-PPO) + $500 co-pay	80% (PPO) 60% (non-PPO) + $500 co-pay	$1,000 co-pay
Outpatient Surgery	100% (contracted facility) 80% (physician)	$100% (contracted facility) 80% (physician)	$500 co-pay
Maternity	80% after deductible	80% after deductible	$1,000 co-pay
Emergency Room	80% + $75 co-pay	80% after deductible	$100 co-pay
Ambulance	80% after deductible	80% after deductible	$100 co-pay for ground $200 co-pay for air & water
Substance Abuse	80% after deductible	80% after deductible	$1,000 co-pay
Skilled Nursing Facility	80% after deductible	80% after deductible	$1,000 co-pay
Home Health Care	80% after deductible	80% after deductible	$25 co-pay
Vision Services	See Below	See Below	See Below

Prescription Drugs

Generic Non-preferred Generic Formulary Brand	$5 co-pay N/A $25 co-pay	**$5 co-pay** **N/A** **$25 co-pay after deductible**	$5 co-pay N/A $25 co-pay When generic available or $25 + cost difference
Non-formulary Brand Specialty Mail Order Benefit	$40 N/A 3 months for 2 co-pays	**$40** **N/A** **3 months for 2 co-pays after deductable**	$40 20% 3 months for 2 co-pays

All Enrollees are covered by the following

Dental Services

Self-funded Dental Plan – Nevada Health Partners PPO
$50 Calendar year deductible on Basic, Major and Orthodontic services
Preventative – 100%, Basic – 80%, Major – 50%, Orthodontia – 50%
$2,500 maximum benefit per calendar year on regular dentistry
$1,000 lifetime maximum on Orthodontia

Vision Services

Vision Service Plan (VSP)
$10 co-pay for annual exam
Basic lenses covered annually
$120 allowance for frames every 24 months or contacts every 12 months

Life Insurance

Enrollee - $20,000 when under 65; $13,000 when age 65-69; $7,000 when age 70 and over
Covered dependents - $1,000

HISTORICAL SUMMARY OF PLAN DESIGN CHANGES

Self-Funded PPO Plan	Fully-Insured HMO Plan	Senior Care Plus HMO (Medicare Advantage Plan)	Self-Funded HDHP/HSA (High-Deductible Health Plan/Health Savings Account)
(all plan design changes are negotiated via the INC process)	(all plan design changes are negotiated via the INC process)	(voluntary plan; not subject to bargaining)	(voluntary plan; not subject to bargaining)
FY 14/15			
Chiropractic Care: Changed from $1,000 limit per calendar year to 25 visits per calendar year *	Chiropractic Care: Changed from $1,000 limit per calendar year to 20 visits per calendar year *	Inpatient hospital visit copay changed from $50 per 3 day period to $125 per 2 day period	HDHP Chiropractic Care: Changed from $1,000 limit per calendar year to 25 visits per calendar year *
Hearing Aids: Changed from $1,000 limit in a five year period to 1 hearing aid and 1 exam every 36 months *	Alternative Medicine: Changed from $1,000 limit per calendar year to 20 visits per calendar year *	Hearing aid coverage changed from $800 to $1,000 allowance every 3 years *	HDHP Hearing Aids: Changed from $1,000 limit in a 5 year period to 1 hearing aid and 1 exam every 36 months *
Added individual out-of-pocket maximum of $6,350 for prescription drug expenses only *	Pharmacy: Added out-of-pocket maximum of $6,350 per plan year *	Rx preferred copay changed from $35 to $40	Added covered out-of-pocket maxium of $5,000 which is a combination of eligible medical and prescription drug expenses *
	Bariatric surgery: Now limited to 1 medically necessary gastric restrictive surgery per lifetime *	Rx non-preferred copay changed from $65 to $70	**HSA County contribution increased from $48.08 per pay period to $67.31 (from $1,250 to $1,750 annually)**
	TMJ: Now includes coverage for 1 surgery per calendar year; 2 per lifetime *	Rx select diabetic drugs copay changed from $15 to $10	
	Home Health Care: Now restricted to 30 visits per year with prior authorization requirement *	Specialist visit copay changed from $30 to $25	
		Emergency room care copay changed from $50 to $65	

*** These changes are a result of the Affordable Care Act legislation**

Self-Funded PPO Plan	Fully-Insured HMO Plan	Senior Care Plus HMO (Medicare Advantage Plan)	Self-Funded HDHP/HSA (High-Deductible Health Plan/Health Savings Account)
(all plan design changes are negotiated via the INC process)	(all plan design changes are negotiated via the INC process)	(voluntary plan; not subject to bargaining)	(voluntary plan; not subject to bargaining)
FY 13/14			
• Added genetic testing benefit up to a maximum of $1,000			
FY 12/13			
• Eliminated adult orthodotia exclusion	• Eliminated adult orthodotia exclusion	• Specialist Office Vision copay decreased from $35 to $30 per visit • Inpatient Hospital copay decreased from $100/3 days to $50/3 days • Urgent Care copays decreased from $20/$40 per visit to $14/$30 per visit • Same Day Surgery copay decreased from $100 per visit to $50 per visit • Various reductions in Rx copays; see plan document for these changes	• Added a voluntary HDHP for active employees (coupled with an HSA) • County contributing $48.08 per pay period ($1,250 annually) to the HSA

Self-Funded PPO Plan	Fully-Insured HMO Plan	Senior Care Plus HMO (Medicare Advantage Plan)	Self-Funded HDHP/HSA (High-Deductible Health Plan/Health Savings Account)
(all plan design changes are negotiated via the INC process)	(all plan design changes are negotiated via the INC process)	(voluntary plan; not subject to bargaining)	(voluntary plan; not subject to bargaining)
FY 11/12			
• Increased out-of-pocket maximum from $1,500/$3,000 to $3,000/$6,000 (ind/family)	• Increased office copays from $20/$40 to $25/$50 (primary care/specialist) • Increased Rx copays from $5/$15/$25 to $5/$25/$40 (generic/brand/non-formulary)		
FY 10/11			
• Deductible increased from $250 to $350 for individual and from $500 to $700 for family • Increased preventative care from $250 to $500 • Increased preferred brand name copay from $20 to $25	• Hospital copay increased from $200 to $1,000 • Same day surgery increased from $200 to $500 • MRI, CT scan, and Pet scan increased from $100 to $225 • All other X-Ray services increased from $0 to $25 • Out of pocket maximum increased from $1,500 to $2,500 ***To offset the preceding plan design changes, the GAP plan was added which reimburses:*** • Up to $1,000 for In-Hospital benefit per confinement • Up to a maximum of $200 for outpatient benefits 4 times per calendar year • Doctor visits up to $25 a visit/5 visits per calendar year	• Added a fully-insured HMO Medicare Advantage Plan to the RHBP (local retirees only)	

Self-Funded PPO Plan	Fully-Insured HMO Plan	Senior Care Plus HMO (Medicare Advantage Plan)	Self-Funded HDHP/HSA (High-Deductible Health Plan/Health Savings Account)
(all plan design changes are negotiated via the INC process)	(all plan design changes are negotiated via the INC process)	(voluntary plan; not subject to bargaining)	(voluntary plan; not subject to bargaining)

FY 09/10

- Limited spinal maniupulation benefit to $1,000 per calendar year
- Increased office visit copay from $10 to $20
- Increased hospital copay from $150 to $200
- Increased office visit copay from $15 to $20 ($40 for specialist)

FY 08/09

There were no plan design changes to either medical plan; however, the calculations for premiums were changed from a 3 tier system (employee only, employee plus one, employee plus two or more), to a 4 tier system (employee only, employee plus spouse, employee plus child/ren, employee plus family).

FY 07/08

- Increased hospital copay from $100 to $150
- Increased office visit copay from $10 to $15

HISTORICAL SUMMARY OF PLAN PREMIUMS

(Premiums Shown are Monthly Rates)

	PPO	% Change from Prev Year	Overall % Change	HMO	% Change from Prev Year	Overall % Change	SCP	% Change from Prev Year	Overall % Change	HDHP	% Change from Prev Year	Overall % Change
FY 14/15	All rates discounted 7% from actuarial/bid rates									Added Rx costs		
Spouse	$669.86	5.39%		$589.38	0.49%		$121.95	21.57%		$467.83	10.82%	
Child/ren	$552.87	6.67%		$478.90	0.48%		n/a			$391.24	11.30%	
Family	$1,150.94	3.14%	5.07%	$1,280.99	0.35%	0.44%	n/a		21.57%	$787.27	9.68%	10.60%
FY 13/14	County and HTH agree to hold rates stagnant for fy 13/14											
Spouse	$635.61	0.00%		$586.53	0.00%		$100.31	10.85%		$422.15	0.00%	
Child/ren	$518.28	0.00%		$476.63	0.00%		n/a			$351.53	0.00%	
Family	$1,115.89	0.00%	0.00%	$1,276.50	0.00%	0.00%	n/a		10.85%	$717.76	0.00%	0.00%
FY 12/13	County and HTH agree to hold rates stagnant for fy 12/13											
Spouse	$635.61	0.00%		$586.53	0.00%		$90.49	0.00%		$422.15		
Child/ren	$518.28	0.00%		$476.63	0.00%		n/a			$351.53		
Family	$1,115.89	0.00%	0.00%	$1,276.50	0.00%	0.00%	n/a		0.00%	$717.76		
FY 11/12												
Spouse	$635.61	-3.49%		$586.53	4.51%		$90.49	-17.74%				
Child/ren	$518.28	-3.69%		$476.63	4.49%		n/a					
Family	$1,115.89	-3.25%	-3.48%	$1,276.50	4.56%	4.52%	n/a		-17.74%			
FY 10/11												
Spouse	$658.58	9.75%		$561.24	-14.37%		$110.00					
Child/ren	$538.15	9.89%		$456.15	-5.80%		n/a					
Family	$1,153.39	9.43%	9.69%	$1,220.87	-16.90%	-12.36%	n/a					

	PPO	% Change from Prev Year	Overall % Change	HMO	% Change from Prev Year	Overall % Change	SCP	% Change from Prev Year	Overall % Change	HDHP	% Change from Prev Year	Overall % Change
FY 09/10												
Spouse	$600.09	13.11%		$655.43	14.65%							
Child/ren	$489.70	7.29%		$484.21	14.45%							
Family	$1,054.03	7.14%	9.18%	$1,469.17	14.77%	14.62%						
FY 08/09	This was the year the tier structure was changed											
Spouse	$530.53	3.77%		$571.70	23.55%							
Child/ren	$456.42	-10.73%		$423.09	-8.56%							
Family	$983.79	1.49%	-1.82%	$1,280.06	27.49%	14.16%						
FY 07/08												
One Dependent	$511.26			$462.72								
Two or More	$969.37			$1,004.02								

Spouse = spouse or domestic partner

Child/ren = one or more children

Family = spouse or domestic partner plus one or more children

FIRST AMENDMENT TO THE

INSURANCE NEGOTIATING COMMITTEE BYLAWS

The Insurance Negotiating Committee Bylaws dated 2000, are hereby amended in their entirety to read as follows:

The purpose of the Committee is to recommend to the Washoe County Commission any benefit changes in the County's medical, dental, vision and life insurance plans. This Committee shall also serve as the Oversight Committee for the Retiree Health Insurance Program.

The Committee shall consist of the following voting and nonvoting members:

I. Voting Members.

A. One (1) voting member from each of the following recognized Washoe County employee organizations:

1. Washoe County District Attorney Investigators Association (nonsupervisory)
2. Washoe County District Attorney Investigators Association (supervisory)
3. Washoe County Employees Association (supervisory/admin. unit)
4. Washoe County Employees Association (nonsupervisory unit)
5. Washoe County Nurses Association (supervisory/admin. unit)
6. Washoe County Nurses Association (nonsupervisory)
7. Washoe County Public Attorneys Association
8. Washoe County Sheriff's Supervisory Deputies Association
9. Washoe County Sheriff's Deputies Association
10. Any other recognized Washoe County employee organization

B. One voting member representing Washoe County Management. This voting member shall be appointed by the County Manager.

The above representative members may be changed at any time by their various organizations as those organizations desire. Otherwise, representative members of the Committee serve until resignation.

The associations may have an expert attend the Insurance Committee meetings and provide input to the Committee.

II. Nonvoting Members

A. One (1) retired employee shall serve as a nonvoting member to provide input on the effects of proposed changes upon retirees. The name of a retiree may be nominated by any voting member. The retiree employee shall be selected by majority vote of the associations and shall thereafter serve at the pleasure of the said associations.

B. The Committee Chairperson and Vice-Chairperson shall be appointed by the County Manager and will not have a vote on the Committee. The Committee Chairperson shall provide notice of and preside over all meetings duly called. In the absence of the Chairperson, the Vice-Chairperson shall preside.

The Committee may conduct a valid meeting when a quorum of at least six (6) voting members is present. A majority vote of the ten (10) voting members is necessary for formal action. If only six (6) voting members are present, for example, six (6) votes are necessary to take formal action. In no event may formal action be taken by the Committee with less than six (6) votes in favor of such action.

Action shall be taken upon a motion made by a voting member, seconded by another voting member, and a subsequent voice vote in which a proper majority votes either for or against the motion. A motion made may be amended at any time prior to its final acceptance or rejection by voice vote of the Committee.

The voting member of each bargaining unit, upon conferring with its association as necessary, shall have the authority to bind said bargaining unit to any modification in benefits agreed to by a majority vote of the Committee. Such modifications shall then be presented to the County Commission, and if so approved by the County Commission, shall be binding upon each bargaining unit.

If the Committee recommendation is rejected by the County Commission, the Commission shall define their objections and parameters and the Insurance Committee shall, within fifteen (15) days of being notified of the Commission's objections and parameters, meet and attempt to redefine plan modifications which meet the Commission-established parameters. If the Committee is successful, the plan modifications shall be resubmitted to the Commission for approval. If the Committee is unable to determine acceptable modifications for submission to the Commission, the County and Insurance

Committee agree to resolve any resulting differences by submitting the dispute to expedited final and binding interest resolution which shall be binding upon the County and the bargaining units.

III. Binding Interest Resolution Process

When the Insurance Committee first convenes in any plan year, no later than January 31, they shall notify the County Manager of their designated representative(s) who shall represent the Insurance Committee in selecting an experienced insurance neutral and scheduling a timely hearing should it be necessary. Within five (5) days of notification of the Committee's representative(s), said representative(s) and the County Labor Relations Manager shall meet and designate an experienced insurance neutral to hear such dispute should it become necessary. If the parties are unable to agree on the neutral, they shall obtain a list of five (5) experienced insurance individuals from the Nevada Insurance Commissioner with the in-depth knowledge of public sector insurance systems who are not associated with Washoe County or with the Washoe County association bargaining units, and alternately strike from the list to select the neutral and the mediator. The right to strike the first name from the list shall be determined by the toss of a coin. They shall immediately contact the neutral and advise him/her of their selection should a hearing become necessary and the conditions for a decision which shall include:

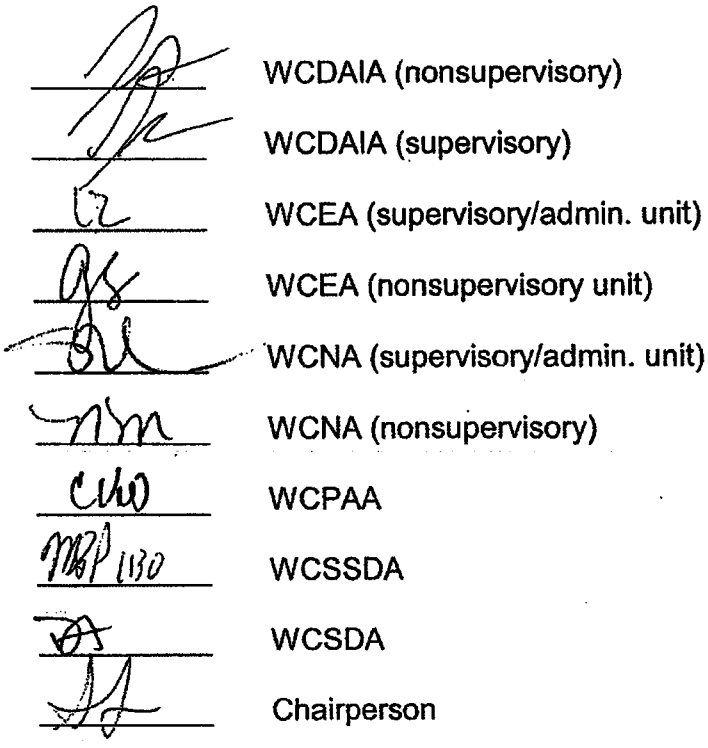
A. the hearing shall be scheduled for two (2) consecutive days, with each party having one (1) day to present their position on the merits of the dispute;
B. the neutral may keep a record of the hearing and the parties will retain a court reporter to transcribe and provide a real time transcript of the hearing;
C. each party shall have five (5) days following the hearing to submit any brief they intend filing;
D. the neutral shall render a decision within fifteen (15) days of when the briefs are due; and
E. the neutral's authority shall be restricted to either selecting the plan design submitted by the Committee or the plan design submitted on behalf of the County Commission. The Insurance Committee representative(s) and Labor Relations Manager shall also be advised of the Insurance Committee schedule and shall set a date with the neutral in advance of any known dispute in order to

insure a timely decision in the event resolution process is necessary. In the event the resolution process hearing is not necessary, the County shall pay any cancellation fees. Each party shall be responsible for their costs of presenting their case to the neutral and any of his/her fees shall be split equally with the Insurance Committee (associations) paying half and the County paying half.

Votes by proxy shall not be allowed. However, a voting member, including the management representative, may designate a representative of their organization or group to attend a meeting and vote in their place and stead.

The Committee may, from time to time, vote (as set forth above) to amend, suspend, revoke, rescind, add to or subtract from these bylaws.

These bylaws are hereby revised and adopted this 17th day of February, 2011.



WCDAIA (nonsupervisory)

WCDAIA (supervisory)

WCEA (supervisory/admin. unit)

WCEA (nonsupervisory unit)

WCNA (supervisory/admin. unit)

WCNA (nonsupervisory)

WCPAA

WCSSDA

WCSDA

Chairperson