STATE OF NEVADA

PUBLIC EMPLOYEES' BENEFITS PROGRAM

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Board Chairman

August 18, 2010

**Plan Year 2012 Plan Design Changes
Approved by the PEBP Board on
August 5, 2010**

The Department of Administration, Budget Division instructed PEBP to keep the subsidy levels flat for the 2012-2013 biennium. The retiree subsidy (REGI) stays at the FY 2011 aggregate approved level ($75.5 million for the biennium), and the active subsidy assessment (AEGIS) remains at the FY 2011 per employee amount ($680.84). Using these targets, PEBP must set its total required subsidies (AEGIS and REGI combined) no higher than $500.0 million for the biennium.

If the PEBP Board had elected to maintain the current (FY 2011) benefit plan design and the current subsidization policies (the amount provided by the State versus the amount provided by the employees and retirees), the trend increase estimate provided by PEBP's actuaries for the self-funded and HMO plans (medical inflation, utilization and the impact of Federal Health Care Reform – e.g., covering children to age 26 and eliminating lifetime and wellness benefit caps) would require $611.2 million in total State subsidies for the biennium. This leaves PEBP with a "shortfall" of $111.2 million.

In order to meet the target set by the Budget Division, the Board was required to shift the $111.2 million in costs to the employees and retirees either through decreased benefits or increased premiums. At its August 5, 2010 meeting, the PEBP Board took the approach of making plan design changes that had the potential to decrease plan utilization in order to generate long-term savings for the plan. The changes approved by the PEBP Board will go into effect on July 1, 2011 and include the following:

A. Medical plan design:
   1. ***Medical Plan Option 2 and 5***
      a. Replace current PPO plan with a PPO High Deductible Consumer Driven Health Plan (CDHP)
         i. $2,000 annual Individual Deductible/$4,000 Family Deductible
         ii. $3,900 annual Individual/$7,800 Family Out-of-Pocket Maximum
         iii. 75% Co-insurance
         iv. Health Savings Account (HSA) for Active Employees
         v. Health Reimbursement Arrangement (HRA) for Retirees

vi. Provide HSA/HRA with $600 plan contribution annually for participants and $200 for each dependent to a maximum of $1,200 total plan contribution

b. Maintain HMO plans

B. Medical plan components:

1. Eliminate plan coverage for all lab tests performed at hospitals except those for pre-admit testing, urgent care, emergency room and in-patient admissions
2. Reduce temporomandibular joint (TMJ) disorder coverage from 80% to 50%
3. Allow for a 90 day supply of certain retail drugs
4. Eliminate routine vision benefits except annual eye exam
5. Eliminate coverage for spouses and domestic partners eligible for coverage through the spouse's or domestic partner's employer
6. Remove "or as needed" from Wellness and Preventive Guidelines in the Master Plan Document

C. Dental plan:

1. Dental Plan Benefit Option 3

i. Eliminate dental benefits except routine preventive services (4 cleanings per year, annual examinations/x-rays, fluoride and sealant treatments)

ii. Leave dental plan included in overall rates as is done currently

D. Fully Insured Supplementary Products:

1. ***Basic Life Option 2*** - Reduce Basic Life Insurance payouts by 50%
2. ***Long Term Disability (LTD) Option 2*** - Reduce LTD benefit from 60% to 40% of base pay and offer employee opportunity to buy up to 60%
3. **Other Fully Insured Supplementary Products** - Eliminate Dependent Life Insurance and Accidental Death and Dismemberment
4. Leave fully insured supplementary products included in overall rates; make the fully insured supplementary products 100% employer paid

E. Medicare retiree coverage:

1. Medicare Retiree Option 3

a. Move Medicare Part A eligible retirees to an individual market Medicare Exchange

b. Fund HRA with plan contributions of $10 per month ($120 per year) per year of service (YOS); minimum of 5 YOS; maximum of 20 YOS. For example, participants with 5 YOS would receive $600 plan contributions per year; participants with 20 YOS would receive $2,400 plan contributions per year.

c. Provide no money for subsidization of premiums; may use plan contributions to pay premiums

d. Move all Medicare Part B eligible retirees who are ineligible for Medicare Part A to the non-Medicare retiree rates and provide the retirees (primary insured only) a premium rate credit in an amount equal to the Medicare Part B premium published by the Centers for Medicare and Medicaid Services (CMS) at the time PEBP sets rates each year (currently $96.40)
e. For Medicare Part A eligible retirees who have dependents who are ineligible for Medicare, provide the following option:
    i. Move the participant and all dependents to the appropriate tier non-Medicare rates and provide the retirees (participant only) a premium rate credit in an amount equal to the Medicare Part B premium published by CMS at the time PEBP sets rates each year (currently $96.40)
f. Allow Medicare retirees to participate in Dental and Basic Life Insurance programs as amended by the Board actions on August 5, 2010

The following Frequently Asked Questions will answer some of the questions we have received regarding the plan changes. More detailed documentation will be created and provided to participants in the coming months.

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Frequently Asked Questions (FAQs)

Plan Year 2012 Plan Design Changes approved by the PEBP Board on
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1. **Why is the PEBP Board making drastic changes and cuts to our benefits?**

   PEBP was directed by the Department of Administration to maintain a level state subsidy budget for the coming biennium. That means PEBP must pass all inflationary increases to participants through benefit reductions and participant premium increases for Fiscal Years 2012 and 2013. Projected inflation, increased plan utilization and costs associated with Federal Health Care Reform will add approximately $111 million to the current cost of providing health insurance to PEBP's 43,000+ participants and their dependents. The PEBP Board and staff looked for alternative plan design options that would reduce plan costs, maintain plan solvency, and still provide essential benefits to all plan participants.

2. **When will these changes go into effect?**

   The changes will become effective July 1, 2011, for Plan Year 2012.

3. **When will the Plan Year 2012 premiums be determined?**

   Premiums for Plan Year 2012 will set by the PEBP Board in March, 2011.

4. **Is it true we will no longer have a PPO plan option?**

   The PPO plan will be replaced with a PPO High Deductible Consumer Driven Health Plan (CDHP).

5. **Will the PPO High Deductible CDHP continue to offer the same network providers? Will I need to find other health care providers?**

   Participants enrolled in the PPO High Deductible CDHP will use the current Statewide PPO Network and the Beech Street (out-of-state network) as their provider networks. Participants will be able to continue seeing their current PPO providers and receive the PPO network discounts.

6. Will I still have my $2,500 annual wellness benefit?

You will continue to have a wellness benefit for preventive/wellness care. Wellness benefits are not subject to deductible or copayment. Under the Federal Health Care Reform, the annual cap on wellness will be eliminated as of July 1, 2011.

7. Is it true there will be increases to the Deductible amounts?

The deductible amounts will increase from the current $800 individual/$1,600 family to a $2,000 Individual Deductible and a $4,000 Family Deductible on the PPO High Deductible CDHP.

8. Is there a change from the current plan in how a family will meet the deductible?

Yes. Under the PPO High Deductible CDHP, there are two deductibles. Deductibles, for individual or family coverage, accumulate separately for in-network provider expenses and out-of-network provider expenses. If both in-network and out-of-network providers are used, the deductible will have to be met twice-- once for in-network and once for out-of-network.

- For single coverage individuals, this plan has a $2000 Individual deductible.
- For coverage of two or more persons, this plan has a $4000 family deductible, which can be met by any combination of eligible medical expenses from *one or more* members of the same family coverage tier.

  Example

  1. Family tier member #1 incurs $2500 in eligible in-network medical expenses, which is applied to the family in-network deductible of $4000. In-network deductible now remaining, $1500.
  2. Family tier member #2 incurs $2000 in eligible in-network medical expenses: $1500 is applied toward the remaining family in-network deductible, which satisfies the $4000 annual family in-network deductible amount. The remaining $500 is paid at the appropriate coinsurance rate.

9. Will the annual out-of-pocket maximums increase as well?

The annual out-of-pocket maximums will increase from the current $3,700 individual/$7,400 family to $3,900 Individual and $7,800 Family.

10. After I have satisfied my deductible on the PPO High Deductible CDHP what will the plan pay toward eligible claims? The current PPO plan pays 80%, will that change?

Yes, the coinsurance percentage will change. The PPO High Deductible CDHP will pay 75% of eligible (in-network) expenses, after the deductible has been met and until the out-of-pocket maximum is reached.

11. What is the Health Savings Account (HSA)?

A Health Savings Account (HSA) is an account owned by the employee that is used to pay for eligible health care expenses. The employer can contribute funds to the HSA and the employee may also contribute money to the account on a pre-tax basis. Contributions, investment earnings and distributions are tax free as long as the money is used only for eligible healthcare expenses. Funds deposited in the HSA can be carried over from year to year.

12. How does the HSA work?

Funds in an HSA belong to the employee and have no expiration date. Total annual contributions to an HSA are limited pursuant to IRS guidelines. You have the ability to save money in your HSA account for future medical expenses, including retiree health insurance premiums.

13. What happens to HSA if I terminate my employment or retire?

The HSA is completely portable, meaning you keep the funds in your HSA if you terminate and/or retire. The only restriction is use of the funds for qualified medical expenses. Use of funds for other than qualified medical expenses will incur taxes and penalties pursuant to the Internal Revenue Service (IRS) Code.

14. What is the Health Reimbursement Arrangement (HRA) that the Board approved for retirees?

The Health Reimbursement Arrangement (HRA) is similar to an HSA but the funds are owned by the plan, not the retiree. It allows retirees to be reimbursed for eligible out-of-pocket expenses, including office visit co-pays, coinsurance, and prescription co-pays. In certain circumstances, the HRA may also be used to pay for premiums charged by an insurer.

15. Will PEBP provide the education and information that I will need to understand how the HSA works?

Yes, PEBP staff is committed to providing you the education you need to understand the mechanics of this new program. PEBP will be issuing a Request for Proposal for a vendor to administer the HSA/HRA. More information will be provided once the contract is awarded.

16. What does the term "seed money" mean in relation to the HSA/HRA?

The term "seed money" simply means the Plan's contribution to the HSA/HRA. The Board approved a contribution of $600 for participants and $200 for each dependent to a maximum of $1,200. PEBP will deposit the amount into each participant's HSA/HRA account. These contributions will be made to the participants' accounts annually but the amounts may be amended by the Board in future plan years. This money may be used for first dollar expenses to offset the plan year deductible.

17. Will PEBP continue to offer HMO plans?

Yes, PEBP will continue to offer the HMO plans in both Northern and Southern Nevada.

18. Why did the Board eliminate dental and vision benefits? Am I still eligible for teeth cleanings and vision examinations?

This decision was part of the Board's overall plan to reduce costs. The Board eliminated all dental and vision benefits except the preventive care benefits under the dental plan (4 cleanings per plan year, examinations, bitewing X-rays, fluoride and sealant treatments) and the annual vision examination.

19. Will our Basic Life Insurance benefit be reduced as well?

Yes, the current $20,000 Basic Life Insurance for active employees will reduce to $10,000. The current $10,000 Retiree Basic Life will reduce to $5,000. The Dependent Life Insurance coverage for dependents of actives and retirees will be eliminated.

20. Will the Long Term Disability Insurance for active employees also be eliminated?

No, this benefit will not be eliminated. The Board chose to reduce the Long Term Disability (LTD) payout, rather than completely eliminate the benefit. Currently, LTD insurance is 100% employer paid and the LTD payout is equal to 60% of the claimant's pre-disability earnings. For Plan Year 2012, the LTD benefit will also be

100% employer paid; however, the payout amount will be reduced to 40% of pre-disability earnings. However, employees will have the option to buy up to the 60% level.

21. Will all Medicare Part A retirees be required to enroll in the individual Medicare Exchange?

Yes. The Medicare Exchange will be the only plan option offered to Medicare Part A retirees. However, PEBP will continue to determine eligibility for Medicare Part A retirees and provide the $5,000 Basic Life Insurance benefit and voluntary/supplemental products.

22. Will the Medicare Exchange's benefits be comparable to the current PPO plan?

The Medicare Exchange will provide a variety of plan options for Medicare Part A retirees. These plans will be Medicare Advantage or Medi-gap plans. In some cases, these plans will offer better or similar benefits to the current PPO plan for a lower premium cost.

23. Will retirees who only have Medicare Part B because they do not qualify for Medicare Part A be required to enroll in the Medicare Exchange?

No. Retirees who do not qualify for Medicare Part A are not eligible for the Medicare Exchange. These individuals will have the option of remaining on either the PPO High Deductible CDHP or one of the HMO plans.

24. Will retirees who only have Medicare Part B because they do not qualify for Medicare Part A continue to receive the Medicare Retiree Rates?

No. There will no longer be separate Medicare Retiree rates. Medicare Part B only retirees will be rated as non-Medicare eligible retirees.

25. Will Medicare retirees who do not qualify for Medicare Part A receive any compensation for having Medicare Part B?

Yes. Medicare retirees (the primary participant only – not dependents) who are moved into the non-Medicare rates because they do not qualify for Medicare Part A will receive a credit in an amount equal to the base cost of the Medicare Part B premium as published by Centers for Medicare and Medicaid Services (CMS) on the date the plan year rates are set.