

Public Employees' Benefits Program

The History of PEBP

The Public Employees' Benefits Program (PEBP) has the fiduciary responsibility to design and manage a quality health care program for approximately 43,000 primary participants and their dependents, totaling over 70,000 lives. PEBP operations funded through legislative appropriations as part of the biennial budget. Funding for PEBP insurance plans are from participant and employer contributions. Each biennium State agencies incorporate the cost of providing a subsidy to their active employees in to their budget request. State retirees are subsidized by the State using a formula based on the number of years employed in State service. Non-State participants receive a subsidy from their participating local government based on the years of service credit earned during their active employment. Assembly Bill 286 (2003), established the requirement that local government employers pay a subsidy to PEBP for their retirees enrolled in PEBP. During the 2007 Legislative Session, Senate Bill 544 changed the rules that govern eligibility for retirees of non-participating local governments.

The PEBP Board provides oversight to the Program, while the Executive Officer oversees the Program's daily operations. The PEBP office is located in Carson City and employs a staff of 32 full-time employees. Operations include Quality Control, Public Information, Account, Information Technology, Member Services and Eligibility.

The following describes the history of the Public Employees' Benefits Program, summarized by plan year beginning with the current plan year.

Plan Year 2012 (July 1, 2011 – June 30, 2012)

The Department of Administration, Budget Division instructed PEBP to keep its subsidy levels flat or at the same level as FY 2011 for the 2012-13 biennium. The aggregate approved for retiree subsidy (REGI) for FY 2011 was \$75.5 million and the active subsidy assessment (AEGIS) per employee for FY 2011 was \$680.84. Using these targets, PEBP had to set its total required subsidies (AEGIS and REGI combined) no higher than \$493.5 million for the biennium.

To maintain the same plan design as Plan Year 2011 and existing subsidization policies (amount provided by the State versus the amount provided by the employees and retirees) and factoring in medical inflation, plan utilization and costs associated with Federal Health Care Reform, PEBP would have required \$85.2 million in total State subsidies for the biennium. To meet the target set by the Budget Division, the PEBP Board could have shifted the costs to employees and retirees through decreased benefits and increased premiums. In lieu of significant cost shifts to participants, the PEBP Board made plan design changes that would have the potential to decrease plan utilization and generate long-term savings for the plan. These changes include:

A. Consumer Driven PPO High Deductible Health Plan

1. Replace the current Self-funded PPO Plan with a Consumer Driven PPO High Deductible Health Plan

2. Increase deductibles from \$800 for an individual and \$1,600 for a family to:
 - a. Participant Only coverage tier: \$1,900 deductible
 - b. Participant plus dependent tiers:
 - i. \$2,400 individual family member deductible
 - ii. \$3,800 family deductible
3. Change the out-of-pocket maximum from a \$3,700 individual, \$7,400 family coinsurance out-of-pocket maximum to a “true” out-of-pocket maximum of \$3,900 for the participant only coverage tier and \$7,800 for all tiers with dependents.
4. Eliminate all copayments.
5. Lower coinsurance from 80% to 75%.
6. Provide a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) for all PPO participants and fund the HSA/HRA with an annual contribution of \$700 for each participant and \$200 for each dependent (max 3 dependents) up to a maximum of \$1,300. Money in the HSA or HRA may be used for any qualified medical expense as defined by IRS except premiums.

B. Various components of the Medicare plan and eligibility for dependents

1. Eliminate plan coverage for all lab tests performed at hospitals except those for pre-admission testing, urgent care, emergency room and in-patient admissions (refer to page 7.)
2. Reduce temporomandibular joint (TMJ) disorder coverage from 80% to 50%.
3. Allow for a 90 day supply of certain retail drugs at certain retail pharmacies.
4. Eliminate vision hardware benefits. Eye exam is subject to deductible and coinsurance.
5. Eliminate the cap of \$2,500 for wellness benefits and match wellness and preventive guidelines to those published by the Centers for Disease Control and Prevention.
6. Eliminate the \$2,000,000 lifetime maximum.
7. Eliminate coverage for spouses and domestic partners eligible for coverage through the spouse’s or domestic partner’s current employer.
8. Cover dependent children through the end of the month in which the child turns age 26 and no longer require proof of full-time student status.

C. Dental Coverage

1. Increase the dental deductible from \$50 to \$100 for individuals and \$150 to \$300 for families (3 or more individuals).
2. Decrease the maximum dental benefit paid by the plan from \$1,500 to \$1,000 per individual regardless of whether the service is in or out of network.
3. Change coinsurance to 75% for basic dental services.
4. Dental coverage is mandatory for any participant who chooses COBRA coverage.

D. Fully insured supplemental products

1. Reduce basic life insurance payouts from \$20,000 to \$10,000 for employees and from

\$10,000 to \$5,000 for eligible retirees.

2. Retain the current 60% payout for long-term disability benefits.
3. Eliminate dependent life and accidental death and dismemberment insurance coverage.

E. Change the rate structure methodology to a more traditional rating calculation

1. Calculate rates such that if a single adult costs \$X and total children per tier cost \$Y, then the rates for each tier would be as follows:

- Participant Only = \$X
- Participant Plus Spouse = \$2X
- Participant Plus Child(ren) = \$X + \$Y
- Participant Plus Family = \$2X + \$Y

F. Blend the rates between Northern and Southern Nevada to offer one single statewide HMO rate.

G. Medicare Part B Credit

1. Provide a \$115.40 premium credit equal to the 2011 base cost of Medicare Part B to retirees and survivors enrolled in the CD PPO HDHP or HMO plans

H. Live Well, Be Well Prevention Plan

1. Continue offering the Live Well, Be Well Prevention Plan to CD PPO HDHP participants with some plan design modifications that will be announced June 2011.

H. Diabetes Care Management Program

1. Continue offering the Diabetes Care Management Program to CD PPO HDHP participants with some plan design modifications that will be announced June 2011.

I. Medicare Exchange – Medicare Coordinator Service

1. Retirees and their spouses or domestic partners with Medicare Part A will be moved to a Medicare Coordinator Service. Through the Medicare Exchange Medicare Part A retirees have more plan options including medical, prescription drug, optional dental and vision plans.

Plan Year 2011 (July 1, 2010 – June 30, 2011)

Plan Year 2011 had significant changes in plan design and rates. PEBP implemented the indexing policy for deductibles and out-of-pocket maximums. Using Plan Year 2010 as the base year, the resulting deductible and out-of-pocket maximums were then rounded to the nearest \$25.00. Based on the calculation, the in-network deductibles increased from \$725 to \$800 individual and \$1,450 to \$1,600 for the family. The out-of-pocket maximums increased from \$3,500 to \$3,700 individual and \$7,000 to \$7,400 for the family. The out-of-network out-of-pocket maximum increased from \$10,000 to \$10,600 individual and \$20,000 to \$21,200 for the family.

- Due to State travel restrictions, PEBP limited the face-to-face open enrollment meetings to Reno, Carson City and Las Vegas. All other meetings were held via video-conferencing.

PEBP also eliminated the mailing of the open enrollment guides and directed participants to the website for information. The guides were made available only by request.

- PEBP contracted with U.S. Preventive Medicine to administer a new wellness program, the Live Well, Be Well Prevention Plan for PPO primary participants in lieu of the Wellness Fairs that were previously offered. U.S. Preventive Medicine also contracted for the disease management program replacing the previous carrier and limited the disease state to diabetes.
- The HMO carrier in the North experienced a \$13 million loss during the previous extended plan year (16 months); therefore, significant plan design changes were implemented for the Northern HMO, which included an individual and family deductible and increased copayment amounts.
- PEBP expanded its eligibility to include domestic partners and dependents of domestic partners on a cost neutral basis (without subsidy).

Plan Year 2010 (November 1, 2009 – June 30, 2010)

In light of the State's economic situation, the State Budget office directed PEBP to submit its budget request for Fiscal Years 2009/2010 with specific subsidy limits (comparable to that which was approved for the 2007/2008 biennium). PEBP receives approximately two-thirds of its revenue from the State subsidy. After accounting for projected cost trends, enrollment growth, and the subsidy reduction compared to what would have been required to sustain the Program's existing benefits, and cost sharing policies, a \$53 million funding gap was identified.

To meet the budget target, the PEBP Board faced some difficult decisions regarding plan design and premium increases. The Board considered a number of options and agreed the most equitable way to meet the budget target would be to meet half of the funding gap through plan design changes and the other half through increased rates.

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While changes were necessary, the Board's primary objective was to provide PEBP participants with financial protection from catastrophic health care expenses. Based on that philosophy, the following changes were incorporated into Plan Year 2010:

- The Self-funded PPO High and Low Deductible Plans were merged into one single plan option. The new PPO plan featured a \$725 Individual and \$1,450 Family deductible. The plan was structured similar to the Low Deductible plan with fixed copayments for physician office visits and urgent care visits.
- The PEBP Board continued the Reserve for Rate Stabilization policy which allowed the Plan to retain the reserves for use in future years to smooth the impact of rate increases and plan changes to participants.

- Reduced the percentage of cost paid by the State subsidy in all tiers, in all plan options.
- Allocated the Medicare Part D revenue between the plan and the Medicare retirees.
- Eliminated the Health Assessment Questionnaire and its plan incentives.
- Approved the policy to index (i.e., inflate) the annual out-of-pocket maximum at 50% the rate of medical trend each year. The annual deductible would be indexed at 100% of the rate of medical trend each year. The indexing would be in increments of \$25 and would begin July 1, 2010.
- Eliminated the neurotherapy and psychotherapy benefits for ADD and ADHD.
- Eliminated the PPO Value Plan for Medicare retirees.
- Increased the PPO retail pharmacy benefit for specialty pharmaceuticals from a \$40 copayment to a \$50 copayment or 25% of the cost of the drug (whichever is greater) to a maximum \$100 out-of-pocket coinsurance per prescription.
- Increased the PPO copayment for mail order prescription drugs on Preferred (Tier 2) drugs from \$80 to \$120 for a three month supply.
- Held HMO premium increases to 5% for Plan Year 2010.
- Implemented additional precertification requirements for participants seeking approval for weight loss surgery and outpatient spinal surgery.

Plan Year 2009 (July 1, 2008 – October 31, 2009)

- In Plan Year 2009, the PPO plan benefits were expanded to include ADD and ADHD treatment. PEBP contracted with a new HMO carrier in Northern Nevada (changed from Anthem to Hometown Health Plan). To comply with Senate Bill 544 (2007), a new limited benefit option for Medicare retirees enrolled in Parts A and B was implemented. The new plan option, the "PPO Value Plan," provided coverage for prescription drugs, dental and vision services that were not covered under Medicare. Medicare retirees were un-commingled (rated separately) from non-Medicare retirees and active employees, and PEBP eliminated the rate reduction credit for Medicare Part B. The Board continued its supplemental subsidy policy (approved March 2008) of providing a supplemental subsidy to any tier with total dollar increases greater than \$100 and cost increases greater than one and a half times the blended medical trend of 10.1 percent for active employees and 11.3 percent for Medicare retirees. The subsidy amount for Plan Year 2009 applied to three State tiers and 32 non-State tiers.
- The rates for the next plan year are generally set in February or early March. However, during that time, there were numerous bills pending in the legislature that, if passed, could impact the rates. The timing was such that if PEBP were to set the rates and move forward

with the open enrollment period for Plan Year 2010, any legislative action that would have modified the subsidy amount and/or change plan design would impact the rates. These changes would have required PEBP to hold a second open enrollment period. To avoid having a second open enrollment, the PEBP Board made the decision to extend the plan year from June 30, 2009 to October 31, 2009. The cost of the plan year extension was made up of two components. First, there was approximately \$7.2 million in cost due to the decrease in base subsidies for Plan Year 2009 to Plan Year 2010 (while participant contributions remained the same during the four month extension). Second, there was an additional \$12.8 million due to increased claims cost for the four month period.

- The 2009 Legislative Session ended with the passage of several bills that impacted PEBP. The most significant bills were: 1) Senate Bill 427, revised the eligibility for years of service subsidy for employees hired by the State on or after January 1, 2010, to a minimum of 15 years of service (except when retirement occurs due to a disability). It also eliminated the retiree years of service subsidy for employees hired by the State on or after January 1, 2010, who reinstate coverage with PEBP after retirement. 2) Senate Bill 283 revised the provisions governing the rights for domestic partners. Senate Bill 283 established a registry through the Nevada Secretary of State to record domestic partnerships. PEBP amended its fiscal note when the bill to make providing benefits for domestic partners discretionary. 3) Assembly Bill 162 required certain policies of health insurance and health care plans to provide coverage for screening and treatment of autism effective July 1, 2011.
- The Plan continued to maintain a fully funded reserve for *Incurred But Not Reported Claims (IBNR)* and a reserve for rate stabilization.

Plan Year 2008 (July 1, 2007 – June 30, 2008)

- Plan Year 2008 brought about some positive changes to the benefits. PEBP waived the \$50 annual PPO deductible for generic prescription drugs and added certain benefits for specific over-the-counter medications. Other enhancements included a benefit for limited genetic testing; the coordination of benefits methodology changed to "Standard" coordination of benefits; PEBP contracted with APS Healthcare to provide Utilization Management and Disease Management; participants received a premium holiday in July 2007; and Medicare retirees received a Medicare Part D credit as a pass-through from the federal government. PEBP also released an RFP for a voluntary short term disability carrier. The contract was awarded to Standard Insurance (replacing Colonial Life) on July 1, 2007. In addition, the ACR 10 Interim Study concluded its recommendations contained in SB544 (2007). The most significant change from ACR 10 was to limit the eligibility of non-state retirees effective November 30, 2008.

Plan Year 2007 (July 1, 2006 – June 30, 2007)

- In Plan Year 2007, PEBP discontinued the Medicare Part B reimbursement and the Plan coordination of benefits methodology for the PPO Plan changed from Maintenance of Benefits to Integration of Benefits for Medicare retirees. A supplemental subsidy was

implemented for retirees in three categories most significant impacted by claims commingling, and provided a premium credit to Medicare retirees and their covered spouses who declined Medicare's Prescription Drug coverage. In addition, PEBP's reserves were fully funded and the PEBP Board provided all participants with a premium holiday in July 2006.

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- Another important provision of SB 547 would be to allow retirees receiving a subsidy under Assembly Bill 286 of the 2003 session to combine all experience from different public employers in computing health care subsidies. Until now a retiree must have had at least five years' experience with each public employer for that time to be counted in computing his or her subsidy.
- The rules that determine how state and local governments present their financial statements are set by the Government Accounting Standards Board (GASB), which is independent of federal, state, and local governments. Under GASB, governments with a certain amount of revenue must disclose what it would cost each year to fund their long-term obligations to pay for retirees' health and other benefits. Although this rule establishes a reporting requirement (not a requirement to pay the unfunded liability), simply reporting the unfunded liability may adversely influence Nevada's credit rating when issuing bonds. In order to reduce the amount of unfunded liability that the State has, the Legislature began pre-funding a portion of the liability in 2007. The Governor recommended and the Legislature approved a total of \$53 million for the 2007-2009 bienniums.

Plan Year 2006 (July 1, 2005 – June 30, 2006)

- PEBP established a Rate Stabilization Reserve and implemented a high deductible plan to create a lower cost option for individuals interested in reducing their monthly premium. The coordination of benefits methodology changed to Maintenance of Benefits. The wellness benefit increased from \$600 to \$2500 per covered participant, per plan year. PEBP introduced the annual Health Assessment Questionnaire (HAQ) and associated incentives that included a 50% reduction to the annual PPO deductible amount and the annual dental maximum increased from \$1500 to \$2000. Other changes included enhanced preventive benefits under the dental plan from two teeth cleanings to four per plan year. Medicare retirees and their covered spouses enrolled in the PPO plan with Medicare Part B received reimbursement of 80% of the Medicare Part B base premium.

Plan Year 2005 (July 1, 2004 – June 30, 2005)

- PEBP introduced its new logo and slogan (Health Matters), launched a new and improved website, and published its first quarterly newsletter.

Plan Year 2004 (July 1, 2003 – June 30, 2004)

- The Plan's financial stability had returned by 2004. During this year PEBP implemented a new disease management program to assist participants with chronic diseases such as diabetes, asthma, congestive heart failure and hypertension.

Plan Year 2003 (January 1, 2003 – June 30, 2003)

- PEBP contracted with a new life insurance and long-term disability vendor, utilization review and management vendor, national PPO network vendor, statewide PPO network vendor, and consultant and actuarial services vendor. In addition, the PEBP Board modified the plan year from a calendar year to a fiscal plan year. In order to change to a fiscal plan year, it was necessary to have a short plan year from January 1, 2003 - June 30, 2003. The fiscal year began July 1, 2003.
- In October 2003, legislative changes resulting from Assembly Bill 286 (codified in NRS 287.023) changed the method of determining retiree subsidy allocation. Under the new method, the subsidy credit was based on the total years of service from all employers with whom the retiree earned a minimum of 5 years service credit. Thus, each employer paid a proportionate share of the subsidy, based on the service credit earned with that employer.
- Following the passage of Assembly Bill 286, and the implementation of subsidy allocation to local government retirees, PEBP experienced a large influx of non-state retiree enrollment. This initiated a four year interim study on the program.

Plan Year 2002 (January 1, 2002 – December 31, 2002)

- In 2002, a strategic analysis of the Program identified areas that required significant changes. As a result, PEBP immediately took measures to contract with a new Pharmacy Benefit Manager (Catalyst RX), a new third party administrator (TPA) (Benefit Planners, Inc. (BPI), and a new enrollment and eligibility system (Iowa Foundation for Medical Care (IFMC)).

Plan Year 2001 (January 1, 2001 – December 31, 2001)

- In 2001, the PEBP Board appointed a new executive officer and management staff to oversee the daily Program operations. During the 2001 Special Session of the Legislature, the Program received a \$24 million bail out to stabilize the Program financially.

Plan Year 1999 (January 1, 1999 – December 31, 1999)

- The Nevada State Legislature provided approximately \$26 million dollars to bail out the program. In February of 1999, the Nevada State Legislature suspended the Committee on Benefits. Senate Bill 544 spelled out the provisions of the dissolution of the Committee on Benefits. The dissolution separated the risk management services from the employee benefit services; thereby establishing the Public Employees' Benefits Program. Senate Bill

544 also included the requirement that a Board oversee the operations of the newly formed agency. The Board consists of nine members. Eight of the members are appointed by the Governor. The ninth member is the Director of Administration or his designee.

Plan Year 1997 (January 1, 1997 – December 31, 1997)

- In 1997, the Committee on Benefits became aware that L & H Administrators, the Program's third party administrator (TPA), had ceased paying claims. The Division of Insurance conducted an investigation and an internal audit was performed. This resulted in the revocation of L & H Administrators' license and their contract termination on May 29, 1997. In August 1997, L & H Administrators was placed into involuntary bankruptcy and ceased all operations. During that same year, the Committee on Benefits approved a contract with a new Third Party Administrator, UICI Administrators. In an effort to stabilize the failing program, the Committee on Benefits implemented premium increases and reductions in benefits.

Plan Year 1996 (January 1, 1996 – December 31, 1996)

- In July of 1996, Coresource, the third party administrator (TPA) for the Program, advised the Committee on Benefits that L & H Administrators would acquire the TPA assets of the western operations of Coresource, and requested that the state contract be assigned to L & H Administrators. The Committee approved the assignment.

Plan Year 1995 (January 1, 1995 – December 31, 1995)

- Coresource was awarded the bid as the new third party administrator for the self-funded PPO plan. The contract was written for the period January 1, 1995, through December 31, 1998.

Plan Year 1994 (January 1, 1994 – December 31, 1994)

- In January of 1994, Mutual Administrators, the Committee on Benefits' self-funded third party administrator (TPA) since 1983, and the fully insured vendor (subcontractor for the program's fully insured plan since 1976) sold their business to Coresource. The Committee on Benefits placed the TPA services out to bid on the normal four year bid cycle.
- In an effort to restore reserve levels, control costs and fiscal solvency to the plan, the Program's actuary recommended the implementation of additional plan design measures.
- By mid-1994, the actuarially sound reserve level had been reached. All previously reduced benefits had been restored and several enhancements to the program had been made.
- Beginning July 1, 1994, non-state retirees were allowed to join PEBP regardless of their employer participation in the program. The non-state retirees were offered the same

benefits as state retirees; however, the non-state retiree rates were determined separately from the state retiree population.

Plan Year 1992 (January 1, 1992 – December 31, 1992)

- The Committee on Benefits faced a projected shortage in the reserve for Incurred But Not Reported (IBNR) claims and in the face of skyrocketing health care costs and inflation in general. The Committee on Benefits significantly increased the cost for dependent coverage, eliminated some benefits, increased out-of-pocket costs in several areas, and implemented various cost control mechanisms.

Plan Year 1984 (January 1, 1984 – December 31, 1984)

- Due to volatility in the insurance industry, periods of skyrocketing health costs, and increased premiums during the 1970s and 1980s, many insurance companies offering fully insured products were not willing to bid on the State of Nevada health plan. Because of this, and in part due to the adverse claim history for the State of Nevada, alternatives were needed. Looking for options, the Nevada State Legislature authorized a 1983 legislative study to examine the feasibility of establishing a self-funded group insurance plan. At the conclusion of the study, it was determined that there would be five major benefits to establishing a self-funded plan, these were: (1) it would provide more flexibility in determining the types and amounts of benefits offered; (2) the ability to retain any interest earnings that would normally become an insurance company's profit; (3) reduce the fixed costs and retain dollars for use within the plan; (4) the ability to choose where "retained" dollars are spent; and (5) to help defray premium costs and maintain benefit levels.

Plan Year 1983 (January 1, 1983 – December 31, 1983)

- The Self Insurance Trust Fund was created in 1983 by the Nevada Legislature to administer group health, life, and disability insurance for covered employees, both active and retired, of the State, and certain other participating public employers within Nevada. The Committee on Benefits developed the benefit plans and the Benefit Services Trust Division of the Department of Administration performed the day-to-day operations. Until 1983, the Program offered comprehensive health care benefits through fully insured policies (HMO plans).