



BRIAN SANDOVAL
Governor

JAMES R. WELLS, CPA
Executive Officer

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM

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LEO M. DROZDOFF, P.E.
Board Chairman

MEETING NOTICE AND AGENDA

Name of Organization: Public Employees' Benefits Program Board

Date and Time of Meeting: January 19, 2012 9:00 a.m.

Place of Meeting: The Legislative Building
401 South Carson Street, Room 1214
Carson City, Nevada

Video Conferencing: The University of Nevada Las Vegas
System Computing Services Building, Room 102
4505 South Maryland Parkway
Las Vegas, Nevada

Internet: www.leg.state.nv.us

AGENDA

- I. Open Meeting
- II. Public Comment
- For Possible Action III. Approve Action Minutes from December 15, 2011 Board meeting

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| For Possible Action | <p>IV. Conduct workshop to solicit comments from interested persons on proposed regulation changes to chapter 287 of the Nevada Administrative Code regarding the following general topics:</p> <ol style="list-style-type: none"> a. Implementation of the Patient Protection and Affordable Care Act (Federal Health Care Reform) as it relates to the coverage of children up to the age of 26, appeals of denied claims and expedited appeals b. Implementation of Assembly Bill 365 (2011) as it relates to the option of groups to leave the Public Employees' Benefits Program c. Implementation of Assembly Bill 556 (2011) as it relates to the billing of premiums and contributions d. Implementation of Assembly Bill 562 (2011) as it relates to the payment of premiums or contributions by retired officers and employees e. Other related matters |
| | <p>V. Executive Officer's Report</p> <ol style="list-style-type: none"> a. Report required pursuant to Section 3 of Assembly Bill 80 (2011) b. Regulation Review |
| | <p>VI. Presentation by AonHewitt Consulting regarding self-funded claims trend experience and projections for Plan Year 2013 (July 1, 2012 through June 30, 2013)</p> |
| For Possible Action | <p>VII. Discussion and possible action regarding plan design changes for hearing aids effective July 1, 2012</p> |
| For Possible Action | <p>VIII. Discussion and possible action regarding the current contract between Hometown Health Providers and Carson Tahoe Regional Medical Center, possible future changes and impacts on the Plan</p> |
| For Possible Action | <p>IX. Discussion and possible action regarding changes to the Board's Duties, Policies and Procedures, including but not limited to:</p> <ul style="list-style-type: none"> • Revising the Rate Setting Process to review the Health Reimbursement Arrangement liability, reserves and carryover limitations • Revising the process for Requests for Proposals and the selection of vendors • Revising Appendix A (Plan Year Rate Methodology) procedures for the rate setting process • Various clarifications, corrections, removal of out-dated references and changes to increase reporting and scheduling flexibility |

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| For Possible Action | X. | Discussion and possible action regarding the legislative platform for the 2013 Legislative Session |
| | XI. | Report from the Executive Officer regarding the State of PEBP |
| For Possible Action | XII. | Discussion and possible action on updates to the Board's Strategic Plan for the 2011-2013 biennium |
| For Possible Action | XIII. | Discussion and possible action regarding the performance evaluation and a vote of confidence or no confidence for the Executive Officer for the period June 1, 2010 through December 31, 2011 |
| For Possible Action | XIV. | Discussion and possible action regarding self-evaluation of the PEBP Board performance |
| | XV. | Information Item – Chief Financial Officer's Report for the quarter ended September 30, 2011 |
| | XVI. | Public Comment |
| For Possible Action | XVII. | ADJOURNMENT |

Unless noted as an action item, discussion of any item raised during a report or public comment is limited to that necessary for clarification or necessary to decide whether to place the item on a future agenda.

Public comment may be limited to three minutes per person at the discretion of the chairperson. Additional comment periods may be allowed on individual agenda items at the discretion of the chairperson. These comment periods may be limited to three minutes per person at the discretion of the chairperson. These additional comment periods shall be limited to comments relevant to the agenda item under consideration by the Board.

All times are approximate. The Board reserves the right to take items in a different order or to combine two or more agenda items for consideration to accomplish business in the most efficient manner. The Board may remove an item from the agenda or delay discussion relating to an item on the agenda at any time. The Board reserves the right to limit Internet broadcasting during portions of the meeting that need to be confidential or closed

Note: We are pleased to make reasonable accommodations for members of the public who are disabled and wish to attend the meeting. If special arrangements for the meeting are necessary, please notify the Public Employees' Benefits Program, in writing, at 901 South Stewart Street, Suite 1001, Carson City, NV 89701, or call Vicki Smerdon at (775) 684-7000, as soon as possible.

Copies of both the Public Employees' Benefits Program (PEBP) Board Meeting Action Minutes and Open Meeting Minutes in transcript form are available, at no charge, for inspection at the PEBP Office, 901 South Stewart Street, Suite 1001, Carson City, Nevada, 89701 or on the PEBP web site at www.pebp.state.nv.us. For additional information, contact Vicki Smerdon at (775) 684-7000 or (800) 326-5496.

Notice of this meeting was posted on or before 9:00 a.m. on the third working day before the meeting at the following locations: BLASDEL BUILDING, 209 East Musser Street, Carson City; PUBLIC EMPLOYEES' BENEFITS PROGRAM, 901 South Stewart Street, Suite 1001, Carson City; THE GRANT SAWYER STATE OFFICE BUILDING, 555 East Washington Avenue, Las Vegas, THE LEGISLATIVE BUILDING, 401 South Carson Street, Carson City, and on the PEBP web site at www.pebp.state.nv.us. In addition, the agenda was mailed to groups and individuals as requested.

I.

Open
Meeting

II.

Public
Comment

III.

Approve Action
Minutes from
December 15, 2011
Board meeting

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM BOARD
The Legislative Building
401 South Carson Street, Room 4100, Carson City, Nevada
Videoconference to the Grant Sawyer State Office Building
555 East Washington Avenue, Room 4412E, Las Vegas, Nevada

ACTION MINUTES (Subject to Board Approval)
Thursday, December 15, 2011

MEMBERS PRESENT: Mr. Leo Drozdoff, Chairman
Ms. Jacque Ewing-Taylor, Vice Chair
Mr. George Campbell, Member
Ms. Karen Caterino, Member
Ms. Julia Teska, Member
Ms. Teri Thienhaus, Member

**MEMBER PRESENT
IN LAS VEGAS:** Mr. Jeff Garofalo, Member

**MEMBER PRESENT
IN ELKO:** Ms. Dawn Stout, Member

MEMBER ABSENT: Mr. Bob Moore, Member

FOR THE BOARD: Mr. John Michela, Senior Deputy Attorney General

FOR STAFF: Mr. Jim Wells, Executive Officer
Ms. Kateri Cavin, Operations Officer
Ms. Donna Lopez, Quality Control Officer
Mr. Jon Hager, Chief Financial Officer
Ms. Vicki Smerdon, Executive Assistant

- I. Open Meeting
- II. Public Comment
 - Ms. Pat LaPutt – UNLV
 - Mr. Ty Windfeldt – Hometown Health
 - Mr. Kent Ervin – Active participant
 - Ms. Susie Sepahpour – Retired teacher
 - Mr. Marty Bibb – Retired Public Employees of Nevada
- III. Approve Action Minutes from November 3, 2011 Board meeting – (Action)

Public Employees' Benefits Program Board Meeting
December 15, 2011 Action Minutes

MOTION: Move to approve the September 7, 2011 Board meeting minutes.
BY: Member Thienhaus
SECOND: Member Teska
VOTE The vote was unanimously in favor of the motion.

IV. Health Claim Auditors, Inc. audit of HealthSCOPE Benefits for the quarter ending September 30, 2011 – (Action)

- a. Presentation of report by Health Claim Auditors
- b. HealthSCOPE Benefits response to audit report
- c. Discussion and possible action to accept audit report finding

MOTION: Move to accept the audit report and HealthSCOPE's response
BY: Member Teska
SECOND: Member Caterino
VOTE The vote was unanimously in favor of the motion.

V. Executive Officer's Report – (Information Only)

- a. Update on reorganization of Operations
- b. Update on Department of Administration Core Function Performance Planning Framework
- c. Executive Order on Regulations
- d. Letter of Intent from the 2011 Legislature

Public Employees' Benefits Program Board Meeting
December 15, 2011 Action Minutes

- VI. Discussion and possible action regarding the following plan design changes effective July 1, 2012: - (Action)
- a. Setting a limit on the amount allowed to be accumulated in participant Health Reimbursement Arrangement for the PPO High Deductible Health Plan
 - b. Setting a limit on the amount allowed to be accumulated in participant Health Reimbursement Arrangement for the Medicare Exchange
 - c. Establishing timing of Health Savings Account and Health Reimbursement Arrangement contributions for PPO High Deductible Health Plan participants
 - d. Using Centers of Excellence for transplants and bariatric weight loss surgery
 - e. Allowing for the payment of travel and hotel accommodations for the patient and one additional individual person (spouse/domestic partner, family member or friend) for organ/tissue transplants and bariatric weight loss surgery when surgery is performed at a Center of Excellence
 - f. Excluding the 50% participant coinsurance for hearing aids from the annual out of pocket maximum
 - g. Revising the Master Plan Document provisions regarding subrogation/third party payment
 - h. Expanding medical precertification requirements to include pacemakers, chemotherapy and kidney dialysis
 - i. Excluding preventive dental from annual maximum benefit

Public Comment

- Dr. Jim Richardson – Nevada Faculty Alliance
- Ms. Pat LaPutt – UNLV
- Mr. Kent Ervin – Active participant

Public Employees' Benefits Program Board Meeting
December 15, 2011 Action Minutes

MOTION: Move to approve agenda item A as presented for 2013 which would be no limit on the carryover of the HRA for the PPO plan. Move to approve Item B as presented for 2013 which would be no limit on the carryover of the HRA for Medicare Exchange participants. Move to approve letter C, number 1, as presented which is to use the same dollar amounts from 2012 for 2013. On Item 2 to fund the HRA and the HSA for the PPO participants on an annual basis. On Item 3, to prorate for new participants and dependents based on the 12-month period as opposed to the six-month period.

AMENDED

MOTION: Clarify that the amount funded is the full amount, whatever that is, on July 1st and not setting the actual contribution amount to the HRA or HSA.

BY: Member Teska

SECOND: Member Ewing-Taylor

VOTE The vote was unanimously in favor of the motion for agenda Item VI, A, B and C.

MOTION: Move to approve staff's recommendation that Centers of Excellence be utilized for organ and tissue transplants and bariatric surgeries and that we allow for the payment of travel and hotel accommodations for the patient and one additional individual person when associated with the use of a Center of Excellence for organ, tissue transplants and bariatric weight loss surgery subject to the limitations as delineated in staff's recommendation with the following changes. That the per diem rates be based on the GSA rates in effect at the time and that travel meals be included as payable under the same rules that state employees' travel meals are paid.

BY: Member Ewing-Taylor

SECOND: Member Caterino

VOTE The vote was unanimously in favor of the motion.

Public Comment

- Ms. Pat LaPutt – UNLV
- Ms. Peggy Lear Bowen - Retiree

Public Employees' Benefits Program Board Meeting
December 15, 2011 Action Minutes

MOTION: On item F move that no action be taken on staff recommendation at this time but ask staff to gather additional information and come back with a recommendation at a future board meeting.

BY: Member Ewing-Taylor

SECOND: Member Thienhaus

VOTE The vote was unanimously in favor of the motion.

MOTION: Move to approve items G, H and I as recommended by staff.

BY: Member Teska

SECOND: Member Caterino

VOTE The vote was unanimously in favor of the motion.

VII. Discussion and possible action regarding the following recommendations from the Wellness Advisory Committee relating to obesity care management: - (Action)

- a. Using and Promoting the Current Plan Design.
- b. Developing an Obesity Care Management Program effective July 1, 2012:
 1. Limiting eligibility criteria for medically supervised weight loss programs
 2. Defining "actively engaged"
 3. Monitoring engagement
 4. Covering claims for medically supervised weight loss programs
 5. Removing certain benefit exclusions for those who are "actively engaged" including:
 - a) Coverage of pharmacotherapy claims
 - b) Coverage of meal replacements
- c. Limiting bariatric weight loss surgeries to once in an individual's lifetime
- d. Limiting the number of nutritional counseling service visits paid under the wellness/preventive benefit

Public Comment

- Ms. Peggy Lear Bowen - Retiree

MOTION: Move to approve staff recommendation to the master plan document that it be revised effective July 1, 2012 as follows, Items I through VII with no changes.

BY: Member Caterino

SECOND: Member Teska

VOTE The vote was unanimously in favor of the motion.

VIII. Discussion and possible action regarding financial penalties or incentives for tobacco use or non-use for participants and/or dependents on the PPO HDHP Plan and/or the HMO plans. - (Action)

No action taken on this item.

Public Employees' Benefits Program Board Meeting
December 15, 2011 Action Minutes

- IX. Discussion and possible action regarding: - (Action)
- a. The addition of a low deductible self-funded PPO Plan with co-payments and a higher co-insurance percentage similar to prior year plans alongside the current Consumer Driven High Deductible (CDHP) self-funded PPO Plan, or
 - b. The addition of a second CDHP self-funded PPO Plan, including:
 1. Setting the deductible for the new CDHP self-funded PPO Plan at the Federal minimum allowed for high deductible health plans,
 2. Increasing the deductible for the current CDHP self-funded PPO Plan, and
 3. Determining the amount of funds to be contributed to a Health Savings Account for each CDHP self-funded PPO Plan

Public Comment

- Ms. Pat LaPutt – UNLV
- Ms. Michelle Kelley – UNR
- Dr. Jim Richardson – Nevada Faculty Alliance
- Mr. Marty Bibb – Retired Public Employees' of Nevada
- Ms. Peggy Lear Bowen - Retiree

No action taken on this agenda item.

- X. Discussion and possible action regarding proposed changes to the Master Plan Document for Plan Year 2012 (July 1, 2011 – June 30, 2012) regarding participant appeals which incorporates the requirements of Federal Health Care Reform – (Action)

MOTION: Move to approve the revisions to plan year 2012 master plan document included in Attachment A to this agenda item to comply with the appeals process as mandated by the Affordable Care Act and NRS 695G.241 through 695G.310 effective July 1, 2011 for internal appeal and October 1, 2011 for external appeals.

BY: Member Thienhaus

SECOND: Member Caterino

VOTE The vote was unanimously in favor of the motion.

- XI. Presentation of the Final Report regarding Cardiac Wellness Program (CWP) by Quality Control Officer – (Information Only)
- XII. Discussion and possible action on Ratification of Southern Nevada HMO Services vendor selection effective July 1, 2012 (Request for Proposal 1946) – (Action)

Public Employees' Benefits Program Board Meeting
December 15, 2011 Action Minutes

MOTION: Move to approve staff recommendation and authorize the staff to negotiate the contract with Health Plan of Nevada to provide Southern Nevada HMO services.

BY: Member Teska

SECOND: Member Thienhaus

VOTE The vote was unanimously in favor of the motion.

XIII. Discussion and possible action regarding 2012 Board calendar and meetings – (Action)

MOTION: Move to approve the calendar as amended changing March 13 to March 14 with the other dates as presented in the agenda item.

BY: Member Teska

SECOND: Member Ewing-Taylor

VOTE The vote was unanimously in favor of the motion.

XIV. Presentation by Chief Financial Officer of self-funded plan utilization reports for the quarter and year ended September 30, 2011 – (Information Only)

XV. Information item - PEBP staff reports

- a. Operations Officer
- b. Quality Control Officer
- c. Chief Financial Officer
- d. Attorney General's Report – Deputy Attorney General

Public Employees' Benefits Program Board Meeting
December 15, 2011 Action Minutes

XVI. Information item –Quarterly Vendor Reports for the period July 1, 2011 through September 30, 2011

- a. APS Healthcare
- b. Beech Street Corporation
- c. Catalyst Rx
- d. Diversified Dental Services
- e. Extend Health
- f. Health Plan of Nevada
- g. HealthSCOPE Benefits
- h. Hometown Health HMO
- i. Morneau Shepell
- j. Sierra Healthcare Options/Hometown Health
- k. The Standard
- l. US Preventive Medicine – Wellness Program
- m. US Preventive Medicine – Care Management

XVII. Public Comment

- Dr. Jim Richardson – Nevada Faculty Alliance
- Ms. Peggy Lear Bowen - Retiree
- Mr. Jeff Monaghan – Catalyst Rx
- Ms. Tina Estay – Catalyst Rx

XVIII. **ADJOURNMENT – (Action)**

MOTION: Move to adjourn
BY: Member Thienhaus
SECOND: Member Teska
VOTE The vote was unanimously in favor of the motion.

The meeting concluded at 4:22 p.m.

PEBP BOARD MEETING ACTION MINUTES, AUDIO RECORDING, & TRANSCRIPT

<p>Copies of both the Public Employees' Benefits Program (PEBP) Board Meeting Action Minutes and Open Meeting Minutes in transcript form at no charge are available for inspection at</p> <p><i>The PEBP Office</i> <i>(775) 684-7000 or (800) 326-5496</i> <i>901 South Stewart Street, Suite 1001</i> <i>Carson City, NV 89701</i></p> <p>◆◆◆</p> <p><i>Or on the PEBP Web site at</i> <i>www.pebp.state.nv.us</i></p>	<p>Free</p>
<p>Copies of audio recordings of the PEBP Board meetings conducted in the Legislature Building are available in CD recording format through</p> <p><i>The Legislative Counsel Bureau Publications</i> <i>(775) 684-6835</i></p>	<p>\$5 plus \$4.50 for shipping</p>
<p>Copies of the PEBP Board open meeting minutes in transcript form are available to the public from:</p> <p><i>Capitol Reporters (775) 882-5322</i> <i>515 West 4th Street, Suite B</i> <i>Carson City, NV 89703</i></p>	<p>\$2.00 per page</p>

IV.

Conduct workshop to solicit comments from interested persons on proposed regulation changes to chapter 287 of the Nevada Administrative Code regarding the following general topics:

- a. Implementation of the Patient Protection and Affordable Care Act (Federal Health Care Reform) as it relates to the coverage of children up to the age of 26, appeals of denied claims and expedited appeals
- b. Implementation of Assembly Bill 365 (2011) as it relates to the option of groups to leave the Public Employees' Benefits Program
- c. Implementation of Assembly Bill 556 (2011) as it relates to the billing of premiums and contributions
- d. Implementation of Assembly Bill 562 (2011) as it relates to the payment of premiums or contributions by retired officers and employees
- e. Other related matters



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LEO M. DROZDOFF, P.E.
Board Chairman

Notice Of Workshop To Solicit Comments On Proposed Regulation

The Public Employees' Benefits Program, 901 S. Stewart Street, Suite 1001, Carson City Nevada 89701, (775) 684-7000 or (800) 326-5496, is proposing the adoption and amendment of regulations pertaining to Chapter 287 of the Nevada Administrative Code. A workshop has been set for 9:00 a.m., on **January 19, 2012**, at the Legislative Building, 401 South Carson Street, Room 1214, Carson City, Nevada, and videoconference to the University of Nevada Las Vegas, System Computing Services Building, Room 102, 4505 South Maryland Parkway, Las Vegas, Nevada. The purpose of the workshop is to solicit comments from interested persons on the following general topics that may be addressed in the proposed regulations:

1. *Implementation of legislation that was enacted during the 2011 Legislative Session*
2. *Implementation of the Patient Protection and Affordable Care Act (Federal Health Care Reform); and*
3. *NAC 287.085 – "Open enrollment" defined*
NAC 287.090 – "Opt-out plan" defined
NAC 287.312 - Dependents: Eligibility of unmarried child of participant, spouse or domestic partner
NAC 287.350 - "Group" defined
NAC 287.357 - Application to leave Program: Contents
NAC 287.359 - Application to leave Program: Dates for submission; duties of Board
NAC 287.361 - Application to leave Program: Considerations for grant or denial; basis for findings by Board
NAC 287.363 - Approval of application by Board: Format and contents of decision; responsibilities of and noncompliance by group
NAC 287.369 - Effective date of departure from Program; coverage by Program until departure; request to rescind approval of Board
NAC 287.371 - Eligibility of officer or employee to join opt-out plan
NAC 287.373 - Notification of Program regarding certain changes in status and court orders
NAC 287.377 - Requirements for change in coverage
NAC 287.383 - Premiums or contributions for participants in opt-out plans: Requirements for billing
NAC 287.440 - Payment of premiums or contributions by retired officers and employees
NAC 287.520 - Coverage as both employee and dependent prohibited; change of status from employee to dependent
NAC 287.660 - Review: Grounds; waiver; terms and conditions

NAC 287.670 - Request for review: Requirements; action by Claims Administrator
NAC 287.680 - Initial appeal of review: Requirements; action by Executive Officer or designee
NAC 287.690 - Appeal to and decision of Board; and

4. Other related matters.

A copy of all materials relating to the proposal may be obtained at the workshop or by contacting the Public Employees' Benefits Program, 901 South Stewart Street, Suite 1001, Carson City, Nevada 89701, (775) 684-7000 or (800) 326-5496. A reasonable fee for copying may be charged. You may also access the information at Public Employees' Benefits Program's web site at <http://www.pebp.state.nv.us>.

This notice of Workshop to Solicit Comments on Proposed Regulation has been sent to all persons on the agency's mailing list for administrative regulations and posted at the following locations:

NEVADA STATE LIBRARY; LEGISLATIVE COUNSEL BUREAU, BLASDEL BUILDING, 209 East Musser Street, Carson City; PUBLIC EMPLOYEES' BENEFITS PROGRAM, 901 South Stewart Street, Suite 1001, Carson City, Nevada; THE GRANT SAWYER STATE OFFICE BUILDING, 555 E. Washington Ave., Las Vegas; THE LEGISLATIVE BUILDING, 401 South Carson Street, Carson City. In addition, the notice was mailed to all State agencies and to groups and individuals as requested.

Date: January 4, 2012

MANDATORY CHANGES FOR STATE AND FEDERAL STATUTORY CHANGES

NAC 287.085 “Open enrollment” defined. ([NRS 287.043](#)) “Open enrollment” means the event in which:

- ~~—1. Participants in the Program may change elections offered by the Program concerning coverage and dependents or, if eligible, join an opt-out plan.~~
- ~~—2. Participants in an opt-out plan may join the Program or another opt-out plan for which they are eligible.~~

(Added to NAC by Bd. of Pub. Employees’ Benefits Prog. by R126-00, 12-22-2000, eff. 1-1-2001; A by R097-03, 9-24-2003; R023-09, 11-25-2009)

NAC 287.090 “Opt-out plan” defined. ([NRS 287.043](#)) “Opt-out plan” means an alternative plan to provide life, accident or health insurance, or any combination thereof, for a group which is approved by the Board and is secured ~~from:~~ *pursuant to NRS 287.0479.*

- ~~—1. An insurer that is authorized by the Commissioner of Insurance to provide such insurance; or~~
- ~~—2. An employee benefit plan, as defined in 29 U.S.C. § 1002(3), that has been approved by the Board.~~

(Added to NAC by Bd. of Pub. Employees’ Benefits Prog. by R097-03, eff. 9-24-2003)

NAC 287.312 Dependents: Eligibility of ~~unmarried~~ child of participant, spouse or domestic partner. ([NRS 122A.100](#), [287.043](#))

1. Except as otherwise provided in subsection 4, the following children of a participant or his or her spouse or domestic partner are eligible for coverage as a dependent if approved pursuant to [NAC 287.313](#):

(a) Any child who is under the age *set by the Board at which the child would not otherwise be eligible to receive coverage under Program* ~~of 19 years.~~

(b) Any child who is *over the age described in paragraph (a)* ~~19 years of age or older~~ if:

(1) At ~~the that~~ age ~~of 19 years~~, the child is incapable of self-support because of a physical or mental disability;

(2) ~~On the 19th birthday of the child,~~ ~~†~~The child is covered by the Program or has received continuous coverage since the child was *the age described in paragraph (a)* ~~18 years of age~~ as a dependent under another group health plan or credible coverage; and

(3) Within 30 days after the ~~19th~~ birthday of the child *at which he or she achieves the age described in paragraph (a)*, if the child is covered by the Program on ~~that~~ ~~19th~~ birthday of the child or, if the child is initially enrolled in the Program on his or her ~~19th~~ birthday *at which he or she achieves the age described in paragraph (a)*, within 30 days after the effective date of the child’s coverage under the Program, the participant or his or her spouse or domestic partner provides to the Program:

(I) A written statement by a physician who provides care to the child that is prepared within 90 days before provision of the statement to the Program indicating that the child has a mental or physical impairment which causes the child to be incapable of self-sustaining employment and to depend on the participant or his or her spouse or domestic partner primarily for support; and

(II) Any other documentation required by the Program that demonstrates financial support of the child by the participant or his or her spouse or domestic partner.

~~—(c) Any child who is 19 years of age or older but less than 24 years of age, if the child is enrolled in a program of secondary education or an independently accredited program of postsecondary education, including, without limitation, a college, university, community or junior college, graduate school and accredited trade or business school, on a full-time basis.~~

~~—(d) Any child who is 24 years of age or older, if:~~

~~—(1) The child was enrolled in a program of secondary education or an independently accredited program of postsecondary education, including, without limitation, a college, university, community or junior college, graduate school and accredited trade or business school, on a full-time basis between the child's 19th birthday and his or her 24th birthday;~~

~~—(2) At the age of 24 years, the child is incapable of self-support because of a physical or mental disability if the disability occurred while the child was a full-time student; and~~

~~—(3) The participant or his or her spouse or domestic partner provides supporting evidence to the Program within 30 days after the 24th birthday of the child which demonstrates that the child qualifies for coverage and insurance pursuant to this paragraph.~~

2. To determine whether the child of a participant or his or her spouse or domestic partner continues to be eligible for coverage pursuant to paragraph (b) of subsection 1, the Executive Officer or his or her designee may require:

(a) Submission of periodic updates to the documentation provided by the participant or his or her spouse or domestic partner pursuant to subparagraph (3) of paragraph (b) of subsection 1; and

(b) Submission of the child to a mental or physical examination conducted by a physician selected by and at the expense of the Program.

3. Children eligible for coverage as a dependent pursuant to this section may include biological children, adopted children, children placed in the residence of the participant for adoption, stepchildren and any other child who is related to the participant or his or her spouse or domestic partner if the participant or his or her spouse or domestic partner is legally responsible for the child and the child is financially dependent on the participant or his or her spouse or domestic partner for care and support.

4. *A foster child*~~The following children~~ of a participant or his or her spouse or domestic partner ~~is~~*are* not eligible for coverage as a dependent.:

~~—(a) A foster child.~~

~~—(b) A child who is married.~~

~~—(c) A child who is in a domestic partnership.~~

(Added to NAC by Bd. of Pub. Employees' Benefits Prog. by R126-00, 12-22-2000, eff. 1-1-2001; A by R154-03, 3-22-2004; R089-05, 6-28-2006; R126-07, 1-30-2008; R016-08, 8-26-2008, eff. 7-1-2009; R107-09, 4-20-2010; R107-09, 4-20-2010, eff. 7-1-2010)

NAC 287.350 "Group" defined. ([NRS 287.043](#), [287.0479](#)) As used in [NAC 287.350](#) to [287.389](#), inclusive, unless the context otherwise requires, "group" means a group of not less than 300 active state officers or employees or retired state officers or employees *who are organized for reasons other than acquiring insurance, or any combination thereof*, who participate in the Program and who apply to leave the Program pursuant to [NRS 287.0479](#).

(Added to NAC by Bd. of Pub. Employees' Benefits Prog. by R097-03, eff. 9-24-2003)

NAC 287.357 Application to leave Program: Contents. ([NRS 287.043](#), [287.0479](#)) An application to leave the Program must include, without limitation:

1. A copy of the plan of benefits to be offered under the proposed opt-out plan, including, without limitation, a description of:

(a) The benefits to be provided under the proposed opt-out plan;

(b) The manner for determining eligibility for benefits under the proposed opt-out plan; and

(c) The circumstances under which any participant in the proposed opt-out plan, including, without limitation, active and retired officers and employees, may lose coverage under the proposed opt-out plan.

2. A description of the manner in which initial eligibility for benefits under the proposed opt-out plan will be determined, including, without limitation, whether members of the group will experience any gap in coverage during the period between when the group leaves the Program and coverage is available for the group under the proposed opt-out plan.

3. *The proposed effective date of the opt-out plan which must coincide with the start of a Program plan year.*

4. *The organizational entity to which all the proposed participants belong and a* list of the proposed participants in the proposed opt-out plan, including, without limitation, the name, social security number and date of birth of each proposed participant.

45. The federal tax identification number of the proposed opt-out plan.

~~5. Audited financial statements of the proposed opt-out plan, if any, for the 2 years immediately preceding the date of application, which must reflect unqualified opinions by the persons who performed the audit of the financial statements concerning the financial soundness of the proposed opt-out plan.~~

6. A copy of the contract pursuant to which the members of the group will receive coverage from the proposed opt-out plan. The contract must include, without limitation, the amount of premiums or contributions that will be required to maintain coverage for the members of the group under the proposed opt-out plan.

7. Evidence establishing that the proposed opt-out plan is or will be operated pursuant to such sound accounting and financial management practices as to ensure that the group will continue to receive adequate benefits. Such evidence ~~shall~~*may* include:

(a) ~~F~~*Financial statements;*

(b) ~~Audits of financial statements of the proposed opt-out plan, if any, for the 2 years immediately preceding the date of application, which must reflect unqualified opinions by the persons who performed the audit of the financial statements;~~*annual audits* and

(c) ~~a~~*Any other information requested by the Board or determined by the group to be relevant to the financial management practices of the proposed opt-out plan.*

in order to evaluate the financial soundness of the proposed opt-out plan.

8. A completed Business Associate Agreement that is consistent with the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, *as amended*, and is in a form acceptable to the Board, or a certification that the opt-out plan is a covered entity under and complies with ~~the~~*all federal* privacy regulations ~~of that federal Act.~~

9. If the proposed opt-out plan is secured from an insurer, a copy of the current certificate of authority issued by the Commissioner of Insurance to the insurer which indicates that the insurer is authorized to provide the coverage proposed to be offered under the proposed opt-out plan in this State.

10. The name and contact information of a representative of the group who will be available to answer questions from the Board concerning the application.

(Added to NAC by Bd. of Pub. Employees' Benefits Prog. by R097-03, eff. 9-24-2003; A by R089-05, 6-28-2006)

NAC 287.359 Application to leave Program: Dates for submission; duties of Board. ([NRS 287.043](#), [287.0479](#))

1. To apply to leave the Program in the next plan year, a group must submit an application to the Board on or ~~after the first day of the first month of the current plan year but~~ before:

~~—(a) T~~ the first day of the ~~fourth-tenth~~ month *prior to the proposed effective date*~~of the current plan year; or~~

~~—(b) If the current plan year is less than a calendar year, the date set forth by the Board as the last day to submit an application to leave the Program in the next plan year.~~

~~→ If an application is received at any other time during the current plan year, the Board will return the application to the applicant.~~

2. If additional information is required to process any application, the Board will notify the representative of the group who is designated pursuant to [NAC 287.357](#).

3. The Board will provide an opportunity for:

(a) A representative of the Program to present arguments for or against the approval of an application.

(b) The representative of the group who is designated pursuant to [NAC 287.357](#) to present arguments that support the approval of an application.

4. The Board will grant or deny each application received pursuant to subsection 1 not later than:

~~—(a) T~~he 15th day of the sixth month *prior to the proposed effective date*~~of the current plan year; or~~

~~—(b) If the current plan year is less than a calendar year, 75 days after the date set forth by the Board as the last day to submit an application to leave the Program in the next plan year.~~

5. The Board will notify each applicant of the date and time of the meeting during which the Board will render a decision on the application of the applicant.

(Added to NAC by Bd. of Pub. Employees' Benefits Prog. by R097-03, eff. 9-24-2003; A by R089-05, 6-28-2006; R023-09, 11-25-2009)

NAC 287.361 Application to leave Program: Considerations for ~~grant~~approval or denial; basis for findings by Board. ([NRS 287.043](#), [287.0479](#))

1. In determining whether to ~~grant~~approve or deny an application to leave the Program, the Board:

(a) Shall consider whether:

(1) The departure of the group from the Program would cause an increase of more than 5 percent in the costs of premiums or contributions for the remaining participants in the Program;

(2) The proposed opt-out plan is financially sound and operated pursuant to sound accounting and financial management practices; and

(3) The proposed opt-out plan provides adequate benefits at the time of application that includes offering the same coverage to active officers and employees and retired officers and employees using rates based on the commingled experience of all active and retired participants.

(4) The applicant meets the requirements of subsection 3 of NRS 287.0479.

(b) May consider:

(1) Whether the cumulative impact of a group leaving the Program on the costs of premiums or contributions for the remaining participants in the Program is so detrimental as to cause a significant negative impact on the Program;

~~(2) Whether the composition of the group indicates adverse selection that would constitute a significant negative impact on the Program;~~

~~—(3) Whether the current financial condition of the Program is such that the departure of the group would constitute a significant negative impact on the Program;~~

(4) Whether the departure of the group is administratively feasible;

(5) Whether independent, actuarial or other reviews obtained by the Board indicate that the departure of the group will cause a significant negative impact on the Program; and

(6) Any other information that the Board deems relevant.

2. Findings by the Board concerning the considerations described in subsection 1 must be based exclusively on substantial evidence.

(Added to NAC by Bd. of Pub. Employees' Benefits Prog. by R097-03, eff. 9-24-2003; A by R089-05, 6-28-2006)

NAC 287.363 Approval of application by Board: Format and contents of decision; responsibilities of and noncompliance by group. (NRS 287.043, 287.0479)

1. A decision of the Board to *grant/approve* an application to leave the Program will be in writing and will include, without limitation, the effective date of departure of the group from the Program and the dates for completion of any administrative tasks necessary to effect the departure of the group.

2. *Such approval of an*~~If the Board grants the~~ application of a group to leave the Program *shall be conditioned upon:*

(a) The group ~~must~~*submitting* to the Board a completed release and waiver of rights agreement, in a form acceptable to the Board, obtained from and signed by each member of the group. ~~Such an agreement must include, without limitation, a description of the circumstances, if any, under which a member of the group, including, without limitation, active and retired members, may return to the Program.~~

(b) A contract, in a form acceptable to the Board, ~~must~~*being* executed between the Program and the proposed opt-out plan of the group. The contract must:

~~—(1) Set forth the terms of coverage for the group, provisions for the payment of premiums or contributions of participants to the opt-out plan and such other details necessary to effect departure of the group from the Program.~~

~~—(2) Include, without limitation, provisions regarding the return to the Program of individual members of the group.~~

↳ Prior to the date set forth by the Board pursuant to subsection 1.

3. The completed release and waiver of rights agreement ~~must be submitted to the Board~~, and the contract between the Program and the proposed opt-out plan of the group that are required pursuant to subsection 2 must be *submitted to and* executed between the Program and the proposed opt-out plan of the group, on or before:

~~—(a) The 25th day of the *fourteenth* month *prior to the approved effective date of the plan year in which the application is approved;* or~~

~~—(b) If the current plan year is less than a calendar year, the date set forth by the Board.~~

4. If a group whose application to leave the Program has been approved by the Board fails to comply with the requirements of this section or any provision of the decision of the Board to

grant the application of the group, the Board may declare the contract between the Program and the opt-out plan of the group void.

(Added to NAC by Bd. of Pub. Employees' Benefits Prog. by R097-03, eff. 9-24-2003; A by R023-09, 11-25-2009)

NAC 287.369 Effective date of departure from Program; coverage by Program until departure; request to rescind approval of Board. (NRS 287.043, 287.0479)

1. The effective date of departure from the Program of a group whose application has been approved by the Board is the first day of the plan year that is at least 120 days after the date on which the Board approves the application.

2. The Program shall provide coverage to participants in a group that has been approved by the Board to leave the Program until the effective date of departure of the group from the Program set forth in the decision of the Board granting the application of the group to leave the Program.

3. ~~At any time before the effective date of departure of a group from the Program, the group may request the Board to rescind its decision to grant the application of the group~~ *A group whose application to leave the Program has been approved by the Board may only rejoin the Program as a group using the procedures delineated in NAC 287.310 for local government agencies.*

(Added to NAC by Bd. of Pub. Employees' Benefits Prog. by R097-03, eff. 9-24-2003)

NAC 287.371 Eligibility of officer or employee to join opt-out plan; *change in coverage.* (NRS 287.043, 287.0479)

1. If an officer or employee is eligible to join an opt-out plan at the time of his or her employment, the officer or employee ~~may elect to~~ *shall* join the opt-out plan or ~~decline coverage the Program~~ upon commencing employment.

2. If an officer or employee :

~~—(a) Was eligible to join an opt-out plan at the commencement of his or her employment but joined the Program; or~~

~~—(b) B~~becomes eligible to join an opt-out plan after the commencement of his or her employment,

~~→ the officer or employee shall~~ *may terminate coverage in join the opt-out plan in lieu of the Program at an open enrollment on the last day of the month concurrent with or subsequent to the date the officer or employee becomes eligible to join the opt-out plan and shall join the opt-out plan or decline coverage on that date.*

3. *If an officer or employee in an opt-out plan transfers to a different participating state agency and loses eligibility to remain in the opt-out plan, the officer or employee shall terminate coverage in the opt-out plan on the last day of the month concurrent with or subsequent to the date the officer or employee transfers to the new agency. The officer or employee shall:*

(a) Join the Program if his or her new position is not part of an opt-out group;

(b) Join a different opt-out plan if his or her new position is part of an opt-out group; or

(c) Decline coverage,

→ subject to the enrollment requirements of the Program or opt-out plan, as applicable.

34. It is the responsibility of an officer or employee that is eligible to join an opt-out plan *or who loses eligibility to remain in the opt-out plan* or the administrator of the opt-out plan to notify the Program of the eligibility *or loss of eligibility* of the officer or employee to join *or remain in* the opt-out plan. ~~Failure to provide such notification to the Program may result in the~~

~~ineligibility of the employee to select the opt-out plan upon commencement of his or her employment or at open enrollment. Notice shall be provided to the Program and to the opt-out plan within 60 days of the officer or employee becoming eligible for or losing eligibility of participating in the opt-out plan.~~

5. The Program is not liable for any expenses or claims of an officer or employee, or any dependents thereof, after the last day of the month in which the officer or employee becomes eligible for participating in an opt-out plan.

6. An opt-out plan is not liable for any expenses or claims of an officer or employee, or any dependents thereof, after the last day of the month in which the officer or employee loses eligibility of participating in the opt-out plan.

7. No lapse in coverage may occur to a participant when he or she changes coverage pursuant to this subsection.

8. A retired officer or employee or the survivor of a deceased officer or employee who was eligible for coverage under an opt-out plan at the time of his or her retirement shall remain in the opt-out plan and is not eligible for coverage under the Program unless the opt-out group rejoins the Program.

9. When a member in an opt-out plan dies, the survivor shall remain in the opt-out plan if he or she is eligible for coverage under the opt-out plan. The survivor is not eligible for coverage under the Program.

10. When an officer or employee joins an opt-out plan, the Program shall not consider that decision to be a declination of coverage.

11. If a participant in an opt-out plan becomes ineligible for participation in the opt-out plan, he or she may elect to continue coverage under the opt-out plan pursuant to the Public Health Services Act, 42 U.S.C. § 300bb-1(a), or the Consolidated Omnibus Budget Reconciliation Act, Public Law 99-272, as applicable.

(Added to NAC by Bd. of Pub. Employees' Benefits Prog. by R097-03, eff. 9-24-2003)

NAC 287.373 Notification of Program regarding certain changes in status and court orders. ([NRS 287.043](#), [287.0479](#))

1. Within 15 calendar days after a change in the status of a participant in an opt-out plan that affects the rate of his or her premium or contribution, the opt-out plan shall notify the Program of that change in an electronic format acceptable to the Program.

2. If an officer or employee has declined participation in ~~the Program and any~~an opt-out plan, the officer or employee shall notify the Program within ~~31-60~~ days after the officer or employee has:

(a) Been ordered to obtain health insurance for his or her child pursuant to [NRS 31A.350](#); or

(b) A change in life status or the addition of a dependent that initiates eligibility for both the declined employee and any affected dependent.

(Added to NAC by Bd. of Pub. Employees' Benefits Prog. by R097-03, eff. 9-24-2003)

~~**NAC 287.377 Requirements for change in coverage. ([NRS 287.043](#), [287.0479](#))**~~

~~1. A participant in an opt-out plan may only join a different opt-out plan or the Program during open enrollment. No lapse in coverage may occur to a participant when he or she changes coverage pursuant to this subsection.~~

~~—2. When a participant in an opt-out plan retires or becomes a survivor of a deceased officer or employee, the participant may not select another opt-out plan for which he or she is eligible or the Program until the next open enrollment.~~

~~—3. When an officer or employee joins an opt-out plan, the Program shall not consider that decision to be a declination of coverage.~~

~~—4. If a participant in the Program elects to join an opt-out plan, the participant shall submit to the Program a signed release and waiver of rights agreement, which is in a form acceptable to the Board.~~

~~—5. If a participant in an opt-out plan becomes ineligible for participation in the opt-out plan, he or she may elect to continue coverage under the opt-out plan pursuant to the Consolidated Omnibus Budget Reconciliation Act, Public Law 99-272, until the next period of open enrollment.~~

~~—(Added to NAC by Bd. of Pub. Employees' Benefits Prog. by R097-03, eff. 9-24-2003)~~

NAC 287.383 Premiums or contributions for participants in opt-out plans: Requirements for billing. ([NRS 287.043](#), [287.0479](#)) The Program shall bill on a monthly basis:

1. Each payroll center that deducts and pays the premium or contribution for a participant in an opt-out plan from the salary or monthly retirement allowance, as applicable, of the participant for the amount of the premiums or contributions for such participants based on the schedule of rates for premiums or contributions for that opt-out plan. ~~A payroll center shall maintain the schedule of rates for each opt-out plan in which persons for whom the payroll center deducts and pays such premiums or contributions participate.~~

2. Each participant in an opt-out plan that is responsible for the paying of his or her premium or contribution directly.

3. The Retired Employees' Group Insurance Budget Account *in the State Retirees' Health and Welfare Benefits Fund* for the portion of the amount of the premiums or contributions for participants in an opt-out plan who retired from the service of the State that is paid by the State pursuant to subsection 2 of [NRS 287.046](#). The Program shall identify separately the portion of the amount billed to the State pursuant to this subsection that is attributable to participants in each opt-out plan.

4. The Active Employee Group Insurance Subsidy Budget Account in the Agency Fund for the Payroll of the State for the portion of the amount of the premiums or contributions for officers and employees in an opt-out plan that is paid by the State pursuant to subsection 1 of [NRS 287.044](#). The Program shall identify separately the portion of the amount billed to the State pursuant to this subsection that is attributable to participants in each opt-out plan.

(Added to NAC by Bd. of Pub. Employees' Benefits Prog. by R097-03, eff. 9-24-2003)

NAC 287.440 Payment of premiums or contributions by retired officers and employees. ([NRS 287.043](#), [287.046](#))

1. Except as otherwise provided in subsections *2 and 3*, retired officers and employees shall pay their premiums or contributions directly to the Program.

2. *Except as provided in subsection 3*, ~~R~~retired officers and employees who receive a retirement benefit from the Public Employees' Retirement System shall pay their premiums or contributions to the Program through an automatic deduction from that benefit unless the retirement benefit is less than the premium or contribution.

3. *Retired officers and employees whose healthcare coverage is provided through the Program by an individual medical plan offered through an exchange to supplement Medicare coverage shall pay the insurer directly.*

(Added to NAC by Com. on Benefits, eff. 5-4-92; A by Bd. of Pub. Employees' Benefits Prog. by R126-00, 12-22-2000, eff. 1-1-2001; R154-03, 3-22-2004; R089-05, 6-28-2006; R107-09, 4-20-2010)

NAC 287.520 Coverage as both employee and dependent prohibited; change of status from employee to dependent. (NRS 287.043)

1. *Except as otherwise provided in subsection 1 of NAC 287.530, Aa person who is eligible to be covered as a participant may not elect to be covered by the Program as both an employee and a dependent—a spouse or domestic partner. If the person qualifies as both an employee and a dependent spouse or domestic partner, he or she must be is-covered only as an employee and not as a dependent.*

2. If a participating officer or employee changes his or her status to that of a dependent because he or she no longer qualifies as an employee, he or she must enroll as a dependent within 60 days after losing status as an employee to be eligible for coverage and insurance as a dependent. If a participant complies with the requirements of this subsection, his or her coverage or insurance is not limited by any waiting period that would otherwise apply.

(Added to NAC by Com. on Group Ins., eff. 5-27-86; A by Com. on Benefits, 5-4-92; A by Bd. of Pub. Employees' Benefits Prog. by R126-00, 12-22-2000, eff. 1-1-2001)

NAC 287.660 ~~Review; Grounds; waiver; terms and conditions~~ Notice of denial of claim; right to appeal. (NRS 287.043)

1. *The Claims Administrator of the Program responsible for the processing and payment of claims shall notify a participant if a claim is denied in whole or in part. The denial shall:*

(a) Be in writing;

(b) Explain the reason for the denial;

(c) Include a reference to the plan provisions on which the denial was based;

(d) Request additional information if it is necessary to process the claim; and

(e) Include the steps required to appeal the denial.

2. A participant may request an ~~appeal~~ review of a claim submitted for himself or herself or a dependent if the participant feels the claim was not adjudicated pursuant to the current terms and conditions of the Program.

~~—2. The failure to request a review in a timely manner will be deemed to be a waiver of any further right of review or appeal under the Program unless the Program determines that the failure was acceptable.~~

~~—3. Upon request, the Program may review claims that are the responsibility of an insurer, health maintenance organization or any other risk bearing vendor which has responsibility for all the processing and payment of claims. A review of claims will be governed by the terms and conditions of the contract between the participant and vendor.~~

(Added to NAC by Com. on Group Ins., eff. 3-9-88; A by Bd. of Pub. Employees' Benefits Prog. by R126-00, 12-22-2000, eff. 1-1-2001; R016-08, 8-26-2008, eff. 7-1-2009)

NAC 287.670 Request for ~~review~~ appeal: Requirements; action by Claims Administrator. (NRS 287.043)

1. To initiate an *appeal-review* of a claim, a participant must submit a written request to the Claims Administrator of the Program within ~~60-180~~ days after the date on which *the participant received the notice of denial*~~the claim was adjudicated or to the insurer in accordance with the terms and conditions of the contract between the participant and the vendor~~. A request for an *appeal-review* of a claim must include:

- (a) The name of the participant;
- (b) The social security number or member identification number of the participant;
- (c) *A copy of the Explanation of Benefits with the initial claim determination provided to the participant by the Claims Administrator;*~~The identifying number of the claim for benefits;~~
- (d) *A copy of the claim submitted to the Claims Administrator*~~statement indicating whether the claim is for a participant or a dependent or surviving dependent of the participant;~~ and
- (e) A statement setting forth the reasons the claim is being contested.

2. *An Appeals Manager of* ~~T~~the Claims Administrator shall:

(a) Review a request for the *review-appeal* of a claim ~~with the vendors and consultants of the Board~~ to determine if the claim was adjudicated pursuant to the current terms and conditions of the Program *and* under the contract between the Program and applicable vendor; and

(b) Within ~~30-20~~ days after receiving the request for an *appeal-review*, advise the participant in writing of:

(1) The decision of the Claims Administrator;~~and~~

(2) The specific provision of the applicable plan of the Program used by the Claims Administrator as the basis for the decision; *and*

(3) *The steps required to appeal the decision.*

3. As used in this section, “member identification number” means the number assigned to a participant by the Program.

(Added to NAC by Com. on Group Ins., eff. 3-9-88; A by Bd. of Pub. Employees’ Benefits Prog. by R126-00, 12-22-2000, eff. 1-1-2001; R154-03, 3-22-2004; R126-07, 1-30-2008; R016-08, 8-26-2008, eff. 7-1-2009)

NAC 287.680 ~~Initial~~*Second level of appeal-of review*: Requirements; action by Executive Officer or designee. ([NRS 287.043](#))

1. If a participant in the Program is unsatisfied with the results of an initial *appeal-review* of a claim, the participant may file an *Level 2* appeal with the Executive Officer or a designee thereof. The *Level 2* appeal must be:

(a) *Submitted* in writing;~~include all supporting documentation and~~

(b) ~~be f~~Filed within 35 days *of receipt of the written decision on the initial appeal of the claim from*~~after~~ the Claims Administrator of the Program ~~issues the written decision on the review of the claim;~~ *and*

(c) ~~The~~*Contain* supporting documentation, ~~must~~*include*, without limitation:

(1)~~;~~~~a~~ *A copy of the request for *appeal-review* of the claim submitted to the Claims Administrator pursuant to [NAC 287.670](#);* *and*

(2) ~~a~~ *A copy of the decision of the Claim Administrator concerning the claim;* and

(3) ~~a~~ *Any other information provided to the Claims Administrator by the participant.*

2. The Executive Officer or the designee shall:

(a) ~~r~~Review the material submitted by the participant to determine if the claim was adjudicated *pursuant to the current terms and conditions of the Program and under the contract between the Program and applicable vendor*~~correctly;~~ *and;*

(b) *Within 30 days after receipt of the participant’s appeal,*

- ~~—3. The Executive Officer or the designee shall~~ notify the participant in writing of:
- ~~(1) The final internal benefit determination decision of whether or not to uphold or overturn the initial appeal;~~
 - ~~(2) The reason for the decision;~~
 - ~~(3) The specific provision of the applicable plan of the Program used as the basis for the decision; and~~
 - ~~(4) The participant's right to request an External Appeal and the steps to file such an appeal within 30 days after receipt of the participant's appeal.~~

(Added to NAC by Com. on Group Ins., eff. 3-9-88; A by Com. on Benefits, 5-4-92; A by Bd. of Pub. Employees' Benefits Prog. by R126-00, 12-22-2000, eff. 1-1-2001; R154-03, 3-22-2004; R126-07, 1-30-2008)

NAC 287.690 External Review of adverse determination Appeal to and decision of Board.
(NRS 287.043)

1. If a participant in the Program is not satisfied with the decision of the Executive Officer or the designee on the appeal made by the participant, the participant may file an *External Review of Adverse Determination appeal* with the *Office for Consumer Health Assistance pursuant to NRS 695G.241 to 695G.310, inclusive.* ~~Board for a review by the Board of the claim.~~

2. The appeal must be filed within *four months of the receipt of the final internal benefit determination from 35 days after the date on which* the Executive Officer or the designee ~~issues the written decision concerning the review.~~

~~—2. Except as otherwise provided in this subsection, after the receipt of an appeal pursuant to this section, the Executive Officer or the designee shall prepare a written report concerning the appeal and present the report to the Board at its next meeting. If an appeal is received after the deadline for placing items on the agenda for the next meeting of the Board, the Executive Officer or the designee shall present the report to the Board at its next following meeting. The report presented to the Board must include the grounds for the appeal, supporting documentation, information concerning the claim and recommendations for action by the Board.~~

~~—3. Not later than 10 days before the date of the meeting in which an appeal that was made by a participant pursuant to this section will be heard by the Board, the Executive Officer or the designee shall notify the participant in writing of the date, time and place of the meeting and provide to the participant the written report concerning the appeal that was prepared by the Executive Officer or the designee pursuant to subsection 2.~~

~~—4. The participant may appear with an attorney or other representative of his or her choosing before the Board in a closed portion of an open meeting held pursuant to NRS 241.030 to review orally the claim and the reasons why the participant is not satisfied with the adjudication of the claim.~~

~~—5. Except as otherwise provided in NRS 241.033, the Chair may at any time before or during the closed portion of the open meeting determine which additional persons, if any, are allowed to attend the closed portion of the open meeting. The Board may allow the Claims Administrator of the Program to present an explanation of the decision that the Claims Administrator made pursuant to NAC 287.670 at the closed portion of the open meeting.~~

~~—6. The Board may render a decision on the claim at that time during its open meeting or defer action to a future meeting if additional information is required for review.~~

~~—7. The Executive Officer or the designee shall mail to the participant by first class mail notice of the decision of the Board within 15 days after the decision is rendered.~~

~~—8. A decision of the Board is final.~~

(Added to NAC by Com. on Group Ins., eff. 3-9-88; A by Com. on Benefits, 5-4-92; A by Bd. of Pub. Employees' Benefits Prog. by R126-00, 12-22-2000, eff. 1-1-2001; R154-03, 3-22-2004; R089-05, 6-28-2006; R126-07, 1-30-2008)

New Section: Expedited Appeal

1. Except as provided in subsection 4, a participant may request an expedited appeal for a medical condition that would seriously jeopardize his or her or his or her dependent's life or health or the ability to regain maximum function if treatment is delayed. A request for an expedited appeal may be submitted to the Program or the Claims Administrator, as applicable, orally or in writing;

2. All necessary information may be transmitted between the participant and the Program or the Claims Administrator, as applicable, by telephone, facsimile or other similarly expeditious method.

3. If the participant provides all necessary information, a decision on an expedited appeal will be provided within 72 hours of receipt of the request.

4. A participant may submit an expedited appeal under the External Review of Adverse Determination provisions with the Office for Consumer Health Assistance pursuant to NRS 695G.241 to 695G.310, inclusive.

V.

Executive Officer's Report

- a. Report required pursuant to Section 3 of Assembly Bill 80 (2011)
- b. Regulation Review



BRIAN SANDOVAL
Governor

JAMES R. WELLS, CPA
Executive Officer

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LEO M. DROZDOFF, P.E.
Board Chairman

Memorandum

DATE: January 9, 2012
TO: Public Employees' Benefits Program Board
Lorne Malkiewich, Director, Legislative Counsel Bureau
Jeff Mohlenkamp, Director, Department of Administration
CC: Laura Freed, Fiscal Analyst, LCB Fiscal Division
Julie Strandberg, Budget Analyst, Budget Office
FROM: James R. Wells, Executive Officer
SUBJECT: Annual Assembly Bill 80 (2011) Section 3 Report

Summary

In accordance with Section 3 of Assembly Bill 80 (2011), this report provides to the Public Employees' Benefits Program Board, the Department of Administration and the Director of the Legislative Counsel Bureau for transmission to various committees of the Legislature the status on several matters pertaining to the Public Employees Benefits Program (PEBP). The report is being provided to the PEBP Board without attachments (only Attachment D-5 is provided to the Board) since most of the attachments were provided to the Board at previous Board meetings. The Board meeting dates at which the items were presented and a link to the reports on the PEBP website are included in this report where applicable. Topics included are as follows:

- A. Section 3(1)(a) – An audited financial statement of the Program Fund for the immediately preceding fiscal year.
- B. Section 3(1)(b) – An audited financial statement of the Retirees' Fund for the immediately preceding fiscal year.
- C. Section 3(1)(c) – A report of the utilization of the Program by participants during the immediately preceding plan year, segregated by benefit, administrative cost, active employees and retirees, including, without limitation, an assessment of the actuarial accuracy of reserves.
- D. Section 3(1)(d) – Material provided generally to participants or prospective participants in connection with enrollment in the Program for the current plan year.
- E. Section 3(2)(a) – An independent biennial certified actuarial valuation and report of the State's health and welfare benefits for current and future state retirees, which are provided for the purpose of developing the annual required contribution pursuant to the statements issued by the Governmental Accounting Standards Board.

- F. Section 3(2)(b) – A biennial review of the Program to determine whether the Program complies with federal and state laws relating to taxes and employee benefits.

Report

A. Section 3(1)(a) – An audited financial statement of the Program Fund for the immediately preceding fiscal year.

The annual audit of the Program Fund conducted by an independent certified public accountant can be found in the following attachment:

Attachment A

Audited financial statements for the Self-Insurance Trust Fund (Fund 625) for the year ending June 30, 2011

The financial statements were presented to the Board at its November 3, 2011 meeting. They are available on the following web page:

<http://www.pebp.state.nv.us/fiscalutilization.htm>

B. Section 3(1)(b) – An audited financial statement of the Retirees’ Fund for the immediately preceding fiscal year.

The annual audit of the Retirees’ Fund conducted by an independent certified public accountant can be found in the following attachment:

Attachment B

Audited financial statements for the State Retirees’ Health and Welfare Benefits Fund (Fund 680) for the year ending June 30, 2011

The financial statements were presented to the Board at its November 3, 2011 meeting. They are available on the following web page:

<http://www.pebp.state.nv.us/fiscalutilization.htm>

C. Section 3(1)(c) – A report of the utilization of the Program by participants during the immediately preceding plan year, segregated by benefit, administrative cost, active employees and retirees, including, without limitation, an assessment of the actuarial accuracy of reserves.

Attachment C

Self-Funded Plan Utilization Report for the year ending June 30, 2011

The annual utilization report was presented to the Board at its September 22, 2011 meeting. It is available on the following web page:

<http://www.pebp.state.nv.us/fiscalutilization.htm>

The HRA Reserve is the liability created by the estimated balances in each HRA account for June 30, 2012. PEBP's actuary provides a Catastrophic Reserve and a Reserve for Incurred But Not Reported (IBNR) claims each year. A summary of all PEBP reserves is provided below. The \$46.7 million in estimated excess reserves for FY 2012 is due to better than expected claims experience caused by the variation due to the plan design changes effective July 1, 2011.

Reserves (est. as of December 21, 2011)		
	FY 2011 Actual	FY 2012 Estimated (as of 12/21/2012)
HRA Reserve	-	8,354,599
IBNR Reserve	33,849,000	33,272,000
Catastrophic Reserve	33,327,000	35,015,000
"Excess" Reserve	37,688,137	46,720,603
Total Reserves	104,864,137	123,362,202

D. Section 3(1)(d) – Material provided generally to participants or prospective participants in connection with enrollment in the Program for the current plan year, including, without limitation:

- (1) Information regarding rates and the costs for participation in the Program paid by participants on a monthly basis; and***
- (2) A summary of the changes in the plan design for the current plan year from the plan design for the immediately preceding plan year.***

The following documents were provided generally to participants or prospective participants in connection with enrollment in the Program for the current plan year

Attachment D-1

Open Enrollment Guide, Plan Year 2012

Attachment D-2

Introduction to Employee Benefits, Plan Year 2012

Attachment D-3

Retiree Enrollment Guide, Plan Year 2012

The Open Enrollment Guides and Introduction to Employee Benefits, Plan Year 2012 are available on the following web page:

http://www.pebp.state.nv.us/forms_pub.htm

A summary of the plan design changes and monthly rates for Plan Year 2012 can be found in the following Board report. The Board selected the rates found in Attachment B of the Board report. Therefore, Attachment A has been excluded.

Attachment D-4

Plan Year 2012 Plan Design and Rates

The Plan Year 2012 Plan Design and Rates were presented to and approved by the Board at its February 24, 2011 meeting. The report is available as Agenda Item VI of the February 24, 2011 Board Packet on the following web page:

<http://www.pebp.state.nv.us/board.htm>

A summary of Plan Year 2011 communications can be found in the following attachment.

Attachment D-5

Plan Year 2011 Communication Activities

- E. Section 3(2)(a) – An independent biennial certified actuarial valuation and report of the State’s health and welfare benefits for current and future state retirees, which are provided for the purpose of developing the annual required contribution pursuant to the statements issued by the Governmental Accounting Standards Board.***

The independent certified actuarial valuation and report of the State’s health and welfare benefits for current and future state retirees can be found in the following attachment:

Attachment E

Nevada Public Employees’ Benefits Program’s Retiree Health and Life Insurance Plans Actuarial Report for GASB OPEB Valuation – FINAL, Fiscal Year Ending June 30, 2011

The GASB OPEB Valuation report was presented to the Board at its September 22, 2011 meeting. It is available on the following web page:

<http://www.pebp.state.nv.us/fiscalutilization.htm>

- F. Section 3(2)(b) – A biennial review of the Program to determine whether the Program complies with federal and state laws relating to taxes and employee benefits.***

The biennial review of the Program to determine whether the Program complies with federal and state laws relating to taxes and employee benefits was included in PEBP's Annual NRS 287.043 and NRS 287.04366 Report dated January 18, 2011.

The Biennial Legal Compliance Review was presented to the Board at its January 13, 2011 meeting. The report is available as Agenda Item X of the January 13, 2011 Board Packet on the following web page:

<http://www.pebp.state.nv.us/board.htm>

Plan Year 2011 Communication Activities

PEBP provided the following communications during Plan Year 2011 (July 2010 – June 2011)

Date	Type	Description	Number of Participants
07/01/2010 - 06/30/2011	Introduction to Employee Benefits	The <i>Introduction to Employee Benefits</i> guide is mailed to all new hire, rehire and reinstated employees. The guide contains detailed information on the following: <ul style="list-style-type: none"> • Medical plan options • Dental Insurance • Basic Life and Accidental Death & Dismemberment Insurance • Long-Term Disability • Eligibility • Premium rates and subsidy • Voluntary products • Initial COBRA Notice • HIPAA Privacy Notice • Enrollment form 	Quantity mailed: 3,531
07/01/2010 - 06/30/2011	Retiree Guide	The <i>Retiree Guide</i> is mailed to all retiring employees. The guide contains detailed information on the following: <ul style="list-style-type: none"> • Medical plan options • Dental Insurance • Basic Life and Accidental Death & Dismemberment Insurance • Eligibility • Retiree premium rates and subsidy • Voluntary products • Initial COBRA Notice • Medicare Part D Notice • HIPAA Privacy Notice • Enrollment form • Years of Service Certification Form 	727

Date	Type	Description	Number of Participants
07/01/2010 - 06/30/2011	Plan Year 2012 Master Plan Document	Plan document containing: <ul style="list-style-type: none"> • Eligibility • PPO Plan medical benefit • PPO dental benefit • PPO Plan pharmacy • PPO vision benefit • Long-term Disability • Basic Life insurance • COBRA • Premium rates/subsidy for all plan options • Vendor contact information 	PEBP website and hardcopy available by request
Jul 2010, Dec 2010	Newsletter	The <i>Health Matters</i> newsletter is mailed to all PEBP participants and may include the following topics: <ul style="list-style-type: none"> • Plan Changes • Important Announcements • Board Meeting Schedule • Contact information • Eligibility • Health and wellness 	42,000
Sep 2010	Frequently Asked Questions and Power Point Presentation	Website postings containing Frequently Asked Questions and Power Point presentations on plan design changes for Plan Year 2012.	PEBP website and hardcopy available by request
Oct 2010	Medicare Exchange Seminars	Medicare Exchange meeting seminar schedule	9,500
Dec 2010	Medicare Part B letter	Letter explaining PEBP's mandatory requirement that retirees and their covered spouses/domestic partners enroll in Medicare Part B at age 65	527
Dec 2010	Medicare Exchange Notice	Announcement regarding the Medicare Exchange enrollment requirement for Medicare retirees and their covered spouses/domestic partners	10,500

Date	Type	Description	Number of Participants
March 2011	Open Enrollment Coverage Letter/online enrollment flyer	Informational letter explaining the requirement that all participants had to take action during Open Enrollment, where to find the Open Enrollment Guide, and how to enroll online.	42,000
April 2011	Open Enrollment Guide	Informational guide containing plan changes for Plan Year 2012. The guides are available on the PEBP website and hardcopies through the mail by request. <ul style="list-style-type: none"> • Open Enrollment form • Medicare creditable coverage letter • Medical Plan options • Dental benefits • Contact information 	PEBP website and hardcopy available by request
May 2011	Medicare Part B Action letter	Notification that immediate action required to enroll in Medicare Part B	192
May 2011	Medicare Parts A and B	Request for verification of Medicare Parts A and B enrollment	1,900

VI.

Presentation by
AonHewitt Consulting
regarding self-funded claims
trend experience and
projections for Plan Year 2013
(July 1, 2012 through
June 30, 2013)

Report
Forthcoming

VII.

Discussion and
possible action
regarding plan design
changes for hearing
aids effective

July 1, 2012



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BRIAN SANDOVAL
Governor

JAMES R. WELLS, CPA
Executive Officer

LEO M. DROZDOFF, P.E.
Board Chairman

AGENDA ITEM

Action Item

Information Only

Date: January 19, 2012

Item Number: VII

Title: Proposed plan design changes for hearing aids effective July 1, 2012

Summary

This report contains additional information regarding a proposed plan design change for hearing aids effective for the plan year starting July 1, 2012.

Report

At the December 15, 2011 Board meeting, staff presented a proposal to exclude the 50% participant coinsurance for hearing aids from the annual out of pocket maximum. That recommendation would have clarified existing practice which has been in place for the past nine (9) years and align the Plan language with that practice. The board requested that staff return to the January 19, 2012 Board meeting with additional information regarding how the hearing aid benefit would be administered, i.e. should PEBP apply a maximum benefit for each hearing aid and apply a benefit frequency limitation.

Additional Information:

1. **Maximum Benefit:** Due to the low utilization of hearing aid benefits, staff has determined that applying a maximum benefit would not be beneficial to the Plan. Staff's recommendation is to continue to apply the PPO allowable rate or the Usual and Customary rates to hearing aids and other related services such as fitting fees, molding and programming.

2. **Frequency of Benefit:** Limit the payment of benefits for hearing aids to once every 5 years. The current benefit does not include a frequency limitation. Staff's research indicates that 5 years appears to be the standard replacement schedule.
3. **Replacement:** Replacement of a hearing aid due to a change in the participant's/covered dependent's physical condition that makes the original device no longer functional would be eligible for benefits prior to the 5 year frequency limitation. The provider of service would need to provide documentation to PEBP's third party administrator that replacement of a hearing aid(s) prior to the 5 year frequency limitation is warranted.
4. **Hearing loss requirement:** To be eligible for the hearing aid benefit, the current requirement that the participant/covered dependent present at least a 50% hearing loss in one ear would remain in force.
5. **Coinsurance level:** The coinsurance level would remain at 50% for in-network and out of network providers.
6. **Annual Out of Pocket and Annual Deductible:** The 50% participant coinsurance would not apply towards the individual or family annual out of pocket maximum. Hearing aids would continue to be subject to the individual or family annual deductible requirement.

Recommendations

Approve the following benefits and limitations effective July 1, 2012 for hearing aids:

1. **Maximum Benefit:** Continue to apply the PPO allowable rate or Usual and Customary rates to hearing aids and other related services such as fitting fees, molding and programming.
2. **Frequency of Benefit:** Limit the payment of benefits for hearing aids to once every 5 years.
3. **Replacement:** Replacement of a hearing aid(s) due to a change in the participant's/covered dependent's physical condition that makes the original device no longer functional would be eligible for benefits prior to the 5 year frequency limitation. The provider of service would need to provide documentation to PEBP's third party administrator that replacement prior to the 5 year frequency limitation is warranted.
4. **Hearing loss requirement:** The current requirement that the participant/covered dependent present at least a 50% hearing loss in one ear will remain in force.
5. **Coinsurance level:** The 50% coinsurance level would continue for in-network and out of network providers.
6. **Annual Out of Pocket and Annual Deductible:** The 50% participant coinsurance will not apply towards the individual or family annual out of pocket maximum. Hearing aids would continue to be subject to the individual or family annual deductible requirement.

VIII.

Discussion and possible action
regarding the current contract
between Hometown Health
Providers and Carson Tahoe
Regional Medical Center,
possible future changes and
impacts on the Plan

Report
Forthcoming

IX.

Discussion and possible action regarding changes to the Board's Duties, Policies and Procedures, including but not limited to:

- Revising the Rate Setting Process to review the Health Reimbursement Arrangement liability, reserves and carryover limitations
- Revising the process for Requests for Proposals and the selection of vendors
- Revising Appendix A (Plan Year Rate Methodology) procedures for the rate setting process
- Various clarifications, corrections, removal of out-dated references and changes to increase reporting and scheduling flexibility



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Board Chairman

AGENDA ITEM

Action Item

Information Only

Date: January 19, 2011

Item Number: IX

Title: Changes to the Board's Duties, Policies and Procedures

Summary

Pursuant to the Public Employees' Benefits Program Board and Agency Duties Policies and Procedures, section XI(D)(1)(b)(ii), approximately four to five months prior to open enrollment the Board will update sections of the Duties, Policies and Procedures pertaining to rate setting. This report summarizes the changes to the procedures. The full Duties, Policies and Procedures are attached.

Report

The following are the proposed changes to the Duties, Policies and Procedures:

IV. Board Governance

- Section E – Clarify strategic planning is in even fiscal years and “fine tuning” is in odd fiscal years

VI. Agency Administration

- Section E – Removed performance measure references to FY 2011

VII. Contracts

- Section A(2) – Add Assembly Bill 365 (2011) which has not yet been codified
- Sections C(1), C(3), D, E, G – Clarification of existing practices
- Sections C(2), C(3)(c)(iii), C(3)(e)(iv-vii) – Add second level of review by Board to the directions provided to staff and add requirements for a second review and award of a contract by the Board (AB 365)

- Section C(3)(e)(i) – Add language regarding the Executive Officer's authority to observe activities of the Evaluation Committee (AB 365)
- Section D(1)(l) – Revise information being reviewed by Division of Insurance pursuant to AB 365.

XI. Premiums and Contributions – Rate Setting Process

- Section A(3) – Included a fully-funded HRA reserve to the reserve policy.
- Section B(7)(a) – Clarification.
- Section C – Language clarification and recognition that plan design changes need to be finalized far enough in advance of open enrollment to be included in the rate setting process.
- Section D(1)(a)(i) – Provide for strategic planning in even numbered fiscal years and “fine tuning” in odd numbered fiscal years to allow greater flexibility in scheduling Board meetings.
- Section D(1)(a)(iii) – Allow the budget framework to be approved in late spring or early summer and the budget to be approved by the Board in July or August to allow greater flexibility in scheduling Board meetings.
- Section D(1)(b)(i) – Remove specific month for strategic planning to allow greater flexibility in scheduling Board meetings and to identify that not all Board priorities will incur costs.
- Section D(1)(b)(ii) – On December 15, 2011 the Board voted to review the liability associated with unused HRA funds on an annual basis to determine whether an HRA carryover limit should be imposed in the future. Recognize that plan design changes need to be finalized far enough in advance of open enrollment to be included in the rate setting process.
- Section D(2)(a) – Staff is in the process of reviewing the reports provided by vendors on a quarterly basis. It is staff's intent to reduce the quarterly reports to only those that are useful for setting policies. This change allows staff to eliminate those reports that are not useful for setting policies.
- Section D(2)(b) – Staff is in the process of improving the quarterly utilization report. Due to the expanded list chronic conditions provided by HealthSCOPE Benefits, staff has determined that the clinical conditions do not provide value to the policy making process.
- Section D(4) – Clarification.

Appendix A – Plan Year 2013 Rating Methodology

- Plan Design, Plan Selection Options (p. 36) – The most recent RFP has required the southern HMO to include Lincoln County in its service area. Coverage for the northern HMO has been corrected. Clarified that retirees are required to seek coverage through the Medicare Exchange if they are eligible for *premium free* Medicare Part A.

- Plan Design, Benefits other than medical, prescription, and vision (p. 36) – On December 15, 2011 the Board voted to include no year over year carryover limit on HRA funds and to review the liability associated with unused HRA funds on an annual basis to determine whether an HRA carryover limit should be imposed in the future.
- Cost Projections, Cost Projection Methodology (p. 37) – Changed rate margin from 66% to 50%. Removed exception for Plan Year 2012 rating methodology.
- Rate Development, Adjustments allocated to PPO participants and HMO participants (p. 39) – Added a reserve adjustment to offset errors in rate blending caused by variations in estimated HMO enrollment for the current plan year. Removed exception for Plan Year 2012 rating methodology.
- Subsidy Allocation and Participant Contribution, Years of Service (YOS) Subsidy (p. 40) – Clarified that the maximum YOS subsidy is for 20 YOS. Pursuant to Senate Bill 553, anyone who is hired on or after January 1, 2012 will not be eligible for a subsidy.
- Subsidy Allocation and Participant Contribution, Supplemental Subsidy (p. 40) – Removed exception for Plan Year 2012.
- Subsidy Allocation and Participant Contribution, Medicare Part B Premium Credit (p. 41) – Pursuant to Board action on August 11, 2011, those retirees identified as having a Medicare Part B premium penalty greater than four-twelve month periods may remain on the PEBP PPO or HMO and will receive a reduction to their premium equal to the base Medicare Part B premium.

Recommendations

Approve the changes as submitted in the attached Duties Policies and Procedures.



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JAMES R. WELLS, CPA
Executive Officer

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LEO M. DROZDOFF, P.E.
Board Chairman

PUBLIC EMPLOYEES' BENEFITS PROGRAM

BOARD AND AGENCY

Duties, Policies and Procedures

January ~~2011~~2012

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I. INTRODUCTION

Nevada Revised Statutes (NRS) 287.041(1) creates the Public Employees' Benefits Program (PEBP) Board (Board) which establishes and carries out a program of health insurance and related benefits (Program). These Duties, Policies and Procedures have been adopted by the Board for the general direction and information of Board members and Agency employees and can be amended, varied, or temporarily suspended at the discretion of the Board by motion passed in an open meeting. As used in this document:

- Board means the PEBP Board members
- Agency means the PEBP agency and its employees
- Program means both the Board and the Agency

II. FIDUCIARY POLICY STATEMENT

A. INTRODUCTION

A comprehensive fiduciary or ethics policy must provide the Board members and Agency employees with functional guidelines within which to conduct themselves as representatives of the Program. The policy must encompass the legal requirements placed upon public servants (in this case, the Nevada Ethics in Government Law found at NRS 281A) and provide the tools with which to apply these somewhat complicated restrictions. This document is a compilation of guidance offered by the Nevada Ethics in Government Law and Board policy. It is intended as a tool to assist the individual Board members and Agency employees in evaluating situations in which fiduciary concerns and ethical considerations may arise.

B. FRAMEWORK

In order for a fiduciary policy to have meaning for Board members and Agency employees, a framework within which the policy is to be applied must be described.

Board members are entrusted with the responsibility of exercising their duties in a fashion that ensures efficiency, legal compliance and the proper operation of the Program. Board members are recruited from various areas of expertise relating to health care benefits. The requirements that the Board and the Agency operate within are the cornerstones of efficient and effective administration and are essential.

Accountability is paramount in the public sector. Board members and Agency employees not only have to deal with accountability demanded by the public at large, they must also be accountable to their peers, and to the participants. To avoid the perception of misuse of influence, the Board

members must be willing to adopt Duties, Policies, and Procedures that preclude and inhibit misconduct, eliminate the wasteful use of resources, and embrace the concepts of sound cost effective measures, both as to the Agency employees and as to their personal involvement as Board members.

Among the major responsibilities are:

- √ Adopting sound actuarial standards
- √ Adopting accounting standards
- √ Approving methods for internal reporting and control
- √ Providing health care benefits in a responsible fashion that does not cause an undue burden to the taxpaying community or to the participant
- √ Ensuring overall compliance of all duties with the appropriate governing provisions

The policy is designed to enable the Board members, and Agency employees, to seek counsel, to remain inquisitive and to exercise their functions with the prudence demanded of them in the public sector.

C. GUIDING PRINCIPLES OF HEALTH CARE BENEFITS ADMINISTRATION

1. Service to the participants of the Program is the primary function of the Board and the Agency. Board members are fiduciaries who are to act for the exclusive benefit of the participants. Participants have the right to expect that Board members will act with integrity, objectivity, independence, prudence and due care. Objectivity is a principle which imposes the obligation to be impartial and intellectually honest. Independence precludes relationships that may appear to impair a Board member or Agency employee's objectivity in rendering fiduciary services.
2. In those situations where the law is not clear, the best interests of the Program must be served. Conscience is critical. Good ends never justify unethical means.
3. Efficient and effective administration and Program management are basic to health care benefits administration. Misuse of influence, fraud, waste or abuse is unacceptable conduct.
4. Safeguarding the Program is paramount. Conflicts of interest, bribes, gifts or favors which subordinate Board members and Agency employees to private gains are unacceptable.
5. Service to the Program demands special sensitivity to the qualities of justice, courage, honesty, equity, competence, and compassion.

6. Timely and energetic execution of fiduciary responsibilities is to be pursued at all times by Board members and Agency employees.

III. ETHICS

A. NEVADA ETHICS IN GOVERNMENT LAW

As public officers appointed by the Governor and public employees of the State, Board members and Agency employees, respectively, are subject to the provisions of the Nevada Ethics in Government Law, NRS Chapter 281A.

Board members and Agency employees are encouraged to review the entire Ethics in Government Law. The keys to interpretation of the ethics statutes are reasonableness, objectivity and disclosure. Prohibition of activity is not the mainstay of the statute. If any Board member or Agency employee has questions concerning situations, they should consult with the Deputy Attorney General assigned to the Board and the Agency. Additionally, should a Board member or Agency employee desire to seek the opinion of the Ethics Commission regarding a specific situation, he or she is encouraged to do so. The Board may also require the seeking of such an opinion should the facts warrant it.

1. Board and Agency Policy
 - a. The purpose of this policy is to inform Board members and Agency employees of the statutory mandates regarding ethics and to provide guidance concerning ethical standards for Board members and Agency employees in the performance of their duties.
 - b. It is the policy of the Board and the Agency that maintenance of the highest standards of honesty, integrity, impartiality, and conduct of its Board members and Agency employees is essential to assure the proper performance of business and to maintain the confidence of the Program's stakeholders.
 - c. Serving as a Board member or Agency employee is a public trust and duties shall be performed to the benefit of the people. Board members and Agency employees shall conduct all their duties in accordance with sound judgment and a sense of the highest business, legal, and ethical standards. Each Board member and Agency employee is personally responsible for abiding by this policy and

promoting an individual and organizational ethical environment.

- d. Board members and Agency employees shall conduct themselves in such a manner that the work of the Program is efficiently and effectively accomplished. Board members and Agency employees shall be courteous, considerate, and prompt in fulfilling their duties. Board members and Agency employees shall conduct themselves in a manner that will not bring discredit or embarrassment to the Program or the State of Nevada. Board members and Agency employees shall conduct all official activities in a manner which is above reproach and free from any indiscretions, including the acceptance of gratuities or favors, which would cast doubt or suspicion upon them or the Program.
- e. Ethical conduct/standards are defined as the principles which govern an individual or group in conformance with accepted professional standards of conduct.
- f. Integrity, honesty, and ethical conduct are the responsibility of each Board member and Agency employee. Ethical considerations should be a priority in all decision making.
- g. Board members and Agency employees shall review and will perform all their duties in strict conformity with all relevant laws as described in NRS Chapter 281A, dealing with the general provisions relating to public officers and employees, as well as any applicable regulations, directives, internal controls, procedures, and the State personnel manual. Any questions regarding these provisions should be directed to the Operations Officer.
- h. As public servants, Board members and Agency employees shall avoid conflicts of interest and shall use the powers and resources of their office only to advance public interests and not to attain personal benefits or pursue other private interests incompatible with the public good.
- i. By way of illustration, but not limitation, the following exemplify prohibitions pursuant to these Duties, Policies, and Procedures. Refer to and review NRS 281A.400 for further provisions of prohibited conduct.
 - (i) No Board member or Agency employee may use his or her position for personal advantage, for the

- advantage of any other person, or to promote any actions contrary to the Board and the Agency's stated ethical standards.
- (ii) No Board member or Agency employee may disclose information regarding business developments of a confidential nature received in the course of his or her duties except in the authorized performance of those duties. Board members and Agency employees shall not attempt to take advantage of such information for themselves or any third party.
 - (iii) Any Board member or Agency employee who owns any interest in or securities of any entity subject to the business interest of the Program shall not vote or participate in any Board or Program decision involving that business. Nevada is a community property state and for that reason, spousal ownership could also potentially result in a conflict of interest or the appearance of impropriety.
- j. A Board member or Agency employee should not take any action if he or she is doubtful of its propriety. In the event there is a question about the propriety of a given action or a concern about a potential conflict of interest, the Board member shall discuss the situation with the Chair or assigned Deputy Attorney General. Agency employees shall discuss the situation with the Operations Officer or the assigned Deputy Attorney General. The Chair or Operations Officer shall use the assigned Deputy Attorney General to assist in determining a proper course of action.
- k. The following questions should be considered in determining the proper course of action:
- (i) Is this action legal?
 - (ii) Is there a directive, internal control, or procedure against this course of action?
 - (iii) Even if this action is legal and there is no directive, internal control, or procedure against it, is the action nevertheless unethical, a conflict of interest, or may it be perceived as such? Although these considerations are a matter of judgment, if there is

any doubt, the issue should be decided conservatively.

- l. If the Chair, Operations Officer, or assigned Deputy Attorney General cannot resolve the ethical question, the question should be referred to the Commission on Ethics.

Commission on Ethics
3476 Executive Pointe Way, #16
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Fax: 775-687-1279
Email: ncoe@ethics.state.nv.us
Website: <http://ethics.state.nv.us>

- m. As role models for ethical behavior, it is important that Board members, Agency executive staff, and others in supervisory positions communicate to Agency employees information regarding ethical conduct and exemplify the same standards in their actions. The example set by Board members, Agency executive staff, and others in supervisory positions communicates the Board and the Agency's ethical standards more effectively than any other means of communication.
- n. The Agency executive staff and others in supervisory positions are to ensure that all Agency employees are familiar with these Duties, Policies, and Procedures and understand the importance of compliance. Discussion of ethical problems and issues is encouraged.
- o. Board members and Agency employees are responsible for reporting suspected ethical violations to the Chair, Operations Officer, or Deputy Attorney General, as appropriate.
- p. Board members and Agency employees may not accept personal gifts and gratuities from contractors bidding on an open Program request for proposal (RFP). For practical reasons, gifts that cannot be returned to the sender will be donated to a local charity.
- q. Board members and Agency employees may accept personal gifts and gratuities from Program contracted vendors.

However, the value of individual gifts and gratuities may not exceed \$25.00.

- r. Board members and Agency employees may not accept meals from contractors bidding on an open Program RFP.
- s. Board members and Agency employees may accept meals from Program contracted vendors. However, the value of individual meals may not exceed \$25.00.
- t. Board members and Agency employees may not accept travel or lodging from contractors bidding on an open Program RFP.
- u. Board members and Agency employees may accept travel or lodging from Program contracted vendors if such travel or lodging is required in the performance of their duties for the Program.
- v. If the cumulative value of gifts, meals, travel, and lodging from a single contracted vendor exceeds \$200.00 in a calendar year, the recipient may be required to file a Financial Disclosure Form with the Commission on Ethics.
- w. Business meetings, such as employee benefits orientations, open enrollment meetings, staff meetings, planning meetings, etc., may, in the interest of efficiency, be conducted at a contracted vendor's facility at no cost to the Agency as long as the expenses are customary and not intended to improperly influence a reasonable person.

B. SEXUAL HARASSMENT

- 1. The Board hereby adopts the Office of the Governor Policy Against Sexual Harassment and Discrimination dated May 1, 2007 available at <http://dop.nv.gov/perds/2007/Perd%2021-07.pdf> and as amended thereafter.

IV. BOARD GOVERNANCE

- A. Official Board action may only result from a majority vote of the Board members present at a legally constituted Board meeting.

- B. The Board shall always conduct business in accordance with the Nevada Open Meeting Law, statutory and regulatory provisions, and current Duties, Policies, and Procedures, as applicable.
- C. The Board shall establish Duties, Policies and Procedures regarding matters that are not specifically enumerated in statute or regulation.
- D. The Board members shall refrain from directly involving themselves in the duties of the Executive Officer.
- E. The Board shall evaluate the Executive Officer annually or more often if circumstances warrant. The performance evaluation is conducted coinciding with the annual strategic planning process (~~even fiscal~~ ~~odd~~ years) or “fine tuning” process (~~odd fiscal~~ ~~even~~ years). The Board goal in evaluating the Executive Officer’s performance is to “speak in one voice” after reaching consensus about performance and to provide constructive feedback, appropriate counseling and coaching designed to improve the Executive Officer’s effectiveness and program success. A vote of confidence or no confidence shall be rendered. The criteria shall include but not necessarily be limited to the following:
 - 1. A review of performance measurements as outlined in PEBP Duties, Policies, and Procedures, Section VI Agency Administration, paragraph ~~D~~E.
 - 2. A discussion of the Executive Officer’s knowledge of the plan, its competitive position, and benefit plans in general.
 - 3. The Executive Officer’s ability to recognize critical issues and prioritization.
 - 4. Communication with the Board.
 - 5. Relationships with the Governor, legislators and their respective staffs.
 - 6. Leadership and managerial capabilities as it relates to management of PEBP staff and the program.
 - 7. A brief discussion of measures taken to enhance and develop key staff members.
 - 8. Budgeting.
 - 9. Progress under the strategic plan.

- F. The Board shall conduct a self-evaluation annually at the same time as the Executive Officer evaluation. The process shall include a personal self-evaluation that each Board member undertakes privately without sharing the results, and an overall evaluation of the entire Board's performance, which is shared with all Board members. The evaluation may include but not be limited to:
1. Attendance at Board meetings.
 2. Preparedness for discussions at meetings.
 3. Ability to make sound decisions.
 4. Interaction among Board members.
 5. Interaction with the executive staff.
 6. Policy development and policy compliance.
 7. Oversight and monitoring activities
 8. Strategic thinking and planning.
- G. The Board and/or Agency shall ensure that all legally required reports and reviews are completed and submitted to the appropriate agency in a timely manner.

V. INDIVIDUAL BOARD MEMBER RESPONSIBILITIES

- A. Board members are responsible for attending all Board meetings.
- B. Board members are not empowered to officially act on behalf of the Board except as directed by Board action.
- C. Board members are responsible for learning the laws pertaining to health care benefits, the Duties, Policies, and Procedures, and other official policies.
- D. Board members shall conduct their affairs in such a manner that they always represent the best interest of the Board. To fulfill these functions satisfactorily, individual Board members must exercise utmost judgment, discretion, and tact in order to ensure good public relations, and to avoid any possible misunderstanding regarding actions as an individual as opposed to actions as a Board member.

- E. Board members are not expected to be recognized as experts, but rather are expected to consider the advice of experts.
- F. Board members shall refrain from making commitments to any individual or entity regarding any matter that is scheduled for consideration by the Board as a whole, or any matter that could jeopardize the united effort of the Board.
- G. Board members shall refrain from performing any function delegated or normally assigned to Agency employees.
- H. Board members shall direct their inquiries which may occur outside of a Board meeting to the Agency through the Executive Officer or Operations Officer.
- I. The response to correspondence addressed to the Chair shall be prepared by Agency employees and signed by the Chair.
- J. The response to correspondence addressed to the Board shall be prepared and signed by Agency employees on behalf of the Board.

VI. AGENCY ADMINISTRATION

- A. The Board authorizes the Executive Officer or his or her designee to provide official press releases and to answer questions from the press and other news media.
- B. The Board authorizes the Executive Officer or his or her designee to carry out all administrative functions of the Agency, including but not limited to:
 - 1. Financial management of all contribution/rate billing, accounts receivable, accounts payable and budgetary compliance.
 - 2. All Agency personnel, operational and vendor contract compliance matters.
 - 3. Interpretation of all Nevada Revised Statutes and Nevada Administrative Code in performing all functions of the Agency.
 - 4. Representing the Agency to other State entities, including all branches of government.
- C. Consistent with Board policies and direction, the Agency shall work with the Department of Administration, the Governor's Office and the

Legislature to ensure that the Program is funded on an actuarially sound basis.

- D. Health care benefit changes may be considered by the Board based upon the recommendation of Board members or the Agency. If the Board changes health care benefits, the Agency shall notify participants of these changes.

- E. Performance measurement is a method of systematically and objectively tracking an agency's progress toward achieving its mission and goals. The Agency's procedures for fiscal years ~~2011~~, 2012 and 2013 that are to be followed in calculating and reporting performance measure results in accordance with the Agency's legislatively approved budget are as follows:
 - 1. Contain expense ratio of operational costs (personnel, travel, operating, administration, information services, and self-funded network expenses) to total revenue (excluding PPO prescription drug rebates) to ~~4.4 percent in FY 2011~~, 4.2 percent in FY 2012 and 3.9 percent in FY 2013.

 - 2. Contain claims loss ratio to total revenue (less PPO prescription drug rebates, fully-insured program costs and operational costs) to ~~100.3 percent in FY 2011~~, 106.7 percent in FY 2012 and 105.3% in FY 2013.

 - 3. Achieve at least 71.6 percent generic prescription drug utilization. Usage to be documented in quarterly reports generated by prescription program manager.

 - 4. Achieve 94.5 percent in-network provider utilization for medical.
 - a. Document in-network provider utilization from reports generated by third party administrator.

 - b. Document out of network provider utilization for type and reason (e.g. emergency, divert status, preference, etc.).

 - 5. Achieve 93.2 percent in-network provider utilization for dental.
 - a. Document in-network provider utilization from reports generated by third party administrator.

 - 6. Limit appeals to less than 0.15 per 1000 participants.
 - a. Record all appeals filed with Agency.

- b. Annually calculate percentage of appeals filed per average number of participants for that fiscal year.
- F. Distribution of these Duties, Policies, and Procedures
- 1. The Executive Officer shall ensure that new board members receive a rigorous new member orientation as soon as practical after the appointment. Such orientation is in the best interest of the Board and the Public Employees' Benefits Program and shall include at a minimum the following:
 - a. History and overview of PEBP and the benefits industry (for example, competitive position, private vs. public sector benefits, etc.)
 - b. A review of the benefits administered by PEBP
 - c. Fiduciary responsibility of the board member and the standards that imposes.
 - d. Board governance for the PEBP including Duties, Policies and Procedures adopted by the Board.
 - e. A review of other precedent established by Board action.
 - f. The role of staff and the Executive Officer and the role of the Board.
 - g. Special terminology applicable to benefit administration.
 - h. The funding and rate setting process review.
 - i. Current issues related to PEBP.
 - j. The PEBP Strategic Plan.
 - k. An office tour and introduction to staff.
 - 2. Each Board member shall acknowledge his or her understanding of the material by signing the "Acknowledgment Form for Board Members."
 - 3. The signed Acknowledgment Form must then be returned to the Executive Officer within 10 working days. The Executive Officer is responsible for ensuring the completion and filing of a signed Acknowledgement Form from each Board member.

4. The Personnel Officer shall ensure that these Duties, Policies, and Procedures are given to all current Agency employees and any new Agency employee within 10 working days of their hire with the Agency.
 5. Each Agency employee shall acknowledge his or her understanding of the material by signing the "Acknowledgment Form for Employees."
 6. The signed Acknowledgment Form must then be returned to the Personnel Officer within 10 working days. The Personnel Officer is responsible for ensuring the completion, and filing, of a signed Acknowledgement Form from each Agency employee.
- G. Requests for Information - A special request from Board members that requires significant agency resources, as determined by the Executive Officer, must be approved by the Chairman before the staff shall be required to act upon the request.

VII. CONTRACTS

A. PURPOSE, AUTHORITY, AND POLICY

1. The purpose of this policy is to establish procedures for the contract process, contract maintenance and contract extensions.
2. The authority for the policy is NRS 333.311 and 333.335; Sections 1, 2 and 8 of Assembly Bill 365 (2011); Nevada Administrative Code (NAC) Sections 333.150, 333.155, 333.160 and 333.162; and State Administrative Manual (SAM) Sections primarily 0308.0; 0314.0; 0316.0; 0318.0; 0320.0; 0322.4; 0324.0; 0326.6; 0336.0; 0338.0; 0342.0; 0344.0; 0516.0.
3. The Quality Control Section oversees the contracting process for all contracts that the Program enters into for benefits or administrative services.
 - a. The preliminary contract proposal, the contract negotiation, the final contract and the later upkeep of terms are all duties assigned to this section. It is the responsibly of the Quality Control Officer to respond to contracting needs originating in PEBP.

B. DEFINITIONS

1. Request for Proposal - A written statement which sets forth the requirements and specifications of a contract to be awarded by competitive selection pursuant to NRS 333.020(8).
2. Contract - A binding agreement between two or more persons or parties; especially one legally enforceable; a business arrangement for the supply of goods or services at a fixed price.

C. REQUEST FOR PROPOSAL AND SELECTION OF VENDOR

1. When a current contract is scheduled to expires, or a new service is required, an RFP is developed by the Quality Control Section.

2. Prior to the release of an RFP, ~~t~~The PEBP Board shall provide direction to staff regarding services to be provided by the following vendors: Third Party Administrator, Pharmacy Benefits Manager, Statewide PPO Network vendors, Actuary/Consultant and Health Maintenance Organization. ~~Such direction is to be incorporated into the RFP developed by the Quality Control Section.~~

(a) The PEBP Board has the opportunity to provide recommendations which may be incorporated into the final RFP document.

(b) The PEBP Board may request a second level evaluation to award the contract.

(c) If a second level review is requested by the PEBP Board, the Board shall:

- i. Disclose the review by the Board of the vendors whose proposals score the highest in the RFP;
- ii. Identify the criteria it will use to evaluate the high scoring proposals;
- iii. Evaluate only the finalist vendor(s) selected by the Evaluation Committee;
- iv. Consider the ranking given to a proposal by a committee appointed to evaluate the proposal, if any;
- v. Review and evaluate the responses of vendors to the RFP who will be interviewed by the Board; and
- ~~i~~.vi. Award the contract based on the best interests of the State.

~~2-3.~~ The Quality Control Officer or PEBP Contract Manager along with State Purchasing Division (Purchasing) will do the following.

a. Create the RFP

(i) Determine criteria for service needed. Resources are existing RFP's, internet, consultants, and Purchasing.

(ii) Create draft RFP. Quality Control Officer finalizes draft document.

(iii) Coordinate with the Agency to develop scoring and weights for the Evaluation Committee and if requested, for the PEBP Board.

~~(ii)~~(iv) Develop score sheets and instructions for scoring each vendor.

~~b. Coordinate with the Agency to recruit RFP Evaluators. Coordinate with the Agency to develop scoring and weights for the Evaluation Committee.~~

~~e.b.~~ Coordinate with the Agency to recruit RFPRecruit Evaluation Committee members. Evaluation Committee will include PEBP Staff, Individual(s) from other state agencies and, at least one PEBP Board member. The Evaluation Committee will not include PEBP's Executive Officer.

~~d.c.~~ Coordinate with Purchasing.

(i) Draft RFP document and any necessary attachments are-is sent to Purchasing, along with Evaluator names, telephone numbers, fax numbers-and mailing addresses and; email address and scoring/weight information.

(ii) Timelines for release of RFP, response to questions from vendors, close of RFP, review of vendor proposals and selection of vendors is coordinated with Purchasing.

(iii) Purchasing reviews, edits, reformats RFP document, and creates agreements with Evaluators and PEBP Board members if a second level evaluation is determined.

- (iv) Purchasing publicizes RFP on Purchasing website and in other media.

e.d. Vendors respond to Purchasing.

f.e. Evaluation and Selection Period.

- (i) Purchasing coordinates Evaluation Committee meeting with Evaluators. The PEBP Executive Officer may attend any/all Evaluation Committee meetings to observe the activities of the Evaluation Committee.
- (ii) Purchasing coordinates ~~any~~ interviews with vendors, if indicated in the RFP to be part of the selection process.
- (iii) Evaluation Committee selects recommended vendor from RFP responses and notifies the Executive Officer. Purchasing and the Quality Control Officer shall provide the committee scores and evaluator comments to the Executive Officer to document the Evaluation Committee's recommendation.

(iv) PEBP Executive Officer will report the Evaluation Committee's vendor recommendation selections to the PEBP Board at the following Board meeting. ~~Board at the following Board meeting for ratification.~~

(v) The Board shall review any recommendation for awarding a contract submitted to the Board and may either approve the recommendation of the Chief of the Purchasing Division or of the Evaluation Committee and award the contract as recommended or schedule a separate public meeting to award the contract if a second level review was requested by the Board pursuant to Section C(2)(b).

(vi) The Board is not bound by the recommendation of the Chief of the Purchasing Division or the Evaluation Committee.

(vii) Subsequent to the Board's approval, the Purchasing Division will post the Intent to Award document.

D. CONTRACT PROCESS

1. The Quality Control Officer is responsible for negotiating binding contracts with service provider vendors when RFP process is successful.
 - a. Coordinate with the Agency to negotiate contract terms, fees and responsibilities with vendor.
 - ~~a-b.~~ Coordinate completion of contract with Purchasing.
 - ~~b-c.~~ Contract Manager or Purchasing will c~~reate~~ at least three copies of Contract Summary.
 - ~~e-d.~~ Contract Manager or Purchasing will c~~reate~~ at least three copies of Contract.
 - ~~d-e.~~ Contract Manager or Purchasing will c~~oordinate~~ required contract signatures. .
 - ~~e-f.~~ Contract Manager will -p~~resent~~ Contract Summary to PEBP Chief Financial Officer for review. Chief Financial Officer will and indicate approval in Nevada Contract Entry and Tracking System (CETS).~~signature on Contract Summary.~~
 - ~~f-g.~~ Contract Summary and Contract go to Executive Officer for review and signature.
 - ~~g-h.~~ Contract Manager or Purchasing forward ~~Contract sent~~ via overnight mail or emailed ~~ed~~ to vendor for signature.
 - ~~h-i.~~ Upon return, Contract Manager or Purchasing coordinates review and signature by~~send Contract to the~~ PE BP Deputy Attorney General or Purchasing Attorney General. ~~for signature.~~
 - ~~j.~~ Upon return Aftern all signatures have been obtained, Contract Manager or Purchasing will send Contract and Contract Summary to Board of Examiners for approval.
 - ~~i-k.~~ Once Board of Examiners approves contract, Budget Division completes final entry of contract into CETS.

- ~~j-l.~~ Some contracts may fall within Division of Insurance jurisdiction per NRS 287.0434 (e.g. licensed administrators and qualified actuaries~~Third Party Administrators, Actuary/Consultant~~). In this circumstance, prior to submission to the Board of Examiners, the Contract and a copy of the Contract Summary~~copy~~ must be sent to the Commissioner of the Division of Insurance for approval as to the licensing and fiscal status of the licensed administrator and status of any legal or administrative actions in this State against the licensed administrator that may impair his or her ability to provide the services in the contract~~of the reasonableness of administrative charges~~.
 Timeline: 30 days prior to PEBP approval of contract.
- ~~k-m.~~ Original Contract and Contract Summary go to PEBP, Purchasing and vendor. Copies of the Contract and Contract Summary go to PEBP Accounting Section.
- ~~l-n.~~ Contract is valid if necessary signatures and approvals have been obtained.

E. CONTRACT MAINTENANCE

- 1. The Contract Manager and Quality Control Officer are responsible for monitoring all vendor contracts and completing: Contract Monitoring
 - ~~a.~~ Update Contract Monitoring spreadsheet monthly.
 - ~~b.~~
 - ~~e-a.~~ Regular sStatus reports to PEBP Board and PEBP Executive Officer~~Quality Control Officer~~ with any notifications of contracts needing attention, i.e., upcoming termination dates, etc. as needed.
 - ~~d.~~ Update Contract Compliance Checklist monthly.
 - ~~e-b.~~ Updates to the Purchasing Contract Data Nevada Contract Entry and Tracking System (CETS)~~base~~, as needed.
 - ~~f.~~ Coordinate with Accounting Section to conduct quarterly vendor invoice audits.
 - ~~g-c.~~ Audits in coordination with the Accounting Section of vendor invoices, including the entire quarter for all new

contracts and 1 month random for current contracts quarterly.

2. Report discrepancies to Accounting Section and resolve.

F. VENDOR SERVICE PERFORMANCE STANDARDS

1. Service performance standards will be included in all contracts. The specific standards will depend upon the type of service(s) being contracted.
2. Financial Guarantees - Percentage guarantees will be determined by type of services provided by vendor

G. VENDOR CONTRACT EXTENSIONS

1. The standard term for the contract is four years.
2. As needed or one year prior to the termination date of the vendor contract when the contracted vendor has satisfied their contractual obligations as indicated in the contract performance standards, a vendor contract may be extended.
 - a. The Quality Control Officer will determine if extending vendor contract will benefit the State of Nevada and PEBP participants using the following criteria.
 - (i) Has the vendor satisfied contract performance standards?
 - (ii) The length of the contract extension.
 - (iii) The monetary amount for the extension period.
 - b. The ~~Quality Control Officer~~ Contract Manager will create the Contract Summary and Contract and will process these documents as outlined above.
 - (i) PEBP Executive Officer will report any contract extensions to the Board at the following Board meeting for ratification.

VIII. EDUCATION

A. BOARD AND EXECUTIVE OFFICER

1. Board members and the Executive Officer must comply with the education requirement enumerated in NRS 287.0428. These

educational requirements must be accomplished over the course of a fiscal year.

2. The Board and Agency employees are encouraged to coordinate and provide classes that would meet the requirements of NRS 287.0428 for Board members and Agency employees.

B. AGENCY EMPLOYEES

1. Eligibility
 - a. All Agency employees are eligible.
 - b. Classes or courses taken, but that do not lead to a degree must be directly related to the Agency employee's position and related duties at the time of enrollment.
 - c. Classes required for a degree directly related to employment are eligible.
2. Reimbursement
 - a. Reimbursement for fees and course materials will be made upon successful completion. Reimbursement will be made for a maximum of one course per quarter/semester. Successful completion is defined as:
 - (i) Receiving a grade of C or better;
 - (ii) Receiving a passing grade if the designation is pass/fail; or
 - (iii) Receiving a certificate of completion.
 - b. A written request for training must be completed and approved by the supervisor and the Personnel Officer prior to enrollment.
 - c. Reimbursement may not exceed the budgeted amount each fiscal year.
3. Release Time
 - a. Release time may be granted for classes or courses meeting the requirements of the policy.
 - b. Release time will not be granted for classes or courses which are available after work hours.

- c. Maximum release time is four hours per week.
 - d. All Agency employees will be afforded the opportunity of up to four hours per week release time provided that:
 - (i) Requirements of the policy are met, and
 - (ii) Release time will not have a negative impact on the operations of the Program.
 - e. Any additional time off must be made up and that request must also be approved by the supervisor.
4. The Agency may provide or send employees to training classes relating to the administration of health care benefits for participants.

IX. TRAVEL

A. PURPOSE, AUTHORITY, AND POLICY

1. The purpose of this policy is to establish procedures for authorization and approval of all travel and provide required forms.
2. The authority for the policy is the State Administrative Manual (SAM) 0200 and 1400. SAM can be found on the Department of Administration, Budget and Planning Division's website.
3. SAM 0204.0 requires all travel be made by the least expensive method available considering all factors including travel time and salary, availability of motor pool vehicles and the cost of transportation and lodging. All travel and associated expense reimbursements must be related to approved State business.

Personnel combining State business and personal travel must clearly delineate expenses associated with State business and those relating to personal travel. Personnel requesting to leave early or return late from a business related trip (i.e., return Sunday evening instead of Friday afternoon) may do so as long as there is no additional cost to the Agency and no additional overtime related to the request. Personnel are expected to submit annual leave for hours not transacting State business.

4. These policies and procedures are intended to augment not contradict the official SAM regulations. If a contradiction does exist, the SAM regulation supersedes. (SAM sections are referenced throughout this document where deemed appropriate.)

B. DEFINITIONS

1. Travel Status – A Board member or an Agency employee is in ‘travel status’ if away from the Agency office and on official State business.

C. PROCEDURES

1. Authorization

- a. The Agency employee’s Executive Staff supervisor shall authorize all travel. Completion of the Agency Travel Pre-Authorization form is required for all Agency employees. Budgetary authority must be verified by the Accounting staff prior to the commitment of any State funds. The Executive Assistant will provide a Board travel summary on a quarterly basis, in advance, and forward to the Accounting staff to verify budget authority.

Authorization for the Executive Officer shall be approved by the Board Chairman if for out-of-state travel.

2. Air Transportation

- a. All air transportation should be booked through any State authorized travel agent or directly with the airline, whichever is lowest cost.
- b. The Agency departmental travel procurement card should be used to reserve and pay for all airline tickets.

3. Automobile Transportation

- a. Motor Pool – SAM Chapter 1400 governs the policy for motor pool vehicle use. A motor pool car should be used whenever possible. Only State employees or other authorized persons may drive or be passengers of motor pool vehicles. Drivers of motor pool vehicles must attend a state sponsored defensive driving course every two years. Motor pool vehicles may not be parked at an employee’s home overnight without prior approval by State Motor Pool. Motor pool vehicles are available in Reno, Carson City and Las Vegas. Motor pool vehicles should be fueled at Nevada Department of Transportation locations or with a State credit card at designated gas stations. Credit cards and a list of locations may be obtained from State Motor

Pool when picking up the vehicle. A personal credit card or cash should not be used to fuel the vehicle. If this occurs, the traveler will have to justify the expense in writing to the State Motor Pool along with the original receipt for reimbursement. Smoking is not allowed in motor pool vehicles.

- b. Local Trips – If an employee is taking a trip under 75 miles, use of a motor pool vehicle is optional. Reimbursement for use of personal car will be made at the standard rate established by the Department of Administration. Mileage to and from local destinations will be considered to have originated at the Agency offices for the purpose of reimbursement.
- c. Personal Car – When an Agency employee uses his or her own car to accomplish State business at the request of or for the convenience of the Agency, the employee will be reimbursed at the standard rate established by the Department of Administration. When an employee uses his or her own vehicle for personal convenience, the employee will be reimbursed at one-half the standard reimbursement rate established by the Department of Administration (SAM 0212.5 for in-state travel and SAM 0214.6 for out-of-state travel). If an employee chooses to use his or her own vehicle to drive to a city serviced by an airline, the employee must be on either annual leave or compensatory time off for the extra travel time involved. Meals and/or expenses en route will not be reimbursed.
- d. Rental Car – SAM 0218.0 requires the use of motor pool vehicles when traveling in-state unless the State Motor Pool gives written notice that motor pool vehicles are not available. When not available, or when traveling out-of-state, a rental car may be rented from companies with which the State has agreements. Collision damage waivers are included in the State's car rental agreements. If the individual wishes to purchase this additional coverage, it will be at the individual's expense. In the event an employee driving a rental car on State business is involved in an accident, the agency will be responsible for the deductible.
- e. Public Transportation – If travel is by bus, taxi or limousine, an original receipt must be attached for

reimbursement. Travel from air terminals should be by the most economical means available.

f. In-State Expense Reimbursement Rates

(i) PEBP reimbursement rates, covered expenses and receipts policies for in-state travel will be the same as those provided in SAM Chapter 0200.

(ii) In order to qualify for meal per diems, the Board member or Agency employee must be in travel status during the following times:

Breakfast	Depart before 7:00 a.m. or return after 9:00 a.m.
Lunch	Depart before 11:00 a.m. or return after 1:00 p.m.
Dinner	Depart before 5:00 p.m. or return after 7:00 p.m.

4. Travel Advances - PEBP does not issue travel advances.

5. State Contracted Travel Credit Card – PEBP does not issue State contracted travel credit cards.

6. Travel Expense Claims

a. Travel Expense Form - All claims for travel reimbursement to an individual must be filed on a *Claim For Travel Expense* form. By signing the statement on the face of the form, the claimant is attesting to the completeness and accuracy of the claim. All claims are to be approved by the supervisor who approved the travel authorization. The supervisor's signature approves the necessity and payment for the trip, attests to the completeness and accuracy of the claim and validates the travel status of the employee.

(i) Travel Expense claims should be accompanied by all original receipts, as required.

(ii) Flight itineraries and conference agendas should be attached to Travel Expense claims for meals justification.

(iii) Travel Expense claims should be filed within 5 days of returning from travel status.

(iv) Do not include supplies purchased on a trip on a Travel Expense claim. Request reimbursement on a

separate signed request and include the appropriate authorization and original receipt.

- (v) Mandatory phone charges at hotels will be paid. Any calls charged to a hotel will be paid if each number called is marked with the person's name, organization and justifiable reason next to the charge.

- b. Completed and approved Travel Expense claims must be submitted to the PEBP Payables Technician for processing. Travel Expense claims will be processed in accordance with Accounts Payable policies and procedures regarding non-reoccurring expenses other than contracts.

X. LEGISLATURE

- A. Board members and Agency employees shall work diligently and cooperate fully with the Legislature and its committees in any study made or information desired in relation to the operation, functions, or status of the Program.
- B. The Board may take a position on all proposed legislative matters affecting the Program and direct Agency employees to make that position known to the Legislature.

XI. PREMIUMS AND CONTRIBUTIONS – RATE SETTING PROCESS

A. PURPOSE, AUTHORITY, AND POLICY

- 1. Purpose - The purpose of setting rates is to establish a financial plan that ensures financial soundness related to each plan year design approved by the Board. These procedures describe the process to be followed in establishing the rates and participant contributions.
- 2. Authority – The following Nevada Revised Statutes (NRS) discuss the Board's powers and duties with regard to the rate setting process. In general, the Board has relatively broad discretion.
 - a. General Authority:
 - (i) NRS 287.043 – Board of the Public Employees' Benefits Program: Powers and duties.
 - (ii) NRS 287.0433 – Board of the Public Employees' Benefits Program: Power to establish plan of life, accident or health insurance; reinsurance.

- (iii) NRS 287.0434 - Board of the Public Employees' Benefits Program: Power to use assets, contract for services and charge and collect certain fees and payments.
 - (iv) NRS 287.04335 – Board of the Public Employees' Benefits Program: Compliance with certain provisions required to provide health insurance through plan of self-insurance.
 - b. Commingling: NRS 287.043 – Board of the Public Employees' Benefits Program: Powers and duties.
 - c. Subsidies:
 - (i) NRS 287.044 Payment of part of cost of premiums or contributions by State for coverage of state officers and employees participating in Public Employees' Benefits Program from appropriated or authorized money; limitations; coverage of dependents.
 - (ii) NRS 287.046 – Payment of premiums or contributions for retired state officers and employees.
 - (iii) NRS 287.023 – Option of retired officer or employee or his dependent to cancel or continue group insurance, plan of benefits or medical and hospital service or to join Public Employees' Benefits Program; notice of selection of option; payment of costs for coverage.
 - (iv) NAC 287.381 – Premiums or contributions for participants in opt-out plans: General administrative duties of Program. (NRS 287.043, 287.0479)
 - d. Budget:
 - (i) NRS 287.049 – Costs of premiums or contributions to be budgeted.
- 3. Reserve Policy - It is the policy of the Public Employees' Benefits Program to maintain fully-funded IBNR and Catastrophic Reserves as determined by plan actuaries using the confidence intervals and margins described herein and a fully-funded HRA Reserve based on the total balance remaining in all HRA accounts. Excess reserves beyond those required to maintain fully-funded IBNR, ~~and~~ Catastrophic and HRA Reserves should be used to reduce overall rates in the subsequent Plan Year, or two Plan Years, if provided for in the biennial budget. Should the Board determine that rate increases are excessive, the Board may use a portion of the Catastrophic Reserve to reduce rates. Should the Catastrophic

Reserve become underfunded or be forecast to be underfunded, the Executive Officer shall notify the Board at the next Board meeting.

B. DEFINITIONS

1. Participant Contribution – The portion of the rate paid by participants.
2. Plan Design – The benefits provided to participants of the plan. This includes provider access, out-of-pocket expenses (deductibles, co-payments, and coinsurance), and lines of coverage (medical, dental, vision, life insurance, etc.). Plan design does not refer to the methodology used to determine rates.
3. Plan Year – The PEBP benefit plan year as approved by the Board.
4. Premium – The cost paid for fully-insured benefits (e.g. health maintenance organization membership, life insurance, etc.) as determined by insurance companies contracted with by PEBP. Premiums are passed-through PEBP to the participants and employers.
5. Rate – The total monthly cost of coverage for a participant in a given plan option and tier.
6. Rating Methodology – The basis for allocating costs between plan options and participant tiers. This includes the application of claims commingling, coordination of benefits, predictive modeling, trend analysis, etc.
7. Subsidy – The amount paid by the employer or from Plan reserves towards the cost of PEBP benefits on behalf of participants. The subsidy is comprised of the following portions:
 - a. Base Subsidy – For state employees, the portion of the rate paid by the employer pursuant to NRS 287.044. For ~~non-Medicare~~ retirees not on the Medicare Exchange, the portion of the rate paid by a retiree's previous employer(s) at 15 years of service pursuant to NRS 287.046.
 - b. Supplemental Subsidy – A reduction to the Participant Contribution for plan options and tiers that have excessive increases in cost since the previous plan year. The cost of the Supplemental Subsidy is absorbed by plan reserves.

- c. Years of Service (YOS) Subsidy – The adjustment to the Base Subsidy, for participants who retired on or after January 1, 1994, based on a retiree’s YOS, paid by a retiree’s previous employer(s) pursuant to NRS 287.046 and NRS 287.023(4)(b).

C. OVERVIEW OF RATE SETTING PROCESS¹

The rate setting process begins approximately six months prior to open enrollment with the Board establishing the priorities for plan design (i.e. options for changes in the plan design). These priorities may include scope of benefits offered by the plan and/or cost sharing methodologies between the Program and its participants. To the extent possible, cost estimates are presented at the same time as the plan design option for inclusion in the discussion. The Board can take into consideration all information provided by Program staff and consultants during the year, along with any other sources available to individual Board members.

The Board make~~s~~ its final determination regarding plan design changes approximately ~~four to five~~^{three} months prior to open enrollment. Composite ~~plan rate~~^{trend} developed by the Plan actuaries ~~is~~^{are} presented to the Board ~~during the same meeting~~^{based on the final plan design changes}.

The PEBP Chief Financial Officer uses the approved plan design changes and rating methodologies to finalize the rates, subsidies, and participant contribution amounts. The final rates are then reviewed and approved by the Board approximately four to eight weeks prior to open enrollment.

D. PROCEDURE

1. Schedule – The planning process for each biennium and legislative session overlaps with the annual rate setting process. The Board actions leading up to the establishment of rates each year should be considered as important as the Board action to approve the rates themselves. Below is a description of the activities that occur on a biennial basis and those that occur on an annual basis.
 - a. Biennial Activities –
 - (i) Strategic Planning - The rate setting process begins with establishing the Board’s strategic direction for each biennial period. In ~~November of odd~~^{even} numbered ~~fiscal~~ years, the strategic plan review and

¹ As written, this process refers to the “normal” planning process for plan years starting July 1st and ending June 30th.

update should be viewed on a three-year horizon. This is because it will serve as the starting point for the next legislative session platform and the next biennial budget. In ~~November of even-odd~~ numbered ~~fiscal~~ years, the strategic plan review and update should be a “fine tuning” of the three-year plan completed the previous ~~year~~~~November~~.

- (ii) Establishing the Legislative Agenda - Planning for each legislative session is also an integral phase in the rate setting process. Using the strategic plan as a basis, any revisions required to the Nevada Revised Statutes (NRS) to implement the strategic plan must be identified. Administrative departments are required to submit non-budgetary bill draft requests (BDRs) by May 1 of each even numbered year. Non-budgetary BDRs will be approved by the Board prior to submission.
- (iii) Preparing the Biennial Budget Request - Departments are required to submit their biennial budget requests no later than September 1 of each even numbered year. Using the strategic plan and the approved allocation methodologies found in Appendix A as a basis, staff preparation of the biennial budget request begins in the spring of each even numbered year. A framework for the budget request will be presented to the Board in ~~late spring or early summer~~~~June~~, with final approval required at the ~~July or~~ August Board meeting. Budgetary BDRs will be approved by the Board prior to submission on September 1.

b. Annual Activities –

- (i) Strategic Planning – The same strategic planning schedule described above for the biennial activities applies to what is used for annual rate setting activities. This occurs each ~~November-year~~ and will result in the Board approving a set of priorities for the upcoming plan year. Staff will work with the Program’s consultant to develop cost impacts of each priority ~~which will be considered approximately three months prior to open enrollment if applicable.~~

- (ii) Finalize Plan Design and Rate Methodology – This step will occur approximately ~~four to five~~ **three** months prior to open enrollment and will provide an opportunity for the Board to select specific initiatives or changes that were discussed during the ~~strategic planning process~~ **year**. This step includes updating this section and Appendix A of the Duties, Policies and Procedures [and a review of the HRA liability and possible HRA carryover limits](#).
 - (iii) Approval of rates – Rates for the upcoming plan year are to be approved by the Board approximately four to eight weeks prior to open enrollment. The rates will be consistent with approved options for plan design and rating methodologies.
2. Data Gathering - PEBP recognizes that sound plan design and rate decisions must be based upon adequate, timely, and accurate information. Below is a listing of the sources of information that will be considered by the Board when making all plan design and rate decisions, along with the timeframe of availability for each item. It is important to note that the information is provided to the Board throughout the year and is not limited to the Board meetings when rates are approved.
- a. Quarterly Vendor Reports – ~~All PEBP vendors are required to submit quarterly reports to the Board.~~ The reports provide utilization activity, participant contacts, provider updates, and other information applicable to each vendor's relationship with PEBP.
 - b. Utilization Reports – PEBP's Chief Financial Officer provides a utilization report for the self-funded plan on a quarterly basis. In addition, an annual utilization report is provided within 90 days following each plan year. The utilization report provides the following data for the entire plan:
 - √ Executive summary and trend analysis
 - √ Plan demographics
 - √ Paid claims by benefit
 - √ Medical claims paid for inpatient/outpatient services
 - √ Surplus and loss summaries broken down by state and non-state groups and active employees, non-Medicare retirees and Medicare retirees.
 - √ Costs by tier and age by medical, dental, prescription

- √ Network utilization and cost sharing
 - √ Analysis of medical paid claims by major diagnostic category, ~~clinical condition~~, large claims and top 25 hospitals
 - √ Chronic conditions and wellness
 - √ Analysis of prescription drug utilization
- c. Disease management and wellness program reports are made available to the Board in vendor quarterly reports. In addition, as each of these programs “mature”, they will be analyzed by PEBP’s consultant on a cost / benefit basis and the results reported to the Board.
- d. The results of each type of participant questionnaire will be reported to the PEBP Board as soon as practical upon compilation of the results.
3. Public Input - The opportunity for public input is available at each Board meeting. The information provided to the Board is made available to the public on the PEBP website (www.pebp.state.nv.us) at the same time it is distributed to the Board. In addition, members of the public may request to be on PEBP’s mailing list for distribution of the Board packet. Subscriptions to the mailing list are updated every six months to confirm that requestors remain interested in receiving the packets.
4. Projected Expenses and Rate Calculations - Any change in methodology for projecting expenses (such as changing from claims trends to a predictive modeling approach) is to be reviewed and approved by the Board during strategic planning and plan design adoption actions. Rate calculations are to be completed by PEBP’s Chief Financial Officer using the approved framework and rating methodology. The consultant/actuary firm is responsible for ensuring that industry standards are met for quality control and accuracy of the [medical, prescription drug and dental](#) cost components for each plan year. PEBP staff will compare the projected expenses and rate calculations to the proposed budget and recommend any amendments to the proposed budget and/or plan design that are deemed appropriate. The rate methodology for each plan year shall be included in updates to these duties, policies, and procedures (see Appendix A)
5. Approval of Plan Year Rates - Final approval of plan year rates and participant contributions is required approximately four to eight weeks prior to Open Enrollment each year. This provides

adequate time to develop and distribute open enrollment materials prior to the beginning of the open enrollment period.

Appendix A - Plan Year 2012-2013 Rating Methodology

Rates are developed first by establishing the plan design. The second step is to project claims costs or premiums for each plan option (e.g. PPO self-funded, HMO, etc.) and participant tier (e.g. single, family, etc.). Finally, PEBP operating costs, administrative costs and reserve adjustments are applied to the various plan options to derive the final rates. Subsidies are applied to the appropriate rate resulting in the participant contribution. Unless otherwise approved by the Board, rates are to be calculated by staff using the following methods.

Plan Design

- Plan Selection Options (medical, prescription, and vision):
 - √ Preferred Provider Organization (PPO) Plan (Base Plan) – self-funded
 - √ Health Maintenance Organization (HMO) Plans – fully insured
 1. Health Plan of Nevada (Clark, Nye, [Lincoln](#) and Esmeralda counties)
 2. Hometown Health Plans(all counties except Clark, Nye, [Lincoln and Esmeralda](#), ~~[Lyon, Mineral, and Lincoln](#)~~)
 - √ Individual Market Medicare Exchange (IMME) – fully insured; only for retirees and their dependents who are eligible for [premium free](#) Medicare Part A; Medicare retirees who qualify for the exchange are not eligible for any other PEBP coverage (other than dental) unless they cover a dependent who is not eligible for the IMME
- Self-Funded Plan Design: See Master Plan Document for details.
- Benefits other than medical, prescription, and vision: See Master Plan Document for details.
 - √ Dental - self-funded; voluntary for IMME retirees, mandatory for all other participants
 - √ Life Insurance - fully insured
 - √ Long Term Disability Insurance (LTD) – fully insured
 - √ Health Savings Account (HSA) – Active employees on the PPO plan only; some eligibility restrictions apply. Plan contribution to be set by the Board each year; if no Board action, contribution is equal to prior year contribution. Employee contribution is voluntary.
 - √ Health Reimbursement Arrangement (HRA) – Retirees on the PPO plan or active employees who do not have an HSA. Plan contribution is equal to the HSA contribution. [There is no year over year carryover limit for unspent HRA funds in an individual's account. The Board will review the liability associated with unspent HRA funds each year.](#)

- √ Flexible Spending Account (FSA) – IRS section 125 voluntary plan guaranteed by PEBP. For active employees only; employees with an HSA are not eligible for a Medical FSA.
- √ Excess Life Insurance – voluntary; fully insured
- √ Long Term Care – voluntary; fully insured
- √ Short Term Disability – voluntary; fully insured
- √ Homeowners and Automobile Insurance – voluntary; fully insured

Cost Projections

- **Commingling:** Pursuant to NRS 287.043(2) and NRS 287.0434(3)(b), claims experience will be commingled for participants for whom the Program provides primary health insurance coverage in a single risk pool.
- **Cost Projection Methodology: Predictive Modeling**
 - √ In addition to taking traditional rating methodologies into consideration, such as demographics and claims experience, predictive modeling considers PEBP's actual disease states and medical conditions to add precision to actuarial projections
 - √ Medical diagnosis data is reviewed by certified clinicians, such as PEBP's Actuary's Medical Director and nursing staff.
 - √ PEBP's actuaries will develop rate cards so that there is ~~66~~50% probability that the developed rates cover plan costs. ~~For Plan Year 2012, PEBP's actuaries will develop rate cards so that there is 50% probability that the developed rates cover plan costs~~
- **Secondary Insurance Coordination: Standard Coordination of Benefits**
 - √ PEBP plan pays the difference between the allowable cost of the health care services and supplies provided to the plan participants less whatever the primary plan paid for them.
 - √ The participant is still responsible for the annual PEBP plan deductible.
- **Rate Structure:** Separate rates are developed for each of the following groups (NRS 287.043(2)(a) and (b)):
 - √ State active employees and non-IMME retirees
 - √ Non-State active employees and non-IMME retirees
- **Participant Tiers of Coverage: Four**
 - √ Single



Duties, Policies, and Procedures - Appendix A Plan Year 2012-2013 Rating Methodology

- √ Single + Spouse
- √ Single + Child(ren)
- √ Single + Family (Spouse and one or more children)

Rate Development

- PEBP's actuaries and HMO vendors will develop costs in accordance with the plan design approved by the Board and in accordance with the methodologies found in the Cost Projections section above.
- Enrollment projections are based on the average change in enrollment over the past 4 years and assumptions approved by the Executive Officer.
- The following costs, revenues and reserve adjustments will be allocated equally to all active employees and non-IMME retirees:
 - √ Life insurance
 - √ Long Term Disability
 - √ PEBP operating costs
 - √ Contracted dental network and claims payment administrative fees
 - √ Miscellaneous Revenues (GL 4254)
 - √ Treasurer's Interest (GL 4326)
 - √ Cost of supplemental subsidies (reduction to excess reserves, Category 86)
 - √ Cost of Medicare Part B premium credit (reduction to excess reserves, Category 86)
 - √ Projected credit due to NRS 287.046(4) (increase to excess reserves, Category 86)
- The following costs, revenues and reserve adjustments will be allocated only to PPO participants:
 - √ Contracted PPO administrative fees
 - √ HSA/HRA plan contributions
 - √ PPO Rx Rebates (GL 4218)
 - √ Adjustments to Catastrophic Reserves (Category 85) in accordance with reserve policies. This adjustment may be applied to all participants if the Board determines that overall rate increases are excessive and chooses to use a portion of the Catastrophic Reserve to reduce rates.
 - √ Adjustments to the Excess Reserves (Category 86) in an amount that is equal to the difference between the projected Excess Reserves at the beginning of the plan year and the budgeted Excess Reserves at the end of the plan year.

less any adjustment applied to HMO rates to offset errors in rate blending caused by changes to estimated HMO enrollment for the current plan year.

Generally, budgeted Excess Reserves at the end of the first year of the biennium will be 50% of the budgeted Excess Reserves at the beginning of the biennium. Generally, budgeted Excess Reserves at the end of the biennium will be zero.

~~√ For Plan Year 2012 only, an additional adjustment will be made in an amount equal to 25% of the budgeted beginning Excess Reserves.~~

- IMME retirees will not be charged for PEBP operating costs, life insurance costs or HRA administration costs. The following costs will be allocated only to IMME retirees who choose PEBP dental coverage:
 - √ Contracted dental network and claims payment administrative fees
- Reserves
 - √ Catastrophic Reserves will be established at a level necessary to ensure plan solvency over the long term at a 95% confidence interval.
 - √ IBNR Reserves will be established at a level to achieve a 95% probability that all incurred claims can be paid.
- HMO rates are blended between the northern and southern HMOs after all of the above adjustments are applied. The blended HMO rate is based on the average cost of coverage by tier and projected enrollment. The purpose of the following reserve adjustment is to offset errors in rate blending caused by variation in the estimated HMO enrollment for the current plan year. The adjustment will be allocated only to HMO participants:
 - √ Adjustments to the Excess Reserves (Category 86) in an amount that is equal to the difference between
 - The product of the projected HMO enrollment used to calculate the blended rates for the current plan year multiplied by the premiums charged by each HMO; and
 - The product of the latest projection for HMO enrollment for the current plan year multiplied by the premiums charged by each HMO.

Subsidy Allocation and Participant Contribution

- Base subsidy allocation
 - √ State subsidy percentages for the primary insured in the base plan as listed below may be adjusted by staff +/- 1.0%, rounded to the nearest tenth of one percent, to account for any projected surpluses or deficits in the Active

Employees' Group Insurance Subsidy (AEGIS) budget account and Retired Employees' Group Insurance (REGI) budget account:

- Active Employee: 91.0%
 - Retiree: 61.0%
 - √ State subsidy percentages for the primary insured in the non-base plans will be equal to the state subsidy percentages for the primary insured in the base plan less 15%.
 - √ State subsidy percentages for dependents will be equal to the state subsidy percentages for the primary insured in each plan less 20%.
 - √ Non-State Active Employee: Determined by employer
 - √ Non-State Retiree: Determined by State Retiree amount (NRS 287.023(4)(b)) as set in session law and is based only upon years of service, regardless of plan selection or participant tier
- Retiree Years of Service (YOS) subsidy adjustment to the base subsidy (NRS 287.046):
 - √ Retirees who retired prior to January 1, 1994: No adjustment.
 - √ Retirees who retired on or after January 1, 1994:
 - For each YOS less than 15, subtract 7.5% of the amount set in session law from the base subsidy.
 - For each YOS greater than 15, add 7.5% of the amount set in session law to the base subsidy (maximum, 20 YOS).
 - √ Retirees who were hired by their last employer on or after January 1, 2010 and who have less than 15 YOS do not receive a YOS or base subsidy.
 - √ Retirees who were hired by their last employer on or after January 1, 2012 do not receive a YOS or base subsidy.
- Supplemental subsidy allocation (~~Plan Years other than Plan Year 2012; Due to the extensive plan design and rating methodology restructuring effective July 1, 2011, no supplemental subsidy will be applied for Plan Year 2012~~):
 - √ A supplemental subsidy will be allocated to any tier and plan with participant contribution increases:
 - greater than one and a half times the blended medical trend as provided by plan actuaries, and
 - greater than \$100.
 - √ The supplemental subsidy will be the amount required to reduce the participant contribution percent increase to the average of the unsubsidized participant contribution and the blended medical trend, but no lower than the amount required to reduce the increase of the participant contribution to \$100.



Duties, Policies, and Procedures - Appendix A Plan Year ~~2012~~ 2013 Rating Methodology

- √ For the purposes of the supplemental subsidy calculation, non-state employees and retirees will be treated as if they receive the base subsidy percentages that state employees and retirees receive.

- Medicare Part B premium credit – Participants who have Medicare Part B but are not on the IMME [and those retirees identified as having a Medicare Part B premium penalty greater than four-twelve month periods](#) will receive a reduction to their premium equal to the base Medicare Part B premium as published by the Centers for Medicare and Medicaid Services ~~four~~ [six](#) weeks before rates are set for persons whose Medicare Part B premium is not deducted from their social security pension.

X.

Discussion and
possible action
regarding the
legislative platform for
the 2013 Legislative
Session



BRIAN SANDOVAL
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Executive Officer

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LEO M. DROZDOFF, P.E.
Board Chairman

AGENDA ITEM

Action Item

Information Only

Date: December 15, 2011

Item Number: X

Title: 2013 Legislative Platform

Summary

Any request for legislative changes will be due to the Department of Administration on or about May 1, 2012. The 2013 PEBP Legislative Platform is being brought forward at this time in conjunction with the Strategic Plan discussion also on this agenda.

Staff has reviewed PEBP statutes as amended by legislation passed by the 2011 Legislature and is not making any recommendations from that review for submission to the 2013 Legislature. If the Board desires any legislation be drafted for submission to the Department of Administration, it needs to provide input to staff so it can be drafted and brought back to the Board at the April Meeting.

PEBP statutes are contained in Chapter 287 of the Nevada Revised Statutes and can be accessed at the following link: <http://leg.state.nv.us/NRS/NRS-287.html> . The relevant sections for PEBP are 287.0402 through 287.049. However, modifications resulting from 2011 legislation have not yet been codified into the written statutes.

XI.

Report from the
Executive Officer
regarding the State of
PEBP

XII.

Discussion and possible action
on updates to the Board's
Strategic Plan for the
2011-2013 biennium



PUBLIC EMPLOYEES' BENEFITS PROGRAM

STRATEGIC PLAN

Updated: ~~December 3, 2008~~ October, 2011

VISION STATEMENT:

To promote improved health status and access to quality healthcare for all PEBP ~~participants~~members.

MISSION STATEMENT:

To design and manage a financially viable quality health care program ~~so that for~~ all PEBP ~~participants-members recognizing experience excellent service, responsiveness to~~ changing benefit needs over ~~career/life~~ spans, and to provide excellent customer service and protection from catastrophic loss/equitable cost sharing, and fiscal soundness for long-term viability of the program.

PHILOSOPHY STATEMENTS:

1. PEBP strives to be an innovative ~~and forward thinking~~ health benefit program
- ~~2. PEBP provides a quality health benefit program to our participants~~
- ~~3. 2. PEBP believes that protection from catastrophic healthcare expense to the participant is core to the program~~
3. PEBP believes that personal responsibility is a cornerstone to the health and welfare of its members
4. PEBP commits to providing tools to assist participants in managing their healthcare resources
5. PEBP commits to maintaining transparency regarding the operation and finances of the plan



PEBP Strategic Plan

Updated: October, 2011

- 6. PEBP commits to a clear communication of program design to all stakeholders
- ~~4. PEBP commits to participant satisfaction through program design and service delivery~~
- ~~5-7. PEBP Board members and staff possess managerial and financial expertise in the health benefits industry~~

Goals:

- GOAL #1:** Provide participants the ability to take personal responsibility for managing their healthcare and provide stakeholders the ability to obtain accurate and timely information regarding the plan~~To provide the best long term delivery systems, plan design, and financially sound rate structure.~~
- GOAL #2:** Establish a plan design which promotes wellness, quality outcomes and controlled costs~~Improve the wellness program so that it is more beneficial to self-funded plan participants~~
- GOAL #3:** Provide for plan financial stability and plan design predictability~~Enhance customer service tools and communication efforts to provide stakeholders the ability to obtain accurate and timely information regarding the plan~~



PEBP Strategic Plan

Updated: October, 2011

Matrix of Goals from December 2008 Strategic Plan to October 2011 Strategic Plan:

Goal 1, Objective 1 – Moved to Goal 2, Objective 3; same Strategies, update Performance Measures

Goal 1, Objective 2 – Moved to Goal 3, Objective 1; Strategy b only; update Performance Measures

Goal 1, Objective 3 – Moved to Goal 1, Objective 4; Strategy a only; update Performance Measures

Goal 1, Objective 4 – Revised language and moved to Goal 3, Objective 2; Strategy b only; update and add Performance Measures

Goal 1, Objective 5 – Moved to Goal 3, Objective 3; Strategies a and c only

Goal 1, Objective 6 – Moved to Goal 3, Objective 4; Strategy a only; Replace strategy b; update and add Performance Measures

Goal 2, Objective 1 – Deleted

Goal 2, Objective 2 – Moved to Goal 2, Objective 1; Strategy a only; Revise Strategy b; Add Strategy c; update and add Performance Measures

Goal 2, Objective 3 – Moved to Goal 2, Objective 2; update and add Performance Measures

Goal 3, Objective 1 – Deleted and replaced with Goal 1, Objective 1

Goal 3, Objective 2 – Deleted

Add – Goal 1, Objectives 2 and 3



PUBLIC EMPLOYEES' BENEFITS PROGRAM

STRATEGIC PLAN

Updated: October, 2011

VISION STATEMENT:

To promote improved health status and provide access to quality healthcare for all PEBP members.

MISSION STATEMENT:

To design and manage a financially viable quality health care program for all PEBP members recognizing changing benefit needs over life spans, and to provide excellent customer service and protection from catastrophic loss.

PHILOSOPHY STATEMENTS:

1. PEBP strives to be an innovative health benefit program
2. PEBP believes that protection from catastrophic healthcare expense to the participant is core to the program
3. PEBP believes that personal responsibility is a cornerstone to the health and welfare of its members
4. PEBP commits to providing tools to assist participants in managing their healthcare resources
5. PEBP commits to maintaining transparency regarding the operation and finances of the plan
6. PEBP commits to a clear communication of program design to all stakeholders
7. PEBP Board members and staff possess managerial and financial expertise in the health benefits industry



PEBP Strategic Plan

Updated: October 2011

GOAL #1: Provide participants the ability to take personal responsibility for managing their healthcare and provide stakeholders the ability to obtain accurate and timely information regarding the plan.

Objectives	Strategies	Success Criteria
1. Improve self-service tools to assist PEBP participants.	<ul style="list-style-type: none"> a. Continuous improvement of usability of on-line enrollment tool by evaluating user feedback. b. Identify and assess health information tools and techniques that would improve participant access to knowledge. 	<ul style="list-style-type: none"> a. Complete upgrades to on-line enrollment prior to Open Enrollment 2012. b. Implement frequently asked question and topic search functionality to plan description documents on website – May 2012. c. Review and provide website content to assist participants with using the consumer driven health plan – Quarterly.
2. Improve stakeholder access to information.	<ul style="list-style-type: none"> a. Identify and assess materials posted to the website to insure they maintain relevance and timeliness 	<ul style="list-style-type: none"> a. Continuously update the redesigned PEBP website to include pertinent and informative materials – Quarterly
3. Improve quality of participant level of plan knowledge.	<ul style="list-style-type: none"> a. Member Services provides accurate and timely information to participants who call into the PEBP offices. b. Participants receive and understand PEBP mailings. 	<ul style="list-style-type: none"> a. Phone statistics b. Accuracy as compiled from call monitoring c. Decrease in volume of returned mail d. Evaluation of results of voluntary customer satisfaction surveys
4. Provide participants with the ability to obtain information regarding provider quality and provider use of new health information technologies.	<ul style="list-style-type: none"> a. Communicate informational items to plan participants, with sample questions to ask providers, about quality services and health information technologies. 	<ul style="list-style-type: none"> a. Establish a dedicated section of the newsletter regarding provider quality and health information technology - beginning Summer 2012. b. Establish and maintain web site content regarding quality standards – beginning July 2012.



PEBP Strategic Plan

Updated: October 2011

GOAL #2: Establish a plan design which promotes wellness, quality outcomes and controlled costs		
Objectives	Strategies	Performance Measures
<p>1. Increase participation in wellness and disease management programs and increase utilization of wellness benefits.</p>	<p>a. Emphasize wellness and disease management benefits in participant communications.</p> <p>b. Implement programs and methods that enhance or increase the use of wellness benefits.</p> <p>c. Increase participant knowledge of wellness and disease management programs.</p>	<p>a. Include wellness information in PEBP's newsletter – Quarterly</p> <p>b. Create a wellness benefit “guide” page on the redesigned website – May 2012</p> <p>c. Present for Board consideration new options that emphasizes wellness compliance with associated incentives for the participant – September 2012</p> <p>d. Screening statistics</p> <p>e. Amend provider directories to allow easier access to wellness providers.</p> <p>f. Survey on why members do or do not participate in diabetes care management program – February 2012.</p> <p>g. Outreach to physicians and providers</p>



PEBP Strategic Plan

Updated: October 2011

GOAL #2: Establish a plan design which promotes wellness, quality outcomes and controlled costs		
Objectives	Strategies	Performance Measures
<p>2. Provide a self-funded plan design that emphasizes value based services that will enhance the wellness status of plan participants.</p>	<p>a. Recognize evolving medical practice initiatives that enhance the wellness status of plan participants.</p> <p>b. Review other plan designs on an ongoing basis that will help identify industry trends in wellness services and disease management efforts for implementation.</p>	<p>a. Update Master Plan Document to allow for administrative adjustments to plan benefits that will allow for a streamlined recognition of new value based medical practice initiatives – May 2012</p> <p>b. Annually review plan design with utilization management and plan consultant vendors to identify plan changes that recognize new value based medical practices.</p> <p>c. Claims savings return on investment.</p>
<p>3. Insure that the self-funded plan design is structured in such a manner as to include services associated with evidence based practices and the provision of medically necessary services.</p>	<p>a. Include provision(s) in the Master Plan Document that reflect the stated objective. The provision(s) should be written in a manner that allows for modification in covered services during the plan year without having to formally amend the Master Plan Document.</p>	<p>a. Complete review and update of Master Plan Document as necessary – May 2012</p>



PEBP Strategic Plan

Updated: October 2011

GOAL #3: Provide for plan financial stability and plan design predictability		
Objectives	Strategies	Performance Measures
1. Insure that providers are of the highest quality and that reimbursement mechanisms recognize quality service from plan providers.	a. Explore financial incentives or pay-for-performance arrangements related to PEBP participants.	a. Present report to PEBP Board regarding such arrangements to be included in the PPO Network request for proposal – May 2013.
2. Insure that in-network provider services are accessible throughout the state.	a. Monitor geographical provider access within the State of Nevada.	a. Design and implement provider access reporting to PEBP – September 2012 b. Where are out-of-network providers being used (use of 50 mile rule).
3. Establish and maintain a rate setting process that is reliable, transparent, and documented.	a. Document methodology and establish internal control procedures for quality assurance and management of data used to determine plan rates. b. Establish procedure by which prior period results are compared to original forecasts.	a. Update Board Duties, Policies, and Procedures – annually. b. Complete look-back analysis – annually.



PEBP Strategic Plan

Updated: October 2011

GOAL #3: Provide for plan financial stability and plan design predictability		
Objectives	Strategies	Performance Measures
4. Establish and maintain contracting procedures that incorporate cost, quality, and participant satisfaction performance provisions	<ul style="list-style-type: none"> a. Identify and take advantage of combined purchasing efforts whenever appropriate (intergovernmental and interdepartmental). b. Work with actuaries, consultants and health claims auditor to incorporate best practices terms and conditions into requests for proposals. 	<ul style="list-style-type: none"> a. Formally communicate with State of Nevada agencies and state and local governments in the Western United States to survey interest in combined purchasing projects – July 2012. b. Continuously incorporate best practices terms and conditions into requests for proposals.

XIII.

Discussion and possible action regarding the performance evaluation and a vote of confidence or no confidence for the Executive Officer for the period June 1, 2010 through December 31, 2011

XIV.

Discussion and
possible action
regarding self-
evaluation of the
PEBP Board
performance

XV.

Information Item

Chief Financial Officer's
Report for the quarter ended
September 30, 2011



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JAMES R. WELLS, CPA
Executive Officer

LEO M. DROZDOFF, P.E.
Board Chairman

AGENDA ITEM

Action Item

Information Only

Date: January 19, 2012
Item Number: XV
Title: Chief Financial Officer Report

Summary

This report addresses the following topics:

1. September 30, 2011 Budget Status
 - a. Budget Account 1338 – Operational Budget
 - b. Budget Account 1368 – Retired Employee Group Insurance
 - c. Budget Account 1390 – Active Employee Group Insurance Subsidy
2. Current Budget Projections
3. September 30, 2011 Unaudited Financial Statements

Report

September 30, 2011 Budget Status

Budget Account 1338 – Operational Budget – Shown below is a summary of the operational budget account 1338 status as of September 30, 2011 compared to the work program (budgeted authority) for FY 2012 with comparisons to FY 2011. The budget status is reported on a cash basis and does not include incurred expenses and income owed to the fund.

The budget status report shows Realized Funding Available (cash) at \$115.6 million. This compares to \$90.1 million for last year. After subtracting \$33.3 million for reserves for Incurred but not Reported (IBNR) claims, \$35.0 million for the Catastrophic Reserve and \$2.1 million for the HRA Reserve, the remaining balance is \$45.2 million. The increase in net realized funding available is largely due to:

1. Higher beginning cash (\$20.5 million); and

2. Decreased self-funded claims expenses (\$23.5 million)

Offset by:

1. Increases to HMO premiums (\$5.3 million).
2. The addition of HSA/HRA contributions (\$13.2 million); and
3. Higher reserve requirements (\$3.2 million).

The budget status is reported on a cash basis. In the previous year, the AEGIS budget account had a deficit which delayed the September 2010 AEGIS payment to the operating budget until October 28, 2010, artificially decreasing total premium revenue as of September 30, 2010 by \$17.5 million when compared to September 30, 2011.

Operational Budget 1338

	FISCAL YEAR 2012			FISCAL YEAR 2011		
	Actual as of 9/30/2011	Work Program	Percent	Actual as of 9/30/2010	Fiscal Year 2011 Close	Percent
Beginning Cash	104,864,137	104,864,137	100%	84,399,437	84,399,437	100%
Premium Income	79,368,334	353,823,161	22%	78,532,179	373,737,931	21%
All Other Income	2,683,167	17,388,887	15%	4,080,623	7,768,824	53%
Total Income	82,051,501	371,212,048	22%	82,612,802	381,506,755	22%
Personnel Services	466,068	2,129,011	22%	402,755	2,116,035	19%
Operating - Other than Personnel	362,376	2,224,047	16%	494,075	2,178,644	23%
Insurance Program Expenses	70,321,424	388,734,874	18%	75,834,297	355,840,495	21%
All Other Expenses	194,853	846,176	23%	182,340	906,881	20%
Total Expenses	71,344,720	393,934,108	18%	76,913,467	361,042,055	21%
Change in Cash	10,706,781	(22,722,060)		5,699,335	20,464,700	
REALIZED FUNDING AVAILABLE	115,570,918	82,142,077	141%	90,098,772	104,864,137	86%
Incurred But Not Reported Liability	(33,272,000)	(33,272,000)		(33,849,000)	(33,849,000)	
Catastrophic Reserve	(35,015,000)	(35,015,000)		(33,327,000)	(33,327,000)	
HRA Reserve	(2,060,000)	(2,060,000)		-	-	
NET REALIZED FUNDING AVAILABLE	45,223,918	11,795,077		22,922,772	37,688,137	

The actual premium income (includes state subsidies) of \$79.4 million is \$0.8 million more than first quarter of FY 2011. This increase is due to slight rate increases offset by subsidy decreases.

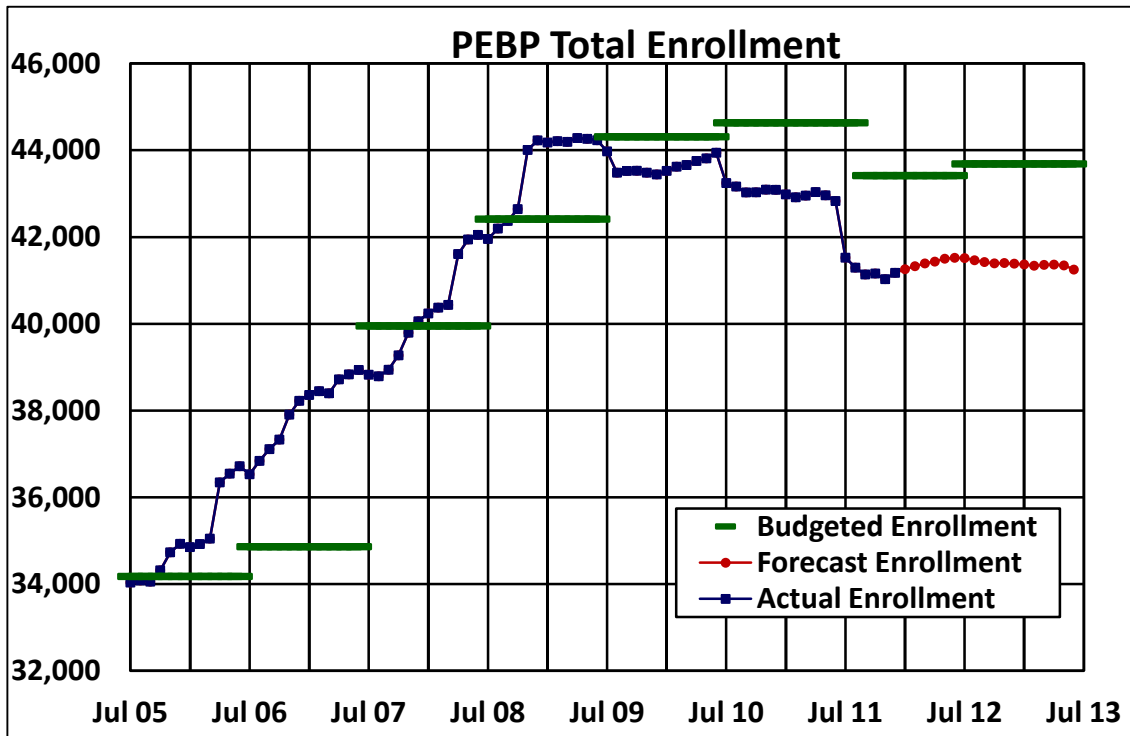
Insurance program costs for the first quarter of FY 2012 decreased \$5.5 million (7.3%) from FY 2011 due to:

1. A \$5.3 million (25.0%) increase in fully insured product costs due to HMO rate and enrollment increases; and
2. The addition of HSA/HRA contributions (\$13.2 million);

Offset by:

1. A \$23.5 million (45.1%) decrease in self-funded claims costs due to plan design changes and the migration of Medicare retirees to the exchange; and
2. A \$476,000 (19.5%) decrease in self-funded network costs mostly due to the migration of Medicare retirees to the exchange;

As of September 30, 2011, there were 41,137 participants enrolled in PEBP. This is 2,279 less than the average budgeted enrollment for FY 2012 of 43,416, due to an additional 700 state employees who elected to decline insurance effective June 30, 2011 and reductions in statewide hiring. Average enrollment in the self-funded plans decreased 31.8% from 30,114 in FY 2011 to 20,544 (estimated) in FY 2012. Average enrollment in the HMO plans decreased 9.1% from 12,915 to 11,739 during the same period. Average enrollment in the Medicare Exchange for FY 2012 is expected to be 9,029. Below is a graphical representation of PEBP enrollment since July 2005.



Budget Account 1368 – Retired Employee Group Insurance – The Retired Employee Group Insurance (REGI) budget account (1368) is used to account for the state funds required to pay retiree subsidies. The REGI budget account is contained within the State Retirees’ Health and Welfare Benefits Fund which is used to account for the money set aside by the State to partially prefund the State’s Other Post Employment Benefits (OPEB) liability. REGI disburses funds to the operational budget (1338) based on actual costs of the State retiree subsidy. For FY 2012, REGI is funded by an assessment of 2.134% of actual salaries to all State agencies.

Actual revenues for the first quarter of FY 2012 were \$5.2 million, an increase of \$2.0 million from the first quarter of FY 2011 largely due to the reduction in the assessment rate in FY 2011 made possible by the withdrawal of \$24.7 million from the Retirees' Benefits Investment Fund (RBIF) as required by AB 3 of the 26th Special Session of the Nevada Legislature (2010). The \$8.0 million transferred to the operational budget (1338) from REGI is \$700,000 less than the first quarter of FY 2011 due to decreased subsidization rates for retirees on the Medicare exchange. Realized funding available for the first quarter of FY 2012 is \$1.4 million. Staff forecasts the REGI budget account will have a \$300,000 deficit at the end FY 2012.

Retired Employees' Group Insurance (REGI) Budget 1368

	FISCAL YEAR 2012			FISCAL YEAR 2011		
	Actual as of 9/30/2011	Work Program	Percent	Actual as of 9/30/2010	Fiscal Year 2011 Close	Percent
Beginning Cash	4,234,554	4,234,554	100%	28,637,644	28,637,644	100%
Assessment Income	5,163,320	29,494,026	18%	3,203,685	10,667,345	30%
Transfer from Investment Trust	-	-	0%	-	-	0%
Treasurer's Interest	-	61,237	0%	-	88,679	0%
Total Income	5,163,320	29,555,263	17%	3,203,685	10,756,025	30%
Transfer to 1338	8,034,160	32,507,537	25%	8,762,966	35,159,114	25%
Transfer to Investment Trust	-	-	0%	-	-	0%
Total Expenses	8,034,160	32,507,537	25%	8,762,966	35,159,114	25%
Change in Cash	(2,870,840)	(2,952,274)		(5,559,281)	(24,403,090)	
REALIZED FUNDING AVAILABLE	1,363,714	1,282,280		23,078,363	4,234,554	

The cash balance above is held in the State's General Portfolio managed by the State Treasurer. Not shown above is \$843,215 invested with the RBIF managed by PERS, as of September 30, 2011. The State's rate of return on the funds invested in the RBIF since fund inception is -0.9%. The one year rate of return as of September 30, 2011 is 1.4%.

Budget Account 1390 – Active Employee Group Insurance Subsidy – The Active Employee Group Insurance Subsidy (AEGIS) budget account (1390) is used to account for the state funds required to pay employee subsidies. For FY 2012, AEGIS is funded by a monthly assessment of \$644.81 to all state agencies for each filled benefit-eligible position (excluding those participants who decline coverage). AEGIS disburses funds to the operational budget (1338) based on actual costs of the State employee subsidy.

Actual revenues for the first quarter of FY 2012 were \$45.2 million, a decrease of \$6.6 million (12.8%) over the first quarter of FY 2011. The decrease is due to the reduction in the AEGIS assessment (5.3%), reductions in statewide hiring and an increased number of employees who have declined coverage. Actual disbursements to the operational budget

(1338) in the first quarter of FY 2012 were \$45.3 million, an increase of \$7.5 million (19.9%). The increased disbursements are due to earlier transfers of the AEGIS assessment to the operational budget account. In the previous year, the AEGIS budget account had a deficit, on an incurred basis, which delayed the September 2010 AEGIS payment to the operating budget until October 2010, artificially decreasing total transfers as of September 30, 2010 by \$17.5 million when compared to September 30, 2011.

As of September 30, 2011, there was a \$127,241 deficit in the AEGIS budget account. This was caused by the timing of transfers that occur during a month. On an incurred basis, the AEGIS budget account had a positive balance of \$1.2 million as of September 30, 2011. Staff has contacted the Controller's Office and the Budget Division to determine why the Integrated Financial System did not block the transfer that created the negative balance.

Active Employees' Group Insurance Subsidy (AEGIS) Budget 1390

	FISCAL YEAR 2012			FISCAL YEAR 2011		
	Actual as of 9/30/2011	Work Program	Percent	Actual as of 9/30/2010	Fiscal Year 2011 Close	Percent
Beginning Cash	-	-	0%	-	-	0%
Assessment Income	45,178,818	197,432,106	23%	51,822,645	211,484,392	25%
Treasurer's Interest	-	100,000	0%	-	71,412	0%
Total Income	45,178,818	197,532,106	23%	51,822,645	211,555,804	24%
Transfer to 1338	45,306,059	197,532,106	23%	37,798,433	211,555,804	18%
Change in Cash	(127,241)	-		14,024,211	-	
REALIZED FUNDING AVAILABLE	(127,241)	-		14,024,211	-	

Current Budget Projections

The following represents estimates for the Fiscal Year ending June 30, 2012 based on data available as of December 21, 2011. The assumptions and calculation methods used to create these estimates may be revised from time to time based on the best data available and could result in material differences in future projections from the estimates included here. It should be noted that the large plan design changes effective July 1, 2011 creates a huge margin of error surrounding the estimates for self-funded claims expenses included in this report for Fiscal Year 2012.

Premium income and state subsidies are projected to be lower than budgeted amounts by \$24.2 million (19.5%) and \$16.5 million (7.2%), respectively due to lower than expected enrollment caused by reductions in statewide hiring and declinations of coverage. Premium income has decreased more than state subsidies because of the

disproportionately higher number non-state participants who moved from the PPO to the lower cost HMO on July 1.

All other revenues are projected to be \$4.2 million (27.2%) greater than budgeted due to:

1. Higher than expected ERRP funding (\$1.5 million); and
2. Delayed receipt of FY 2010 and 2011 Retiree Drug Subsidies (\$3.6 million);

Offset by:

1. Lower than expected PPO drug rebates due to lower than expected PPO enrollment (\$100,000); and
2. A decrease in treasurer's interest resulting from the State's General Portfolio loss on an investment with Lehman Brothers and the general decrease in market interest rates (\$300,000).

Budgeted and Projected Income (Budget Account 1338)					
Description	Budget	Actual 11/30/11	Projected	Difference	
Carryforward	104,864,137	104,864,137	104,864,137	0	0.0%
State Subsidies	230,039,643	74,857,511	213,583,856	(16,455,787)	-7.2%
Contributions	123,783,518	40,976,759	99,623,639	(24,159,879)	-19.5%
All Other	17,388,887	3,493,940	22,115,905	4,727,018	27.2%
Total	476,076,185	224,192,347	440,187,536	(35,888,649)	-7.5%
Budgeted and Projected Expenses (Budget Account 1338)					
Description	Budget	Actual 11/30/11	Projected	Difference	
Operating	5,199,234	1,603,398	4,960,949	238,285	4.6%
Self-Funded Admin	9,596,989	3,200,980	8,341,692	1,255,297	13.1%
Self-Funded Claims	231,797,660	49,990,068	168,958,141	62,839,519	27.1%
Fully Insured Products	116,325,945	44,358,552	106,975,504	9,350,441	8.0%
Reserves	80,082,077	105,774,527	115,007,603	(34,925,526)	-43.6%
Total	443,001,905	204,927,525	404,243,889	38,758,016	8.7%

Expenses for FY 2012 are projected to be \$77.1 million (19.6%) less than budgeted when changes to reserves are excluded. Operating expenses are projected to be \$238,000 (4.6%) less than budgeted due to reduced payroll costs caused by position vacancies and reduced use of our consultant, Aon-Hewitt. Self-Funded Admin and Self-Funded Claims categories costs are projected to be \$1.3 million (13.1%) and \$62.8 million (27.1%) less than budgeted respectively due to reductions in self-funded enrollment and lower than expected utilization. Fully Insured Products costs are projected to be \$9.4 million (8.0%) under budget due to lower than expected enrollment.

Total reserves for FY 2012 are projected to be \$115.0 million. Reserves include \$33.3 million for Incurred but not Reported (IBNR) claims, \$35.0 million for the Catastrophic Reserve to insure plan solvency, \$8.4 million in HRA reserve and a balance in excess of the required reserves of \$46.7 million. However, due to the nature of the plan design changes effective July 1, 2011, there is insufficient data to validate these reserve estimates.

September 30, 2011 Unaudited Financial Statements

A draft statement of revenue, expenses and changes in fund net assets (income statement) for the year ending September 30, 2011 and the corresponding statement of net assets (balance sheet) are provided in Appendix A.

Due to the addition of Health Savings Accounts (HSA) and Health Reimbursement Arrangements (HRA) effective July 1, 2011, several new categories of expenses have been added as well as an HRA Reserve. HRA claims paid to participants as reimbursement for premiums and other out of pocket expenses have been added as claims expenses. HRA contributions that have not yet been distributed as well as all HRA contributions have been added as contribution expenses. The HRA reserve is the total of the PPO HRA and Medicare HRA contributions that have not yet been distributed. Because PPO HRA contributions are funded at the beginning of the year, as the year progresses and PPO participants receive reimbursements from the HRA, the PPO HRA claims expense will increase and the PPO HRA contribution expense will decrease.

The income statement shows a net gain of \$8.7 million for FY 2012 resulting in a claims loss ratio of 86.7%. Ending Net Assets of \$85.3 million are available to fund the budgeted reserve for catastrophic losses of \$35.1 million, leaving \$50.2 million in excess of required reserves.

From September 30, 2010 to September 30, 2011, current receivables decreased \$3.1 million to \$5.4 million. Current intergovernmental receivables (see Assets; Current Assets; Receivables) increased \$0.4 million due to the timing of Medicare D subsidy collections. Current due from other funds (see Assets; Current Assets; Receivables) decreased \$1.4 million due to the elimination of the AEGIS shortfall (currently running at a surplus). Current due from component units (see Assets; Current Assets; Receivables) decreased \$2.1 million (99.0%) due to the move of the AEGIS budget account from the Self-Insurance Trust Fund to the Payroll Trust Fund pursuant to Assembly Bill 556 (2011).

There are two significant changes in liabilities from September 30, 2010 to September 30, 2011. Accounts payable (see Liabilities; Current Liabilities) decreased \$2.4 million, due to timelier payment of September 2011 premiums to PEBP's Southern HMO. The HRA Reserve (see Liabilities, Noncurrent Liabilities) was created to account for the cost of HRA contributions that have not yet been distributed to participants.

Recommendations

None.

State of Nevada
 Public Employees' Benefit Program
 Self Insurance Trust Fund

Statement of Revenue, Expenses and Changes in Fund Net Assets - **UNAUDITED**
 for the three months ending September 30, 2011 and September 30, 2010 and the twelve months ending June 30, 2011

	Unaudited September 30, 2011	Audited June 30, 2011	Unaudited September 30, 2010
OPERATING REVENUES:			
Insurance premiums	94,137,382	370,543,399	93,366,353
Other	98,889	4,031,677	967,202
Total Operating Revenues	<u>94,236,272</u>	<u>374,575,076</u>	<u>94,333,555</u>
OPERATING EXPENSES:			
Salaries and Benefits	525,514	2,158,411	544,506
Operating Claims	562,503	3,230,764	857,745
Medical, Dental and Prescription Drug	34,027,977	237,323,825	53,773,462
PPO HRA	1,374,711	-	-
Medicare HRA	2,696,562	-	-
Total Claims	<u>38,099,250</u>	<u>237,323,825</u>	<u>53,773,462</u>
Contributions			
PPO HSA	9,407,889	-	-
PPO HRA	6,669,489	-	-
Medicare HRA	1,766,538	-	-
Total Contributions	<u>17,843,916</u>	<u>-</u>	<u>-</u>
Depreciation	12,062	34,097	14,161
Insurance premiums and contractual obligations	<u>28,597,431</u>	<u>109,586,367</u>	<u>27,605,743</u>
Total Operating Expenses	<u>85,640,677</u>	<u>352,333,464</u>	<u>82,795,617</u>
Operating Income (Loss)	<u>8,595,594</u>	<u>22,241,612</u>	<u>11,537,938</u>
NONOPERATING REVENUES (EXPENSES):			
Investment income (loss)	75,955	(763,892)	80,521
Interest Expense	-	476,518	-
Total Nonoperating Revenues	<u>75,955</u>	<u>(287,374)</u>	<u>80,521</u>
Change in Net Assets	8,671,549	21,954,238	11,618,459
Net Assets, Beginning	<u>76,644,137</u>	<u>54,689,899</u>	<u>54,689,899</u>
Net Assets, Ending	<u><u>85,315,686</u></u>	<u><u>76,644,137</u></u>	<u><u>66,308,358</u></u>
Expense Ratio	3.3%	4.2%	4.3%
Claims Loss Ratio	86.7%	90.9%	81.7%

State of Nevada
 Public Employees' Benefit Program
 Self Insurance Trust Fund
 Statement of Net Assets - **UNAUDITED**
 as of September 30, 2011, June 30, 2011 and September 30, 2010

	Unaudited September 30, 2011	Audited June 30, 2011	Unaudited September 30, 2010
ASSETS:			
Current Assets:			
Cash and cash equivalents			
Cash deposits with the State Treasurer	128,960,730	111,556,212	103,905,348
Receivables:			
Accounts receivable	2,304,378	1,941,662	2,356,893
Intergovernmental receivable	2,892,822	5,700,415	2,451,494
Due from other funds	154,624	616,770	1,593,098
Due from component units	21,800	1,168,691	2,108,380
Total Current Assets	<u>134,334,354</u>	<u>120,983,750</u>	<u>112,415,213</u>
Noncurrent Assets:			
Capital Assets			
Property and equipment	375,831	361,572	367,605
Less: Accumulated depreciation	(304,697)	(292,635)	(272,698)
Total Capital Assets (net of accum depr)	<u>71,134</u>	<u>68,937</u>	<u>94,907</u>
Total Non Current Assets	71,134	68,937	94,907
Total Assets	<u>134,405,488</u>	<u>121,052,687</u>	<u>112,510,120</u>
LIABILITIES:			
Current Liabilities:			
Bank overdraft	4,950,684	2,516,747	5,330,205
Accounts payable	1,647,717	7,632,611	4,082,637
Accrued payroll	55,213	98,960	134,650
Due to other funds	25,541	19,720	5,669
Unearned revenue	75,584	97,226	115,190
Compensated absences	124,423	124,423	106,048
Reserve for losses (IBNR)	33,704,750	33,849,000	36,381,500
Total Current Liabilities	<u>40,583,912</u>	<u>44,338,687</u>	<u>46,155,899</u>
Noncurrent Liabilities:			
HRA Reserve	8,436,027	-	-
Compensated absences	69,863	69,863	45,864
Total Noncurrent Liabilities	<u>8,505,890</u>	<u>69,863</u>	<u>45,864</u>
Total Liabilities	<u>49,089,802</u>	<u>44,408,550</u>	<u>46,201,763</u>
NET ASSETS:			
Invested in capital assets	71,134	68,937	94,907
Restricted for Losses	85,244,552	76,575,200	66,213,451
Unrestricted	-	-	-
Total Net Assets	<u>85,315,686</u>	<u>76,644,137</u>	<u>66,308,358</u>

XVI.

Public
Comment

XVII.

ADJOURNMENT