



STATE OF NEVADA  
**PUBLIC EMPLOYEES' BENEFITS PROGRAM**

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**AGENDA ITEM**

Action Item

Information Only

**Date:** January 19, 2012

**Item Number:** XI

**Title:** 2012 State of PEBP

**Introduction**

As we look toward building the 2013-2015 biennial budget during the summer of 2012, the economic condition of the State seems to have hit bottom. Several of the State's major revenue sources are currently ahead of their respective forecasts; however, any good news continues to be offset by high unemployment in Nevada. It remains to be seen what direction PEBP will receive from the Department of Administration regarding the State subsidies to be provided for creating the Agency budget submission. The subsidy amounts will determine what changes, if any, the Board will need to consider for plan years 2014 and beyond.

For Plan Year 2013, staff recommended only minor plan design changes since we do not yet know the full impact of the plan design changes implemented for Plan Year 2012 on medical inflation and plan utilization. As such, it is the intent of staff to maintain as much of the status quo as possible for Plan Year 2013 which will become clear as we move into the annual rate setting process at the March Board meeting.

**2011 – Implementing Change**

In 2011, participants experienced the most fundamental changes in their health insurance since the Self Insurance Trust Fund was created in 1983. The implementation of a Consumer Driven Preferred Provider Organization High Deductible Health Plan (CD PPO HDHP) for active employees and non-Medicare retirees and the transition of coverage for Medicare retirees to an Individual Market Exchange meant that over 30,000 participants were covered under a different plan type than they were in the prior plan year. Adding the implementation of a new third party administrator (HealthSCOPE Benefits) and conducting the first positive enrollment since 2001 combined to create an extraordinarily difficult year for PEBP.

These events culminated in a record number of phone calls, e-mails and walk-in visitors to the PEBP customer service staff. The number of calls received during the open enrollment period for Plan Year 2012 was more than the last three open enrollment periods combined and the average length of each call was almost twice as long as previous open enrollment periods. Despite diverting staff from their regular duties to assist with participant inquiries, the volume overwhelmed staff's ability to keep up and resulted in higher than anticipated call waiting times and dropped calls. The high call volume continued into the third quarter of calendar year 2011 but began returning to normal during the fourth quarter. As a result of the high call volume experienced during open enrollment, Executive staff has been working on an overflow plan for future open enrollment periods to insure participant calls are answered in a timely manner. This overflow plan should be in place for the 2012 open enrollment period.

The positive open enrollment could not have been accomplished without the implementation of on-line enrollment. During the fourth quarter of 2010 and the first quarter of 2011, PEBP and Morneau Shepell staff worked diligently to make on-line enrollment available April 4, 2011 just after the open enrollment period began. While PEBP still received just over 8,100 paper open enrollment Forms, staff processed a total of over 41,500 enrollment transactions. There were some reported difficulties from participants using on-line enrollment with the most common problem that of needing a password reset. Overall, the implementation of on-line enrollment was very successful. Staff met with Morneau Shepell after open enrollment to review the on-line enrollment program and is working on enhancements to be added prior to the next open enrollment. On-line enrollment will allow PEBP to hold positive enrollments more frequently in the future. A positive enrollment every four or five years would keep participants engaged with their healthcare options and insure PEBP receives updated demographic information on a regular basis.

The 2011 open enrollment period and on-line enrollment also highlighted some other operational issues within the Agency. While current State Regulations require participants to notify PEBP of an address change within 30 days, over 800 open enrollment Notices were returned as undeliverable. This number does not include those forwarded by the US Postal Service to a new address. PEBP utilizes the Address Change Service from the US Postal Service which forwards mail to the recipient if the recipient has a forwarding order on file and notifies PEBP of an address change via an electronic file. Those address changes are subsequently confirmed by PEBP staff in an endeavor to keep participant addresses current. However, it was obvious that a significant number of participants do not update their addresses timely. The on-line enrollment tool allows participants to change their address at any time and should reduce the number of incorrect addresses in the future.

The high call volume and a number of customer service complaints highlighted the need for PEBP to record incoming phone calls for both quality control and training purposes as well as to verify the content of disputed communications. PEBP is currently working on

adding call recording capability to its phone system which should be completed prior to the commencement of the next open enrollment period.

Staff has been working in the fourth quarter of 2011 on a reorganization of the Operations section of the Agency. As more transactions are completed on-line, the need for the Document Processing Unit which scans incoming forms will decrease. As a result, this Unit will be dissolved with part of the Unit being absorbed into the Eligibility Processing Unit and the balance added to the Member Services Unit. The new, larger Member Services Unit will be organized into two teams each with a Supervisor, a Senior Member Care Agent and three Member Care Agents. The two teams will report to a Customer Care Manager who reports to the Operations Officer. A second component of the reorganization is the reclassification of a currently vacant Administrative Assistant position to a new Training Officer position. The Training Officer will create a training program for customer service and plan design and deliver the training to both new staff in a more formal on-boarding process as well as to existing PEPB employees as refresher training is needed or new areas for training are identified. This position will also create Member Care Manuals to provide staff with the necessary documentation to respond to participant inquiries in a more uniform manner. This position will also create a standardized call evaluation template in order to assess the performance of Member Care Agents and identify additional training opportunities. The Training Officer and the Supervisors will monitor both live and recorded calls on a regular and recurring basis in order to improve the customer service provided by the Agency. The reclassification will be on either the February or April Interim Finance Committee agenda for approval. Staff will keep the Board apprised of the reorganization activities throughout calendar year 2012.

### **Financial Picture**

The Program continues to maintain financial solvency with fully funded Incurred But Not Reported (IBNR) reserves for each of the last eight years and fully funded Catastrophic reserves for each of the last six years. On a budgetary basis (cash as opposed to incurred basis), there were \$37.7 million dollars in the Program above those required reserve levels as of June 30, 2011. This has been possible due to the conservative financial policies adopted by the Board, the adoption of plan design changes when necessary to balance increasing medical costs and responsible funding of any benefit enhancements. The reserves in excess of the required reserve levels will be used to reduce premiums and contributions during future plan years. The reserves in excess of the required levels are scheduled to be reduced significantly during the current biennium. See Figure 1 below.



Over the same two year period, budgeted staffing levels have remained constant at 32 full time equivalent positions. PEBP did increase available staff to keep up with the heavy workload during open enrollment by filling a position being held vacant to comply with previous budget cuts with a temporary hire and authorizing just over 1,000 hours of overtime to existing staff between April and September.

### ***Plan Enrollment***

Generally, if different health insurance plans are priced appropriately, changes during open enrollment will be similar across all plans. For Plan Year 2012, there were several additional factors impacting the enrollment migration of PEBP participants. The first was transitioning Medicare retirees to the Individual Market Medicare Exchange, the second was replacing the traditional PPO self-funded plan with a high deductible health plan, and the third was blending the Northern and Southern Health Maintenance Organization (HMO) rates to come up with a single composite rate for HMO participants.

As a result of these additional factors, from June to August 2011:

- Enrollment in the self-funded plan decreased by 9,182 participants (approximately 30.7 percent);
- Enrollment in the Southern Nevada HMO decreased by 1,162 (approximately 16.0 percent; excludes Medicare Advantage plan);
- Enrollment in the Northern Nevada HMO increased by 851 (approximately 17.9 percent; excludes Medicare Advantage plan);
- Participants who declined coverage increased by 650 (approximately 76.7 percent); and
- Enrollment in the Medicare Exchange was 8,818.

See Figure 2 below.

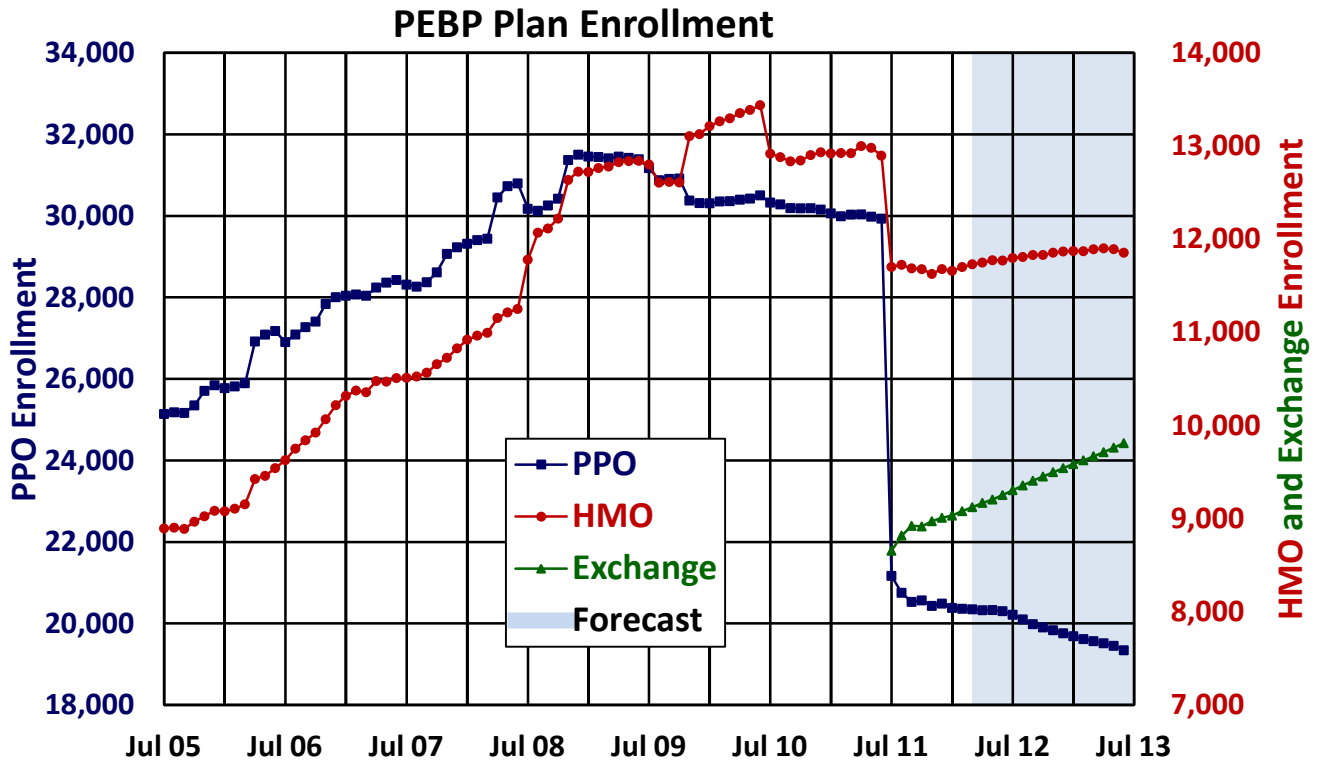


Figure 2

**Average Age**

As expected, the average member age of participants in the Self-Funded plan decreased significantly in Calendar Year 2011 as a result of transitioning Medicare eligible retirees to the Individual Market Medicare Exchange. The average age of participants in Plan Year 2011 was 45.4 years while the average age for the quarter ending September 30, 2011 was 39.9 years. The average age is projected to continue decreasing slightly until sometime between 2016 and 2018 when the majority of non-state retirees will have transitioned to the Medicare Exchange. See Figure 3 below.

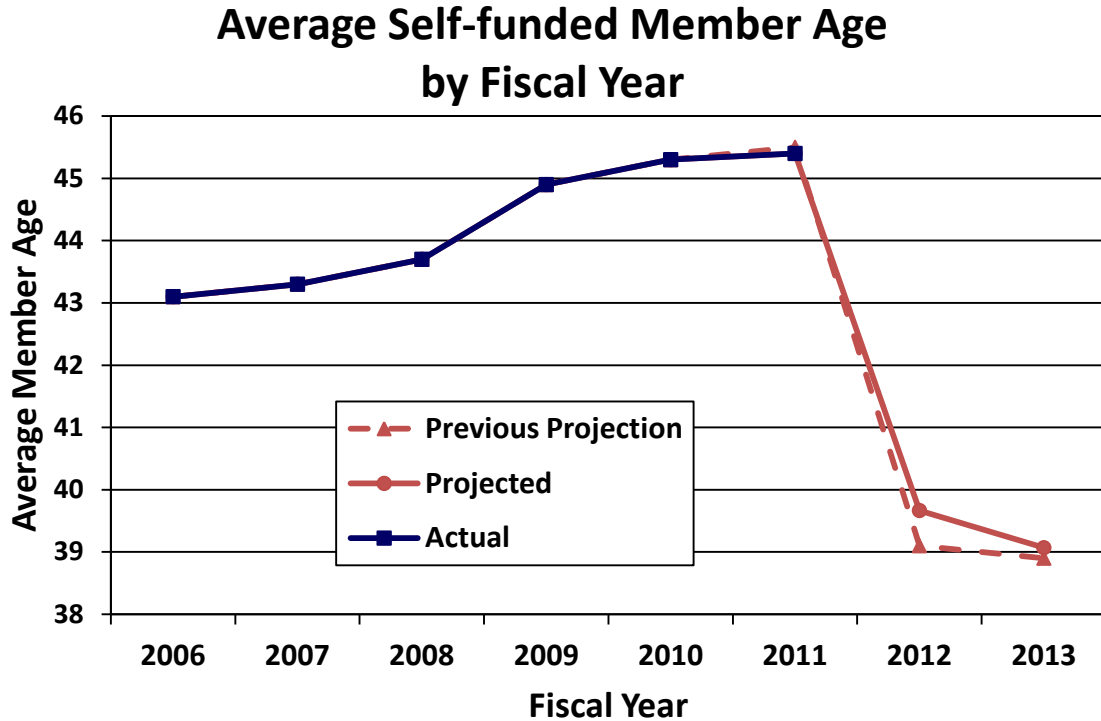


Figure 3

### 2011 Legislative Session

During the 76<sup>th</sup> Legislative Session, the Legislature approved the PEBP budget with only minor changes from that submitted by the Board to the Governor. Further, most of the PEBP sponsored legislation was passed by the Legislature and signed into law by the Governor as introduced. There were eight bills whose passage and approval directly impacted PEBP operations. Of those eight bills, four were submitted by PEBP. A short summary of the eight bills follows:

Assembly Bill 74 submitted by the Division of Insurance revised the timing regarding claims appeals, added an external appeal step for participants to appeal a claim to an independent review organization and added requirements for an expedited claims appeals. These requirements were necessary in order to comply with Federal Health Care Reform guidelines.

Assembly Bill 76 submitted by PEBP eliminated the biennial “Late Enrollment” and replaced it with a provision allowing participants to reinstate during any open enrollment period. This bill also limits participants to one reinstatement in their lifetime after October 1, 2011. The provision to allow closed meetings to select Executive Officer finalists and review the performance of the Executive Officer was removed from this bill.

Assembly Bill 80 submitted by PEBP:

- Eliminated pre-existing condition exclusions pursuant to Federal Health Care Reform;
- Provided for the coverage of children up to age 26 pursuant to Federal Health Care Reform;
- Simplified the annual reporting requirements in various statutes and requires providing the report to the Board, the Department of Administration and the Legislature;
- Removed duplicative language regarding the subsidization of local government retirees that is included in another section of the NRS;
- Clarified language regarding the subsidization of State active employees to conform with the actual practice of the Board;
- Clarified language regarding the subsidization of State retirees that was added in 2009; and
- Clarified that subrogation rights apply to all members not just primary participants.

Language clarifying a domestic partner's right to join PEBP or continue coverage in the event their domestic partner police officer or firefighter is killed in the line of duty was removed from this bill.

Assembly Bill 365 sponsored by Assemblyman Kirner:

- Amended the purchasing procedures for PEBP and outlined the requirements to allow the Board to conduct a separate review during the Request For Proposal process after the evaluation committee concludes its work and for the Board to award a contract to the selected vendor;
- Allowed for the Executive Officer to observe the evaluation committee deliberations;
- Allowed the Board to engage an attorney who specializes in healthcare if the Board deems it necessary;
- Amended the criteria to be reviewed and approved by the Commissioner of Insurance for contracts with licensed administrators and actuaries; and
- Required a group of 300 attempting to leave the Program to be organized for reasons other than acquiring insurance and to include all active participants of the group as well as any retiree who would have been a member of the group at the date of his or her retirement.

Assembly Bill 553 submitted by the Division of Budget and Planning eliminated retiree healthcare subsidies for any employee hired after January 1, 2012. While those retirees will still be allowed to participate in the Program, they will not be entitled to any subsidy towards their premium or contribution.

Assembly Bill 556 submitted by PEBP moved the Active Employee Group Insurance Budget Account to the Payroll Trust Fund.

Assembly Bill 562 submitted by PEBP allowed for the provision of Health Reimbursement Arrangement Accounts for Medicare Retirees.

Assembly Bill 563 submitted by the Division of Budget and Planning set the employee and retiree subsidies for the 2011-2013 biennium.

**Plan Costs**

On a paid claims basis, total self-funded claim dollars decreased by 1.2% from Fiscal Year 2010 to Fiscal Year 2011. This decrease generated a surplus to the self-funded plan of approximately \$121.95 per participant per month. Only State non-Medicare retirees did not generate a surplus for the year.

In Fiscal Year 2010, the non-Medicare retiree population, which is typically between the ages of 55 and 64, cost approximately \$688 per member per month while the average cost of all members was only \$393 per month. For Fiscal Year 2011, the non-Medicare population cost increased to approximately \$709 per member per month while the average cost of all members decreased slightly to \$392 per month.

Figure 4 below shows the actual operating costs (salaries, travel, rent, information technology support and State central service assessments) for Fiscal Years 2006 through 2011 and projected costs for Fiscal Years 2012 and 2013. Operating costs as a percent of total expenses decreased in Fiscal Year 2011 to 1.44 percent from 1.49 percent in Fiscal Year 2010. This decrease is due in part to a net decrease in operating costs of 0.3 percent plus increased HMO premiums offset by the decrease in paid claims from Fiscal Year 2010 to Fiscal Year 2011. Operating costs increased on a per participant per month basis in Fiscal Year 2011 to \$10.07 from \$9.96 in Fiscal Year 2010 due mostly to a 1.4 percent decrease in enrollment.

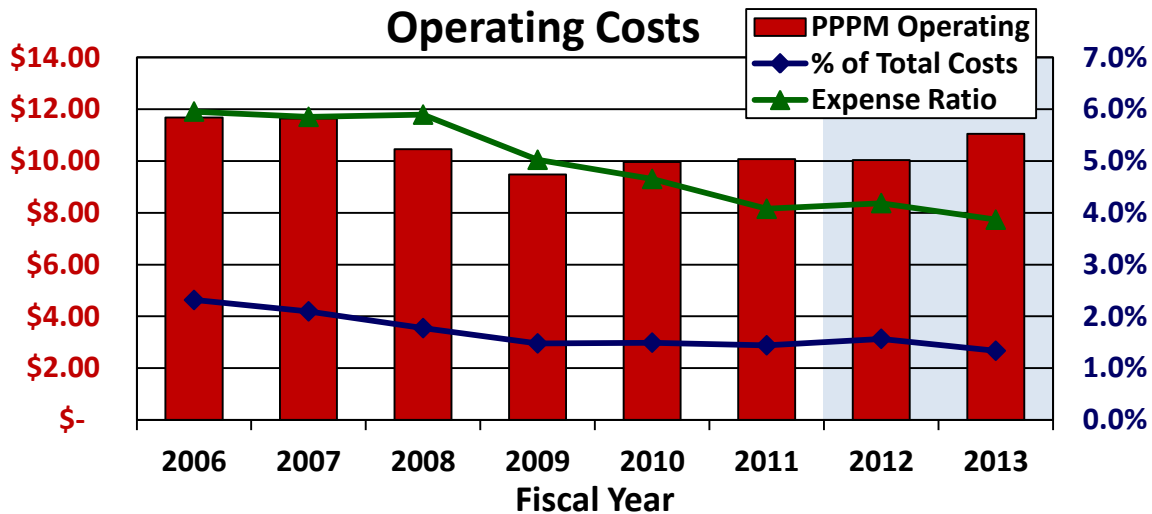


Figure 4

The expense ratio measures administrative costs (operating costs described above plus the contract costs associated with the Preferred Provider Organization network administration) as a percentage of total premium revenue, including state subsidies and

Medicare Part D reimbursements. While the actual expense ratio of 4.7 percent for Fiscal Year 2010 was slightly above the performance measurement goal of 4.5 percent, the 4.2 percent actual expense ratio for Fiscal Year 2011 was below the goal of 4.4 percent. The 0.5 percent decrease in the expense ratio from Fiscal Year 2010 to Fiscal Year 2011 is due to a combination of medical inflation and contract restructuring.

Federal Health Care Reform mandates that large insurance plans spend at least 85 percent of their premiums on claims costs. For Fiscal Year 2011, PEBP spent 90.9 percent of its premiums on claims costs.

### **Plan Design**

PEBP staff and that of vendors spent considerable time implementing the plan design changes made by the Board for Plan Year 2012, transitioning to a new third party administrator (TPA) as well as integrating information between the TPA and the pharmacy benefit manager (PBM) necessary for the new high deductible health plan.

Staff recognizes that change is always difficult and it will take time for participants to get used to the new high deductible health plan. As a result, staff proposed and the Board approved only a few minor changes to the self-funded high deductible health plan for Plan Year 2013 (effective July 1, 2012). Those changes include:

- Requiring the use of a Center of Excellence for organ and tissue transplants and bariatric surgery as well as providing travel and hotel accommodations for the patient and one additional individual when utilizing a Center of Excellence;
- Expanding precertification requirements for cardiac pacemakers, illnesses requiring chemotherapy and kidney dialysis; and
- Excluding preventive dental benefits from being charged against the annual dental maximum benefit.

### ***The Live Well, Be Well Prevention Plan Wellness Program***

Plan Year 2012 is the second under the Live Well, Be Well Prevention Plan wellness program operated under a contract with U.S. Preventive Medicine (USPM). The Prevention Plan uses a health risk assessment and the results of a blood test and biometric screening to identify specific activities to maintain or improve the health status of each participating individual. Those who participated in Plan Year 2011 and earned enough points by following their individual Prevention Plan to qualify are receiving premium credits of up to \$30 towards their monthly premiums in Plan Year 2012. There are 13,996 eligible participants with an approximate average monthly premium credit of just under \$14 in Plan Year 2012.

During 2011, the Board appointed a Wellness Advisory Committee to review the current wellness program and make recommendations for improvements. Meeting four times over the last six months, the Wellness Advisory Committee made a series of

recommendations adopted by the Board for implementation effective July 1, 2012, including:

- Moving the biometric screenings and blood tests to the spring for use in computing the participants' incentives for the subsequent plan year;
- Adding a monetary participation incentive for joining the Live Well, Be Well Prevention Plan, completing the health risk assessment and obtaining the biometric screening and blood test;
- Revising how participants accumulate points for future monthly premium credits and revising the amount of the monthly premium credits;
- Adding a tobacco use test to the biometric screening;
- Expanding the Prevention Plan to include children (spouses were eligible to participate for Plan Year 2012 effective July 1, 2011); and
- Adding an Obesity Care Management Program with various participation incentives.

### **Vendor Contracts**

After six new contracts or contract renewals were awarded in Calendar year 2010, PEBP staff spent a significant portion of 2011 integrating new vendors into the Program. Converting third party administrator services from UMR to HealthSCOPE Benefits (HSB) was a significant undertaking on a short implementation schedule. Due to diligent work by both PEBP and HSB staffs, HSB commenced processing claims on schedule in July; however, as a result of the complexity of the transition, HSB was not up to full processing capacity until late August.

Similarly, transitioning almost 12,000 Medicare retirees and spouses to the Extend Health Individual Market Medicare Exchange during a five month special enrollment period was no small task. Taking the No Retiree Left Behind motto seriously, PEBP and Extend Health were unable to locate or contact only 51 eligible Medicare retirees (0.04 percent). PEBP staff continues to work with both HSB and Extend Health on operational issues to insure the best service for our participants.

In 2011, PEBP also issued Requests For Proposals for three of its existing vendors, all of whom are on the normal bid rotation cycle.

Following is a short summary of each of these three contracts:

Southern Nevada HMO – The current contract with Health Plan of Nevada (HPN) for Southern Nevada HMO vendor services is scheduled to expire in June 2012. Requests For Proposals were due to Nevada Purchasing in November. Only one proposal was received from the incumbent vendor. The Board ratified the contract in December and it should go to the State Board of Examiners (BOE) for approval in February with an effective date of July 1, 2012.

Health Plan Auditor Services – The previous contract with Health Claim Auditors, Inc. (HCA) for health plan auditor services expired on September 30, 2011. Requests For Proposals were due to Nevada Purchasing in July. Upon review of five proposals, HCA was chosen as the winning vendor by the selection committee. The contract was ratified by the Board in August and approved by the BOE in October with an effective date of October 1, 2011.

National Network – The current contract with Multi-Plan (aka Viant or Beechstreet Corporation) to provide a national network for out-of-state participants is scheduled to expire on June 30, 2012. Requests For Proposals will be due to Nevada Purchasing early this year. Contract ratification and BOE approval will be obtained in order for the new contract to be effective on July 1, 2012.

In 2012, staff will work on Requests For Proposals for the dental preferred provider network, life insurance, long-term disability and the voluntary insurance product offerings. These contracts are all on the normal bid rotation cycle and are scheduled to expire in June 2013.

Staff appreciates the partnership with its vendors and their commitment to providing our participants with first class customer service.

### **Communications**

Communications continue to be one of the more difficult aspects of day-to-day operations, and reaching over 43,000 participants plus their dependents is a constant challenge. In 2011, PEBP deployed a redesigned website that is more user-friendly and easier to navigate. The new website also includes on-line enrollment capability, a first for PEBP.

Due to the magnitude of the changes effective July 1, 2011, staff held information meetings to provide an overview of the high deductible health plan and the Individual Market Medicare Exchange from October 2010 through February 2011 in addition to the normal open enrollment meetings held during April 2011. These meetings combined to reach over 14,000 people.

An open enrollment announcement was mailed via first class mail to all participants in late-March. PEPB held a two month “positive” open enrollment from April 1 to May 31, 2011 meaning every participant needed to submit an open enrollment election either on-line or by paper form even if they were not changing their plan or their dependents. This was necessary because of the need to collect certain information regarding eligibility for a Health Savings Account and spouses or domestic partners having other employer-based coverage. As a default, anyone who did not submit an open enrollment election was enrolled in the Consumer Driven PPO High Deductible Health Plan with a Health Reimbursement Arrangement and participant only coverage.

After the open enrollment period ended, staff identified 1,183 participants whose dependents would have lost coverage because the participant failed to submit an open enrollment election. As a result, staff extended a “Second Chance” enrollment period to enable those who did not submit a timely enrollment election the opportunity to reinstate coverage for their dependents. The “Second Chance” enrollment only allowed participants to enroll in the Consumer Driven PPO High Deductible Health Plan with a Health Reimbursement Arrangement and only allowed the reinstatement of previously covered dependents. Staff mailed “Second Chance” letters to all affected participants and with the help of the Nevada System for Higher Education and the City of Elko attempted to contact each individual by telephone and/or e-mail. As a result, 883 participants re-enrolled their dependents. Only 300 people failed to respond to the “Second Chance” enrollment and their dependents were not re-enrolled in PEBP coverage for Plan Year 2012.

Staff has been working with its vendors on enhancements to the self-service tools available to participants so they can be more successful in managing their healthcare costs. These enhancements are intended to provide participants with better information on what to expect from a cost standpoint when they utilize services. PEBP staff has been working with the networks and HSB to add more detailed information relative to the cost of medical services offered by PEBP in-network providers. PEBP and HSB are currently working on the first set of relatively common procedures which should be available on the secure portion of the HSB website behind the sign-on some time in the first half of 2012 with additional procedures to follow as the details are tested and any problems resolved. Staff has also been working with Catalyst RX to improve the “Price & Save” tool on their website for prescription drugs and will provide a list of enhancements and the timeline for implementation in the near future, especially for pricing medications that are not in a pill or single dose form. Staff will work on a communications strategy to participants once the enhancements are in place and will continue to work with these and other vendors to improve the quality and availability of information to participants.

In response to questions regarding “how” the new benefit plans work, PEBP staff and our vendors held 35 “Maximize Your Benefits” information sessions during the month of November in Carson City, Las Vegas and Reno reaching another 1,407 participants to explain how both the Consumer Driven PPO High Deductible Health Plan and the Medicare Exchange operate and how to understand the changes to participants’ healthcare coverage. In an effort to reach as many participants as possible, both the Navigating Your Benefits plan design presentation (given from October 2010 to February 2011) and the “Maximize Your Benefits” session were recorded and posted on our website for those who were unable to attend a live meeting.

In November, PEBP mailed out a reminder by certified mail to those retirees who are eligible for Medicare Part B coverage but who have not enrolled and provided proof of coverage to PEBP. The letter reminds the retirees that unless they meet the penalty threshold set by the Board in August and supply us with documentation their penalty

exceeds the threshold, they will be required to purchase Medicare Part B during the Medicare General Enrollment Period that runs from January 1 to March 31, 2012 with an effective date of July 1, 2012. If the retiree does not enroll in Medicare Part B or provide proof that their penalty exceeds the threshold, their PEBP coverage will terminate July 1, 2012.

In December, PEBP mailed a letter to all non-State retirees reminding them of the statutorily required biennial reinstatement provision which entitles them to return to their last employer's health insurance plan in even numbered years. This was done in order to notify these retirees that due to the shrinking non-state pool their premiums could increase significantly in coming years and their window of opportunity to return to their previous employer's plan was upon them. PEBP staff cannot provide details of how much PEBP premiums will increase in future years nor can we inform retirees of the cost of returning to their last employer's plan. The impetus behind the letter was simply to let them know about alternatives they may want to pursue.

PEBP staff continues to strive to provide meaningful communications to our participants and encourages them to visit the PEBP website for the most current Program information.

### **Staff**

Calendar year 2011 was also difficult for PEBP staff. Position vacancies and participant anger regarding the plan design changes made working conditions difficult at best. I commend the staff on their dedication to PEBP's mission and acknowledge we would not be where we are without them. I also look forward to the proposed organizational changes and training programs improving the Agency's day-to-day operations.

Calendar year 2011 also saw the resignation of two Board members and the appointment of Bob Moore to replace Randy Kirner who resigned in 2010. The Governor's Office has been informed of the current vacancies and is working to fill those seats.

### **Conclusion**

Calendar year 2011 was more difficult than any could have ever imagined. The Board's ability to thoughtfully deliberate and resolve difficult issues is a tremendous benefit to our members and stakeholders, and I appreciate the diligence and efforts made by the Board to provide direction to staff.

As 2012 will not entail significant plan design changes, a TPA conversion or a positive open enrollment, I look forward to working with the Board in what should be a more stable period than what has been experienced over the last several years.

### **Recommendations**

None.