MEMORANDUM

Date: **January 26, 2011**

To: **Dan Klaich, Chancellor, NSHE**

From: **Gerry Bomotti, Chair, NSHE PEBP Benefits Task Force**

Re: **Transmittal of Final Report**

We appreciate the fact that you charged this Task Force to review the major changes in the health care programs offered to NSHE employees through PEBP. We have taken our charge seriously and within this final report are providing background data and information, as well as a series of recommendations for your consideration. We believe the comparative data included in this report will allow NSHE to put our current, and proposed, health care benefits within a context of large public and private employers, both in and out of state. We also believe this factual data presents a very different reality from some of the previous reports about "public employee" benefits. Not only do we have concern for our ability to retain and recruit faculty and staff with this decline in the health care program, it is possible these major health care changes could lead to significant differences in future retirements for NSHE faculty and staff. These changes could be a result of concerns about lack of adequate retiree health care benefits, which could lead to less turnover and less opportunity to rehire new employees at lower salary levels.

Additionally, we are providing a set of recommendations for your consideration, all within the context of recognizing the critical nature that health care benefits play in the retention and recruitment of NSHE faculty and staff. We also highlight the fact that NSHE is unique amongst public employers in this state relative to having a defined contribution retirement program for its professional staff and faculty (and unlike PERS does not contribute to a future state financial liability), and suggest the System would benefit from a much more direct involvement in benefits management for faculty and staff.

The Task Force would like to thank you for addressing the important issue of health care benefits for NSHE employees, and we would also like to highlight the important contributions to the Task Force made by Bart Patterson and Chris Haynes. Bart was our primary contact with the System relative to our work, and Chris was both a Task Force member and provided invaluable support to help assure the efficient and effective operation of the Task Force. I very much enjoyed chairing this group, and appreciate the fact that you allowed me to be involved in this important project.

Thank you again for creating this Task Force. Please do not hesitate to contact us if you have any questions about our report.

Cc: Task Force Members
Bart Patterson

NSHE PEBP Benefits Task Force

Final Report to the Chancellor
January 2011

NSHE PEBP Benefits Task Force

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Section 1: Background:

The Task Force was formed by Chancellor Klaich in early September, 2010, due to his concern about how the PEBP health care plan for FY12 could impact faculty and staff recruitment and retention. The Chancellor provided the Task Force members with their charge, which is included directly below.

Chancellor's Charge to PEBP Benefits Task Force:

1. Review and analyze the current legislative recommendations of the PEBP Board.
2. Put the PEBP recommendations in perspective, both as to recent cuts and their impact on employees. This may be redundant, but we want to know how this impacts a typical employee.
3. Propose alternatives to the current proposals.
4. Provide comparison with benefits provided in other states for perspective.

   The Chancellor noted that the Task Force may also discuss the longer term sense of staying in the system but this should only be considered after the Task force gathers the information above.

We held our first meeting on September 22, 2010, and had a total of nine (9) meetings, each lasting at least 1 ½ hours. One of the earliest steps taken by the Task Force, in cooperation with NSHE administration, was to hire a consultant to assist us with gathering comparative data and identifying near-term alternatives to provide supplemental benefits for NSHE employees. The consultant hired was Don Heilman, from Gallagher Benefit Services. **This final report of the Task Force includes the following information, which is based on the PEBP action through their 1/13/11 meeting** (any changes after this time frame would not be reflected in this report).

1. This report includes comparative data on our current PEBP health care coverage, as well as the plans currently approved for July 1, 2011, with national higher education averages; specific data from regional public higher education institutions; other public employers in the state of Nevada, and private employers in the state of Nevada. This data allows us to put our current and FY12 PEBP health care coverage in context with other large employers, both public and private, and both in and out of state. Once the PEBP rates are published in early 2011, we hope NSHE will refresh this data analysis with that important information.
2. The Task Force drafted an overall response to the PEBP plan, and included this information in the letter Chancellor Klaich sent to the PEBP Board in advance of their December 2, 2010 meeting. This letter is available on the Task Force web page (see link below), but also included as Attachment #15 to this report.
3. We provide specific recommendations to support changes to the PEBP plan during the next legislative session, which has already been identified as a high System priority. We also suggest, as an alternative, consideration of opportunities for viable, near-term options for how NSHE provides health care benefits to its employees.
4. We identify specific alternatives for the Board of Regents to provide direct supplemental health care benefits for NSHE employees, if resources and some specific technical issues can be overcome. While there are specific options available to provide supplemental benefits, we must caution that

there are significant issues to overcome, including identifying resources in this financial environment.

5. We provide recommendations for NSHE to focus on the longer term issue of taking more direct involvement in managing health care and other benefits for NSHE faculty and staff, and even suggesting the future direction may differ significantly from the status quo.
6. NSHE worked with PEBP to get details on the past 3 ½ years of actual claims information for NSHE employees. We recommend that NSHE finalize the analysis of this data from PEBP on actual claims experience, as the results of this analysis will be important to understanding the longer range options and opportunities for NSHE relative to health care programs.

A complete set of notes on the activities of the PEBP Benefits Task Force are included on the Task Force web page, which can be accessed at the following site:
http://www.scs.nevada.edu/default/index.cfm/committees/nshe-pebp-taskforce/%20

Section 2: High Level Summary of Report Content:

Following are several key findings we would like to highlight before presenting specific recommendations. Each is summarized below and supported by more detailed information referenced in the cited appendices. The information below, we believe, verifies that the PEBP plan proposed for FY12 will put NSHE faculty and staff at a competitive disadvantage, both in-state (public and private sector), as well as regionally and nationally. It is also important to note that this data presents a very different, and we believe much more accurate, analysis of the health care benefits provided to NSHE employees than many have gathered from past reports of "public employee" benefits (those from the Las Vegas Chamber of Commerce and the SAGE Commission, in particular). It is also very important to connect these issues relative to health care benefits to overall employee compensation. NSHE employees have experienced a pay reduction with furloughs, no longevity pay, no merit or COLA, and now the affordability of the cost of health benefits is added to this concerning and lengthening list. The concern for retention and recruitment of employees is well beyond just health care benefits, although that is indeed a significant issue.

***Summary information from Gallagher Benefits' report on comparative data for PEBP health care plan with other public plans. (Attachment #1, slides 3-8 for complete executive summary):**
The various data comparisons provided from the surveys suggest the current plan provisions (FY11) are generally in line to somewhat less favorable to the comparators, while employee contributions are generally more favorable than comparators. However, in looking at the proposed plan provisions (FY12), they appear to be consistently less favorable than various comparators. This is particularly the case when compared to public higher education institutions and other Nevada public employers, both with respect to current benefit design, and especially, the plan design proposed by PEBP effective July 2011.

Because PEBP has not yet specified what the employee contributions will be for medical and dental for FY12, it is not possible to comment on that important element. If employee contributions are favorable, that does offset what generally would be viewed as a less than comparable set of plan design provisions. Short of that, it is our view that the plan design provisions as proposed are less than competitive, when compared to prevailing practices.

Supplemental health care benefit options (for current employees and retirees) (Attachment #1, slides 12-16 for more details).

The Task Force would also like to highlight information regarding the potential for the Board of Regents to consider offering supplemental health care benefits, if the current PEBP plan is implemented for FY12. A summary of that information is highlighted below for a flexible benefit option, but there are also options the Board of Regents could consider for specific benefit programs (LTD, vision, etc.), which are covered in more detail in the attached material. It is important to note this option is considered as a near-term alternative, as we believe NSHE must also consider longer term solutions to what appear to be on-going challenges to providing health care benefits to its employees.

The "flexible benefit credit" approach to provide employees with additional health care funding seems to be the most flexible and easiest to implement, if the Board so chose this direction. This approach would cover both CDHP and HMO participants. However, this approach would not be applicable for retirees, and NSHE will need to investigate the overhead associated with NSHE providing additional health care benefits directly to "retirees," since they are not currently linked with NSHE in any way (their interactions are directly through PEBP, and while we could more easily identify those in the RPA retirement program, those in the PERS system may be very difficult to identify). Some additional specifics on this proposal are included in the recommendations from the Task Force.

***Summary information to date from NSHE analysis of private employers in the state (Attachment #2)**. We contacted a total of nine (9) private employers in the state of Nevada to request information on the health care benefits they provide to their employees. Not all were willing to provide this data, and those that did were, in general, only willing to share more general data than what was gathered through the Gallagher survey. However, in total we received information from six (6) of the employers covering banking, resort/casino industry, public utility companies, and other private employers. However, these six (6) private employers in Nevada cover an estimated 12,000 employees (larger than all of NSHE) and therefore we are pleased with the return. Overall, the results indicate that the current PEBP plan is in line with those of these private employers, but they are in general not making major changes for the 2011 plan year (they are on calendar year plan schedule while PEBP is on a fiscal year plan). Therefore, with the plan changes occurring July 1, 2011, NSHE will drop significantly in comparison to what they are offering their employees. It was also noted that some of these private employers offer health care programs for their retirees. It is also important to note that this information is very different from the publicized results of the SAGE Commission, for which no detail data was ever provided.

***Benefits as a percent of salary comparisons - Nevada and the western states (Attachment #3):**

The data listed in Attachment 3 shows how Nevada higher education compares with total benefits provided for most of the western states. NSHE does not participate in Social Security, so an adjustment for this benefit has been made (however, it must be noted that the states participating in social security provide this employer benefit in addition to other retirement, health care, and other support). Even with the adjustment for social security, it is important to note that the total cost of benefits (as a percent of salary) for NSHE institutions is well below the average of these western states. When you consider the fact that these other states are also providing the social security match, the NSHE benefit rates drop even further below the average (to nearly 7 1/4 percentage points below the average).

Section 3: Specific Recommendations to the Chancellor:

The Task Force developed a series of recommendations for consideration by NSHE. The recommendations vary from near-term communications issues to longer term planning for overall benefits for NSHE employees, so we can be competitive in the marketplace for faculty and staff.

The recommendations below are sorted into one category that is more urgent, and a second category that while critical and important, may have slightly longer time periods for consideration. Please note, the recommendations below are not in any priority order.

Activities for the 2011 Legislative Session and Near Term PEBP Related Health Care Plan Action Recommendations:

a. The Task Force recommends that NSHE have Gallagher Benefits update and finalize their comparative data analysis as soon as the PEBP premium levels are known (February). This is a very important issue to ensure the data analysis is complete and accurate and we can identify how NSHE health care benefits and costs compare with other relevant employers.
b. The Task Force recommends that NSHE be very active in the upcoming legislative session regarding health care benefits for its employees. This could include supporting improvements in the PEBP health care program over what has been approved by the PEBP Board, adjusting the structure to include both a high and low deductible option (since the current plan with only a high deductible option and an HMO will be relatively unique in comparison to other public and private employers) and/or consideration of viable near-term alternatives for how NSHE provides health care benefits to its employees. While we are mindful of the financial constraints and potential political challenges, these major changes in health care program support should be a high priority for NSHE.
c. It is recommended that NSHE develop a communications plan with an external focus, to highlight that NSHE employees do not have high benefits, and are in general not in the PERS retirement program (except for classified and a very small percentage of faculty/professional staff who came from PERS covered employment). It is important that NSHE use the factual information available to address the recent perceptions that NSHE employees (as part of a "public employee" analysis) enjoy unusually high levels of benefits compared to other private or public groups.
d. The Task Force recommends NSHE support an implementation year adjustment for spouse or domestic partners that are covered under non-PEBP plans, to allow flexibility for the six (6) month period of overlap between those on a calendar year plan schedule. For a participant who covers their spouse or domestic partner, PEBP coverage will be eliminated for the spouse or domestic partner who has or who is eligible for coverage under their own employer sponsored health plan (this policy exists now for any PEBP covered individuals). The PEBP plan year is on a fiscal year basis, where it appears the plan year for many employers is on a calendar year basis, meaning the spouse or domestic partner may face challenges in claiming a qualifying event for opting into their employer health plan midyear. The PEBP could resolve this issue by being flexible during the six (6) month overlap period.
e. The Task Force suggests consideration be given to extending the enrollment period, as was done last legislative session. Concern is being expressed about how easily employees will be able to

adjust to the radical changes in the PEBP plan, and still have a July 1, 2011 implementation date. It is recognized there is a relatively large cost associated with this option.

f. The Task Force recommends a phase-in of the reductions in HMO rates in the North, if in fact these rates drop over what exists now. There is a PEBP policy for short-term/2 -year subsidy for large rate increases, and this is inserted below. It should be noted that this subsidy policy is currently in effect with the Northern HMO program for FY10/FY11, but at their 1/13/11 meeting the PEBP Board suspended this policy for the FY12/FY13 biennium. This adds additional concern since the northern HMO rates have been under this subsidy policy for the current biennium, combined with the fact that the pooling of rates north and south will clearly lead to reductions in the north and increases in the south. The HMO participants in the south will therefore have no advantage of this subsidy policy during a biennium when their rates will increase due to higher costs in the north.

> Below, is language from the PEBP Board Duties, Policies and Procedures, which was adopted in 2008 (and suspended on 1/13/11):
>
> Supplemental subsidy allocation:
> *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.

Other Overall Recommendations:

a. Health care benefits are a critical and required offering for our faculty and staff, in order to retain and recruit quality employees. Health care coverage, along with retirement program offerings, are the two key benefit programs important to all NSHE employees. NSHE needs to take a more active and consistent role in tracking our health care programs, as the near-term projections appear to suggest on-going challenges. Therefore, it is the recommendation of this Task Force that NSHE establish a system-wide standing committee on NSHE benefits overall, to include Health Care Benefits but not just limited to this program. It is essential that we be pro-active and stay ahead of the curve in terms of influencing the direction of our future health care coverage for NSHE employees, and the entire benefit package for NSHE employees. This would include a focus on future health care coverage (including impacts of federal requirements), but also deal with retirement issues. This group, while working with System staff, would also focus on how we can effectively communicate with legislators and other key groups that NSHE employees have major differences in retirement coverage, and that our "compensation" is not consistent with the previous reports distributed about overall "public employee compensation." The System needs to take immediate action in communicating these facts to key constituent groups.

b. The Task Force recommends that NSHE immediately begin researching future options to identify alternative approaches to providing health care benefits for NSHE employees that are independent and outside of the current PEBP program, including viable options for communications and/or action steps initiated in the 2011 legislative session. This could include consideration of fully insured programs, self-insured, and/or combining with other large public employee groups. A key priority includes not only the programs offered, but their overall affordability and the value they provide compared with other large employers.
c. If the current PEBP plan for FY12 cannot be changed, the Task Force recommends that a request be made to the Board of Regents to provide some funding to support a Flexible Health Benefits Account for each NSHE employee to offset medical cost increases and improve retention and recruitment. The "flexible benefit credit" approach to provide employees with additional health care funding seems to be the most flexible and easiest to implement of any options reviewed. It is recognized that a key factor in implementing this recommendation is identifying funding, especially in this financial climate. A summary chart is provided at the end of this attachment to estimate the potential costs for providing supplemental benefits to active employees. A secondary priority would be to provide some supplemental policies available to NSHE employees in areas not covered in a competitive manner by the PEBP health plan (LTD, vision, life insurance, etc.).
d. As the Chancellor and Board of Regents consider the option of providing supplemental benefits for NSHE employees, we would like to highlight several potential challenges and key issues that would need to be addressed if supplemental benefits are provided. We have attempted to highlight these issues below.
    1. A major issue relates to identifying funding to provide additional health care support, which will be challenging in this fiscal environment.
    2. Another major issue that would have to be discussed relative to supplemental benefits is a legal one relative to the Board authority over NSHE state classified staff. It is clearly the view of the Task Force that any supplemental benefits authorized by the Board cover ALL NSHE employees. However, we are aware that there are technical and legal differences relative to the Board of Regents' authority over academic and administrative faculty vs. state classified. State classified staff are, in general, the lowest paid employees within NSHE and at highest risk for not being able to afford coverage.
    3. A second major issue that would have to be discussed relative to supplemental benefits involves retirees. The supplemental benefit approach recommended by this Task Force would not be applicable for retirees, at least under the current administrative structure. In fact, we have not been able to identify any supplemental option for retirees that would not require the development of an administrative solution to the fact that NSHE does not have direct interactions with retirees (i.e. they are not in our payroll/HR system). Retirees interact directly with PEBP for health care, and this information does not come through NSHE. While we could more easily identify those retirees in the RPA retirement program (with the cooperation of PEBP), those in the PERS system may be very difficult to identify (and were not included in the recent data received from PEBP on NSHE claims). There would be other issues that would need to be addressed, including

who would meet an NSHE developed definition of "retiree" eligible for supplemental benefits (e.g. NSHE being the last place they worked before retirement?). The Task Force did not have a unanimous position on the issue of providing supplemental benefits to retirees; although a majority felt current employees should be given a higher priority. It was also noted that NSHE could address this current technical challenge of supporting retirees within its planning for an alternative structure to PEBP, for NSHE providing health care benefits for its current and past employees.

4. The Task Force recommends the Board of Regents consider the option for a graduated rate/premium structure based on income levels (or allocation of supplemental benefits from NSHE based on the same): The Task Force recommends that if supplemental support for health care benefits are provided by the Board of Regents, those benefits be distributed in an inverse relationship to the employee's salary (i.e. the lower the salary the more the funding amount). Please note that this was not a unanimous recommendation of the Task Force, but was a strong majority recommendation.

e. The Task Force recommends NSHE seek additional flexibility in managing all "benefits," specifically, the option to consider retirement and health care programs as a package within all benefits, given they are the two largest benefit programs by far. Additionally, there will be an added opportunity this coming legislative session, with the projected significant increase required for the PERS employee/employer contributions (moving from the current 11.25% for employee and employer to 12.25%). Most NSHE professional/faculty do not participate in PERS, thus NSHE is rather unique in this area compared with other state/public employees in the state, and we therefore do not contribute to any future state retirement liability. If NSHE received the normal funding for retirement, health care and all other benefits, but was given the flexibility to manage them as needed, we would be able to consider a total compensation review of our competitiveness for recruitment and retention of faculty and staff, with no increase in funding from the state over what they provide to all other agencies.
f. The PEBP Board has been most helpful in providing NSHE with actual claims experience on NSHE employees within PEBP. NSHE should move ahead to finalize the analysis of the data from PEBP on actual claims experience for NSHE employees in a form appropriate to compare the revenue and expenses from NSHE (net costs), along with utilization trends relative to the NSHE population. The results of this analysis will be important to understanding the longer range options and opportunities for NSHE relative to health care programs.
g. The Task Force recommends that NSHE should argue for alternative approaches to what exists now relative to how PEBP negotiates rates for medical procedures (and including overhead and profit costs). It is not clear that PEBP is as aggressive as it should be in effectively negotiating favorable rates with health care providers, on behalf of all PEBP members.
h. NSHE should consider developing specific health care options for NSHE employees for the following biennium (2013-2015). These options/alternatives should consider ways that NSHE resources of health professionals, health programs (med school, dental school, nursing programs, etc.), and health and wellness centers might be used as part of an overall plan to provide health care benefits to our employees.

Estimated Amounts Per Month to Provide Supplemental Health Care Benefits for NSHE Employees.

The information below on current participants from NSHE in the PEBP program is used to provide some rough estimates as to the potential annual costs for "supplemental benefits," should the Board of Regents wish to consider this option. The estimates are projected based on examples of amounts per month/year that would be provided – for example, if the Board of Regents were to provide $50/month for each employee participating in PEBP ($600/year), we estimate the annual cost at $4.8M total (all funds). These are "average" estimates, and the Board would have an opportunity to distribute funding to employees in many different ways, as long as the method did not violate federal requirements (i.e. more support to highly compensated employees).

CURRENT PARTICIPANT INFORMATION					
PPO PLAN		%	**HMO PLAN**		%
EMPLOYEE ONLY	3127	52.7%	EMPLOYEE ONLY	1277	54.1%
EMPLOYEE PLUS SPOUSE	864	14.6%	EMPLOYEE PLUS SPOUSE	332	14.1%
EMPLOYEE PLUS CHILD	845	14.2%	EMPLOYEE PLUS CHILD	359	15.2%
EMPLOYEE PLUS FAMILY	1100	18.5%	EMPLOYEE PLUS FAMILY	391	16.6%
TOTAL	**5936**		**TOTAL**	**2359**	
			TOTAL COMBINED	8295	
			DECLINED	**156**	1.8%

COST TO PROVIDE ADDITIONAL FLEX BENEFITS @ FIXED DOLLARS				
% that continue coverage	**$50**	**$100**	**$150**	**$200**
100%	$414,750	$829,500	$1,244,250	$1,659,000
95%	$394,013	$788,025	$1,182,038	$1,576,050
90%	$373,275	$746,550	$1,119,825	$1,493,100
85%	$352,538	$705,075	$1,057,613	$1,410,150

Estimated Cost/Year	$4.8M	$9.6M	$14.4M	$19.2M
Amount/year to Employee	$600	$1,200	$1,800	$2,400

NSHE FY11 State GF Budget = $558.9M. Therefore, 1% is $5.6M

Gallagher Benefit Services, Inc.
thinking ahead

I. EXECUTIVE SUMMARY

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Gallagher Benefit Services, Inc. (GBS) was retained by the Nevada System of Higher Education (NSHE) to conduct a comprehensive benchmarking study of benefits practices. In addition, GBS was requested to explore possible means by which NSHE might supplement the benefits offered through the Nevada Public Employees Benefits Program (PEBP). This study was precipitated by the proposed benefit modifications PEBP is contemplating for the 2011-2012 plan year.

Key Findings

General

According to a 2009-2010 AAUP study, the employer cost for benefits among colleges and universities in surrounding states averaged 23.25% of salary (when adjusted to remove Social Security contributions, where applicable), compared to a figure of 21.6% for NSHE.

Medical

Current PEBP Plans

- The current medical plan design provisions offered by PEBP are generally in line with, to less comprehensive than, prevailing practices.
  - Larger employers, generally offer a choice of two or more options. NSHE employees have a choice of a PPO, and for the majority of employees, one HMO. Nearly ¾ of respondents in GBS survey (and 78% of higher education) offer 3 or more plans.
  - The deductibles are generally above norms. Specifically, the average deductible was $428 for higher education respondents in the GBS survey, $391 for public CUPA and $543 CUPA overall.
  - Office visit copays are within norms for primary care, and above norms for specialists.
  - Prescription drug coverage is comparable, except for non-preferred brand drugs, which are not covered under PEBP (other than on an exception basis).
  - Out-of-pocket maximums are much higher than various survey data, including public higher education institutions and large Nevada public employers responding to the GBS survey. That said, given the varying ways out-of-pocket maximums are designed and reported in conjunction with deductibles, caution in viewing these results is encouraged.
- While the plan design is generally less favorable than prevailing practices, employee contributions, as a percent of premium, for both single and family coverage are favorable, when compared to a variety of benchmarks.
- Retiree health benefits, which are available to both pre-Medicare retirees and Medicare-eligible retirees through PEBP, are commonly offered by governmental entities, but less frequently among corporations reflected in published survey results.
- Domestic partner benefits are fairly prevalent, in general, and in particular among colleges and universities.

I. EXECUTIVE SUMMARY

Medical (continued)

Proposed PEBP Plans

- While not prevalent, it is not uncommon to offer a consumer driven health plan (CDHP). The percent of employers offering a CDHP ranged from about 15%-35% among the various sources. According to the Kaiser survey, about 13% of employees from surveyed workers were enrolled in a CDHP. However, it is not common for larger employers to offer only a CDHP (i.e., no other more comprehensive plan(s), except possibly HMOs). Moreover, there is little evidence to suggest that employers are planning to move to a CDHP-only environment.
- Deductibles, both in general and when compared to other CDHPs, are higher than on average. This is especially true, when compared to states, colleges and universities and Nevada public employers participating in the GBS survey.
- Out-of-pocket maximums are somewhat higher than reported. This takes into account recent guidance from PEBP that indicates the deductible will count toward the out-of-pocket maximum. Further, this is the case when compared to average CDHP plans, and especially when compared to other PPOs. This also true when compared to other states, colleges and universities and Nevada public employers participating in the GBS survey.
- PEBP has proposed a contribution to a companion health savings account (HSA) of $700 for single coverage and $200 per dependent, up to a total of $1,300, for family coverage. Among other plan sponsors, a majority of plan sponsors provide an employer contribution, with the average contributions in line with what is being contemplated by PEBP.
- The employee will be responsible for 9% of the premium for the CDHP plan for the employee portion, and 29% for the dependent portion. Further, there will be a significant increase in the premium share paid by employees or the HMOs. It is worth noting that the HMO employee contributions for HMO coverage are proposed to be consolidated for the 2011-2012 plan year, which, all other things being equal, will be of relative benefit for participants in Northern Nevada and unfavorable for those in Southern Nevada.
- Coverage for early and Medicare-eligible retirees continues to be prevalent among governmental sector organizations. The extent to which retiree rates are subsidized – either directly through employer funding or indirectly by assessing a lower rate than is reflected by underlying retiree experience, varies. Among public colleges and universities responding to the GBS survey, over two-thirds provide some contribution toward early retiree medical coverage, and over one-half do so for Medicare eligible retirees. It is important to note that Nevada public employers do not participate in Social Security, and correspondingly, FICA contributions were not made for retirees/employees hired prior to 1986. As a result, unless entitlement to Medicare is achieved through other means, these individuals would need to pay a significant premium to participate in Medicare, along with any premium associated with any Medicare supplement or Medicare Advantage offering that will be available through the contemplated PEBP arrangement.

I. EXECUTIVE SUMMARY

Other Benefits

According to a MetLife survey, 39% of employers view dental, vision, life and disability benefits as contributing to employee loyalty, compared to 65% of employees surveyed.

Dental

- While current dental coverage is generally in line with prevailing practices, the proposed dental plan will offer much less comprehensive coverage than is commonly offered across all survey sources, including the various GBS survey cohorts, which typically includes coverage for preventive, basic, major and in many cases orthodontia. Annual maximums (not including orthodontia) typically approximate $1,500.
- Employee contributions generally range from 40% to 50% of the premium for single coverage, and 50% to 60% for family.

Vision

- Apparently, only vision exams will be covered by PEBP. It is common practice for larger employers to offer a stand-alone vision plan. The extent to which employer contributions are available for vision coverage varies markedly. Roughly one-third of GBS survey respondents provide some employer contribution for vision, but none of the participating higher education entities provide an employer contribution.

Basic Life/AD&D

- PEBP currently provides a $20,000 life/AD&D benefit, with the amount to be reduced to $10,000.
- This is much lower than many large employers offer, especially large colleges and universities, for which flat dollar benefits range from about $50,000 - $80,000, and benefits that are based on salary range from roughly 1.5 – 2.0 times annual salary.
- According to a MetLife survey, 54% of employees who own life insurance obtain it through their employers.

I. EXECUTIVE SUMMARY

Other Benefits (continued)

Disability

- It is our understanding that (beyond sick leave provisions) PEBP offers a voluntary short term disability (STD) benefit, as well as a non-contributory long term disability benefit that replaces 60% of pre-disability earnings. PEBP is proposing to reduce the percentage of income replacement for employees from 60% to 40%.
- STD insurance is commonly offered by large private employers, while most typically addressed through a sick leave accrual mechanism in the public sector. With NSHE also offering a voluntary STD benefit, this environment is viewed as reasonable, although a specific review of the nature, level of benefit, quality or competiveness of this benefit is beyond the scope of this project.
- For LTD coverage, the percentage of income replacement most commonly observed among a variety of survey sources is 60%. With the proposed reduction, this would be viewed as less than competitive, both in terms of the percentage, and correspondingly, the maximum benefit that is available and supported by employer funding.

Retirement

- Through the Nevada Public Employees Retirement System (Nevada PERS), classified employees are provided a comprehensive benefit, with contributions and corresponding benefits greater than that observed in the private sector. However, as the State does not participate in Social Security, it is important to view this contribution and the underlying benefit in that context.
- It is important to note that NSHE is the only public entity in Nevada that has a defined contribution retirement program. This program covers all academic and administrative professional staff (with exceptions for small numbers of professional staff grandfathered in PERS), but all NSHE state classified obviously participate in the PERS retirement system. For all NSHE and State of Nevada employees under PERS, an employee contribution is made either through a payroll deduction or the employer pays the entire contribution on behalf of the employee and the employee's salary is reduced to reflect that contribution. For all other public employees in Nevada there is no election and the employer covers the PERS contributions.
- Employees covered under the defined contribution plan realize an employer retirement contribution of 11.25%, and as is the case for other public employees in Nevada, are not covered by Social Security. The AAUP study reported average employer contributions to retirement of 10% of compensation, and other sources suggest a range for higher education from 8% - 10%. These contributions generally would be in addition to Social Security.

I. EXECUTIVE SUMMARY

Miscellaneous

Other observations that are worth noting, based on findings and the data gathering process.

- Only one other state in the GBS survey indicated that they do not participate in Social Security.
- Generally, the large majority of private sector plans are maintained on a calendar year basis. Among the GBS survey respondents, slightly over one-half maintain their plans on a fiscal year basis.
- Of the nine public colleges/universities that participated in the survey, only one – Arizona – indicated that they are required by statute to participate in the state health plan. This is consistent with our general understanding that it is not common to require public institutions to be limited to their state's health plan as the sole benefit offering.
- Another of the universities that responded currently, by election, participates in the state health plan. However, they are in the midst of a study to assess the feasibility and merits of withdrawing from the state plan, and introducing their own stand-along benefits programs.
- While the University of California did not participate in our survey, information gleaned from their website suggests a comprehensive level of medical, dental and vision benefits, with a number of medical plan options.
- We attempted to gather data, both through our survey and through published benchmark data, as to the cost of health & welfare benefits and/or retirement benefits, as a percent of covered payroll. However, due to varying methods of calculating these percentages, varying components contributing to those percentages and/or lack of readily available data, we have not included any of these metrics in our report, beyond that reported in the AAUP study, and as compiled by NSHE staff.

Conclusion

The various comparisons suggest the current plan provisions are generally in line to somewhat less favorable, comparing to various comparators, while employee contributions are generally more favorable than comparators. However, in looking at the proposed plan provisions, they appear to be consistently less favorable than various comparators. This is particularly the case when compared to public higher education institutions and other Nevada public employers, both with respect to current benefit design, and especially, the plan design proposed by PEBP effective July 2011.

Employee contributions will be in line with other colleges and universities (with respect to CDHP plan offerings), and appear to be more favorable than broad-based benchmarks. This level of employee contribution does, to some extent, offset what generally would be viewed as a less than comparable set of plan design provisions. Short of that, it is our view that the plan design provisions as proposed are less than competitive, when compared to prevailing practices.

That said, it is important to consider what changes might occur to plans over the next 12 months, to more fairly assess what is being proposed by PEBP. Our experience, as well as survey data, suggests that employers/plan sponsors likely will be making changes to their plans, whether through increased cost sharing or higher employee contributions. However, these changes are generally expected to be more incremental than that being contemplated by PEBP. It should also be noted that surveys suggest more than ever that employees place a high value on benefits, especially given the uncertainty of healthcare reform.

Gallagher Benefit Services, Inc.
thinking ahead

III. POSSIBLE BENEFIT SUPPLEMENT ALTERNATIVES

III. POSSIBLE BENEFIT SUPPLEMENT ALTERNATIVES

In light of the significant changes in benefits being contemplated by PEBP, and how those anticipated designs compare to various comparators, GBS was requested to explore possible means by which NSHE could conceivably supplement those offerings. The following provides what are viewed as options that are seen as both possible and viable.

These elements have been broken into two central themes – additional benefit alternatives and additional financial alternatives. You will note that there is/could be overlap in a variety of cases. Also, further research as to state and federal rules, PEBP requirements, marketplace solutions and potential cost implications may be warranted.

Supplemental Benefit Offerings

Medical/Prescription Drugs

Notwithstanding any concerns that could be raised by PEBP with regard to any supplemental medical/prescription drug offering(s), the distinct rules surrounding high deductible health plans – and more specifically health savings accounts – effectively precludes any supplemental benefit offering for NSHE participants.

Other

- Dental

  It would seem plausible that a dental insurance benefit could be offered to complement the limited benefit contemplated by PEBP. Note that at the December 2 PEBP board meeting, it was announced that they will be exploring fully insured dental alternatives. As such, the comments below should take this into account.

  For example, a dental insurance offering presumably could be secured that provides a reasonable level of coverage for basic and major restorative services, and potentially, orthodontia – services which we understand will not be covered under the PEBP dental program. This program could be underwritten by a carrier on a fully insured basis, or subject to appropriate risk management principles, be maintained on a self-insured basis.

  While not clear, if not available through PEBP, it would also seem possible to secure an option that could provide access to discounted dentistry, through a vendor that has established a network of dentists who have agreed to provide services at discounted rates. This arrangement would presumably require a monthly access fee, which could either be paid by NSHE, or possibly, be made available on an employee paid, voluntary basis, through payroll reduction.

III. POSSIBLE BENEFIT SUPPLEMENT ALTERNATIVES

- Vision

  Similar to dental, a vision insurance benefit could be offered to complement the limited benefit contemplated by PEBP. For example, if an annual vision exam is covered by PEBP (and/or the HMOs), an insurance offering presumably could be secured that provides a reasonable level of coverage for frames and lenses, as well as discounted services otherwise not eligible for benefits – especially vision corrective procedures. This program could be underwritten by a carrier on a fully insured basis, or subject to appropriate risk management principles, be maintained on a self-insured basis.

  While not clear, if not available through PEBP, it may be possible to secure a vendor that could provide access to discounted vision materials and services, through a vendor that has established a network of vision providers who have agreed to provide services at discounted rates. This arrangement would presumably require a monthly access fee, which could either be paid by NSHE, or possibly, be made available on an employee paid, voluntary basis, through payroll reduction.

- Life/AD&D

  Certainly NSHE could pursue additional, employer paid term life/AD&D insurance, above and beyond that proposed by PEBP. In addition, it would be suggested that any supplemental offerings currently in place be revisited and marketed concurrently with any core offering, as it is likely that superior rates/terms could be offered in conjunction with a basic/employer paid program.

- Long Term Disability

  Any enhancements would likely need to be approved by PEBP, as there could be a corresponding impact to their rating methodology and/or program administration. One alternative that could possibly be pursued would be to seek authorization to not offer the PEBP LTD program, and then pursue a stand-alone policy. In that way, NSHE could design the plan, both in terms of benefits and tax treatment, as desired. Also, any exploration of LTD benefits outside of PEBP should include/integrate NSHE's current STD offering. For that matter, there may be merit in assessing the current STD offering, irrespective of the LTD benefit, to assure a contemporary and competitive offering.

III. POSSIBLE BENEFIT SUPPLEMENT ALTERNATIVES

Supplemental Financial Support

It would appear that a number of alternatives might be available to financially enhance the benefit offerings for NSHE employees. Some of these allow for differentiating based on dependents covered, while others do not. In addition, attention would be needed to various nondiscrimination requirements that apply under various aspects of the federal tax code. While not viewed as preclusive, these issues would need to be taken into consideration. Finally, while not all alternatives address all constituents, they need not necessarily be viewed a mutually exclusive. With regard to retiree applicability, irrespective of whether an option is viewed as feasible from a regulatory perspective, systems and/or administrative limitations would have to be carefully assessed to determine whether practically feasible.

- *Flexible benefit credits* – a more comprehensive and flexible solution would be to provide an allotment of employer dollars as flexible benefit credits. These credits would be paid through payroll, and employees – during their annual election period – would make elections as to what qualified, pre-tax benefits they would like to direct those monies for the upcoming plan year. Among pre-tax uses for these dollars are employee contributions for any group sponsored medical, dental, vision, disability and to a limited extent, life/AD&D premiums, health/dependent flexible spending accounts, an HSA . Through plan design, NSHE could make a determination that these credits must be used in their entirety for tax-qualified health and welfare benefits, which philosophically sends a message that these are indeed supplemental benefit dollars. Amounts could vary by salary level, so long as the plan fully satisfies applicable nondiscrimination issues. This concept would have broad applicability for enrollees in both HMOs and the HDHP, and could conceivably be extended to the retiree population.

- *"Cafeteria" credits* – much like flexible benefit credits, cafeteria credits would function in the same way, except that NSHE could take a more liberal approach and allow any unused credits to be paid out as additional compensation, subject to taxation. This provides greater flexibility for employees, and effectively (although not directly) would enable an employee to make a separate but comparable deferral into an available defined contribution retirement program (403(b) or 457, if available). Amounts could vary by salary level, so long as the plan fully satisfies applicable nondiscrimination issues. This approach would have broad applicability for enrollees in both HMOs and the HDHP, but would not appear to be a viable option to address retiree issues, in that any unused credits would then effectively have to be reported as income – presumably through 1099s.

- *Additional compensation* – while not necessarily recommended, presumably salaries/wages could be increased, under a total compensation philosophy, which would argue that the objective is to achieve a comparable total compensation package, and so dollars are merely being shifted away from benefits and toward compensation. Amounts could vary by salary level. For retirees, this would not appear to provide a solution, other than if NSHE were to provide a direct contribution toward retirees' coverage.

- *Additional employer contributions* – presumably NSHE could "buy down" the employee contributions that will be required by PEBP, under the guise of seeking to achieve a given total effective medical cost share. That said, until PEBP announces what the employee contributions will be, it is premature to comment on what logic or benefit there would be in pursuing this course. Amounts could vary by salary level, so long as the plan fully satisfies applicable nondiscrimination issues. It would appear that this would be an option to address retirees as well.

III. POSSIBLE BENEFIT SUPPLEMENT ALTERNATIVES

- *HSA contributions* – it appears to us that federal rules would permit NSHE to make a contribution to an employee's HSA, in addition to that contemplated by PEBP. This contribution, in combination with the PEBP contribution would need to fall within federal limits, and could be different for employee only coverage versus that for dependents (so long as federal comparability rules are met). Unfortunately, this would not be equitable for HMO enrollees, if that is a concern, since an HSA is not available for individuals not enrolled in a HDHP. Amounts could not vary by salary level, as comparability rules would be violated. This could be extended to early retirees, but again only to the extent that they are enrolled in the HDHP.
- *Health reimbursement arrangement (HRA)* – allowed under IRC section 105(h) of the tax code, an HRA would allow NSHE to provide an employer paid benefit for reimbursement of generally the same expenses as are permitted under an HSA or health FSA. In addition, unused allocations may be carried over from year to year. Further, the employer has broad latitude as to how it defines eligible expenses, and to what degree account balances are available from year to year, and upon termination or retirement. The big difference is that no employee money may be directed into an HRA. Also, as noted with the health FSA above, federal rules do not necessarily preclude an HSA from being established/funded for an HDHP enrollee, although the HRA would need to be designed to include the same restricted use aspects to accommodate the HSA requirements, which would need to be considered, in terms of the attraction/viability of this vehicle as a sole option. Amounts could vary by salary level, so long as the plan fully satisfies applicable nondiscrimination issues. An HRA approach could be extended to retirees, but would be subject to the above limitations.
- *Health FSA contribution* – an option to supplement their medical offering would be to make an employer contribution to a health FSA. While generally comparable to an HSA, in terms of what expenses can be reimbursed, the big difference with a health FSA is the use it or lose it requirement under IRC Section 125. Differentiation could possibly be accommodated for dependents, although nondiscrimination requirements under IRC Section 125 do exist. While federal rules do not necessarily preclude an HSA from being established/funded for an HDHP enrollee, the requisite restricted use aspects that come into play would need to be considered, in terms of the attraction/viability of this vehicle as a sole option. Amounts could vary by salary level, so long as the plan fully satisfies applicable nondiscrimination issues. Further, this approach would not be available to address any retiree concerns.

We are prepared to support NSHE in further exploring, analyzing, designing, securing and implementing any/all of these arrangements, based on further direction.

NSHE SURVEY OF PRIVATE FIRMS

The NSHE Task Force surveyed the following private firms within the State of Nevada: MGM, Harrah's, IGT, Mining, Microsoft, NV Energy, Southwest Gas, Wells Fargo, and Bank of America We were only able to receive responses from six companies, but these cover approximately 12,000 employees within their healthcare program. Most of them were hesitant to provide detailed information regarding their plans. Employer names were removed to protect confidentiality.

All private employers that were surveyed offered their plan on a calendar year basis, so we were able to gather both CY2010 and CY2011 plan information. PEBP's plan is on a fiscal year basis. PEBP's current plan for the most part is in line with what large private in Nevada offer. However with the changes that PEBP is making effective July 1, NSHE's benefits drop in comparison to what these private employers offer. Most of the private firms surveyed did not provide information regarding what percentage of the premium the employer subsidizes. Two employers provided this information and one subsidized 70% and the other 96%. PEBP's current subsidy level is 93% (base plan).

With the plan changes that PEBP is making, PEBP is with the minority in offering a High Deductible Plan. Out of the six respondents, only two companies offer a High Deductible Plan and both provide funds into Health Savings Accounts. The amount of money PEBP plans on providing in the HSA is in line with what the other companies currently provide. However, some have plans to phase out this contribution over the next few years. Most companies surveyed provided 2 or more options for healthcare coverage (except for 1 that only offered 1 choice). Of those that offer High Deductible Plans, it is offered along with another plan either a traditional PPO or an HMO Plan. Most of the respondents offer a standalone dental and vision plan, but did not disclose whether they subsidize any portion of the benefit.

QUESTION	ANSWER	ANSWER	ANSWER	ANSWER	ANSWER	ANSWER
NAME OF PRIVATE FIRM	Employer 1	Employer 2	Employer 3	Employer 4	Employer 5	Employer 6
How many benefits eligible employees?	2100 (approximately)	2100 in Nevada	2450	270	20,000 Nonunion-internationally	3500 (approximately)
When does your plan year begin?	January 1	January 1	January 1	January 1	January 1	January 1
How many plans do you offer?	9	2	2	1	2	4
What type of plans do you offer?	5 levels of CDH Plans, 1 PPO Plan, 1 - indemnity plan, 1 - EPO, 1 - HMO	PPO Plan and a CDH Plan	2 Levels of PPO	PPO - In-Network: No deductible, No Co-insurance. Out-of-Network: $100	PPO & HMO	2 - PPO Plans, 1 - HMO (North and South), 1- HRA
Medical Deductibles	PPO Plan - $300 individual/ $600 family	PPO Plan - $350 individual/$700 Family	Unknown	PPO Plan - $100 deductible	Unknown	1st PPO Plan - No deductible
	CDH Plan - range from $500 to $2000 for individual and from $1000 to $4000 for family	CDH Plan - $1500 individual/ $3000 family				2nd PPO Plan - $250 individual/ $750 family
	EPO Plan - No deductible					HMO Plan - No deductible
	HMO Plan - No deductible					HRA - $1000 individual/$3000 family
Is prescription included in the medical plan?	Yes	Yes	Yes	Yes	Yes	Yes
If prescription is included, does it have a separate deductible?	Unknown	PPO - yes, CDH - Rx is included in medical deductible	Yes	No	No	No deductible - employee just pays co-pays
Is dental included in the medical plan?	No	No	No	Yes	Yes	No
If dental is not included, do you offer a stand alone plan?	Yes	Yes	Yes	No	No	Yes
If offering a stand alone dental plan, do you subsidize a portion of the premium?	Unknown	Partially	Partially		n/a	Unknown
Is vision included in the medical plan?	No	No	Yes	Yes	Yes	No
If vision is not included, do you offer a stand alone plan?	Yes	Yes	No	N/A	n/a	Yes
If offering a stand alone vision plan, do you subsidize a portion of the premium?	Unknown	No	N/A	N/A	n/a	Unknown
If offering a CDH Plan, do you provide funds into an HSA? If yes, how much?	Yes. $350 for single coverage, $750 for family coverage.	Yes -Single = $600. Adult+Adult= $900, Adult+Child = $1200	N/A	N/A	n/a	Does not offer a CDH
How are premiums charged?				100% subsidized by employer. Unless spouse has own coverage - if so, then employee is charged $75 bi-weekly		
Is it based on salary tier?	Unknown	Yes. 4 tiers - < than $50K, $50K to $99K, $100 to $500K, >$500K.	No	N/A	Yes	Unknown
Is it based on coverage tier?	Unknown	Yes	Yes	N/A	No	Unknown

Does the employer cover 100% of the employee's premium?	Unknown	The lower the salary tier, the higher the subsidy	70%	Yes	No	Unknown
If subsidizing dependent premium, what percentage of the depedent's premium do you subsidize?	Unknown	Subsidy is based on salary tier	70%	See above, 100% unless Spouse has own group coverage then a chanrge of $75.00/bi-weekly is assessed.	we pay an blended rate of 96% of premiums for all members, including employees and dependents	Unknown
Do you offer coverage to retirees?	Unknown	Yes	Yes	No	No	Unknown
If yes, do you offer the same type of plans as those for actives?		No	Only for those under age 65			
If yes, do you subsidize any portion of the premium?		Yes - based on years of service	small subsidy			
Are you planning on making major changes to your plan for this upcoming plan year?		Yes	Yes	No	Yes	Unknown
If yes, what might those be?		Eliminating contributions to H S A	Offering a CDH plan in addition to 1 PPO Plan		two dental options	Unknown

***The data above highlights the summary of our survey of health care benefits by major private employers in the state of Nevada. It is important to note that all of the private employers in this survey are on a calendar year basis for health care benefits, so we were able to gather information in their current (calendar year 2010) and future (calendar year 2011) health care benefit plans. Overall, this data shows that the current PEBP health care program is in line with the calendar year 2010 benefits offered by these private employers, but they are not making the major changes in their health care programs similar to what PEBP is for 2011, thus the PEBP health care program going forward will drop below that which is being offered by private employers in the state.

Attachment #3

Benefits as a Percent of Salary Comparisons - Nevada and the Western States:

The data listed below shows how Nevada higher education compares with total benefits provided for most of the western states. NSHE does not participate in Social Security, so an adjustment for this benefit has been made (however, it must be noted that the states participating in social security provide this employer benefit in addition to other retirement, health care, and other support). Even with the adjustment for social security, it is important to note that the total cost of benefits (as a percent of salary) for NSHE institutions is well below the average of these western states. When you consider the fact that these other states are also providing the social security match, the NSHE benefit rates drop even further below the average (to nearly 7 1/4 percentage points below the average).

SOURCE: 2009-10 AAUP Report on the Economic Status of the Profession. Benefits represent the institution or state contribution on behalf of the individual faculty member; the amount does not include employee contribution. Benefits include: retirement, medical insurance, disability income protection, tuition for faculty dependents, dental insurance, social security, unemployment, group life insurance, workers compensation.

	Benefits as % of Salary	Contributing to Social Security	Adjusted Rate without Social Security*
Average of all states (not including Nevada)	28.83		23.25
ARIZONA			
Arizona State University	28.8	Y	22.6
Northern Arizona University	33.9	Y	27.7
University of Arizona	27.7	Y	21.5
CALIFORNIA			
San Francisco State University	25.5	Y	19.3
San Jose State University	25.4	Y	19.2
University of CA-Berkeley	33.4	Y	27.2
University of CA-Davis	34.6	Y	28.4
University of CA-Irvine	34.4	Y	28.2
UCLA	33.2	Y	27
University of Southern California	34.7	Y	28.5
COLORADO			
Colorado State University	25.1	N	25.1
Colorado State University-Pueblo	18.9	N	18.9
University of Colorado-Boulder	25.5	N	25.5
University of Colorado-Denver	22.1	N	22.1
MONTANA			

Montana State University-Billings	32.4	Y	26.2
Montana State University-Bozerman	27.3	Y	21.1
Rocky Mountain College	23.4	Y	17.2
University of Montana	31.7	Y	25.5
University of Montana-Western	35.7	Y	29.5
NEVADA			
University of Nevada Las Vegas	21.6	N	21.6
University of Nevada Reno	21.6	N	21.6
NEW MEXICO			
New Mexico State University-Grants	26.1	Y	19.9
New Mexico State University-Main	27.6	Y	21.4
University of New Mexico-Main	26.1	Y	19.9
University of New Mexico-Taos	28.2	Y	22
University of the Southwest	26.6	Y	20.4
OKLAHOMA			
Northwestern Oklahoma State University	29.4	Y	23.2
Oklahoma State University-Main	31.2	Y	25
Oklahoma State University-Oklahoma City	36.2	Y	30
Southeastern Oklahoma State University	23	Y	16.8
Southwestern Oklahome State University	37.3	Y	31.1
University of Tulsa	29.6	Y	23.4
TEXAS			
Texas A&M University	19.3	Y	13.1
Texas State University-San Marcos	22.2	Y	16
University of Dallas	30.2	Y	24
University of Houston	23.8	Y	17.6
University of North Texas	16.1	Y	9.9
WYOMING			
Northwest College	35.7	Y	29.5
University of Wyoming	31.5	Y	25.3
UTAH			
Southern Utah University	40.8	Y	34.6
University of Utah	21.3	Y	15.1
Utah State University	37.2	Y	31

* Rate is adjusted if the institution is contributing into Social Security. The rate is reduced by 6.2%.

Attachment #4:

Recommended Priorities for Changes in PEBP Plan for FY12

The Task Force identified and prioritized adjustments to the existing PEBP plan that would be important to NSHE. Each Task Force member voted for the three (3) top priorities, and the votes are included in the "( )" in front of each item below.

a. **(15)**: Overall affordability of the plan/deductibles. There is a major concern that the PEBP plan may not be perceived as affordable, especially for lower paid individuals, and whether we will see many more opt out of coverage (which in some cases could mean no medical coverage, with an expectation that when they consume medical care it is paid for through other sources, including the public hospital and other state/county health and human services programs). It is noted that while we do not have premium rates, the assumption is that there will be significant increases combined with significant decreases in the value of the program.

b. **(13)**: Prescription Drug Coverage.

c. **(10)**: LTD reduction, and the note about many NSHE employees not being eligible for LTD under Social Security.

d. **(3):** HMO issues, including overall affordability and the blended rate north and south (and what the rate will be, for those who are concerned about the CDHP as a viable alternative), but also wondering if there are options to strengthen the HMO offerings with more doctors in the plan. It should also be noted that there is a split on the reception of this issue, with those in the north (in general) supporting the PEBP plan and those in the south (in general) being against it. <u>It is important for the System to recognize this split, as it will likely lead to significant concern if the rates move in the directions expected</u>. A concern also is being expressed as to whether the HMO programs would even be able to support any significant increase in participants (given the number of health care providers now supporting those programs), especially with a migration from the PPO plan, and how the premiums might impact any possible migration. The current assumption is that both the northern and southern HMO plans currently suffer from a significant lack of access to medical providers.

e. **(2)**: Dental Coverage.

f. Eligibility of spouse/domestic partner, or at least requiring comparable coverage before declaration of non-eligibility (there is also the question about spouses on a CY vs. FY plan basis – how is PEBP going to address this? It was noted that PEBP is now aware of the question, but they have not provided a response). It was also noted that this change will have an even greater impact on employees where the spouse/domestic partner also works for NSHE or

another state agency, as the cumulative deductible for a family under this circumstance will be $5,700 (individual of $1,900 and then family of $3,800).

Note: The two items listed below may be treated differently from the plan issues highlighted above. The Task Force will discuss this at future meetings.

g. A discussion of whether it would be better to delay the Medicare Exchange program implementation for a year, so that more information and understanding of the change could be effectively communicated to faculty and staff. (Note: recent action by the Board of Examiners seems to eliminate this as a current option).

h. Extend the enrollment period, as was done last legislative session. Concern is being expressed about how easily employees will be able to adjust to the radical changes in the PEBP plan, and still have July 1, 2011 implementation date.

Attachment #5 NSHE Employee Enrollment in PEBP Health Care Programs

PPO PLAN		%	HMO PLAN		%
EMPLOYEE ONLY	3127	52.7%	EMPLOYEE ONLY	1277	54.1%
EMPLOYEE PLUS SPOUSE	864	14.6%	EMPLOYEE PLUS SPOUSE	332	14.1%
EMPLOYEE PLUS CHILD	845	14.2%	EMPLOYEE PLUS CHILD	359	15.2%
EMPLOYEE PLUS FAMILY	1100	18.5%	EMPLOYEE PLUS FAMILY	391	16.6%
TOTAL	**5936**		**TOTAL**	**2359**	

DECLINED	**156**	1.8%

SALARY RANGE	TOTAL ENROLLED IN PPO	PPO enrollees w/ State Acct	PPO Enrollees w/ Non-State Acct	TOTAL ENROLLED IN HMO	HMO enrollees w/ State Acct	HMO Enrollees w/ Non-State Acct	TOTAL DECLINED INS	DECLINED INS w/ State Acct	DECLINED INS w/ Non-State Acct
<$50k	1847	1180	667	1203	771	432	86	47	39
$50K TO $75K	1866	1349	517	728	517	211	33	17	16
$75K TO $100K	1044	807	237	265	201	64	14	10	4
$100K TO $$150K	863	662	201	141	118	23	12	6	6
$150K AND UP	316	182	134	22	11	11	11	7	4
	5936	**4180**	**1756**	**2359**	**1618**	**741**	**156**	**87**	**69**

Percentages									
<$50k	31.1%	28.2%	38.0%	51.0%	47.7%	58.3%	55.1%	54.0%	56.5%
$50K TO $75K	31.4%	32.3%	29.4%	30.9%	32.0%	28.5%	21.2%	19.5%	23.2%
$75K TO $100K	17.6%	19.3%	13.5%	11.2%	12.4%	8.6%	9.0%	11.5%	5.8%
$100K TO $$150K	14.5%	15.8%	11.4%	6.0%	7.3%	3.1%	7.7%	6.9%	8.7%
$150K AND UP	5.3%	4.4%	7.6%	0.9%	0.7%	1.5%	7.1%	8.0%	5.8%
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

NSHE Employee Enrollment in PEBP Health Care Programs:
Listed above is data on BCS and BCN current enrollees in program, along with those not participating and NSHE totals. The percentage of the declined counted the total benefits employees(PPO, HMO, and declined). The last two columns next to the declined shows if those employees' are paid through state or non-state dollars. Also, if a person declines coverage, no money for the employer subsidy is sent to PEBP. Note the very high percentage of overall participation in PEBP health care programs by NSHE employees, but also note the very high percentage of enrollment at the employee only level - over 50% for both the PPO and HMO programs.

	PY06 (7/1/05 to 6/30/06)				PY07 (7/1/06 to 6/30/07)				PY08 (7/1/07 to 6/30/08)			
	PLANS OFFERED				PLANS OFFERED				PLANS OFFERED			
	HIGH DEDUCTIBLE PPO	LOW DEDUCTIBLE PPO	Northern HMO	Southern HMO	HIGH DEDUCTIBLE PPO	LOW DEDUCTIBLE PPO	Northern HMO	Southern HMO	HIGH DEDUCTIBLE PPO	LOW DEDUCTIBLE PPO	Northern HMO	Southern HMO
EMPLOYEE ONLY	$0.00	$20.81	$22.73	$14.83	$0.00	$23.44	$25.25	$15.99	$0.00	$27.62	$25.00	$16.58
EMPLOYEE + SPOUSE	$85.19	$177.84	$157.89	$83.81	$95.98	$200.37	$175.29	$89.93	$79.72	$182.48	$180.75	$100.70
EMPLOYEE + CHILD/REN	$14.57	$47.67	$70.59	$74.10	$16.42	$53.71	$77.19	$78.51	$7.04	$41.29	$66.33	$71.91
EMPLOYEE + FAMILY	$50.85	$114.54	$174.65	$142.56	$57.29	$129.06	$192.93	$152.17	$48.55	$121.93	$180.05	$147.87
MAJOR PLAN CHANGES	* Deductible for High Deductible Plan went up to $2000/$4000. * Deductible for Low Deductible Plan remained at $500/$1000 * Introduction of Health Risk Assessment (HRA). Incentives for completing the HRA is cutting your deductible in half and increasing your dental plan maximum from $1500 to $2000 * Wellness Benefit of $2500				* Premium Holiday for July premiums.				* Premium Holiday for July Premiums * Prescription deductible not applicable to Generic Drugs			

UPDATED 6-year History 2/2

PY09 (7/1/08 to 10/31/09)				PY10 (11/1/09 to 6/30/10)			PY11 (7/1/10 to 6/30/11)		
PLANS OFFERED				PLANS OFFERED			PLANS OFFERED		
HIGH DEDUCTIBLE PPO	LOW DEDUCTIBLE PPO	Northern HMO	Southern HMO	LOW DEDUCTIBLE PPO	Northern HMO	Southern HMO	PPO	Northern HMO	Southern HMO
$0.00	$28.02	$27.29	$17.14	$34.94	$87.82	$55.63	$43.73	$64.69	$54.81
$98.08	$211.57	$193.57	$102.69	$232.32	$293.57	$173.35	$278.84	$393.57	$172.52
$10.29	$46.90	$71.77	$73.44	$55.73	$149.66	$133.51	$81.53	$138.63	$138.26
$61.85	$143.13	$193.69	$150.84	$160.44	$293.69	$240.29	$195.14	$301.93	$255.07
* Plan extended to October 31 due to uncertainty with State Budget * Northern HMO vendor changed from Anthem to Hometown Health				* Eliminated the High Deductible Plan * Deductible for PPO Plan went from $500/$1000 to $725/$1450 * Prescription co-pays in both the HMO and PPO Plans increased * Health Risk Assessment and associated incentives were removed * Northern HMO co-pays increased			* Deductible for PPO Plan went up from $725/$1450 to $800/$1600 * Annual out of pocket maximum for PPO went up from $3500 to $3700 and for HMO from $6200 to $6800 * Northern HMO now has a $250/$750 deductible per year * Coverage for Domestic Partners * Live Well/Be Well Prevention program introduced.		

*** History of PEBP Premium Rates:

Listed above is information on premium rates and major plan changes going back to July 1, 2005. There are several items to highlight:

1. There was both a high and low deductible PPO until 11/1/09. After this time only the one PPO option was retained.
2. The Employee + Spouse premium has always been the most expensive, exceeding the Employee + Family coverage by as much as 67% over this time period, and down to the current 44% difference.
3. The North and South HMO prices have always differed, but mostly the difference is noted in the Employee + Spouse coverage option, where the North premium is currently 128% above the South premium, with the lowest difference over this time period being 80%.

Attachment #7

State of Nevada Rankings on Health Care Related Metrics

The data listed below highlights the consistent low ranking of Nevada relative to most health care metrics, including availability of health care providers for the population; high uninsured population; high child and adults in medicaid and/or just lacking any preventative or other health care services. The major changes in PEBP may well drive more individuals outside of health care coverage, and create an even larger challenge for Nevada to comply with the federal health care requirements on the near term horizon (2014).

Nevada Ranking (* = Including DC)	**OVERVIEW OF FINDINGS FROM THE NEVADA ACADEMY OF HEALTH "NEVADA HEALTH SCORECARD" JAN. 2009**
NV RANKING	**HEALTH CARE FINANCING AND EXPENDITURES**
43	Population uninsured
49	Children uninsured
48	Public health funding
50	Adults enrolled in Medicaid
51*	Children enrolled in Medicaid
NV RANKING	**HEALTH CARE WORKFORCE**
46	Primary care physicians (per 100,000)
50	Registered nurses (per 100,000)
47	Dentists (per 100,000)
46	Psychiatrists (per 100,000)
46	Rate of residents in core and specialty programs (per 100,000)
46	Paramedics
NV RANKING	**HEALTH CARE ACCESS AND CAPACITY**
45	Community hospital beds (per 100,000)
46	Geographic disparity of health outcomes (as a differential percentage)
38	Persons lacking access to primary care
51*	Adults with a usual source of care
50	Children with a medical home
47	Adults who visited a doctor in the past two years
40	Adults who visited a dental clinic in the past year
50	Children who received medical and dental preventive care
NV RANKING	**HEALTH CARE QUALITY**
38	Mortality rate of cases amenable to health care (per 100,000)
50	Medicare readmissions after 30 days (of admissions)
45	Medicare patients who gave a best rating for health care received in past year
45	Hospital patients who received recommended care for acute myocardial infarction, congestive heart failure, or pneumonia
46	Adult diabetics who received recommended preventive care
NV RANKING	**MATERNAL & CHILD HEALTH**
39	Mothers receiving late or no prenatal care
50	Children immunized

NV RANKING	MINORITY HEALTH DISPARITIES
1 (worst)	Diabetes death rate among Blacks (per 100,000)
40	Preterm births among Hispanics
41	Preterm births among Blacks
NV RANKING	**HEALTH & WELL-BEING**
41	Years of life lost due to premature death (per 100,000)
48	Age-adjusted death rate by suicide (per 100,000)
42	Heart disease death rate (per 100,000)
31	Breast cancer death rate (per 100,000 women)
50	Colorectal cancer death rate (per 100,000)
51 *	Adults reporting poor mental health

Attachment #8

LTD Comparative Information:
Listed below is a side-by-side comparison of Social Security Disability Income (SSDI), Long Term Disability Benefits, and PERS Disability Retirement.

We believe part of the PEBP's Board's rationale for reducing the LTD benefit is that State employees are eligible for disability retirement benefits under PERS. This is true for most state agencies, but does not apply to NSHE faculty and professional staff (in general) since the vast majority are on the NSHE Defined Contribution Plan.

Only employees with at least 5 years of service under PERS are eligible for apply for PERS Disability Benefits. In addition, the benefit received is not the same as those who retire under Service Retirement. The Disability Retirement Benefit only removes the penalty for early retirement. The benefit that the employee will receive will still be based on the service credit that they've accrued at the time of retirement. For example, an employee with 10 years of service who is approved for disability retirement will only receive 26.7% of their three highest years of earnings.

For example, an employee with 10 years of service who makes $2000 per month and is disabled would receive:
LTD = $1200 per month (60% of pre-disability wage)
PERS Disability Retirement = $534 per month (26.7% of $2000)

COMPARISON OF SSDI, LTD AND PERS BENEFIT

<table>
<tr><th>CATEGORY</th><th colspan="2">SOCIAL SECURITY DISABILITY INCOME</th><th>LONG TERM DISABILITY</th><th>PERS DISABILITY RETIREMENT</th></tr>
<tr><td>Purpose</td><td colspan="2">Disability income for those who are unable to work due to a medical condition that is expected to last at least one year or result in death</td><td>Disability income for those who are disabled for an extended period of time due to an illness or injury and are under the regular care of a physician</td><td>Benefit provided to an eligible PERS member who becomes totally unable to perform his current or any comparable job for which he is qualified by this training and experience because of injury or physical or mental illness of a permanent nature</td></tr>
<tr><td rowspan="5">Eligibility</td><td colspan="2">Must meet the earnings test under Social security for "recent work" and "duration of work"</td><td rowspan="5">Must be enrolled in the PEBP health plan and actively employed before the disability began.</td><td rowspan="5">Must have five or more year of services in PERS and
Totally unable to perform the current job or comparable job due to an injury or mental or physical illness of a permanent nature and
Employed by a Nevada Public Employer at the time you submit your application for disability retirement to PERS</td></tr>
<tr><td colspan="2">Recent Work Test</td></tr>
<tr><td>If you become disabled the quarter you turn 24</td><td>1.5 years of work (paying SS) during the 3-year period ending the quarter your disability began</td></tr>
<tr><td>If you become disabled in the Qtr after you turn age 24 but before the Qtr you turn 31</td><td>Work during half the time for the period beginning with the Qtr after you turned 21 and ending with the Qtr you became disabled</td></tr>
<tr><td>In the quarter you turn age 31 or later</td><td>Work during 5 years out of the 10-year period ending with the Qtr your disability began</td></tr>
</table>

<table>
<tr><td></td><td>Duration of Work Test (list is not complete)<table><tr><td>Disabled before the age 28</td><td>1.5 years</td></tr><tr><td>Age 30</td><td>2 years</td></tr><tr><td>Age 34</td><td>3 years</td></tr><tr><td>Age 38</td><td>4 years</td></tr><tr><td>Age 42</td><td>5 years</td></tr><tr><td>Age 44</td><td>5.5 years</td></tr><tr><td>Age 46</td><td>6 years</td></tr><tr><td>Age 48</td><td>6.5 years</td></tr><tr><td>Age 50</td><td>7 years</td></tr></table></td><td></td><td></td></tr>
<tr><td>Waiting period</td><td>have to be disabled a full five months. Benefits start on the 6 month</td><td>180 calendar days during which you are disabled. Benefits begin the day after the benefit waiting period is completed.</td><td>Employee must terminate employment and begin drawing a benefit within 60 days of the approval date.</td></tr>
<tr><td>Benefit Amount</td><td>Based on your average lifetime earnings in jobs in which social security was taken out</td><td>60% of monthly earnings to a maximum of $7500 per month</td><td>Benefit is calculated using the employee’s accrued service credit at the time of disability, multiplied by their average compensation. Average compensation is based on the 36 highest consecutive months of compensation reported by the employer. For example, an employee with 10 years of service will have 26.7 service credit, therefore their retirement benefit will be 26.7% of their average compensation.</td></tr>
<tr><td>Maximum period of benefits</td><td>- Benefits will end if you work at a level that is considered “substantial.” In 2007, average earnings of $900 or more per month is considered substantial
- Benefit will stop if SS decides that your medical condition has improved to the point that you are no longer disabled.</td><td>Continue while you are totally disabled to the maximum period of payment. The maximum period is based on your age when you became disabled<table><tr><td>Age at Disability</td><td>Max Period of LTD</td></tr><tr><td>Age 59 or less</td><td>To age 65</td></tr><tr><td>Age 60-61</td><td>Age 65</td></tr><tr><td>Age 62</td><td>3 years, 6 months</td></tr><tr><td>Age 63</td><td>3 years</td></tr><tr><td>Age 64</td><td>2 years, 6 months</td></tr><tr><td>Age 65</td><td>2 years</td></tr><tr><td>Age 66</td><td>1 year, 9 months</td></tr><tr><td>Age 67</td><td>1 year, 6 months</td></tr><tr><td>Age 68</td><td>1 year, 3 months</td></tr><tr><td>Age 69 or over</td><td>1 year</td></tr></table></td><td>Lifetime</td></tr>
</table>

Attachment #9

Summary of Federal Health Care Changes:
The information below is a summary of the federal health care changes that are projected for the near term. "PPACA" stands for the Patient Protection and Affordable Care Act, more popularly known as the HealthCare Reform Act. In general the PEBP plan addresses most of the federal requirements, with the two biggest potential issues being "affordability", when defined; and accommodating full coverage for all employees.

PPACA HEALTH CARE REFORM
2013, 2014 IMPLICATIONS

- Employees (prior to and in 2014) will be required to be defaulted to coverage, with an employee allowed to opt out. *PEBP currently defaults individuals to the PPO Self Funded Plan if no form is received.*

- Benefits must meet the essential benefits test – i.e., actuarial value of at least 60%. *This should not be a problem, as the HDHP should exceed this threshold.*

- In 2013, health care flexible spending accounts will be limited to a maximum of $2,500 per year. *Given the limited scope health FSAs contemplated in conjunction with the HDHP/HSA, this should be of little practical impact.*

- Beginning in 2013, a clinical effectiveness research assessment will be payable by health plans. The assessment is $1 per participant per year in 2013, $2 beginning in 2014 and sunsets in 2019. *So long as NSHE is participating in PEBP, this should be PEBP's responsibility – although likely built into funding rates or otherwise recaptured from employers.*

- Must offer health care coverage to full time employees (those working 30 hours or more per week). *This does not change anything, since the plan currently defines full time as those working 80 hours or more per month.*

- No pre-existing condition limitations or exclusions will be permitted, beginning 2014. *To the extent PEBP currently has any such limitations, they will need to be eliminated.*

- No waiting period over 90 days. *This does not change anything, since the waiting period for classified is 90 days, and for professional and faculty, their benefits kick in on the first of the month concurrent with or following their date of hire* .

- Maximum out of pocket maximum may not exceed the HSA calendar year limits of $5,950 per person/$11,900 per family. *This should not change anything, as the HSA out of pocket maximums are well above what is currently in effect, and what is contemplated by PEBP (especially if the deductibles do count toward the out-of-pocket maximum).*

- There must be an unlimited lifetime maximum, 100% coverage for preventive services, and no pre-existing condition limitations. *The PEBP plans as proposed appear to accommodate these requirements.*

- Medical coverage for employees must be "affordable". While yet to be confirmed, it appears to be based on employee cost for single coverage.

  - Three fundamental thresholds:

    - **Under 8% of household income (HHI): affordable**

    - **8.0%-9.5% of HHI:**

      - HHI <400% of poverty and purchases coverage on the exchange

      - Voucher equal to employer contribution for plan with highest % contribution for tier of coverage actually purchased

      - If voucher is greater than cost, excess retained by employee

      It is our understanding that this voucher would generally be provided by the employer. That said, given the dynamics between each college/university, the System and PEBP, additional guidance or research will be needed to lend insight as how this situation would be handled.

    - **Greater than 9.5% of HHI:**

      Penalty of $3,000 for anyone <400% of poverty, but no greater than sum of $2,000 x (number of FTEs less 30). *It is our understanding that this penalty is generally payable by the employer. That said, given the dynamics between each college/university, the System and PEBP, additional guidance or research will be needed to lend insight as how this situation would be handled.*

  It is our understanding that the employee contributions are intended to support not only medical, but all benefits provided by PEBP. As such, it is not possible to comment on what portion of this employee contribution is allocable to medical, which in turn would then be the basis for assessing affordability.

- Retiree coverage – not required for group health plans. *Notwithstanding the lack of any federal mandate, Nevada state laws may continue to have an impact.*

Attachment #10:

Las Vegas Chamber, SAGE, and NTA Information Regarding Public Employee Benefits

This information, although sometimes incomplete or not accurate concerning NSHE professional employee benefits, should be considered when finalizing a communications plan to address NSHE health care and other benefits needs in order to stay competitive.

Potential Supplemental Information to Help Frame Our Data Presentation (Las Vegas Chamber Information; SAGE Report Information; and Nevada Taxpayer Association Data).

2008 State and Local Employee Compensation and Benefits Analysis – Las Vegas Chamber of Commerce:

These reports from the Las Vegas Chamber have driven some of the debate about public employee compensation and benefits in Nevada. One of these reports looks specifically at retiree health care benefits. The last report listed below is the Analysis Brief, Volume 2, Issue 1 State-to-State Comparison of Public Employee Compensation Levels – 2008, Updated in January 2010. Pasted below are some quotes from this report, which are important background and context for the NSHE employee benefits.

"Nevada's state and local government employees were paid more than the national averages in all but four job classifications: 1) air transportation (94.6 percent of the national average); 2) social insurance administration (96.6 percent of the national average); 3) elementary and secondary instruction (95.3 percent of the national average); and 4) higher education instruction (95.0 percent of the national average)."

"There continued to be notable variances between wages earned by state and local employees. State workers' average annual salary of $55,300 was 107 percent of the national average and ranked 9th highest nationally. By contrast, public employees classified as "local" reported earning salaries 117 percent of the national average, which placed the group 8th highest nationally. Worth noting is that the U.S. Census Bureau data classified K-12 teachers as "local" employees. If teachers are removed from the "local" calculation, Nevada's local government workers report wage payments 131 percent of the national average."

"Also worth noting is that approximately 82 percent of state and local government employees participate in the "Employer-Pay" plan offered by Nevada Public Employees' Retirement System (PERS), as opposed to the "Employer/Employee-Pay" plan. Those participating in the "Employer-Pay" plan receive a lower salary in exchange for contributions to be made on their behalf to their own retirement fund by their employer. Both the "Employer-Pay" plan and the "Employer/Employee-Pay" plan have unique advantages and disadvantages, but what is relevant to this analysis is the fact that the majority of government employees in Nevada "earn" higher salaries than what is generally reported as take home pay."

http://www.lvchamber.com/files/pdf/FAB-public-private-comp-analysis.pdf

http://www.lvchamber.com/files/pdf/FAB-state-to-state-comparison.pdf

http://www.lvchamber.com/files/pdf/FAB-retiree-health-subsidy.pdf

http://www.lvchamber.com/files/pdf/FAB-public-employee-comp-update.pdf

Information from final SAGE Report – Nevada Spending and Government Efficiency Commission. Pages 18-19.

"In 2008, the Las Vegas Chamber commissioned Hobbs, Ong & Associates and Applied Analysis to analyze state and local fiscal issues including public sector employee compensation levels with particular emphasis on wage, salary and benefit parity between public and private sector employees in Nevada……..It is important to note that SAGE was primarily concerned with state employees, who are paid significantly less than their counterparts working for city and county jurisdictions in Nevada. For example, state workers were paid at 102% of the national average, ranking 15th nationally among the 50 states and District of Columbia, while "local" public sector employees in Nevada earned 116% of the national averages, making them 8th highest paid in the nation. If Nevada's teachers, who are paid 6.5% less than the national average, are removed from this "local" employee category, the state's local government workers report wages which are 131% of the national average." (Note: it is important to highlight to legislators and others that this data applies to public workers over which they have no direct control for any element of compensation, and those they have control over are about average).

NEVADAISSUES = A publication of the Nevada Taxpayers Association, Issue 7, July 2010, page 7

"20. Both the employer and the employee should share all retirement contributions.

Reason: In Nevada, the Public Employee Retirement System (PERS) functions in place of Social Security for government employees. State employees make their employee contribution either through a payroll deduction reflected on their pay stud, or by being placed on a lower salary scale. *The same is not true for local government employees* who collectively bargain and are permitted to declare their employee contribution as being "in lieu of equivalent basic salary increases or cost-of-living increases, or both." This effectively shields local government employees from sharing the cost of their retirement, contrary to the intent of the law."

Attachment #11

Hiring of a Consultant and Their Scope of Work:

Gallagher Benefits was hired as a consultant to support the work of the Task Force. Gallagher Senior Vice President Don R. Heilman is the principle on this engagement. The first priority items in their initial contract included the following:

a. Evaluation of PEBP plan within a broader context, and in specific with what other employers support, this includes comparing PEBP with what other Nevada private businesses of similar size provide to their employees. It would also be good to have this comparative data for similar sized private businesses in other states.
b. Provide comparative data from other states/institutions of higher education (broken down by active and retiree, as well as employee, dependent, and domestic partner), and specifically considering how other public institutions of higher education structure their health care programs (i.e. are they part of large state pools; are there system pools; are there campus pools, etc.).
c. Assist in developing viable near-term (FY12/FY13 in specific) alternative options (if any) to supplement the PEBP plan for NSHE employees, and estimating costs and possible effects on PEBP plans/projections. (Note: these options may or may not be programmatically and/or financially feasible.)

   It was noted that if in fact we are able to get the PEBP data on NSHE participants, we will talk with the consultant (in coordination with Bart Patterson) about getting their help to analyze the information, as we would not be able to complete this task on our own.

The Task Force also identified other potential priority items for support from the consultant, as noted below, but no action on these items was taken.

Other Potential Priority Items:

a. Estimate potential impacts/projections (if any) of NSHE members' declining coverage on other programs/areas within the state (including costs). For example, additional uncovered NSHE employees requiring medical services.
b. Evaluate, to the extent feasible, any adverse selection risks which might drive employees from the CDHP to HMO plans.
c. Help evaluate claim expense of NSHE employees in the PEBP pool.

Attachment #12

Summary of Employee Feedback Received Through the NSHE Web Page

The Task Force worked with NSHE administration to set up a web page. The two main purposes of the web page were to provide information on the activities of the Task Force, including meeting notes, but also to serve as a point for NSHE employees to submit comments and questions about the PEBP changes. Overall about 300 comments were received through the NSHE web page. The top items mentioned in the comments were overall affordability; prescription drug coverage; and dental coverage. A summary of prevalent comments is highlighted below:

-employees saying they will opt out of PEBP benefits altogether
-employees considering or working on leaving NSHE
-employees considering or working on leaving the state
-recurring concern about retention & recruitment of quality faculty & employees
-concern about MS drugs & others being labeled "specialty drugs"
-many with the nearly $6000 deductible issue for couples who both work for the state w/dependents
- recurring suggestions to reduce cleanings to 2 per year and add back some dental coverage
-recurring requests to offer a separate dental/vision plan for purchase
-recurring idea that large families should pay more than childless couples
-recurring idea that those who make more should pay more

Several of the comments didn't address any specific issue but expressed frustration at not understanding the changes and wanting to know what the HMO changes are. Several were unclear whether the out-of-pocket max includes the deductible. Many said they'd be willing to pay more for more coverage and seem to be unaware that they will already be paying more for less.

Attachment #13

Summary of December 2, 2010 PEBP Board Meeting

The PEBP Board approved the following recommendations from the PEBP staff:

- Establish an individual family deductible of $2,400 for a participant and his dependents, if the participant covers dependents. The deductibles for Plan Year 2012 will be:
  - Participant only coverage = $2,000 deductible
  - Participant plus dependent tiers:
    - $2,400 individual family member deductible
    - $4,000 family deductible
    - See Table Below

	FY11 PPO	FY12 Current Plan	FY12 Change
Single:			
Deductible	800	2,000	2,000
Stop-Loss	3,700	3,900	3,900
HSA amount	n/a	(600)	(600)
Out of Pocket	$4,500	$5,300	$3,300
Family:			
Deductible	1,600	4,000	4,000
Stop-Loss	7,600	7,800	7,800
HSA amount	n/a	(1,200)	(1,200) (assume 4)
Out of Pocket	$9,200	$10,600	$6,600

The far right column assumes the deductible becomes part of the stop-loss total. We are anxious to see what the cost estimate is for this change.

- Include the deductible in calculating the yearly out-of-pocket maximum.
- Funding for HSA and HRA accounts for PPO Participants will be as follows:
  - For plan year beginning July 1, 2011, the entire HSA contribution will be credited to employee accounts at the beginning of the plan year.
  - For employees who are hired after the plan year begins, a prorated amount will be credited to their account based on the number of months that they are covered under the PPO Plan (For example, an employee hired in August will receive a credit of 11/12ths of the annual amount).
  - For the plan year beginning on or after July 1, 2012, provide $1/12^{th}$ of the annual contribution each month.
  - For active employees ineligible for an HSA, PEBP will fund their HRA in a similar manner as the HSA.
  - Non-Medicare retirees will have a limited use HRA. They can use their HRA to pay for qualified expenses except for premiums.
  - Medicare retirees will be able to use the HRA to pay for qualified expenses as well as for premiums.
- Move forward with an RFP for a dental plan. The RFP will determine what is available in the marketplace. Two options could be pursued depending on the costs associated with a full insured dental product:
  - Mandatory dental plan that includes coverage for both preventive and other dental benefits with partial or full subsidy from PEBP

    - Voluntary employee paid only dental plan. Preventive care coverage will still be provided under PEBP's self-insured plan, but an employee could elect to purchase additional dental benefits
- Ratified the Medicare Coordinator Service (Extend Health) Vendor selection effective on the Board of Examiner's approval
- If the Board of the Examiners does not approve the contract with Extend Health, PEBP will not be able to realize the savings they've projected previously since Medicare retirees will now need to stay in the plan. These costs will be passed on to the retiree group through an increase in their monthly premiums for Plan Year 2012 (during that time the Board would go out for RFP for the contract to start 7/1/2013). The CFO estimated that the shortfall would be about $7 million dollars for the 12 month period. The cost increase to Medicare retirees would be approximately $84/month (this was a very rough estimate). NOTE: The BOE's did approve this contract shortly after the 12/2/10 PEBP meeting.

Please note that these changes will result in additional costs to the plan; if no additional funding is available, the costs will be passed on to participants in the form of higher premiums. Rates and subsidy levels will not be decided until the February PEBP Board Meeting.
Michelle Kelley did an excellent job of highlighting the Chancellor's letter and the concerns expressed by NSHE employees. John White of the UNLV Boyd School of Law also provided comment regarding the effect of these benefit reduction in our ability to retain and recruit faculty. Jim Richardson echoed the sentiments expressed by both Michelle Kelley and John White and added that NSHE is also concerned with the implications of these changes to retirees.

Another item on the agenda is discussion on prioritizing benefits that could be restored in the event that additional funding may become available. Additional funding may become available if PEBP's claims experience results in a surplus in the plan's reserve or if the Legislature decides to provide additional funding to PEBP. If reserves exceed the 95% confidence level, then PEBP could use those additional funds to restore benefits.

The PEBP Board approved the following benefit restoration in the event of additional funding in the following order:

- Increase funding to the HSA/HRA. Each additional $100 into this plan will cost approximately $4.2 million.
- Adding back some dental benefits
- Decrease the deductible
- Restore the Long Term Disability Benefit to 60%

The Board also ratified the vendor selection of a new Third Party Administrator who would process medical claims for the plan beginning July 1, 2011. The vendor selected is HealthSCOPE out of Little Rock, Arkansas. There is some concern with interface with Sierra Health Care Network (PPO Provider Network) that PEBP staff is still looking into.
The next PEBP Board meeting is scheduled for January 13th. To accommodate board member schedules as well as allow more active employees the opportunity to attend the meeting, the board meeting is scheduled to start at 4:00 p.m. Locations for the meeting will be announced as soon as possible.

Attachment #14

Summary of January 13, 2011 PEBP Board Meeting

The Public Employees Benefits Program (PEBP) Board met January 13, 2011, and approved most PEBP Staff recommendations. Due to lower than expected plan utilization, PEBP was able to use excess reserves to fund these add backs -- PEBP does not expect these actions to affect rates when they are decided in February.

The following benefit plan changes were approved:

- Increase contributions to the Health Savings Accounts (HSA) for participants in the Consumer Driven Health Plan from $600 to $700
- Restore dental benefit coverage for fillings, crowns and other work with the following changes:
  - Double the dental deductible from $50 to $100 for individuals and $150 to $300 for families
  - Decrease the maximum dental benefit paid by the plan from $1500 to $1000 a year
  - Dental cleanings will remain at 4 cleanings per year
  - Decrease the co-insurance to 75% for any dental procedure that is currently paid at an 80% co-insurance level
- Reduce the medical in-network deductible
  - Participant only coverage tier from $2000 to $1900
  - Participant plus dependent tiers:
    - $2400 individual family member deductible (as approved at the December PEBP Board meeting)
    - From $4000 to $3800 family deductible
- Retain current out-of-network and out-of-pocket maximum amounts

The Board also approved PEBP Staff recommendations for subsidy percentages as noted below.

Setting the base subsidy for active employees at 91% (dependent subsidy currently and as recommended is 20% less than the active employee subsidy).

	CURRENT SUBSIDY		PLAN YEAR BEGINNING JULY 1, 2011	
	PPO PLAN	HMO PLAN	CDH PLAN	HMO PLAN
Participant	93%	85%	91%	76%
Dedendent	73%	67%	71%	56%

With these changes and the change approved by the PEBP at the December 2010 Meeting, expected out-of-pocket costs for participant will be:

	FY11 PPO	FY12 Current Plan	FY12 Change	
Single:				
Deductible	$800.00	$2,000.00	$1,900.00	
Stop-Loss	$3,700.00	$3,900.00	$3,900.00	
H SA Amount	n/a	-$600.00	-$700.00	
Out of Pocket	$4,500.00	$5,300.00	$3,200.00	
Family:				
Deductible	$1,600.00	$4,000.00	$3,800.00	
Stop-Loss	$7,600.00	$7,800.00	$7,800.00	
H SA Amount	n/a	-$1,200.00	$1,300.00	Assume 4
Out of Pocket	$9,200.00	$10,600.00	$6,500.00	

Nevada System of Higher Education
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November 18, 2010

Public Employee Benefits Program Board
c/o James R. Wells, CPA,
Executive Officer
901 S. Stewart Street
Suite 1001
Carson City, NV 89701

Dear Board,

As Chancellor of the Nevada System of Higher Education, I would like to first take this opportunity to thank the Board and the staff of the PEBP for all of your hard work. As you are aware, the issue of health care coverage is one of vital importance to the Nevada Higher Education System and its employees. The quality of our health insurance benefits is one of the significant factors in the recruitment and retention of quality faculty and staff, particularly in a budget climate in which we have experienced furloughs and continuing uncertainty.

As the magnitude of the financial impacts facing PEBP became apparent, I formed a task force to examine the changes occurring in our health care benefits. PEBP staff have assisted the task force by providing us with data through the vendors, and Chair Kirner, Vice Chair Ewing-Taylor and Executive Director Wells have provided us with background and explanations of the changes to the PEBP program.

While the work of the NSHE task force continues and should be completed by the end of the year, I would like to share with you some of the concerns that have emerged regarding the PEBP changes planned for FY 2012 plan year. Among the primary concerns that have been provide to me from the task force:

1. Deductibles are in addition to the "stop-loss" amounts, creating an even larger increase in out of pocket expenses. We understand the PEBP is planning to address this issue, and hope there will be some action on this at the December 2, 2010 meeting.
2. The new structure for prescription drug coverage will have significant financial impact on those individuals who are under regular monthly drug requirements.
3. Could PEBP consider offering a "low" and "high" deductible option as existed in the past, even with the assumption that the premiums would be significantly different?

4. We are interested in understanding what options for Dental coverage are being investigated by PEBP, either through a fully insured/participant paid program or partially covered by premiums, and whether PEBP is considering optional vs mandatory participation.
5. There is confusion as to why PEBP proposes 4 cleanings per year under the only remaining dental coverage, and whether a change to 2 would allow a redirection of funds to some other dental coverage area.
6. There is unique concern about the LTD reduction, as many NSHE employees are not eligible for LTD under Social Security or under PERS. While many State employees are eligible for disability retirement benefits under PERS, it in general does not apply to NSHE faculty and professional staff most of our professional employees are on the NSHE Defined Contribution Retirement Plan. This has a major negative impact on NSHE faculty and professional staff that is not true for any other PEBP covered employers.
7. There is great interest in understanding what rate reductions PEBP has negotiated, on behalf of its members, for covered medical procedures. The assumption is that in this economy vendors may be willing to agree to price concessions. What PEBP rate decreases over existing PPO in-network costs are projected for medical procedures for FY12/FY13? There is a desire to understand whether cost sharing will be absorbed by the medical providers, and not just the overall plan and the individual participants.
8. The same basic question as above, but for the HMO providers - what have been the results of the PEBP rate negotiations with HMO providers relative to the rates that would be effective for the FY12 plan year? Also, how are the health care providers selected? Again, is the cost sharing being absorbed, at least in part, by providers.
9. What are the PEBP assumptions on final enrollments for next plan year in the CDHP and HMO plans compared to existing PPO and HMO levels? What are the PEPB assumptions on the level of eligible participants that would drop all coverage? For those who might drop all coverage, what are the PEBP assumptions on whether this would result in any significant cost transfer to other health care programs in the state (e.g. HSS, UMC, etc.)?
10. A concern also is being expressed as to whether the HMO programs would even be able to support any significant increase in participants (given the number of health care providers now supporting those programs), especially a migration from the PPO plan, and how the premiums might impact any possible migration. The current assumption is that both the northern and southern HMO plans currently suffer from a significant lack of access to medical providers. What discussions has PEBP had with the HMO providers about their current and projected future ability to serve covered participants?
11. Our retirees (and those current employees that might be considering retirement in the near future) are specifically concerned about the implementation of the Medicare Exchange program, and having sufficient time to fully understand the program before it is implemented. What is the PEBP plan to help assure the implementation of this new program is effective and efficient?

12. There are a number of significant concerns arising from the new policy on spouse or domestic partner coverage. For a participant who covers their spouse or domestic partner, PEBP coverage will be eliminated for the spouse or domestic partner who have or who are eligible for overage under their own employer sponsored health plan (this policy exists now for any PEBP covered individuals).

    a. How is it feasible for PEBP to monitor and enforce this new policy, especially relative to whether the spouse or domestic partner declined alternative coverage from their employer? If it cannot be monitored and enforced, can it be effectively implemented?
    b. This policy has been in effect for PEBP participants, but combined with the large increase in deductibles will have a significant financial impact on PEBP covered employees (a cumulative deductible for a family under this circumstance will be $6,000, a combination of the individual and family) up from the existing cumulative deductible of $2,400 (the $6,000 would net down based on HSA contributions, but still represents a significant increase). Employees whose spouse/domestic partner works for a non-PEBP may also see a major financial impact as they will now be subject to two deductibles.
    c. There is also concern that the options available to a spouse or domestic partner through a non-PEBP plan may not be anywhere equivalent.
    d. A great concern has been raised relative to the fact that the PEBP plan year is on a fiscal year basis, where it appears the plan year for most employers is on a calendar year basis, meaning the spouse or domestic partner are currently in open enrollment (for a CY11 plan year) and it is not clear what viable options are available to deal with this first year of implementation of this new rule (given the overlap for the last six months of CY11 with the first six months of FY12 PEBP coverage). It is not clear the other employers outside PEBP will in fact consider this PEBP policy change as a "qualifying event" under their plan and allow a spouse to enroll in health coverage mid plan year. Has PEBP verified their assumptions about the qualifying event with other employers in the state, and if so, which ones?

NSHE set up a web site to gather employee comments/suggestions on the PEBP changes.

A summary of the 232 comments received to date is outlined below:

* employees saying they will opt out of PEBP benefits altogether
* employee considering or working on leaving NSHE
* employees considering or working on leaving the state
* recurring concern about retention & recruitment of quality faculty & employees
* concern about MS drugs & others being labeled "specialty drugs"
* many with the $6000 deductible issue for couples who both work for the state w/dependents
* recurring suggestions to reduce cleanings to 2 per year and add some dental coverage back into the basic plan.

I am including a chart of these comments for the Board's reference.

SURVEY RESPONSES		
As of November 3, 2010		
	Total Responses	%
Respondents	232	
Supports Changes	1	0.43%
Supports Extending the plan year	2	0.86%
Other comments/suggestions	229	98.71%
AREAS OF CONCERN		
Overall affordability	182	
High Deductibles	102	
High Out of Pocket Costs	93	
Dental	80	
Prescription	33	
Vision	30	
Lack of HMO Providers	14	
Blending of HMO Rates	13	
Spouse Eligibility	11	
Reduction in Life Insurance	8	
Reduction in LTD	4	
Medicare Exchange	2	

We understand that the State of Nevada and the PEBP Board have a daunting task of dealing with the State's budget situation. We wanted to let you know of the concerns our employees are expressing and the importance of this issue to the entire System. While we recognize many of these issues cannot be solved without adequate funding, as the NSHE task force completes its work, we will certainly continue our dialogue with PEBP about how these impacts can best be managed and any viable alternatives.

Yours truly,

Daniel Klaich

Cc: Vice Chairperson, Jacque Ewing-Taylor

Attachment #16

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**not members of the Task Force but provide support to the Task Force and Chair as needed