NSHE PEBP Benefits Task Force

Summary Notes from Meeting – October 24, 2012

1. **Follow-up on FY14 PEBP budget assumptions as "Flat" given FY13 increase was not fully utilized.** Details of this question were provided to Jim Wells on 9/17/12 via e-mail from Gerry Bomotti. Jim has indicated he is working on a response. Gerry will share the response from Jim when it is received.

2. **Review of November 1, 2012 PEBP Board Meeting agenda and discussion of any issues for public comment.** The agenda just came out prior to the Board meeting and it was not discussed, however, we will get out an e-mail discussion of the agenda items in the near future and seek Task Force comments on whether or not any public comments should be provided by NSHE.

3. **Status of PEBP Board openings**. Michael Torvinen from the Department of Administration in Carson City was named to the Board earlier this month to replace Cindy Jones (not a Governor-appointed slot). There remains one currently vacant slot (formerly held by City of Elko), and there is an assumption that one existing member will resign in the near future.

4. **Status of BBI's analysis of data from PEBP on NSHE employee claims, and discussion of near term employee health care benefit options to bring to the November 2012 Board of Regents meeting**. BBI was at the meeting and helped lead a discussion about the data they had received and the modeling they had completed. A summary of this discussion is outlined below.

Overall Background Note: Improvements to the existing health care program have been a priority for NSHE. The current health care program negatively impacts our ability to recruit and retain faculty and staff, and puts many of our employees (especially those that are lower paid) at significant financial and health risk. One of the goals of the Task Force has been to focus on options for better health care programs for our faculty and staff, and recognizing the financial realities, we have assumed that this would have to be done within the existing budget (but not a reduction in the budget in order to save employer funds and provide the same level of unacceptable health care coverage for our employees). It should also be noted that we would have liked to get experience data for all PEBP covered employees, in order to better and more fully understand the context for the NSHE experience data, as well as better understand potential options for all PEBP participants. However, we were not allowed to have access to the non-NSHE PEBP experience data, and spent a great deal of time simply obtaining the data we received on NSHE employees participating in PEBP.

A. We/NSHE initiated requests for detailed NSHE experience data on all employees in February 2012. This data is needed in order to understand our current coverage levels, their costs and whether there is a reasonable basis for achieving better options for health care coverage for our employees in the future. We received the last batch of data a few weeks ago, but were not able to get all the information we would have desired (to include data on all of PEBP covered employees in order to review that experience data as well). However, there was sufficient data in order to provide reasonable models for both the relative experience of NSHE employees within the overall PEBP, as well as to model potential costs for the same basic benefits through a fully

insured approach. The limitations on data, however, do not make this a perfect model but the general outcomes of the analysis should be statistically sound. It was also noted that this overall lack of data by PEBP could be an important contributing factor to their pricing levels for PEBP programs. The PEBP, in their July 2012 budget request, noted the desire to initiate a new program whereby they would be able to collect all data on employees covered by PEBP (exactly like the data we have requested) in a single database within PEBP.

B. Based on Calendar Year 2010 and 2011 experience data from PEBP for NSHE employees, BBI modeled these two years retroactively, treating NSHE as a self-contained self-funded system. They made the following (conservative) assumptions and projections:
-Assume the very same health care programs for NSHE employees and the exact same distribution by program type (HMO vs. PPO/CDHP) and based on costs per employee location (e.g. north, south, rural).
-Assume all HMO expenses (since it is fully insured) remain the same, which means for approximately 1/3rd of the total NSHE population there would be no projected cost savings.
-Use the actual data from PEBP for the costs for all NSHE employees in the PPO/CDHP.
-Assume the PERS retirees in NSHE had the same average experience as the defined contribution retirement plan retirees (since we were not able to get the PERS retiree data).
-Assume 10% or up to 15% administrative overhead costs for the NSHE employees (PEBP reports they are at about 8%, or at least that is their defined target and it appears from their financial statements this is about their level).

Based on these assumptions, the medical loss ratio ranged from approximately 65% to 75%, or total projected savings over actual PEBP expenditures of $10.2 - $22.6M per year, depending on the year and the assumption on administrative costs (10% vs. 15%). For CY11 the potential savings might range as high as approximately 27%, based on this model.

C. Using the data available, BBI projected a fully insured NSHE plan for calendar year 2011, working with a large and well experienced vendor. They projected the financial outcomes for CY12, under the following assumptions.
-Assume the very same health care programs for NSHE employees and the exact same distribution by program type (HMO vs. PPO/CDHP) and based on vendor's projected claim costs per employee location (e.g. north, south, rural).
-Assume all HMO expenses (since it is fully insured) remain the same, which means for approximately 1/3rd of the total NSHE population there would be no projected cost savings.
-Adjust for the actual employer contributions during this time period.
-Used most recent CY (2011) data from PEBP and trended PPO/CDHP by 7% (higher than overall average increase in medical CPI) and includes additional ACA (federal health care law) projected additional costs.
-Worked with a vendor and gave them the detailed data we had received from PEBP including, but not limited to, NSHE employee experience and location and asked them to price the cost of a fully insured health care program for the PPO/CDHP. The vendor had north/south data on each NSHE employee and used this information to model estimated costs based on their location (e.g. north, south, rural), in addition to other typical considerations. BBI cannot give us the name of the specific vendor they used, but they have confirmed they are a market leader in the western region of the US with millions insured. In Nevada they are present both in the north and south and have comparable networks of providers to that which the PEBP utilizes now. The vendor

used the data we were able to get from PEBP and did their normal thorough and methodical analysis of the population in order to come up with their estimates.

Based on these assumptions, the vendor provided total costs that were approximately $15.6M less in the year than the actual expenditures for NSHE within PEBP - which equates to approximately a 17% savings. By contrast the total employee contributions towards premiums for the last CY were approximately 18% - meaning that this model projects (it is important to note these are all projections) a savings about equivalent to what all employees paid in premiums.

D. The final model projected by BBI was to look at the total annual expenditures for the last cycle and determine what options for health care might be available to NSHE employees within this total budget. This model also had many assumptions including but not limited to:
-Used a standard model to predict selection by NSHE employees into the various options modeled.
-Used the experience data from PEBP for NSHE employees as the basis for costs.
-Used the vendor's data on projected health care and administrative costs for employees based on their location (north, south, rural, etc.)

Based on these assumptions BBI projected that NSHE could offer to employees, within the same overall total budget, the following types of options for health care:
-A Point of Service plan with relatively rich benefits.
-An HMO program roughly equivalent to what is offered today within PEBP.
-A "middle tier" PPO program similar to what was offered prior to FY12.
-A CDHP similar to what exists today within PEBP.

Overall comments/concerns/discussions:
*The report from BBI was received just prior to the meeting, so it was very hard to fully understand it within such limited time.
*There were significant and serious questions concerning whether or not the model accurately captured cost differences for health care between the north and south, and in rural areas, even though BBI stated that employee location was a specific variable in their model. BBI has noted, however, that all claims data that was available from PEBP was used to analyze and capture these differences in costs north and south (and rural). It is noted that the analysis done so far is NOT a substitute for getting final quotes from vendors, but represents a modeling that provides important feedback for NSHE decision makers. However, the only absolute way to remove the perceived risk to the northern participants is to move forward with the appropriate, standard, detailed and methodical methods of securing firm commitment underwritings based on careful plan design.
*Given we could not get all the data we wanted from PEBP, the models have some level of error.
*The data does seem to suggest there is a reasonable assumption that better health care coverage for NSHE employees can be achieved, within the same total expenditures. More analysis and pursuit of this is needed.
*BBI believes this modeling provides strong evidence to support the assumption that significantly better health care benefits for our employees and retirees for the same budgeted level is feasible. Health care for our employees and retirees is a very high NSHE priority,

especially affordability for our lower paid employees.
*There was overall agreement from the Task Force that this remains a very high priority issue – better health care options for our employees – and this should be pursued in some reasonable way. However, there was not agreement as to how/if we are ready for a discussion at the Board of Regents meeting on this modeling done by BBI. We will talk with the Chancellor about the status of this issue and seek his input for appropriate next steps.

5. **Status of follow-up items from last quarterly meeting with PEBP staff, and schedule for next quarterly meeting**. The following items remain on our listing for quarterly discussions with PEBP staff. ***Updates are noted based on the October 15, 2012 quarterly meeting***:

*Open enrollment data from this last cycle. We would like to get from PEBP the open enrollment details for all NSHE employees, specifically relative to changes made (including dropping PEBP coverage). Pat LaPutt provided a summary chart on NSHE enrollment information in PEBP for planned years 2011, 2012 and 2013. The total HMO enrollments have stayed about the same over this time period, with reductions in the PPO/CDHP. Declined percentages were at 1.8% for PY11, 7.2% for PY12, and 6.63% for PY13, with the declines correlated with income (low) level. We will get information broken down by BCN/BCS in the near future.

*Development of a viable "middle tier" option for employees in the future. Rejected for FY13, but we have raised this issue for FY14/FY15 planning. *No recent update, although it is on the November 1st PEBP agenda for discussion.*
*Provide read access to E-PEBP system for NSHE employees by some key NSHE HR staff. Concern was expressed about how long NSHE would stay with PEBP. Apparently PEBP will prepare a memo outlining the plan and costs for such an approach and send it to us in the near future. Additionally, this was noted at the last PEBP Board meeting and the impression was that PEBP was not pursuing this at all – we need to follow-up to check on status. *Most recent update: PEBP is back to asking if there are HIPAA issues that prevent such access. PEBP is also now expressing concerns that all questions should go directly to PEBP vs. being handled by trained NSHE HR individuals. As of early September we did hear from PEBP staff about the specific data elements that we needed access to. We hope this means that this item is back under consideration and that we will have access to the system in the near future. October update: PEBP does not appear inclined to grant any such access.*
*Provide current contracted prices for health services to PEBP employees, in a similar approach to the prescription drug information currently available. PEBP indicated they are working with network providers to make this available, perhaps through a HealthScope secure website. However, no specific schedule was indicated. *No recent update.*
*Address the current delays in new NSHE hires receiving their information from PEBP. A new form was created that we think will be helpful, in addition to the plans for NSHE to add some language/information to the standard offer letters. *October update: PEBP is testing a new FAX process.*
*Status of HSA/HRA changes that impacted NSHE distribution of W-2's. PEBP is going to make some schedule changes to help with this issue in future years, but noted they expect additional tax year 2011 adjustments to come forward in the near future – this will cause a problem for NSHE relative to manually issuing revised W-2's (and the fact some employees likely already completed their tax filing) and the potential for additional fines. In fact, NSHE

received another round of corrections impacting the W-2's in April. We would like to recommend to PEBP that NSHE handle employee contributions to these accounts like all others we already handle, and then feed these deductions to HealthScope. This would eliminate this as a problem for the future. Update: PEBP staff is now indicating that they are considering allowing NSHE to push the data to HealthScope for the HSA voluntary deductions. The recent issues with HealthScope and the June (now paid in July) payroll and failure to capture voluntary HSA contributions also were a problem for many NSHE employees. There were also comments on problems accessing the full funding in the HSA accounts early in the calendar year. *October update: PEBP indicates that the NSHE process for working with HealthScope is different/ unique from other state entities and they will help us push our data directly to HealthScope; otherwise they are opposed to this option. PEBP staff indicated they were not aware of these more recent issues with HealthScope files with errors in it to NSHE but will address them with HealthScope. It was also noted that NSHE could create HSA accounts for its employees as a substitute for, or in addition to, what PEBP has – we will review this to see if there are any viable options for us to consider.*

*Health Care Concierge program. We would like to see PEBP move forward to issue an RFP to bring on such a vendor, or allow NSHE to pilot this program for PEBP. PEBP was indicating that there are legal reasons why they cannot enter into such a program and the same reasons prevent us from running a pilot. We are trying to get more specific information from PEBP on the legal interpretation. *October update: PEBP in the midst of negotiations with Jack London group for a 6-month pilot program (July 2013 – Dec 2013); if the pilot can be worked out and shows benefit compared to their current vendor programs they will consider extending it, or decide if this is a unique service or not and whether they go out to bid.*

*Work with PEBP to cooperate on a follow-up survey of participants next fall, so we can track who made changes and why. We will ask Chris Cochran to prepare a proposal for what type of survey we would have so that we can share this with PEBP staff.

*We would like to talk with PEBP staff about any opportunities in the "medical tourism" area, which they are apparently investigating. We will share this item with Marcia Turner as an FYI.

6. **Next Task Force Meeting**. The PEBP Board's next meeting is December 13, so we will look to meet the week of December 3rd. (The PEBP Board's 2013 meeting schedule is included in their November Board agenda for approval and we will continue to schedule our meetings just prior to their meetings, if possible.)

7. **Potential Future Agenda Items**:

* Follow-up on FY14/FY15 PEBP state funding levels compared with FY13.
*BBI report on NSHE health care models based on data from PEBP.
* Open enrollment final data for NSHE employees: annual comparison to previous year's enrollment, including those that opt out, vs. the new year, including shifts between the CDHP and the HMO.
*Status of voluntary NSHE supplemental benefit offerings, and specifically the feasibility of vision and long-term care being added.
*Discussion about a potential follow-up after the start of the new plan year to track any changes by NSHE employees.
*Priority items to highlight at future Board of Regents meetings.
*Status of follow-up items from last quarterly meeting with PEBP staff, and schedule for next quarterly meeting.

*Review next PEBP Board agenda for possible comments during public comment.
*PEBP Board openings.
*Information on HMO participant change from FY11 to FY12, as well as changes from FY12 to FY13.
*Meet with BBI to discuss longer term planning for NSHE health care options.
*Invite SDM and UNSOM representatives to discuss options for providing services to NSHE employees.