

**NSHE PEBP Benefits Task Force**

**Summary Notes from Meeting – December 4, 2012**

1. **Follow-up on FY14/FY15 PEBP State funding levels compared with FY13.** Although we have not received a written response from PEBP, we did have a phone conversation with Jim Wells. It does appear the FY14 PEBP budget request was for a lower level of funding than the FY13 base, but there was an increase built in for FY15.

2. **Review of December 10, 2012 PEBP Board meeting agenda** and discussion of any issues for public comment. Agenda item VI relates to the “middle tier” proposal. The summary information we provided to PEBP on the middle tier option is highlighted below:

Priority Items for a Middle Tier Plan.

A. The key priorities for health care for NSHE employees are access to affordable health care necessities for the employee and their dependents. These are base level and critical needs. Our view of the middle tier program is significantly impacted by these assumptions on priorities.

B. The middle tier program proposed by PEBP staff at the November 1, 2012 PEBP Board meeting would be a great option to implement, if the premiums could be adjusted within the parameters noted below.

C. If the implementation of the PEBP middle tier proposal from November 1, 2012 within the premium levels noted below is not feasible, we offer the following key principles. A viable middle tier alternative must present options for employees in between those currently presented by the CDHP and the HMO. In our view, the key elements that cannot be compromised in a final middle tier structure are noted below:

\*Rx program with co-pays, a reasonable deductible, and with a very strong priority on generic.

\*Monthly premiums within the parameters noted below:

Participant only	<\$100
Participant + Spouse	<\$350
Participant + Child(ren)	<\$200
Participant + Family	<\$450

\*Co-Pays for Access to Services within the parameters noted below:

Primary Care	No greater than \$25
Specialist	No greater than \$40
Urgent Care	No greater than \$60

The recommendation from PEBP staff is not to implement a middle tier option. After some discussion, we agreed the Task Force should highlight the following items at the PEBP Board meeting on 12/10/12:

\*The priorities we shared with PEBP about the middle tier design, which are noted above.

In general, the proposal in the PEBP packet is pretty close to our priorities, except for the monthly premiums.

\*That we continue to be supportive of the Board adopting a middle tier option for FY14, even if the participation in the wellness program is made mandatory.

\*Gerry Bomotti will follow-up with Jim Wells to ask him for the monthly premium estimates for the middle tier program with the participation in the wellness program being mandatory (in our previous phone conversation the reduction in rates was very significant), and Gerry will ask him to define who the participation in the wellness program is mandatory for (e.g. employee only vs. others).

\*Renee will check with the PEBP Chair to see if we can make our comments on the middle tier proposal at the time this is under discussion, or if we will need to make them at the public comment time at the start of the meeting.

\*Chris Cochran will review the survey from last year and highlight any information which would be useful to include in the public comments from NSHE on the middle tier option.

We will also want to follow the discussion on the Executive Officers Report on “London Medical Management Pilot.”

Gerry Bomotti will talk with Pat LaPutt and Michelle Kelley about who can make these comments at the 12/10/12 PEBP Board meeting.

3. **Status of PEBP Board Openings.** Romaine Gilliland has been appointed to fill the retiree spot previously held by George Campbell. Mr. Gilliland served as Administrator of the Division of Welfare and Supportive Services from 2008-2012. He retired in January 2012. Mr. Gilliland has been a Carson City resident since 1987. He received his Bachelor of Science from the University of Nevada, Reno and is licensed as a CPA.

Ashok Mirchandani, the Deputy Director of the Department of Business and Industry, has been appointed to the seat representing State Management previously held by Chuck Duarte. He is based in the department’s Las Vegas office. Previously, he was Chief Financial Officer of Workforce CONNECTIONS and, before that, Assistant to the Director at the state Department of Employment, Training & Rehabilitation.

A complete list of PEBP Board appointments is noted below, with one vacancy remaining:

PEBP Board Member	Date Appointed	Expiration Date	Location	Additional information
Ronald Bratsch	6/2012	6/2016	Carson City	
Leo Drozdoff	9/2008	6/2015	Carson City	
Jacque Ewing Taylor	2/2002	6/2016	Reno	Re-appointed 7/2012
Jeffery Garofalo	7/2011	6/2015	Las Vegas	Private atty - Las Vegas
Romaine Gilliland *	11/2012	6/2016	Carson City	
Ashok Mirchandani *	11/2012	6/2016	Las Vegas	
Robert Moore	6/2011	6/2015	Sparks	
Mike Torvinen	10/2012	None	Carson City	Budget Director designee - no exp. date

VACANT – non-state rep	Formerly held by Dawn Stout, but City of Elko left PEBP 6/30/2012 so new rep will need to be appointed and doesn't need to be a non-state person
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We continue to hope that Chris Cochran will be an NSHE appointment for the remaining PEBP Board vacancy.

4. **Status of BBI's analysis of data from PEBP on NSHE employee claims, and follow-up from last Task Force meeting.** There is a meeting with PEBP Staff and Board Leadership scheduled for December 5, 2012 to review this report/information, and the Chancellor will be in attendance. A copy of the complete BBI report was provided to the Task Force with this Agenda (see attached).

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. The only update from the last report is on the middle tier program.

\*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 previously 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.

\*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 (Jan. 2013 – June 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. December 2012 update: This item is on the 12/10/12 PEBP Board agenda for discussion.*

\*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. *December 2012 update: We have asked Chris to give a proposal for what GA support he would need to work on this follow-up next Spring, and to have a written proposal to share with PEBP as to the proposed survey.*

\*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. We will schedule this prior to the January 17, 2013 PEBP Board meeting.

7. **Potential Future Agenda Items:**

- \*Status of follow-up Survey. Chris Cochran.
- \*Status on Middle Tier Plan.
- \*Status of outcome from 12/5/12 Meeting with PEBP and Chancellor Klaich.
- \* 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.
- \*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.

**NSHE Benefits Review and Analysis**

Prepared By Business Benefits, Inc.

At the request of the

**Nevada System of Higher Education**

**11/30/2012**

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## **Executive Summary**

On March 9<sup>th</sup> 2012, NSHE entered into a contract with Business Benefits Inc (BBI) for an analysis of NSHE health benefits provided to its employees. Specifically, NSHE requested that BBI provide a comprehensive review of PEBP performance relative to NSHE, including an analysis of the strengths, weaknesses, and documented comparisons with health care coverage that NSHE could achieve on its own. Additionally, BBI was asked to review and evaluate PEBP plans for NSHE employees and retirees for FY13, and possibly subsequent years, including a potential middle tier health plan option, and to assist NSHE in determining if there were options to improve employee benefits under the current structure of the Public Employees Benefits Program (“PEBP”) and what other options may exist. As part of this analysis, NSHE requested BBI to use claims data from the PEBP to help it determine whether the NSHE population was a higher or lower risk population compared to the rest of the State.

Improvements to the existing health care program have been a priority for NSHE for some time. The current health care program negatively impacts NSHE’s ability to recruit and retain faculty and staff, and places many employees (especially those that are lower paid) at significant financial and health risk.

## **Preliminary Findings and Results**

- Given that PEBP was unable to provide all the data requested, the models have some level of error. We attempted to mitigate the error as much as possible by working with the PEBP to reach agreement on many of the necessary assumptions used as part of our analysis.
- The results of the analysis do suggest that it is reasonable to assume that better health care coverage for NSHE employees can be achieved within the existing



budget. More data, analysis and pursuit of this finding are required.

- Health care for NSHE employees and retirees is a very high NSHE priority, particularly affordability for lower paid employees.
- Based on the data received from PEBP, and the subsequent analysis performed, we have determined that the NSHE risk is better than that of the aggregate PEBP population; therefore, benefits for NSHE can be enhanced within the current budget.
- Although not guaranteed, it is reasonable to assume from the limited data available on the balance of the state population that healthcare benefits can be improved for all State Employees at no additional cost on an aggregate basis utilizing our recommended model. (Note: We requested data on the entire PEBP pool but were only able to get data on the NSHE Employees).

### ***Calendar Year 2011 – Potential Savings***

Based on Calendar Year 2010 and 2011 experience data from PEBP for NSHE employees, we made the following (conservative) assumptions and projections:

- Assumed identical health care benefits for NSHE employees to those that are currently offered by PEBP, identical distribution by program type (HMO vs. PPO/CDHP) and underlying costs per employee based on location (e.g. north, south, rural).
- Assumed all HMO expenses (since it is fully insured) remained the same, resulting in approximately 1/3rd of the total NSHE population generating no projected cost

savings.

- Used PEBP provided cost data for all NSHE employees in the PPO/CDHP.
- Assumed PERS retirees in NSHE had the same overall experience as the defined contribution retirement plan retirees because PEBP was unable to provide the PERS retiree data.
- Assumed 10% and 15% administrative costs within our models for the NSHE employees (PEBP reports they target 8%, this is supported within the audited Financials)

Based on these assumptions, the loss ratio (percentage of total cost vs. total funding) ranged from approximately 65% to 75%, or total projected cost reductions as compared to actual PEBP expenditures of \$10.2MM - \$22.6MM per year. This depended on the year and the administrative cost assumption used (10% or 15%). For CY 11 the potential savings may have resulted in cost reductions to NSHE of up to 27% based on this model.

### ***Calendar Year 2012 – Projected Savings***

Using the data provided by PEBP, we next projected the financial outcomes for CY12, using the following assumptions:

- Assumed identical health care benefits for NSHE employees to those that are currently offered by PEBP, identical distribution by program type (HMO vs. PPO/CDHP) and underlying costs per employee based on location (e.g. north, south, rural).

- Assumed all HMO expenses (since it is fully insured) remained the same, resulting in approximately 1/3rd of the total NSHE population generating no projected cost savings.
- Adjusted for actual employer contributions during this time period.
- Used most recent CY (2011) data from PEBP and trended PPO/CDHP cost by 7% to account for both the increases in costs for 2012 and the projected trend for the illustrated 2013 CY. Although the average annual 3.5% upward cost adjustment is conservative we felt it important to remove any perception of bias. The 2013 trend adjustment includes additional ACA (federal health care law) projected costs of at least 3% for transitional reinsurance costs and fully insured plan mandated taxation.

We then requested a vendor to price the cost of a fully insured health care program for the PPO/CDHP. The vendor was provided 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.

The vendor is a market leader both nationally and 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 limited data we received from PEBP and did their normal thorough and methodical analysis of the population to provide pricing for NSHE.

Based on these assumptions the vendor provided a fully insured quote identical to the current PPO/CDHP provided through PEBP. This resulted in approximately \$15.6MM in prospective reduced cost effective 1-1-13 as compared to the actual expenditures for NSHE within PEBP. This cost reduction equates to approximately 17%. It is important to note that the total employee contributions towards premiums for the last CY were approximately 18%. The cost

reductions projected are approximately equivalent to what all employees paid in premiums.

### ***Private Exchange Model***

The third model we prepared illustrates a private exchange. The exchange is a defined contribution model that assumes total annual expenditures for the last cycle and illustrates what options for health care benefits might be available to NSHE employees within the existing budget. This model incorporated many assumptions including but not limited to:

- The use of a standard model to predict plan selection by NSHE employees.
- Experience data from PEBP coupled with the assumption that the NSHE population is no better or worse than the illustrated group as the basis for costs.
- Used vendor's data on projected health care and administrative costs for employees based on their location (north, south, rural, etc.).

Based on these assumptions we projected that NSHE could offer to employees, within the existing budget, the following types of options for health care:

- A Point of Service plan with relatively rich benefits.
- An HMO program equivalent to what is offered today within PEBP.
- A "middle tier" PPO program similar to what was available prior to FY12.
- A CDHP similar to what exists today within PEBP.

### ***Limitations of the Analysis***

BBI, together with NSHE, initiated requests for detailed NSHE PEBP data on all employees in February 2012. This data was required to review current coverage levels, costs, and to determine if a reasonable basis for achieving better health care coverage for NSHE employees existed. We received the last of the data in September from PEBP. Unfortunately, PEBP was unable to provide the information we requested in its entirety. Our request included data on all PEBP covered employees in the aggregate to develop a more comprehensive review.

It took more than six months for us to accumulate all of the data necessary to conduct our analysis because of limitations within PEBP with respect to data collection and storage, although the information requests are the same as those we utilize frequently within the industry. In addition, it is common in the industry for us to receive responses to the standardized requests for data within two weeks or less. PEBP does not appear to track and collect data in the same ways as typical private insurance carriers.

It is important to note that we also requested experience data for all PEBP covered employees, in order to better and more fully understand the context for the NSHE experience data, and to better understand potential options for all PEBP participants. We were denied access to the non-NSHE PEBP experience data. This increases the difficulty in providing concrete analysis concerning the overall improvement of the benefits for NSHE employees within the PEBP structure. Nevertheless, based on the preliminary analysis as described in this report, we believe that it is likely that benefits for all State employees can be improved at no additional cost.

Although we did not receive all that we had requested, there was sufficient data provided to develop reasonable models for both the relative experience of NSHE employees within PEBP and to model potential costs for the same basic benefits through a fully insured approach. The lack of complete data resulted in a less than perfect model although, generally, the outcomes of the analysis should be statistically sound.

The lack of data collected and tracked by PEBP could be an important contributing factor to their pricing levels for PEBP programs. The PEBP, in their July 2012 budget request for the next biennium, indicated a need for more funding to initiate a new program whereby they would begin to collect data on employees that we had requested, and that they are currently unable to provide, in a single data base within PEBP.

## Market Overview and Trends

Group medical insurance markets are ever changing. Legislative changes alone that have occurred over the last several years have had, and will continue to have, significant impact on consumers, insurance carriers, employers and the medical profession.

Conditions nationally reflect several ongoing changes. Pharmaceutical costs are increasing. Technology is outpacing the capacity of the existing medical delivery systems to support the cost of new and improved equipment. Insurance carrier and hospital group consolidations via mergers or acquisitions continue to make the market choices smaller and more controlled by a few powerful companies.

Plan designs are constantly reinvented to try to maintain cost control. Consumers demand more choice and are more knowledgeable. Private HMOs and PPOs by and large have been running thin margins. Average nationally is approximately 4.4% before income taxes.

Many self-funded plans have been experiencing cost overruns and have in many instances moved part of their insured populations to fully insured managed care plan designs forgoing the potential savings previously enjoyed, in exchange for pricing stability and medical care delivery cost controls.

Overall, the trend can be summarized by more consolidation of the insurance and hospital industry, increasing medical delivery costs, more and better "life enhancing pharmaceuticals" with heavier utilization, and increasing premiums if no action is taken.

## NSHE Stated Objectives

- Reduce and stabilize costs to NSHE participants to affordable levels, particularly for lower income staff.
- Stabilize and improve benefits, especially Rx and access to basic doctor visits.
- Consider supplemental benefits as possible interim solution.
- Build the framework for possible future expansion of plans.
- Provide more choice to participants/ increase access to providers.
- Provide competitive health care benefits in order to effectively recruit and retain faculty and staff.

The changes in the PEBP that were implemented July 2011 have significantly increased the out of pocket costs for many NSHE participants. The increased deductible coupled with increasing cost of pharmaceuticals has created the bulk of the burden, especially on lower income employees.

Additionally, concerns that the HMO networks are inadequate to support the enrolled populations both north and south and changes in HMO employee contributions required by the blending method have generated negative employee feedback.

Because a large segment of the population uses drugs to treat chronic disease, the visibility of the reduced benefit is high and impact is widespread.



## Benefits Review and Analysis

Business Benefits Inc. was retained by Nevada System of Higher Education (NSHE) to provide analysis and recommendations to NSHE regarding the health care programs offered to NSHE employees through PEBP. Included in this report are background data and recommendations. This analysis provides NSHE with information needed to make informed decisions regarding the current plans and possible future direction.

NSHE's ability to retain and recruit faculty and staff were stated as primary goals, which requires access to affordable care for employees and their families/dependents.

There are three primary components within the report:

- I. Historical perspective
- II. Prospective cost estimates matching current benefits
- III. Prospective alternate benefits

I. Our historical perspective assumes the current benefits provided by PEBP to NSHE were delivered to NSHE independent of all other state employee populations. This review was based only on the NSHE related data we were able to acquire from PEBP and as such some assumptions had to be employed in the analysis. We had asked for PEBP data in the aggregate as well, however, they have declined to provide this, citing various legal issues. Although not critical to the historical analysis, this data may be helpful in the future. The purpose of the analysis was to illustrate the relative risk of NSHE as compared to the aggregate population.

II. The prospective cost estimates with matching benefits were prepared using the same historical claims data, however, for this analysis we endeavored to provide NSHE with a comparative model. We used a commercial insurer to underwrite the current high deductible plan design. This analysis generates an exact match of benefits and assumes the same funding

sources and amounts. This results in an equal comparison of both the current PEBP plans and a hypothetical group of plans replacing the aggregate PEBP population with that of NSHE's, and replacing the PEBP self-funded delivery mechanism with a fully insured private carrier.

III. Lastly, we illustrate prospective alternate benefits that include several choices of plan designs including a high deductible plan not unlike the current plan offered by PEBP in design and funding features. This model is commonly referred to as a private exchange. In proposing alternatives to the current plans it should be made clear from the onset that the design possibilities are infinite, and that as such, no one entity can be completely objective in this process. We have included in this section an example of current plans offered to comparable employers in both size and employment type. This portion of the analysis assumes that the NSHE population is no better or worse than the illustrated group and as such, costs will be commensurate with that of the example. Based on our historical analysis this hypothesis is reasonable but not guaranteed.

## **I. Historical Perspective**

We have constructed a comparison of the Nevada System of Higher Education (NSHE) paid premiums during 2010 and 2011 to premium estimates during that time period had NSHE been rated solely on its own claims experience. Our results reflect two scenarios under which past premiums were estimated using expense ratios of either 15% or 10%. We believe our expense estimates are conservative as compared to the PEBP target of 8%.

### ***Results***

The results below summarize the estimated NSHE health plan premiums for the 2010 and 2011 calendar years under the two aforementioned scenarios both illustrate that NSHE would have experienced lower overall cost had they been self-funded on a standalone basis during the periods reviewed reducing overall annual costs by 10MM to over 22MM:

**Calendar Year 2010**

Premium	Claims Experience w/15%Expens Ratio	Difference	Claims Experience w/10% Expense Ratio	Difference	Medical Loss Ratio
<b>Active</b> \$80,220,648	\$63,749,930	\$16,470,719	\$60,208,267	\$20,012,381	67.5%
<b>Retiree</b> \$5,454,082	\$11,728,043	(\$6,273,962)	\$11,076,485	(\$5,622,404)	182.8%
<b>Total</b> \$85,674,730	\$75,477,973	\$10,196,757	\$71,284,752	\$14,389,978	74.9%

**Calendar Year 2011**

Premium	Claims Experience w/15%Expens Ratio	Difference	Claims Experience w/10% Expense Ratio	Difference	Medical Loss Ratio
<b>Active</b> \$78,808,519	\$58,575,883	\$20,232,636	\$55,321,667	\$23,486,852	63.2%
<b>Retiree</b> \$4,084,100	\$5,227,103	(\$1,143,003)	\$4,936,708	(\$852,608)	108.8%
<b>Total</b> \$82,892,619	\$63,802,986	\$19,089,633	\$60,258,376	\$22,634,243	65.4%

Total retiree claims and enrollment information was not available (PERS retirees missing), therefore we have developed results only for the retiree subset noted within the files used for our analysis.

The incorporation of the missing retiree claims and enrollment may result in altered “Difference” amounts. Please see the Methodology and Assumptions section for an explanation of how the above amounts were determined.

***Methodology and Assumptions for the Historical Perspective Model***

Utilizing the provided information, we estimated the amount of claims which have been incurred but are not yet paid using a claim reserve model, which utilizes amounts and patterns of historical payments in order to estimate the amount of claims which have been incurred but are not yet paid. As the HMO plans are understood to be mostly capitated (not fee for service) there was no estimation of the amount of claims which have been incurred but are not yet paid applied to the HMO portion. In addition, no “completion” was applied to the prescription drug

claims of both the PPO and the HMO plans, as prescription drug claims are assumed to already be complete. We then summarized the claim costs, separately by calendar year and by active/retiree to develop total claim costs for these categories. We then estimated past premiums for each category by applying expense ratios of either 15% or 10% of total costs. As the Hometown Health (HTH) claims information did not contain an identifier for retiree status, we used Medicare eligibility status as a proxy. To the extent that this assumption may be incorrect, it would not alter the differences in total. However, it would increase the retiree claim costs, while decreasing the claims costs for the active category.

We have assumed that the claim information provided reflects the following:

- a. is reduced by Coordination of Benefits savings,
- b. is not reduced by subrogation savings, if any,
- c. does not include reinsurance recoveries (i.e.: are not reduced by),
- d. is not reduced by voided claims,
- e. reflects negotiated reimbursement rates and provider discounts, if applicable, north, south and rural areas.
- f. is reduced by stop payments and/or provider refunds,
- g. includes out of area claims payments,
- h. includes all capitation payments,
- i. includes all withholds, and
- j. does not include network access fees
- k. component used the data provided by PEBP, for each employee, for component II we used the same data for each employee that we used for option I. Component III is an example of the NSHE population being no better or worse than the illustrated group and as such, illustrative costs will be commensurate with that of the example. Based on our historical analysis, consultation with the commercial carrier and broad based estimates as to underlying contracted cost of care both north, south and rural areas this hypothesis is reasonable but not guaranteed.

These assumptions were necessary in order to complete the requested analysis. To the extent that these assumptions are inconsistent with the information provided the results could differ. Further, we utilized the provided enrollment and premium rates by tier to estimate the aggregate premiums paid by NSHE for 2010 and 2011 calendar years. Note that the premium rates are inclusive of both the state and employee contributions (including HSA/HRA contributions by PEBP for those periods they existed in CY2011).

## II. Prospective Cost Estimates Matching Medical Benefits

This perspective illustrates the cost of a fully insured group of plans provided to the Nevada System of Higher Education (NSHE) rated solely on its own historical claims experience. Our results reflect the estimated pricing of an identical mix of plans that currently exist for NSHE employees through PEBP. We include the two currently available HMO's at the current blended premiums for illustrative purposes only. We included current funding of the HRA accounts, and removed funding for dental, Life and LTD. The exclusion of dental, life and LTD funding was required to maintain a comparable analysis, as the PEBP claims received ultimately excluded those items at our request.

This method of review provided the comparative validity check against the historical perspective. The commercial insurer selected to underwrite and quote this project insures tens of millions throughout the US, is a market leader in the region and within the state of Nevada. The commercial insurer was not aware of the historical analysis preparation or its results.

The cost reductions depicted are a result of comparing both unadjusted and adjusted costs of the current plans and commercial insurer plans illustrated. Commercial plans build in trend for the 2013 calendar year, profit, assume underlying provider contract costs, and insurer operating expenses. Not unlike the previous historical self-funded model, NSHE would have experienced a lower overall cost of between 9.8MM and over 15MM annually had they been fully insured on a standalone basis during the periods reviewed.

## Results

Current Cost Unadjusted for 2013 trend		Prospective Commercial Premium w/ trend adjustment		Cost Reduction	
Active	\$78,808,519	Active	\$69,702,404	Active	\$9,106,115
Retiree	\$4,084,100	Retiree	\$3,329,923	Retiree	\$754,177
<b>Total</b>	<b>\$82,892,619</b>	<b>Total</b>	<b>\$73,032,327</b>	<b>Total</b>	<b>\$9,860,292</b>
<b>Total w/ Trend *</b>	<b>\$88,695,102</b>			<b>Total w/ Trend*</b>	<b>\$15,662,775</b>

\*Projected PPO/HDHP trend 2013 @ 7% no trend in HMO rates were assumed.

### III. Prospective Alternative Benefits

This section of the analysis illustrates a model commonly referred to as a private exchange. The Exchange is a defined contribution model. This portion assumes that the NSHE population is no better or worse than the illustrated group and as such, costs will be commensurate with that of the example. Based on our historical analysis this hypothesis is reasonable but not guaranteed. Until we are able to develop and release a comprehensive RFP to multiple fully insured carriers both north and south this hypothesis will remain unproven. This component was developed using a known model and assumptions as to future costs, contracting leverage, and design features that, in the estimation of several experts, would more likely than not materialize once a formal RFP was developed, released, negotiated, and implemented.

The Clark County School District (CCSD) employs this benefits delivery method for the support staff employees. Federal employees have had this delivery system in place for many years. Medicate eligible Nevada state retirees have the option to participate in Extend Health which is a private exchange model, and this has proven to be successful. Many retirees have migrated to this option as it is less expensive and offers more choice. Although the exchange model is receiving significant recognition today it is not new.

We submit for your consideration that the current self-funded model employed by PEBP, particularly with the inclusion of fully insured plans, and the resultant adverse selection management issues, make the current model less attractive and more difficult to control or provide choice.

Stabilizing benefits and cost are primary so as to remove the uncertainty of future plan design changes. PEBP must review and adjust the plans design and cost to participants with a conflicting objective of plan preservation in its current form. Introducing private plans or offering a middle tier plan is potentially destructive to the core (CDHP) plan. Although offering choice to plan participants is very desirable, it is unattainable by PEBP, if they are to avoid damage to the core plan.

Privately delivered plans offer better benefits for lower premiums, and most importantly remove risk from the state and NSHE. The combination of health care market expertise, employee communication and education, data access, and a strong history of success with the private exchange model gives us a high level of confidence that this alternate option will ideally position NSHE to achieve the goals set by leadership. The fact that fully insured plans must, by law, spend 85% of all premiums collected on medical care, that profit margins for the largest of these carriers is approximately 4% and that the competitive market demands for lower pricing has led to private sector insurers negotiating lower costs for providers, establishes a good foundation for the further development of our model. As the market share for these carriers has grown the leverage they have has increased and resulted in lower premiums for the consumer.

PEBP will need to increase employee contributions again, and/or reduce benefits again soon under the current model. Shifting the responsibility of managing benefits to NSHE or creating the private exchange model recommended, will result in immediate improvements in cost, benefits, and long term stability.



Most states, including Nevada, are currently in the process of establishing exchanges, for individuals and employer groups under 100 lives that are mandated to take effect in 2014 by the Patient Protection and Affordable Care Act.

Our proposed private exchange design is similar to the proposed state model. NSHE may offer several plan designs: High Deductible Plans with HRA and/or HSA, PPO plans, HMO Plans, Retiree PPO, and Medicare Advantage Plans or any other combination of plan designs it desires. Over time more or less plans can be offered as desired, since the framework will be in place. This method of benefits delivery will provide coverage in an environment that produces more choice to the employees of NSHE. We are confident that this model can be delivered within the existing budget.

Plan design, creativity, and wellness strategies that encourage healthy lifestyles provide opportunities to manage change and control costs while ensuring quality medical service. Ultimately, we are confident that we can design and deliver fully insured benefits that increase plan stability, offer more choice to participants, and operate within the budget. We will need complete access to data, commitment to explore, design and negotiate with carriers in order to achieve the desired results.

### ***Advantages of Fully Insured Plan Designs***

Although we are unable to prove at this time that this model will resolve all of the issues identified by NSHE, we are confident that once we have the necessary data, the commitment to explore, and negotiate we will acquire firm commitment underwritings from private insurers. Our position stems from over 30 years in this field, a significant knowledge base regarding fully insured plans, and most importantly, over a decade of success in designing, implementing and managing the model we are recommending. Advantages of the plan designs we recommend are as follows:

- Improved Benefits
- Pricing stability, cost control, and predictability
- Guaranteed rates for 24-60 months
- Full choice program offering multiple health plans and extensive provider networks
- The freedom to choose the healthcare that suits the employees individual needs
- Employee contribution stability
- Choice & competition among carriers (Exchange) over time
- Benefit Design Control and Collaboration
- Carrier Administration of Claims
- Access to National Networks
- Contract Control & Insurance Risk Elimination
- Simple and efficient online administration
- Full Carrier and BBI team support from enrollment through renewal
- Highly effective recruitment and retention tool

## Caveats

BBI has prepared this report for the specific purpose of providing estimated health plan premium costs for the Nevada System of Higher Education. This report should not be used for any other purpose. This report has been prepared solely for the internal business use of NSHE. In order to provide the information requested, we have constructed several projection models. Differences between our projections and actual amounts depend on the extent to which experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

In performing this analysis, we relied on data and other information provided primarily by PEBP. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a more detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. We were unable to conduct a broad based comprehensive analysis of the entire PEBP as it would require more data for PEBP. Given this information we could conduct a more thorough review.

## Future Recommended Activities Analysis and Review

A collaborative effort between NSHE and PEBP to perform an additional review and analysis of data and test the market, if authorized, will include a more complete analysis of the strengths, weaknesses, and comparisons with health care coverage that NSHE may potentially achieve independently of PEBP.

We will consider the practicality of providing comparable benefits for employees and retirees in the Southern, Northern, and rural regions of Nevada with access to health care providers which are appropriate for the individual employee and retiree's geographic locations.

We will identify coverage and service needs based on NSHE's demographics. This will result in the development of some criteria that will be used in evaluating health benefit plan options for NSHE's consideration.

It will consider assuming more direct involvement in managing health care benefits for NSHE faculty and staff, and all State employees by NSHE and PEBP together.

It will consider providing additional supplemental benefits (voluntary) to NSHE employees (and all State employees if applicable) in areas not covered in the PEBP health plan. These include long term care insurance, vision, and additional life insurance, if not incorporated into a comprehensive solution.

### **Action Item:**

We recommend a collaborative effort towards the accumulation and review of all PEBP data so that we can most effectively test the market to improve health care benefits for all State employees through a carefully prepared and well-designed solicitation of coverage.

Until we are authorized to immediately pursue options to significantly improve the health care benefits for employees and retirees within the existing budgets, we are unable to make firm commitments. We believe that the PEBP board and staff are valuable as a plan design collaborator and communications board and as an internal employee advocate organization and an administration arm.

Once we test the market to improve benefits for all State employees we envision that the outcome would involve PEBP forming its own private exchange offering several fully insured plans to all eligible employees and their dependents. This will not require any of the several subcontracted entities that currently enjoy contracts with PEBP. All participating carriers will compete for the business of the employees and their dependents at least annually.

## Exhibit A

### Requests for Information from PEBP

After some delays, and the need to resubmit our requests due to incomplete responses from PEBP, we ultimately received most of the data. BBI attended eight NSHE Task Force meetings over the course of the last eleven months. Prior to initiating the analysis we submitted a Request for Information (RFI) to NSHE for data from PEBP. The first RFI was submitted by NSHE to PEBP on February 21, 2012. All RFI's submitted were consistent with similar requests our firm makes to plan sponsors, carriers, TPAs, actuaries and others in the routine process of accumulating information needed to provide a benefits analysis to our clientele. Below is a summary of the main exchanges with PEBP on our requests for data.

Ultimately we received data on approximately 650 retirees participating in the NSHE defined contribution retirement program. However, we are missing potentially, an equal amount of retirees from PERS. We have requested data on PERS retirees since February. We have been advised that this data is not tracked by PEBP and will therefore not be available.

We have concluded that PEBP cannot provide all the data we have requested. In fact, generally, PEBP cannot provide the same data that other plan administrators and private sector insurers do. They appear to have recently become aware of this fact by virtue of our requests.<sup>1</sup>

Unfortunately, lack of good and complete data generates conservative outcomes because it implies higher potential financial risk to underwriters. These unknowns force underwriters to assume the worst case which generates higher cost estimates.

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<sup>1</sup>PEBP enhancement request biennial budget request: "Due to increasing data requests and reporting requirements, Staff believes it is appropriate to create a data warehouse to maintain all PEBP data in a single location, and that PEBP contract with a vendor to use analytical tools to query the data from that single location. Currently, data inquiries are requested from numerous vendors and merged in-house, creating additional Staff burden, inconsistencies, and long fulfillment times. The addition of Data Analytics will also allow PEBP to create better utilization reports and to benchmark our plan to national averages. It is projected that Data Analytics will cost approximately \$75,000 per year." We are awaiting a final estimate from Aon Hewitt.

***Provided in chronological order, below reflects only a synopsis of the communication sent and received by BBI, NSHE and PEBP.***

The initial RFI was sent to PEBP by the System office on February 21, 2012. .

- 3/19/12 Request by PEBP to accept zip codes in the data instead of full address.
- 3/23/12 Notified that census is ready to be mailed on disk.
- 4/1/12 NSHE staff requests status of the data we requested from PEBP and agenda for the 4/20/12 meeting. Would there be a reason to meet without this data
- 4/12/12 Received census data. Notified by PEBP claims would be sent soon.
- 4/16/12 NSHE staff requests status from PEBP on claims files. PEBP indicates an FTP site will be required.
- 4/16/12 BBI establishes FTP site to receive data
- 4/16/12 BBI received the PEBP claims transfer to our FTP site. HMO claims were received in requested format. PEPB PPO claims were sent in text.
- 4/16/12 BBI reviewed PEBP data requested Excel format. PEBP PPO claims information not in Excel format. I cannot understand why PEBP is unable to submit as requested. HMO data by itself was of very little value without the PPO data in its entirety.
- 4/16/12 BBI and NSHE staff discuss the best method to reiterate to PEPB that which we need.
- 4/17/12 NSHE staff requests that BBI convert the PEBP PPO claims into Excel Format.
- 4/19/12 NSHE staff inquired as to our ability to import the PEBP data.
- 4/19/12 NSHE staff communicates that the PEBP response is very poor regarding direct questions regarding the "excess reserve." NSHE Staff comments, "The vast majority of the "excess reserve" clearly comes from the employer contribution (more for the PPO than for the HMO given the employer subsidy rates). At the end of the day, as you can see, the employer is contributing much more for the PPO than the HMO."

- 4/24/12 BBI completes the PEBP Claims files conversion to Excel. Upon closer review BBI uncovers that:  
Claims include the dental and vision and must be separated out by PEBP.  
Retirees are not separated out from the actives. We do not have membership by month as requested.
- 4/25/12 BBI has been able to convert data received from PEBP into the format originally requested. A more thorough review is initiated.
- 4/30/12 BBI and NSHE staff conference to discuss the PEBP missing claims data.
- 4/30/12 BBI notifies NSHE staff that we do not have all the data requested from PEBP and will report further on this at the NSHE Task Force meeting on 5/3/12
- 5/1/12 NSHE staff communicated to BBI that PEBP has indicated the membership is included in the files sent over by month. However, membership was only reflected by month for those who had a claim during that month. BBI clarified for that members could have had multiple claims in one month and some members would not show up at all if they had no claim in that month and as such the data was incomplete.
- 5/7/12 NSHE staff developed a new RFI for PEBP. BBI reviewed and requested that it be sent.
- 5/9/12 NSHE staff forwarded PEBP the new RFI.
- 5/22/12 PEBP staff communicated to NSHE staff apologizing for the current delay. PEBP indicated that this was due to open enrollment and out of office staff. BBI is notified by PEBP that dental and vision claims are included in the data because all dental and vision claims are paid under the medical part of the program. PEBP directs us to separate the data using the provided claim codes on each claim record.

PEBP indicates they will deliver the Long term disability claim data in a few days and that the missing data was an over sight.



PEBP indicates that Life Insurance data cannot be collected/provided at the agency level

Because this information is not maintained on each record and that cannot separate out this data specific to NSHE retirees.

PEBP indicates that they will provide a group summary report for all PEBP participants and the incidents that occurred during this period, with payments. They suggest that this can be used to extrapolate statistical ratios based on the NSHE population as a subset of the PEBP whole.

The original data that was posted to FTP included census information. That data is still available on the PEBP FTP site. There is a file in each corresponding sub-folder [HPN/HTH/PPO] that lists all the participants with their effective data on the plan. All records are for active participants. DOB, division, plan, tier, and dependent count are included. The use of one census file avoids the replication of data. By using the effective date you can determine the participants that were eligible in any given month [if the effective date is greater than the month in question, then the participant was not enrolled for that month]. The PPO census data would be also used for the RX claims.

- 5/23/12 NSHE upper management communicates to PEBP upper management to inquire as to the delays.
- 5/23/12 BBI and NSHE staff conference again and concluded that a month by month census was not provided. We cannot use one snapshot census for a moment in time to compare to a month by month claims file. Any new employees or termed employees would not be correctly represented in a snapshot.
- 5/24/12 NSHE upper management requests a face to face meeting with PEBP upper management to discuss the data issues.
- 6/8/12 NSHE staff provides notes from PEBP meeting:

- 6/8/12 BBI communicates with NSHE staff indicating that it appears that some progress on the Data is occurring.
- 6/11/12 NSHE staff develops a new RFI. BBI is asked to review for input.
- 6/11/12 BBI indicates that we would like the dental and vision claims broken out, but if not possible at least we need the Dental separated.

7/13/12 to 9/14/12

Multiple communications between NSHE and PEBP concerning problems getting complete data. PEBP ultimately states it gave NSHE everything it had and was unable to identify NSHE PERS retirees

## Exhibit B

### Data Reliance

PEBP personnel provided the following files, which were essential in our analysis:

*YYYYMM.xlsx (24 total)* – monthly PPO medical claims for CY 2010 and 2011 which were used to assess the historical claims expense for the active population.

*R-YYYYMM.xlsx (24 total)* – monthly PPO medical claims for CY 2010 and 2011 which were used to assess the historical claims expense for the retiree population.

*STNV JANtoJUNE2010.zip* – monthly PPO prescription drug claims for the first half of CY 2010 for both Active and Retiree populations which were used to assess the historical Rx claims expense.

*STNV JANtoJUNE2011.zip* – monthly PPO prescription drug claims for the first half of CY 2011 for both Active and Retiree populations which were used to assess the historical Rx claims expense.

*STNV JULYtoDEC2010.zip* – monthly PPO prescription drug claims for the second half of CY 2010 for both Active and Retiree populations which were used to assess the historical Rx claims expense.

*STNV JULYtoDEC2011.zip* – monthly PPO prescription drug claims for the second half of CY 2011 for both Active and Retiree populations which were used to assess the historical Rx claims expense.

*HPN\_PEBP\_Claims.zip* – monthly HPN HMO medical and prescription drug claims for CY 2010 and 2011 which were used to assess the historical claims expense for the active HMO population.

*NSHE-HTH\_PEBP\_claims 2010-1* - monthly HTH HMO medical and prescription drug claims for CY 2010 and 2011 which were used to assess the historical claims expense for the active HMO population.

*HTH Eligibility YYYYMMDD (24 total)* – monthly eligibility files for the HTH HMO population.

*PEBP\_Elig.zip* – monthly eligibility files for the HPN HMO population.

*PEBP\_PPO\_Elig.zip* – monthly eligibility files for the PPO population.

*PY2010rates.pdf* – FY 2010 state Active rates.

*NSHE rates eff. 712010.pdf* – FY 2011 state Active rates.

*2010ActiveInsRates* – FY 2010 member premium amounts.

*PEBP\_Health\_Ins\_REGIA\_FY08-FY13.xlsx* – total premium per retiree per year, separate by fiscal year.

## Exhibit C

### Assessment Formula

We received data on the defined contribution retirement plan NSHE employees; however we were never able to acquire that information for PERS retirees from NSHE. NSHE is assessed a charge for this population but PEBP cannot directly identify them. This charge is based entirely on a formula.

Assessments for premiums and contributions for retirees are determined by the Legislature. The information on how these assessments are to be charged is in AB80 and AB 563.

An assessment is charged to NSHE to pay for a portion of the cost of current and future health and welfare benefits for retirees. Each biennium, the Legislature establishes the base amount for the share of the cost of premiums and contributions for each person who has retired with state service. The amount for FY 11 is \$344.30 and the amount for FY12 is \$418.41.

The amount of the assessment is determined by the Legislature each biennium. This is called the Retired Employee Group Insurance Assessment (REGIA). REGIA is assessed on salaries in state and self-supporting NSHE budgets and as such, the NSHE total remittance for REGIA will be higher than the appropriated amounts. The REGIA rate will be assessed on actual salaries as adjusted for furloughs.

The FY 11 rate was reduced from the Legislative approved amount by the 26th special session.

FY 11 2.57%

FY 11 Adjusted 0.658%

FY 12 REGIA 2.134%

FY 13 REGIA - 2.690%

How the subsidy applied to benefit retirees is dependent upon when they were initially hired and their total years of service. The higher the employee's years of service, the higher the subsidy. The subsidy amount caps at 20 years of service.

- For individuals hired before January 1, 2010, they receive a subsidy towards health insurance premiums for their years of service if they have at least 5 years of service.
- For individuals hired on or after January 1, 2010, they receive a subsidy towards health insurance for their years of service if they have at least 15 years of service.
- No subsidy will be provided for retiree health insurance for those hired on or after January 1, 2012. These individuals will not be included in the REGIA assessment.