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March 11, 2011

Daniel Klaich, Chancellor  
2601 Enterprise Road  
Reno, NV 89512

Dear Chancellor <sup>Dan</sup> Klaich:

I am providing this letter in response to the Final Report and recommendations made by the Nevada System of Higher Education's Public Employees' Benefits Program (PEBP) Benefits Task Force on the health insurance plan design changes approved by the PEBP Board for the plan year starting July 1, 2011.

I appreciate and share the concern regarding reduced overall compensation impacting the entire State's ability to attract and retain staff, especially at the professional level. When coupled with furloughs, pay reductions and increases in retirement contribution the changes to the health benefits have created the perfect storm on employees' paychecks.

Just like every other State agency, PEBP was asked to tighten its fiscal belt. The PEBP Board was presented with a State subsidy target from the Department of Administration that left the State contributions flat for the upcoming biennium. That meant our participants would have to absorb all of the costs of medical inflation and utilization. Keeping the same plan design and subsidization policy currently in place left a "shortfall" of about \$85 million. Without changing the benefits structure, it would have meant an increase in the monthly premium of every participant by over \$100. The PEBP Board had to make some very difficult decisions to balance the PEBP budget and insure the financial solvency and long term sustainability of the plan.

The PEBP Board held a full day workshop and another full day meeting to solicit input from those impacted by the changes to health insurance plans offered by PEBP. In order to close the "shortfall", the Board, at public meetings over several months, adopted the following:

- Significant benefit changes to the self-funded PPO plan, transitioning it to a consumer-driven high deductible health plan (CDHP) and adding Health Savings Accounts and Health Reimbursement Arrangements;
- Reductions to the dental benefits and life insurance;

- Rate increases for the HMO plans where the benefits were not changed from the current offerings; and
- Transition of Medicare eligible retirees to the individual market.

The decisions by the PEBP Board mark a significant shift towards a cafeteria style of benefits. Instead of providing a “one premium fits all” approach, the Board chose to replace the existing preferred provider organization (PPO) plan with a consumer driven high deductible health plan while adding and partially funding health savings accounts to provide some first dollar coverage. This allows participants flexibility in designing their own health plan with an emphasis on personal responsibility and accountability.

A Segal Group survey shows that in 2010, 23 states included some form of a CDHP among their health insurance plan offerings. The State of Indiana began offering CDHPs in 2006 and has over 70% of their 30,000 employees in one of two different high deductible plans. Mercer consulting published a case study last May on the savings and experience of Indiana’s two CDHPs compared to the remaining PPO plan. The findings of that study validated that CDHPs have the potential to be one of the foundational components of strategies to “bend the healthcare cost curve”. The study pointed out that employees and dependents have historically been largely insensitive to and shielded from the actual cost of healthcare services and that CDHPs increase personal accountability for making informed healthcare decisions.

The historical concern is that participants enrolled in CDHPs will defer or avoid important healthcare services causing more expensive health problems down the road. While it may have happened in a few instances, Mercer found no evidence it happened in any material way during the four year study period in Indiana. Savings appeared to come from better use of healthcare resources and more cost conscious decision making. Participants were exposed to the full cost of healthcare and forced to decide if the care is appropriate.

From reading the Gallagher study done for the Nevada System of Higher Education, one might be led to believe that the State of Nevada is in a minority when trying to deal with the escalating costs of health care (Slide 22 states that “many states contemplate no changes”; “potential change includes wellness”; “no movement to CDHP”). From what I see and hear this is an inaccurate statement. Almost every employer in the country, both public and private, is grappling with this issue. There have been articles in the last several weeks on the states of Maine, Wisconsin, New Jersey, Pennsylvania and Georgia as well as the City of Los Angeles proposing significant changes to their employee health benefits. How each employer addresses the increasing costs of healthcare is based on an individual approach that best fits the needs of that organization. Some entities have proposed eliminating retiree health care; others have increased the participant share of premiums while others have decreased benefits. Many employers are looking to

wellness and preventive care programs to control cost, including PEBP, but these have only a nominal proven impact on overall costs and take years to realize the benefits of a healthier workforce. As medical inflation continues to exceed Consumer Price Inflation by a significant margin, the pressures of these increases will continue to take their toll on government and private entities alike.

The Gallagher study provides averages and compares PEBP's plans to those averages but not necessarily to specific comparable organizations. As each entity will design its benefit structure in a different manner, comparisons to average can be misleading. The Gallagher study shows that PEBP's current plans are "in line with, to less comprehensive than, prevailing practices" (Exec Summary Pg 4). It states that the current physician co-payments are "within norms for primary care, and above norms for specialists". Interestingly, the chart on slide 35 shows that both primary care and specialist physician co-payments are within norms. Slide 46 shows the southern HMO below average for both primary and specialist physician co-payments while the northern HMO is above average for both.

The study does state that "while the plan design is generally less favorable than prevailing practices (which somewhat contradicts the statement above that it is in line with to 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". Not only are the contribution percentages favorable, they are significantly lower than every benchmark in the study (7% versus 20% for employee – slide 40; and 16% compared to 20% or more for family – slide 41). The fact that PEBP's current plan is comparable to those in the study while our participant contributions are very low tells me we are competitive with the other organizations in the study. The study highlights that PEBP has opted for a lower participant contribution/higher deductible and out-of-pocket philosophy that passes more of the costs on to those who use the plan as opposed to a higher participant contribution philosophy where everyone pays a higher monthly amount and those who utilize services pay less to do so.

The Gallagher study points out that  $2/3^{\text{rds}}$  of the entities surveyed provide some monetary contribution toward early retiree medical coverage and over half do so for Medicare retirees. The inverse is that  $1/3^{\text{rd}}$  do not provide any contribution for early retirees and almost half do not for Medicare retirees. Providing retiree healthcare has a significant impact on the costs of a plan, and a significant savings results from not covering retirees. In the most recent utilization report for the PEBP plan, active participants incurred costs of about \$657 per month while early, or non-Medicare, retirees incurred costs of \$977 per month. Medicare retirees, while cheaper than early retirees because of the coordination of benefits with Medicare, still incur significant costs due to very high drug utilization. On the PEBP plan, the average Medicare aged

retiree utilizes twice the dollar amount of prescription drugs than the average participant does.

As to the specific recommendations in the memo, I have the following comments:

1. Recommendation b on page 4 of the Task Force's memo suggests adding a low deductible PPO option. It is not feasible for PEBP to create a low deductible PPO option for the plan year that starts July 1, 2011. However, there are low deductible alternatives for those who are concerned about the high deductible of the CDHP. A participant can either elect HMO coverage which has no deductible or can contribute pre-tax dollars to their individual Health Savings Accounts to reduce the deductible on the PPO plan. The Task Force's memo states that providing "only a high deductible option and an HMO will be relatively unique in comparison to other public and private employers". While this would put us in a minority compared to other states, this pair of offerings would not be unique. Colorado and Minnesota both offer only CDHP and HMO alternatives.
2. Recommendation e on page 4 of the Task Force's memo suggests extending the plan year as was done last legislative session. PEBP's extension of the plan year by four months in 2009 cost somewhere in the neighborhood of \$20 million dollars. Given the economic condition of the State, this would mean passing the additional costs associated with a plan year extension on to our participants. The plan design changes approved by the PEBP Board have been discussed since July 2010 and PEBP has offered information sessions throughout the State to our participants. We have extended the open enrollment period for an extra month to allow participants the time to select the plan that is correct for them. I would not support a plan year extension and the resulting increase in participant contributions.
3. Recommendation f on page 5 of the Task Force's memo suggests a "phase-in" of the HMO rate changes by using the supplemental subsidy policy in the PEBP Board Duties, Policies and Procedures. The PEBP Board suspended the policy of providing supplemental subsidies for the upcoming plan year because of the decisions on how to handle the shortfall. Additional costs for the PPO plan were passed on to the participants through plan design changes. Since there were no plan design changes for the HMO plans, the contributions were intentionally increased for HMO participants. To provide a supplemental subsidy in order to phase in the HMO rate increases would result in inequitable treatment with other participants. The decision to blend the HMO rates in the North and South

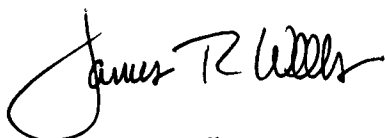
- arose from another inequity in the treatment between Northern and Southern Nevada employees. Only those participants who choose HMO coverage have a different health insurance premium deducted from their paycheck every month. All other aspects of their compensation – retirement contributions, leave accruals and even PPO participant contributions – are exactly the same. The blending of rates eliminates that inequity. Even with the blending of rates, however, Southern Nevada participants still pay less when they access services due to the differences in plan design between the two HMO products. On a side note, the HMO participant contribution for an employee + spouse in southern Nevada is currently less than the PPO plan with a richer benefit, causing significant adverse selection between these two plans. The increase to that tier was unavoidable and rectifies the problems arising from that adverse selection.
4. We will work with our participants whose spouses become ineligible as a result of access to other employer based insurance coverage to insure the change results in a qualifying event allowing them to access their employer's coverage.

I urge the System to use caution in offering extra benefits to its employees, and potentially to its retirees. That would create equity issues with other State employees and also could create Internal Revenue Code discrimination issues regarding benefit differentials for highly compensated employees.

I also do not believe it would be allowable for the System to offer a different benefit program outside PEBP without a legislative change or without using the current Groups of 300 provision in Nevada statutes and regulations. Withdrawal from PEBP could also create significant issues for both PEBP and the System as it relates to the setting rates, covering retirees, calculating reserves and managing the cost differentials between the North and South as well as duplicating the current PEBP operational costs.

I look forward to working with you and the Nevada System of Higher Education to identify alternatives to and improvements of our existing programs. In the end, we should all be working toward a common goal to improve the overall health of our participants.

Sincerely,



James R. Wells, Executive Officer  
Public Employees' Benefits Program