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NEVADA HEALTH AUTHORITY
PUBLIC EMPLOYEES' BENEFITS PROGRAM
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PUBLIC EMPLOYEES' BENEFITS PROGRAM

BOARD AND AGENCY

Duties, Policies and Procedures

November DRAFT

I. INTRODUCTION

Nevada Revised Statutes (NRS) 287.41 creates the Public Employees' Benefits Program (PEBP) Board (Board) to establish and carry out a Program for health, life, and other voluntary insurance benefits.

The Board has adopted the following Duties, Policies and Procedures for general direction, information, and guidance of the Program. The Duties, Policies and Procedures may be amended, varied, or suspended at the discretion of the Board by a motion passed in an open meeting.

A comprehensive fiduciary policy provides the Program with functional guidelines within which to operate. The Program is accountable to the Participants and the Public. Board Members and agency employees must be willing to perform their responsibilities that preclude and inhibit misconduct, eliminate waste of resources, and embrace the concepts of sound cost effective measures.

GUIDING PRINCIPLES OF HEALTH CARE BENEFITS ADMINISTRATION

Service to the participants of the Program is the primary function of the Board and the Agency. Board members are fiduciaries who are to act for the exclusive benefit of the participants. Board members will act with integrity, objectivity, independence, prudence, and due care.

II. APPOINTING AUTHORITY

The "Appointing Authority" is made up of the Governor, the Senate Majority Leader, and the Speaker of the House.

In making appointments, the Appointing Authority shall coordinate to ensure that the membership of the Board is diverse and, to the extent practicable, proportionally and equitably represents the constituencies served by the Program.

III. GOVERNANCE

The policy is designed to enable Board members and agency employees to seek counsel, to remain inquisitive, and to exercise their functions with the prudence demanded of them in the public sector.

Board members are entrusted with the responsibility of exercising their duties in a manner that ensures the efficient and effective administration of the Program in compliance with all applicable Federal and State laws and regulations, including those relating to ethics (NRS 281A), contracting (NRS 333) and the Nevada Open Meeting Law (NRS 241).

FRAMEWORK:

- "Board" means the PEBP Board members
- "Agency" means the PEBP agency and its employees
- "Program" means both the Board and the Agency

A. BOARD RESPONSIBILITIES

Board members are entrusted with the responsibility of ensuring efficient administration of the program in accordance with all applicable laws and regulations, and shall:

1. Be responsible for adopting the Mission Statement, Values, Goals and Objectives (i.e., the Strategic Plan) of the Program.
2. Provide health care, life insurance, and other voluntary benefits in a responsible manner balancing the needs of the State, Plan participants and the taxpaying community. Benefit changes may be considered by the Board based upon recommendations from individual Board members, the Agency or from the public.
3. Adopt sound actuarial and accounting standards and appropriate internal controls.
4. Review and revise Duties, Policies and Procedures regarding matters that are not specifically enumerated in statute or regulation as needed.
5. Take a position on any proposed legislative matters affecting the Program and direct Agency employees to make that position known to the Legislature. During the legislative session, the Board authorizes the Executive Officer to take a position of "neutral" on any new bill affecting the Program by default. This allows for rapid response to legislative committee meetings scheduled prior to a Board vote. The Board can revise the default position at the next Board meeting.
6. Prior to the commencement of each biennial legislative session, review and approve the framework for the biennial budget to be submitted to the Governor's office.
7. Be responsible for PEBP's contracting activities in accordance with NRS 287.04345.
8. Interview qualified candidates for the position of Executive Officer and make recommendations to the Director and the Governor concerning the appointment, to oversee the day-to-day operations of the Program in accordance with NRS 287.0424.
9. Delegate to the Executive Officer the authority to manage the Program within the parameters defined by the Board.
10. Evaluate the Executive Officer as needed in a public forum adhering to all

applicable open meeting law requirements.

11. To the extent money and resources are available, compile a report on or before August 31st of each even number year comparing benefits under Medicare to those under the Program for retirees, and submit the report to the Director of the Legislative Counsel Bureau in accordance with Senate Bill 494 (2025).
    a. The Board may use the resources of the Nevada Health Authority to prepare the report.
12. The Director of the Department of Administration appoints the Quality Control Officer for the Program. The Director shall define the duties of the Quality Control Officer with the concurrence of the Board. The Quality Control Officer serves at the pleasure of the Director.

B. BOARD MEMBER CONDUCT

Individual Board members shall:

1. Prepare for and attend Board meetings.
2. Refrain from making commitments to any individual or entity regarding any matter that is scheduled for consideration by the Board.
3. Not communicating with the press or plan participants on behalf of the Board.
4. Be encouraged to obtain continuing education credits pertaining to the administration of group benefits for public employees as funding is available.
5. Conduct their affairs in such a manner that they always represent the best interest of the Board. To fulfill these functions satisfactorily, individual Board members must exercise utmost judgment, discretion, and tact to ensure good public relations, and to avoid any possible misunderstanding regarding actions as an individual as opposed to actions as a Board member.
6. Not acting in any official capacity on behalf of the Board except as directed by Board action.
7. Refrain from performing any function delegated or normally assigned to Agency employees.
8. Not obligate expenses on behalf of the Agency without following state law, regulations, policy, and Agency procedures.
9. Direct their inquiries and requests for information which may occur outside of a Board meeting to the Agency through the Executive Officer. A request that requires significant Agency resources, as determined by the Executive Officer, must be approved by the Board Chair before the staff shall be required to act upon the request.

C. BOARD MEETINGS

Board meetings shall be held in accordance with NRS 287.0415. The Board shall conduct business in accordance with Nevada Administrative Code NAC 287.170-176 the Nevada Open Meeting Law pursuant to NRS 241, federal and state statutory and regulatory provisions and current Duties, Policies and Procedures, as applicable.

1. The board shall meet no less than once every calendar quarter. The Chair may call additional meetings as necessary.
2. Any Board member may submit to the Executive Officer, or in his or her absence, the Operations Officer of the Program, a request for a matter to be placed on the agenda.
3. At the first meeting of each calendar year, the Board will elect a Chair. The Governor will designate a Vice Chair. The Vice Chair shall serve as the Board Chair in the absence of the Board Chair.
4. Meetings may be transcribed by a court reporter who is certified pursuant to NRS Chapter 656. A transcription shall be posted no later than 30 days from the date of the board meeting.
5. The board may meet in closed session for any of the following reasons.
    a. To discuss matters relating to personnel.
    b. With investment counsel to plan future investments or establish investment objectives and policies.
    c. With legal counsel to receive advice upon claims or suits by or against the Program.
    d. To prepare a request for a proposal or other solicitation for bids to be released by the Board for competitive bidding; or (e) As otherwise provided pursuant to NRS 241.
6. The Board may appoint advisory committees as necessary.

D. EXECUTIVE OFFICER AND AGENCY ADMINISTRATION

The Executive Officer serves at the pleasure of the Governor, is appointed by the Director of NVHA, but is interviewed by the Board who makes recommendations to the Director of NVHA and Governor. The Executive Officer is delegated the responsibility to implement the plan of benefits, decisions, directions, internal controls, and policies approved by the Board. Except as may otherwise be specified in plan documents approved by the Board, the Executive Officer executes the authority of Plan Administrator as described in such documents.

1. The Board authorizes the Executive Officer or his/her designee to provide official press releases and to answer questions from the press and other news media.
2. The Board authorizes the Executive Officer or his/her designee to carry out

administrative functions of the Agency, including but not limited to:

a. Financial management of contribution/rate billing, accounts receivable, accounts payable and budgetary compliance.
b. Management of Agency personnel, day-to-day operations and vendor performance matters.
c. Interpretation of NRS and NAC in performing functions of the Agency.
d. Approval of subrogation settlements and other financial settlements relating to claims processing.
e. Representation of the Agency to other pertinent governmental bodies.

3. Consistent with Board policies and directions, the Agency shall work with the Governor's Finance Office (GFO) and the Legislative Counsel Bureau (LCB) to ensure that the Program is funded on an actuarially sound basis. The Agency shall ensure the use of funds and resources directly related to the purpose of the agency and the statutory intent for the use of those resources.
4. Ensure the Agency notifies participants of health care benefit changes as approved by the Board.
5. As soon as practical, but within 120 days of the appointment of a new Board member, the Executive Officer shall provide the new Board member with a comprehensive orientation and overview of the Program which the new member shall acknowledge receipt by signing and dating the "Acknowledgment Form for Board Members". The orientation will include, at a minimum, the following:
   a. The history and overview of PEBP and the benefits administered by the Program including any special terminology generally used by the Program.
   b. The Board governance, including the Strategic Plan and these Duties, Policies and Procedures. A review of recent Board actions and precedents and current issues being considered by the Board.
   c. An overview of the funding and rate setting process.
   d. The continuing education opportunities for the members pending available funding.
6. The Executive Officer will also ensure these Duties, Policies and Procedures are provided to all employees upon approval of any changes by the Board and to new employees within 10 working days of their hire with the Agency. Employees will acknowledge receipt and understanding by signing the "Acknowledgment Form for Employees."

7. The Executive Officer may obtain continuing education credits pertaining to the administration of group benefits for public employees as funding is available.
8. The Executive Officer will provide Agency employees with relevanteducation and training and will allow employees to attend training classes relating to the administration of health care benefits or to the employee's individual work assignments. The Executive Officer is responsible for setting the eligibility requirements for an employee attending a training or other educational event and the appropriate reimbursement of cost and/or release time to be provided for the training within the budgetary limits established for the purpose of employee training.
9. The Executive Officer is responsible for interacting with the Executive and Legislative branches of government and shall work diligently and cooperate fully with both to provide any information desired in relation to the operations, functions, or status of the Program.
10. Responses to correspondence addressed to the Chair may be prepared by Executive Staff. Responses to correspondence addressed to the Board may be prepared and signed by Executive Staff on behalf of the Board.

E. ETHICS

The Board and agency employees must:

- Avoid the perception of misuse ofinfluence.
- Be willing to adopt and abide by Duties, Policies and Procedures thatpreclude and inhibit misconduct.
- Eliminate the wasteful use of resources; and
- Embrace the concepts of sound cost effectivemeasures.

Each Board Member and each member of the Executive Staff will read the most current Ethics Manual and sign an acknowledgement of their understanding of the ethics requirements upon appointment or hire and receive annual Ethics Training provided by the staff of the Commission on
Ethics every subsequent year. The most current Ethics Manual may befound at: ethics-manuals.

In addition to the Ethics Manual and annual Ethics Training, Board members and agency employees will not:

1. Disclose information regarding business developments of a confidential nature received in the course of their duties except in the authorized performance of those duties.

2. Attempt to take advantage of confidential information received in the course of their duties for themselves or any third party.
3. Accept meals, travel, lodging or any other gift from any contractor or vendor in accordance with NRS 281A.

Business meetings, such as employee benefits orientations, open enrollment meetings, staff meetings, planning meetings, etc., may, in the interest of efficiency, be conducted at a contracted vendor's facility at no cost to the Agency if the expenses are customary and not intended to improperly influence a reasonable person.

If the Chair, Executive Officer, Director of the Nevada Health Authority, or assigned Deputy Attorney General cannot resolve an ethical question, the question should be referred to the Commission on Ethics:

Commission on Ethics
704 W. Nye Lane, Suite 204Carson City, Nevada 89703Telephone: 775-687-5469
Fax: 775-687-1279
Email: ncoe@ethics.nv.gov Website: www.ethics.nv.gov

Nothing herein precludes a Board member from directly contacting the Commission on Ethics with a question about his or her ethical obligations as a Board member.

F. SEXUAL HARASSMENT

The State of Nevada has a sexual harassment policy that prohibits unwelcome sexual conduct that creates a hostile work environment or affects employment. The policy requires state employees to receive training, and employees have a process for reporting harassment through their supervisor or the agency's Equal Employment Opportunity (EEO) officer.

The policy applies to all executive branch employees and is enforced through state law and federal Title VII of the Civil Rights Act.

The Board hereby adopts and authorizes the Executive Officer to enforce the most current State Policy Against Sexual Harassment and Discrimination approved by the Office of the Governor. Information regarding sexual harassment is located within the Division of Human Resource Management.

G. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITYACT (HIPAA)

Each Board member and agency employee must complete annual training regarding the privacy, protection, and disclosure requirements of HIPAA and sign an acknowledge form for PEBPs Executive Assistant and Quality Control Officer.

Information regarding HIPAA is located within the United States Department of Health and Human Services.

H. CONFIDENTIALITY

Each Board member and agency employee shall sign a Confidentiality andSecurity Statement of Understanding upon appointment/hire.

This form shall be provided to PEBPs Executive Assistant and Quality Control Officer.

I. TRAVEL POLICY

1. If a member of the Board must travel, they must adhere to the State of Nevada's travel policy which may be found the State Administrative Manual in sections 0200 (Travel) and 1400 (Fleet Services)
2. Board members are subject to the same travel requirements as Agency employees and will receive a copy of the Travel Policy and Procedures during their orientation. The Travel Policy and Procedures outline the requirements for submitting travel requests, travel reimbursements and necessary supporting documentation to the Agency.

IV. CONTRACTS

A. PURPOSE, AUTHORITY, AND POLICY

1. The purpose of this policy is to establish procedures for new contracts and contract extensions which will be in accordance with NRS 333, SAM 1500, and the Nevada Health Authority (NVHA).
2. There shall be a standing item on the Board meeting agenda to review the status of current contracts and active RFPs.

B. PROCUREMENT PROCESS

1. The Board shall act as the chief of the using agency pursuant to NRS 333.335 (1) (a).
    a. The Board delegates the role as chief of the using agency to the Executive Officer for routine administrative contracts under $100,000 pursuant to NRS 333.162, e.g., auditors, leases, PEBP

web site management, etc.

b. The Executive Officer shall solicit the participation of Board members to participate in the development of a solicitation as well as serve on the committee as an evaluator.

c. For all other contracts including any that involve the procurement of services to PEBP members or actuarial services, the Board delegates ministerial and administrative duties as chief of the "using agency" to the Executive Officer. The Executive Officer should ensure that accurate and detailed information and supporting documentation, within the bounds of statute and regulation, is provided to the Board and other governing bodies when seeking to bid new contracts and amend existing contracts.

d. The Board retains the power and duty as chief of the usingagency to appoint members of the Board to evaluation committees pursuant to NRS 333.335.

e. The duty of negotiating and administering the contracts isdelegated to the Executive Officer.

2. If a committee to evaluate proposals for a contract for the Program is established pursuant to NRS 333.335, any number of members of the Board may be appointed to the evaluation committee. If one or more members of the Board are appointed to an evaluation committee:

   a. No action or deliberation regarding any business of theBoard other than the confidential review of the proposals pursuant to NRS 333.335 may be taken or conducted by theevaluation committee.

   b. Except as otherwise provided above, a meeting of the evaluation committee is not subject to NRS 241.

3. If the Board determines to review the results of any evaluation of proposals for a contract for the Program, it shall conduct such review in a closed meeting pursuant to NRS 333.335.

   a. The Executive Officer will provide an appropriate check list to assist the Board in their review of the RFP.

4. The Board shall take the following actions only in an open meeting:

   a. Award the contract pursuant to NRS 333.335;

   b. Cancel the request for proposals; or

   c. Modify and reissue the request for proposals.

5. The Board shall review sufficient documentation to ensure justification for the recommended action(s) and validation of recommendations by PEBP management.

6. Service performance standards and Financial Guarantees and/or Penalties

will be included in all contracts. Specific standards, guarantees and penalties will depend upon the type of service(s) provided by vendor.

7. Contracts which are subject to an audit pursuant to the scope of work: the contracted auditor will conduct the audit in accordance with the schedule in the scope of work and provide the results to the Board at the next meeting after the conclusion of the audit and response from the vendor have been rendered.
8. The Board shall oversee significant scope of modifications and ensure a competitive bid process is followed for (but not limited to):
   a. Changes in the scope of the competition or vendor status.
   b. Changes which were not within the contemplation of the parties when the original contract was entered.
   c. Changes that materially alter the contract.
   d. Changes in the quantity of major items or portions of work;or
   e. Historically provided services under a separate contract.

C. Amendments

1. The Board shall review and discuss all contract extensions and ensure extensions receive all required approvals, i.e., solicitation waivers, appropriate justification, and documentation.
2. The Executive Officer shall provide appropriate check lists to the Board to assist the Board in their evaluation of the amendment.

V. PREMIUMS AND CONTRIBUTIONS – RATE SETTING PROCESS

A. INTRODUCTION

PEBP sponsors both self-insured and fully insured plans of benefits.

For benefit plans that are self-insured, the Board will annually establish plan contributions based on the recommendation of PEBP's contracted actuarieswhich fund the plan(s) for the forthcoming plan year on an actuarially sound basis. Rates so established will be sufficient to fund anticipated paidclaims as well as reserves. These reserves include Incurred but Not Reported (IBNR) claims, Health Reimbursement Arrangement (HRA) fund balances and a Catastrophic reserve.

For benefit plans that are fully insured, the Program will negotiate rates with insurance underwriters for the provision of benefits based on equity to both the underwriters and to the Public Employees' Benefits Self-Insured Plan.

The Authority of the Board to establish rates are contained in NRS 287.043 (1) and (2).

B. RESERVE POLICY

PEBP will maintain fully funded IBNR and Catastrophic Reserves as determined by plan actuaries using the confidence intervals and margins described herein and a fully funded HRA Reserve based on 80% of the total balance remaining in all HRA accounts. Should the Catastrophic Reserve become underfunded or be forecast to be underfunded, the Executive Officer shall notify the Board at the next Board meeting.

The IBNR Reserves will be funded at a 95% confidence level to pay all known claims incurred. The Catastrophic Reserves will be funded at a level of 45 days on hand to meet unknown expenses which do not include IBNR. Both IBNR and Catastrophic Reserve levels will be recommended by PEBP's actuaries. The HRA Reserve will be funded to cover 80% of available balances.

Any cash-on-hand in addition to required reserves (IBNR, Catastrophic, and HRA) when the Program closes a fiscal will be identified as "Excess Reserves." Per section 20(2) of Senate Bill 501 (2025) (the Authorizations Act), "the Public Employees' Benefits Program, including, without limitation, the Board of the Public Employees' Benefits Program, shall not expend or otherwise obligate any reserves, either realized or projected, in excess of the amounts authorized in section 1 of this act for purposes of changing the health benefits, including, without limitation, reducing or off-setting participant premiums, available to state and nonstate active employees, retirees and covered dependents over the ~~2019~~25-2027~~1~~ biennium without approval of the Interim Finance Committee upon the recommendation of the Governor."

C. DEFINITIONS

As used herein the following terms mean:

1. **Open Enrollment** – The period during which participants in the Program may select among all health benefit programs that are offered by PEBP or eligible individuals not currently enrolled in the Program may enroll for coverage.
2. **Participant Contribution** – The portion of the rate paid by participants.
3. **Plan Design** – The benefits provided to participants of the plan. This includes provider access, out-of-pocket expenses (deductibles, co-payments, and coinsurance), and lines of coverage (medical, dental, vision, life insurance, etc.). Plan design does not refer to the methodology used to determine rates.
4. **Plan Year** – The PEBP benefit plan year as approved by the Board.
5. **Premium** – The cost paid for fully-insured benefits (e.g., health

maintenance organization membership, life insurance, etc.) as determined by insurance companies contracted with by PEBP. Premiums are passed through PEBP to the participants and employers.

6. **Rate** – The total monthly cost of coverage for a participant in each plan option and tier.
7. **Rating Methodology** – The basis for allocating costs between plan options and participant tiers. This includes the application of claims commingling, coordination of benefits, predictive modeling, trend analysis, etc.
8. **Subsidy (Contribution)** – The amount paid by the employer or from Plan reserves towards the cost of PEBP benefits on behalf of participants. The subsidy is comprised of the following portions:
    a. Base Subsidy – For state employees, the portion of the rate paid by the employer pursuant to NRS 287.044. For retirees not on the Medicare Exchange, the portion of the rate paid by a retiree's previous employer(s) at 15 years of service pursuant to NRS 287.046.
    b. Years of Service (YOS) Subsidy – The adjustment to the Base Subsidy, for participants who retired on or after January 1, 1994, based on a retiree's YOS, paid by a retiree's previous employer(s) pursuant to NRS 287.046 and NRS 287.023(4)(b).
9. **Differential Cash** – The difference between revenue and expenditures.

D. OVERVIEW OF THE BIENNIAL PROCESSES

1. **Rate Setting** – Prior to the commencement of each plan year, the Board will establish rates based upon the recommendation of the Agency and PEBP's contracted actuaries based upon a variety of factors, including, but not limited to:
    a. Established plan designs
    b. Forecast claims costs for self-insured plan(s)
    c. Forecast premium costs for fully insured plan(s)
    d. Forecast fixed expenses from plan administrative vendors
    e. Forecast PEBP internal administrative expenses
    f. Forecast required adjustments to reserves
    g. Consideration of material demographic changes
2. **Plan Design** – The Board will identify the priorities for plan design (i.e., options for changes in the plan design). These priorities may include scope of benefits offered by the plan and/or cost-sharing methodologies between the Program and its participants. To the extent possible, cost estimates are presented at the same time as the plan design option for inclusion in the discussion. The Board can

Take into consideration all information provided by Program staff and consultants during the year, along with any other sources available to individual Board members.

The Board makes its initial determination regarding plan design changes approximately four to five months prior to Open Enrollment. Composite trend developed by the Plan actuaries is presented to the Board based on the final plan design changes. Final plan design is approved at the rate setting Board meeting to allow for flexibility and an opportunity to adjust rates at that meeting.

PEBP uses the approved plan design changes and rating methodologies to finalize the rates, subsidies, and participant contribution amounts. The final rates are then reviewed and approved by the Board approximately four to eight weeks prior to open enrollment.

3. **Strategic Planning** – The Board will review, revise, and approve the program's Strategic Plan on an annual basis. The Strategic Plan will be the guiding document designed to assist the Board and the Agency to develop and maintain a high-quality program of benefits at affordable prices. Every effort will be made to review and approve the Strategic Plan prior to the initial annual plan benefit design approval meeting.
4. **Establishing the Legislative Agenda** – Using the strategic plan as a basis, any revisions required to the Nevada Revised Statutes (NRS) to implement the strategic plan will be identified. The Agency will present Bill Draft Request (BDR) recommendations to the Board every even numbered year and develop approved summaries and BDRs in accordance with State mandated schedules. Administrative departments are required to submit non-budgetary Legislative Summaries to the Governor's office by early April of each even numbered year. Upon approval of the Legislative Summary by the Governor's office, completed BDRs are due by June 1st of each even numbered year. Legislative Summaries and final non-budgetary BDRs will be approved by the Board prior to submission.
5. **Preparing the Biennial Budget Request** – Departments are required to submit their biennial budget requests no later than September 1st of each even numbered year. Using the strategic plan and the approved allocation methodologies found in Appendix A as a basis, staff preparation of the biennial budget request begins in the spring of each even numbered year. A framework for the budget request will be presented to the Board in late

spring or early summer, with final approval required at the July or August Board meeting. Budgetary BDRs will be approved by the Board prior to submission on September 1st.

6. **Program Reporting** – Per NRS 287.0425, the Executive Officer shall submit a report regarding the administration and operation of the Program to the Board, the Director of NVHA, the Director of the Office of Finance, and the Director of the Legislative Counsel Bureau for transmittal to the appropriate committees of the Legislature or, if the Legislature is not in regular session, to the Legislative Commission and the Interim Retirement and Benefits Committee of the Legislature created by NRS 218E.420. Additionally, the Board receives reports on a prescribed schedule to assist in strategic planning, decision-making, and program design. Below is a list of the sources of information that will be considered by the Board when making all plan design and rate decisions, along with the timeframe of availability for each item. It is important to note that the information is provided to the Board throughout the year and is not limited to the Board meetings when rates are approved.
    a. Quarterly Vendor Reports – The reports provide utilization activity, participant contacts, provider updates, and other information applicable to each vendor's relationship with PEBP.
    b. Self-Insured Plan Utilization Reports – PEBP's Third Party Administrator provides a utilization report for the self- funded plan on a quarterly basis. In addition, an annual utilization report is provided within 90 days following each plan year. The utilization report provides the following data for the entire plan:
        - Executive summary and trend analysis
        - Plan demographics
        - Paid claims by benefit
        - Medical claims paid for inpatient/outpatient services
        - Surplus and loss summaries broken down by state and non-state groups and active employees, non-Medicare retirees and Medicare retirees
        - Costs by tier and age by medical, dental, prescription
        - Network utilization and cost sharing
        - Analysis of medical paid claims by major diagnostic
            - category, large claims, and prevalence
        - Chronic conditions and wellness
        - Analysis of prescription drug utilization
    c. Disease management and wellness reports are made available to

the Board in vendor quarterly reports. In addition, as each of these programs "mature", they will be analyzed by PEBP and PEBP's consultant/actuary on a cost
/ Benefit basis and the results reported to the Board.

d. The results of any participant questionnaire will be reported to the Board as soon as practical upon compilation of the results.

e. Differential cash will be reported in September to provide the most sound and consistent figures.

7. **Projected Expenses and Rate Calculations** – Any change in methodology for projecting expenses (such as changing from claimstrends to a predictive modeling approach) is to be reviewed and approved by the Board during strategic planning and plan design adoption actions. Rate calculations are to be completed by PEBP using the approved framework and rating methodology. The consultant/actuary firm is responsible for ensuring that industry standards are met for quality control and accuracy of the medical, prescription drug, and dental cost components for each plan year. PEBP staff will compare the projected expenses and rate calculations to the proposed budget and recommend any amendments to the proposed budget and/or plan design that are deemed appropriate. The rate methodology for each plan year shall be included in updates to these Duties, Policies and Procedures (see Appendix A).

Appendix A - Plan Year Rating Methodology

Rates are developed first by establishing plan design. The second step is to project claims costs or premiums for each plan option (e.g., PPO self-funded, HMO, etc.) and participant tier (e.g., single, family, etc.). Finally, PEBP operating costs, administrative costs and reserve adjustments are applied to the various plan options to derive the final rates. Subsidies are applied to the appropriate rate resulting in the participant's contribution. Unless otherwise approved by the Board, rates are to be calculated by staff using the following methods.

Plan Design

- Plan Selection Options (medical, prescription, ~~and~~ vision, dental, and basic life):
  - ✓ Preferred Provider Organization (PPO) Consumer Driven Health Plan (CDHP) (Base Plan) – self-funded with a

    Health Savings Account (HSA) – Active employees on the CDHP plan only; some eligibility restrictions apply. Plan contribution to be set by the Board each year; if there is no Board action, contribution is equal to prior year contribution. Employee contribution is voluntary.

    OR

    Health Reimbursement Arrangement (HRA) – Retirees on the CDHP plan or active employees who do not have an HSA. Plan contribution on the CDHP isequal to the HSA contribution. Plan contribution on the Medicare Exchange is based on the retiree's years-of-service. There is no year over year carryoverlimit for unspent HRA funds in an individual's account. The Board will review the liability associated with unspent HRA funds each year.
  - ✓ Exclusive Provider Organization (EPO) Premier Plan – self-insured
  - ~~✓ Low-Deductible Copay plan (LD) – self-insured~~
  - ✓ Health Maintenance Organization (HMO) Plans – fully insured
  - ✓ Individual Market Medicare Exchange (IMME) – fully insured; only for retirees and their dependents who are eligible for premium free Medicare Part A; Medicare retirees who qualify for the exchange are not eligible for any other PEBP coverage (other than dental) unless they cover a dependent who is not eligible for the IMME. Includes a Health Reimbursement Arrangement (HRA) for those hired before January 1, 2012.

- Self-Funded Plan Designs: See Master Plan Documents for details.
- Benefits other than medical, prescription, and vision: See Master Plan Documents fordetails.
  - ✓ Dental - self-funded; voluntary for IMME retirees, mandatory for all other participants
  - ✓ Basic Life Insurance - fully insured

- ~~Long Term Disability Insurance (LTD) – fully insured~~
- ~~Health Savings Account (HSA) – Active employees on the CDHP plan only; some eligibility restrictions apply. Plan contribution to be set by the Board each year; if there is no Board action, contribution is equal to prior year contribution. Employee contribution is voluntary.~~
- ~~Health Reimbursement Arrangement (HRA) – Retirees on the CDHP plan or active employees who do not have an HSA. Plan contribution on the CDHP isequal to the HSA contribution. Plan contribution on the Medicare Exchange is based on the retiree's years-of-service. There is no year over year carryoverlimit for unspent HRA funds in an individual's account. The Board will review the liability associated with unspent HRA funds each year.~~

- Voluntary Benefits Option/s:
  - ✓ Flexible Spending Account (FSA) – IRS section 125 voluntary plan guaranteed by PEBP. For active employees only, employees with an HSA arenot eligible for a Medical FSA.
  - ✓ Additional Life Insurance – voluntary; fully insured
  - ✓ Long Term Care – voluntary; fully insured
  - ✓ Long Term Disability – voluntary; fully insured
  - ✓ Short Term Disability – voluntary; fully insured
  - ✓ Homeowners and Automobile Insurance – voluntary; fully insured
  - ✓ Accident/Indemnity – voluntary; fully insured
  - ✓ Legal Support – voluntary, fully insured
  - ✓ Identify Theft Protection – voluntary, fully insured
  - ✓ Buy-Up Vision Insurance – voluntary; fully insured
  - ✓ Pet Insurance – voluntary; fully insured

Cost Projections

- Commingling: Pursuant to NRS 287.043(2) and NRS 287.0434(3)(b), claims experience will be commingled for participants for whom the Program provides primary health insurance coverage in a single risk pool of low and high.

- Cost Projection Methodology: Predictive Modeling
  - ✓ In addition to taking traditional rating methodologies into consideration, such as demographics and claims experience, predictive modeling considers PEBP's actual disease states and medical conditions to add precision to actuarial projections
  - ✓ Medical diagnosis data is reviewed by certified clinicians, such as PEBP's Actuary's Medical Director and nursing staff.
  - ✓ PEBP's actuaries will develop rate cards so that there is 50% probability that the developed rates will cover plan costs.

- Secondary Insurance Coordination: Standard Coordination of Benefits

- ✓ PEBP plan pays the difference between the allowable cost of the health care services and supplies provided to the plan participants less whatever the primary plan paid for them.
- ✓ The participant is still responsible for the annual PEBP plan deductible.

- Rate Structure: Separate rates are developed for each of the following groups (NRS 287.043(2)(a) and (b)):
  - ✓ State active employees and non-IMME retirees
  - ✓ Non-State active employees and non-IMME retirees

- Participant Tiers of Coverage: Four
  - ✓ Single
  - ✓ Single + Spouse
  - ✓ Single + Child(ren)
  - ✓ Single + Family (Spouse and one or more children)

Rate Development

- PEBP's actuaries and HMO vendors will develop costs in accordance with the plan design approved by the Board and in accordance with the methodologies found in the Cost Projections section above.

- Enrollment projections are based on the average change in enrollment over the past 4 years and assumptions approved by the Executive Officer.

- The following costs, revenues and reserve adjustments will be allocated equally to all active employees and non-IMME retirees:
  - ✓ Life insurance (per $1,000 of coverage)
  - ~~✓ Long Term Disability (active employees only)~~
  - ✓ PEBP operating costs
  - ✓ Contracted dental network and claims payment administrative fees
  - ✓ Miscellaneous Revenues (RGL 4254)
  - ✓ Treasurer's Interest (RGL 4326)
  - ✓ Cost of Medicare Part B premium credit (reduction to excess reserves, Category 86)
  - ✓ Projected credit due to NRS 287.046(4) (increase to excess reserves, Category 86)
  - ✓ IMME administrative costs for Health Reimbursement Arrangement
  - ✓ Life Insurance for IMME retirees

- The following costs, revenues and reserve adjustments will be allocated only to ~~CDHP~~ self-funded participants:
  - ✓ Contracted CDHP administrative fees
  - ✓ HSA/HRA plan contributions
  - ✓ ~~CDHP~~ Rx Rebates (RGL 4218)

- ✓ Adjustments to Catastrophic Reserves (Category 85) in accordance withreserve policies.

- IMME retirees will not be charged PEBP operating costs, life insurance costs or HRA administration costs. The following costs will be allocated only to IMME retirees who choose PEBP dental coverage:
  - ✓ Contracted dental network and claims payment administrative fees

- Reserves
  - ✓ Catastrophic Reserves will be established at a level necessary to ensure plansolvency over the long term to a set ~~50~~ 45 days on hand.
  - ✓ IBNR Reserves will be established at a level to achieve a 95% probability that all claims incurred can be paid.

Participant contributions for HMO/EPO rates are blended between the northern EPO and southern HMO after all the above adjustments are applied. The blended HMO/EPO rate is based on the average cost of coverage by tier and projected enrollment.

Subsidy Allocation and Participant Contribution

- Base subsidy allocation
  - ✓ The employer subsidy percentages will be recommended by the Board to the Governor during the Agency Request phase of the Biennial Budget. The Legislature, through the Senate Finance Committee and Assembly Ways and Means Committee, will approve the final employer contribution percentages for each biennium when approving PEBP's biennial budget.
  - ✓ Non-State Active Employee: Determined by employer
  - ✓ Non-State Retiree: Determined by State Retiree amount (NRS 287.023(4)(b)) as set in session law and is based only upon years of service, regardless of plan selection or participant tier.
  - ~~✓ A single contribution strategy (flat dollar amount) will be applied equally across PEBP plans CHDP, EPO, LD, and HMO).~~

Include a table here: EE Share (Pending percentages from Segal)

Base Plan:	State Actives Employees %	Dependents %
Base Plan:	State Retirees %	Dependents %

All Other Plans:	State Actives Employees %	Dependents %
All Other Plans:	State Retirees %	Dependents %

- Retiree Years of Service (YOS) subsidy adjustment to the base subsidy (NRS287.046):
  - ✓ Retirees who retired prior to January 1, 1994: No adjustment.
  - ✓ Retirees who retired on or after January 1, 1994:

- For each YOS less than 15, subtract 7.5% of the amount set in session law from the base subsidy.
- For each YOS greater than 15, add 7.5% of the amount set in session law to the base subsidy (maximum, 20 YOS).

✓ Retirees who were hired by their last employer on or after January 1, 2010, and who have less than 15 YOS do not receive a YOS or base subsidy.

✓ Retirees who were hired by their last employer on or after January 1, 2012, do not receive a YOS or base subsidy.

- Medicare Part B premium credit – Retired primary participants enrolled in the Consumer Driven Health Plan, EPO, LD or HMO plan with Medicare Part B coverage will receive a CDHP, EPO or HMO premium reduction as approved by the Board. In no case shall the premium contribution for an individual be less than zero.