MINUTES OF THE
NEVADA LEGISLATURE'S
INTERIM RETIREMENT AND BENEFITS COMMITTEE
(*Nevada Revised Statutes* 218E.420)
February 19, 2016

The first meeting of the Nevada Legislature's Interim Retirement and Benefits Committee (IRBC) was held at 9:00 a.m. on February 19, 2016, at the Nevada Legislative Building, 401 South Carson Street, Room 3138, Carson City, with videoconference to the Grant Sawyer State Office Building, 555 East Washington Avenue, Room 4412, Las Vegas, Nevada.

COMMITTEE MEMBERS PRESENT IN CARSON CITY:
Senator Ben Kieckhefer, Chair
Assemblyman Paul Anderson, Vice Chair
Senator Pete Goicoechea
Assemblyman Randall Kirner

COMMITTEE MEMBERS PRESENT IN LAS VEGAS:
Assemblywoman Maggie Carlton
Assemblywoman Joyce Woodhouse

STAFF MEMBERS PRESENT IN LAS VEGAS:
None

STAFF MEMBERS PRESENT IN CARSON CITY:
Mark Krmpotic, Senate Fiscal Analyst, Fiscal Analysis Division
Cindy Jones, Assembly Fiscal Analyst, Fiscal Analysis Division
Alex Haartz, Principal Deputy Fiscal Analyst, Fiscal Analysis Division
Eileen O'Grady, Chief Deputy Legislative Counsel, Legal Division
Donna Thomas, Committee Secretary, Fiscal Analysis Division

EXHIBITS:

Exhibit A: Agenda and Meeting Packet 1
Exhibit B: AON Handout - Additional Information for Agenda Item IV.1
Exhibit C: Meeting Packet 2

I. ROLL CALL.

Chairman Kieckhefer called the meeting to order at 9:06 a.m. The secretary called roll; all members were present.

Chairman Kieckhefer thanked members and staff for their attendance.

II. PUBLIC COMMENT.

Peggy Lear Bowen, speaking as an individual, said that she voiced her concerns at the PEBP Board meeting held on February 16, 2016, regarding the valuation process for the selection of a state insurance carrier. She noted the PEBP Board worked diligently on a request for proposal (RFP) for the Health Maintenance Organization (HMO) participants within the State of Nevada. Previously, Nevada had one insurance vendor for Northern Nevada and one vendor for Southern Nevada. Traditionally, four carriers were selected from the RFP for consideration by the Board; Anthem Blue Cross Blue Shield; Prominence Health Plan; Hometown Health; and Health Plan of Nevada.

Ms. Bowen stated the previous selection process for a statewide insurance vendor worked perfectly. The vendors were narrowed down and voted on at least twice by the Board before the selection of an insurance carrier. Previously, Hometown Health was the carrier in Northern Nevada and Health Plan of Nevada was the carrier in Southern Nevada. Ms. Bowen said that a Committee was formed of members of the PEBP Board to review all the RFP applicants and selection was reduced to a few vendors. The selected vendors would typically appear before the Board, and usually the Board selected the vendor recommended by the Committee. However, the Board selected Anthem Blue Cross Blue Shield as the insurance carrier for both Northern Nevada and Southern Nevada for Plan Year 2016, which went against tradition. The Committee, which were appointed members, heard the concerns and complaints of the Southern Nevada HMO participants regarding the need for a referral to see a specialist, whereas, the Northern Nevada participants could self-refer to select specialists. Ms. Bowen stated that the Board based its' decision on what was best for State of Nevada public employees, which was based on access to care. She said the two carriers, Hometown Health in Northern Nevada and Health Plan of Nevada in Southern Nevada were maintaining two systems and separate ways of providing care for their participants. Because of the two different systems, the southern participants had to get a referral to see a specialist; the northern participants did not need referrals, but were limited to one hospital – Renown Health. Ms. Bowen noted that Renown Health was not a provider for the HMO, but was a provider for the high-deductible plan. Ms. Bowen stated that with the HMO, she was only allowed to go to Renown Health for medical care. She said Saint Mary's Hospital, Northern Nevada Medical Center, or any other hospital entities within her area were considered out-of-network. She reiterated that Northern Nevada participants were limited to one hospital and Southern Nevada participants had to get referrals before going to a specialist, which was a double payment for the participant. She noted the agenda for the Board meeting on February 16, 2016, indicated that the Board could award Anthem Blue Cross Blue Shield as the HMO vendor for statewide services, or reject the contract. The Board could rescind the current RFP and request a new one, negotiate to keep Northern Nevada in the single hospital situation, or negotiate to select Anthem Blue Cross Blue Shield as a provider for Southern Nevada participants so they did not need referrals for specialists and had access to out-of-state health care. Ms. Bowen said NRS provided the PEBP Board with authority to submit or rescind RFPs, which had been done over the years, but that authority was suddenly removed

from the Board's purview. She said that Mr. Haycock, Executive Director, PEBP, provided responses based on the advice of attorneys. The Board did what they were supposed to do and followed the advice of counsel so not to incur personal liability, regardless if they agreed with counsel. She said the action of rescinding the RFP was done at approximately 11:45 a.m., on February 16, 2016, at the Public Employees' Benefits Program meeting, before the scheduled 1:30 p.m. Public Employees' Benefits Program Board meeting, where procurement of services of the HMO vendors was set to be finalized by the Board. She said the PEBP Board was made to look inept and unintelligent, because the RFP was rescinded by another entity not empowered by the Committee to rescind that action. Ms. Bowen believed that when there was a meeting agenda with a specific time to hear an RFP, and the RFP was rescinded prior to public discussion, input, and action, that it seemed to be a violation of the Open Meeting Law. She said the Purchasing Administrator, Attorney General's Office, and Mr. Haycock, were told what to do; the rescinded motion was not done by PEBP. She asked the Committee to empower the PEBP Board to be the Board it was meant to be. She said that PEBP did a good job and had the intestinal fortitude to make a decision that was not popular. Ms. Bowen asked the Committee to give the PEBP Board the power to reverse the rescinded motion and put the RFP back in place and let PEBP finish its' job, because the Board worked hard for the good of the participants in the State of Nevada.

Marlene Lockard, Retired Public Employees of Nevada (RPEN), stated that she wanted the record to reflect the issues with the ongoing customer service with Towers Watson, the vendor who managed the Medicare Exchange. She stated that RPEN was pleased that the PEBP Board implemented a trial program to have an actual representative in the state to meet with RPEN participants. Recently, representatives from Towers Watson were in Carson City and the response from RPEN members was overwhelming; members were very gratified, and the face-to-face meetings were very helpful. She said RPEN believed the numbers were there from the pilot program, both in Las Vegas and Northern Nevada, to justify the need for Towers Watson to maintain an actual presence in the state to provide customer service to Medicare Exchange participants. She indicated another concern was the ongoing issue of the non-state retiree group, referred to as "orphans." She said the PEBP Board adopted regulation with respect to the orphan issue, but there were winners and losers with the adopted regulation. Ms. Lockard said that RPEN was hopeful that PEBP would include the orphans in the general pool in the 2017 budget, so the issue could be dealt with. She said that the orphans were a diminishing number, and she believed the budget impact would not be significant. Concluding her presentation, Ms. Lockard said that RPEN was not in a position to offer its' opinion on the RFP that was terminated at the February 16, 2016, PEBP meeting, because the proposals and review of the RFPs were confidential. She said that RPEN had stated on the record its' concern with the action of contracting with any entity that would increase rates for retirees in a new contract. She said that at the February 16, 2016, PEBP Board meeting when the RFP was terminated, a Board member stated on record that she wanted to terminate the blended rates for the HMO, which was a significant concern for RPEN. Ms. Lockard said if the blended rates were terminated going forward, it would cause a significant increase in monthly premium rates for RPEN members in Northern Nevada. She hoped the statement from the

Board member was in frustration and not a suggestion that PEBP would actively pursue.

III. PUBLIC EMPLOYEES' RETIREMENT SYSTEM (PERS).

1. Approval of executive staff salaries (NRS 286.160).

Tina Leiss, Executive Officer, Public Employees' Retirement System, provided an overview of the salary modifications approved by the Retirement Board (Board) for Fiscal Years (FY) 2016 and 2017 (page 5, Exhibit A). She introduced Steve Edmundson, Investment Officer, PERS. Ms. Leiss stated that pursuant to NRS 286.160, the PERS executive staff salaries were fixed by the Board on an annual basis and subject to the approval of the Interim Retirement and Benefits Committee (IRBC). At the January 2014 IRBC meeting, the IRBC approved a maximum salary for seven positions that were in statute at that time. Currently, there were eight positions in statute as a result of Senate Bill (S.B.) 420 (2015), which added a General Counsel position. The IRBC approved the maximum salaries for those positions for FY 2016 and FY 2017 and applied the contribution rate change to the salaries as of July 2015, which essentially was a reduction in salaries of approximately 1.125 percent. The Board then approved a 1 percent cost-of-living adjustment (COLA) as of July 1, 2015, and a 2 percent COLA as of July 1, 2016, which followed suit with the COLA's provided to classified and unclassified state employees by the 2015 Legislature. Ms. Leiss referenced the chart on page 6 of the meeting packet (Exhibit A), which displayed the maximum salaries for each position listed in NRS 286.160, as approved by the Board for FY 2016 and FY 2017. She noted the FY 2016 salaries were lower than the salaries approved in FY 2015, which was a result of the contribution rate increase and to reflect the COLA.

Ms. Leiss stated that the General Counsel position was created in S.B. 420, and the maximum salary for the position was not previously approved by the IRBC. The Board established a salary for the position equivalent to the salary of the Chief Financial Officer.

> ASSEMBLYMAN KIRNER MOVED TO APPROVE THE PROPOSED EXECUTIVE STAFF SALARIES OF THE PUBLIC EMPLOYEES' RETIREMENT SYSTEM. SENATOR GOICOECHEA SECONDED THE MOTION.
>
> THE MOTION CARRIED UNANIMOUSLY.

2. Report on actuarial valuation for the Public Employees' Retirement System as of June 30, 2015.

Ms. Leiss directed the Committee to page 7 of the meeting packet (Exhibit A), which provided an update on the FY 2015 actuarial valuation for PERS. By statute, the Board must perform an actuarial valuation at least every other year to monitor the assets and liabilities associated with the pension plan. However, the odd-numbered year valuation

did not affect contribution rates, but was used in the interim to review demographics and funding. She added that if it had been a rate-setting year the rates would not have changed. The actuarial rate decreased approximately .2 percent, from 27.99 percent to 27.80 percent in the employer-paid Regular fund, which essentially indicated what was going on in the valuation. The news was good for the System, and they were right on track with expectations. Ms. Leiss indicated there was an overall gain with the System and when all the assets, demographic and economic changes were combined, there was a $642.0 million gain above what was assumed in FY 2015, and when the gain was applied, the actuarial gain decreased slightly. In addition, there was $893.0 million in unrecognized gains as a result of the asset "smoothing" process, and essentially, there was a process where the investment gains and losses were rolled together and combined over a five-year period to meter the volatility of the asset returns. She noted that currently, PERS was carrying $893.0 million in gains that would be recognized in portions over the next four years with any gains and losses PERS had in investments over that time period.

Continuing, Ms. Leiss stated that PERS indicated that the number of active members in both the Regular fund and the Police/Fire fund increased from 100,522 members to 103,108 members, which was still below PERS' highest active membership of 106,123 seen in FY 2008. PERS total payroll increased by 2.22 percent, which was still below the high in 2009. The estimated time period until both plans were fully funded declined as the funds continued to make progress on paying off the unfunded liabilities. Based on the 2015 valuation, assuming all actuarial assumptions were met, the Regular fund would be fully funded in 20.8 years, a decrease of approximately one year from the last evaluation, which was exactly where PERS expected it to be. The total unfunded liability decreased by $179.0 million from FY 2014 to FY 2015. Ms. Leiss stated that all contribution rates for the employer and the employee/employer pay for the Regular fund and the employer pay and the employee/employer pay for the Police/Fire fund showed a slight decrease in the actuarial rate and were below the current statutory rate for those funds.

Referring the Committee to pages 11 and 12, Exhibit A, Ms. Leiss stated that the pages showed the demographic information for the Regular fund and Police/Fire fund for the active and retired members.

Assemblyman Kirner asked if the unfunded liability had actually decreased, and Ms. Leiss replied that it decreased by $179.0 million.

Assemblyman Kirner said the actuarial-funded ratio for the total fund increased from 71.5 percent to 73.2 percent, but the return on investment was only 4.1 percent, half of the assumption. He asked if the five-year flattening out helped PERS reach its desired level.

Ms. Leiss responded that there were a number of things that resulted in the flattening out – the actuarial return was 8.36 percent because of the five-year smoothing. For instance, in FY 2014, there was a return of approximately 17 percent and those gains and losses were not taken all at once to meter the volatility. She stated there

were unrecognized gains combined with the layers of losses, and in this case, PERS rolled over a portionable loss from 2015, because the market return was about 4.19 percent. Therefore, combined, those five-years of gains and losses showed a small gain on the assets and there was still an unrecognized gain as well, creating a small cushion for the next three years.

Assemblyman Kirner asked, when an investment return of 4.2 percent was reported and an actuarial return was even higher, if the assumption of 8 percent was based on an actuarial return or investment return.

Ms. Leiss replied that the 8 percent was an actuarial assumption, which was what was assumed on an actuarial basis. She said that PERS reported both ways – the valuation was done on an actuarial basis; otherwise, reporting was generally on a market basis. Currently, under the Governmental Accounting Standards Board (GASB) 68, the assets reported for financial purposes were on a market value basis, which was why there were two funded ratios. For instance, the PERS funded ratio on a market value basis, was 75.1 percent and on an actuarial basis, it was 73.2 percent due to the unrecognized gains on the actuarial side.

Assemblyman Kirner asked which year PERS used for inception since returns were recorded from inception, and Ms. Leiss replied the inception year was 1984. She explained that prior to 1984, PERS used a book value of accounting for assets, so the book value was just what PERS paid for the assets. She said PERS used the 1984 inception date because that was when PERS went to a market value of accounting for the assets.

Chairman Kieckhefer asked if there were other factors that contributed to the investment return to determine the years until fully funded or the percentage funded, or if it was just the actuarial investment return above 8 percent.

Ms. Leiss replied there were a number of demographic and economic factors involved in the actuarial valuation, and many years those factors were more significant for the valuation than just the investment return itself. The payroll growth was significant because it determined the timing and method of contributions, retirement, longevity, and if there were more or less deaths than assumed. In addition, a large factor was the post-retirement increases, essentially the COLAs that were paid to retirees, which were set as a percentage in statute, but capped by the rolling three-year average of the Consumer Price Index (CPI). Therefore, when there were low inflationary rates, PERS paid out less in benefits, which contributed to the ultimate liability number. She said that for this particular valuation, the investment return was neutral and many of the demographic factors were much more significant.

Chairman Kieckhefer said he was aware it was not a rate-setting year, but looking at the different demographic factors, he asked if PERS adjusted the demographic factors based on the valuation, or waited for the calculations or until a rate-setting year to adjust those factors.

Ms. Leiss replied that PERS monitored the demographic factors every year, which was why it conducted an annual valuation to avoid overlooking a trend. She noted that typically there were few changes year-to-year. She added that PERS would conduct an experience study in calendar year 2017 to review the experience and assumptions to determine where there were deviations, and the necessary changes would be made the following year.

Chairman Kieckhefer asked Ms. Leiss if she had a sense of the outlook for the next cycle in terms of rate setting, since there was $893.0 million in unrecognized gains that would be carried forward.

Ms. Leiss replied she could not predict what the rates would be, although more information would become available around mid-November 2016. Based on the current valuation, the trends looked favorable; however, she could not predict what would happen between now and June 30, 2016, which was the cutoff date for the data and valuation. Because of the contribution rate mechanism, particularly the Police/Fire fund, PERS was currently funding a percent over the actuarial rate, or the statutory contribution rate. PERS was slightly over funding by .2 percent in the Regular fund, which would be helpful as well. Ms. Leiss said, ultimately, the trends were looking good, but she could not predict how the rates would change.

Assemblyman Kirner stated that his personal funds had taken a hit since January 1, 2016, and he was curious how contribution rates would look in the future. He understood that Ms. Leiss could not make a prediction, but at this point, things were not looking good.

Ms. Leiss replied there were unrecognized gains, and the reason for the smoothing process was because PERS was aware there would be fluctuations over the years and PERS would never hit its' assumptions exactly. In addition, other factors could be noteworthy, such as significant gains or losses, which would not help predict the contribution rate. She stated there could be an investment loss causing rates to decrease, or an investment gain causing rates to increase, and it depended on all the factors combined.

3. Report on actuarial valuation for the Judicial Retirement System as of June 30, 2015.

Ms. Leiss referred the Committee to page 13 (Exhibit A), 2015 Actuarial Valuation for the Judicial Retirement System (JRS). She stated that similar to PERS, 2015 was a non-rate setting year for the JRS. The JRS covered state judges, municipal judges and justices of the peace for local jurisdictions who opted to participate in the JRS. However, unlike PERS, the JRS did not have cost sharing and each employer had its' own rate and funding. She said PERS only provided rates for state judges. Ms. Leiss said there were 12 participating employers that had individual rates and contributions. The actuarial-funded ratio of the JRS, in aggregate, increased from 79.3 percent to 82.1 percent. The total unfunded liability decreased from $22.4 million to $21.3 million, and the total unrecognized investment gains as of June 30, 2015, were $2.8 million.

Ms. Leiss stated the contribution rate for state judges was paid differently than for PERS. State judges had a contribution rate called the "normal costs," the costs of the accrual of the benefits going forward and administrative expenses, which was a percentage of payroll made on the judges' salary. In addition, the state paid a lump sum payment for the unfunded liability payment each year. She stated the unfunded liability was set up differently, because when the System was created in 2001 it was a pay-as-you-go system. Therefore, the state appropriated funds each year to pay the pensions of district court judges and Supreme Court justices. When the System began in 2001, it absorbed the liabilities of the previous pay-as-you-go system and began making the benefit payments to all previously retired state justices and judges. Payment on the state's unfunded accrued liability of the JRS was done annually on a lump-sum basis as part of the judicial budget. Ms. Leiss indicated that the current statutory rate for state judges was 21.25 percent and the actuarial rate was 21.26 percent, so the rate would remain unchanged. The actuarial calculated lump sum payment on the unfunded liability came in lower than it had in 2014 by approximately $15,000. Ms. Leiss stated that PERS was right on track on where it expected to be with the JRS.

Assemblyman Kirner asked if the creation of the public court had an impact on the JRS. Ms. Leiss replied that the public court would not impact the judicial system, but added three potential positions into the System. She said if the judges were PERS' members when they took the bench, they could remain with PERS or transition to the JRS.

4. Report on actuarial valuation for the Legislators' Retirement System as of June 30, 2015.

Ms. Leiss continued with her presentation, page 14 of Exhibit A, Fiscal Year 2015 Actuarial Valuation for the Legislators' Retirement System (LRS). She stated that 2015 was the first year that an annual valuation was performed for LRS. Previously, LRS valuations were done biennially, because it was a relatively small system and did not have the demographics and economic changes like PERS. However, PERS decided to do an annual valuation because of the GASB 67 and 68 reporting, which would provide the most current reporting each year. She added that the valuation did not impact the funding of the LRS. She noted that legislators had the ability to opt out of participation in LRS, so the membership was decreasing; there were 35 active members in 2015 compared to 40 active members in 2014. The number of beneficiaries decreased from 79 to 78. The funded ratio of the System increased from 77.5 percent to 83.5 percent for the valuation, and the LRS had $230,000 in unrecognized investment gains. She added there were good demographic experiences in the unfunded liability in 2015, decreasing from $1.2 million to approximately $888,000.

Chairman Kieckhefer asked if it made sense to operate and maintain the LRS, because most legislators did not remain in office for an extended period of time due to term limits.

Ms. Leiss replied that was a policy decision for the Legislature. Obviously, PERS would continue to operate as long as it had beneficiaries to pay, but it was something for the

Legislature to consider going forward. She stated that the maximum benefit was achieved after 30 years of service, and with term limits, it was impossible for legislators to receive the maximum benefit.

Chairman Kieckhefer asked if it took five years to be vested in the LRS, and Ms. Leiss replied that the LRS was the only system that required ten years to be vested.

Chairman Kieckhefer commented that most legislators would term out before they were fully vested in the LRS.

5. Update on investment earnings – PERS, Legislators' Retirement and Judicial Retirement Funds.

Steve Edmonson, Investment Officer, PERS, referenced page 17 (Exhibit A), Investment Update on PERS, LRS and JRS through Fiscal Year 2015. Mr. Edmonson stated page 17, Investment Results, summarized investment performance for PERS, LRS, and JRS for various time periods ending June 30, 2015. He said for the most recent fiscal year, FY 2015, PERS generated a 4.2 percent return net of investment fees and ended the year with $34.5 billion in assets, which represented a $1.0 billion increase from the prior year. Over the last 31 years, PERS generated an average annual return of 9.4 percent net of all investment fees. The return for the LRS fund, for FY 2015, was 3.7 percent and the year ended with $4.9 million in assets. The JRS fund return for FY 2015 was 3.4 percent and ended the year with an asset value of $98.6 million. Mr. Edmonson stated that PERS investment strategy was attributed to a simpler, common sense strategy that was unique in the industry. The approach emphasized exposures to high quality publicly traded stocks, and government guaranteed U.S. Treasury bonds. In addition, PERS utilized 100 percent index management throughout stock and bond portfolios, which was also unique in the industry. As a result of the simpler structure, PERS investment expenses were the lowest among its peer group in the industry by a significant margin and PERS achieved considerable competitive results relative to its peers in terms of returns. For both short and long-term periods, PERS generated better returns with less risk and for FY 2015, PERS returns ranked in the top 15 percent of its peer group. On a fee-adjusted basis, PERS returns over every meaningful time period, end of June 2015, were either within the top 30 percent or better, which included inception returns of 31 years. PERS risk adjusted returns were also very competitive and ranked within the top 15 percent in the country for nearly every trailing time period. Continuing, Mr. Edmundson stated that the LRS and JRS funds were comparatively competitive relative to their respective peer groups. Since inception, the LRS fund total fee adjusted return ranked within the top 15 percent of its peers groups, and the JRS fund ranked within the top 34 percent since its inception.

Directing the Committee to page 18 (Exhibit A) PERS' Annual Performance, Mr. Edmundson said the chart provided a year-by-year netted fee return. He explained that the horizontal line on the page depicted the 8 percent actuarial objective, and as a long-term investor, he did not expect to achieve an 8 percent return each year. However, looking at all the years, the 8 percent had been achieved since inception.

Moving to page 21 of Exhibit A, Mr. Edmonson stated that PERS' Investment Strategies were detailed on the page; and the legislators and judicial investment strategies were detailed on page 22. He noted that the legislators and the judicial portfolio strategies differed slightly from the larger PERS fund due to the difference in asset size between the funds. However, on a statistical basis, the portfolio strategies were very similar to the PERS fund based on the total allocation of risk assets. He said that diversification was, and continued to be, a key measure for all three plans. In addition, the portfolios were allocated to both domestic and international stocks, U.S. Government guaranteed Treasury bonds, and in the case of PERS, private real estate and private equity investments. The System holds an excess of 2,000 individual securities to diversify risk and stabilize returns over time. PERS also avoided direct exposure to some of the more complex and expensive investment strategies that were utilized in the industry, such as the use of leverage, high-yield bonds or hedge funds. Mr. Edmundson noted PERS total investment expenses were 11 basis points or 0.11 percent, which were considerably lower than its peer group. The savings relative to a similar size fund was in excess of $2.0 billion compounded out over a decade, assuming that the fund had the same number of assets as PERS, or approximately $151 million per year. In 2012, the Maryland Public Policy Institute published a paper that indicated Nevada PERS was the lowest cost, externally managed public fund in the industry. He added the LRS and JRS portfolios were comparatively low cost as well and total costs were 94 percent less than its respective peer groups. Mr. Edmundson stated that to his knowledge the LRS and JRS funds were probably the lowest cost funds in the entire public fund industry.

Assemblyman Kirner asked if the 8 percent return assumption discount rate was a function of the PERS Board coming to an agreement, or if it was an actuarial assumption.

Mr. Edmundson replied that it was an actuarial assumption adopted by the PERS Board; however, PERS also utilized consideration provided by the actuary in the process of determining that number. He noted that the PERS Board made the final decision on the percent return assumption based on input from the actuary.

Assemblyman Kirner stated that half of the 126 large plans in neighboring states, such as California and Oregon, reduced their assumption discount rate to 8 percent or lower, which was the "new normal." He asked Mr. Edmundson if there were any recommendations from the actuary, or from other sources, to suggest adjusting that number.

Mr. Edmonson replied the 8 percent return assumption had been discussed many times by the PERS Board. He said that based on the information that PERS had, approximately one-third of funds continued to utilize the 8 percent or higher return assumption as a discount rate. The funds that were reducing the number below 8 percent, in the context of the long-term investment return assumption, implied there was a level of specificity or precision over the course of 30 years, where investment returns could be predicted within 25 basis points, which he thought would be difficult. He said looking at it in that context, the discount rate, as much as anything else, was

really a measure of financing risk. He stated that when another public fund reduced its investment return assumption from 8 percent to 7.75 percent, that fund was really reducing the financing risk rather than making an explicit investment return prediction.

Assemblyman Kirner stated that it really did not matter if there was a defined benefit; it was about funding the defined benefit and not changing the investment return and it did not change the obligation PERS had toward the employee, and Mr. Edmundson agreed.

Assemblyman Kirner stated that for example, if the percentage for investment return assumption was increased to 9 percent it would lower the unfunded liability, or if it was lowered to 7.5 percent like California used, which was a large plan, it would increase the unfunded liability, and Mr. Edmundson agreed.

Assemblyman Kirner asked the status of PERS' policy to invest in Nevada-based businesses. Mr. Edmundson replied that PERS does not specifically invest in Nevada-based businesses. In fact, the System's obligation was to invest specifically for economic benefit of its members and beneficiaries, so it was not something the System necessarily took into account. However, there were a number of publicly traded and privately held companies that PERS invested in that had significant exposure to the State of Nevada.

Assemblyman Kirner stated that it seemed the policy to invest in Nevada-based businesses had been adjusted.

Mr. Edmundson responded that the current policy for PERS had been in place since the 1980s. He stated that PERS would sometimes report on its exposure to Nevada companies, but there was no specific obligation to invest in Nevada businesses.

Chairman Kieckhefer said that some states adjusted their contribution rates downward and expected returns to be down. In addition, some states had fixed contribution amounts, so there were implications for Nevada since the state had a movable contribution rate. If the state were to adjust its expected rate of return, it could have a dramatic effect on how much people had to pay into the System to keep it actuarially sound.

Ms. Leiss replied that the structure of contribution rates in Nevada was very unique and most states did not automatically adjust to the actuarial rate. She believed that Nevada had one of the best funding mechanisms because the state was always "taking their medicine" every two years and adjusting the actuarial rate. The other factor was that Nevada was one of a few states where the employees paid half of the full rate; therefore, when the unfunded payment increased, the employee's contribution increased as well, which was also a consideration. For many states that made adjustments to the 8 percent return assumption, it did not flow directly to their contribution rate, which was one of the many factors that the Board considered when it did the actuarial assumptions. She noted that PERS would conduct an experience study in calendar year 2017, which was one of the many assumptions PERS would look at and the Board would consider and adjust if necessary. She cautioned that the

assumptions had a direct link to Nevada's contribution rate, which was not necessarily the case in other states.

Chairman Kieckhefer asked Ms. Leiss if PERS reduced the expected rate of return if it would result in an increase in contributions, and Ms. Leiss replied it would most likely increase contributions. She added that because PERS adjusted the rates every two years based on Nevada's actuarial evaluation, PERS looked at all the gains and losses against the assumptions, including the gain and losses versus the 8 percent return assumption, which would ultimately be added to the unfunded liability and reflected in the contribution rates. She said Nevada was funding based on actual returns, but it was just a different mechanism. Ms. Leiss stated that she did not want to give the impression that PERS was not funding based on its actual returns, because the cost was going to be the same whether the assumption was 7 percent or 8 percent, and it was a matter of timing of the payments and contributions. Ms. Leiss noted that other states had very different circumstances, whether the rate was lowered or raised in their assumption was one of the many factors, including what their particular mechanism was, which was different than Nevada.

Ms. Leiss reiterated that Nevada had a great system in place and the state recognized those gains, losses and ultimately the contribution rate. She stated that ultimately, the cost was what the cost was, no matter what the assumption was.

Chairman Kieckhefer added that it was fair to say some states had very bad financing mechanisms in place.

6. Status report on one-fifth of a year purchase of service benefits for certain education employees provided under the former provisions of NRS 391.165.

Ms. Leiss referenced page 29 of the meeting packet (Exhibit A), which provided an update on the benefit for certain educational employees pursuant to NRS 391.165. She stated that under the provisions of NRS 391.165, certain qualified educational professionals were eligible to purchase one-fifth of a year service after any school year if they were teaching in a school designated as "needs improvement" or where at least 65 percent of the pupils were at-risk. The provisions also required a purchase for teachers holding an endorsement in specified areas if they had been employed for one year in the area of endorsement and met other eligibility requirements. Section 4 of Assembly Bill 1 of the 23rd Special Session repealed this benefit effective July 1, 2017, and phased the benefit out over time, so PERS was seeing the purchases under this program decline. However, if the employee was under contract prior to the repeal of the provision, they could continue in the program until they earned one full year of service credit pursuant to the program; therefore, PERS would still be carrying the one-fifth of a year purchase of service.

Moving to page 31 of Exhibit A, Ms. Leiss stated the two charts on the page reflected the purchases of one-fifth of a year service for 2014 and 2015. In calendar year 2014, approximately $1.4 million was paid for 328 purchases of one-fifth of a year service

credit, and in calendar year 2015, approximately $1.1 million was paid for 257 purchases. Since the inception of the program, Ms. Leiss indicated more than $144.0 million was paid for 40,935 purchases of one-fifth of a year service benefit.

Chairman Kieckhefer clarified for the Committee that the yellow sheet inserted before page 29 of Exhibit A was the correct information provided by PERS. He said the last paragraph on the page showed the correction – $144,469,000 was the correct amount the System received since inception of the program, and not $3,999,233 as shown in the meeting packet.

Responding to Chairman Kieckhefer, Ms. Leiss stated that PERS could not estimate how many members would access the one-fifth service credit going forward, because it depended on whether the members were in the same position during the current school year versus the previous school year. However, purchases were expected to diminish as the restrictions of A.B. 1 limited the group of employees eligible for the benefit.

7. Status report on administration and investment of the Retirement Benefits Investment Fund (NRS 355.220).

Mr. Edmundson directed the Committee to page 33 of Exhibit A, Status Report on the Retirement Benefits Investment Fund (RBIF). He stated that by statute, the Retirement Benefits Investment Fund was managed by the Retirement Board solely as an investment vehicle for public employees who chose to participate in the program to fund other post-retirement benefits. The decision to invest or withdraw from the program was at the discretion of each employer, and the structure was similar to how mutual funds were managed for individual investors. The RBIF held $290.0 million in assets as of June 30, 2015, and generated a return of 3.4 percent for Fiscal Year 2015. The portfolio experienced an annual return of 6 percent since its inception in January 2008. Mr. Edmundson stated that due to the structure of the funds, the investment performance for each member of RBIF was dependent on when they actually contributed their funds. Therefore, since inception performance was actually 6 percent, it only represented the performance for the first investor in the plan and then everyone else had a different performance depending on when they actually contributed funds. Because the Board utilized 100 percent index management and RBIF took advantage of the multibillion dollar investment management relationships, PERS maintained that the portfolio's investment fees were very low and approximately 94 percent less than the median fund in its peer group.

Concluding, Mr. Edmundson stated that the statute required RBIF to be managed in a similar manner as PERS. Due to its smaller structure ($290 million in assets versus $34.5 billion), there were some differences between the funds; however, the overall long-term risk allocation was identical between the two funds. He added that for the last three years and since inception, RBIF's return was within 0.1 percent of PERS.

Assemblyman Kirner asked the current Public Employees' Benefits Program (PEBP) balance, and Mr. Edmundson replied that he thought the balance was approximately $300,000.

8. Annual report of investments of money from the Public Employees' Retirement System in scrutinized companies (NRS 286.723).

Mr. Edmundson referenced page 35 (Exhibit A), Assembly Bill 493 reporting, companies with exposure to Iran. He stated that pursuant to the reporting requirements in A.B. 493 (2009), PERS was required to report any exposure to investments in companies that had exposure to Iran. Similar to prior years, Mr. Edmundson stated that Nevada did not own stock in any company on the current list of companies that were being scrutinized for doing business with or in the country of Iran. He reported that, however, due to the recent sanctions being lifted on Iran, although PERS was not sure what its exposure would be in the future, he assumed exposure would be higher as multi-national companies started looking for some exposure to Iran.

9. Update on legislation passed during the 78th Legislative Session.

Ms. Leiss directed the Committee to page 37 of Exhibit A, which listed the legislation passed during the 78th Legislative Session that had a direct impact on PERS and the status on the implementation of the bills passed in 2015.

Ms. Leiss stated that Assembly Bill 180 (2015) changed the process for PERS' financial audit of the System. She said that a financial audit of the System was performed on a yearly basis, in addition to a biennial audit performed pursuant to statute. Assembly Bill 180 required PERS to select an independent certified accounting firm through an open bidding process once every four years. Assembly Bill 180 prohibited the Board from considering any bid or proposal submitted by a person who was selected to provide the audit of the System in the immediately preceding cycle of selection, so essentially, the System would be changing auditors once every four years. The current audit cycle was through FY 2017, and at that point, the System would conduct a request for proposal process for audit services pursuant to A.B. 180 for FY 2018. The current audit firm would not be included in that proposal process.

Chairman Kieckhefer asked if there was a higher cost associated with changing auditors that were unfamiliar with the System. Ms. Leiss replied that potentially there could be an added cost because the new firm would require additional hours to become familiar with the System. However, the System had certain requirements for auditors before they bid on the contract and the independent certified public accounting firm that performed the audit was required to have a specific level of experience with public pension plans of a certain asset size. Therefore, the audit firm had to be familiar with the industry as a whole, but not specifically familiar with Nevada's plan. She reiterated there could be added costs and she presumed the firm would build in more hours in the contract because of the lack of familiarity with the state; however, she did not think the cost would be significant.

Senate Bill 12 was requested by the Retirement Board to change the title of the Assistant Investment Officer to Chief Financial Officer. Ms. Leiss thought the title change would enhance the System's financial controls and recognize the simple and externally managed investment program. The position was filled with a qualified candidate to become the Chief Financial Officer for the System, so it was simply a title change with no change in pay; however, the responsibilities and duties were changed, and the position was responsible for the accounting and financial functions of the agency.

Senate Bill 69 was requested by the Supreme Court. The bill provides for the continuation of the Senior Judge Program with certain criteria established for a judge who had retired. Ms. Leiss stated that Senate Bill 69 essentially took the sunset off of the ability of retired judges to become Senior Judges and not face a suspension of their retirement benefits. The program was put into place with certain restrictions to ensure there were cost containment features on the provisions. She added that S.B. 69 was not anticipated to have a fiscal impact on the JRS because of the limitations placed on the eligibility for reemployment.

Senate Bill 406 was the most significant bill for changes to the System. She said the bill was a benefit reform bill with very significant funding implications that resulted in cost savings in the future. However, she cautioned that for new members as of July 1, 2015, and as new members were rolled in, it would lower the ultimate cost of the benefits going forward, and would take a long time to roll in so that all active members and retirees were under the provisions. Some pertinent points on S.B. 406 were:

- An additional benefit option for a surviving spouse or survivor beneficiary of a police officer or firefighter killed in the line of duty or other member killed in the course of employment, judicial service or legislative service on or before July 1, 2013.

- Amended the age of eligibility to receive retirement benefits for persons, other than police officers or firefighters, who become members of the PERS or JRS on or after July 1, 2015, which had the effect of lengthening careers by removing the provision for someone to retire at any age after 30 years, and put it to the provision that was in effect in 1989, which was 30 years of service at age 55. In addition, it created a 33 ⅓ years and out of service, which matched up with the maximum benefit of 75 percent with the new multiplier of 2.25. Ms. Leiss stated that one of the adjustments in PERS demographics was to adjust to the longevity of the members; members were living longer, which continued to increase. Therefore, when careers were lengthened it was good for the state to keep people on the job, but in addition, it would mediate the effects of the increased longevity, and PERS would be paying benefits for the same length of time as for the members who retired a little earlier and died a little earlier. She stated the way that saved the System money over the long-term made it so that PERS could meter the effects of increased longevity on their members and retirees. She noted it reduced the multiplier to 2.25 percent, which matched the eligibility so members could achieve the same 75 percent benefit, but just took 33 ⅓ years for the Regular fund, but it matched up with the increased longevity that PERS was seeing. In addition, it provided that purchase of

service could no longer be used for retirement eligibility purposes and made it so members could not buy their way to eligibility, which had the effect of increasing careers and was part of the mission of the System. In addition, when the length of careers was increased it metered the effects of longevity.

- Limited the amount of compensation that could be used to determine retirement benefits for people who became members of the public retirement systems on or after July 1, 2015. The provisions of A.B. 406 also instituted a cap of reportable salary of $200,000, which would ultimately affect the top end of the benefit for higher wage earners. In addition, the Internal Revenue Service also put a cap on that reportable salary, which was a little higher than $200,000.

- Clarified that the term "spouse" includes a domestic partner for purposes of eligibility for survivor benefits from a public retirement system.

- Removed the sunset of certain provisions relating to retired public employees who fill positions for a critical labor shortage. She stated the governing body of employers may designate positions as critical labor shortage and then those members filling positions, if they met the requirements, would not be subject to the reemployment restrictions.

- Provided that a member who was convicted of or plead guilty or nolo contendere to certain felonies, which arose directly out of his or her duties as an employee, forfeit all rights and benefits under the System.

- Reduced the post-retirement increase formula for retirees who became members of the retirement system on or after July 1, 2015.

Ms. Leiss stated that the 2009 Legislature removed the possibility of a 5 percent COLA and the 2015 Legislature removed the possibility of the 3½ percent and 4 percent COLA, which was the same benefit formula that was in place in 1989. She said that those higher-level post-retirement increases had been added in the 1990s.

Ms. Leiss stated that the System had made the initial changes necessary to implement those provisions effective July 1, 2015. The System enrolled members as new members and flagged them as July 1, 2015, tier members. The System was in the early stages of the necessary computer modifications to fully implement the provisions of S.B. 406. There was a five-year vesting and the System had essentially five years to institute all of the changes. The System expected the computer modifications to be included in its budget for the 2017 Legislative Session.

Ms. Leiss indicated that since July 1, 2015, the System enrolled over 6,000 new members in the new tier. Over time, S.B. 406 was expected to generate significant cost savings. She noted that since the 2009 changes, enrollment was between one-quarter and a third of PERS membership. Therefore, the System would be seeing those savings in the future in the normal costs of the contribution rate.

Chairman Kieckhefer asked if the program changes were applied only to the members coming in to the System effective July 1, 2015, and Ms. Leiss replied that was correct. She added that the processing system was set in place to calculate benefits for the people that were PERS members prior to January 1, 2010, because those people had one structure. She said that most of the changes made were for people hired between January 1, 2010, and June 30, 2015, because those members had a different structure. In addition, there were new members coming into the System July 1, 2015, and thereafter, so essentially PERS needed three different systems based on the membership date of the members.

Ms. Leiss added that similar changes were made to the JRS and the multiplier was reduced by the same amount as for the Regular fund. In addition, every member of the JRS hired prior to July 1, 2015, had a "true employer-pay" provision – the employer paid 100 percent of the contribution without a reduction of salary. She stated that any new judge on the JRS on or after July 1, 2015, would be paying half of the contribution rate as an after-tax deduction from their salary. She clarified if a judge was a member of PERS and transferred their PERS service into the JRS, those judges maintained their PERS membership date of prior to July 1, 2015.

Chairman Kieckhefer asked if the components of Senate Bill 406 were included in the actuarial valuation of the date for full funding, and Ms. Leiss replied the actuarial valuations were a snapshot of where the System was on June 30, 2015, and because those provisions were not put into place until July 1, 2015, they had no effect on the last valuation. However, she noted there would be some effect on the new valuation, because that process projected liability for each member in the System and then the new benefit structure would be taken into account.

Chairman Kieckhefer said that it seemed like 6,000 new members in just over six months was significant. Ms. Leiss replied it was a significant number due to a combination of employers hiring new positions, positions that had not been filled previously, or positions that were vacant. In addition, that figure included new employees hired to replace recent retirees.

Chairman Kieckhefer stated that he worked on Senate Bill 406 during the 2015 Legislative Session, and it was estimated the bill would save approximately $1.0 billion a decade. Ms. Leiss responded that $1.0 billion was an estimate based on the current payroll, so essentially the actuary had estimated that when the provisions were fully rolled in it would reduce the contribution rate by a certain percentage and that percentage would be applied to the current payroll to determine an estimate. She said that $1.0 billion was still a good estimate; although, it may be a little conservative if payroll increased by the time the changes were rolled in.

Assemblywoman Carlton asked if there were three or four different retirement structures for employees with the changes encapsulated in Senate Bill 406.

Ms. Leiss replied there were three major tiers; people hired before January 1, 2010, people hired between January 1, 2010, and June 30, 2015, and people hired on or after July 1, 2015. She indicated that the fourth tier were people referred to as the "90 percenters," which were employees hired prior to July 1, 1985, whose maximum benefit could go up to 90 percent; whereas employees hired after July 1, 1985, had a maximum benefit of 75 percent. Ms. Leiss stated the System operated under four different structures depending on membership date.

Assemblywoman Carlton stated that theoretically four employees with the same position title could be earning different retirement benefits. Ms. Leiss replied that was correct because there were the four different retirement structures. She said that most of the "90 percenters," employees hired prior to July 1, 1985, had retired and currently, there were only a few members remaining in that category. In addition, a lot of the changes were related to retirement eligibility. Part of the reason for that was due to increased longevity for newer employees and retirees.

Assemblywoman Carlton asked if some of the benefit changes were modeled after the 1989 structure, and Ms. Leiss agreed. Ms. Leiss stated that a number of the benefits removed from the structure were benefits that were put into place in the 1990s, so essentially with the changes made by the 2009 and 2015 Legislatures, the current structure matched the structure in 1989 prior to the benefit increases that were instituted in the 1990s.

Assemblywoman Carlton said she wanted to ensure the minutes reflected that the state was going backward and not forward in taking care of Nevada state employees and retirees, and dealing with benefits that needed to be addressed. She disclosed that her husband was a retired state employee and had taken a position to fill a critical labor shortage need. She stated that because of the expiration date of the provisions related to retired employees who filled critical labor shortage needs, she thought it was important for PERS to track how those employees were being utilized and where the shortages were, because if retirees continued to fill the critical labor shortages, the state was never going to bring up the next generation of workers, especially with decreased benefits. She expressed that it was important to track the number of retired employees returning to work and the impact and cost it had on the retirement system, because it could impact retirements in the future. Assemblywoman Carlton recalled that a few years ago there was an issue with retirees being hired as contractors and "double-dipping," and now the state was seeking retired employees to return to work, which was the same as double-dipping.

Ms. Leiss responded that PERS would track the critical labor shortage to ensure the System was paying appropriately. In addition, the System had to ensure that anyone in a critical labor shortage position had met the statutory requirements, so it would absolutely be tracked.

Senate Bill 420 was requested by the Retirement Board in its biennial budget for the creation of a General Counsel position. Ms. Leiss indicated the position was important for the System because of its fiduciary requirements and the increased workload. The General Counsel position was filled August 2015.

Chairman Kieckhefer called for a recess at 10:29 a.m. The meeting reconvened at 10:42 a.m.

VI. PUBLIC EMPLOYEES' BENEFITS PROGRAM (PEBP).

1. Report on utilization of the Program by participants for the plan year ending June 30, 2015, for active employees and retirees, including an assessment of the actuarial accuracy of reserves, pursuant to NRS 287.425 and on non-state participant enrollments and rates for the plan year ending June 30, 2016.

Damon Haycock, Executive Officer, Public Employees' Benefits Program (PEBP), introduced Tim Nimmer, Global Chief Actuary, AON, and Celestina Glover, Chief Financial Officer, PEBP. Mr. Haycock directed the Committee to Agenda Item IV.1., page 41 of Exhibit A, Self-Funded Plan Utilization for the year ending June 30, 2015.

Ms. Glover, Chief Financial Officer, PEBP, stated that the 2015 Utilization Report (page 52, Exhibit A) provided an overview of how the plan was used and the costs of the plan. She said the table on page 52 was a review of self-funded net paid claims. She stated that total medical costs increased by $10.0 million or 9.8 percent to $112.7 million compared to the previous year (2014) of $102.6 million. Dental claims were up 18.0 percent and prescription medication increased 16.8 percent. The overall result was a 12 percent increase in the utilization of the consumer driven health plan and dental benefits. Ms. Glover said that the bottom on the table, page 52 of Exhibit A, showed a breakdown of the costs of the self-funded net paid claims on a per participant per month basis.

Assemblyman Kirner asked if the overall total increase of 12 percent for medical, dental and prescription claims for the self-funded claims were consistent with what the general market was experiencing.

Mr. Nimmer responded there were a couple variables that were working into those numbers – the underlying population and underlying trends. Therefore, in terms of pure trend, the pure trend would be lower nationally, but the expansion of the program and the other variables built into that number made it rise.

Assemblyman Kirner asked if the expansion of the program meant the benefit levels had changed.

Mr. Haycock stated that Mr. Nimmer was referring to the increasing population, and the benefits provided to PEBP participants were at an enhanced rate based on the ability to

burn down the excess reserves, which the System was asked to do years ago by the Legislature. Mr. Haycock stated that an apples-to-apples comparison of those plans were difficult, but the trend was up and the 12 percent included those numbers, although they were little higher than what was seen nationally. Mr. Haycock stated that PEBP was conducting a comparison of different plans across the United States and the federal government, which he hoped would be complete in the near future.

Assemblywoman Carlton stated that she was concerned about the increase in paid claims, because the idea behind the consumer driven health plan was to put the patient or employee in charge of their health care with the intention of saving money, but every year claims increased. She said the total for the self-funded net paid claims for medical on the chart on page 52, Exhibit A, was broken down by inpatient and outpatient claims. She did not see the claims and costs for routine preventative and acute care versus urgent care or emergency care included in the backup material. She said that with the high deductible health plan, state employees that had not received a pay raise for a long period of time could not afford routine care and tests to address chronic illnesses, and their condition exacerbated, and the employee ended up at urgent care clinics, emergency rooms or in the hospital. Assemblywoman Carlton stated the inpatient and outpatient claims shown on the chart on page 52 did not provide her the information that she needed to be able to determine if the self-funded plan was really going to save the state money in the long run.

Chairman Kieckhefer said that he believed that the information was available in the Utilization Review for PEBP on page 53 of the meeting packet (Exhibit A).

Ms. Glover indicated that the information requested by Assemblywoman Carlton was located in the meeting packet (Exhibit A), Utilization Review for Nevada PEBP, page 53, and provided the detail for the summary chart on page 52. The chart on page 52 provided all the information regarding the costs for participants, as well as to the plan itself and the total claims paid. Ms. Glover directed the Committee to page 60 (Exhibit A), the financial summary breakout of the plans, which showed the number of members in the plan, and the gross amount paid by the plan. In addition, the chart showed physician costs, other costs, facility inpatient and outpatient costs, which would help Assemblywoman Carlton with her concerns.

Ms. Glover added that page 66 (Exhibit A) provided a detailed breakdown of the utilization for PEBP benefits. The center section of the table showed all groups combined; office visit utilization, office visits paid, and office visits paid by member. She said the number of claims may be decreasing, but the cost of the individual claim was going up, so medical inflation itself, which was what that cost was to the plan and the participant.

Assemblywoman Carlton stated that information addressed her concerns regarding the types of office visits, but not the reason for the visits, such as an office visit for a cold, to monitor blood pressure, or for a refill for diabetes medication. She said she was

trying to see where the utilization was and why it was tipping into the red, because there were many negative numbers on the chart (page 66, Exhibit A).

Ms. Glover stated that typically, PEBP did not break down medical visits by type for the utilization report, because PEBP did not have access to that information. She believed PEBP could get that data, in aggregate, from their third-party administrator, HealthSCOPE. Directing the Committee to page 73, Ms. Glover stated the chart on the page showed routine care visits, chemotherapy/radiation, rehabilitation/therapy/aftercare, childbirth, mammograms, etc., which provided some aggregate numbers.

Chairman Kieckhefer stated the chart on page 73 showed a small percentage of paid claims. He asked if $15.3 million was the total amount paid for preventative care. Ms. Glover replied the $15.3 was only for the particular visits shown on the chart.

Chairman Kieckhefer asked what the Medical Diagnostic Code (MDC) 25, factors affecting health (page 70) was for, and Ms. Glover replied that code was a "catchall" for any diagnosis without a specific code. She added that page 70 provided a list of the various MDC codes and the diagnosis descriptions.

Mr. Haycock said he wanted to address Assemblywoman Carlton's concerns on whether emergency room and urgent care visits increased for members based on the notion that people were putting off doctor visits because of the high deductible health plan. He said the chart on page 66 provided a breakdown of patient office and emergency room visits. He stated the number of visits decreased from Plan Year 2014 to 2015, which led him to believe the costs were not shifting for routine care to emergency room visits and that actual utilization had gone down. However, what was important was that the average paid per visit was up 18.8 percent, so the unit cost of care had grown substantially and the cost of the health plan continued to grow regardless if utilization was growing as well.

Chairman Kieckhefer said that goes back to Assemblywoman Carlton's point of whether the high deductible health plan discouraged people from getting routine preventative and acute care, and if the per unit cost was higher if people went to the emergency room instead of an office visit.

Mr. Haycock stated that he did not have that analysis available, but could provide the information to the Committee. He did not want to assume that one directly led to the other. He did not know if, nationally, emergency room visits were more expensive because of the higher costs of health care and treatments, or because of the advantage of newer equipment and new forms of medicine.

Assemblywoman Carlton stated she had the same concern since inception of the program and it seemed the state did not have answers to whether the high deductible plan was effective. If state employees had received pay raises, and health care costs were increasing, then that led her to believe that employees were not going for routine preventative and acute care visits because of the increased costs. She appreciated

Mr. Haycock pointing out that money spent in preventative care at the frontend was worth $10.00 spent at the backend. She requested that PEBP pull some cases and examine them closely to determine whether the high deductible plan was working. If a state employee had a yearly out-of-pocket max of approximately $4,000, and only made $30,000 per year, it caused a significant dent in take home pay by having to fund the $4,000.

Chairman Kieckhefer stated the utilization summary by members (page 66, Exhibit A) stood out in terms of the number of participants driving the percentage of the costs. He said that less than a half of a percent of members were leading to the expenditure of more than 32 percent of all claims. He asked what was being done to engage people with chronic illnesses and issues that were driving up health care costs. He stated that 80 percent of members resulted in no cost to the plan, and either filed no claims, or had claims under their deductible.

Ms. Glover stated the high cost claims were not routine in nature. Those claims were generally catastrophic situations, such as premature births, which were a big cost driver, or accidents that caused serious physical injuries, so often it was not that those individuals were not getting preventative care, but a situation that occurred that was beyond their control. She said PEBP used the cost of claims to determine the number of high-dollar claims received, which was 157 in 2015, and the cost of those claims and percentage of the population it equated to. To address Assemblywoman Carlton's concerns about the costs of preventative care versus emergency care, Ms. Glover stated that preventative visits were paid 100 percent by the plan so there were no out-of-pocket costs to participants. In addition, deductibles were not affected by preventative care treatment. She said the high costs for participants were for treatments due to a diagnosis, such as chronic conditions, like someone with high blood pressure that required medication and resulted in more routine visits.

Mr. Haycock added there was a PEBP participant that cost the state $1.0 million a year, and certain specialty treatments were extremely expensive, such as the drug regime to cure hepatitis, which cost around $100,000 a year. He said members with active chronic disease conditions were connected to programs like utilization management and case management. In addition, there were outreach services, nurses, doctors and providers, to ensure participants were compliant with their medication and treatment to help reduce some of the catastrophic issues that occur thereafter. He stated the key was to develop a program that dealt with preconditions before the conditions progressed. Mr. Haycock said PEBP was aware there were the very healthy people that rarely used their health plan, and participants at the other end of the spectrum who truly had illnesses or major catastrophic medical situations. He said PEBP was actively looking for ways to reach participants in the middle of the spectrum. Unfortunately, there was not a lot PEBP could do when someone was injured in a car accident, had a heart attack, or a cancer diagnosis; however, the state had a real opportunity to address the participants in the middle through programs and other efforts, similar to the wellness program. He expressed that preventative medicine was available to all participants at no cost to them. Participants did not have to satisfy the out-of-pocket maximum before

the state would cover a portion of the costs; they just had to satisfy the annual deductible on the high deductible health plan. Although, the annual deductible in Plan Year 2016 and Plan Year 2017 was $1,500 for a single participant, PEBP contributed $1,100 to participant's health savings and health retirement accounts on July 1, which basically reduced the deductible to $400. He said participants could use the $1,100 for medical expenses, including doctor visits. After that money was expended, participants were responsible for the remaining $400 toward their deductible.

Chairman Kieckhefer asked if preventative care was covered 100 percent for participants on the Consumer Driven Health Plan, and Mr. Haycock agreed.

Chairman Kieckhefer asked Mr. Haycock to discuss the dental utilization. He indicated that 30 percent of members did not have any dental claims, which meant they were not utilizing preventative care. He asked if there was direct outreach for dental participants to ensure people were aware of their benefits and utilized those services.

Ms. Glover replied that a number of participants choose not to take advantage of their dental benefits. She stated that PEBP increased annual dental benefits from $1,000 to $1,500 per year, and four cleanings were allowed per year, which was part of the preventative care at no cost to participants. She stated that PEBP tried to inform participants of dental benefits, but there were no outreach programs that specifically addressed the dental plan benefits.

Mr. Haycock added that PEBP reinstated in-person outreach education in the rural counties to inform individuals on how to use their medical and dental benefits, and the Medicare exchange. He said the outreach was well received, and PEBP would continue to build outreach education into the program every year. He stated there was not a specific dental education plan. Outreach education covered the entire benefits plan, which included instructing participants how to use their benefits appropriately and effectively.

Chairman Kieckhefer asked about the prescription drug utilization and the driver behind the increased costs of prescriptions. He said the chart on page 84 of Exhibit A showed that more than 80 percent of drug claims were for generic medicine, which he assumed were not driving up the costs.

Mr. Haycock replied that was correct, and nationally, the cost of pharmacy utilization had increased. He said certain types of specialty drugs were extremely expensive; for example, the drug regime to cure Hepatitis was approximately $100,000 a year. It was becoming increasingly common to use a drug designed to treat one illness to treat another. In addition, there was the introduction of biological drugs, which were expensive, and the argument at the national level was about how to use the generic version of an expensive drug or biosimilar drugs. Mr. Haycock stated that in his conversations with other health plan providers across the United States, and various staff on Capitol Hill, there was the existing potential for market gouging, which was a problem at the national level. Mr. Haycock stated that PEBP was actively and

aggressively trying to lower the cost of prescription drugs and to manage and mitigate the issue in the program moving forward.

Mr. Nimmer, Global Chief Actuary, AON, discussed the different types of reserves for PEBP. He said there were three major categories of reserves that AON accounted for when discussing the financials under PEBP (Agenda Item IV.2.a, Exhibit B). The first category was Incurred But Not Paid (IBNP), also known as Incurred But Not Reported. When a participant went to the doctor, the plan would not see or pay that claim for over a month, because it took time for the doctor to submit the necessary paperwork; this was defined as IBNP. He said that IBNP was a true liability or an actual liability of the plan, because those claims had been incurred but not reported or paid. The second major category was catastrophic reserves, which was a strategy that many plans implemented to ensure the overall solvency of the program. He said the current PEBP Board chose to utilize a 95 percent confidence level, meaning PEBP could cover the costs in any given year at a confidence level of 95 percent. The third major category was excess reserves, which were reserves over and above categories one and two.

Mr. Nimmer stated the overall experience for plans across the country, similar to PEBP, was that many plans had seen excess reserves growing recently due to the unprecedented low trends in the industry over the past few years. He said PEBP had been in a similar position and therefore, those reserves had expanded. Similar to other plans across the country, PEBP strategically utilized those reserves to reduce overall plan costs and return those monies to the participants in a very methodical and strategic way.

Mr. Nimmer said the overall reserve liability increased by $6.4 million or 26.0 percent in the IBNP category, which was attributed to the following:

- An overall increase in membership of approximately 8 percent, which contributed approximately $2.0 million.
- Claims trends for Medical/Rx/Dental of approximately 8 percent, which contributed $2.0 million.
- Plan design changes on July 1, 2014, that enriched both the medical and dental plans, which caused an increase of $1.7 million. The overall deductible decreased from $1,900 to $1,500, which meant the plan paid earlier in the overall cycle of a participant than in prior plan years where the plan paid more money, as well as the coinsurance amount. The coinsurance for the plan was raised from 75 percent to 80 percent, which was an increase in plan costs. Mr. Nimmer stated that, similarly, the dental plan increased from $1,000 to $1,500 per year, resulting in increased plan costs.
- Due to the increase volatility in the claims, the catastrophic load was now at 30 percent, up from 25 percent from the prior year, which was approximately $0.8 million.

Mr. Nimmer stated that actuaries worried about the overall solvency of the program, so when there was increased volatility, actuaries tended to be more conservative or set aside more money to cover the claims. He stated that he was often asked how volatility

increased, and if it was primarily with the younger population or older population, which he said depended on the mix of claims the plan experienced. He said it was easy to explain volatility for a young participant, such as a young family with annual visits over a long period of time, or if the family had a child that required more office visits, therefore, their claims spiked. Whereas, an older participant might have higher utilization on average, meaning their claim costs were higher throughout the year, but were much more consistent, so then the volatility of the older participant fell within a narrower range; however, their overall costs were higher. Mr. Nimmer noted that he looked at those types of elements of the plan when determining where to set the reserves.

Concluding his presentation, Mr. Nimmer stated the catastrophic reserves increased from $22.4 million to $23.9 million, primarily due to the volatility of the overall plan. In addition, the introduction of certain drug programs, such as the Hepatitis cure mentioned previously, or a change from a less expensive medication to a newer, more expensive drug, increased the volatility. He estimated the catastrophic reserves would be $23.9 million as of June 30, 2015.

Chairman Kieckhefer stated that the 2015 Legislature budgeted approximately $25.0 million a year to fund benefit enhancements through excess reserves. He asked if that was the experience that PEBP was seeing in terms of the value of those benefits.

Mr. Haycock replied that PEBP experienced between $17.0 and $18.0 million for the increased benefit design, but it did not necessarily include the life insurance increase from $10,000 to $25,000. He said PEBP projected the excess reserves that had to be expended over the last three plan years would be almost expended by the end of the next plan year or by June 30, 2016. Mr. Haycock said that PEBP was spending down the excess reserves at a very stable but consistent rate and believed those reserves would not be available or included in the 2017 PEBP budget.

Chairman Kieckhefer asked if there was a plan, from a benefit perspective for members, to try to include those enhancements or excess reserves in the budget.

Mr. Haycock replied the Governor's Finance Office was having a budget kickoff meeting on March 9, 2016, which would provide policy oversight and guidance on the Governor's budget for the 2017-19 biennium. After the meeting, PEBP would determine trends and projected costs of the current plan benefit design based on utilization and experience in 2015. Mr. Haycock thought the real question was who was going to pay for the costs of the plan benefit design; therefore, it was too early to tell if enhancements would be included in the budget. He noted that PEBP did not want to present an enhancement unit to the Budget Office indicating they wanted to keep the enhanced benefits if they were off the table; however, the goal of PEBP was to produce the highest level and quality of benefits at the most affordable cost. Mr. Haycock said PEBP Board members and staff recognized the existing benefit design was unsustainable at the current level of employer contributions without placing the additional cost on the participant, which no one had the appetite to do at this point.

Chairman Kieckhefer asked Mr. Haycock about the plan design schedule for the 2017 budget cycle. Mr. Haycock replied that traditionally the preliminary plan benefit design was determined in November of each year and the trend was analyzed by the actuarial consultant in January, which would bring PEBP closer to rates. In February or March, the rates were developed and on March 11, 2016, the rates for the next plan year would be determined for July 1, 2016. He said the timeframe would be adjusted when the budget was being built, so there was an initial projected rate and plan benefit design, which would be built into the PEBP budget. As PEBP received more information, the agency would submit budget amendments and update all the parties involved until May when a final budget amendment was submitted, which would include the plan benefit design and employer contributions or state subsidy for the 2017 plan year.

Assemblyman Kirner asked if open enrollment was in May, and Ms. Glover replied that was correct. She explained that PEBP would set rates for the 2017 plan year at the March 11, 2016, PEBP Board meeting; the rates would be published and tested and everything had to be in place when open enrollment began on May 1, 2016.

Assemblyman Kirner asked if PEBP had any indication of the rates for the 2017 plan year. Mr. Haycock replied that at this point, PEBP was almost ready to determine the final rates for Plan Year 2017.

Assemblyman Kirner stated that he hoped PEBP was modulating the plan design so that state employees were not “taken to the cleaners.”

Mr. Haycock stated that the plan costs for participants were a priority and there was no appetite, at any level, to impose higher costs on the backs of state employees, retirees and their families unnecessarily.

Mr. Haycock referred the Committee to page 87 of Exhibit A, Non-State PEBP Participants – Plan Year 2016. He stated that as of January 2016, there were 1,143 non-state participants in the Consumer Driven Health Plan (CDHP); 923 non-state participants in the Hometown Health and Health Plan of Nevada (HMO) plans, both in Northern and Southern Nevada; and 5,044 non-state participants were enrolled in the Medicare Exchange. He said that PEBP projected there was an average monthly reduction of 30 retirees from both the CDHP and the HMO plans, which was attributed to people that had other coverage, people that passed away, and people that qualified for the Medicare Exchange. He said PEBP anticipated by the end of June 2016 there would be 1,899 remaining non-state participants.

Continuing, Mr. Haycock stated a regulation was passed by the Legislative Commission that adjusted the manner of calculating the employer contribution for non-state participants. He said on pages 88 and 89 of Exhibit A, the charts showed how the temporary regulation change, which was passed during the 2015 Legislative Session, affected the premiums. He said PEBP was aware of participants whose premium rates were raised drastically due to the regulation change. Mr. Haycock explained that the

temporary regulation passed during the 2015 Legislative Session changed the manner of calculating the subsidy required to be paid by local government employers for certain retired public officers and employees. He said PEBP calculated the subsidy requirement from the employer for state retirees on a percentage basis, but for non-state retirees, prior to the temporary regulation, the subsidy requirement was calculated on a flat-dollar amount. For example, a single participant on the plan – if the plan cost $500 and the prior employer paid $100, the participant paid $400. When families were included, it became more disadvantageous with only $100 off a family plan, so the $500 plan may be $750 when the spouse and children were added. Consequently, those participants were negatively impacted by the way PEBP originally developed the process to determine employer contributions from non-state entities. In addition, there was discussion about what was fair – whether a state retiree should pay more than a non-state retiree, and the idea and hope was that everyone paid as little as possible, because it was expensive, but also to provide some parity between the two similarly-situated groups. He stated that PEBP wanted to ensure that the plan did not have any discriminatory benefit designs

Mr. Haycock referred the Committee to the charts on page 88 (Exhibit A), which displayed the changes that occurred from the temporary regulation for how much non-state, non-Medicare retirees paid as their portion of their monthly CDHP premiums. On the CDHP plan, every participant received a reduction. For the non-state, non-Medicare participants of the HMO, every participant, with the exception of a single retiree on the HMO plan, received a reduction in their premium cost; the single retiree on the plan received an increase of $44.49 in their monthly premium. He indicated there were a series of situations that existed prior to the 2015 regulation change that contributed to the increase in monthly premium contribution rates, which were shown on the chart on page 89. In response to the increased premiums, some retirees experienced a significant increase to their monthly premium contributions due to a multitude of factors. The first factor was that rates increased in Plan Year 2016 (Table 6 and 7, page 90 of Exhibit A). If the Plan Year 2015 rate for a retiree only on the CDHP was just under $900, and increased to $957.06 in Plan Year 2016, regardless of the regulation change, rates increased prior to enacting the regulation process. Similarly, the legislatively approved subsidy decreased from Plan Year 2015 to Plan Year 2016, and for a 15-year of service retiree (Table 6 and 7, page 9 of Exhibit A), the subsidy decreased from $462.20 to $425.56, a reduction of $36.63; so right away the premium increased by $57 and the state subsidy decreased by $38, so everyone was paying more regardless. He stated if he took those two situations, and reduced or removed the $50.00 per month wellness incentive at the end of Plan Year 2015, when those three factors were added it was easy to see how the situation could have been drastically different in the direction of increased costs to the participants and then the $43.00 was added from the regulation change.

Mr. Haycock said there were significant decreases based on the regulation that affected a significant amount of the population to really get back down from those massive increases. He said the regulation was needed to produce equality between similarly situated participants and to reduce costs for as many participants as possible.

Assemblyman Kirner said that Mr. Haycock provided a good explanation; however, it did not solve the problem. The number of non-state retirees continued to decrease, and as long as the numbers decreased, the costs would continually increase. He expressed that the issue had not been dealt with over the last two legislative sessions and it was incumbent on the PEBP Board to finally come to a decision. He said explaining the increase away by saying the state reduced its numbers, and the long arguments about the wellness program premiums at the last IRBC meeting, did not solve the problem. He stressed that PEBP took on the burden of non-state employees, which he had been part of, and something needed to be done to help the non-state participants. He implored the Committee to address the issue of non-state participants in a more affirmative way – whether it meant spending excess reserves to put the non-state participants on the state plan, or modulating the amount of increase for those participants, things had to change.

Assemblywoman Carlton echoed the comments of Assemblyman Kirner regarding the non-state participants. She said the state made a commitment when it took on the non-state participants, which needed to be honored. In addition, the state could not forget about the employers that benefited from the state taking in the non-state participants. She said there needed to be a serious discussion with those employers, because the state had taken on the responsibility of those employers, and now the state needed help with part of that responsibility. She was unsure what the options were, but as the number of non-state participants diminished, the whole burden could not be placed on a handful of remaining participants. She reiterated that the non-state employers also needed to be held accountable for non-state retirees

Chairman Kieckhefer asked if the regulation change required significantly larger contributions from the former employers of the non-state participants, and Mr. Haycock agreed. He said the former employers had been paying larger contributions since July 2015.

Chairman Kieckhefer stated that non-state participants expressed a desire to see the two pools of state participants and non-state participants merged into one plan. He asked if the PEBP Board looked at the cost to merge the two pools of participants.

Ms. Glover responded that PEBP considered the cost of merging the two pools into one during the last two legislative sessions. She said that PEBP would consider it again during the 2017 Legislative Session when the current rates were set. She said when it was discussed during the 2015 Legislative Session the additional cost was close to $30 per participant per month for state retirees, and there was no relief in that cost for several years, or until the non-state population dwindled, transferred to the Medicare Exchange, or moved on to other coverage. She said there was concern for how those additional costs would be absorbed – should the costs be shifted to state employees, the state, or split between both. Also, utilizing reserves was discussed, although, reserves was a finite number and would not be available to offset costs indefinitely, so it was just a temporary fix. She added that the PEBP Board was concerned about the non-state retirees and how to best address those participants.

Chairman Kieckhefer asked if the total number of non-state non-Medicare retirees would be approximately 1,900 in FY 2017. Ms. Glover replied it was projected that approximately 30 non-state retirees would leave that group each month, so by June 30, 2016, the projected number of participants would be around 1,899, assuming that trend was consistent through the end of the plan year.

Chairman Kieckhefer asked Ms. Glover for the estimated number of years until there were no non-state retirees on the plan. Ms. Glover replied that the latest enrollment projection showed the non-state population decreasing over the next seven to ten years depending on how many qualified for Medicare. She said PEBP recognized there was a certain population that did not pay into Medicare and would never qualify for Medicare.

Assemblyman Kirner asked if he was correct that PEBP was not going to make any changes in Plan Year 2017 and premiums would be raised. He asked when participants could expect a firm commitment, and when there would be a solution concerning the non-state group.

Mr. Haycock replied that the plan benefit design discussions and approval from the Board occurred on November 19, 2015, although it was possible to revisit the plan benefit design when the rate discussion occurred on March 11, 2016. However, he did not see a solution for the non-state retiree participants by July 1, 2016. He stated that PEBP had every desire to put forth a plan on how to address the matter, but he thought the real issue was who would pay for the higher premium rates. He said there were multiple options to pay for the increased rates; however, the reserves would be gone so PEBP could not “tap that well” to initially solve the problem. He added, if PEBP were to absorb the non-state participants to try to offset the increased costs, and costs increased, PEBP would have to reduce benefits for all participants to absorb the costs unless the subsidies were increased. He said it was something that needed to be addressed, because PEBP could adjust rates and plan benefits to reduce rates, but participants may not see the same plan in the future. Mr. Haycock stated that the state ran the risk of creating multiple new issues by trying to solve one issue. For example, even though the monthly outlay for participants was reduced and their premium had decreased, it could be too expensive for participants to go to the doctor, because they had to pay more throughout the plan year. Mr. Haycock stated that PEBP would bring the issue before the Board, which had been done previously, but the math would be difficult, and it had to be a collective decision with all parties involved.

Assemblyman Kirner asked what would happen if PEBP dropped the non-state participants completely, which would allow them to participate in the Silver State Health Insurance Exchange (SSHIX).

Mr. Haycock replied that participants could drop out voluntarily and transition to the SSHIX. He said retired participants could qualify for a federal subsidy to obtain an individual marketplace plan, although there were some affordability requirements based on the federal poverty level. He said the plans were age-banded, so the costs of the

plans increased based on the age of the participant. Mr. Haycock said the Affordable Care Act placed a cap on how much participants were required to pay based on household income and the second lowest priced silver-level plan. He said the difference determined their federal subsidy, which offset the age-banding and made the individual marketplace plans more affordable for retirees. Mr. Haycock said the PEBP plans were equivalent to high-gold and low-platinum level plans on the individual marketplace; therefore, participants seeking a lower premium rate may have to select a bronze-level plan, which would provide less coverage than the PEBP plans. He stated it was a difficult decision, which was why PEBP had licensed agents and brokers to help with the process. He stressed that the state needed to find a solution for health care overall, not just for premium reductions. He said that PEBP did not have an issue when non-state retirees found it was in their best interest to transition to the SSHIX and obtain an individual plan. He added that if a non-state retiree received a subsidy, it would have to be paid back at the end of the year, which was a drastic tax burden. He reiterated that retirees were authorized to decline PEBP coverage and go on the SSHIX, but when they declined PEBP coverage, they also declined dental insurance, life insurance and all the secondary and tertiary plans associated with PEBP. Mr. Haycock said it was not a simple process and involved comprehensive discussions, which PEBP was willing to have.

Chairman Kieckhefer asked if PEBP was statutorily required to maintain the non-state participants as a separate pool. Mr. Haycock replied that was correct; however, if the Board was interested in pursuing a single pool of participants, a bill draft request could be developed during the 2017 Legislative Session. He said the statute currently stated that the non-state group must be rated separately.

2. Report from independent certified public accountant regarding audited financial statements for the Program dated November 2, 2015 (NRS 287.0425).
   a) Fund for the Public Employees' Benefits Program (NRS 287.0435)
   b) State Retirees' Health and Welfare Benefits Fund (NRS 287.0436)

Ms. Glover referenced page 95 of the meeting packet (Exhibit A), the report from independent certified public accountant regarding financial statements for the program dated November 2, 2015. The reports were annual audits of PEBP's two funds – the Self Insurance Trust Fund, which was PEBP's operating fund and State Retirees' Health and Welfare Benefits Fund, which was where the employer contribution was deposited for transfer into the operating account. She said page 104 of Exhibit A showed the excess reserves and how they were utilized. The operating income line item on the chart showed a loss of $3.7 million, which indicated that PEBP was utilizing its reserves to pay for plan benefits. Ms. Glover reported there were no material deficiencies or issues identified between management and the auditors and PEBP received an overall positive report for both funds.

Chairman Kieckhefer stated that Ms. Glover specifically spoke to the Self Insurance Trust Fund and asked if there were any questions from the Committee on the second

audit, the State Retirees' Health and Welfare Benefits Fund (page 117, Exhibit A). There were no questions or comments from the Committee.

3. Report on the September 11, 2015, Actuarial Valuation of Post-Retirement Health Benefits provided by the State of Nevada pursuant to Statement Number 45 of the Governmental Accounting Standards Board (NRS 287.0425).

Mr. Nimmer, Global Chief Actuary, AON, stated that he had the privilege to serve PEBP in the State of Nevada for over ten years, and the one thing he learned over that time was that less was more when it came to the actuarial valuation of post-retirement health benefits report. He said the valuation determined how PEBP was valuing the cost for retirees' benefits or other post-employment benefits (OPEB), which were all the benefits outside of the state pension plan. The valuation looked at active and retired participants and followed them through their lifetime, and estimated the costs to ensure that PEBP was able to pay for those participants. He disclosed that the annual required contribution as of July 1, 2015, for the plan was $157,588,000 and the OPEB cost of the unfunded liability, was $1,427,192,000 for the same time period.

Mr. Nimmer stated he was often asked how well-funded other state plans were or how other plans across the country were funded in the public sector. Similar to Nevada, he indicated that many plans were "pay as you go" benefits. He said there were a few individual entities that prefunded their liabilities, which was primarily due to their state, city or township specific finances.

Chairman Kieckhefer stated the annual required contribution for fiscal year ending June 30, 2015, was $157.6 million, which fluctuated over time. He asked Mr. Nimmer if he expected the annual required contribution to remain consistent.

Mr. Nimmer replied it depended on a few major variables, such as the overall trend of the program and the underlying experience of the population to the demographics. He stated a major component of the annual required contribution would be the normal cost and how much participants were accruing in a given year. Therefore, if there were more participants in the future compared to today, that number would grow, and if trends continued to increase, that number would grow as well. He stated, on average, the number was growing at a fairly steady pace, similar to a retiree valuation for the pension plan. Mr. Nimmer said he looked at the numbers over a 30-year period to see if the numbers were smooth with time. For this particular valuation (PY 2016), the numbers were rolled forward, which was primarily a cost consideration, because there were no major material differences. He said, from the accounting standards board, the results could be rolled forward from one year to the next. In FY 2015, because it would be an odd-numbered year, AON would do a full valuation and look at every participant on an individual basis.

4. Report on biennial review of PEBP's compliance with federal and state laws relating to taxes and employee benefits, dated December 5, 2014 (NRS 287.0425).

Mr. Haycock directed the Committee to page 139 of the meeting packet (Exhibit A), a Presentation of 2014 Biennial Compliance Review that was presented to the Board. He said that Section B, page 144, was the Executive Summary, which AON performed for PEBP. He stated that overall, AON found that PEBP had done an excellent job ensuring that documents and procedures complied with applicable federal and state laws. AON found there were significant improvements in addressing issues noted in previous reviews, in particular, the 2015 Master Plan Document improvements that addressed the vast majority of suggestions identified in prior reviews. However, there were areas that could be enhanced mostly surrounding federal law issues, both current law and areas related to the Affordable Care Act (ACA). Mr. Haycock indicated that PEBP looked at each recommendation and was able to fix the concerns and address the issues appropriately. In addition, PEBP implemented extra policies to address issues and would provide the master plan document revisions to the PEBP Board once the ACA completed its federal rules and regulatory guidance. Mr. Haycock indicated there was only one remaining issue that PEBP was continuing to address. He said PEBP would submit a policy on the issue by the end of June 2016.

Assemblyman Kirner stated it was his understanding the Cadillac Tax, a tax on expensive employer-sponsored health plans, was delayed until 2020. He asked how PEBP was addressing the delay of the tax and if PEBP was prepared for the implementation of the tax.

Mr. Haycock replied that multiple reports were brought to the PEBP Board, even before his time at PEBP, to discuss the impacts of the Cadillac Tax. He stated that Assemblyman Kirner was correct that the Cadillac Tax, or the Affordable Care Excise Tax, had been delayed to 2020. He said the two-year delay meant PEBP and its participants had a little more time to plan and prepare for the tax. If no changes were made to the plan today, and the tax became effective in 2018, PEBP was looking at a $1.0 million tax liability in the first year, which virtually doubled every year thereafter. He was aware that other plan benefit administrators were looking at cutting benefits to ensure premium rates went down. He said the Cadillac Tax was levied at 40 cents on every dollar over a certain threshold, so it was not a cheap tax, and at this point, no one had a desire to pay the tax. Mr. Haycock stated it would be a policy decision by the PEBP Board, and eventually the Legislature, to determine if continuing to provide high-level benefits that resulted in higher rates constituted the additional costs and taxes that would be absorbed, whether the costs were absorbed by participants, the state, and/or the non-state employers. He said the delay of the Cadillac Tax until 2020 provided PEBP more time to plan for the tax. Currently, PEBP was looking to put provisions in place in contracts as it moved forward to ensure PEBP had an "out" in 2020, especially with PEBP's fully insured plans. He said it was recognized that PEBP had no intention of absorbing the tax and benefits, so it would need to be adjusted appropriately. Mr. Haycock said that PEBP was not waiting until 2020 for the tax to

become effective and was actively looking at what could be done immediately. He said there was no guarantee the tax would even remain, because multiple bills had been presented to Congress to repeal the Cadillac Tax, which was supposed to generate approximately $93.0 billion over ten years, due to employers cutting health benefits and increasing premiums. He was uncertain employers would cut health benefits and increase pay to net the $93.0 billion, so it could be a "pipe dream" for the federal government. He said PEBP would wait until after the 2016 Presidential Election, but at this point, PEBP was patiently observing the situation and creating some safety nets in case the tax became effective in 2020.

Chairman Kieckhefer thanked Mr. Haycock for his explanation. He was aware that Senator Dean Heller was pushing the repeal of the Cadillac Tax, so there was pressure from both sides; the state saying the plan was not rich enough and the federal government saying the plan was too good.

Assemblywoman Carlton asked what were the benefit thresholds that would make participants of the plan subject to the Cadillac Tax, and Mr. Haycock replied the thresholds were currently $10,200 a year for a single participant and $27,500 a year for a participant and family. He stated those thresholds had some adjustments that could be done for retirees based on years of service. He indicated the thresholds for the new plan year were not finalized and the thresholds were one of the things the federal government was looking at adjusting if it continued to implement the Cadillac Tax. He said the $10,200 a year was the totality of the costs of the health plan rate; therefore, it was the combined cost paid by participants and employers. Mr. Haycock said there were some issues surrounding the HSA disbursements that cut into the threshold. Currently, participants in the HSA were allowed to contribute $6,000, pre-tax, in coordination with their employer contributions per calendar year. He stated, if the participant and employer contributed $6,000 into an $8,200 threshold, then the total rate had to absorb the difference and there was no way to create a health plan that only cost $2,000 a year. Mr. Haycock stated it was a difficult scenario; he reiterated that Senator Dean Heller was leading the charge to repeal the Cadillac Tax bill. He added that the threshold could be adjusted regardless.

Assemblywoman Carlton thanked Mr. Haycock for the explanation. She was aware the president of the UNITE HERE union, was working closely with Senator Dean Heller on repeal of the Cadillac Tax, because the tax would drastically impact any person employed in the casino industry, and ultimately that money would come out of the employees' paychecks.

5. Report on Plan Year 2017 Plan Design Components for the High Deductible Health Plan (HDHP) Preferred Provider Organization (PPO) and the Health Maintenance Organization (HMO) Plans.

Mr. Haycock stated that on November 19, 2015, the Board approved the Plan Year 2017 benefit design, which primarily continued to provide health care benefits at the levels that people were expecting and currently utilizing, and kept the HSA and HRA

contributions at the current levels, because at the time of that meeting the reserves appeared to be able to support the plan design. Currently, Mr. Haycock believed the state could support the same level of benefits through Plan Year 2018. He added that retirees enrolled in a medical plan through Towers Watson One Exchange would receive an increase to their monthly HRA contribution, from $11.00 per month per year of service to $12.00 per month per year of service. Retirees that retired prior to January 1, 1994, would receive $12.00 per month per year of service based on 15 years of service. Retirees covered under a medical plan through One Exchange through July 1, 2016, would also receive a one-time supplemental contribution of $2.00 per month per year of service. Retirees that retired prior to January 1, 1994, would receive $2.00 per month per year of service based on 15 years of service, so there was a small increase to the retiree population on top of maintaining the current health plan benefits. He said the Committee would know more after the March 11, 2016, PEBP Board meeting when rates were discussed, because at that point if there was the potential for a rate increase to meet the current plan benefit design, the Board could exercise its capacity to adjust the plan benefit design to keep rates flat or do what the Board thought was in the best interest of the state. He stated that currently, the plan benefit appeared to be set, but PEBP would know more on March 11, 2016.

Chairman Kieckhefer asked Mr. Haycock to discuss the issue brought up during public comment regarding the customer service of Towers Watson and the opportunity to have a local representative in the state.

Mr. Haycock replied that having a consumer-oriented approach to Towers Watson was brought to his attention when he first arrived at PEBP in August 2015. He noted that Towers Watson was not located in the state and retirees who transitioned to the Medicare Exchange in 2011 had difficulties utilizing the benefits and getting customer service. He stated PEBP looked into setting up a pilot program, because having representation in the state was desired. He noted that an in-house representative was provided to the state from the third-party administrator, HealthSCOPE, to help retirees with questions and concerns. He said the pilot program was created to gauge demand, because that was going to be the impetus for setting the stage for state representation. Pilot meetings were held in Henderson and in Carson City, and there was a large turnout, which indicated the desire to have in-person contact with Towers Watson.

Mr. Haycock stated the next step was to evaluate the pilot meetings and inform Towers Watson that in-state representation was needed. He said PEBP would tabulate the results of the pilot meetings and present the results to the PEBP Board. In addition, PEBP would review the findings of the pilot meetings with Towers Watson.

Chairman Kieckhefer noted there were 6,000 non-state retirees in this category that deserved to have representation to address their concerns.

Assemblyman Kirner stated that when the contract was set with Towers Watson's parent predecessor, Extend Health, there was an agreement to have in-state representation. He said having an advocate for participants was not a new concept,

and was promised when the contract was set. He added that he did not think that the state should have to pay for in-state representation.

Mr. Haycock referenced page 187 of the meeting packet (Exhibit A) Health Maintenance Organization (HMO) Plan Options. He said the PEBP Board selected the vendor, Anthem Blue Cross Blue Shield on January 12, 2016, for statewide HMO services. Part of the PEBP Board's statutory right was to perform a second level review and pick a vendor in the best interest of the state with the highest quality of health benefits. During that time, there was discussion regarding increased rates in the proposal from Anthem Blue Cross Blue Shield, and now that the RFP was pulled and negotiations were complete, he could appropriately share the basics of what ensued. At the January 12, 2016, meeting, the PEBP Board met and scored each proposal based on pre-selected criteria. When the vendor was selected by the PEBP Board, there was discussion of a potential premium increase of approximately $100 per month for state employees. Once the analysis was performed, the increase in health care premiums was approximately $86 to $240 per month, depending on the tier of the participant. He said PEBP was charged to negotiate the best rates and options and ensure the exceptions taken on the proposal were something that PEBP could live with before an agreement was reached. Mr. Haycock stated that between the January 12, 2016, and January 26, 2016, Board meetings, the Purchasing Administrator, PEBP, Attorney General's Office, in addition to other representatives, were peppered with complaints about increased premium rates and the vendor selection process, which PEBP believed was done in accordance with statute. He stated there were concerns about the process conducted for the selection of the vendor, because the vendor selected did not have the highest ranked score. Mr. Haycock stated, traditionally, in an RFP committee the valuation criteria to select a vendor was determined before the RFP "hit the street." The RFP committee rated vendors in each category, and generally, the vendor with the highest score was awarded the contract. At that point, negotiations occurred with the vendor, and if successful, a contract was awarded; however, if negotiations failed, the PEBP Board selected the second ranked vendor. Mr. Haycock stated that because the scores were not utilized in the determination of the statewide vendor, and the premise for selection was taken directly from NRS 287.04345(e): "Award the contract based on the best interests of the state," there was a clear cut choice for a statewide vendor. Mr. Haycock stated that from January 12 to January 26, 2016, PEBP received notices and public record requests, in addition to hinting of appeals by the other vendors, because of the process utilized to select the vendor. After discussions with the Attorney General's Office and the Purchasing Administrator, a decision was made to pull the RFP on January 26, 2016. Mr. Haycock stated that PEBP's preference was to contract for HMO services with at least one statewide vendor; however, regional proposals would be considered. He stated the selection process was difficult and there were definite concerns and issues presented by various law firms representing the vendors. Mr. Haycock stated that he and the Purchasing Administrator thought it was in the best interest of the state to pull the RFP on January 26, 2016, and to extend the contract with the current vendors, and rebuild and strengthen the RFP to make it more specific and defendable. At that point, Mr. Haycock stated the PEBP Board reaffirmed they wanted Anthem Blue Cross Blue Shield, and additional direction was provided on

the type of negotiations needed to move forward. Mr. Haycock indicated that a "team" was built of representatives from the Attorney General's Office, Risk Management, Purchasing, along with staff from PEBP, and negotiations were discussed with Anthem Blue Cross Blue Shield. One of the critical issues mentioned by the PEBP Board was they did not believe an increase in rates was acceptable, because some of the alternative proposed bids showed a reduction in premium rates. Therefore, if rates were proposed to be raised by one vendor, but reduced by another vendor, how could PEBP sell that to the State of Nevada employees, retirees and dependents. He said PEBP started negotiations and looked at a plethora of options, but was unable to come to an agreement on the rates. To provide some comparison, Mr. Haycock said that if PEBP accepted the initial proposed premium increase on January 12, the premium increase would have been between $86 for a single participant and $240 per month for a participant and family. He stated the net total for the premium increase would be approximately $14.0 million, in addition to what participants were currently paying. He indicated that PEBP was able to negotiate a lower net total increase of $3.0 million, which represented a $20 increase per month for single participants, up to a $50 increase per month for families on the HMO plan. However, PEBP did not believe that was good enough, because the alternative vendor bids were flat or potentially lower rates. Mr. Haycock said the team believed the increase was not fair for state employees, retirees and their dependents, especially since there was no requirement to do so; therefore, negotiations ended. A timeframe was set for the final negotiated contract; PEBP provided its ideas on the cost and rates and negotiations were unsuccessful. Mr. Haycock stated the Committee heard testimony earlier in the meeting from Ms. Bowen that the notice to pull the RFP occurred before the PEBP Board meeting on Tuesday, February 16, because it was the earliest available time to send out the RFP. Mr. Haycock explained that he and the Purchasing Administrator were advised, through the Deputy Attorney General assigned to both agencies that pulling the RFP was in the best interest of the state, because there was not a clear cut second ranked vendor. He said that per Purchasing regulations, if negotiations failed there were only two options 1) to negotiate with the second ranked vendor, or 2) to cancel the RFP. Therefore, after arduous conversations with legal counsel, the RFP was pulled at the PEBP meeting on Tuesday, February 16, scheduled for 9:00 a.m., which was before the PEBP Board meeting held on the same day at 1:30 p.m. The PEBP Board was able pursue extensions on the current contracts and redevelop and strengthen the RFP. Mr. Haycock stated that PEBP received information from the current vendor and was awaiting information from another vendor, and would crunch the numbers and negotiate with the vendors to ensure the best rates and highest quality health benefits were provided to state participants.

Assemblyman Kirner stated there were probably a lot of points in the negotiations to indicate the selection process did not work well. He said that he first heard of the negotiations from the Benefit Wise Bulletin, PEBP sent in January 2016 stating its attempt to negotiate with the proposed vendor, and if that failed, PEBP would negotiate an acceptable solution for participants with the lowest bid vendor, which was the current vendor, Anthem Blue Cross Blue Shield. Assemblyman Kirner said the way the contract

process was managed left much to be desired and he was unsure why PEBP did not have the alternative to start negotiations with the lowest bidder.

Mr. Haycock responded that steps have been established to ensure the RFP process would not be repeated in the future. He said PEBP recommended that the Board eliminate second level reviews, because the mechanism to do so in a public setting, and the statute that allowed the disregard of another agency, could frustrate people. Therefore, the Board agreed to eliminate the second level reviews as long as there were at least two Board members on the RFP committee to help manage potential conflicts of interest. In accordance with the Open Meeting Law, Mr. Haycock indicated that five Board members could be on the RFP committee without having a quorum. Mr. Haycock further indicated PEBP would do a better job in the future.

Assemblyman Kirner stated that he thought it would be good idea if PEBP had a contract administrator.

Chairman Kieckhefer asked Mr. Haycock how PEBP determined what was in the best interest of the state. He asked if it was the best interest of the members and how much money they would have to pay for benefits, the ease of management from the Board's perspective, or the taxpayers' perspective of who had to pay the state's share.

Mr. Haycock replied the statute was specifically attributed to the PEBP Board. The Board had the statutory authority to award a contract based on the best interests of the state. In addition, the Board could disregard the recommendations of the RFP committee or the Purchasing Administrator on the vendor selected in any procurement process. Mr. Haycock explained that PEBP stopped negotiations with the current vendors because they did not believe it was appropriate to increase costs to state employees. He said that in a non-legislative year there was no mechanism, even if the Legislature was willing to increase premiums, to increase the subsidy for the off year. Mr. Haycock explained that subsidy amounts were set for two-year increments, but rates were set each year, so there had to be some form of true up. Mr. Haycock hoped to avoid raising premiums, which could not be done because trend and national costs were up and it was probable that rates would also increase. However, if there was an opportunity to keep benefits similar and not increase rates then he thought the state owed that to the participants. Mr. Haycock stated that at the end of the day, the PEBP Board had to make the best decision for participants, considering not only costs, but also access to care and providers. He added there were things in the Anthem Blue Cross Blue Shield bid that were very attractive, such as a national network. The question was who was willing to pay for the additional access to care and opportunities. In addition, were participants going to utilize those opportunities and were they willing to have their premiums increased each month so that a smaller group of people had a different benefit access level.

Chairman Kieckhefer commented that a $240 a month increase in premiums did not seem like it was in the best interest of state participants.

Assemblyman Kirner asked Mr. Haycock if he was confident that PEBP was able to negotiate with the current vendors, in time for open enrollment in May, and Mr. Haycock replied that was correct.

6. Report on material provided generally to participants or prospective participants in connection with enrollment in the Program for the plan year beginning July 1, 2015, pursuant to NRS 287.0425.

Mr. Haycock referenced the second meeting packet (Exhibit C) which discussed PEBP's communication activities for the period of July 2014 through June 2015. He indicated that PEBP stepped up communication, education and outreach to participants and stakeholders. He said that PEBP provided a plethora of handouts, such as employee benefits enrollment guides, retiree benefits enrollment guides, Medicare enrollment guides and a master plan document – the health plan bible on how participants could access and utilize their care, which was also supported with a summary of benefits and coverage. In addition, PEBP provided a flexible spending account summary plan for participants that wanted to utilize flexible spending accounts. He said the handouts discussed how to utilize the health reimbursement arrangements, monthly newsletters were provided, and credible coverage letters were sent to participants with the requirements participants needed for IRS filings. Mr. Haycock stated that PEBP offered wellness fairs and updated its website to a more user friendly, efficient tool to help individuals choose between the consumer driven health plan, high deductible health plan and the HMO options. Participants were able to compare plans to help make the best decision on health care coverage before the May 1 open enrollment date. In addition, mass e-mails were sent out to inform participants of benefits, such as flu shot clinics. Mr. Haycock said that PEBP provided benefit orientations to different parts of the state, including the rural areas. The Public Information Officer for PEBP provided communication to Winnemucca, Elko, Ely and Tonopah, to ensure PEBP hit the major areas across the state so that everyone had an opportunity for in-person communication. In addition, Towers Watson held meetings for retirees transitioning into Medicare. Mr. Haycock reiterated that communication was very important to PEBP. He noted that he spent time with the Nevada System of Higher Education (NSHE), and other state agencies to hear the needs and concerns of participants. Concluding, Mr. Haycock stated that PEBP developed a state employee benefits advisory committee of representation from major departments in the state. He said that PEBP was fortunate to have the Retired Public Employees of Nevada (RPEN) attending the meetings to ensure that the largest population of participants had a voice. Mr. Haycock stated that the advisory committee developed a survey, which was sent to state participants regarding their benefit plans. Mr. Haycock stated that PEBP wanted to ensure they heard the voice of the customer to ensure the appropriate plan could be built moving forward.

Mr. Haycock thanked the Committee for the opportunity to share the accomplishments of PEBP. He appreciated the feedback and suggestions of the Committee and ensured that PEBP would appropriately share the suggestions with the PEBP Board.

V. PUBLIC COMMENT.

Janice Florey, non-state retiree from the Douglas County School District, said that in 2015, the PEBP Board modified the provisions related to the participation of the "orphan" group, a term used to describe non-state retirees. She stated a lobbyist was hired before the start of the 2015 Legislative Session, because the cities, counties and school districts believed they would be burdened with increased monthly premiums. She stated that A.B. 426 (2015) was referred to the Assembly Committee on Government Affairs, but no action was taken on the bill. Ms. Florey stated the premise of A.B. 426 was to return the non-state retirees to their originals employer's health insurance plan or to the Silver State Health Insurance Exchange (SSHIX). Unfortunately, for Clark County School District retirees who retired prior to 2008, their only option was to transition to the SSHIX, because they had the Teachers Health Trust, which was separate from their school district. Ms. Florey stated if the non-state retirees were "kicked out" of PEBP, they would lose dental coverage, life insurance coverage, in addition to the opportunity to receive a small subsidy to purchase Medicare Part B insurance. She stated that many of the non-state retirees were teachers, so over the years they have accumulated 40 quarters from part-time or full-time work during their retirement to qualify for Medicare Part A insurance. During the 2013 Legislative Session, the previous PEBP director suggested that non-state retirees be returned to their original employer's health insurance plan. It was addressed again during the 2015 Legislative Session when the Excise Tax looked like it was on the horizon, and the "knee-jerk" reaction from one of the PEBP Board members was to cut the non-state retirees, which annoyed the non-state retirees, because that was the thought every time they were mentioned. Ms. Florey stated that the door was open for the non-state retirees to join PERS, and even though they were a small group, the retirees wanted to have the choice whether to remain in the state retirement system.

Ms. Lockard added to her earlier testimony and stated that she agreed with Assemblyman Kirner on having in-state representation from Towers Watson. She said that RPEN had requested in-state presence since 2011, and the predecessor to Towers Watson received a no-bid contract from the state funneling 10,000 lives into one contractor. Ms. Lockard stated the non-state retirees had no choice, and if they did not want to go with the vendor selected and obtain private insurance, they would lose the state employer contribution. Ms. Lockard recalled that the requirement for an in-state representative was not put into the original contract, but at a Board of Examiner's meeting, the predecessor to Towers Watson assured the Governor that an in-state representation would be provided. She stressed that when the contract was renegotiated, RPEN members begged the former executive director to include representation in the RFP, which was ignored. When the contract was approved, RPEN members made an additional request for in-state presence in the contract and that request was also ignored. Ms. Lockard said that in the current contract, Towers Watson did not employ one Nevadan, and Nevada insurance brokers did not receive any commissions. In addition, she thought it was outrageous that the state should pay to have a Towers Watson presence in Nevada to assist the Medicare exchange retirees.

She stressed that Towers Watson needed to fulfil its obligation and provide in-state representation to retirees in Nevada.

Chairman Kieckhefer asked Ms. Lockard if she knew when the contract with Towers Watson expired, and she replied the contract was recently renewed.

Continuing, Ms. Lockard stated that she applauded PEBP for appropriately allocating excess reserves that had accumulated to help defray the costs of the benefit plan and decrease premiums. In earlier testimony, there was discussion about rate setting and an increase in premiums and she wondered who was going to pay for the increase in premiums. However, what was not discussed was by the end of FY 2015, there was $52.1 million in excess reserves, and by the end of FY 2016, excess reserves were projected to be $46.5 million, which she thought should be factored in to the rate-setting going forward for FY 2017, to avoid increasing premiums. In addition, she thought PEBP could absorb the costs for the 1,800 orphans with the excess reserves. Ms. Lockard commended Mr. Haycock because he reinstituted discussions with RPEN, which allowed for open dialogue and communication. Although, the state could not always depend on excess reserves, Nevada consistently accumulated large reserves. She thought the excess reserves should be included in the conversations about benefit costs.

Ms. Bowen added to her previous testimony and stated that the purpose for the separation of the orphans from the population of state retirees was a way of knowing the cost for someone that did not have 40 quarters and was reliant upon the state's insurance program. She said the non-state retirees were asked to join the state insurance program, which she thought was to help "shore up" the state numbers in order to get a better "bang for their buck" on insurance coverage. However, the bottom line was the orphans were never separated to determine the cost of benefits, in terms of participants having to pay higher premiums for benefits. Mr. Bowen stated that Mr. Haycock mentioned the surveys that were mailed to participants and the responses received, and 92 percent of participants in the surveys stated they wanted the same vision benefit they had before the 2010-11 benefit changes. The previous vision benefit paid 100 percent for one eye exam per year, in addition to an allowance for contacts or glasses, which was removed. She said participants were not utilizing the dental benefits even with the $1,500 deductible. She stated, if she had to get a crown for a tooth or a cavity filled, she should be able to use her $1,500 benefit toward the filling or crown instead of paying 50 percent of the cost the crown or filling to avoid incurring another out-of-pocket expense. Ms. Bowen added the fever blister medicine she was previously prescribed, which was covered under her deductible, now cost over $800 because of the drug price increase. Ms. Bowen noted that when it came to blending rates, the orphans were literally set against the state employees. She stated that an insurance plan should be the same for all participants and she urged PEBP to consider blending the rates, which would be helpful.

Concluding her presentation, Ms. Bowen stated that preventive care was not free for participants. She stated the wellness benefit of $50.00 per month was not going into

participants paychecks anymore. In addition, the RFP was pulled at the PEBP Board meeting because the Board decided that the health care provider selected was not in the best interest of participants. She hoped the PEBP Board considered what was in the best interest for the people of the state and allowed open access to medical care at all hospitals for the HMO participants, and at some point, for the participants on the high deductible plan.

Vicki Cameron said, as a non-state PEBP participant, she was worried about the comment made by Mr. Haycock stating that the excess reserves would be spent by the beginning of July 2016. She was concerned the HSA and HRA funds were paid from the excess reserves and she did not believe that information was passed on to the participants. In addition, she was worried that when the excess reserves were gone, so were the participants HSA and HRA funds, and most of the participants receiving the funds, banked on the reserves in case of a major medical situation. Ms. Cameron encouraged the committee to pursue a legislative solution to the orphan issue. She stated that she was a non-state, non-Medicare retiree and would be part of the retirement system for a long time. She encouraged the Committee to direct the PEBP Board to find a legislative solution for the non-state non-Medicare retirees.

VI. ADJOURNMENT.

The meeting was adjourned at 12:45 p.m.

Respectfully submitted,

_____
Donna Thomas, Committee Secretary

APPROVED:

_____
Senator Ben Kieckhefer, Chair

Date:_____

Copies of exhibits mentioned in these minutes are on file in the Fiscal Analysis Division at the Legislative Counsel Bureau, Carson City, Nevada. The division may be contacted at (775) 684-6821.