MINUTES OF THE
NEVADA LEGISLATURE'S
INTERIM RETIREMENT AND BENEFITS COMMITTEE
(*Nevada Revised Statutes* 218E.420)
February 22, 2018

The first meeting of the Nevada Legislature's Interim Retirement and Benefits Committee (IRBC) was held at 10:00 a.m. on February 22, 2018, at the Grant Sawyer State Office Building, 555 East Washington Avenue, Room 4401, Las Vegas, Nevada with videoconference to the Nevada Legislative Building, 401 South Carson Street, Room 3138, Carson City.

COMMITTEE MEMBERS PRESENT IN LAS VEGAS:
Assemblywoman Maggie Carlton, Chair
Senator Joyce Woodhouse, Vice Chair
Assemblywoman Olivia Diaz

COMMITTEE MEMBERS PRESENT IN CARSON CITY:
Senator Ben Kieckhefer
Senator Julia Ratti
Assemblyman Al Kramer

STAFF MEMBERS PRESENT IN LAS VEGAS:
Cindy Jones, Assembly Fiscal Analyst, Fiscal Analysis Division
Sarah Coffman, Principal Deputy Fiscal Analyst, Fiscal Analysis Division
Cathy Crocket, Program Analyst, Fiscal Analysis Division

STAFF MEMBERS PRESENT IN CARSON CITY:
Mark Krmpotic, Senate Fiscal Analyst, Fiscal Analysis Division
Brenda Erdoes, Legislative Counsel, Legal Division
Eileen O'Grady, Chief Deputy Legislative Counsel, Legal Division
Donna Thomas, Committee Secretary, Fiscal Analysis Division

EXHIBITS:

Exhibit A: Agenda and Meeting Packet
Exhibit B: Testimony provided by Professor Douglas Unger, Vice Chair and Chair Elect, UNLV Faculty Senate and member of the UNLV Employee Benefits Committee

I. ROLL CALL.

Chair Carlton called the meeting to order at 10:01 a.m. The secretary called roll; all members were present.

II. PUBLIC COMMENT.

The following testimony was provided by Professor Douglas Unger, Vice Chair/Chair Elect, University of Nevada Las Vegas (UNLV), Faculty Senate and member of the UNLV Benefits Committee

Statement to Interim Retirement & Benefits Committee – for 2-22-18

Good morning. I'm grateful for this opportunity to speak before this distinguished committee, and thank you all for your service in meeting today. I'm Douglas Unger, Vice Chair and Chair elect of the UNLV Faculty Senate, and a member of the UNLV Employee Benefits Committee reporting to President Jessup and the UNLV community. I represent some three thousand UNLV Faculty and Staff who, by word of mouth, written report, and our many internal surveys and an external COACHE appraisal of our university, are very greatly concerned about the inadequacy of our state employee healthcare benefits.

All too many hard working state employees, devoted teachers, world-class scholars and researchers, cannot afford healthcare that meets their needs. In an era of relatively sound state budgets, our salaries have remained flat for nearly a decade other than COLA raises which do not keep up with the cost of living while our healthcare benefits have not been restored to pre-Recession levels, and continue to be cut. We are experiencing hiring and retention issues at UNLV and at all our Nevada colleges and universities in part because these benefits are noncompetitive. UNLV has high aspirations to achieve Top Tier status in the very near future. As a full professor at UNLV for twenty-six years, and in higher education thirty-six, I can state with some experience that our healthcare benefits do not live up to the high aspirations of our university or of this great state.

Today, I submit to this distinguished committee a few selected stories, eighty in total, that serve as testimony that our health insurance does not meet our needs (Exhibit B). In them, you'll find accounts of teachers and classified staff who cannot afford the drugs prescribed for them and either put off taking necessary amounts or forgo taking them at all, endangering their health; a story of parents who cannot find adequate providers for their afflicted child unless they be "out of network" and thus caring for their child has driven the family to the edge of poverty; stories of surgeries and tests too long delayed; of a widow left tens of thousands of in debt because of uncovered costs for her dying husband; of a prize-winning professor with a chronic disability who every single year pays more than 10% of her income in uncovered care; and on and on. Read these accounts – these are only a few -- to understand not only the financial burdens, but, more importantly, the personal costs inadequate health insurance causes for some of the best

and brightest in our society, all of whom give of their lives in service to Nevada and its future.

Please know that it is not our intention to criticize the PEBP board or its administration for the failure of our state to provide sufficient healthcare to state employees. Over the past five years, we've seen many improvements in our relationship with the PEBP board and with its Executive Director, and we are grateful to PEBP for revising its website and procedures, for its staff members who speak to us in caring, personalized ways, and to Damon Haycock and the board for doing their level best to negotiate contracts with the resources the state provides. We thank all at PEBP for their professionalism and efficiency.

However, we must state that we strongly disagree with PEBP concerning accruing excess reserves from state contributions and our premiums, adding up to tens of millions of dollars, year after year. We do not agree with PEBPs explanations of why and how such excess reserves are adding up, nor with PEBP's justifications for not expending these reserves in ways that better benefit state employees. A good example is our current plan year – even with a relatively prosperous budget for Nevada, our health benefits were, in effect, cut, by $200, to the HSA/HRA accounts for individuals and the equivalent for families; we did see a new drug plan that lowered costs for one group but, on the other hand, raised costs for Tier 4 or so-called "specialty" drugs for another group, in some cases catastrophically. And from our appeals to seek at least some relief or restored benefits from excess reserves, what we got was a small improvement to pay for 3D mammograms that our plan should have been paying for in the first place, followed by an explanation that millions in reserves must be held back due to an abundance of caution for the funding a new EPO care plan in northern Nevada that no one, not even the actuaries, can state how much will actually cost. So we must ask why the actuaries have been so consistently wrong, and why these excess reserves are not being expended to improve our benefits.

Still, this is but one chronic issue, for today's discussion. The more important concern is our request to this distinguished committee to keep in mind that our health insurance is not adequate to meet our needs. Please read our stories. And as this year's election approaches, know that some three thousand state employees at UNLV among some forty-six thousand in Nevada will be thinking of the well-being of our colleagues, our coworkers, our families and friends, and of our fellow public servants, hoping for improved healthcare benefits we not only need but believe without question we have earned and deserve.

Thank you,
Doug Unger, Vice Chair, UNLV Faculty Senate

Chair Carlton asked if there was anyone who wanted to provide public testimony in Carson City. Senator Ratti stated there was no one at the Carson City location to provide public testimony at this time, but added there were members present in the audience representing the Retired Public Employees of Nevada (RPEN).

III. APPROVAL OF THE MINUTES OF THE DECEMBER 14, 2016, MEETING.

SENATOR WOODHOUSE MOVED TO APPROVE THE MINUTES OF THE DECEMBER 14, 2016, MEETING OF THE INTERIM RETIREMENT AND BENEFITS COMMITTEE.

ASSEMBLYWOMAN DIAZ SECONDED THE MOTION. THE MOTION CARRIED UNANIMOUSLY.

PUBLIC EMPLOYEES' RETIREMENT SYSTEM (PERS).

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

Tina Leiss, Executive Officer, Public Employees' Retirement System, stated that she would provide an overview of the approval of executive staff salaries, page 46, Tab IV.1 (Exhibit A). She introduced Steve Edmondson, Investment Officer, PERS. Ms. Leiss stated that pursuant to NRS 286.160, the salaries of the Executive Officer, General Counsel, Operations Officer, Investment Officer, Chief Financial Officer, Manager of Information Systems, Administrative Services Coordinator and Administrative Analyst were entitled to salaries that were set by the Retirement Board upon the approval of the Interim Retirement and Benefits Committee (IRBC). In February 2016, the IRBC approved maximum salaries for each of the positions, reflected under FY 2017, page 47 of the meeting packet (Exhibit A). The Retirement Board at its July 2017 meeting voted to approve a 3 percent cost of living increase (COLA) for Fiscal Years 2018 and 2019 in accordance with the COLAs that were granted to state employees by the 2017 Legislature. She noted that the cost of living increase was in accordance with the Board's policy that provided for the same COLA's to the executive staff as granted to state employees in general. She stated the Board requested that the IRBC approve the salaries shown on page 47 (Exhibit A) for Fiscal Years 2018 and 2019. The salaries were maximum salaries and not every employee was at the maximum salary. There was a ten-step schedule in keeping with the classified system that employees worked through, but the increases were the 3 percent COLA on top of the maximum salary. She added that none of the employees received the 3 percent COLA because they were waiting for approval from the Committee.

SENATOR WOODHOUSE MOVED TO APPROVE THE 3 PERCENT COST OF LIVING INCREASE FOR EXECUTIVE STAFF SALARIES OF THE PUBLIC EMPLOYEES' RETIREMENT SYSTEM.

SENATOR KIECKHEFER SECONDED THE MOTION. THE MOTION CARRIED UNANIMOUSLY.

2. Report on actuarial valuation for the Public Employees Retirement System (PERS) as of June 30, 2017.

Ms. Leiss stated that by statute, the System must perform an actuarial valuation at least every other year. The Retirement Board by policy has determined that annual valuations are appropriate to monitor the assets and liabilities associated with the pension plan. Per statute, the contribution rates could change on July 1 of odd numbered years based on the even numbered valuations, and since this was an odd numbered year valuation, the valuation did not affect contribution rates for the System. To project the liabilities and costs of the System, assumptions were made about future events that may affect the timing and payment of benefits and contributions. Therefore, as part of the valuation process, PERS looked at the experience for the year, and reviewed it against the assumptions, which would create a gain or loss in various categories and then those gains and losses were recognized in each year's valuation. Ms. Leiss stated it was important for PERS to ensure the assumptions remain appropriate, so by policy, the Board conducted an experience study through its actuary once every four to six years. She indicated the previous experience study was conducted in 2013 to be applied to the 2013 valuation, so the Board had its actuarial firm, Segal Consulting, perform an experience study for the FY 2017 valuation. Therefore, part of what was seen in the valuation was affected by the experience study because any changes to the assumptions approved by the Board in October 2017 were applied to the valuation. She noted the types of assumptions that were reviewed in an experience study included demographic and economic actuarial assumptions. The demographic assumptions included retirement rates, mortality, termination rates and incidence rates. The economic assumptions were mainly investment returns, inflation, individual salary increases and active member payroll. Therefore, changes were made to each of the assumptions based on the experience during that period. For the demographic assumptions, the biggest effect of the change was to the mortality table and during the four-year experience period, the actuary reviewed the number of deaths that were expected and the actual number of deaths. Ms. Leiss noted the experience was very close to the assumption for that period, but actuarial practice required that future expected gains and longevity were built into the assumption. Thus, the change was to build in some expected improvement in longevity – building in and expecting fewer deaths in the coming years. Hence, that changed mortality since benefits were being paid longer, which had the effect of increasing projected costs on the liabilities. The biggest impact on the assumption changes on the demographic side was the mortality change.

Regarding the economic assumptions, the major change was the long term rate of inflation, which affected a number of assumptions. The long term rate of inflation was a component of the investment return, expected salary increases, in addition to a component of the post retirement benefit increases. Therefore, a change in inflation would change each of the assumptions. The change to PERS investment return assumption was primarily driven by the change to inflation. The long term rate of inflation was 3.5 percent and reduced to 2.75 percent, which had the effect of both increasing and decreasing costs.

Continuing, Ms. Leiss stated the long term rate of inflation increased costs because it lowered the rate of investment return and the assumption was lowered from 8 percent to 7.5 percent. Therefore, if lower investment returns were assumed it increased the cost as far as the contribution, but if the inflation on the salary side was also lowered, then lower salary increases were assumed in the future, which had the effect of lowering long term benefits as well. However, the largest impact on the inflation, as far as the benefits was on the post retirement increases, and Nevada statute paid post retirement increases on the benefits and had set percentages, which were limited by inflation, so if the inflation assumption was lowered it meant PERS was assuming long term benefits being slightly lower, which also reduced the long term costs. Therefore, the reducing of the inflation assumption affected those three assumptions and there was a netting effect, not a direct one-to-one netting effect. Ms. Leiss noted the other assumption that was changed was the payroll growth assumption. The payroll growth assumption was used to calculate the payments on the unfunded liability. PERS projected future payroll growing. She indicated that PERS reduced payroll growth assumptions for the Police/Fire and Regular fund by one percentage point. When lower future payroll was assumed, it would increase contributions as a percentage of payroll. Ms. Leiss noted those were the changes that the Board made pursuant to the experience study, which had increasing and decreasing costs. The actuarial rate in the 2017 valuation was higher in both the Regular and Police/Fire fund than it was in 2016, solely because of the assumption changes. She noted if there were no assumption changes, the actuarially calculated rate would have been slightly lower because there was an overall experience gain for 2017.

Moving to page 52 of the meeting packet (Exhibit A), Ms. Leiss stated the contribution rates were shown for the Employer Pay Rate, which was the contribution rate where the employees' portion was paid by the employer on behalf of employee either through a salary reduction or in lieu of a promised pay increase. For the Regular fund, the total calculated rate was 29.19 percent compared to the current statutory rate of 28.00 percent. If it had been a rate setting year, the higher calculated rate would have triggered a contribution rate increase. However, the ultimate impact to statutory contribution rates would not be known until the 2018 valuation and the experience the state had through 2018. For the Police/Fire fund, the total calculated rate was 41.97 percent compared to the current statutory rate of 40.50 percent. Page 53 (Exhibit A) showed the Employee/Employer rate changes. She noted the Employee/Employer fund was the contribution where the employees have opted to pay for their half of the contribution rate through an after tax deduction, so it was divided exactly in half between the employee and the employer. This total rate was somewhat more expensive than the employer paid rate because it included refundability of the employee contributions. The employees that had their contributions through reduction of salary do not have the option of refundability of employee contributions. Page 54 showed the change in actuarially determined contribution rates by cause. She noted that the change in actuarially determined contribution rates was the average rate between employer pay and employee/employer pay. Ms. Leiss noted that in 2017 there was a gain in investments and individual salary increases. Payroll growth was lower than expected and there was a gain in changes in normal costs. In addition, there was a gain in post-retirement increases. She noted the

chart provided an idea of the magnitude of the various components that went into the gains and losses and then the effect of the assumption changes.

Continuing, Ms. Leiss stated that pages 56 through 62 of (Exhibit A) provided information on the active membership, retiree membership and the average benefit payments. The total active membership increased from 105,167 members to 105,801 active members between the two funds, which was still below PERS highest membership of 106,123 in 2008. Total payroll increased by 3.66 percent from 2016 to 2017, and the prior year increase was 2.2 percent, so total payroll did grow slightly in 2017. The estimated time period for both funds to be fully funded was 18.7 years in aggregate, 18.9 years in the Regular fund, and 18.2 years in the Police/Fire fund.

Moving to page 59 (Exhibit A), Mr. Leiss noted the chart showed PERS Actuarial Funded Ratio for the last ten years. She noted the chart showed the actuarial value of assets versus the actuarially calculated liabilities. To determine the actuarial value of assets, investment gains and losses were taken over five years to reduce the volatility on the contribution rates for funding purposes. She indicated the rate was an actuarial funded rate and the total funded ratio increased to 74.5 percent in 2017. The funded ratio for the Police/Fire fund decreased slightly and the funded ratio increased for the Regular fund. The demographics were fairly different between the two funds. She added that because participants in the Police/Fire fund retire earlier, it has a bigger effect on the fund when the mortality and the post retirement increases.

Ms. Leiss directed the Committee to page 60 of (Exhibit A), which showed PERS Total Funded Ratio from FY 1984 to FY 2017.

Ms. Leiss explained that the graph on page 61 (Exhibit A) showed PERS' Market Value of Assets and the Unfunded Liability. She noted that the black bar on the page showed the market value of assets and the white bar showed the unfunded liability, which showed the difference and growth of the two over the ten-year time period. She noted that the total bar on page 62 (Exhibit A) was the liability and the black column on the chart was the market value of assets, to show how the two assets changed over that ten-year period of FY 2008 through FY 2017.

Chair Carlton asked how the assumptions were made and the future impacts it would have on the netting effect. She acknowledged the fact the workforce in the state was low and fewer people were paying into the System. She asked how the assumptions were encapsulated into the payroll growth assumptions.

Ms. Leiss indicated that Nevada had fewer public employees per capita in the nation. She noted that up until FY 2008, the state consistently exceeded its payroll growth assumption as far as averages, because the payroll was growing at a fairly fast pace compared to the rest of the nation. After FY 2008, that payroll growth in some years was negative. Therefore, because the payroll did not grow the way it was assumed, the actuary calculated an amount that was needed for contributions and divided it by the expected payroll to come up with a percentage of payroll for contributions. Ultimately, if

the payroll ended up being lower than what was assumed, there was a lower number on dollars. Since FY 2008, there were lower contributions coming in simply because the payroll was not as large as it was assumed to grow. Therefore, a downward adjustment was made on the assumed payroll growth assumption, because the payroll was increasing slightly – 2.2 percent in FY 2015 and 3.66 percent in 2016. Thus, when the payroll growth declined, lower payroll was assumed, which meant the contributions needed were a higher percentage of that payroll. Ms. Leiss noted the payroll growth assumption contributed to approximately 1 percent of contribution costs.

Chair Carlton asked if a larger workforce and more contributions would help deal with the unfunded liability, and Ms. Leiss agreed. She added if the payroll grows faster than assumed or it continued its upward growth, there would be more contributions, which would work to pay down the unfunded liability. However, PERS made adjustments for that to ensure that it was getting contributions to make those payments. She noted that part of the adjustments was to ensure that even with lower payroll growth PERS was getting the contribution rate it needed to make the payments on the unfunded liability over the remaining 18-year period.

Chair Carlton asked if higher wages for state employees would deal with the unfunded liability, and Ms. Leiss replied it would mean higher contributions as a total payroll growth.

Senator Kieckhefer asked about the chart on page 54 (Exhibit A) showing the change in actuarially determined contribution rates that added up to the 1.19 percent change in the contribution rate. He asked if there was a breakdown on how the different assumption changes combined to the 1.6 percent.

Ms. Leiss replied she had an estimated breakdown of the components, which was never put into an official report. However, she had an idea of the estimated breakdown of those components.

Senator Kieckhefer asked what effect the 0.5 percent reduction of the expected investment return would have on the contribution rates.

Ms. Leiss replied that looking at just reducing the investment rate of return from 8 percent to 7.5 percent, it had a big impact by itself. She noted the estimate between the two different funds was approximately 4 percent in the Regular fund and 6 percent in the Police/Fire fund because of the different demographics and sizes. However, there was an offset as well, and the effect of inflation on the post retirement increases was approximately a negative 2.9 percent in the Regular fund. Therefore, just changing the inflation assumption for those two areas, one was a 4.3 percent increase and one was 2.83 percent decrease, and another decrease of .87 percent for the individual salary increases, so combining those was approximately a 1 percent increase on the Regular fund. There was a different dynamic for the Police/Fire fund, and just looking at the investment rate of return being reduced 0.5 percent, that had over a 6 percent impact. However, the lowering of the same inflation assumption for the post retirement increases had almost a 5 percent decrease on the rates, so when the two were netted together, the

Police/Fire fund had no increase based on the inflation assumption change and there was 1 percent change for the Regular fund.

Senator Kieckhefer asked if there would be a significant impact on the investment expectation if the inflation were to increase, and Ms. Leiss replied that she assumed if the inflation increased there would be an impact on the investment side. In addition, there would be an impact on the liability side, because the post retirement increases would be higher as well.

Steve Edmundson, Investment Officer, PERS, stated that the impact of inflation on the expected return assumptions was really the foundation of building those investment return assumptions for both the total fund and the underlying asset classes. Therefore, the net effect of reducing the inflation assumption ultimately brought down the total fund return expectations. In terms of how that might change going forward, inflation has been low since the financial crisis. More recently, inflation has turned around 1.5 percent and when the CPI number was announced it was the biggest increase in 13 years so inflation was starting to increase. Currently, the rate of inflation was around 2.1 percent on an annualized basis. He stated that the direct impact of the rate of inflation was seen in interest rates. Basically, the ten-year treasury bonds rates on those securities was starting to move higher in relation to inflation expectations. So as the expectations of the inflation number increases, so does the underlying interest rates of fixed income securities. If there was a 3 percent inflation number then the expected return would be significantly easier to achieve, and potentially at some point, start reducing risk in the total fund.

Senator Kieckhefer stated that it seemed when originally discussing the varying dynamics of the inflation rate assumption that the change in inflation assumption led to the decision to reduce the expected rate of return. He asked if he was correct or if PERS looked at previous returns and projections and then changed the assumption from 9 percent to 7.5 percent.

Mr. Edmundson replied the return expectation number was one of the actuarial assumptions, and ultimately the recommendation for that number was made by the Systems actuary to the Board. He noted the Board's obligation was to approve assumptions based on the recommendations of the independent actuary. Hence, when the independent actuary looked specifically at the investment return assumptions, the inflation component was a critical piece. The actuary looked at the experience and the inflation rate over the last decade, which has been trending lower than historically. If the actuary thought the inflation number was slightly high, post-retirement increases might be assumed to be high. It was the foundation of that investment return assumption as well, so as the inflation number decreased, it was really the direct impact on the reduction in the investment return assumption as well.

Assemblyman Kramer asked about the tradeoff between interest rates and the rate of return and how that effected both the returns going forward, and the expenses. He said it seemed the same was true when talking about a decline in the number of people paying

into PERS over the last ten years, which would also reflect in a reduction in the payouts down the road 20 to 30 years. It seemed that dip should have been mitigated somewhat by what happened when people retired with fewer years of service in the future.

Ms. Leiss replied that the dip in the active membership in payroll began around 2008, so it could show an impact but it was a long way down the road, because PERS was looking at retirees who would not be retiring for 10 to 30 years. Ultimately, that may have an effect because potentially there would be fewer retirees due to the dip in membership. However, she thought the bigger impact was the drop in payroll, because it does not provide the contributions that might have been expected and adjustments would have to be made for that going forward.

3. Report on actuarial valuation for the Judicial Retirement System as of June 30, 2017.

Ms. Leiss stated as of June 30, 2017, similar to the PERS system, the Judicial Retirement System (JRS) required a biennial valuation. By policy, the Board performs an annual valuation to keep up on the trends with the fund. The Judicial Retirement System was different from PERS because it had multiple employers but was not a cost-sharing plan. Therefore, each of the employers in the System paid a separate contribution rate and paid individually for the retirees and members. She explained that the JRS was enacted in 2001 and was a pay-as-you-go system prior to 2001. It was unfunded and there was a provision in the judicial statute that allowed for a certain pension to be paid to retired judges based on the number of years of service. Essentially, the JRS was a General Fund appropriation every legislative session to pay for those benefits. In 2001, the Legislature set up the JRS to be like PERS and advanced funded, the contributions were made and was set up just for the state judges. The JRS covered most District Court Judges, Court of Appeal Judges, and Supreme Court Judges at that time. When the JRS was set up in 2001, the System absorbed all existing retiree judges, so all of the unfunded benefit payments were taken into the System to be paid. Therefore, the System started with an unfunded liability to the extent of those payments and PERS was still paying a number of judges that were retired under the prior unfunded provisions. By election, local jurisdictions were allowed to join JRS, so county commission and city councils could elect to cover their municipal court judges and justices of the peace in the JRS, but they had to pay their own costs, which was why PERS calculated different contribution rates.

Ms. Leiss stated that she would mainly focus on the state portion of the JRS. She noted that because of the way the funding came about, there was a calculated statutory rate for the JRS, and does not include an unfunded liability payment because of the unfunded nature that came when the System started. The unfunded payment was calculated as a lump sum payment that was billed to the Administrative Office of Courts each July, so a lump sum payment was made of approximately $1.5 million, which was calculated based on the even number year valuation. She noted that the valuation had no effect on the funding of the JRS just like PERS had no effect. The assumption changes were also put into place in the JRS similar to the PERS system. However, the changes were not the same as the salary assumptions because it was easier to track judicial salaries since they

were set in statute for the state. Ms. Leiss stated that mortality and other types of changes were also made for the JRS.

Continuing, Ms. Leiss stated the actuarial contribution rate for state judges for the valuation was 22.02 percent, which compared to the current statutory rate of 20.25 percent. The JRS contribution rate adjusted downward as of July 1, 2017, from 21.25 percent to 20.25 percent. The state annual amortization payment stayed fairly level so the cost did not increase. The actuarial funded ratio increased in the fund on a total fund basis from 86.1 percent to 87.4 percent. The unfunded liability was reduced from $17.2 million to $16.8 million, mainly due to mortality and investment gains, which were offset by the assumption changes. Therefore, there were more deaths in the fund than was assumed over the time period.

Ms. Leiss noted that pages 65 through 69 (Exhibit A) contained information on the active membership for both the state judges, non-state judges, retirees and the calculation of the contribution rates for the JRS.

Assemblyman Kramer commented that the non-state judges were in the System when their respected entities elected to allow them to participate. He asked for the number of judges that were in the System. He asked if the number was likely to change because he presumed there would be an annual payment coming from the local entities similar to the state for judges that were retired. He asked how that would affect the System moving forward.

Ms. Leiss responded that when the local jurisdictions elected to allow its justices of the peace or municipal court judges to participate in the System, then those judges were given an election as well. Therefore, those justices could either remain in PERS or move into the JRS. If the justices elected to move into the JRS and were PERS members, then their assets transferred with them. If the justices were not PERS members originally then they would start 100 percent funded as new members in the JRS. Almost the entire unfunded liability rests with the state because of that prior unfunded system. With regard to the number of judges, she thought there were approximately 11 local jurisdictions that were in the System and a few of the larger local jurisdictions that were not under the JRS.

4. Report on actuarial valuation for the Legislators' Retirement System as of June 30, 2017.

Ms. Leiss continued with her presentation on page 71 (Exhibit A) Fiscal Year 2017 Actuarial Valuation for the Legislators' Retirement System (LRS). She noted that because it was an even numbered fiscal year, it did not affect the funding of the System. Due to the size of the System, even numbered valuations were performed until 2015. Therefore, PERS performed the valuation on a biannual basis up until 2015, when the Governmental Accounting Standards Board (GASB) rules changed and valuations were performed on an annual basis. The LRS was funded differently in that legislators paid 15 percent of their legislative salary as the employee contribution. The Legislative Counsel Bureau (LCB) paid the System directly for the administrative costs in

a lump sum amount. The actuary calculated the amount needed after the 15 percent was applied, which was what the employer paid as a lump sum amount to the System for payment for the employer contribution. The provisions of the LRS allowed legislators to participate, or opt out of participation in the System at any time. She indicated there were legislators who do not participate in the System. In the 2017 valuation, the active membership remained the same as the prior year with 31 active members in the LRS. The number of retirees decreased from 59 to 58, while the overall number of beneficiaries, including survivors, decreased from 77 to 75. The funded ratio of the LRS increased from 87.4 percent to 89.2 percent and the unfunded actuarial liability decreased from $658,000 to $561,000 for the valuation. She added that the assumption changes for PERS and JRS were also adopted for the LRS.

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

Mr. Edmundson directed the Committee to Agenda Item IV.5., page 77 (Exhibit A), Investment Update on PERS, LRS and JRS. He stated the page showed the investment returns for the three funds for various periods ending June 30, 2017. For FY 2017, PERS portfolio produced a return of 11.9 percent net of fees. The LRS fund return for FY 2017 was 12.1 percent and the JRS return was 12.3 percent net of fees. He noted the last five years were strong for the economy and financial markets and the five-year returns for all three funds were about 9 percent and reflected that strength. Currently, Nevada PERS investment returns since inception was 9.3 percent net of fees.

Mr. Edmundson stated that in addition to the absolute numbers, PERS was pleased to report that the reported numbers were also strong on a relative basis compared to its median public pension fund large defined pension programs. For the last three, five and seven-year time periods, Nevada PERS absolute returns were within the top 30 percentile for large public funds, and over the last decade, PERS' returns ranked in the top 20 percentile for large public funds. On a risk-adjusted basis, or a sharp ratio, there was a dual mandate with the investment program – one was to produce returns and another was to minimize volatility. Nevada PERS portfolio ranked within the top 20 percentile for virtually every meaningful time period and was one of the top funds in the country since inception. Mr. Edmundson stated that investing efficiently with consistency was a key piece for a mandate in the portfolios.

Continuing, Mr. Edmundson stated PERS was able to produce returns with an investment strategy unique among the public pension fund industry. He noted that people in the institutional community would refer to Nevada's style of investing as "The Nevada Model" in that rather than a very complex portfolio, PERS employed a simpler approach to managing the funds' assets with a focus on S&P 500 stocks and a high-quality fixed income portfolio that was 100 percent indexed to U.S. Government Treasury bonds. He stated PERS would diversify an asset with U.S. Government Treasury bonds and growth assets in high-quality U.S. and develop market large capitalization stocks. He said PERS employed a 100 percent index management across all of its public market asset.

He noted that PERS deliberately chose to avoid exposure to high-risk assets classes and complex investment strategies, such as the use of leverage and hedge funds.

Mr. Edmundson stated that a byproduct of the simple approach was that the Nevada PERS program was extraordinarily cost efficient and among the lowest cost investment program in the industry. In FY 2016, PERS total investment costs were 12 basis points, which was significantly lower than the median fund investment cost of around 53 basis points. The cost savings resulted in an estimated $150 million a year savings to the System, which was a significant cost savings relative to its peer group.

Concluding his presentation, Mr. Edmundson stated PERS investment strategies were working as expected. He noted that PERS could not control the direction of financial markets; therefore, considerable time was focused on what would drive returns, such as implementing a disciplined common sense investment strategy, keeping costs as low as possible and an absolute unwavering discipline fashion.

Assemblyman Kramer stated that Nevada PERS should be recognized for its common sense investment strategy, low costs, and for having a highly ranked program nationwide.

Chair Carlton asked Mr. Edmundson if the simplicity of the plan was one of the factors that contributed to the Nevada's national ranking.

Mr. Edmundson replied that consistency in PERS approach across all market cycles and the fact that the fund has embraced the simple approach historically, which was implemented in a purely disciplined fashion attributed to Nevada's national ranking. He reiterated that more than anything else, Nevada's ranking was due to its consistency and discipline rather than chasing the "fad of the day" or returns.

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 provided an update on the benefit provided to certain education employees pursuant to NRS 391.165, page 89, (Exhibit A). The benefit was designed to be an incentive to certain employees to work at schools designated as needs improvement or at least 65 percent of the pupils were at-risk children. Additionally, this benefit was also provided to teachers with specialty areas that were difficult to recruit.

Mr. Leiss stated that Assembly Bill 1 of the 23rd Special Session repealed this benefit effective July 1, 2007. For a person to continue in the benefit they had to been under contract prior to July 1, 2007, and elect to participate in the program rather than electing to participate in another incentive program. She noted there were still people who elected to purchase the one-fifth of the year service credit and their participation ceased once they had one full year of service credit purchased. Therefore, teachers come in and out of positions that entitled them to this benefit, because generally one-fifth of a year would be five purchases to get to a year before they would be out of the program.

Ms. Leiss explained that page 91 of (Exhibit A) reflected the one-fifth of a year purchase program for 2016 and 2017. In calendar year 2016, over $1.0 million was paid for 238 purchases; in calendar year 2017, purchases decreased to $490,000 for 111 purchases. Ms. Leiss noted that since inception, the program resulted in 41,479 purchases, which was approximately $146.0 million, so the program was winding down and would be phased out in a few years.

7. Status report on Critical Labor Shortage exemptions from PERS' Reemployment Restrictions (NRS 286.523).

Ms. Leiss referred to page 93 (Exhibit A), which outlined the current reemployment restrictions and the critical labor shortage exemptions to those reemployment restrictions. In general, a retiree was restricted from returning to work, and if they returned to work, generally the benefit would be suspended unless there was an exemption that allowed the benefit to continue while working. Ms. Leiss stated that one of the exemptions was for critical labor shortage, which was originally started in the early 2000's. Assembly Bill 488 (2009 Legislative Session) significantly restricted the use in that it required the designating authority, which was generally the Board of Examiners for the state, the county commission, city council or the school district, to make certain findings in an public meeting in order to designate a position as one of critical need. The designated authority must declare that the findings were appropriate and necessary for delivery of services to have a critical need position. Once the designated authority made the designation, a form needed to be filed with the System, and once filed, the law required the System to compile the forms and provide a biennial report to the IRBC on the compilation of the forms. Therefore, it was solely up to the designating authority whether the position was one of critical need, and if approved and the appropriate paperwork was provided, the position would be declared a critical need position. If a retiree was fully eligible to retire then they could return to work in a critical need position and continue to receive their benefit and collect the salary. She added that this provision was scheduled to sunset June 30, 2015; however, Senate Bill 406 (2015 Legislative Session) removed the sunset making it a permanent feature of the benefit structure.

Ms. Leiss noted the report on page 93 (Exhibit A) was slightly different from the previous report, and prior reports with the sunset provision required an estimation of certain costs; however, now that it was a permanent feature, those provisions were no longer in statute. She stated that the law required the System to report a compilation of the positions that have been designated as critical labor shortage. She noted that this was a position-driven designation and was not a person or employee-driven designation, so when the designating authority designates, it had to consider the length of time the position has been vacant, how many of the positions were vacant, and the candidate pool. She said that not every position designated would have a retiree to fill it. In addition, she noted that since it was position-driven, for instance, if the Clark County School District designated a special education teacher, it would be designated for all special education teacher positions. Ms. Leiss indicated the designation was required to be redesignated every two years to remain effective and the chart on page 95 (Exhibit A) showed every position that had an effective redesignation for the biennial period from July 1, 2015, to

June 30, 2017, with the original date of designation. Therefore, if there was an original date of designation prior to that period, it has been redesignated to be effective during this time period. Ms. Leiss indicated that during this time period there were 118 positions that had an effective designation of critical labor shortage, which meant a retiree could be hired for that position without loss of benefit. She said the State of Nevada had 2 employers designate 4 positions; school districts and charter schools had 19 employers designate 94 positions; counties had 8 employers designate 10 positions; public hospitals had 5 employers designate 9 positions; and 1 water district designate 1 position. Ms. Leiss indicated that page 95 (Exhibit A) contained a complete listing of all of the forms the System received from designating authorities designating a position as critical labor shortage.

Senator Ratti asked if PERS knew how many people were hired and paid under the critical labor shortage designation, and Ms. Leiss replied that PERS needed to track the positions to the extent that it was tracked in an individual member's account, because PERS needed to know whether or not to suspend their benefit. She stated that PERS had an idea of the number of people hired, which changed on a daily basis. She stated that number could be tracked but has not been tracked as heavily as it did prior to the sunset, because PERS had to track it for the experience study to determine the actual cost.

Senator Kieckhefer asked if the positions listed on page 95, for example, Department of Public Safety (DPS), Rural Correctional Officer and Correctional Officer Trainee, was a category or an individual position, and Ms. Leiss replied that was how the employer designated the position to PERS. She explained that the employer sent PERS a form that designated its DPS officers, and then I and II as a designation. Any number of full-time equivalent positions within the DPS Officer I and II designation would then be eligible for a retiree in the position.

Senator Kieckhefer asked the current number of full-time equivalent positions employed by the State of Nevada that were filled with individuals exempt from the normal reemployment restrictions due to their positions critical labor shortage designation, and Ms. Leiss replied that she did not know the number of people in each category; however, it was a number that could be developed for the Committee.

Senator Kieckhefer stated that the critical labor shortage designation was discussed with the Department of Corrections as a way to try to alleviate some of difficulty in recruiting and retaining correctional officers in rural Nevada, which resulted in overtime. He noted that he would work with Fiscal staff to get the answer from PERS or from the Department of Corrections.

Chair Carlton requested that the information be provided to staff and the Committee on the total positions that were currently filled by a retiree utilizing the critical labor shortage exemption from the reemployment restrictions.

Ms. Leiss responded that the number could be developed because it was tracked for the individual accounts, and it would just be a matter of compiling the information.

Chair Carlton disclosed that her husband was working under a critical labor shortage designation.
Senator Kieckhefer asked when an individual was rehired for a position at a higher wage, if it changed their retirement eligibility, resulting in a recalculation of their PERS benefit.

Ms. Leiss responded that it partially depended on the choice of the retiree. For example, if a retiree returned to a critical labor shortage position and was paid their previous salary, their retirement continued. The law provided the retiree a choice as to whether or not to reenroll; therefore, the retiree may not enroll, which would have no effect on their retirement benefit in the future. However, if the retiree reenrolled then there were provisions for what happened to that additional service and if it was greater than six months or five years, there were different ways it was calculated. If it was less than five years, the retiree could have an additional benefit calculated for the additional benefits, so if they worked for three years at their previous salary they would have a three-year benefit calculated, which was added to their other benefit. If it was more than five years, the retiree had the option to have their entire service recalculated. Therefore, it depended on the option the retiree chose.

Senator Kieckhefer asked if the retiree would get enhanced benefits based on salary or longevity if they decided to opt back into the System, and Ms. Leiss replied that was possible but the retiree would be limited to restrictions of the 75 percent cap.

Senator Ratti stated there were positions on the list on page 95 (Exhibit A) that went back to 2009. She asked if once the position was designated as critical labor shortage, if it continued until there was no longer a need, or were similar actions required if the position was no longer needed.

Ms. Leiss responded that there was a required redesignation every two years for a critical labor shortage designation, so if there was a position going back to 2009, the position has been redesignated every two years.

Chair Carlton stated that the critical labor shortage designation was meant to be a short-term fix. The issue was complicated because the state would much rather be hiring new employees and bringing up the next generation of employees, but there seemed to be a problem in certain areas to keep the correct number of personnel to deal with the issue.

8. Status Report and Update on the Administration and Investment Portfolio for the Retirement Benefits and Investment Fund (NRS 355.220).

Mr. Edmundson stated by statute the Retirement Benefits Investment Fund (RBIF) was managed by the Retirement Board solely as an investment vehicle for Nevada public employers who choose to participate in the program to fund other post-employment benefits. The decision to invest or not, or withdraw money rests solely upon each employer to decide. Therefore, in this respect it could be thought of as it was a mutual

fund, an investment portfolio, and the participating public employer could elect whether to add money to the mutual fund. As of June 30, 2017, RBIF held $418 million in assets and generated a return of 12.3 percent. Since its inception in January 2008, the fund has returned 6.2 percent on an annualized basis. Mr. Edmundson stated it was important to note that while that has been the investment performance for the fund in aggregate, each participating employer would have a different performance based on whenever it ultimately decided to contribute money to the fund, so each employer had a different start date. Because PERS was able to leverage some of the relationships with the PERS fund, they were able to negotiate some of the most competitive fee schedules in the institutional investment management industry. The total fund investment cost for the RBIF portfolio was extraordinarily low and at one point was 1.5 basis points or .015 percent of assets, which was estimated at about 96 percent lower than a similar size institutional investment portfolios. The RBIF mandate by statute was a little different than the PERS fund in that it was actually mandated with doing its best to mimic the risk and return profile of the larger PERS fund. Therefore, rather than having an absolute return target, PERS put together a portfolio that would mimic the larger PERS relationship. However, due to the smaller size, a portfolio of $418 million versus the much larger PERS fund could not be invested identically. He noted that over the last five years and since inception, the returns of the RBIF relative to the larger PERS fund, have been under 20 basis points, so the risk and return over time has been very similar to the larger PERS fund.

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

Mr. Edmundson reported that at the end of the most recent calendar year, December 31, 2017, Nevada PERS does not own any stock in any companies on the current list of companies that were being scrutinized for doing business in or with the country of Iran. He noted it has been many years since Nevada PERS had anything to report on this agenda item, which was largely due to the fact that the state did not have to exposure to emerging market stocks, and only owned developed market stocks, which typically do not fall under the scrutinized list.

V. PUBLIC EMPLOYEES' BENEFITS PROGRAM (PEBP).

1. Report on utilization of the Program by participants for the year ending June 30, 2017, including an assessment of the actuarial accuracy of reserves, pursuant to NRS 287.0425.

Damon Haycock, Executive Officer, Public Employees' Benefits Program (PEBP), stated that PEBP's NRS 287.0425 Summary Report was located under Tab V.1., of the meeting packet (Exhibit A). He directed the Committee to page 109, which listed the reports required under NRS 287.0425.

Mr. Haycock referred to page 115, Self-funded Plan Utilization Report for the Plan Year (PY) 2017 period ending June 30, 2017. The Consumer Driven Health Plan (CDHP) experienced an overall increase in population with overall reduced costs on a per

participant per month basis. Medical and dental costs were down 3.8 percent and pharmacy costs were up 3.5 percent, but when the additional rebates were received by changing to a new pharmacy benefits manager, the actual overall experience dropped a combined 3 percent; therefore, there were negative trends in FY 2017. He stated that PEBP had a trend presentation from its actuarial consultants in January 2017, confirming a negative trend for the last two years, which was amazing for a health plan that does not make major changes to its benefits. He said that PEBP was able to continue the general basic benefit program, but there was a negative trend in both medical and pharmacy benefits. Mr. Haycock indicated there was a decrease of 3.8 percent in high costs claimants, which were participants with bills in excess of $100,000 and PEBP paid about 3.2 percent less per claim. Inpatient and Outpatient costs decreased approximately 2 percent; emergency room visits decreased approximately 1 percent; and urgent care visits decreased 4.3 percent. He noted that the state continued to experience high utilization of in-network providers, which meant the state was able to maximize those contracts and discounts. Mr. Haycock stated there was a question at the December 14, 2016, IRBC meeting about the Health Maintenance Organization (HMO) Utilization, and two additional reports were included in the meeting packet (Exhibit A) to addresses those questions. One report was the Northern Nevada HMO, whose participants continued to experience risks resulting in higher costs shown on page 178 (Exhibit A), and pharmacy costs on the per member per month basis for the primary member was about $145, which was significantly higher than what PEBP experienced in the HDHP. He noted it was a good trigger to understand why those costs continued to increase and it defined a lot of the risk issues around the HMO. Similarly, the Southern Nevada HMO continued to experience higher risks and prescription costs were approximately $117 per member per month, up almost 17 percent from the prior year. He noted the risk pools in the HMO plan offerings have increased, and to be candid, the unhealthy participants were gravitating toward these plans because of the lower copay model and the unnecessary need to hit the out-of-pocket maximum because of copayments. He noted that was the basic overview of program utilization, although he could provide more detail if there were questions from the Committee.

Chair Carlton acknowledged she was aware of the inflation rate for the cost of prescriptions and the discussions the Committee had previously about the costs. She asked how that played into the actual cost of prescriptions for members.

Mr. Haycock replied that prescription costs were put into the numbers. Looking at the CDHP, prescription costs were initially up by approximately 3.5 percent, which was the inflation that occurred with those prescriptions, but when the rebates were applied on the backend there was a negative cost. Therefore, PEBP basically saved money and the savings were included in the per member per month costs. On the HMO, those costs were driving a lot of the increased premiums seen over the years, which he thought would be more apparent when he discussed another report later in the meeting on the HMO plan in Northern Nevada and why those rates were increased and what PEBP had to do to combat that increase.

Senator Kieckhefer asked Mr. Haycock if the participants with chronic conditions were driven more to the HMO because they did not have to meet a higher out-of-pocket deductible.

Mr. Haycock replied there were multiple reasons why participants liked the HMO. The HMO plan does not require a lot of thought outside of budgeting for the monthly premiums. The participant was aware of what they were going to pay when they went to the doctor, or for a surgery and the plan was transparent. In addition, the participant was not necessarily dealing with inflation from month-to-month as providers changed pricing and the contracts allowed for certain things. He indicated the participants who were a higher risk would generally move toward an opportunity to pay less for healthcare. Therefore, it was more lucrative for a member with a chronic disease not to have to pay a coinsurance model for care or hit their out-of-pocket maximum. Although, the Committee needed to understand that PEBP had its high share of chronic disease participants on the CDHP. There were approximately four members on the plan with hereditary angioedema, one of the most expensive chronic diseases in the nation and there was an unproportional share of those members in PEBP's plan due to its population. Mr. Haycock explained that everyone managed chronic disease a little differently, there were tools, triggers and levers, and participants would migrate to the HMO because they were going to have a surgery in the upcoming year and wanted to pay a lower cost and maximize their Health Savings Account (HSA), which could be used to offset copays. Therefore, there was a migration between plans. However, migration has moved away from the HMO programs but the cost continued to rise and naturally the idea was it was because the higher cost members were staying behind to meet those monthly premiums.

Assemblywoman Diaz asked Mr. Haycock to what did PEBP attribute the increase in Medicare-eligible retirees and if the increase in projections would continue over time. She said the data from 2015 showed 5,743 Medicare retirees, and currently, PEBP projected 6,727 Medicare retirees in 2018.

Mr. Haycock replied that people were getting older and aging into Medicare, so those participants who were 63 in 2015 would be 65 in 2017. There was a population that was aging and PERS mentioned life expectancy earlier in the meeting and the assumptions it made for mortality rates. He noted that PEBP had a similar ideology and recognized that people were going to live longer and lead healthier and more productive lives because of modern medicine. Therefore, people were retiring and aging into Medicare at 65 years of age.

Assemblywoman Diaz asked about the projected impact of the increase in Medicare-eligible retiree participant enrollment on the retired employee group insurance rate in the upcoming biennium.

Mr. Haycock replied that he was cautious talking about rates before the actuaries have developed them. Currently, PEBP was in the process of projecting the rates for FY 2019, and as customary, PEBP would provide a rate projection during the budget building process through agency requests during the summer of 2018, which would be available

in January 2019. He indicated there were still a significant number of people retiring who were not Medicare eligible and not of that age bracket. Therefore, PEBP would generally save money when the participants moved from the plan that were non-Medicare eligible to the Medicare Exchange through the Medicare program, which seemed like it would reduce costs to the program. However, PEBP was also seeing a significant number of people retiring from the state or from other employers that PEBP provided services for, which was happening across the nation, and PEBP anticipated those numbers increasing as well. He said when an employee retired, if they moved into a pre-Medicare situation they were backfilled by another employee and therefore, PEBP was covering the new employee plus covering the pre-Medicare retiree. As the pre-Medicare retirees aged into Medicare and moved into the Medicare Exchange, PEBP was reducing the amount that it needed to pay for them, because the retirees were covered by Part A, Part B or Part D, and other gap and supplemental plans they purchased. However, PEBP was seeing more retirees coming up right behind them and taking their place. He said it was too early to talk about rates for PY 2020-21, but if there were any indicators, as long as the trend remained low or negative, PEBP should be in a good place to continue to offer services with the funding provided by the Legislature.

Chair Carlton stated a concern of the Committee was the actuarial assumptions and the projections from the actuary, which have been off over the years. She stated that PEBP either ended up with not enough money resulting in cuts to benefits, or with too much money in reserves. Chair Carlton was aware the assumptions would be off the first year because the CDHP was new, and there were a lot of changes in the second year with the Affordable Care Act. However, she thought the actuaries should be able to come up with a more dependable projection so PEBP did not have to take away benefits, such as life insurance, removing the allowance for eye glasses and decreasing dental benefits. Chair Carlton said that consistency was needed for the employees and retirees so they could plan for the future. She asked if the Board had discussed the issue, and if not, she hoped PEBP would have that discussion with the Board at a future meeting.

Mr. Haycock stated that these issues were discussed during the 2017-18 Legislative Session, and PEBP approved rates and developed a program of benefits that restored enhanced benefits in the base plan to meet the consistency discussion. He said the rates, especially for employees, were kept flat for the CDHP that PEBP internally managed. He agreed there were certain processes and policies that the Board approved and certain opportunities that PEBP capitalized on to meet that consistency requirement. He said that some benefits that were due to sunset in 2016, were restored and made part of the discussion moving forward and were no longer considered enhanced benefits.

Continuing, Mr. Haycock stated that PEBP has had multiple conversations with its Board on PEBPs' policies and how it established reserves, program of benefits, and the consistency and plan benefit design that PEBP has been providing even though it was scheduled to be inconsistent. He noted the consistent rates were a testament to the Board's decisions and listening to the legislative body. He stated that PEBP would continue to improve and have conversations about PEBP's legislative agenda. PEBP

heard the concerns of the Committee on the need for consistency because people needed to budget for future healthcare needs.

Chair Carlton thanked Mr. Haycock for listening to the concerns of the Committee and the people. She said that she had concerns with the inconsistent projections of the actuaries, because those dollars come from the people who chose the CDHP, and it was their reserves. She has heard from participants who did not necessarily want richer benefits but lower costs in order to make their paychecks go further. She hoped the Board would consider not just enhancing benefits, but actually look at real costs and what was taken out of peoples' paychecks in the future. She thanked Mr. Haycock for listening to the concerns of her constituents because healthcare was one of the issues she heard about a lot, whether it was through the state, ACA, Medicaid, or a lack of healthcare. Chair Carlton asked Mr. Haycock to work with staff on the projections and how the percentages translated into dollars.

Discussion turned to Agenda Item V.2.a.

Mr. Haycock noted that attached to the Utilization Report, page 215 (Exhibit A), was the Incurred But Not Reported (IBNR) and Catastrophic Reserve Actuarial Report provided by AON. He said the report was updated for 2017, and there was a modest increase to the IBNR and Catastrophic Reserves to reflect the increased enrollment. He said that one of the triggers in changing those specific reserves was the number of people who were actually in the plan and how well those people were utilizing the plan. Although, PEBP had a negative trend for the year there were more people in the plan and history has shown that as they maintain benefits within the program that they would eventually, if not immediately, start utilizing benefits and therefore the reserves needed to be adjusted accordingly. Mr. Haycock stated that the IBNR and Catastrophic Reserves were set at a 95 percent confidence level per Board policy, which ensured that PEBP remained fiscally solvent. He recalled in 2000 when PEBP was created on the tail of the Committee on Benefits that there were a few years when his predecessor was forced to go to the legislative body to ask for bailouts of approximately $20 million. Therefore, the 95 percent confidence level was designed to ensure that was not repeated.

Responding to a question from Chair Carlton, Mr. Haycock stated that high-cost claims were over $100,000 and were not broken down in the report. However, he could provide a breakdown of high-cost claims over $100,000 in $100,000 increments to the Committee.

Chair Carlton asked if emergency room (ER) and urgent care visits were analyzed to see the contributing factors for the increase in those visits.

Mr. Haycock replied that there was a reduction in utilization and costs during a certain period in PY 2017. He directed the Committee to the Utilization Summary chart on page 135 (Exhibit A). He noted that looking at PY 2015 through PY 2017, the variance for the numbers in FY 2016 were either flat for visits per member or negative in visits per 1,000 and paid per visits, and admittance per visits from the ER utilization data. Emergency room usage was down for the plan year and PEBP was paying less when participants

went to the ER, and less people were being admitted to the hospital from those ER visits. He added that he received a monthly ER report from PEBPs third-party administrator in response to questions that were asked during the 2017 Legislative Session. Mr. Haycock clarified for the record that there was a misconception that PEBP does not pay for ER visits that were ultimately deemed non-emergent, which was not the case. PEBP paid for all emergency room visits whether emergent or non-emergent, which was done by design and how it was done when he inherited the program. He stated he did not see a need to change; although, there were a percentage of people who utilized the ER with non-emergent needs. However, PEBP did not want to prevent someone with a true emergency from going to the ER because they were fearful of having to pay that ER bill.

Chair Carlton said she thought ER visits increased by 270 people in PY 2017 or 4.4 percent over PY 2016, from 6,109 to 6,379 participants, and was curious about that increase.

Mr. Haycock replied that there was an increase in utilization overall, but there was also an increase in population, so one of the more defensible data points was the ER visits per 1,000 people. Therefore, the number of people who went to the ER for every 1,000 people in the plan has reduced by a person. Although, there was an increase in population on the program, it relatively reduced the amount of participants going to the ER proportional to the number of people on the plan. He said it would be a natural inclination to think if there was an increase in people, some of the people were going to the ER because of necessity. He agreed that ER visits increased by 270 people, but the overall population increased almost 900 people, so there was a 4.2 percent increase in population and really a 4.7 percent increase when dependents were added. Hence, the ER utilization was one person less per 1,000 people or a slight decrease. Mr. Haycock added that urgent care visits also decreased as well for total visits. However, urgent care visits increased about 35 people for total overall costs, but visits per member and visits per thousand decreased by about 4 and 4.3 percent, respectively, and what PEBP paid for those visits decreased 13.5 percent.

Assemblywoman Diaz asked the strategies PEBP utilized to manage prescription drug costs as new drugs were introduced.

Mr. Haycock responded that Express Scripts was PEBP's pharmacy benefits manager. He noted that page 151 (Exhibit A) contained the Collaborative Planning Guide for Nevada PEBP for FY 2017 provided by Express Scripts. He said the guide was detailed with financial reviews and the rebates that reduced plan costs, as well as what was paid for certain types of drugs. He noted when new drugs were introduced they went through a review panel through PEBP's pharmacy benefits manager and the clinical pharmacists reviewed the drug for medical necessity and safety. He stated that generally, PEBP took a conservative approach so not to "guinea pig" the drug on PEBP's membership only to see that drug be pulled. He indicated that a few years ago a drug was approved by the Food and Drug Administration (FDA) that needed to be pulled within the first year and a half due to deaths. Mr. Haycock stated that PEBP took very cautious and purposeful steps to ensure that the drugs put into the program were appropriate and that PEBP

received the “best bang for the buck” on the cost for the drugs, because as new drugs were introduced they were expensive. He stated the top priority for PEBP when new drugs were introduced was to consider member’s safety.

Assemblywoman Diaz asked why prescription drug costs were increasing for the participants on the HMO plan.

Mr. Haycock replied that the HMO plans had a significant utilization of pharmacy drugs and over 60 percent of its members were using prescription drugs on a regular basis. Therefore, the mix of the population was driving some of the drug costs and the overall costs for any program or service, whether it was drugs, a facility or healthcare service, such as an exam, was predicated off the cost negotiated with the party where the drugs were purchased from, who managed their benefit, type of programs in place, both clinical and cost containment, as well how many people were going to utilize the drug. Therefore, a $1,000 drug utilized by one person does not have as much impact as a $100 drug used by 1,000 people and there were a plethora of different factors for the reason drug costs were increasing for some participants. Additionally, PEBP had a different pharmacy benefits manager than the HMO participants. PEBP used a national pharmacy benefits manager who leveraged its book of business across the nation and worked to get drug discounts as low as possible and rebates as high as possible to ensure that the cost of the plan was manageable.

Chair Carlton stated that PEBP had reported that prescription drug utilization increased from 26.9 percent of members in FY 2016 from a former Prescription Benefits Manager (PBM) vendor, which she believed was OptimaRX, to 69.2 percent of members with Express Scripts, which was a large increase. She asked for clarification that the PBM, Express Scripts was not just for the HMO, but for all PEBPs’ programs.

Mr. Haycock replied that when PEBP looked at the data on the Utilization of Pharmacy Benefits for its previous PBM and the data from the current PBM, Express Scripts, once PEBP received the first report it had the same question, how did utilization drastically increase but costs were relatively the same or lower. He thought no one could be that much better than its competitor especially when it was a national PBM. He stated that to this day, PEBP had a disagreement with the previous PBM on how it derived that utilization figure. He said PEBP believed the total costs spent on those drugs utilized in the previous PBM was an accurate data element, but it was not an accurate element for the participants who were utilizing those drugs. He said that PEBP was able to show in the first half of FY 2017 that utilization was more consistent now that PEBP had over a year with its current PBM. Mr. Haycock agreed with Chair Carlton and it was an issue that PEBP could never understand. However, he noted that PEBP was more confident in the number of utilizers with Express Scripts than the numbers reported by the previous PBM, OptimaRX.

Mr. Haycock stated that PEBP’s PBM provided pharmacy benefits, utilization management, case management, precertification, discounts, rebates and purchases on behalf of PEBP and others across the nation strictly for the CDHP. Currently, each HMO

that PEBP contracted with in Northern Nevada and Southern Nevada utilized its own PBM, which was built into the monthly rates, so as fully insured programs the two HMOs were required to offer a comprehensive suite of benefits to include medical and pharmacy benefits. He added that dental benefits and life insurance were offered to all participants regardless of the plan participants were in or group they were part of, and those benefits were also offered to the Medicare eligible members on the Exchange.

Chair Carlton stated that she hoped Mr. Haycock would come up with the appropriate review process for the reports so the issue does not occur in the future.

Senator Kieckhefer asked about the Preventative Services Compliance Report – Chronic Conditions Report, page 148 (Exhibit A) which showed the total percentage of members with certain conditions and care management. He asked if there were opportunities to help people with chronic conditions so they could be in greater compliance with care management to improve overall health and to help manage costs for inherently expensive conditions.

Mr. Haycock replied there was an opt-in process for chronic disease management. For example, participants with diabetes, or who were obese, could participate in the obesity care management if they completed a series of metrics to qualify for the program. In addition, there was a utilization and case management vendor that would reach out to people with chronic conditions to entice them and present opportunities and benefits of going through case management. Mr. Haycock said it was his understanding that the opt-in process had been around for years and it was a choice model and not a mandatory model. If the program was a mandatory model then more people would be required to participate and there would definitely be some cost savings, and hopefully better outcomes.

Senator Kieckhefer said that similar to the different levels of copay, depending on the level of service, participants paid the highest if they went to the ER and lowest when they went to their primary care doctor and it would seem that there could be some financial incentives through plan design to entice people to participate in the disease management programs, if not, making the programs mandatory. He asked if that option had been looked at before.

Mr. Haycock explained that PEBP was one of the few plans that still offered insulin replacement for $25 for people who participate in the diabetes management program. He noted there has been a lot of discussion about diabetes medication during the 2017 Legislative Session and the overall cost to the PEBP plan was greater than $400 for some of the diabetes prescriptions and PEBP only charged members $25, which was a great deal for all members in the plan. In obesity care management, participants also had access to meal replacement and counseling, so there were some excellent incentives for people to participate, but there were no requirements. As far as case management, PEBP was not incentivizing participants through any monetary benefits to participate; however, the people who participated generally responded well to the program, especially the people with dependents and children who contract some very difficult conditions and

PEBP had to arrange for their care in another state. Mr. Haycock noted that PEBP provided incentives and could potentially do more to incentivize participation and it was something the Board could look into, in addition to making care management mandatory. However, PEBP was still trying to preserve the traditional PPO approach to choice, so participants could choose the care they wanted. He stated that PEBP was trying not to punish participants for choosing not to take advantage of the disease management programs.

Senator Kieckhefer asked if there an analysis on the efficacy of the chronic disease management program, including the programs for diabetes and obesity management in reducing plan costs and improving health outcomes for the participants who were compliant with the program versus those who were non-compliant.

Mr. Haycock responded that PEBP received reports which were presented to the Board each quarter on the chronic disease programs and utilization and case management. He stated that PEBP had all that data; however, due to the size of the reports, it was not included in the meeting packet (Exhibit A). He indicated the information on the efficacy of the chronic disease management program could be included in the meeting packet going forward. He stated that people who were compliant with the obesity care management program cost PEBP significantly less than the people with a diagnosis of obesity who do not participate in the program.

Senator Kieckhefer requested the report regarding the efficacy of the chronic disease management programs in reducing plan costs and improving health outcomes.

Chair Carlton asked Mr. Haycock if the preventative services compliance programs were more of reward than penalizing participants, and Mr. Haycock confirmed that was correct. He added the report was recently implemented and one thing that was not included in the report was preventive services to include preventive drugs, so people would get “day one” coverage at their 20 percent coinsurance versus having to satisfy their deductible. He said that PEBP has seen a significant uptick in utilization and compliance, especially in the Asthma and COPD types of services, which often cost hundreds of dollars per month for the drugs, and consequently, because of the high cost, participants would forgo the preventive drugs. Therefore, PEBP recognized the need to increase the opportunity for preventive services and a program was implemented, which was in its first year. The report was provided to the Board at the end of each quarter and could be provided to the Committee. Mr. Haycock stated that PEBP was making progress through incentives, but it was not a perfect process.

Chair Carlton asked when a member on the HDHP needed a high cost drug on the preventative services side, PEBP was covering first dollar, but if the person was on the HMO plan it would be a base rate for the prescription and there was no need to subsidize the person. If the person was in the HMO, the prescription cost would be less and there would be no reason to provide an incentive.

Mr. Haycock replied that PEBP did not incentivize any participant on the HMO plan to seek services; the participant signed up for those programs and those programs were comprehensive. The HMO participants had different disease management processes and preventative services and there were often different formularies and tier structures, as well as a different copay models. Mr. Haycock said the many of the high cost drugs were specialty drugs and currently, there was no direct copay on the HMO plan, it was a coinsurance amount that was twice what PEBP charged. He noted when PEBP was talking about prescription drugs, it was talking about the CDHP, those that it had control or some influence over, and the discussion on the HMO plan was strictly up to fully insured products.

Chair Carlton stressed that the point she was trying to make was that due to the cost, people were not being compliant in the drugs they were supposed to use when they were on the CDHP. When a participant was on an HMO plan, because the cost of medication was not as draconian on participants, those participants were more complaint. She wanted to ensure that everyone realized the difference between compliance was sometimes the plan the participant was on, and not necessarily the person, but the cost of the drug in that plan.

Mr. Haycock stated that he would look at the data in the compliance report from PEBPs' HMOs and let the data decide.

Chair Carlton said that logically, PEBP could assume if a participant could not afford their prescription it was harder to be compliant, and because PEBP was incentivizing those participants they were able to afford their prescriptions.

Mr. Haycock referenced page 173 (Exhibit A), which contained the Northern Nevada HMO Utilization Report for the period July 2016 through June 2017. He stated that page 178 contained a bar chart, which showed the pharmacy costs for the subscriber, which was PEBP's participant, the primary member, the employee or retiree, spouse and children. He stated that children cost a lot less because they were taking less prescriptions compared to the primary participant and spouse. He noted the report was fairly standard and provided a snapshot of the costs. He said that both HMOs declared high cost claims at over $50,000, whereas a high cost claim for PEBP was over $100,000. He noted that the list of the high cost claims go a lot further and deeper into the costs, because PEBP only recognized $100,000 claims as high cost.

Chair Carlton asked Mr. Haycock to discuss the difference between utilization for the high deductible plan and the HMO plans.

Mr. Haycock explained that prescription costs were over $100 per person on both HMOs. He noted the Express Scripts report on page 153 (Exhibit A) showed that PEBP's plan costs per member per month was $58.76, so the CDHP was significantly less costly on a per member basis than the HMOs. In addition, when the rebates were added, prescription costs were under $50.00 per member, which was less costly than the HMO plans. He noted that one of the highest utilized and most expensive drug in the report was Humira,

a biologic drug available in an injectable pen, which generally worked and the reason it was one of highest cost drugs on every plan. He noted that Hometown Health spent approximately $1.0 million on Humira alone, and PEBP spent $1.8 million in plan costs per year; however, PEBP was approximately four times the size of the HMO. He stated that PEBP had a different mix, levers and volume changes and what could be done, which would drive the costs. Mr. Haycock stated that he would have preferred to see a utilization report from the HMOs that mirrored more of what PEBP received from its third-party administrator to have an apples to apples comparison. He stated the current numbers were more an aggregate, and from his understanding there were legacy system issues on what reports could be provided, whereas PEBP, since 2011, has been able to produce a basic similar report year after year. He noted that PEBP just started getting the HMO reports but it had to recognize the risks that were absorbed in the plans and when PEBP absorbed the risks, it also had windows into those exact claims and drivers that were driving those risks. However, when PEBP did not absorb the risks, it basically sent members to another program and agreed to pay a monthly premium on their behalf, combined with state funding and the employee's portion, and PEBP did not get to see that window into how it was managing those programs.

Chair Carlton stated that when the high deductible health plan was compared to the HMOs as far as utilization, one of things noticed at the beginning was that participants were not seeking treatment because of the out-of-pocket expense. However, those issues were addressed over time by putting money into the HSA fund, but there was still the "donut hole" issue. She asked the impact of the donut hole between the amount in the HSA, which at one time was $800, the total deductible for the member, which was another amount between the two, and how that was related to the people actually getting the care that was needed. Whereas, on the HMO there was no donut hole and no out of pocket expense. She asked if that issue was resolved and if PEBP came up with the cost for prescriptions, because that would be a total cost and once the participant hit the total deductible, it was 80/20. She wanted to ensure the financial burden of the high deductible health plan was not impacting access and utilization, whereas the financial burden on an HMO would not impact those things.

Mr. Haycock replied that there were multiple levers for health plans to try to affect behavior to ensure access to high quality health care and to ultimately make it affordable. Currently, an employee on the CDHP was paying about $42 a month or $504 per year. The employee was given an initial $700 in HSA funds, and about 18 percent of the population on the HDHP had zero claims and approximately 5 percent of participants only seek preventative services. Therefore, looking at it on a single employee perspective, PEBP was paying single participants on the plan $700 a year in HSA funds and those participants were paying PEBP $504 in premiums and a lot of those participants were not using the plan. Therefore, PEBP was actually paying people to be on the plan, because once those HSA funds increased to a certain level, the money could be invested tax free and the account became more of a retirement account. He stated the participants on the HMO plans may be accessing care more but were paying significantly more a month for the care. Therefore, at end of the day, the A plus B plus C scenario, the employer contribution plus what the employer or retiree paid, A and B equaled C, what the overall

rate was, and PEBP has done everything it could, in addition to its partners, to reduce C as much as possible. However, at the end of the day PEBP had to figure out who was going to fit and how much A and B was, and when the Legislature approved the PEBP budgets, it approved A, and what was left was B, which was what the employee and retiree had to pay. He said there was a lot of price sensitivity and PEBP repeatedly heard from its partners, the Retired Public Employees Nevada (RPEN), and the Association of Federal, State and Municipal Employees (AFSME) that they did not want a reduction of benefits or increased rates, which painted PEBP into a position of where it needed to make the best of the environment it had. He said when PEBP received its budget from the state, it supported the budget, Legislature and Governor, and he believed PEBP did a great job optimizing the budget, because PEBP was able to have negative trend over the last two years without making any drastic plan changes. He wanted to provide all the different factors not just if PEBP was preventing people from seeking care, but whether PEBP was a system designed to maximize care and have the providers prepared for that capacity. Mr. Haycock was aware there were people moving from the HMO to the CDHP for cost reasons, because they did not want to pay 40 percent for a specialty drug on Health Plan of Nevada or Hometown Health, based on the plan design that the Board approved. Therefore, people were moving to the CDHP and PEBP was absorbing those costs and risks and was able to continue to do so and still save money. He stressed that PEBP was providing the highest quality and access to care and made health care affordable to its members, because members did not want to pay HMO rates without getting HMO style benefits, and if they did, participants moved to the CDHP. He noted that what could be seen from the migration was that people were moving away from the HMO on to the CDHP, so if the CDHP was a bad plan, it would be the opposite.

Chair Carlton stated that she wanted to ensure that the plans offered to employees and retirees were appropriate, affordable and employees still had access to care. She asked if was true that if an employee does not choose a plan when they were hired, or during open enrollment, that they would automatically default to the CDHP because of the lower premiums.

Mr. Haycock confirmed that was true and employees were defaulted into PEBP's primary plan, a health reimbursement option because there were people who were not eligible for the HSA, which PEBP was not aware of until they enrolled. He noted that PEBP did not want to present an IRS liability to the participant when they entered the plan, so the employees were defaulted into the CDHP at the employee level with HRA, which was $41.91 per month. In addition, those employees had the opportunity to change plans during the next open enrollment period to meet their needs and the needs of their family.

Responding to a question from Assemblywoman Diaz, Mr. Haycock stated that PEBP could only determine the number of people who declined PEBP coverage and did not have information on the reason they declined coverage or where they chose to go. He noted that PEBP did not track the people who declined coverage from a program perspective, because they were not enrolled in the PEBP program and there was no mechanism to do so. He said it was his understanding that few people declined coverage. Mr. Haycock noted that when a person was offered affordable employer coverage, the

coverage was required to be affordable for the employee only, which does not include dependents. Basically, the affordability test was off the $41.91 paid by every employee in the plan. He stated there was no affordability requirement for retirees and no requirement to provide retiree health care outside what PEBP did as a state. As far as people moving to the Individual ACA Exchange, if a person declined coverage with the state and moved to the Exchange, they were ineligible for federal subsidy, because they were offered and declined affordable coverage. If the person was collecting subsidies they may have to make good with the IRS at some point, but they were supposedly ineligible for the subsidies, which was to continue to treat employers as one of the functions to offset the costs of those Exchanges, because the idea of the Exchange was not to supplant the employers but to supplement the people in the individual marketplace. He stated that PEBP offered affordable coverage and the $41.91 was about 9.5 percent of $5,000 a year and he thought every full-time employee made more than that. Therefore, PEBP met the affordability test every year, but did not have any information on people who declined PEBP's coverage and moved on to other plans, whether it was the Exchange, other employer or individual plans.

Mr. Haycock referenced page 215 (Exhibit A) which contained the letter received from PEBP's actuary, AON, basically truing up the reserve level. He said PEBP received an initial projection at the beginning of the year to help determine the reserves levels projected by AON, and at the end of the year PEBP received a true up based on the experience of the plan. Therefore, every year there was a projection, a true up for the actuals and then another projection moving forward. He noted the chart on the page showed the difference between FY 2016 and FY 2017, which had a moderate $1.0 million increase to all the total reserves for the IBNR, and the expense margin represented the 95 percent confidence level. He said the reserves were recommended to be increased. Moving to page 218, under Catastrophic Reserves, the reserves were estimated to be $25.8 million as of June 30, 2017. He recalled during the 2017 Legislative Session, the reserves were reduced and now were brought to a similar level of confidence because there were more people enrolled in the plan. Mr. Haycock believed there was the potential increased use of the plan by having more people stay on it because the non-state retiree issue was resolved that was driving people out of the state plan due to the high cost of premiums. Therefore, the unaffordability issue has been addressed to some point and he believed people would stay on the plan longer, which was reflected in the Catastrophic Reserve level. He added the PEBP would receive another Catastrophic Reserve actuarial report for its projected budget biennium moving forward, which would be included in PEBP's agency budget request.

Mr. Haycock responded to a question from Chair Carlton, and stated that PEBP provided the Committee with a budgeted and actual number in the NRS 287.0425 Summary, page 109 (Exhibit A), which was how it was always provided. However, he could include the excess reserve amount in the Catastrophic Reserve Actuarial Report section of the meeting packet, if requested. He said that page 112, showed the reserves that were budgeted for FY 2017 and how the state ended the year, and what PEBP budgeted at the time it established the funds for FY 2018. He added that a true up would be done at the end of the fiscal year. Mr. Haycock stated that at the end of FY 2017 there was

approximately $40 million in excess reserves, which was originally budgeted for $13.6 million; for FY 2018, excess reserves were budgeted for $42 million, and it trued up at the end of the fiscal year through the carry forward of dollars, and as of November 30, 2017, was estimated to be about $22 million. He noted this was also discussed in the CDHP Plan Options Report, where there was a start to finish true up of the how the prior year ended, the amount of revenue to start the new year, the reserves that were earmarked, what was available for benefit discussion or any other discussion, and what was earmarked for future benefits and services offset by future cost containment actions.

2. **Report from independent certified public accountant regarding audited financial statements for the years ending June 30, 2016 and June 30, 2017 (NRS 287.0425) for:**
   a) **Fund for the Public Employees' Benefits Program (NRS 287.0435)**
   b) **State Retirees' Health and Welfare Benefits Fund (NRS 287.0436)**

Returning to Agenda Item 2, V.2.a. and V.2.b., Mr. Haycock said the audited financial statements, page 219 of (Exhibit A), showed the assumptions that were taken and the process the auditor used to account for PEBP's assets and liabilities and how the financial statements were reported. He noted the opinion of the auditor was that the financial statements were presented fairly, in all material respects for PEBP's financial position for both the Self Insurance Trust Fund and State Retirees Health and Welfare Benefits Fund. He stated the auditor did not find any issues with PEBP's internal controls, the way PEBP managed its money, or with the way PEPB processed claims through the audit period. Mr. Haycock stated that the audit was a success and accurately reflected its position and there were no questions or concerns by the auditors. He stated that it appeared that PEBP was doing things appropriately in the financial accounting world.

3. **Report on the October 9, 2017, actuarial valuation of post-employment health and welfare benefits provided by the State of Nevada pursuant to Statement Number 45 of the Governmental Accounting Standards Board (GASB) for Fiscal Year 2017 (NRS 287.0425).**

Mr. Haycock stated that PEBP elected to utilize a roll-forward valuation for the post-employment health benefits report for FY 2017, because the plan itself had no material or significant changes. The report was pursuant to Statement Number 45 of Governmental Accounting Standards Board (GASB) and the numbers were rolled forward, which was primarily a cost consideration, because there were no major material differences. He noted that GASB 75 changed the reporting requirements moving forward, and PEBP was in the process of implementing those changes for FY 2017 and FY 2018, and would do a full valuation in the future. He said it would be easier for the Controller's Office and PEBP and it was an important transparent device to show where PEBP was in its other post-employment benefits (OPEB) liability. He said PEBP's liability was a fraction of the state's overall OPEB liability in comparison to PERS, but the liabilities the state was required to pay would eventually end based on the legislative decision to no longer provide retiree subsidies on behalf of the state. For the employees initially hired

after January 1, 2012, eventually the liability would start decreasing, and as people died and no longer needed health care and benefits, somewhere in years 2040 to 2050, PEBP would no longer have liability. Therefore, unless that decision was changed by the Legislature, the liability had a potential end date.

Mr. Haycock stated that PEBP's liability was increasing, although not drastically, and as more retirees hired before January 1, 2012, entered PEBP's program and were eligible for health care, PEBP would have to pay for them, which would increase PEBP's liability. Therefore, the number would increase year over year, even though PEBP attempted to place downward pressure on the costs through its cost containment activities. He said that PEBP's actuaries evaluated all of those factors to come up with what they believed met those annual costs, PEBP's net obligations, as well as the schedule of employer contributions. He noted the report would change in the future, because the process was changing on how PEBP had to evaluate the 30-year amortized rate.

Senator Kieckhefer asked Mr. Haycock if the liability was a "pay as you go" benefit and not funded in advance. He asked when PEBP would hit the peak of the arch, in terms of the cost for the OPEB liability.

Mr. Haycock confirmed that the liability was a pay as you go benefit. He added that he could speculate about the peak looking at the retirement benefits and the process in which people could earn their pension. Starting January 2016, people could vest with five years of service after January 1, 2012, and then face the situation where they were not going to be receiving that contribution. However, it does not mean that people would not enroll in PEBP's plan because they still could enroll in the plan but were unsubsidized. Looking at the rates and how much PEBP subsidized retirees today, there was a significant difference. Mr. Haycock stated that nothing was more illustrative than the non-state retiree's issue, where it was a smaller amount, but still was an amount; therefore, it was a large difference in cost. He thought PEBP was still on the rise for the OPEB liability and would be for the next decade or two, but it depended on the decisions that were made outside of PEBP's control. He added that recruitment and retention policies would drive the processes for people to be employed or to remain employed by the state. However, there were people hired after January 1, 2012, that would get their PERS benefit, but not a PEBP benefit, which would potentially drive people away from the program when they retire, but also from enrolling in health care and working for the state. Therefore, the total benefit compensation package has been reduced by the 2012 decision and people were starting to learn about that, especially the people looking at retirement and trying to figure out what they would have to pay. Mr. Haycock stated that he thought the OPEB liability would continue to rise, because there were a lot people scheduled to retire in the next 10 to 20 years; although, there were a lot of people in their last 5 years of service and he assumed the liability would continue to increase.

4. Report on biennial review of PEBP's compliance with federal and state laws relating to taxes and employee benefits, dated February 2017 (NRS 287.0425).

Mr. Haycock directed the Committee to page 263 (Exhibit A), PEBP's Biennial Compliance Review that was presented to the Board. He said the report should have been provided to the Committee at its December 2016 meeting, but due to timing, it was not included in the meeting packet. He noted the report was the two-year biennial compliance report and was sent to Fiscal staff, who provided it to the Committee. He noted the report was truncated for size because it was so voluminous. Mr. Haycock explained that the consultants conducted a thorough review of PEBP's compliance with federal and state laws related to taxes and employee benefits, and there were no show stoppers in the report. Although, there were certain things that PEBP needed to update, such as federal noticing, language and appeals, and once PEBP received the report in February 2017, it updated, performed and succeeded at implementing all recommendations by July 1, 2017, with the exception of one item. He noted that one recommendation was that PEBP perform a secondary audit on its Health Insurance Portability and Accountability Act (HIPAA) compliance, even though HIPAA compliance was one of the deliverables and requirements of the audit. Mr. Haycock said the recommendation was from the same consultant who provided HIPAA training, updates and the auditors looked at the annual HIPAA notices and he felt that the recommendation was covered. Although, it may be best practice to do multiple audits, PEBP paid for the audit and for the consultant's expertise, and their job was to protect PEBP through the compliance. Therefore, once PEBP made a few small changes it did not have to implement that recommendation.

Chair Carlton said as far as monitoring the ACA and some of the changes and impacts that the ACA would actually have, if the state was considered within the Cadillac Tax realm that has been discussed so often.

Mr. Haycock replied that PEBP was constantly monitoring the federal role making process for the ACA, as well as some of the things that come out of the other facilities, like the United States Preventative Services Task Force, which was how PEBP was able to implement the 3-D mammogram inclusion. The Cadillac Tax (Excise Tax) was initially designed to charge a tax amount on a threshold, which was approximately $850 per person. He noted the current plan was about $600 per person, so there was room to grow. He said even if PEBP did not charge the employee more, and the employer picked up more of the cost of the rates, as benefits were increased or costs were reduced for the member or if additional access points were opened up, there was a cost associated and that overall rate may grow, and if it did, it could start to creep up toward the Cadillac Tax. Mr. Haycock stated that when PEBP initially did an assessment for FY 2018, he found that the Northern Nevada HMO plan was on its way to cresting the Cadillac Tax, and the rates were approximately $850 per person. However, one of things PEBP did to protect the state, employee and the retirees on the plan, was when new contracts were signed with the HMO, specific language was placed in the contract that stated if the plan crests the Excise Tax, and if the Excise Tax was implemented, the HMO would pay the tax, not the state, member, PEBP or employee. Therefore, there was a protective clause in the

contract and PEBP felt confident that the Excise Tax would go away, but there was no dire need to change the PEBP plan to meet the requirements of the current version of the Excise Tax threshold.

5. Report on material provided generally to participants or prospective participants in connection with enrollment in the Program for the plan year beginning July 1, 2017 (NRS 287.0425).

Mr. Haycock stated that Agenda Item V, page 269 (Exhibit A) was the report on the material provided to participants or perspective participants in connection with enrollment in the PEBP program for the plan year beginning July 1, 2017. He said that PEBP provided a very similar set of enrollment guides, such as access to masterplan documents, notices, newsletters and was sending as much information on the plan as possible to participants without saturating the population. He noted that PEBP also sent out a customer service survey, which impacted some of the results and request for this type of communication to continue. In addition, each year PEBP would look back at the information to ensure that the decisions made by the Board or the requirements and the requests made by the Legislature, as well as any other legal ramifications from compliance, were updated and included in the enrollment documents. Currently, PEBP was in the process of reviewing all of its documents, which would be revised for the upcoming plan year to make the material easier to read and follow. He noted there was some duplicative and unnecessary language in the material. He added that the legally required documentation provided by PEBP was reviewed by PEBP's Deputy Attorney General to ensure that PEBP was not exposing the state to undue liability. Mr. Haycock stated he was confident that since PEBP increased communication that it has been successful in helping educate and truly "turning the tide" on people becoming better consumers on the CDHP. A summary was provided of approved plan design changes and rates, which was linked to PEBP's March 23, 2017, Board meeting and PEBP tried to be as transparent as possible. He noted that PEPB had a communications plan, which was an important guide to know who the stakeholders were, the type or median of communication PEBP was going to provide and to whom and when. However, one item that was not included in the meeting packet due to space, was PEBP's schedule of activities that occurred in 2017. Mr. Haycock explained that PEBP had 31 face-to-face activities last plan year to reach out to membership regarding benefits. There were 13 mailings and 16 emails and 10 website notices, so the major way that PEBP was communicating to its membership was with face to face communication. In addition, PEBP was currently in the process of purchasing and implementing a technology solution to reach out to more people that were not easily available, which helped PEBP justify driving to certain locations that had low attendance. He stated that PEBP provided a significant amount of benefit information and would continue to provide that information to ensure PEBP was 100 percent transparent in an easy to understand manner. He noted there were plan comparison tools, a more user friendly website was created, and PEBP continued to look at the member experience and updating their ability to receive, accept and utilize the information that PEBP provided. Mr. Haycock stressed that PEBP made a purposeful implementation of face-to-face activities that in the end the participants would feel a lot better about PEBP's health program. He stated that PEBP recognized

that was a very effective median, but a cost prohibitive one, but PEBP was maximizing the capabilities and opportunities it currently had.

Chair Carlton stated she was aware that PEBP sent out a lot of Explanation of Benefits (EOB) and she thought there might be a better way for that communication because it was confusing to some participants. She thought an electronic version of the EOB would be appropriate, unless the participant requested a hard copy.

6. Report on PEBP's implementation of the provisions of Senate Bill 552 (Chapter 536, Statutes of Nevada 2017).

Mr. Haycock referred to page 425 of (Exhibit A), Senate Bill 552, Non-State Retiree Subsidy. He noted the report was on the non-state retirement premium balancing. He said that PEBP was asked by the Legislature during the 79th Legislative Session to implement a rapid solution to ensure that the non-state retirees experienced an immediate premium rate relief beginning July 1, 2018. He stated that PEBP was successful and expedited a technology solution in under 30 days to apply the results of Senate Bill 552; however, it was not perfect, and approximately 30 non-state retirees did not receive the appropriate subsidy amount and adjustments in their premiums. However, as soon as it was discovered, PEBP worked to resolve the issue and overpayments were refunded to the affected retirees. Mr. Haycock stated that PEBP appreciated the solution and was excited not to have to explain the options to the Committee to try to make the situation better. He believed that the phased-in process over a four-year period shifted responsibility of cost over time to the employers that participants paid into when they were employees. He stated that PEBP projected approximately $2.5 million in State General Funds for FY 2018 to offset the premiums. Page 426 of the meeting packet (Exhibit A) displayed a chart that showed what PEBP already accrued and what was projected starting in January 2018, and PEBP could provide updates to the numbers at any time. Mr. Haycock stated that PEBP believed Senate Bill 552 finally solved the unaffordability issues that separated state and non-state retirees. The non-state retirees appreciated the services that were performed and they felt more equitable to the state retirees. Mr. Haycock believed the process approved by the Legislature had finally solved the unaffordability issues for the non-state retirees.

Chair Carlton thanked her colleagues who worked on Senate Bill 552 and was glad PEBP was able to address the non-state retiree subsidy. She asked Mr. Haycock to keep the Committee informed moving forward on any issues that may arise in the future to keep the issue on track.

Assemblywoman Diaz thanked PEBP for working so expeditiously on Senate Bill 552. She indicated that she worked with Assemblywoman Swank and others to ensure that the Legislature found a better solution for the non-state retirees who had been in limbo for some time. She was relieved to hear that the solution was working well and that the non-state retirees were happy.

7. Report on plan benefit design changes for the Health Maintenance Organization (HMO) Plan adopted by the PEBP Board for Plan Year 2019, as compared to Plan Year 2018.

Mr. Haycock stated the Plan Year 2019 HMO Decision report details the decisions the PEBP Board made for PY 2019 regarding the Northern Nevada HMO design changes. He referenced page 427 of the meeting packet (Exhibit A). Mr. Haycock stated at the November 10, 2017, PEBP Board meeting, the Board approved to replace the Northern Nevada HMO in PY 2019, which started in July 2018, with a PEBP managed self-insured replacement plan to absorb that risk, taking back the members and paying their claims directly instead of simply paying premiums and allowing a fully insured product to manage the claims. He noted that after much dialogue, the PEBP Board unanimously approved the alternative plan but faced an impossible situation of potentially losing both of the HMOs in 2018. The Southern Nevada HMO no longer desired to have member increases because of the increased rates in Northern Nevada. Therefore, PEBP blended rates, which it had done for many years and was one of the policies that was presented to the Legislature, so PEBP was not looking to change that policy. He noted for many years when rates increased, those increases were split across the entire HMO population, so the member ended up paying more for the program of benefits and less for what the increased costs would have been in the new program.

Continuing, Mr. Haycock stated that the Northern Nevada HMO submitted a renewal and PEBP reviewed it and made some suggestions and the HMO came back with a 13 percent increase. Mr. Haycock said he could talk about percentages all day but in the end it was the dollar amount, so 13 percent of $100 was $13.00, and 13 percent of $50.00 was $6.50 and PEBP could not say that one increase was higher in one location and lower in another, and had to look at the net effect to the overall rate. When there was already a higher cost plan in Northern Nevada, every percentage point applied to that rate in Northern Nevada had a larger dollar impact and the same percentage applied to Southern Nevada, because the base rate was significantly higher in the north. Therefore, Southern Nevada did not want to renew the HMO plan if PEBP was going to increase member rates, especially when it was willing to come in at a much lower rate renewal. Southern Nevada submitted a renewal with no increases; however, that renewal had conditions, and Southern Nevada did not want to offset the cost of a rate increase in the HMO in Northern Nevada. He noted the caveat to the Northern Nevada HMO rate renewal, the 13 percent, was that the contribution percentages or policy did not change and the rates remain blended, because if not blended, that increase would be borne by the members in Northern Nevada and would price them out of the market. He was concerned that the Northern Nevada HMO would pull out if PEBP did not blend the rates, because people could not afford an already expensive HMO premium. Therefore, PEBP had to ultimately choose whether to have an HMO. He explained that Northern Nevada did not want to reduce its HMO rates, and PEBP presented the opportunity to also match the Southern Nevada HMO rates with a flat rate to try to encourage migration back to the HMO plans to drive some of its less moderate utilizers from the CDHP to its HMO plan to help reduce the per member per month cost rate. However, it required a long-term strategy, because that was what created the problem of people migrating away from the

plan. Therefore, both plans wanted to work together; however, Hometown Health stuck to the 13 percent increase and Health Plan of Nevada (HPN) wanted no increases with assurance that the rates in Northern Nevada would not increase, which could not be guaranteed. He said that HPN had no intention of supporting member-increased costs for its plan, because too many people migrated away. Therefore, if HPN pulled its HMO in Southern Nevada, there would be no HMO to blend with, and Northern Nevada would have to absorb the entire 13 percent increase. He was confident PEBP would not provide an HMO product because it did not meet those caveats.

Mr. Haycock stated that he was initially prepared to take back all the risks and do the types of management that created the lower trends, costs and excess reserves, and supply the cost containment activities to the entire state and offer two statewide plans – a CDHP, and basically a no deductible self-insured version of an HMO plan, which were called "Exclusive Provider Organizations." He said PEBP would basically be offering a very similar plan to an HMO, but PEBP was self-insuring the plan and taking on the risks, paying the claims, and PEBP could also control more of what happened within the plan. However, Health Plan of Nevada's network for its HMO plan was predicated on a capitated model of payment and a certain amount of money per person was received, whether they were seen or not, and there was also some cost containment strategies, because the plan also had to give up some of that money if a participant was referred out for care along with other situations. Mr. Haycock said from PEBP's analysis, it was the only capitated network in Nevada, so those cost controls have kept the costs lower on the HMO plan, and there would be a 20 percent increase in costs to HPN. However, they were able to offer PEBP a lower rate because of those cost containment strategies, which did not exist in Northern Nevada, and no network has been able to accomplish capitation in Northern Nevada in a very long time. Therefore, it was a much different provider environment, so it did not have that cost control and at the end of the day, he did not think that PEBP could out manage a capitated model, because it would have then moved on to the PPO network if PEBP took over Southern Nevada's HMO plan and paid more for the same healthcare. Mr. Haycock did not want to recommend paying more for health care than necessary. However, he believed that PEBP could create a program in Northern Nevada that would beat the benchmark of a 13 percent increase in rates, because of the types of services and access that PEBP had to national entities and partners that other partners did not have access to. Mr. Haycock stated that PEBP presented the situation to its Board to look at the potential costs.

Continuing with his presentation, Mr. Haycock referenced page 427 (Exhibit A). He stated that PEBP entered hypothetical increases into its rate development process, applying the reduced inflation rate of 4 percent, and at the time, it also reflected an increased rate by HPN if both the HPN and Hometown Health came to the table with what they wanted to do, which was their initial request. He stated the HPN came in at 15 percent and Hometown Health started at 17 percent and reduced its rate to 13 percent, but when those increases were applied, they had to recall that the Legislature awarded PEBP a budget predicated on a certain inflationary amount. He stated that PEBP was asked by the Legislature to stick to a 4 percent inflation rate in PY 2019, and the employee and retiree would have to cover the 4 percent, which would then turn into 13 to 15 percent.

PEBP recognized in the off-year that the good choices PEBP made that lowered the rates, 100 percent of that went to the employee and retiree, but the decisions that increased rates, 100 percent of that went to the employee and retiree as well. Therefore, PEBP did not feel good about raising rates from $42 to $144 for employees depending on their tier. Directing the Committee to the chart on page 428 (Exhibit A), Mr. Haycock said that Hometown Health wanted to shift the pharmacy risk of its HMO plan back to PEBP. He said it would be hard for a retiree with a family to pay $200 more a month, or someone on a fixed income to absorb $70 to $200 more a month, if there was a better way. Therefore, PEBP worked with its partners, PBM, and its third-party administrator and the rate was discussed at PEBP's strategic planning meeting, because he assumed it would be a reality in a few years and was not really fleshed out until PEBP received the annual rate renewals. Consequently, PEBP felt it was painted in a corner and had an opportunity not to present increases to its membership, but to maximize the employer contributions that the Legislature approved and continue to provide high access to quality health care at affordable prices, which was how PEBP would address affordability. He noted that it was not PEBP's intention to ask for a budget that was predicated on two HMOs and the CDHP, and then do something different a year later. Mr. Haycock said that PEBP felt there was no other option with the rate renewals it was presented.

Mr. Haycock referenced the chart on page 428 (Exhibit A) and noted that PEBP was provided other options from Hometown Health, but those options wanted to shift the pharmacy risk back to PEBP, and at $145 per person it set the precedence that when a fully insured product does not like the risk, it was shifted back to the state and PEBP might as well own all the risks to begin with. Secondly, to reduce the service areas from 15 counties to one county, he did not want to add to the health care crisis by not having an HMO option, a second option to the CDHP. Mr. Haycock stated if service areas were cut, it might as well put everyone back on the CDHP, but PEBP wanted to allow for choice and affordability. PEBP had discussions with the CEO of Hometown Health who agreed with his recommendations and recognized that the HMO plan was on a tailspin, which has been discussed at previous IRBC and IFC meetings, but when rates increased every year, and families had to pay more every year and people were migrating away from the plans, PEBP was on a road to disaster, and needed to find a purposeful strategic solution to try allow choice for its members. Mr. Haycock stated that the Board unanimously approved PEBP's rate, which allowed PEBP to continue to blend rates. The rate approved for the replacement plan would be blended with Southern Nevada and all participants would pay the exact same amount on the same tier for benefits. He indicated the only changes PEBP was making to the Northern Nevada offering of benefits was because it was moving away from the HMO network to a PPO network, Banner Churchill Hospital in Fallon, NV, was not in the PPO network because its pricing was very high. He said that Banner Churchill did not want to negotiate premiums, which only affected scheduled surgeries and in-patient services, not emergency services. Mr. Haycock indicated that PEBP would implement a few cost saving activities to save the state money, such as reference-based pricing for certain activities implemented in the Northern Nevada HMO and a more controlled pharmacy benefit, but in reality, the average member was not going to see a difference outside of the logo on their membership card and they would pay a lot less than they would if PEBP renewed the program.

Senator Ratti asked about PEBP's communication strategy, and Mr. Haycock replied the PEBP had monthly communication and emailed notices to all the participants in the system along with updating the PEBP website announcing the plan changes. He noted that PEBP already received phone calls from participants and PEBP had specific scripts to address those questions. He noted that the plan PEBP was replacing had the same network of providers, with the exception of Banner Churchill Hospital. Therefore, a member today on a HMO in Northern Nevada in all 15 counties across Northern and rural Nevada would be able to see the same doctors and facilities, with the exception of Banner Churchill. In addition, if participants were going through an episode of care and had a chronic disease or injury the utilization and case management services provided by Hometown Health would be provided to the members again in FY 2019. Therefore, if a participant was already talking to a case worker or registered nurse about their care, they would continue with that person for the care needed. He said that PEBP was in the process of finalizing and signing contracts to ensure that Hometown Health would pick up participants and provide them the exact same services as the HMO, so not to cause a disruption of care for members. He said the networks were the same and if a doctor falls off the network, they would have fallen off the network for both the HMO and PPO as well, with the exception of Banner Churchill Hospital. PEBP was sending out newsletters, information, and had open enrollment fairs and would continue to create a shared understanding of the program. He noted there were about 8,000 members on the plan and PEBP did not have the resources to call all the members individually.

Senator Ratti asked if there was any hope of changing the situation with Churchill Banner hospital in Fallon, and Mr. Haycock replied that at one time, the CEO of Banner Churchill Hospital showed interest in becoming part of the network. However, Banner Churchill Hospital wanted to keep the same rates and discounts and was not willing to budge. Mr. Haycock stated, in his words "it was ridiculous the amount of money that Banner Churchill wanted PEBP to pay." PEBP paid usual and customary for emergency room and urgent care services, but if someone needed to have an elective procedure done that was not an emergency or urgent condition, the participant would go to another hospital under the plan so they could save money and still receive high-quality health care. Therefore, it was up to Banner Churchill to negotiate, and they did not want to budge on the percentage, which Mr. Haycock believed was not a negotiation but an ultimatum. Mr. Haycock stated that he was more than willing to discuss the rates with Banner Churchill to come up with a more appropriate and fair payment, recognizing that he had data on what PEBP paid every hospital across the state for every service down to the CPT code, and PEBP needed to make sure it was appropriate so they could protect the member, plan, and ultimately, the Nevada taxpayer.

Senator Kieckhefer stated there was talk that the HMO was becoming a difficult model for many reasons and people were migrating away from it, and now PEBP was recreating the same benefits package that people migrated from. He asked Mr. Haycock how PEBP expected the new plan to be successful.

Mr. Haycock replied that when PEBP controlled all the risks it had a lot more levers to make corrections to the model. After the first year of experience, PEBP would be able to determine if it was the right model and if it wanted to make course corrections as was done every year with the CDHP. He stated those course corrections would be brought to the Committee and the Legislature and PEBP would make a purposeful strategy to determine the best solution for this type of service. He noted that there were people willing to pay more for a HMO copay model of care rather than worrying about deductibles, coinsurance and the necessary out-of-pocket maximums. Therefore, it was just a choice model, but when PEBP had all the data on what was being spent, it would know the pain points and triggers to see if PEBP had an opportunity to implement and maximize cost containment activities to make the program work. However, PEBP did not have a clear and transparent window into the HMO world, but it was fully insured and did not have to report on everything it was paying for the discounts and the network, because ultimately, the HMO were PEBPs' partners, but also were competitors, because it needed enrollment for people to be able to pay premiums so it could pay claims and make a potential profit. The Northern Nevada HMO was a nonprofit, but it was going to put that money back into its program to invest into its system of care.

Mr. Haycock said if the new plan does not work then PEBP and its Board would address that and would have the data needed to make that decision. However, if people wanted the program and PEBP could reduce the costs of the program then PEBP should offer a choice to its members. Mr. Haycock stated that the prevailing decision from the Board has been to offer a choice where PEBP could.

Senator Kieckhefer stated that they would have to wait to see the experience of the first year to know if the program was more efficient and effective than a professional insurance company.

Mr. Haycock explained that there was something that government health plans had that commercial health plans do not have. When a plan was self-insured there was no premium tax and a 3.5 percent premium tax was added to all the premiums that was paid to fully insured products. Therefore, if the PEBP plan was exactly the same, it would be 3.5 percent cheaper from the start. In addition, PEBP's plan did not have shareholders or stakeholders to pay and generally a commercial health plan liked to have enough premiums coming in and claims going out to be at an 88 percent or 89 percent loss ratio. He stressed that PEBP runs at a 95 percent loss ratio because it did not have a lot of the requirements that fully-insured products had, such as specific filings with the Division of Insurance, certain fees and taxes, or have to meet a bottom line profit margin, and all PEBP had to do break even, which was the goal. Mr. Haycock stated that he was not saying that PEBP had a plan that was better than commercial health plans, but he has personally negotiated deals with providers that beat what PEBP's partners were doing; however, he thought PEBP would give the other health plans competition, which would be seen in the data.

Chair Carlton asked Mr. Haycock to address the following concerns of the risks on a self-insured group insurance model;

- How the plan would deal with a catastrophic incident and how would it handle the reinsurance model, which the marketplace had to handle;
- The cost of reinsurance, if PEBP offered reinsurance;
- Address the concern with the state being the decider of who gets what benefits, because in essence, PEBP was going to act like the insurance company and handling referrals if a participant wanted to appeal a decision. She was uncomfortable with an employer having that much impact over an employee's healthcare, because there was a fine line between the knowledge of an insurance company versus the knowledge of an employer on insurance issues. She wanted to ensure that PEBP was not denying participants' services due to a high cost procedure;
- Address the concern that if the new program failed that the Southern Nevada constituents would end up paying for the Northern Nevada experiment;
- Premium tax supported many different things for the state, which could be a significant amount and could put a "divot" in future budgets; and
- Why a simple PPO was not one of the options, which everyone knows and understands, and it kept the employer out of the participant's health without a financial cost for the state.

Chair Carlton stated there were self-insured plans in Southern Nevada offered through large corporations like MGM, which could absorb the risk. She expressed her concern that if something went wrong with the PEBP EPO that the state and the Southern Nevada members would be liable for its failure. Although she was aware the Committee had no real impact on the decision, and PEBP already made the decision, it would have an impact on how the Legislature funded the budget in the next Legislative Session.

Mr. Haycock said he would discuss the risks for the catastrophic costs that the state may be incurring. He explained that one of decisions made was what to do with excess reserves and PEBP had its actuary look at what they felt would still meet the Board's policy for Catastrophic Reserves if PEBP were to implement the plan in Northern Nevada, Southern Nevada and across the state. The costs that PEBP anticipated were needed for Catastrophic Reserves was $10.3 million and that money was already earmarked by the Board at its November 2017 meeting as part of the discussion on what to do with the excess reserves; therefore, PEBP accounted for that. He added that the entire CDHP was approximately $25 million, which was four times the size of the HMO, so the cost of the EPO was approximately $10.3 million, because of the additional risk that it was going to assume, which was conservative. He added that because of the excess reserves that PEBP carried forward over the last few years there was the opportunity to earmark those funds for the Catastrophic Reserve. Mr. Haycock stated that he would get another letter from PEBP's actuary to state that for the Committee.

Chair Carlton commented that those reserves came from the members that paid into high deductible health plan and those reserves were going to be used to supplement a previous HMO participant. Therefore, that money does not actually belong to the state, and PEBP was using the money for something that does not benefit the previous HMO participants.

Mr. Haycock responded that he did not disagree with Chair Carlton's statement; however, they needed to look all employees as important members of PEBP's asset pool. Currently, there were employees that migrate to the HMO from the CDHP because they had a surgery coming up, and once their surgery was complete, those employees would migrate back to the CDHP. Therefore, when talking about the participant earning the reserves, the participant that created the reserves may not work for the state anymore. Therefore, to put the reserves in a bucket and say that the reserves belonged to the participants on the CDHP, HMOs, non-state retirees or the retirees, the idea of a multiemployer group health insurance program was that risk was shared and reward was shared.

Chair Carlton expressed that she distinctly recalled a few sessions ago being an advocate for the HMO participants and was told the reserves came from the HDHP and could not be blended and only utilized for participants of the HDHP, and she was concerned with the change in philosophy. She stated if PEBP was going to set a policy she believed it should be consistent and she had concerns that this would set up the state for problems using those excess reserves and not returning them to the people who paid into it, regardless if they were with no longer with the state. She said that everyone in the state should have health insurance and it was very concerning to her that when the HMO really needed help and rates were increasing she was told the rates could not be blended, which now has changed so PEBP can help one particular group of people in the HMO.

Mr. Haycock clarified that in the past excess reserves were utilized to support increases in the HMO premiums, and PEBP was not setting a precedent today, just activating something that has been done in the past. He said that he could provide staff with the exact time this action was adopted and the resulting impact to the HMO premiums and excess reserves, because by lowing the rates for that year, the following year when rates increased, it started at where the rates should have been so the "sticker shock" was dramatic. Therefore, PEBP did not want to repeat that to adjust rates. He said that Catastrophic Reserves were not expended every year, in fact PEBP has not expended its Catastrophic Reserves for its CDHP since the inception of the program. He said PEBP might have dipped slightly into the reserves in the first few years, but that was cash that was set aside for unexpected events. It does not mean that money was actually going to the plan and the reserves were there to protect the plan to maintain long-term solvency. Therefore, it was taking money and moving it from one bucket to the other and was not actually going to the members unless it was utilized.

Chair Carlton interjected that the Committee did not have an impact on the decisions made by PEBP, but she felt that the issue needed to be discussed in case issues arise in the future. She stated not knowing what was actually discussed at the PEBP Board meeting that these discussions were important for the Committee and to have on the record, because she had a feeling there would be more discussion on the issue in the future. She asked Mr. Haycock to address the reinsurance to transfer a portion of the risk associated with self-insurance coverage.

Mr. Haycock explained that any payments that PEBP had to make toward any risk adjustment, reinsurance or any other ACA requirements, the Patient Centered Outcomes Research Initiative (PCORI fees) and those types of things, PEBP would continue to make those in accordance with the program. He noted that up until the last HMO renewal, PEBP used its funds to pay those fees on behalf of the Northern Nevada's HMO, which was in the contract. He stated that PEBP has been paying the Northern Nevada HMO's fees for years to the federal government while the Southern Nevada HMO had those fees built into its rates.

Chair Carlton asked Mr. Haycock if the $10.3 million in reserves that were going to be used as a catastrophic fund to soften the blow of the Northern Nevada HMO discussed at the PEBP Board meeting so that it could still move forward to address the 13 percent, and Mr. Haycock replied that was not discussed.

Chair Carlton asked Mr. Haycock if he had an idea of the amount of the premium tax, and Mr. Haycock replied he did not have the amount of the premium tax that was no longer going to the Division of Insurance from Hometown Health for the members; however, he could obtain that information and provide it to staff and the Committee.

Chair Carlton asked how PEBP would handle the referral process with the state-managed insurance and making the decisions on the different levels of care and ensure there was a hard line between the patient in the state and the health care provider.

Mr. Haycock said that would be done exactly how PEBP handled its CDHP, which was a self-insured plan of benefits that the state managed since 2011. He noted the PEBP has already acted like an insurance company since 2011 for the bulk of its members in PEBP's self-insured CDHP. He noted that there was an appeals process, which started with PEBP's third-party administrators for Level 1; Level 2 went to PEBP; and Level 3 went to an outside reviewer, which included the Governor's Consumer Health Assistance Office, which has been in place since 2011 with the CDHP and would be in place for PEBP's HMO plan. Mr. Haycock stated that PEBP was not inventing a new program, but capitalizing on what it has already accomplished and utilizing a model of care that was expected in Northern Nevada and trying to mimic it moving forward. He added there were things in place to prevent him from having access to staff's medical records, and there were very stringent HIPAA requirements on who had access to participants' records. In addition, there were various tiers that meet the federal requirements, as attested to in PEBP's compliance review that successfully created that line of demarcation, the prohibited zone that PEBP and its employees could not know about any employee's medical care. However, PEBP received calls from members with certain conditions, but PEBP does not track those members in anything that was unprotected and generally tried to stay out of the medical decision-making process. He noted that PEBP did not have a medical director or clinician on staff, and outsourced medical decisions, which were made by PEBP's utilization and case management vendor that utilized a medical director and clinical staff to follow the appropriate national guidelines for referrals and care determinations. Mr. Haycock stated that state-managed health care was no different in concept or in practice than how PEBP has operated for the last seven years with its own

self-insured program of benefits. He said that all PEBP was doing was no longer going to pitch premiums to a fully-insured product to manage the process, and was going to collect premiums and manage the self-insured program like it did with its current CDHP, while adhering to the copay and no deductible model that people on that plan have grown accustomed and relied upon for their budgetary needs.

Chair Carlson stated that Mr. Haycock addressed most of her questions and concerns, except for the possible issues that could come up if the plans in Northern Nevada and Southern Nevada were blended, and the impact a misstep could have to the Southern Nevada participants. She asked if safeguards could be implemented to ensure that the southern participants did not end up bearing the brunt of any possible misstep.

Mr. Haycock replied the safeguards that PEBP was going to put in place on the EPO, similar to the CDHP, was a healthy and conservative 95 percent confidence level for reserves. The rate PEBP would establish that would be announced in March 2017, would include the ability to create an incurred but not reported reserve similar to the CDHP, so there would be two safety nets for the plan just like what was done for PEBP's current plan of benefits, which both would be at a 95 percent confidence level. He indicated PEBP felt confident with its conservative rating policies and was going to ensure it did not take a misstep that it could not recover from. However, the idea of blending was a discussion that he was aware that Southern Nevada would continuously bring to the Board. He recommended to the Board, and the Board unanimously decided to limit the amount of disruption and change, because participants did not like change. Therefore, PEBP wanted to get through the first year with as close to the same plan as possible, and prove that PEBP could provide this other opportunity. Mr. Haycock stated there was no discussion on going back to the PPO model, and there was talk about absorbing everyone back into CDHP, which was the last part of the four option Board meeting packet, which was not looked at positively. However, PEBP did not look at recreating a PPO because then it had to be looked at again doing it one of two ways – if PEBP were to recreate a PPO plan like in 2010, it had to decide to self-insure or fully-insure, and if fully-insured then all it would do with the high-costs of health care in Northern Nevada was shift it from the health plan to the member, with deductibles, coinsurance and a standard PPO model. In addition, the standard PPO model was an open access model, which allowed members to go anywhere for health care, with specific benefits for in-network and different benefits for out-of-network. HMO plans do not offer out-of-network services that were not emergent or urgent; therefore, a member on the HMO plan today would be covered if they had an out-of-state emergency. However, if the member was out-of-state for an extended period of time and needed care that was not emergent or urgent, it was not covered by the program, which was how HMOs were designed. PEBP was looking at mimicking that process and if access was opened up, they had to remember the more access people had to care, the more it was going to cost, and that has always been part of pinch limits in health care. The more access that was wanted, the more it would cost, and the regular plan was not discussed because PEBP was not only looking at the financial issue, but also trying to mimic the same access to care. Therefore, PEBP thought the EPO was the best process moving forward. Mr. Haycock added that PEBP offered multiple options in the report. The original PPO's cost on a per member per month basis was much higher

than what the members were currently paying. He noted that seven years later, PEBP was paying less for its members today than when there was the traditional PPO model and there was an argument when PEBP had the previous PPO that participants were over utilizing that model. Mr. Haycock stated he had a suspicion he would receive a plethora of questions from staff to justify that statement, which he was prepared to provide, understanding that access to care, quality of care and affordability going back to the PPO would mean higher costs and it would have to look at who was going to pay for those costs.

Senator Ratti stated that after listening to the conversations it felt like the state was really absorbing the risk, because it was trying to keep consistency for the members. She asked about the size of the pool, the best practices across the nation in terms of the self-insured plan, and what a reasonable person would think a good size risk pool was for a self-insured plan.

Mr. Haycock clarified that in the February 2017 enrollment report there were approximately 8,500 lives covered in Northern Nevada on the current HMO plan. However, when looking at absorbing this risk they had to remember that in essence, the risk always existed, because PEBP was pitching subsidies and member premiums to a fully insured product to cover the risk, plus taxes, fees, premium tax and profit, and PEBP has always paid for the risk, just not directly. He noted when rates increased, then the cost to the state and to the members increased and it was absorbing the risk. Therefore, it was not like the state was taking on risks that did not exist previously or that the state has not collectively paid for; the state was taking on the risk anyway, but basically cutting out a lot of the processes and managing it in-house. As far as what was an appropriate level to self-insure, PEBP was going to treat the plan separately but would look at the experience of the EPO plan and the CDHP as well. He indicated that he did not have any intention to raise rates on the CDHP to offset the HMO replacement plan in Northern Nevada, so the risk model had to be appropriate, but recognize that if the state was going to absorb the risk, carving that out similar to how non-state retirees were carved out has already proven to be unsuccessful. Therefore, when looking at taking the collective risk pool that the program had to offer benefits to – 8,500 lives were going to be combined with the 40,000 lives on a CDHP from a risk basis, and PEBP was going to create different opportunities and levers to try to find the right mix of plan benefits at the end of the first year. He added that he did not have an exact number to show the going rate for the self-insured plan, because each employer had to decide their comfort level. He stated there were self-insured programs that were much smaller that would buy stop-loss insurance and any claim over $500,000 moved on to another insurance; however, PEBP was too large to need stop-loss insurance and could absorb the $500,000 claims. Recently, PEBP received a $1.4 million claim for a premature baby and PEBP was able to absorb that cost and still save money, but PEBP was not going to leave the group out on its own. However, PEBP was also cognizant that it did not want Southern Nevada to offset the costs of Northern Nevada or visa versa, so PEBP was working diligently with its partners in the HMO offering in Southern Nevada and that they were fully aware of the process and still wanted to partner with PEBP.

Senator Ratti asked about the “bells and whistles” that a fully-insured plan offered in terms of wellness programs to encourage members to access care differently or to prevent the need for care. She asked if PEBP offered wellness programs for participants.

Mr. Haycock replied that PEBP had certain preventive service programs, mostly on a cost basis to “incentivize” incentive utilization. He recalled the wellness program a few years ago that was not well received by the members. He stated that he would be willing to relook at implementing wellness programs in the State of Nevada, but he needed to know that it would not become a point of contention with the various groups that had issues with the previous wellness program. He indicated that he was a firm believer in preventing the necessity for care if behavior changes could be made. He said that PEBP offered members access to the care that they already had today, and there were certain programs that PEBP was going to implement that do not exist in the HMO plan. He said PEBP was implementing a new transparency vendor, and participants could use technology or access a call center to look at the costs of health services at different facilities to get the lowest cost for services. He said if PEBP was overpaying today for costs and certain disciplines, PEBP was going to incentivize the utilization of those lower cost high-quality providers through cash incentives. On the CDHP, if PEBP gave a member a $50 check and the member had a $100 provider appointment, the member would feel a lot better about the fact that they were getting money back for choosing the lower cost provider. On the HMO replacement plan that had copays, because now it could potentially wipe out the entire copay and the plan was saving because it was first dollar coverage after the copay was paid. Therefore, there were a lot of opportunities to implement programs and PEBP would always look at additional programs, but the program dollars similar to any other state agency, were predicated on the amount of money PEBP had as resources.

Senator Ratti asked about the features that might come with fully-insured health plan versus what PEBP was able to offer and could there be a reduction of such features now that PEBP was operating the EPO plan.

Responding to the question from Senator Ratti, Mr. Haycock said that to his knowledge there were no features that would be removed, but there were certain services provided in the HMO plan in Northern Nevada that PEBP believed had comparable services to the CDHP, and the CDHP plan had some services that the HMO did not have. He said the HMO and CDHP plan had telemedicine, and the HMO plan offered access to nurse health lines and to other services. Mr. Haycock stated that he thought what set Hometown Health apart was its model of personal care and it worked well with the members and they appreciated that personal touch. PEBP had addressed that by ensuring case management and the people the member were in touch with today would be there for the participant tomorrow.

Mr. Haycock stated that PEBP wanted to create a utilization management/case management opportunity for all the plans that it offered, because not only was it cost effective, but also helped members through difficult parts of their lives. The current utilization/case management contract was due to expire June 30, 2019, and before PEBP

talked about renewing/or resoliciting the contract and could say who the vendor would be in two to three years, he had to ensure that PEBP had those conversations with its Board.

Senator Ratti asked when absorbing risks if PEBP was more tied into a biennium or a budgeting process that made it a little riskier for the state compared to a nonprofit or for profit, which could balance the risk over multiple years.

Mr. Haycock responded that it had to define the part of risk that applied because every plan had the risk of the unknown – the costs that it knew about and the unknown costs, so every plan had to try to meet a bottom line. However, more importantly, if other fully insured products had the ability to go multiple years to balance risk, he thought they had multiple employers to balance risks, whereas, PEBP represented the state and for the most part the members were from the State of Nevada. So PEBP was leveraging the potential risk of a successful high-deductible health plan with the unknown of how successful the HMO replacement plan was going to be. He said maybe at the end of the first year when PEBP went through the analyses of the plan that the Board was compelled to make a decision on whether to continue this model of care. He noted that he would be providing updates every other month at the PEBP Board meeting regarding the status of plan and how it compared to where it would have been. He said the issue of the risk with a biennium process was that there was no mechanism to make adjustments to the plan that would not affect the member, so PEBP was very cautious about what it did in the off year. Mr. Haycock indicated that he would often recommend waiting until the legislative year to give the legislators an opportunity to provide input, and to approve the funding necessary to implement the program. He stated the risk was not going to change, and if someone needed health care today they would need health care tomorrow.

Chair Carlton stated her concerns with PEBP's self-funded HMO replacement plan. She expressed that it seemed like PEBP had a flat tire and decided to go buy a new car. She hoped the HMO replacement plan was successful, but there were some options that should have been discussed that were not, and unfortunately, the Committee did not have a voice in those decisions. However, ultimately, the state would be financially accountable for those decisions.

8. **Report on other plan benefit design changes, including changes for the High Deductible Health Plan (HDHP) adopted by the PEBP Board for Plan Year 2019, as compared to Plan Year 2018.**

Moving to page 433 of the meeting packet (Exhibit A), Mr. Haycock stated that at the November 20, 2017, PEBP Board meeting, the Board approved to continue enhanced benefits for the CDHP into PY 2019 of $9.0 million, which included the Medicare Exchange life insurance premium; Medicare Exchange HRA administrative fees; enhanced life insurance levels for all participants regardless of plans, which was $25,000 for employees and $12,500 for retirees; and enhanced HSA and HRA funds for the high-deductible health plan of an additional $200 per participant that was tied to preventative services. In addition, two new costs saving activities were introduced and approved; the Healthcare Blue Book for high quality low cost provider member incentives;

and the Voluntary Narrow Pharmacy Network (Smart90), which were designed to save members money if they wanted to switch to a lower cost pharmacy. However, the activities were an option and not a requirement. He noted that the two new cost saving activities were projected to save the program a minimum of $400,000 in PY 2019. In addition, new programs and services were approved for PY 2019, which included procurement of a voluntary vision benefit provider; an additional requirement to the $200 enhanced HSA/HRS benefit to enroll in Doctor-on-Demand and Healthcare Blue Book; designation of 3-dimensional mammography paid 100 percent under the preventative benefit; and state procurement of a voluntary vision benefit provider. Mr. Haycock stated that his goal was to make the enhanced benefits part of the base plan moving forward.

Chair Carlton asked Mr. Haycock the benefit for enrolling in the Doctor-on-Demand and Healthcare Blue Book and why those programs were worth the $100 incentive.

Mr. Haycock replied that Doctor-on-Demand was a telemedicine virtual experience where a member could talk to a licensed and certified Nevada-based doctor, similar to going to a minute clinic or urgent care for standard acute issues, such as colds, flu, or a urinary tract infection. He noted the real benefit was the member was not going to the emergency room or urgent care, so therefore, PEBP and members were not ultimately paying more than they had to for services. He said that the $100 incentive was to expose the members that did not grasp this process when Doctor-on-Demand was initially implemented last year. Members who utilized this service provided positive feedback on the program, and it curbed access to care issues, especially in the rural counties where it was hard to get to a doctor. Mr. Haycock believed it was a very good opportunity and the cost was about $49 for a visit to a doctor's office; therefore, the member was automatically saving money using Doctor-on-Demand if the situation warranted it. He said it was a cost savings across the board and incentivizing it would at least expose members to the program.

Chair Carlton asked Mr. Haycock to explain how PEBP was going to evaluate the programs to determine if they were valuable and should be expanded. In addition, she requested an update at the next IRBC meeting about the pilot programs so the members could understand more about the programs.

Mr. Haycock stated the he could provide any report the Committee requested. The pilot program was changing the reimbursement model for care, so currently, in the PEBP network across Northern Nevada and rural Nevada, there was a percentage off bill care model, which placed the risk back on the employers that enrolled in those networks. If someone wanted $100 for a service today, and were aware that they get 50 percent off bill of charges arrangement, they were just charged $200 and get their $100 incentive. There was no inflationary protection in these, employers were often not allowed the opportunity to negotiate on behalf of the state for these providers agreements to try to build an inflationary protection. Therefore, the best way PEBP was able to come up with an appropriate amount of money for a service, which was a legislative bill, was to form a database to determine an appropriate amount of money for a service. He said PEBP chose a Medicare Plus model, and evaluated what it paid for these services in the last

two years on a Medicare model to see where it fit on the pendulum of Medicare and Medicare Plus, a percentage and an additional percent and where it fit. PEBP agreed upon a rate that it felt was going to be less expensive that what PEBP was currently paying, and would match what it paid every month for this reimbursement model against what PEBP would have paid if it did not have the reimbursement model, and that delta would determine the savings. He said if PEBP saved significantly, which he was confident it would, then PEBP would look at doing the same model on a more robust basis and pilot the program and ensure that the projections that PEBP had for success were realized, and if so, PEBP would report the success or failure of the program and the decision it made. He added there were other pilot programs that PEBP implemented that did not create a net-positive result, which were terminated. Mr. Haycock stated that PEBP was prepared to try the two-year pilot, because it had a one-year timely filing requirement for providers to send into PEBP for payment. Therefore, things that happened in the first year may not come in until after the first year and PEBP wanted to ensure it had an accurate reflection of what was accomplished. He would look at the costs, and the next best alternative to see what PEBP would have paid for those had it not gone to this model under the original contract amounts.

Chair Carlton asked Mr. Haycock to provide a report to staff on the Nearside Health Clinic, Nurse Health Line, and Expansion of the Disease Management in the ACA programs, Wellness Program and the increased partnerships with the state agencies.

Chair Carlton asked Mr. Haycock if PEBP was currently working on any new initiatives that the Committee needed to be aware of, and Mr. Haycock replied that PEBP was not looking at any additional initiatives at this time. However, he was always looking for opportunities to save money, increase access to care, and to improve the quality of care for its members, and when he finds those opportunities he presented them to the PEBP Board.

9. Report on results of participant survey conducted by PEBP in November and December 2017.

Mr. Haycock stated the 2017 PEBP Member Satisfaction Survey was located under Tab V.9., page 435 of the meeting packet (Exhibit A). He said the survey was available to members for about six weeks. The survey was sent to multiple entities for distribution to include all member emails on file, all system administrators who had email addresses for everyone within their agencies, account representatives assigned to all PEBP pay centers for collecting payments and premiums, and to the advocate groups – RPEN and AFSCME. He noted that PEBP developed a simple six question survey with four multiple choice style questions and two open-ended questions to allow the opportunity for members to write in their comments to see exactly how they felt about their interaction with PEBP. He noted that PEBP received 9,618 responses to the survey. He said the intent of the survey was not to determine what benefits were the most desirable, but rather, customer satisfaction, the areas that needed improvement, and communication preference, because PEBP wanted to implement policies and procedures that met the needs of its members regardless of who they were or where they were located. He noted

that the largest response rate for member satisfaction, on a scale of one to ten, was ten, extremely satisfied. He noted that PEBP did not want to skew the survey and there were people that felt whatever PEBP asked it did not apply to them, so PEBP removed the non-applicable answers; however, the highest rating was extremely satisfied. In addition, PEBP also learned that the methods of communication used today, were actually preferred over some new methods PEBP was exploring, and participants wanted to continue to receive information by mail, email and from the website. He stated that PEBP was ready to implement a social media campaign to provide information to members, but when it received the feedback, not many members wanted that type of communication. Therefore, it helped PEBP decide exactly where to put its resources for communication. In addition, PEBP learned it needed to continue to improve access to and quality of training and education of all programs and services PEBP received the lowest score of seven on a scale of one to ten in that category. Therefore, PEBP is planning to expand training and education through additional in-person activities, as well as capitalizing on technology solutions to provide more access to remote locations. PEBP was continuing to look at new opportunities and resources to improve the member experience so that members received the training and education necessary. Overall, PEBP received a high rating for its services and was proud of the survey, and he believed the survey would have been significantly different if it was conducted when he first started with PEBP in 2015. He indicated that PEBP has taken very purposeful and pain staking steps to repair relationships with all the agencies, advocacy groups, and potentially with the Legislature, because PEBP wanted the Legislature to be proud of the products and services offered that implemented the laws, rules and regulations. PEBP wanted to be part of the solution and was excited to share the survey with the Committee. In addition, PEBP would continue to strive to provide the best service to its participants and was dedicated to improving the scores and looking forward to repeating the survey again.

Assemblywoman Diaz asked Mr. Haycock to provide a brief overview of the responses to the survey, specifically the top three responses, and how PEBP was going to use that feedback to improve customer service.

Mr. Haycock replied that he did not want to mislead the results of the survey and those who read it by cherry picking the best answers or showcasing the worst. He said PEBP literally had a complete gamut of responses, from PEBP was the greatest thing ever and to keep up the good work, to PEBP was the worst. Therefore, PEBP has seen everything from good to bad and categorized all of those comments, which was PEBP's own biased categorization, and he did not want to present biased data. However, he could provide all the responses and comments from the survey to staff and the Committee if desired. He noted that PEBP received a lot of feedback and was not just looking for positive feedback; PEBP also wanted to see the negative comments to look at the areas where it could improve. He added that many of the comments PEBP received had to do with PERS, so some participants were confused with the agencies. In addition, some comments were made about deteriorated benefits over the years and he did not have an answer to why benefits were not the same today as they were 20 to 30 years ago.

Continuing, Mr. Haycock stated that he wanted to ensure that members had a better experience with having access to the information they needed, because health insurance was very complicated and difficult, and often members do not think about it until it was needed. He said that PEBP was dedicated to providing additional tools and training opportunities to members to maximize benefits. In addition, PEBP needed to implement more technology solutions for people who liked that type of communication and less technology solutions for people who do not like that type of communication and to provide a complete gamut of communication medians to reach its membership. He stated that PEBP wanted to keep looking for innovative ways to continue to provide high quality benefits at affordable prices to employees, retirees and their families enrolled in its plans. PEBP wanted to become a partnership with the Board, Governor, Legislature and state to come up with an optimal plan for participants and then collectively own that decision. Mr. Haycock stated that participants do not like paying a lot for pharmacy drugs and was applying pressure to drive down the cost of prescriptions. In addition, he was on the Government Advisory Panel for the state's pharmacy benefits manager who represented all government employers across their book of business; PEBP had a voice and would continue to use it to drive down pharmacy costs.

Chair Carlton commented that the survey was done as part of the process for accreditation through the Utilization Review Accreditation Commission (URAC). She stated the decision was made at the Board meeting to extend a contract for the accreditation; however, the contract was not included in the legislatively approved budget for PEBP. She asked if the money for the accreditation came from PEBP's Operating Category. In addition, she asked the benefits that the accreditation had for the state.

Mr. Haycock confirmed that was correct and PEBP did not move any additional money from other areas to cover that specific contract as requested by the Budget Office. He said that PEBP did not purposely withhold that information from the Legislature, the opportunity came up fast and PEBP took that opportunity to implement a rapid solution to the accreditation request. He stated that PEBP believed that it was a good health and welfare plan, but the question was how to defend that statement and define a good health plan, and the metrics and national standards that health plans adhere to. He noted that there were accreditation and licensing requirements for a plethora of services across the state, but there was not one for government health plans. Therefore, URAC went through the entire program, from a non-clinical perspective, to see if PEBP was meeting national standards for accreditation. He said that URAC and the National Committee for Quality Assurance (NCQA) were the only two federally approved accreditation entities in the nation for the ACA's individual marketplace, and there was a requirement to participate on the ACA exchanges to have accreditation. He said that PEBP does not have to have the accreditation, because it did not participate on the exchanges, but it meant a lot to the federal government to have accredited health plans providing services that it was made a mandate in the ACA. Therefore, PEBP had an opportunity to be accredited at a very low cost to be held at national standards, as well for its own internal policies, procedures, state laws and rules. Mr. Haycock wanted to know how PEBP compared to other states health plans, or to the marketplace, and the accreditation was a comparison tool. He noted that the cost was $25,000 for a three-year accreditation. On March 8, 2018, there

would be a site visit and then PEBP should receive notice whether it had successfully been accredited by the first week of April 2018. If PEBP was accredited, at that point he would be proud to share that PEBP was the first and only government health and welfare plan in the nation that has gone through accreditation. He said that Nevada would be number one on the only list for accreditation which set PEBP apart. Therefore, PEBP's policies, procedures and regulations were meeting national standards, which PEBP took pride in and PEBP was very confident that they would meet that accreditation.

VI. PUBLIC COMMENT.

Priscilla Maloney, AFSCME, stated that the culture of PEBP changed substantially in the area of reaching out to the advocacy groups and there was more transparency and engagement between PEBP and the advocacy groups. The advocacy groups were meeting regularly with the facilitation of Mr. Haycock and the meetings were respectful and all advocacy groups were invited. If there were any disagreements at the meetings, she said that Mr. Haycock was aware that all the advocacy groups had to report to their boards to explain what was being proposed by PEBP, which allowed the advocacy groups to get a board position before meeting with PEBP. She expressed her concerns with the Northern Nevada HMO plan design change. AFSCME retirees took that metadata and did an analysis on the number HMO members that the change would impact. The data was narrowed to the number of pre-Medicare retirees because the change would not impact the Medicare retirees other than the funds to capitalize the Catastrophic Reserves that could be used to enhance benefits for the Medicare retirees. The data was looked at for the group retirees, using birthdates from a database, and the change would impact approximately 100 participants. She noted that AFSCME used this type of analysis when it made a position. AFSCME had concerns, which were expressed at the PEBP Board meeting where the decision was made, on the use of reserves to fund this Northern Nevada experiment. She stated that she understood the difficult position that the Northern HMO was in, which was highly regarded plan. She said her recollection was that PEBP was going to have to build in a 19 percent increase, but through the discussion at the Board meeting, PEBP decreased to a bottom line of a 13 percent increase. Therefore, the increase would have been substantial to active and pre-Medicare retiree members. She emphasized that Mr. Haycock and his staff have been very respectful of meeting with the advocacy groups before the decisions were discussed and they listened to the concerns of the advocacy groups, even though they did not have vote in the decisions. Ms. Maloney appreciated the robust conversation around the policy changes and AFSCME was represented adequately and there was transparency between PEBP and the different advocacy groups.

Marlene Lockard, Retired Public Employees of Nevada (RPEN), thanked the Committee and Legislature for working hard to take care of the orphan issue. She stated it had been a long standing problem for the state retirees and they were grateful for the positive response. In addition, she thanked Mr. Haycock for improving communication with the different advocacy groups allowing for a better opportunity to express concerns and voice questions. She stated there was considerable concern and angst about the proposed HMO changes, which was brought to the advocacy groups in November 2017, not

allowing enough time to vet or review the significant changes. The advocacy groups only had one weeks' notice that the proposed changes were going to be on the PEBP agenda, and there were concerns about the unintended consequences. She indicated a brief comment was made at the PEBP Board meeting that the HMO plan has always being a "problem child" with all the different issues over the years and the migration away from the HMO. She noted it was briefly discussed and no additional details were given about the changes, and if a significant changes were made, then the HMO should be cut and there should be one high-deductible plan for the entire state. Ms. Lockard stated that all of the members have a stake to the excess reserves and the Medicare retirees that were kicked out of plan in 2011 left behind significant funds in the PEBP system. Therefore, the retirees and all members believed they had a claim in part of the excess funds, which was a result of the 2011 decision, the continual amassing of the excess funds. She believed the $10.3 million in excess reserves was going into PEBP's Catastrophic Reserves. She asked how the state was going to pay claims as they were just beginning to collect premiums, and where the initial seed money would come from to pay the claims. Mr. Lockard stated that the advocacy groups expressed their concerns at the PEBP Board meeting and asked for more time because it was brought up and decided in one Board meeting, similar to when the PEBP decided to take Medicare retirees out of PEBP, which had significant ramifications for years.

Concluding, Mr. Lockard stated that March 2018 was PEBP's rate setting Board meeting, and the advocacy groups had no way of knowing if current premiums would increase, stay flat or what would be offered in that rate setting. She noted the advocacy groups were very concerned if PEBP increased rates overall when developing the new program. She noted that RPEN believed when the decision was made in 2011 to no longer offer retirees and new hires health coverage from 2012 forward, was really a decision made in a financial crisis and RPEN felt the Legislature needed to take another look at that to determine if it was the best approach and policy for state employees and an incentive to hiring and filling open positions.

Peggy Lear Bowen, speaking as an individual, commended Mr. Haycock for allowing 3-D mammograms without an additional charge to members. She stated that something horrific has happened in the State of Nevada regarding PEBP Board meetings and any other state, county or city meetings. For example, how the former Executive Director of PEBP and a former member of PEBP exercised their influence in regard to how meetings were conducted. She said that Jim Wells, State Purchasing Agent, and Mr. Laxalt, Nevada Attorney General, found a loophole in the open meeting law, in providing information and being transparent in the state. Currently, if someone could not physically able to pick up a PEBP Board meeting packet within a reasonable time in order to study the meeting material, or if someone did not have access to a computer or technology, or was indigent and could not afford a phone, or elderly and did not understand how to use technology, those people were literally cutoff from transparency unless they could physically drive to Carson City to pick up a meeting packet. She hoped that PEBP would find a way to set aside funding to send packets via mail to the members who were unable to access the packets online. In addition, there was no requirement to hold the meetings in more than one location. Therefore, if someone could not attend a meeting in

Carson City then they were unable to access the meeting and would not know what was discussed. Videoconferencing has been discontinued because a loophole was found in the open meeting law. Ms. Bowen stated that access and transparency has ceased and desisted for the State of Nevada, under the current Governor, Attorney General and Mr. Jim Wells. She believed the State of Nevada should investigate all aspects of the changes in the health insurance for the State of Nevada, its employees, and she wanted the state to follow the money and how it was being used. She was aware one employee was terminated for accepting gifts from insurance companies in order to help with a decision. Ms. Bowen continued to express her concern with transparency during the insurance company bid process. The PEBP Board recognized that the bid process was flawed and it was not fair that they voted to go with Anthem Blue Cross/Blue Shield rather than continuing with the insurance it had been with. She reiterated the whole process was flawed and things had to be done over and there needed to be a change. Ms. Bowen stated there was turmoil within the PEBP Board and in PEBP and she commended Mr. Haycock for doing a good job bringing insurance to the State of Nevada participants. She wanted to keep the PEBP Board in place no matter what because they were the voice for the people and the people needed to have that voice, but it needed to be a fair voice, open and transparent. She asked for more access to 3-D mammograms for participants.

VII. ADJOURNMENT.

The meeting was adjourned at 2:49 p.m.

Respectfully submitted,

_____
Donna Thomas, Committee Secretary

APPROVED:

_____
Assemblywoman Maggie Carlton, Chair

Date: _____