MINUTES OF THE
NEVADA LEGISLATURE'S
INTERIM RETIREMENT AND BENEFITS COMMITTEE
(Nevada Revised Statutes 218E.420)
February 5, 2020

The first meeting of the Nevada Legislature's Interim Retirement and Benefits Committee (IRBC) was held at 1:30 p.m. on February 5, 2020, 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 3137, Carson City, Nevada.

COMMITTEE MEMBERS PRESENT IN LAS VEGAS:
Senator Marilyn Dondero Loop
Senator Ben Kieckhefer
Senator Joyce Woodhouse, Chair
Assemblywoman Maggie Carlton, Vice Chair
Assemblywoman Brittney Miller

COMMITTEE MEMBERS PRESENT IN CARSON CITY:
Assemblyman Jim Wheeler

STAFF MEMBERS PRESENT IN LAS VEGAS:
Alex Haartz, Principal Deputy Fiscal Analyst, Fiscal Analysis Division
Sarah Coffman, Principal Deputy Fiscal Analyst, Fiscal Analysis Division
Eileen O'Grady, Chief Deputy Legislative Counsel, Legal Division

STAFF MEMBERS PRESENT IN CARSON CITY:
Mark Krmpotic, Senate Fiscal Analyst, Fiscal Analysis Division
Cindy Jones, Assembly Fiscal Analyst, Fiscal Analysis Division
Brenda Erdoes, Legislative Counsel, Legal Division
Donna Thomas, Committee Secretary, Fiscal Analysis Division

EXHIBITS:

Exhibit A: Agenda and Meeting Packet

I. ROLL CALL.

Chair Woodhouse called the meeting to order at 1:44 p.m. The secretary called roll; all members were present.

II. PUBLIC COMMENT.

Tom Wellman, resident of Senate/Assembly District 1, stated that he successfully retired from the Clark County School District (CCSD) over nine years ago. He worked for the

school district as a teacher and school counselor for 32 years. Currently, he was serving as the president of Nevada State Education Association-Retired (NSEA-R) program. He indicated that he was present at the meeting to speak about health insurance, which was a serious issue faced by all retired educators and support professionals across the State of Nevada. The number one expense that retirees faced as they moved into retirement was the rising cost of health insurance and prescription drugs. He said the NSEA-R spent the better part of 2019 meeting with active teachers and support professionals in the state hoping to educate them on the issues and concerns they could face as they moved into retirement. Most teachers had no idea about their insurance upon retirement and what they needed to do to qualify for insurance. When pressed, the teachers found that they could qualify to stay on their district insurance plan but would be responsible to pay the whole premium without any assistance. Most of the premiums were between $800 to $900 per month, or more if a spouse or dependent was covered under the plan, which was expensive for someone on a fixed income pension check. He noted that only two counties in the state have negotiated agreements toward retired health care, which were Clark County and Lander County; although, anyone hired after 2014 would not be eligible for the benefit in Lander County. The state needed to do better for its educators who made a career of educating the children in the state. In addition, the state needed to address the problem that many educators faced, which was the ability to qualify for Medicare. He noted that people hired between 1978 and 1986 did not pay any Medicare tax; therefore, do not qualify for enrollment in Medicare, which was unacceptable. Members needed to know that they had a safe and secure retirement and not have to worry about qualifying for Medicare. Mr. Wellman indicated that NSEA-R was available to help and wanted to ensure that retiree health care was a priority. He added that NSEA-R was willing to work with the Legislature to make this priority a reality.

Steven Horner, Vice President, Clark Retired Education Association (CREA) and member of NSEA-R, indicated that two of his great passions were traveling rural Nevada and playing golf on the courses in rural Nevada. He noted that during the summer of 2015, while playing golf in Ely, he fell and broke his oxygen concentrator and was not traveling with back-up oxygen. With a breathing disability at close to 7,000 feet above sea level, the need for oxygen was important. When he called the nearest hospital he found that he would have to pay full price for an oxygen concentrator because he was not yet eligible for Medicare. Therefore, he had to go without oxygen. He stated that he was very lucky because his wife was able to drive from Las Vegas to Ely to bring backup oxygen to him. However, while waiting for his backup oxygen he only had albuterol and a nebulizer to keep his oxygen at safe levels. Thankfully, Mr. Horner stated that his breathing disability had not progressed to needing to be hospitalized. At that point, he realized that affordable health coverage was necessary for the educators and state workers that either had to retire, or could retire before Medicare eligible. As the next legislative session approached, he urged the Legislature to work to find a solution to this important issue. Teachers, educators and other state workers have given their lives to the state and deserved the best.

Harry Beall, board member, NSEA-R, and member of the Clark County Retired Education Association, stated that his wife began teaching elementary school in 1979, which was an important date to remember. After working 30 years as a teacher, and later as a school librarian, his wife retired a few years before reaching the age of 65. A few months before she turned 65, she went to the Social Security Office to sign up for Medicare. However, she left the Social Security Office in tears after being told she was not eligible because her employer never deducted Medicare taxes from her paycheck, which was a huge shock to them. He noted that his wife did not recall any member of the school district, or anyone in the school district's health plan, Teachers' Health Trust, informing her that she would not qualify for Medicare. Later, he discovered that his wife could enroll in Medicare through his work credits because they were married and she could "borrow" his credits to use for her Medicare insurance. Mr. Beall wondered why anyone would work for 30 years in the Clark County School District and not be eligible for Medicare.

Providing some history, Mr. Beall stated that Medicare payroll deductions began in 1966 for private or corporate employers, their employees, and people who were self-employed at that time. In 1983, federal employees started paying Medicare taxes. In 1986, newly hired state and local government employees started having Medicare payroll taxes withheld from their paychecks. In 1986, his wife had already spent seven years with the school district and she, like others who were hired before 1986, were "grandfathered" into the way payroll deductions were made on their previous paychecks, without Medicare deductions.

Mr. Beall wondered how many other employees similar to his wife would find out when they retired from the school district that they may not have any Medicare. The answer to that was unknown. However, PERS provided some raw data indicating that between 1977 and 1986, 414 employees were initially hired by a school district and were still active employees. He wondered if they were married to someone with enough credits to receive Medicare, or if they have enough odd jobs while they were teaching to earn credits. Lastly, Mr. Beall believed that no one should retire with their PERS benefits only to have an expensive monthly premium which basically penalized them for working in the public sector. He urged the Legislature to do something to help these people.

Linda Gingras, member, Clark County Educational Association-Retired, and Nevada State Education Association-Retired, in addition to a member of Sierra Health and Life-PPO Insurance for over two decades, stated that in 2007, her husband Arthur was diagnosed with a rare form of cancer, Gastrointestinal Stromal Tumors (GIST). After an immediate removal of one tumor, he was prescribed 400 mg of Gleevec, which was a pill form of chemotherapy to help manage his cancer. Ms. Gingras said her husband was advised that he would need to take Gleevec for the remainder of his life. Their group insurance, Sierra Health, paid for this costly medication until her husband lived longer than expected, an ugly reality of today's insurance system.

Ms. Gingras noted that her husband was known by the insurance company as ID#021206074-00. However, she stated that Arthur was much more than a mere number and she wanted to take a minute to introduce him to the Committee, not as a number but

as a survivor of cancer. Arthur is a husband, father, and grandfather of three handsome boys. He served in the United States Air Force, and is a 100 percent disabled veteran and Purple Heart recipient of the Vietnam conflict, which is where they understood he developed his cancer. Since his honorable discharge, Arthur has been an upstanding citizen as well as a productive contributor to society. Together, they have raised two university-educated children who are also productive citizens. In addition, Ms. Gingras stated they have always owned their own homes, and were employed taxpayers until their retirement. In the 40 years living in Las Vegas, she said they continuously volunteered for the betterment of others. These volunteer services included, but were not limited to the following: coaching soccer, baseball, and softball through community youth programs, and extracurricular activities with elementary, middle and high school students. In addition, they were instructors for senior self-improvement programs through the Osher Lifelong Learning Institute (OLLI) program at the University of Nevada, Las Vegas (UNLV), and were currently devoting more than 40 hours a month as first responders for the Trauma Intervention Program (TIP). She and her husband have always believed in going beyond the extra mile for others, and were now in need of companionate help of their own.

In June of 2007, Arthur went to the emergency room with flu-like symptoms that had plagued him for weeks. After many hours of tests and diagnoses, they were told he had two large masses – one in his lower abdomen and one on his liver. To correct these problems, the doctors surgically removed a part of his lower intestine requiring him to wear a drain in his liver for approximately one month. The final outcome of the tests showed he had a GIST tumor and would need a pill form of chemotherapy for the rest of his life.

Continuing, Ms. Gingras said that Arthur was introduced to Dr. Russell Gollard, a noted oncologist who prescribed 400 mg of Gleevec, 30 tablets per month. From July 2007 to September 2017 her husband did not experience any type of negative symptoms from the prescribed medication. During that time, he would have two computerized axial tomography (CAT) scans and one positron emission tomography (PET) scan, monthly blood draws, along with scheduled visits to Dr. Gollard four times a year. The scans, doctor visits and blood draws were ongoing. In September of 2017, Arthur was told by the insurance company that he would have to accept the generic drug Imatinib Mesylate 400 mg to replace the more costly Gleevec medication, which they were told was the same medication only a lower cost generic version. They agreed to the lower cost medication; however, in the 14-month period on the generic brand Arthur developed symptoms such as Tolosa Hunt Syndrome; upset stomach, vomiting and diarrhea; night sweats; pain and swelling in his joints; multiple cysts, resulting in surgical removal; bruising; fatigue and depression. Arthur contacted the manufacture of the generic pill to explain his symptoms and to discuss the reason he was experiencing those symptoms. The manufacture of the generic drug requested that he fill out some forms and talk with two of their technicians, which he did as requested. However, to date he has not heard back from anyone, even after several follow-up telephone calls requesting the information.

Ms. Gingras indicated, in doing their own research, they found that the generic brand contained 400 mg of Imatinib Mesylate. However, different binder elements were used, which may have caused the many problems he was experiencing. In discussions with Dr. Gollard, it was decided that it was medically necessary for Arthur to go back on Gleevec 400 mg. Arthur returned to Gleevec in December of 2017, and to date, has not experienced any of the mentioned symptoms. In January 2020, the insurance company once again advised Arthur to return to the generic brand because they would no longer pay for Gleevec. She stated that they were both PERS retirees paying a high fee for the privilege of remaining on the group insurance under the CCSD.

Ms. Gingras questioned why her husband would accept the generic brand when in the past it caused the aforementioned symptoms. His history showed that her husband was doing well on Gleevec for 122 months until the insurance company forced him to use the generic brand. Complying with the insurance company request, Arthur experienced serious health issues for 14 months, at which time the oncologist found it was medically necessary to put him back on Gleevec. Since his return to Gleevec, he has had no problems, or side effects in the last 12 months.

Concluding her presentation, Ms. Gingras stated, because one medication might work for many, it does not work for everyone. Insurance companies were only concerned with its bottom line of profits. Her husband simply lived too long on the right medication, Gleevec, and it became a problem to the profits for the insurance company. She wondered how much a life was worth and if Arthur was being a victim of death panels created by insurance companies to justify their inhumane treatments. She wondered if she would have to lose her husband of over 50 years because this death panel would not allow Gleevec. Lastly, Ms. Gingras stated that the medical field has learned how to treat and save her husband's life and the insurance company should let the medical field treat him properly.

Marlene Lockard, representing the Retired Public Employees of Nevada (RPEN) stated that she wanted to address the massive turnover and changes on the PEBP Board and leadership within the PEBP agency. She noted that because of the previous history with PEBP, she thought PEBP needed to stabilize the PEBP Board as quickly as possible and recruit knowledgeable board members with expertise in insurance and other fiscal issues. In addition, she wanted to address the continuing excess reserves that PEBP enjoyed since 2011 when dramatic changes to health insurance and benefit cuts were made. The continuation of the excess reserves indicated that premiums were too high and the cuts were too deep, and at some point that needed to be trued-up to restore the benefits that were cut in 2011. Ms. Lockard stated that an additional cut was made in 2011 to eliminate the early retirees from PEBP coverage. Therefore, there were the retirees of an age prior to being eligible for Medicare, which resulted in a gap and different tier of individuals currently hired after 2011, which was similar to the previous "orphan" issue. The people who retired before the age 65 would be another group from 2011 who were ineligible for insurance until Medicare eligible. Ms. Lockard said that rather than let the retiree issue accumulate over a period of years like the orphan issue, she thought it was important to

bring the issue of the elimination of the early retirees to the Committee's attention, so they could start looking at that gap and implement some remedial action.

Kent Ervin, representing the Nevada Faculty Alliance (NFA) stated that the NFA worked to empower the Nevada System of Higher Education (NSHE) to be fully engaged in the NFA mission to help students succeed. Being fully engaged for state employees required a robust benefits package that protected employees and their families and kept them healthy and on the job. He noted that NFA recognized that PEBP, its Board, and the Department of Administration have undergone some significant leadership changes recently. He welcomed Laura Rich, Interim Executive Officer, PEBP, and expressed appreciation for her willingness to engage with the employee advocates.

Continuing, Mr. Ervin stated that the level in fluctuations of the "so called" excess reserves continued to be an issue. The NFA applauded the PEBP Board, which at its meeting in January 2019 authorized a request for information (RFI) to determine the cost of an independent review of actuarial assumptions used by PEBP. He noted that a third-party actuarial review was overdue and important and PERS did such a review on a regular schedule. Over the past eight years, excess reserves were generated nearly every year. As of the close of FY 2019, the excess reserves were $26.9 million while total cash on hand increased by $7.0 million over the prior year, which was in contrast to the projections earlier in the biennium that excess reserves were to be spent down to near zero. Therefore, even with reserves being absorbed by the creation of a new EPO, self-funded, HMO-like option by supplemental contributions to the HSA, and by an uptick of high-cost claims in FY 2019, the excess reserves still accumulated. He asked the Committee to encourage PEBP to conduct the actuarial review because the RFI would determine the feasibility and costs of such a review. He noted that information would be critical to have in the 2021 Legislative Session to determine how to solve the problem and perhaps restore some of the benefits that were cut.

Mr. Ervin stated that the hiring of the independent actuary was not in the budget and may require one-time use of funds from excess reserves to be approved by the Interim Finance Committee. He indicated that NFA maintained that the continual accrual of new excess reserves meant that some of the benefits that have not been restored since the Great Recession could be restored without an increase in state funding. For example, the annual maximum for dental benefits was $1,500, the identical dollar amount in 1989, which he was aware of from his original hire benefits package from 1989. The dental maximum was still $1,500; however, dental price inflation increased prices over a factor of three in those three decades. He said that employees were delaying crowns and other major dental work to the next plan year, which caused a great risk for complications and harm to overall health.

Mr. Ervin thanked the Committee for allowing his testimony. He thought an auctorial review needed to be conducted during the interim so there was good information for the next legislative session.

Pricilla Maloney, representing American Federation of State, County and Municipal Employees (AFSCME) echoed the previous concerns and issues offered at the meeting. In addition, she noted that the PEBP Board was aware that there were a list of suggestions from the advocacy groups about building some increases in benefits that would restore the retirees back to the level of benefits before cuts were made in 2011. The items of concern were listed and voted on, and cost estimates for budgetary purposes would be provided by PEBP's current actuary, AON, and presented at the next PEBP Board meeting. She expressed that an independent review of the actuarial assumptions to true-up the excess reserves was needed by an independent third-party outside of the actuary that PEBP has been using since 2011. Concluding, Ms. Maloney said the utilization report in the meeting packet (Exhibit A) showed a decrease in the Medicare retiree population in claims on the dental plan. As stated earlier, if people do not have the money to get the appropriate dental care, sometimes it caused a false positive and fewer claims were reflected in the data. She noted that after the benefit cuts were made during the 2011 Legislative Session, there was a large decrease in the utilization rate once PEBP moved to a consumer-driven high deductible plan. However, when that happened, the question was, were people unable to afford the out-of-pocket costs for the necessary services. Ms. Maloney stated that PEBP needed to be careful that members were not filing claims because they were not utilizing benefits, which led to much bigger medical problems.

III. APPROVAL OF THE MINUTES OF THE DECEMBER 12, 2018, MEETING.

ASSEMBLYWOMAN CARLTON MOVED TO APPROVE THE MINUTES OF THE DECEMBER 12, 2018, MEETING OF THE INTERIM RETIREMENT AND BENEFITS COMMITTEE.

SENATOR DONDERO LOOP SECONDED THE MOTION. THE MOTION CARRIED UNANIMOUSLY.

IV. PUBLIC EMPLOYEES' RETIREMENT SYSTEM (PERS).

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

Tina Leiss, Executive Officer, Public Employees' Retirement System (PERS), directed the Committee to Agenda Item IV.1., beginning on page 40 of the meeting packet (Exhibit A). She introduced Steve Edmundson, Investment Officer, PERS.

Ms. Leiss stated that Agenda Item IV.1., outlined the executive staff salary modifications approved by the Retirement Board beginning Fiscal Year (FY) 2020 pending approval by the Interim Retirement and Benefits Committee (IRBC). She stated the proposed FY 2020 maximum salaries for all positions reflected the maximum salaries that were previously approved by the IRBC, with the addition of a 3 percent cost of living adjustment (COLA) approved by the 2019 Legislature for all state employees. The executive staff salary modifications reflected the reduction for the retirement contribution increase that went into effect July 1, 2019. If the salary increases set by the Retirement Board, pursuant to

NRS 286.160, were approved by the IRBC, the 3 percent COLA would be applied as of July 1, 2020. Pursuant to statute, the salaries were stated under the pre-tax contribution plan, the employer-pay plan. She stated the Retirement Board requested that the IRBC approve the maximum salaries shown on page 41 (Exhibit A) for Fiscal Years 2020 and 2021.

SENATOR KIECKHEFER MOVED TO APPROVE THE 3 PERCENT COST OF LIVING INCREASE FOR EXECUTIVE STAFF SALARIES OF THE PUBLIC EMPLOYEES' RETIREMENT SYSTEM FOR FISCAL YEARS 2020 AND 2021.

ASSEMBLYWOMAN CARLTON SECONDED THE MOTION. THE MOTION CARRIED UNANIMOUSLY.

2. Report on actuarial valuation for the Public Employees' Retirement System (PERS) as of June 30, 2019.

Ms. Leiss stated that Agenda Item IV.2., began on page 43 of the meeting packet (Exhibit A) and provided an update on the FY 2019 actuarial valuation for the Public Employees' Retirement System. She said, by statute, the System must perform an actuarial valuation at least every other year; however, the Retirement Board determined that annual actuarial valuations were appropriate to monitor the assets and liabilities associated with the pension plan. Per statute, the statutory contribution rates could only be adjusted on July 1 of odd-numbered calendar years (even-numbered fiscal years) based on the biennial actuarial valuation and report from the preceding year. The annual valuation report for FY 2019, ending June 30, 2019, was conducted during the interim between legislative sessions and was used to track trends, but did not affect contribution rates. To project the costs and liabilities of the System, assumptions (projected experience) were made about future events that could affect the amount and timing of benefit payments as well as the accumulated assets needed to pay those benefits. She explained, as part of the valuation process, actual experience was compared against projected experience and deviations were recognized as gains and losses in that years' experience. Each years' actual experience would impact the actuarial contribution rates and could impact the statutory rates that were set every two years. Ms. Leiss stated it was important to use appropriate assumptions in order to maintain adequate funding; therefore, by policy, the Board conducted an experience study through its actuary every four to six years. She noted the previous experience study was conducted in 2017, and that the next experience study may occur as early as 2021.

Ms. Leiss noted the charts on pages 46 and 47 (Exhibit A) showed the actuarially calculated contribution rates for FY 2019. The actuarially determined contribution rate for Regular active members under the employer pay contribution plan (EPC) was calculated at 29.65 percent compared to the current statutory rate of 29.25 percent. The actuarial rate for Police/Fire active members under the employer pay plan was calculated at 43.33 percent compared to the current statutory rate of 42.50 percent. The FY 2019 actuarial valuation results for the employee/employer contribution plans for both

Regular and Fire/Police members were similar to those on the employer pay plans. Since FY 2019 was a non-rate-setting year, there were no changes in the statutory rate. She noted that if it was a rate-setting year, the Regular fund rate would not have changed, but the Police/Fire fund rate would have increased. The ultimate impact to the statutory contribution rates would not be known until the FY 2020 valuation, and would depend on the actual experience through that date.

Moving to page 53 (Exhibit A), Ms. Leiss noted the chart showed PERS funded ratios for the last ten years based on the ratio of actuarial value of assets versus actuarial calculated liabilities. She indicated that PERS used the actuarial value of assets for funding purposes because it smoothed data over a five-year period to reduce or eliminate short-term volatility that could otherwise be seen in the market value of assets. The unfunded actuarial liability (UAL) included all projected benefit payments owed in the future for current members and retirees based on the Retirement Board's current adopted assumptions. The actuarial funded ratio for the Regular fund increased from 74.7 percent as of June 30, 2018, to 74.9 percent over the same reporting period in 2019, while the Police/Fire fund remained the same in both FY 2018 and 2019 at 76.5 percent, for a combined ratio of 75.3 percent in FY 2019. She noted that if PERS used the market value of assets for the ratio, the combined funded ratio would have been 76.5 percent in FY 2019 because of the $675 million in unrecognized gains.

Ms. Leiss referenced pages 54 and 55 (Exhibit A) and stated the market value of PERS assets as of June 30, 2019, totaled $44.1 billion compared to $41.3 billion as of June 30, 2018. She explained that the tables on pages 54 and 55 showed PERS value of assets and UAL for the last ten years on both actuarial and market value basis. The difference between the two showed the asset smoothing process and the reduced volatility over time, but ultimately reflected the same growth in PERS value of assets and UAL.

Assemblywoman Carlton stated, in the past, the Retirement Board had its actuary perform an experience study over a four-year period (2012 to 2016). She asked if a future experience study was planned to determine where the state was moving forward.

Ms. Leiss replied that the last study was conducted in FY 2017; therefore, the next study would be conducted in FY 2021 using data through June 30, 2021. The results would be presented to the Retirement Board in September, or October 2021 to be used in the valuation for FY 2021.

Senator Kieckhefer asked if the potential changes and actual contribution rate changes as a result of the experience study would be implemented for the 2023 Legislative Session.

Ms. Leiss replied that the Retirement Board previously conducted an experience study on a three to five-year cycle. However, it was changed to every four to six years because the Board liked to apply the assumption changes in a non-rate-setting year to see what the changes might do, and to provide fair warning of any possible changes. Essentially,

the results of the experience study would apply to the FY 2021 valuation, but the first time it would be applied to a rate-setting valuation would be the FY 2022 valuation to go into effect July 1, 2023.

Senator Kieckhefer asked if PERS evaluated return expectations at the same time as the experience study, and Ms. Leiss replied it was one of the assumptions that the Board always looked at during an experience study.

3. Report on actuarial valuation for the Judicial Retirement System as of June 30, 2019.

Ms. Leiss stated that page 57 (Exhibit A) provided an update on the FY 2019 actuarial valuation for the Judicial Retirement System (JRS). By policy, the Board performed an annual valuation to monitor the assets of liabilities associated with the JRS; however, similar to PERS, it was a non-rate-setting year for the JRS. Pursuant to NRS 1A.180 (5), the contribution rate was only adjusted based on an even-numbered year valuation (2018). The JRS covered state judges, municipal judges and justices of the peace of the local jurisdictions that have opted to participate in the JRS. She stated that, unlike PERS, the JRS was not a cost-sharing plan among the various employers, and that the valuation information provided was for the JRS as a whole. However, the participating local government employers had their own individual contribution rate and were valued on an individual jurisdiction basis. The actuarial contribution rate for JRS state judges, consisting of normal costs and administrative expenses, was 22.14 percent as of June 30, 2019, compared to the current statutory rate of 22.00 percent. The 2019 amortization payment for the state's unfunded actuarial accrued liability (UAAL) was not included in the calculated contribution rate, but was submitted to PERS annually by the Administrative Office of the Courts. The lump sum payments were due in July each year of the 2019-21 biennium and were based on the 2018 valuation. The calculated lump sum payment, which did not affect what the JRS paid to PERS, was slightly higher based on the 2019 valuation. The ratio of the actuarial value of assets to actuarial accrued liability remained at 91.8 percent on a total fund basis. Ms. Leiss stated that, although the UAAL increased from $11.3 million to $12.0 million, the UAAL was still below the $16.8 million that was calculated in 2017. The JRS made very good progress on its unfunded liability and the funded ratio was over 90 percent. Concluding her presentation, Ms. Leiss noted that pages 58 through 60 (Exhibit A) contained contribution and demographic information for the JRS.

Senator Kieckhefer asked the state's percentage of UAAL liability versus other government entities, and Ms. Leiss replied that, under the Governmental Accounting Standards Board (GASB) rules, accounting rules required a separate calculation for the state and all the various employers because the JRS was not a cost-sharing plan. She said, although she did not have that information in front of her, she believed the JRS state judges made up approximately 17 percent of the total UAAL. The total unfunded liability was calculated on a contribution basis so it would change each year. Ms. Leiss offered to research the exact number from the last calculation that was done and provide that information to the Committee through staff.

4. Report on actuarial valuation for the Legislators' Retirement System as of June 30, 2019.

Ms. Leiss continued with her presentation on page 63 (Exhibit A), Fiscal Year 2019 Actuarial Valuation for the Legislators' Retirement System (LRS). She noted that the even-numbered fiscal year valuation for the LRS determined the lump sum contribution made by the employer for each year of the biennium; therefore, the FY 2019 valuation would not affect the contributions made to the LRS. She reported that the FY 2019 valuation reflected a decrease in the amount of the actuarially calculated employer contribution compared to the FY 2018 valuation. The provisions of the LRS allowed legislators to participate, or opt out of participation in the System. The FY 2019 valuation showed that active memberships increased from 30 legislators to 35 legislators between July 1, 2018, and June 30, 2019. She noted the number of retirees remained the same at 56 members while the overall number of beneficiaries, including survivors, remained at 72 members. The actuarial funded ratio of the LRS increased from 90.5 percent to 95.8 percent for the FY 2019 valuation, and the unfunded actuarial accrued liability decreased from $493,622 to $201,528 primarily due to large gains in mortality and post-retirement offset by losses in other experience categories. Concluding her presentation, Ms. Leiss noted that page 64 (Exhibit A) displayed the year-over-year change in the demographic and financial information relative to active and retired members of the LRS.

5. Update on Investment Earnings - PERS, Legislators' Retirement and Judicial Retirement Funds.

Steve Edmundson, Investment Officer, PERS, directed the Committee to the table on page 69 of the meeting packet (Exhibit A) and provided a summary regarding investment portfolios for PERS, the LRS and the JRS. The first column detailed each system's performance through FY 2019. PERS generated an 8.5 percent return with $44.1 billion in assets in FY 2019, and produced an annualized return of slightly below 10.0 percent over the past decade, and 9.2 percent over the last 35 years since inception. The LRS fund generated an annualized return of 7.6 percent in FY 2019 with $4.8 million in assets. The JRS produced an annualized return in FY 2019 of 7.7 percent with an asset value of $133.4 million. Mr. Edmundson noted that due to the smaller size of the LRS and JRS portfolios, the composition of those assets were a little different than the larger PERS fund. He said PERS designed those portfolios to mimic the risk and return profile of the larger PERS portfolio and individual returns relative to PERS would bounce around a little; however, over the long term, the LRS and JRS returns were expected to generally line up with the larger PERS portfolio.

Continuing, Mr. Edmundson referenced the chart on page 70 (Exhibit A) that measured PERS investment returns over the last 35 fiscal years. He explained that the horizontal line across the middle of the page depicted PERS actuarial assumed rate or return, which was reduced from 8.0 percent to 7.5 percent in the fall of 2017, and was used as the actuarial assumption for long-term periods versus by fiscal year. In any single year, PERS expected to see a normal investment return ranging from negative 5.0 percent to positive

20.0 percent. Long-term investment returns were expected to average closer to 7.5 percent. He noted that PERS focused more on long-term investment returns.

Mr. Edmundson noted that, although the most recent valuation report was through FY 2019, ending June 30, 2019, his update included performance through the start of FY 2020. Currently, PERS portfolio was up about 9.0 percent with approximately $47.5 billion in assets. While the strong start to FY 2020 was definitely encouraging, it was not necessarily indicative of where the state would end the fiscal year with five months remaining. He noted that given current equity market valuations and absolute level of interest rates, in addition to the strong return environment over the last decade, it would not be surprising to see returns moderate somewhat over the near- to mid-term periods.

Concluding his presentation, Mr. Edmundson stated PERS investment strategy was unique in the industry and the fund embraced a simple approach relative to its larger public fund peers. He stated that PERS utilized a higher allocation to high quality, publically traded U.S. stocks and Government Treasury securities. In addition, the System used 100 percent indexed management across all public trading asset classes, so U.S. and international stock portfolios along with PERS fixed income allocation were 100 percent indexed. Likewise, PERS deliberately avoided exposure to complex investment strategies, such as hedge funds, derivatives, or the use of total fund leverage. PERS simple structure not only goes beyond the composition of the assets of the PERS portfolio, but extends into staff size as well. Mr. Edmundson indicated that he is currently the only Investment Officer employed at the System, whereas other public pension funds sizeable to PERS with approximately $40 billion to $50 billion in assets, employed approximately 12 to in excess of 20 investment staff members. Mr. Edmundson acknowledged that while there are advantages to a small staff size, there are also risks associated, especially with PERS approaching the $50 billion asset mark. Moving forward, the System will evaluate the need for an additional investment staff member given the asset level and the Board's ongoing succession planning. He believed the evaluation was prudent and warranted to maintain effective and efficient management of the investment program.

Mr. Edmundson stated that PERS simple approach has proven to be highly competitive relative to industry peers. PERS rate of return ranked in the top quartile, or better, of large public funds over the past 20 years. In addition, PERS investment costs were among the lowest in the industry due to its simple structure. PERS estimated average annual cost savings was approximately $170 million per year compared to a similar sized public plan. He emphasized that $170 million compounded over a decade equated to more than $2.0 billion in cost savings, and that keeping a low-cost plan was one of PERS competitive advantages relative to the rest of the industry.

Concluding, Mr. Edmundson said the PERS investment program was working as designed. He said PERS could not control the direction of the financial markets; therefore, considerable time was focused on the things it could control, such as

implementing a disciplined common sense investment strategy and keeping costs as low as possible, in an unwavering, disciple fashion.

Assemblywoman Miller acknowledged the low management costs due to the System utilizing index funds, and asked what the fee savings equated to per year for participants. Mr. Edmundson replied a calculation of the cost savings per member and beneficiary has not been done; however, PERS could provide a fee-savings estimate to the Committee through staff.

Senator Kieckhefer asked if statute required the PERS fund to be managed and invested for the sole purpose of maximizing returns for its members, and Mr. Edmundson concurred. He said, per statute, the System invested money in the PERS trust exclusively for the members and in the best economic interest of the members and beneficiaries of the System. He emphasized that PERS was not influenced by political or social issues.

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 explained that, pursuant to NRS 391.165, the board of trustees of each school district was required to purchase one-fifth of a year of retirement service for certain employees of the school district as an incentive to attract and retain those employees, page 81 (Exhibit A). She stated that Assembly Bill 1 (23rd Special Session) repealed NRS 191.165, effective July 1, 2007; however, anyone under contract prior to July 1, 2007, could elect to participate in the program until a full year of service had been purchased for them as long as they met the qualifications under NRS 191.165. She noted that because teachers moved in and out of positions, there were still a few members that qualified for this purchase; however, she expected the program to phase out soon. She explained that the chart on page 83 provided information on service credit purchases made in the Clark County and Churchill County school districts for calendar years 2018 and 2019. In 2019, the System received $339,720.13 for 61 purchases through calendar year 2019. Therefore, approximately 61 people were remaining that were still eligible for the benefit. Ms. Leiss noted that since inception of the program, the System received over $147.0 million for approximately 41,607 purchases.

7. Status report on critical labor shortage exemptions for PERS reemployment restrictions (NRS 286.523).

Ms. Leiss referred to page 85 (Exhibit A), NRS 286.523(6), Biennial Report on Critical Labor Shortage Designations. The report briefly outlined PERS normal reemployment restrictions for retirees of the System, as well as the reemployment exemption under NRS 286.523 that allowed retirees of the System to return to public employment for positions deemed by the governing body to be suffering from a critical labor shortage of qualified applicants. The designating authority is required to submit to the System its written findings that supports designation of the positions, which subsequently is compiled into a biennial report by the System and presented to the IRBC. A report on the compilation of the forms received from each designating authority that designated a

critical need position, effective July 1, 2017, to June 30, 2019, was illustrated on pages 87 through 90 (Exhibit A). Miss Leiss stated that Assembly Bill 488 (2009 Legislative Session) significantly revised the critical labor shortage exemption from the PERS reemployment provision. First, it declared that it was the policy of the state to ensure that reemployment of retired public employees was limited to positions of extreme need. It required public employers who seek to employ retired public employees for which there is a critical labor shortage to make that determination based upon the appropriate and necessary delivery of services to the public. In addition, it required the designating authority to hold a hearing in an open public meeting in order to determine a position as one of critical need. The critical labor shortage provisions in A.B. 488 were scheduled to sunset on June 30, 2015; however, Senate Bill 406 (2015 Legislative Session) removed the sunset. Effective for the period July 1, 2017, to June 30, 2019, there were 96 positions with critical labor shortage designations, including 5 positions designated by the state; 73 positions designated by school districts and charter schools; 7 positions by counties; 10 positions by hospitals; and 1 position by a water district, for a combined total of 32 public employers. Designated positions for which there is a critical labor shortage are valid for two years. To be redesignated, the designating authority must consider, and make new findings using the same process as the original designation to validate the criteria set forth to support the designation. Ms. Leiss clarified that the declaration of critical need was position driven, and not individual specific; therefore, one designation may cover multiple employees in a school district. For example, a school district could designate a special education position to cover all of those positions within that school district under the one designation. She reminded the Committee that not all critical labor shortage positions were filled with retired public employees and retirees only qualified when all other recruitment efforts have been exhausted.

Ms. Leiss reiterated that page 87 (Exhibit A) contained a list of all the positions currently designated as critical needs effective during the period of the report, along with the original date they were designated.

Assemblywoman Carlton asked if page 87 (Exhibit A) was a listing of all the people that were currently active in a critical need position.

Ms. Leiss replied that the spreadsheet on page 87 (Exhibit A) displayed all active critical labor shortage positions for the period July 1, 2017, through June 30, 2019, that could be filled by a retiree without suspension of their System benefits. However, that did not mean the designation was filled with a retiree. Ms. Leiss stated she was unaware if a position with the critical need designation was currently filled with a retiree.

Assemblywoman Carlton stated the list on page 87 (Exhibit A) showed the different positions that were designated to continue in a critical labor shortage designation; however, she did not see teachers on the list. She thought it would be good to know if there were teachers working in a critical labor shortage designation.

Senator Kieckhefer asked for the number of individuals who were receiving both a salary and a retirement benefit. He asked if retired state employees hired back under the critical labor designation provisions could augment their original retirement benefit through these additional years of service if they retired prior to completing 30 years of service.

Ms. Leiss stated as of the June 30, 2019, valuation date, there were 211 retired PERS members currently working in a critical labor shortage position. She noted when a retiree returned to work in a critical labor shortage position, they had the option to reenroll in the System. If the retiree opted to reenroll in the System, they would be under PERS reemployment retiree provisions, which meant they could accrue additional benefits. If they retired with maximum service credit, additional service time could not be accrued. In addition, depending on how long the retiree remained in the critical labor shortage position, it was possible to accrue a separate benefit, if eligible, or improve their existing benefit if they remained in the position for five years, depending on the status of their benefit when they retired.

Senator Kieckhefer stated that it seemed like an odd structure for a retired employee of the state to be able to return to work and reenroll in the System where they could improve both their salary and retirement benefit at the same time.

Ms. Leiss explained that it was the same structure as when a retiree suspends their benefit by returning to work in order to improve their retirement benefit. She emphasized that the critical labor shortage provision in NRS 286.523 is what reinstated the allowances under the System for the duration of that employment.

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

Mr. Edmundson stated that, by statute, the Retirement Benefits Investment Fund (RBIF) was managed by the Retirement Board solely as an investment vehicle for Nevada public employers who chose to participate in the program to fund other post-employment benefits. The decision to invest or withdraw from the program was solely up to each employer; therefore, in this respect, the structure was similar to how mutual funds were managed for individual investors. In FY 2019, the RBIF generated a return of 7.9 percent and experienced an annualized return of 6.6 percent since its inception in January 2008. Due to the fund's structure, the investment performance for each participating member of RBIF was dependent on their individual contribution date, so while the inception return for the program was 6.6 percent, it only represented the inception performance for the first investor of the plan. He noted employers that invested on different dates had different performance experiences in the program. The RBIF portfolio has grown considerably since its inception in FY 2008, and has only one participating employer with less than $16.0 million in total fund assets. Mr. Edmundson indicated that as of June 30, 2019, the RBIF had grown to 13 trusts established by participating local government entities with a sizable portfolio of $534.0 million in total assets.

Continuing, Mr. Edmundson stated that, because the PERS Board utilized 100 percent index management in the RBIF, and was able to take advantage of the multibillion dollar relationships that PERS maintained, the portfolio investment fees were low at approximately 1.3 basis points, and were approximately 97 percent lower relative to comparable investment programs of that size. He noted that statute required the RBIF to be managed in the same manner as PERS; however, due to its smaller asset size of $534.0 million versus the $44.1 billion in assets for PERS, there were some structural differences relative to the funds. However, the overall risk and return profile of the two portfolios remained identical. Over the last five years and since inception, the return of the RBIF portfolio was within 0.2 percent, or 20 basis points of the PERS fund, which confirmed the Board's success in meeting the statutory requirements for the RBIF.

9. Report on investments of money by PERS in scrutinized companies (NRS 286.723).

Mr. Edmundson stated that, pursuant to the reporting requirements outlined in Assembly Bill 493 of the 2009 Legislative Session, Nevada PERS was required to report any company affiliated with doing business with, or being scrutinized for doing business with the country of Iran. He noted it was a reporting requirement and not an investment-related requirement. He stated that as of December 31, 2019, PERS does not own stock in any company on the current list of companies that were scrutinized for doing business in or with the country of Iran.

10. Status report on the implementation of the new pension administration system authorized by the 2019 Legislature.

Ms. Leiss stated that Agenda Item IV.10., page 99 (Exhibit A), provided an update on the status of the new pension administration system replacement project. She stated there were no changes as of November 2019 and that PERS was proceeding with the timeline for the implementation plan and projected deployment. Ms. Leiss said that currently PERS was working on selecting a vendor and anticipated that the PERS Board would select a finalist at its February 2020 meeting. Upon selection of the vendor, PERS staff would begin finalizing contract negotiations. She noted that, subject to successful contract negotiations, PERS anticipated an April 2020 start date.

Chair Woodhouse asked if PERS experienced any issues that would cause a delay in the April 2020 start date for project implementation. Ms. Leiss replied that PERS does not expect any delays; however, contract negotiations have not been finalized.

Assemblywoman Miller asked if the vendor process and request for proposal (RFP) was open to the public. Ms. Leiss explained, although the System was not required to use the State Purchasing Division for its RFP programs, the System designed a procedure that paralleled the State Purchasing process and was essentially identical to what every state agency used for its RFP process. She indicated that it was a public process and there were limited vendors qualified to bid on the implementation plan. Ms. Leiss noted that PERS received the response it expected from the RFP, and reiterated that the process

was in accordance with the same rules and procedures as any RFP through the State Purchasing Division.

Senator Dondero Loop asked if the RFP process for vendor selection was put out for public bid in addition to its posting on the PERS website.

Ms. Leiss replied that PERS retained a project manager in accordance with generally accepted principles to provide data management services for the planning of the pension administration system project, and the decision was made for the System to conduct the RFP. She explained that typically the System did not use State Purchasing to contract services because of the unique way the statute was set up. The RFP notice was put out for PERS public meetings and posted on a website that was highly frequented by vendors qualified to bid on a public pension project of this nature. In addition, the RFP was available directly from the System for anyone who was interested.

V. PUBLIC EMPLOYEES' BENEFITS PROGRAM (PEBP).

Laura Rich, Interim Executive Officer, PEBP, introduced herself to the Committee, along with Cari Eaton, Chief Financial Officer, PEBP, and Stephanie Messier, Actuary, AON Consulting (AON). In addition, attending the meeting were Scott Syverson, AON, and Mark Thorlton, Health Plan of Nevada (HPN), who were available to answer questions from the Committee. Ms. Rich stated she would present a series of reports on the PEBP programs, including the audited financial statements; utilization of PEBP's plans; communication strategies for PEBP; actuarial valuation report; and an update on the Exclusive Provider Organization Plan (EPO) and its performance in PY 2019.

1. Report from independent certified public accountant regarding audited financial statements for the year ending June 30, 2019, pursuant to 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)

Ms. Rich stated that every year an audit of the Self Insurance Trust Fund and the State Retirees' Health and Welfare Benefits Fund was performed by Casey Neilon, page 111 (Exhibit A). The audit, which covered the period through June 30, 2019, assessed PEBP's financial statements to ensure it complied with generally accepted auditing principles and standards. She directed the Committee to page 140, which showed that no deficiencies were identified in internal controls in the report that were considered to be material weaknesses for the two funds. In addition, there were no instances of noncompliance, or other matters to be reported under *Government Auditing Standards.*

2. Report on utilization of PEBP by participants for the plan year ending June 30, 2019, including an assessment of the actuarial accuracy of reserves, pursuant to NRS 287.0425.

Ms. Rich referred the Committee to pages 164 and 165 (Exhibit A) displaying the Executive Summary for the Consumer Driven Health Plan (CDHP) and the PEBP Premier Plan (EPO). She would provide an update on the medical cost trends that were presented to the PEBP Board at its January 2020 meeting. She said the update was to the September 26, 2019, memorandum that was included in the meeting packet, page 163 (Exhibit A). Ms. Rich noted that the CDHP plan paid costs increased 6.5 percent in Plan Year (PY) 2019 for medical, pharmacy and dental combined. In PY 2018, PEBP experienced a 3.8 percent overall trend; prior to PY 2018 the trend was zero percent. She noted the Committee may recall that often PEBP presented at previous meetings that the trend for medical, pharmacy and dental combined was not normal and below the national average, which was not expected to continue. However, the trend normalized and was up to 6.5 percent, which was higher than PEBP expected. Ms. Rich stated that the trend for medical claims on the CDHP was 7.1 percent. Putting it into perspective, Ms. Rich noted there was a 0.2 percent trend in PY 2018, and prior to PY 2018, there was a negative 1.2 percent trend for medical claims, which was due to the many high cost claims on all three plans.

Continuing, Ms. Rich indicated that in PY 2018, pharmacy utilization reflected a 20.4 percent increase, normalizing to 7.1 percent in PY 2019, which was lower than expected. In PY 2018, PEBP made changes to the plan which shifted costs from the medical side to the pharmacy side contributing to the 20.4 percent trend in PY 2018. Therefore, PEBP was seeing more normal trends in PY 2019 on the pharmacy side.

Ms. Rich stated that utilization for enrollment on the CDHP, page 175 (Exhibit A), experienced an insignificant increase with approximately 700 people added to the plan. High cost claims increased by 20 percent with 198 high cost claims in PY 2019, compared to 164 high cost claims in PY 2018. She indicated a high cost claim for the CDHP were claims that were over $100,000. Health Plan of Nevada defined high cost claims as $50,000, and $100,000 for PEBP's CDHP. She added PEBP received email notifications when there were high cost claims, and to date, she has received three high cost claims, so there were a lot of high cost claims at this point in PY 2020. High costs claims contributed to 32 percent of the plan spend, which reflected a 20.7 increase. Referencing page 181 (Exhibit A), Inpatient Facility Utilization showed a variance from PY 2018 to PY 2019 with a 20 percent increase, which may look concerning; however, it was due to the length of stay for people in the hospital because PEBP was paying less per day and there were less admits per 1,000 members.

Ms. Rich said the Emergency Room and Urgent Care Summary, page 188 (Exhibit A) showed that emergency room visits were down, which was a national trend. However, urgent care was being utilized more. The national peer index showed that PEBP was in line with what other plans were experiencing. Page 194, Chronic Conditions Summary, showed an error on the page for chronic kidney disease and should be $7.0 million instead of $43.0 million. She said, it was important to note, there were approximately

43,000 members on the CDHP, and 13,316 of those members had at least one, or more chronic condition, which was almost one-third of the population. The cost per member type on the page showed members with a chronic condition were expensive. Ms. Rich indicated chronic conditions such as asthma, cancer, kidney disease, and COPD were very costly and the state had a high percentage of members with these conditions. Continuing, page 195 showed the pharmacy costs summary and members were paying 3.6 percent less than what they were paying in PY 2018, which was attributed to the preventive drug list that PEBP implemented. The preventive drug list had certain types of maintenance medications that allowed members to bypass their deductible and go straight into their coinsurance. Therefore, instead of paying for their prescription medication upfront until they met their deductible, members could utilize their 20 percent coinsurance for their medication, which likely contributed to that 3.6 percent decrease on the member side. Conversely, PEBP was paying more on the plan and reflected a 9 percent increase in pharmacy costs. She noted that PEBP was paying upfront for preventative medications hoping that it would eventually reduce high cost claims later on the medical side. Ms. Rich stated that, overall there was high utilization of specialty drugs, both on the CDHP and EPO, which was the most significant factor affecting the pharmacy costs on the CDHP.

Assemblywoman Miller stated page 192, Preventative Services Utilization and Compliance, showed members participating in preventative compliance services was below 50 percent. She expressed interest in understanding why members appeared to underutilize preventative services and whether it was due to members being covered by another plan within their household. She asked PEBP to provide a summary of the data that explained participant underutilization. Additionally, she asked how PEBP's preventive services utilization and compliance experience compared to national utilization and rates data. If national data was available for generally comparable high deductible health plans, she asked PEBP to provide those plans' experience for Plan Years 2017, 2018 and 2019.

Ms. Rich replied that she did not have the national preventative services compliance rates; however, that data would be easy to get and she would provide the data to the Committee through staff. She added that the preventative drug list has helped with pharmacy compliance. In addition, PEBP has implemented a series of things they hoped would increase compliance. During PY 2018 and PY 2019, PEBP incentivized preventative services by providing additional funding to participants' HSA and HRA for members who utilized preventative care services, such as an annual exam, routine lab work, a dental exam and cleaning, which provided an uptick in services. However, PEBP always struggled with members who were non-compliant. In addition, PEBP's third-party administrator distributed mailings about preventative services strategically targeted to specific populations. She said PEBP was continually striving to improve wellness care for its membership to try to increase compliance rates. She indicated that the financial incentive earnable for utilizing preventative services was eliminated in the 2019 Legislative Session.

Directing the Committee to page 198 (Exhibit A), Overview for the Exclusive Provider Organization (EPO), Ms. Rich indicated that the annualized plan cost per employee was 40.8 percent above the Health Scope Benefits (HSB) Book of Business Index. Ms. Rich noted that HSB, PEBP's third-party administrator does not have similar plans in their Book of Business, so the comparison was unfair, which she wanted to point out because the number was quite concerning. In 2019, PEBP replaced its Northern Nevada HMO through Hometown Health with a PEBP-managed EPO plan. The EPO was comparable to the HMO; the benefits were structured similarly with a copay model that closely mirrored the HMO. When the EPO was implemented, PEBP basically took the same benefits offered through Hometown Health and mirrored them for the EPO plan. Therefore, the members that went from the HMO plan to the EPO plan did not experience any differences in benefit plan design. Page 200 showed there were approximately 8,500 members on the EPO plan, similar to the membership on the previous HMO. She noted that there was not a lot of migration and members that were previously on the HMO stayed on the PEBP EPO plan. Ms. Rich indicated that high cost claimants were also an issue on the EPO plan. Given that the EPO was a PEBP-managed plan and the HMO plan in PY 2018 was run by a vendor, there was nothing to compare the plan against. She noted that the average high cost claim paid was $274,000 and on the CDHP it was approximately $219,000. Referencing page 205, Ms. Rich said that emergency room visits were fairly in line with the CDHP with 171 visits per 1,000 on the EPO; emergency room visits on the CDHP were 162 visits per 1,000. She added, typically the sicker population were on the EPO rather than the CDHP, so higher emergency room visits were expected on the EPO.

Ms. Rich stated that page 206 (Exhibit A) displayed the EPO network utilization. The network utilization was high at 98.3 percent because of the way the EPO was set up. The EPO was a regional plan and set up similarly to a HMO and members could only access services in their region outside of emergent situations. Page 207 showed that the clinical classifications on the EPO were fairly similar to those on the CDHP. The top four categories by claim type were diseases of the respiratory system, musculoskeletal system, circulatory system, and neoplasms such as cancer. Moving to page 213, preventive services compliance, Ms. Rich stated that HMO compliance was fairly similar to members on the CDHP. She indicated that PEBP was struggling with preventative services compliance and the rates of compliance ranged from 20 percent to 45 percent, depending on the type of compliance.

Moving to page 215 (Exhibit A), Ms. Rich noted the page displayed the Chronic Conditions Summary. As noted for the CDHP, one in three members on the EPO plan had at least one chronic condition, which was 40 percent of the population on the plan. Page 216 showed prescription costs and since there was nothing to compare against, PEBP was comparing the third quarter to the fourth quarter; therefore, the data was premature. PEBP saw a drop in pharmacy utilization from the third quarter to the fourth quarter. She noted that the costs displayed on the table do not include rebates, which were significant and would definitely reduce the numbers when applied.

Senator Kieckhefer asked the advantage of the EPO for the state and members. He asked if PEBP found the EPO plan cost effective from an administrative standpoint, and if it was able to utilize any potential savings to pass on to the benefit structure. Ms. Rich responded that PEBP would present the end-of-year evaluation report of the EPO under the last agenda item of the meeting. However, she noted the state and members experienced a significant savings on the EPO plan.

Continuing, Ms. Rich stated that the HMO was administered by Health Plan of Nevada (HPN) and was offered in Southern Nevada. She added that a representative of HPN was present at the meeting to answer any questions from the Committee. She noted the Quarterly Health Plan Performance Review, page 223 (Exhibit A) provided by HPN was updated with additional detailed information due to a request of the Committee. Referring to page 226 (Exhibit A) she noted that the HMO membership decreased approximately 1.5 percent to 6,700 membership for this period. Its risk factor decreased by 25.7 percent from the prior period, but was still 25.8 percent higher than peer. Additionally, the HMO had a sicklier population than what was seen on the CDHP. Page 227 showed net paid per member per month trend on the pharmacy increased 22.5 percent, which was a significant increase. Page 228 displayed the emergency room and urgent services for the HPN, which were similar to the CDHP and EPO. She stated that Health Plan of Nevada was seeing a decrease in emergency room utilization with stable urgent care utilization. Page 230 (Exhibit A) showed that high cost claimants on HPN, defined as claims over $50,000, increased but were not as high as the claims on the EPO and CDHP.

Assemblywoman Carlton stated the emergency room visits for the CDHP decreased, but urgent care visits increased. However, on the HMO plan, emergency room visits decreased and urgent care visits were fairly stable and only decreased a little. She asked if an analysis was done to see if members were more likely to use a primary care physician rather than going to urgent care.

Ms. Rich replied that because the HMO was run by HPN she did not have a lot of insight for the reason members were utilizing the different services. However, the national trend was people were utilizing urgent care services as opposed to emergency services. She noted that plan benefit design could help steer the services' members were utilizing, so it also depended on the cost of urgent care versus emergency services, which she thought was around $500 for an emergency room visit and less for urgent care. The model in Southern Nevada was a managed care model through HPN due to the health care environment in the Las Vegas area.

Stephanie Messier, AON, explained part of the HPN numbers for urgent care visits versus emergency room visits were due to the 1.2 percent decrease in membership. She said that page 228 (Exhibit A) showed HPN urgent care visits per 1,000 stayed relatively flat from the prior period with a 0.4 percent increase. Therefore, the decrease of 1.1 percent for urgent care visits was really a result of the membership decreasing, with flat urgent care utilization similar to the CDHP.

Assemblywoman Carlton asked if the membership decrease in the HMO was translating over to the CDHP, or was it translating to retirees entering Medicare, and Ms. Messier replied that it was a little of both. The CDHP reflected a slight increase in membership but some of that could be from new hires to the plan, as well as some members moving to Medicare.

Senator Dondero Loop asked if any of the figures were "skewed" because of the ability for members to go to a free-standing emergency room, or an urgent care facility, and Ms. Rich concurred and added that it was not happening just in Southern Nevada, but across the country. Ms. Rich agreed the free-standing facilities were increasing and people were utilizing those facilities more as opposed to the emergency room, or an urgent care facility.

Moving to the Incurred But Not Paid (IBNP) Liability and Catastrophic Reserve Actuarial Letter, page 235 (Exhibit A), Ms. Rich stated that each year AON actuaries developed an estimated IBNP, which was incurred but not paid liability. She said that IBNP reserves increased from $37.6 million at the end of FY 2018 to $58.8 million at the end of FY 2019. She indicated that $14.7 million of that increase was due to the implementation of the EPO plan, and the remaining $6.5 million went to increase the IBNR reserves, due to the increase in enrollment in the CDHP, in addition to an overall increase in claims. In addition, the claims processing speed also affected that number as well. Ms. Rich noted that because PEBP funds the IBNP reserves at a 95 percent confidence level, when claims grow they had to be funded and PEBP had to add to those funds; therefore, PEBP increased those IBNP reserves.

Chair Woodhouse asked if the PEBP Board had discussed benefit plan design changes moving forward that could result in plan design changes beyond PY 2021.

Ms. Rich replied that the Board addressed plan design changes in November 2019 and the changes approved were insignificant. She said that as part of the budget, PEBP addressed the possibilities of those changes. PEBP would conduct an analysis and costs for those plan design changes and the data would be presented to the PEBP Board in May. That data would then be included in PEBP's August 2020 agency budget request that was sent to Governor's Finance Office to become part of The Executive Budget.

3. Report on material provided generally to participants or prospective participants in connection with enrollment in PEBP for the plan year beginning July 1, 2019 (NRS 287.0425).

Ms. Rich referenced pages 241 to 254 (Exhibit A), the Public Employees' Benefits Program Communications Plan for Plan Year 2019. The communication plan described PEBP's approach and objectives for communication, strategic messaging, tools, tactics and measures for the outcomes. In addition to the typical plan documents that PEBP provided to its members there were benefit guides and other informational material available for members. Page 249, Communication Schedule, showed that PEBP had a significant number of mailings, in-person training and general outreach to its members.

Ms. Rich stated that, ultimately communication was vital, and members indicated that they desired more training and education. Therefore, PEBP has taken many measures to ensure it expanded education and communication with its members. She stated that communication has been a challenge even when PEBP provided mailings, email and everything it could to communicate with members. Some members do not look at their email messages and the message went directly to their trash, so there were definitely some challenges. However, PEBP has placed an emphasis on communication and expanded its program and staffing internally to address some of the issues, which has improved its communication with members.

In addition, PEBP partnered with PERS because it also experienced a change in leadership and they thought it was a good time to leverage their resources. She said PERS and PEBP shared a significant retiree population, so they partnered to provide better communication for retirees. She said anyone retiring from the state had a lot responsibility in terms of what they needed to do to receive their PEBP and PERS' benefits. Ms. Rich stated the PEBP was excited to work with PERS, and they were constantly looking for new ways to improve communication, provide training and education, because healthcare was confusing and was not something that the average person understood until they had to deal with it.

Assemblywoman Carlton asked the last time PEBP conducted an outreach to the retirees on the Medicare Exchange, because she had heard that it was hard to reach someone by phone and she was concerned with the turnaround time for member reimbursement.

Ms. Rich responded that she thought Assemblywoman Carlton was referring to Medicare VIA Benefits, which helped members choose the medical, prescription drug, dental and vision plans that fit their requirements and budget to make informed and confident benefit enrollment decisions. Previously, this benefit was offered by Towers Watson One Exchange, which was the Medicare Exchange. Members experienced problems with the Exchange and the Exchange was on a performance improvement plan and presented bimonthly updates to the Board. She noted that there has been an improvement and the issues that currently existed were largely because of legislation in place. Once a person elected not to participate in the Exchange and moved somewhere else to purchase a Medicare policy, many members could not return, and therefore, lose their benefits. State employees have a one-time return policy and non-state members, such as school districts, could not return to the plan and would lose their subsidy. She said that typically during the Medicare open enrollment period, there were plans that end and when they did, the participant needed to choose another plan through the Exchange. If members did not choose another plan through the Exchange and went directly through their carrier, they were reported as terminated. Ms. Rich said that once PEBP was aware of this issue it reached out to retirees through a phone call, via mail, or email in anticipation of the issue; however, not all members were reached. Some retirees were negatively affected and followed up with their representative, or the Office of the Governor to complain. She noted she had conversations with the Governor's Office on the issue and how it would be addressed it in the future.

4. Report on the July 1, 2018, actuarial valuation of post-employment health and welfare benefits provided by the State of Nevada, pursuant to Statement Number 75 of the Governmental Accounting Standards Board (GASB) for Fiscal Year 2019 (NRS 287.0425).

Scott Syverson, AON, stated that he would provide an overview on the June 30, 2019, actuarial valuation of post-employment health and welfare benefits provided by the State of Nevada, pursuant to Statement Number 75 of the Governmental Accounting Standards Board (GASB). He indicated that the results were summarized in the report, Tab V.4. (Exhibit A). He noted that per the GASB 75 rules, the June 30, 2019, valuation was a roll forward valuation and utilized the same census and plan provisions as the prior FY 2018 valuation. The valuation was an allowable method under GASB, which essentially allowed efficiencies in having to collect information on an annual basis versus every other year. The assumptions used in the valuation were largely the same as the assumptions used in the prior valuation. However, the one discount would be the discount rate, which was updated to reflect market conditions as of the measurement date. In that situation, the discount rate increased slightly from 2018 to 2019. With the change in discount rate, when there was a higher interest rate, there were reductions in liabilities of above $40.0 million. Other assumptions were largely the same and those assumptions would be updated for the next year valuation to be consistent with the most recent demographic assumptions used by PERS. The assumptions considered were mortality, retirement rates, withdrawal rates, and the assumptions that PERS used as developed with their actuaries. AON leveraged those assumptions as the populations were very similar, if not the same in certain situations. Mr. Syverson said it was an efficiency to utilize assumptions for the same purpose. He said another way to think of it was when a person retired and received a benefit from PERS, they would likely have the same probability of retiring, or continuing to work, as someone receiving a benefit under PEBP, so they wanted a consistent model between the two different valuations.

Moving to the total OPEB liability, Mr. Syverson stated that page 261 (Exhibit A) showed the liability increased approximately $25.0 million; from $1,301 billion on a net basis in FY 2018 to $1,324 billion on a total basis in FY 2019. The assumption changed the lower liabilities, and the other factors for the increase were due to benefit accruals of around $50.0 million for participants through working additional years of service, which earned benefits of approximately $50.0 million. The other increase was driven by time, value of money, and interest costs and the liability grew with interest each year around $50.0 million. Lastly, the liability itself decreased with the benefits that were paid each year of around $40.0 million in FY 2018.

5. Report on End-of-Year (Plan Year 2019) Evaluation of PEBP Exclusive Provider Option (EPO) Plan.

Ms. Rich stated that in PY 2017, PEBP was faced with potential 13 percent and 15 percent rate increases for both the Northern Nevada and Southern Nevada HMO plans. As a result, the PEBP Board approved the development and implementation of a PEBP

managed self-insured EPO organization, similar to the CDHP. The EPO plan was effective July 1, 2018, and first year data was now available. PEBP has completed a comparison of the benefit design, utilization and cost of the PY 2018 HMO plan as compared to the PY 2019 EPO plan. She noted the EPO plan only replaced the Northern Nevada HMO plan because once PEBP decided to implement the plan, Health Plan of Nevada (HPN) in Southern Nevada ultimately agreed to decrease rates by 8 percent for its members. Therefore, PEBP continued to offer HPN in Southern Nevada and only replaced the Northern Nevada HMO plan.

Continuing, Ms. Rich explained that the EPO and HMO plan had almost identical plan benefit designs. The EPO plan offered a better specialty prescription drug copay, so PEBP was able to lower the copay by 10 percent allowing members to receive a better benefit. In addition, PEBP added benefits, such as telemedicine, and the quality and cost comparison tool. The plan was identical to the previous HMO plan and the only differences were benefits to the members. She added that utilization on the EPO was lower than the HMO plan utilization. Ms. Rich referenced page 288 (Exhibit A) showing that enrollment in the EPO was steady and PEBP experienced very minimal migration from PY 2018 to PY 2019 with the loss of the Northern Nevada HMO and the addition of the PEBP EPO plan.

Moving to page 289 (Exhibit A), Ms. Rich stated that comparing the total HMO and EPO rates for PY 2019, the rate change on almost every tier was lower on the EPO plan. The tiers that were higher only changed by $1.37 to $2.50 depending on the tier of coverage, which was an insignificant amount. Members were paying less to be on the EPO than if they had remained on the HMO. Page 290 displayed the total HMO/EPO rates by comparing the actual versus the projected rate, so the HMO rate with the cost increases would have been what PEBP projected. The participant HMO/EPO premium rates for state employees and state retirees experienced a cost savings in every tier. Any rate changes to the PEBP plans had a direct effect on the contribution, which was a subsidy that was provided by the state. If PEBP did not implement the EPO plan and approved the HMO rate increases as presented, the state would have provided a total of $291.0 million for PY 2019. Ultimately, PEBP saved over $14.7 million in PY 2019 by implementing the EPO plan and not increasing the HMO rates. Ms. Rich noted that page 292 showed that the HMO cost analysis for PY 2020 was very similar and the unsubsidized total rates were much lower than what PEBP would had paid if it kept the HMO. In addition, the participant premiums were lower and in PY 2020, PEBP saved the state over $10.9 million by implementing the EPO plan and not increasing the HMO rates. In total, the switch to the EPO plan saved not only on the member side, but on the state side as well with $25.6 million in savings. Ms. Rich said that overall, PEBP believed it was a very good decision to move to the Northern Nevada EPO plan.

Senator Kieckhefer stated that he represented a lot of state employees and has not received any complaints from his constituents about the PEBP-managed EPO. He said financially, it seemed like a successful transition for the members and state. He asked if the apparent success of the EPO roll out made PEBP consider creating an EPO in conjunction to HPN in Southern Nevada. Ms. Rich replied that an actuarial analysis was

done on having a similar plan in Southern Nevada and the results would not be the same because of the environment in Southern Nevada. The same cost savings would not be realized with the managed care that existed through the United Health Care plan in Southern Nevada.

Assemblywoman Carlton stated it was not often to hear that the price of health care decreased. She asked the analysis that was done to determine the differences between the previous HMO and the services, access and utilization, verses what was currently on the PEBP-managed EPO keeping in mind there was only one year of data. She indicated there were similar numbers when PEBP switched to the CDHP, and three years later they found out it was because members were not going to the doctor. She asked where the EPO plan was actually saving money.

Ms. Rich replied the data provided for utilization was premature with only one year of the PEBP-managed EPO. She noted that PEBP was comparing the data to what PEBP would have paid given the 13 percent and 15 percent rate increases proposed at the time, versus what PEBP paid. Moving forward, the utilization and landscape could change like it was changing on the CDHP as well. The EPO plan was run differently than Hometown Health and many cost containment measures were taken into account. The previous HMO was a regional plan and the regional limitations were not necessarily being followed by the previous vendor. Therefore, since PEBP was implementing those rules and following them more to its plan documents, PEBP was able to do the cost containment measures and members were seeking service within the network instead of outside of the network. Since, PEBP has been able to put in cost containment measures and enforced the rules that should have been enforced, PEBP has seen better cost containment in the PEBP-managed EPO plan. However, the data was very premature and utilization would change and PEBP was watching the situation closely.

Assemblywoman Carlton stated that she was interested in seeing the change in the coinsurance amount, prescription drugs, and if participants were paying more out of pocket. She wanted to see the differentiation between generic and name brand drugs. In addition, she wanted to understand the changes made for participants, not just the cost savings, but what PEBP was actually providing to the members, because state employees have not received a pay raise in three years and finding money to actually go to doctor was the difference.

Ms. Rich responded that she could provide that information but noted that the pharmacy coinsurance benefit has been lowered throughout the years. Previously, the coinsurance was 40 percent and was now down to 20 percent to match the CDHP, so members were paying less on their coinsurance on the EPO versus the HMO.

Senator Kieckhefer asked if the cost of copayments for doctor and emergency room visits also changed. He believed the PEBP-run EPO plan was supposed to match, or mimic the CDHP, so that out-of-pocket costs would not spike dramatically like it did with the shift to the CDHP.

Ms. Rich stated that the coinsurance model was different depending on the type of services. For example, if a member was going to a primary care physician the copay could be $20.00. If a member was going to see a specialty physician there were different tiers and coinsurance costs for each one on that benefit plan. However, it was identical to the previous HMO plan.

Ms. Messier explained that the information in the report was mainly on a paid date basis. She said that actuaries liked to look at incurred dates and what people incurred in terms of services on the plan to get to Assemblywoman Carlton's concern whether people were getting the care needed. When looking at the EPO plan on an incurred date basis, as the trend was analyzed and looking forward to underwriting the plan for the March PEBP Board meeting, the actuaries were seeing that costs did not decrease to the extent the paid dates showed. Members moved to the Health Scope Benefits plan from Hometown Health paying those claims through June 30, 2019, and starting July 1, 2019, members moved to Health Scope Benefits, the TPA administer. Therefore, for the first few months Health Scope Benefits was not paying the claims, and when claims slowly started to trickle in there was not a lot of money going out, which caused a lag in payments. Thus, comparing the first 12 months of payments when moving from a fully insured plan to a self-funded plan there was a payment lag and with Health Scope Benefits there was up to a 60-day lag. Accordingly, it was similar to comparing an immature service calculation to a full 12-months, which was why there was the IBNR. Ms. Messier noted, when those were added together, there was not as large of a decrease as was seen from a paid date basis. She explained that there a little "hush" of services as people moved from one plan to another because they would seek a lot of services on the old plan, such as fill prescriptions before the new plan began. Therefore, there was a rush of services followed by a little hush, so there were probably some people who did not get as many services in July and August as they normally would, but would seek services in May and June. Ms. Messier said she did not think they should be concerned with what was seen in 2011 when people moved to the CDHP and a much larger increase in the deductible was seen, which scared members. If it cost $1,500 to go to a doctor, members would not go if they did not have the money. She did not think it was the same as what was seen with the EPO plan, and the numbers in the report were due to the payment mechanism. Ms. Messier noted, when looking at on an incurred basis, there was not as much of a decrease and it certainly saved the plan money. She said PEBP has done a good job of lamenting cost saving measures and she wanted to ensure that she was not illustrating that people were not going to the doctor and there was a 20 percent drop in utilization of services. The report indicated it was a pay-to-pay comparison and a truer actuarial comparison would be to look at incurred dates of services for utilization, which was an accurate measure of what happened to members on the plan.

VI. Public Comment.

There was no public comment.

VII. ADJOURNMENT.

The meeting was adjourned at 4:06 p.m.

Respectfully submitted,

_____
Donna Thomas, Committee Secretary

APPROVED:

_____
Senator Joyce Woodhouse, Chair

Date: _____