MINUTES OF THE
NEVADA LEGISLATURE'S
INTERIM RETIREMENT AND BENEFITS COMMITTEE
(*Nevada Revised Statutes* 218E.420)
December 16, 2020

The second meeting of the Nevada Legislature's Interim Retirement and Benefits Committee (IRBC) was held at 8:00 a.m., December 16, 2020, via videoconference. There was no physical location for the meeting pursuant to the Governor's Emergency Directive 006.

COMMITTEE MEMBERS PRESENT:

Senator Chris Brooks
Senator Marilyn Dondero Loop
Senator Ben Kieckhefer
Assemblywoman Maggie Carlton, Vice Chair
Assemblywoman Brittney Miller
Assemblyman Jim Wheeler
Senator Joyce Woodhouse, Chair (Term expired 11/3/2020)

STAFF MEMBERS PRESENT:

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
Bryan Fernley, Legislative Counsel, Legal Division
Donna Thomas, Committee Secretary, Fiscal Analysis Division

EXHIBITS:

Exhibit A: Agenda and Meeting Packet
Exhibit B: Written Testimony provided by Priscilla Maloney, representing American Federation of State, County and Municipal Employees (AFSCME)

I. ROLL CALL.

Vice Chair Carlton called the meeting to order at 8:08 a.m. Ms. Coffman called roll; all members were present.

II. PUBLIC COMMENT.

John Starkey, administrative faculty member, Nevada System of Higher Education (NSHE), stated that he reviewed the proposed changes to the medical benefits for NSHE employees for the upcoming years and was concerned with the changes. He noted, he had cystic fibrosis, a lung disease, and the medication for his disease was very expensive. Unfortunately, he had to go to the emergency room at least twice a year, to

the doctor at least once a month, and usually had surgery at least once a year because of his disease. He stated his concerns with the proposed changes to the medical plan because he was in the middle-class income range and had many medical appointments throughout the year due to his illness. Mr. Starkey said he worried about the proposed changes and the additional costs for medication, copays, emergency room charges and hospitalizations and believed he would be unable to afford the medications and medical care needed. As an employee of NSHE, he thought what was being proposed only hurt the sick people and benefited the healthy people, and the proposed changes scared him, especially financially.

Cameron Hopkins, state employee and member of American Federation of State, County and Municipal Employees (AFSCME) Local 441, expressed that he opposed the increase in premiums and cuts to benefits, which he believed would cause a burden to state employees. It was unfair to cut health care benefits, or ask state employees to pay more for less coverage during a global pandemic, especially after the numbers provided to the public in advance of meeting were different from the numbers presented at a recent PEBP Board meeting.

Jose Garcia, a concerned state employee, stated that he was a 24-year state employee and opposed the proposed changes to the state health insurance benefits and the increase in premiums. He noted, with the proposed changes and furloughs for state employees, many people would be adversely affected monetarily and unable to afford their homes. Mr. Garcia said, when he first starting working for the state, health insurance was free and slowly over the years has increased; the life insurance benefit decreased; and longevity pay was eliminated. The subsidy was removed for people who started with the state after 2010 and there was an age requirement for retirement unless an employee worked in state service for 33 1/3 years. In addition, there was also a reduction to the retirement amount, from 75% to 67%, depending on when employees were hired. He added that Nevada already had the lowest paid government workers and he wanted to show a clear picture of the substantial benefits that have been taken from state employees over the years. He noted that his three sons, in addition to relatives and friends, worked for the state because he did. He would often tell people how wonderful it was to be a state employee with good benefits. He was deeply concerned for his children, their families and friends because of the reduced benefits. State employees took a hard hit to their benefits during the last recession. He asked the Committee to consider exempting PEBP and PERS from the proposed reductions when making decisions for the future of the state in order to garner quality candidates to work and run the state. He added that when employees leave state employment, if would be difficult to hire new employees given the chipping away of health care benefits over the years.

Amber Morczek, academic faculty, Nevada State College, wanted to express her concern with the proposed budget and health care benefit cuts. Benefit cuts and premium increases were one of the most regressive ways to tax state employees to fill a revenue gap. She stated the cuts were definitely worse than furloughs as an average percentage of salary. Health care benefits for state employees were already lower than faculty at peer institutions, and the greatly increased out-of-pocket maximum on the

Consumer Driven Health Plan (CDHP) hurt people the most who had serious illnesses or chronic conditions. She understood the difficulties with rectifying the state budget but asked the Committee not to balance the budget on the back of state employees.

Cameron Hopkins, state employee and member of American Federation of State, County and Municipal Employees (AFSCME) Local 441, stated he testified earlier in the meeting and was disconnected. He wanted to add to his previous testimony and said that the PEBP Board was determined to vote on the budget cuts before the Economic Forum's report for December, because the Board feared the recommendations of the Forum would be bad. However, the December Economic Forum forecast report was far better than expected and the current numbers that the PEBP Board proposed do not reflect the reality, because the PEBP Board meeting was held before the Economic Forum numbers came in to avoid extra calamity. He was aware health care costs increase, but the increases would be devastating for families at a time when affordable health care was needed more than ever. Family members who lost their jobs during the pandemic would be crippled by the proposed increases. Additionally, PEBP should not be increasing its premiums during the COVID-10 crisis as families were facing personal economic challenges caused by the pandemic. He stated he was in high school during the last recession and was still seeing the effects. State employees have worked hard, and continued to care for and provide services to the community as they fight the pandemic and rebuild the community. He recognized some of the members from previous hearings and asked the Committee to think of the taxpayers as the employees of the State of Nevada were also taxpayers and any increases were functionally the same as a percentage income tax increase. Health services were currently stretched and he asked the Committee not to paralyze state workers by putting public service workers in the position to make tough choices about the health of their families.

Dr. Brittany Krueger, faculty member, Desert Research Institute (DRI) and secretary, DRI Faculty Senate, presenting on behalf of the DRI Faculty Senate, said she wanted to comment on the Agenda Item IV., The Proposed Changes to Public Employees Benefits Program. She stated as faculty members within NSHE, the members appreciated that the state was experiencing unprecedented budgetary challenges as the result of the ongoing pandemic, and understood there would be difficult decisions to make. While the faculty members were extremely grateful to maintain their employment during this time, they believed, unequivocally, that the Legislature and Governor should be making every effort possible to preserve health insurance benefits of employees during the public health crisis. She said that passing the burden of a revenue shortfall on to state employees was short-sided and further hindered the ability of the state to recover economically. By drastically cutting health benefits during a time when employees needed the benefits the most, and also imposing an increased financial burden to employees who were already being mandated to take furloughs, sent the message to public employees that they are neither valuable, nor important for economic resilience, which could not be further from the truth. Significant increases in premiums, deductibles, and especially out-of-pocket maximums would turn members' health insurance coverage into disaster only plans, which does little to offset the costs of regular and important health care. A particular concern was the fact that no provisions were included to ensure benefits

would be restored as budgetary constraints ease; thereby, effectively making the benefit cuts a permanent change in response to a temporary issue. In that regard, employees were also concerned about the impact the changes would have to retention and recruitment of employees in the coming years. Dr. Krueger expressed that employees strongly opposed the proposed cuts to PEBP benefits and asked the Legislature and Governor to consider a more nuanced approach to addressing the budgetary shortfall, one that avoids imposing health benefit reductions to employees during the public health crisis.

Jerry Beam, supervisor, National Guard Facility, Office of Military, stated that he has been employed with the state for eight years and has slowly watched the state chip away at employees' benefits and pay. He said state employees were categorically 20 to 30 percent under market for pay in their respective areas of work, whether custodial, maintenance, HVAC or supervisors. Approximately, six years ago, state employees received a survey via mail from PEBP to rate benefits by the least and most important to them, with a rating system of one to ten. After completing the survey, employees did not expect the repercussions of losing benefits. Previously, one of the main benefits of working for the state was for health insurance, which has progressively gotten worse over the years. He said that he interviewed people for positions and often people indicated that they did not want to work for the state anymore because the pay was terrible. Health insurance was previously a "shining star", and the cuts would become permanent without a provision to restore benefits. He said the state could not keep chipping away benefits when it was one of the highlights of working in the state. In addition, at a previous meeting, a retiree explained that she was going to be moved to the Silver State Health Exchange because she was no longer able to be on state health insurance. He stated that people were retiring and making life decisions based on state benefits, which should not be negotiable and should be steady during their employment.

Doug Unger, president, University of Nevada, Las Vegas (UNLV) Chapter, Nevada Facility Alliance, member of UNLV Employee Benefits Programs' Advisory Committee, thanked the Committee for its compassionate consideration to revisit and recommend changes to the proposed PEBP plan designs being reported at the meeting. He said that the new proposal put forward by PEBP was an all-eating chain and disregards more fair and comprised suggestions of employee advocates. The proposal means nothing less than the abandonment by Nevada to provide affordable health care and benefits to its employees and their families. The new proposal laid out a formerly high deductible plan now converted into a catastrophic health plan only; a new PPO that calls itself a PPO, which is really a substandard high deductible plan. In addition, the proposal offered a HMO option so costly with premiums and deductibles that it no longer meets the commonly accepted intentions of an HMO. PEBP seeks to balance the 12% budget reserve mandated from the Governor's Office almost entirely from the body of the sick by raising deductibles and out-of-pocket maximums in excess of 33%, which also raised premiums and meant that state employees facing medical crisis on the CDHP would pay more for their families. The other plans offered similarly unaffordable maximums. He said, imagine being a state employee facing cancer, heart surgery, taking specialty medications to stay alive, or a young state employee hoping to start a family and realizing

that doing was no longer affordable. He often told his students half-jokingly that everybody in Las Vegas were only two bad choices from ruining the rest of their lives, which should be wise advice for the world. The PEBP proposal presented at the meeting meant far too many state employees were only two bad luck events from abject poverty that would destroy their lives. A serious illness, child, or family member in trouble, or spouse losing their job would be devastating. Mr. Unger said the employees understand the state was in a budget crisis and they were willing to do their part through increased furloughs, if necessary, or the compromise many advocates suggest that would add a COVID-19 surcharge to premiums until the economy turned around. He asked the Committee to consider other reasonable alternatives and not let the Governor and Legislature be forever known as the ones who cut health care during a pandemic. He said that state employees would work with the Committee to get through this challenging time if only they could find another way to balance the budget.

Raven Summer, administrative faculty staff member, University of Nevada, Las Vegas (UNLV), with 16 years of service stated that she understood the challenging financial and public health issues occurring in the state. The state has been through an economic recession before, but this time the state was faced with the added impact of a global pandemic. While state employees are facing furloughs, which could continue through the next biennium, the proposed dramatic cuts to employees' access to health care was dangerous and causes further harm to their physical, emotional and mental health. The cuts to benefits from the previous recession were never restored. She indicated that she had a brain tumor, which is next to her left optical nerve and had to take out personal loans to help cover the out-of-pocket expenses for her surgery and radiation treatments, as well as her ongoing management for the tumor and optical nerve issues as a result of the tumor. Ms. Summer noted that every year she faced out-of-pocket expenses for her continued treatments, which piled up on top of her loan payments. In addition, she had other expenses that the insurance did not cover, such as the travel to the UCLA Medical Center because the state did not have the necessary specialists. Also, her vision care was not completely covered, which usually cost upwards of $1,500 a year on top of all the other expenses. Ms. Summer respectfully requested that the proposed cuts to health care benefits were reworked with the goal of providing access to the necessary health care that state employees needed to maintain a healthy and productive environment.

Janell Woodward, state employee and member American Federation of State, County and Municipal Employees (AFSCME) Local 4041, stated that she absolutely loved the work she did as a state employee in Emergency Management. Her job is extremely fulfilling and it is a lifetime dream to be able to help the state with mitigation. However, she opposed cuts or increases to the health and retirement benefits that employees have earned. While state employees know that health care costs increase, the proposed increases would be devastating to her as a cancer survivor. She noted that she was extremely concerned over the cuts in benefits and increased costs. She was still paying off medical bills from her original treatment and continued to add to them because of continued care and needed follow up, which was detrimental to her from the last round of cuts when PEBP changed the benefits. During the time of the global pandemic, it was unconscionable that PEBP would reduce benefits and increase costs. State employees

were already seeing cuts because of the lack of a diversified tax structure in the State of Nevada. She asked the Committee to think hard about the devastating effects from cuts to benefits while increasing costs, which would force many people to purchase insurance without being able to afford to use it, which could result in a death sentence to cancer survivors and those who ultimately were diagnosed with cancer. This financial situation is the very same thing that occurred with Obama Care, and as costs increased in the plan, people were unable to use the plan they were forced to purchase, which she knew from personal experience. Concluding her presentation, Ms. Woodward asked the Committee to consider putting state employees ahead of balancing a budget because it was the right thing to do.

Marlene Lockhard, representing the Retired Public Employees of Nevada (RPEN), stated that the Governor has appointed excellent new members to the PEBP Board. It was clear that the Board members would have probing questions and would independently evaluate the answers, which was good news for PEBP and the members participating in the plan. However, the Board meeting on November 23, 2020, was utter chaos, and decisions were made based on inaccurate data provided by AON. RPEN was requesting a review of that data and perhaps a complete redo of the evaluation. RPEN appreciated the difficult decisions that needed to be made with respect to the state budget and was aware that members would need to participate in the pain. However, budget cuts need to be made on accurate information and in a way that does not harm the fundamentals of the state health plan. Any cuts should be temporary and easily restored and she requested that new revenue sources be considered. Medicare retirees saved the state millions of dollars when they were removed from the system in 2011. She said another example was the unequal treatment and different tiers for retirees. Early retirees received the same allocation as Medicare retirees from the state, which was in the budget bill at the end of the session. Approximately $400 was allocated to PEBP for each retiree including Medicare retirees; however, PEBP does not have to pay any claims for Medicare retirees as they do for early retirees. Therefore, Medicare retirees were once again leaving money in the PEBP budget to be used elsewhere to offset other benefit costs. Concluding, Ms. Lockhard stated that RPEN has been asking for an audit of AON for a year, since their inaccurate estimate resulted in millions of excess reserves, now called differential cash. She urged the Committee to really look at, and evaluate, the new proposed cuts to state health care benefits.

Vice Chair Carlton stated that the Committee would hear public comment until 9:00 a.m., and then begin its meeting. She indicated that anyone that does not have the opportunity to testify before 9:00 a.m., could call back at the end of the meeting to make their public comment.

Priscilla Maloney, representing American Federation of State, County and Municipal Employees (AFSCME) stated that she submitted a written document that encapsulated her testimony, Exhibit B. She said that the Governor recently announced that all state agencies, including PEBP, would be required to cut budgets by at least 12% in anticipation of an upcoming budget crisis precipitated by a deep decline in state revenue caused by the public health crisis and the localized effect of the global COVID-19

pandemic. In light of steps already taken as proposals for cuts by PEBP and sent to the Governor's Finance Office (GFO), outlined in Agenda Item IV.1., the AFSCME retirees proposed some objections to the cuts. She noted the objections to the cuts and the underlying basic personnel fiscal philosophy that the proposals were built on are many. However, whenever there is a fiscal crisis in Nevada state government, the default was always to look to cuts to benefits for both active employees and retirees' state provided health care insurance, in combination with reductions in pay for active employees through furloughs, pay freezes and the like. As was already mentioned in previous testimony, cutting benefits was a dysfunctional way to govern if maintaining a robust workforce through recruitment and retention was a policy goal of the State of Nevada. In general, the state workforce has not recovered from the cuts in benefits and pay imposed over a decade ago in the 2009 Session. She stated it was important to stress that the advocacy groups have met multiple times with the Laura Rich, Executive Director, PEBP, and applauded her and her excellent staff for her proactive approach in always bringing all stakeholders to the table to facilitate open discussions. However, there was consensus that the proposal cutting benefits and increasing health care costs are opposed by all participating advocacy groups, both active and retired employees. Ms. Maloney noted that it is a crucially important for the AFSCME retirees' remarks as the bulk of the AFSCME membership is in the Medicare Exchange. For purposes of discussing the account funding Retired Employee Group Insurance (REGI), Medicare Eligible Exchange retirees, and non-Medicare retirees are insured differently even though the REGI funding account received the same appropriation per member retiree from the Legislature each budget cycle. The pre-Medicare retirees are those that are eligible for Medicare when they reach the age of 65. The non-Medicare retirees involved several groups as Nevada governments as employer were not paying into Medicare for several years after it was first created by Congress in 1965. Ms. Maloney stated, the important thing to understand was according to Senate Bill 550, there was a monthly appropriation for FY 2020 and FY 2021 of $478.15 per PEBP member regardless of which category the retiree was in, but the Medicare Exchange Retirees were capped at $260 a month per member for their HRA. Therefore, while combining risk and associated costs in an insurance pool of insureds is common, it is clear that the Medicare retirees are contributing on average well over $200 a month per member to the combined costs of the entire REGI account covering retirees.

Kevin Ranft, member AFSCME Local 4041, stated that he represented hard working state employees who were often working two to three positions, which would be no different during the economic downturn. He said AFSCME was very appreciative of the Committee's biannual review of PEBP. With respect to the PEBP and PERS Board, AFSCME understood there was a revenue shortfall due to the COVID-19 pandemic and the state was faced with various difficult decisions; however, state employees were concerned that the presentations that were being brought to the Committee would have extreme consequences that may leave many state employees and their families in financial debt. He said the AFSCME was opposed to the cuts to benefits totaling $36.0 million, which was unmanageable and was clearly being funded on the backs of state employees. Many employees live paycheck-to-paycheck and the $36.0 million in cuts was just a 12% proposal that PEBP has put together at the request of the Governor's

Office. Unfortunately, PEBP taking action and building their plan design at its November Board meeting was heartbreaking because PEBP basically told the Governor, no problem, it was okay to take the 12% and run with it, even though there were other options. Mr. Ranft strongly encouraged PEBP to look at other opportunities instead of balancing the shortfall on the backs of the employees. He said that everyone was aware that there was a retainment issue with state employees and benefits paid a big part in peoples' decisions to work for the state, or to stay employed with the state. He said the Committee could utilize this opportunity to understand and prioritize what needs to be done because affordable and quality health insurance made a big difference for state employees and their families. He said that AFSCME requested that PEBP have additional discussions with the Governor's Office explaining the hardship that state employees would face and to reevaluate the design plan passed in November. He said it was stated that PEBP had no choice and had to build a plan design in November of 2020, but the employees were aware that PEBP has delayed open enrollment in the past to make appropriate changes to the plan design and there was still time to make things right. Further, the employees called on the Governor and legislative leaders on both sides of the isle to find new revenue sources and fund the state equally across the board. In regards to PERS, employees respectful ask PERS to reconsider imposing a rate increase to take effect July 1, 2021, because an increase of one-quarter percent for regular members and three-quarter percent for Police/Fire was unacceptable. Employees were aware that PERS has numerous options to reassess these increases and the state and local governments and its employees cannot afford these increases during the COVID-19 pandemic. Mr. Ranft asked PERS to temporarily postpone paying down the unfunded liability for two years and look at other options to prevent an increase in insurance premiums during the current economic conditions.

Julie Balderson, stated that she was a current state employee along with her spouse, and they were the millennials that people heard about who have delayed major life decisions, such as starting a family, purchasing a home and limiting the number of children they had based on health care costs and concerns for their uncertain income. She asked PEBP to consider that state workers were preparing for furloughs in a few weeks, along with a reduction in health care benefits and increases to premiums, which was wrong especially during a pandemic. She noted that PEBP should be exempt from the Governor's recommended budget reduction and the Legislature had the opportunity to correct the Governor's mistake. She sincerely hoped the Committee took the opportunity to stand up for state workers who were keeping essential government programs working when Nevadans needed them the most and who were already being thanked with their service with pay cuts in the foreseeable future.

Kent Ervin, representing the Nevada Faculty Alliance (NFA), independent association of faculty at the Nevada System of Higher Education (NSHE) institutions statewide, stated that the draconian cuts to benefits and increases in employee premiums for PEBP was unacceptable to fix general revenue problems with the regressive tax just on state employees. He echoed the comments of earlier presenters as far as the various plan design issues and how the high deductible and out-of-pocket costs would hurt the sickly employees who needed health care to keep productive in their jobs. He stated, for over

a year employee advocates have been asking for an audit of the actuarial assumptions and methods used by PEBP and AON, who has been the contracted actuary for PEBP for decades. He added that PERS has a long-term actuary, but would regularly seek second opinions from independent actuaries, which PEBP has never done. The cost would be about $100,000 compared to the millions of dollars in fluctuating excess reserves and now the projected deficit. He said the audit was a small price to pay to determine whether best practices were being followed. He believed that PEBP should be directed to obtain a second actuarial opinion. He asked the Committee to keep in mind that the benefits cuts approved in November by PEBP would be "baked" into the next fiscal year's plan design long before budgets are finalized during the legislative session when it would be too late to change anything. Premium increases that were necessary should be characterized as a temporary COVID-19 surcharge with a sunset when the economy approved. One proposed change to the plan was the unfair differential premiums for dependent children. He referenced the chart in the meeting packet, Exhibit A, page 40, which showed a premium of $94 per month for a single parent to add coverage for children versus $53 per month for adding children in a two-parent household, and the discriminatory treatment on the basis of the status of family was wrong. He noted that he mentioned it primarily because the information provided to PEBP was insufficient to realize what they were doing. Although the advocates supported the introduction of the third new low deductible plan as proposed, it had a deductible that was more than the previous CDHP deductible as of the beginning of the biennium after the HSA contribution, so it was not really a low deductible plan at all. Concluding his remarks, Mr. Ervin stated that the Legislature and the Governor need to find other methods, including revenue, to fix the budget shortfall.

Vice Chair Carlton thanked the presenters and clarified that the changes to plan designs were proposed changes that would be provided to the Governor for his budget. She added that the IRBC does not take action on the agenda items presented at the meeting and would review the agenda items and ask questions of the agencies during the 2021 Legislative Session.

III. APPROVAL OF THE MINUTES OF THE FEBRUARY 5, 2020, MEETING.

ASSEMBLYMAN WHEELER MOVED TO APPROVE THE MINUTES OF THE FEBRUARY 5, 2020, MEETING OF THE INTERIM RETIREMENT AND BENEFITS COMMITTEE.

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

Senator Brooks stated that he would abstain from voting on the approval of the minutes since he was not present at the IRBC meeting on February 5, 2020.

Ms. Coffman took a roll call vote for approval of the minutes from the February 5, 2020, meeting. The motion carried unanimously.

V. PUBLIC EMPLOYEES' BENEFITS PROGRAM (PEBP).

1. Presentation on the health (medical, pharmacy, dental), life and disability insurance plan design and policy changes considered, and adopted, by the Board of the Public Employees' Benefits Program for the plan year that begins on July 1, 2021 (PY 2022).

Laura Rich, Executive Officer, Public Employees' Benefit Program (PEBP), introduced herself to the Committee, along with Cari Eaton, Chief Financial Officer, PEBP; Stephanie Messier, Actuary, AON Consulting (AON); and Scott Syverson, also from AON, who would also be presenting at the meeting.

Ms. Rich noted that on the agenda for the meeting were a series of reports from PEBP that provided a synopsis of the performance of the plan and agency operations from the previous plan year. However, she thought it would be important to include a new report that has not been previously presented to the Committee. She indicated the first report, Agenda Item IV.1., was a presentation on the plan design changes considered, and adopted, by the PEBP Board for Plan Year 2022. She referenced page 35, Exhibit A, and stated, typically, the Committee was not updated on program and policy changes moving forward, but she thought it would be beneficial for the Committee to receive an update on where the program was today given the current economic situation in the state. She stated when she was appointed as the Executive Officer of PEBP in March of 2020, utilization and costs were creeping up, and PEBP was projected to burn through excess reserves by the end of the plan year. However, soon after the global pandemic occurred everything changed. In April of 2020, agencies were asked to submit budget reserves proposals of 4% for FY 2020 with an additional 6%, 10% and 14% proposed cuts for FY 2021. Realizing it was too late in the plan year to make benefit changes, the Governor's Finance Office (GFO) exempted PEBP from the FY 2020 budget cuts but requested a 6% budget reserve proposal, which was approximately $24.5 million for PEBP for FY 2021. Given that plan design, rates and all open enrollment material had already been finalized, PEBP was very limited in options as to how it would come up with the 6% budget reserve proposal. In the end, PEBP was able to come up with a 6% cut by reducing the required reserve levels, which freed up one-time funding. PEBP reduced the Health Reimbursement Arrangement (HRA) reserve levels from 100% to 80%, because the likelihood that members were going to use their HRA balances all at once was slim. Therefore, PEBP thought reducing the reserve levels to the 80% level was safe. In addition, PEBP implemented the Medicare HRA balance cap of $8,000 because many of the retirees were not using their Medicare HRA balances. Additionally, PEBP reduced catastrophic reserve levels from a 95% confidence level to 50 days on hand, which freed up a significant amount of cash and the one-time funding as well. PEBP also had some savings from pharmacy contract adjustments and programs that PEBP implemented, which were the first round of decisions made by the Board in April 2020.

Assemblyman Wheeler asked the actual confidence level if the reduction of the catastrophic reserves were reduced from a 95% confidence level to 50 days on hand, because he was unsure how one equated to the other.

Responding to Assemblyman Wheeler, Ms. Rich replied that was a question she asked the actuaries as well, and essentially the reduction was a different methodology, so it did not equate, and was basically a more standard actuarial methodology for the catastrophic reserves. She said the 50 days on hand was enough to cover a catastrophic event for 50 days.

Assemblyman Wheeler asked how PEBP would see a $7.0 million savings by just using a different accounting methodology, and where the $7.0 million came from.

Ms. Rich replied, to put it in simple terms, PEBP had a large safety net in reserves, which was reduced. Therefore, by using the different methodology, some money was freed up. PEBP was no longer required to keep as much reserve and able to reduce some of the reserve, so that safety net became a little smaller, which freed up the $7.0 million. She added it was a one-time shot of freeing up the funding, because the reserve was only reduced one time, so the funding was coming from that reduction.

Vice Chair Carlton asked about the cap of $8,000 for the Medicare Exchange members, because previously, members who did not use their HRA balances during the plan year were allowed to roll their balance over to the next year. Therefore, by not using the money those members ended up accruing larger balances over the years, which could be used in a catastrophic event. However, PEBP implemented a cap of $8,000, and members would be reset to an $8,000 balance each year, so essentially, PEBP was taking money back from members who saved it over the years.

Ms. Rich confirmed that Vice Chair Carlton was correct. She said, when PEBP did the analysis, it found a large number of members had never touched their HRA balances since PEBP moved to the Exchange in 2011. Additionally, it only affected the members on the Medicare Exchange, so for the most part it was different from the PEBP plans because there were deductibles and much higher out-of-pocket expenses. The Medicare Exchange retirees were not the “on the hook” for those high out-of-pocket expenses because they paid premiums, which covered the majority of their medical costs. However, that was not to say all of their medical costs were covered, because there were costs associated with Medicare plans that were not covered. For example, a hearing aid would not be covered through a Medicare plan so people might want to use their HRA funds for the hearing aid. She said it was not to say that members do not use their savings, or to minimize the need for it, but PEBP had to look at all options and it was one of the least impactful options it had at the time, which was why the PEBP Board chose to implement the $8,000 cap.

Vice Chair Carlton stated, she respectfully disagreed that the Medicare HRA balance cap reduction was a savings for PEBP, and it took $5.4 million from state employees who had saved that money. In the future, when having the final discussions, she wanted to know how many members were impacted and the amount of money the impact had on those members. She said in essence, the savings was a benefit for state retirees and the state was taking the money back. In addition, she thought the Governor’s Office would probably want to know the amount retirees were losing. She believed there would be

interest in more detail in the future, because members made decisions based on the money. She said state employees had a plan for their money and because they let the money sit in their account, the state was essentially taking it back because it had not been used. She was unsure if the $8,000 cap was correct and there may be a better level to discuss in the future. She added the issue would be reviewed in the Governor's budget cycle before it gets to the Legislature and she looked forward to seeing how the issue evolved during the upcoming legislative session.

Ms. Rich moved to the Fiscal Year 2022 and 2023 Agency Budget Request, page 36, Exhibit A, and stated that prior to the pandemic, the GFO released its budget kickoff directives for agencies, which included instructions to use flat budgeting (2x FY 2021 cap). Because of trend, flat budgeting for PEBP was essentially a cut of approximately 5%. In order to meet the directive, PEBP knew it had to reduce benefit levels. PEBP decided to move up its annual strategic planning event to May 2020, which typically did not occur until September. PEBP staff, partners, and several board members convened to discuss strategies and consider innovative solutions that would reduce the direct member impact and maintain affordable access to care.

Continuing, Ms. Rich stated that knowing potential policy and plan changes would need to be built into the agency request budgets, the results of the strategic planning were presented at the July 23, 2020, PEBP Board meeting. Referencing page 37, Exhibit A, she noted the PEBP Board made significant plan design decisions at the July meeting. The first change was modification to benefit design of existing plans. The Consumer Driven Health Plan (CDHP), Premier Plan (EPO)/Health Maintenance Organization (HMO) were modified and a new middle tier, low deductible, copay-based plan was introduced. Additionally, the underwriting of all the self-funded plans into a single risk pool was approved, which was one of several items the PEBP Board approved in order to afford more actuarially sound practices in the plan. By underwriting self-funded plans together, PEBP essentially eliminated the plan "death spirals", a situation that occurred when a less healthy population or overly large risk pools moved to, or away from a specific plan. Hence, by underwriting plans as a single risk pool, it essentially neutralized the impact from a single high-cost claimant on any given plan. If a person had a high-cost of care and moved from one plan to another, it does not impact the plan and PEBP was not dependent on where the person was in the plan selection. In addition, PEBP implemented a single contribution strategy. When the CDHP was introduced, the intent was to price the HMO and CDHP plans so that the total out-of-pocket expenses (premiums and copays) were equivalent. However, in later years, that concept was not maintained and PEBP started to essentially prefer one plan over another. Therefore, applying a single contribution strategy consistently across all plans allowed PEBP to make stable budget projections because it was no longer dependent on participant plan selections. As a result, every participant, regardless of the plan they were on, would receive the same contribution strategy and the same flat dollar amount regardless of the plan chosen. In addition, PEBP changed the HSA/HRA funding to a single amount for employees. Currently, PEBP funded the CDHP with HSA/HRA contributions in different levels, so it was funded by a base amount and then there was additional funding based on the number of dependents. However, it caused some difficulties for PEBP because it had to guess

what that number was going to be and what to budget for dependents. Typically, PEBP knew the number of employees it had, but dependents were more of a guess. Therefore, the Board chose to apply HSA/HRA funding per employee regardless of tier. Ms. Rich said that PEBP made a decision to streamline tier factors, which was another decision that made the plan more actuarially sound and moved the plan toward more of the industry standards. Historically, PEBP received claim estimates from AON that were tiered-based on medical and pharmacy experience. AON provided rates based on the experience and tier plan, and then PEBP added on what was referred to as "administrative load", or administrative costs of the program that were built into the rates. Previously, AON was not part of the administrative loading process, so AON provided the actuarial sound rates and PEBP added to the rates, which then made the rates not actuarial sound. Therefore, to correct it, PEBP used AON to ensure the administrative load was correctly built into the overall rates to ensure the rates PEBP used were actuarially sound rates.

Lastly, Ms. Rich stated that although not technically a policy change, the Board voted to adjust how pharmacy rebates were showing. Previously, PEBP used the pharmacy rebates to offset administrative costs; however, moving forward PEBP would be working with the GFO to ensure the rebates were moved into the claims category to provide a more accurate reflection of the underwriting of the claims' calculations.

Vice Chair Carlton said she had questions pertaining to the proposal for a new low deductible plan and the need to understand what that actually meant and how participants reached the deductible, because it seemed like a mishmash between a per visit and HMO-type structure. She asked Ms. Rich to elaborate on the addition of the low deductible PPO plan so the Committee had a better understanding of the choices. In addition, she asked about separating out dental because she did not want to see dental benefits not included in the plans, or there would be no option for dental, or it was too expensive of an option.

Ms. Rich replied that the dental portion of benefits would be discussed later in her presentation. She was trying to present the information chronologically up until the November 20, 2020, PEBP Board meeting. She said, knowing that PEBP had to make budget cuts even before the 12% cut was implemented, based on flat budget, it would equate to approximately 5% cut for PEBP because of trend. PEBP had to look at the plan design knowing those cuts would be painful especially for the people on the CDHP. PEBP would have to raise the deductibles and possibly reduce HSA funding among other things. Therefore, PEBP wanted to minimize that cut, or minimize the impact as much as possible. Ms. Rich said that during strategic planning there was discussion about a new low deductible copay plan, because it was something that members have requested because the high deductible was not for everybody, just as the HMO is not for everybody. The low deductible plan was a middle plan that was based on copays, so for the most part anytime the plan was used, the member would be paying a copay and not meeting a deductible. A primary care doctor office visit was $30; a specialist visit was $50; therefore, it was copay based. Referencing the grid on page 40, Exhibit A, Ms. Rich stated the only time the deductible applied was for anything that was not on the grid on the page. For example, if a participant needed imaging, the deductible was applied, or

an inpatient hospital visit was 20% after the deducible was applied, so the plan was similar to a hybrid plan and introduced choice for members. She noted that every member was in a different financial or health situation, so PEBP wanted to introduce choice and the plan was more a of middle-level plan. Therefore, if a member was a 25-year old single male with no health issues who never went to the doctor, that member would want the cheapest plan possible to cover his medical needs. The member would probably choose the CDHP because it had the low premium. Since the member does not expect to have any major medical expenses, the CDHP seemed to be a good choice. However, in the future, if he got married and had children with frequent visits to the doctor, all of sudden the out-of-pocket costs were a burden. The new copay plan may become more palatable, and members were more willing to pay the higher premium to leverage their copays, knowing it would only be $30 for a doctor visit, or $50 to go to a specialist. In addition, there were the other groups of people who were sicklier, and aware of the high out-of-pocket costs and those people wanted to rely on the cost per month, and what they paid to see a doctor. The sicker participants would want a plan where they did not have to meet a deductible, or there was a low deductible, and those people wanted to be able to plan and have the consistency of just paying their monthly out-of-pocket premium knowing that when they went to the doctor they were not going to have those high out-of-pocket expenses.

Vice Chair Carlton said it was her understanding that the copays went toward the participants' deductible and if a person went to see a specialized doctor ten times, which was $500, it would not go toward the deductible, and Ms. Rich agreed and said the money was applied to the out-of-pocket maximum. Vice Chair Carlton said, the left side of the chart on page 40 showed that the participant paid 20% after the deductible was paid, but not what went toward the deductible and the amount of the 20%. She said it could get complicated and it was hard to know the actual impact to families without going through different scenarios. It seemed if a participant was paying for an office visit it was not going toward the deductible. However, the participant was paying more every month for the plan, and was now paying for the office visit, in addition to other doctor visits, and none of those payments went toward the deductible. She was unsure how participants would meet their deductible under that scenario. Due to the current situation of the state, she thought state employees would look for the best option and the new low deductible plan might be more appealing because of the cost per month. However, she wondered if the plan would have enough overage to protect families if something happened down the road.

Mr. Rich stated, if a participant or family member paid $1,000 for a hospital visit, the participant would pay 20% of the $1,000, or $200, which was applied to their deductible.

Senator Kieckhefer asked Ms. Rich if an assessment was conducted to determine what PEBP anticipated in terms of migration of members to the new plan and what it meant for the other benefit plans.

Ms. Rich replied that Stephanie Messier, Actuary, AON Consulting, would address the assessment because it was an actuarial function. However, she believed that the assumption was that PEBP would see a 50% migration of members to the new plan.

Ms. Messier stated, a new copay plan was implemented on July 1, 2020, in a state similar to Nevada, and AON's original thought was that 50% of members would migrate to the new plan. She noted that AON wanted to be mindful of the fact that the high deductible health plans caused a lot of stress on many families, and therefore, AON wanted to provide families access to a copay plan so participants were no longer paying $200 to $300 for a doctor's visit. Under the new copay plan, members would pay $30 for a doctor's visit rather than getting a large unknown bill from their doctor on the high deductible health plan. She said that based on her experience with the state that recently implemented a similar plan, 50% of the participants left the cheapest plan for the new copay plan. She said AON's original assumption was that Nevada would see similar results; however, that assumption was made before the additional budget cuts were implemented, and peoples' choices were highly correlated to what they paid out of their payroll for health care benefits. Looking at the plan differential at the bottom of the grid, page 40, Exhibit A, AON changed its assumptions after the additional budget cuts were implemented, and thought only 25% of participants would be able to pick up that additional cost and move into the plan. Conversely, there were members that were picking up the employee plus child tier on the EPO plan. Given the savings the employee would see by moving to the low deductible PPO plan, some people might migrate out of that particular plan because they could save almost $100 per month. She noted the difference was the new plan offered out-of-network benefits and had a higher copay of $30 versus paying $20 for a doctor's visit on the current EPO. In addition, the other benefit for the middle plan was the pharmacy and prescriptions benefits, which would be a benefit to employees if they were trying to weigh the difference between the lower plan and the middle plan. Members would pay $10 for each generic prescription for the first months of the plan year versus on the current CDHP, which initially went toward the deductible. On the new plan, members were able to go to the doctor or fill a prescription at a set cost.

Senator Kieckhefer commented that 50% of members migrating to the new plan was a substantive number. He asked if the percentage correlated to the decision the PEBP Board made to move to a single risk pool for underwriting, or were those separate decisions.

Ms. Messier replied those were separate decisions and moving to a singular risk pool would help to stabilize the plan and make it more sustainable moving forward. AON was trying to help reduce the fluctuations historically seen in PEBPs forecasting and projections, which would help with the extra revenue moving into excess reserves. She noted that she met with Ms. Rich early in the calendar year to discuss different things that were standard for a majority of PEBPs' clients and ways it could benefit moving to a more standardized actuarial practice and one of the elements discussed at that time was stabilizing the risk pool. For instance, if someone had a significant condition and cost the plan $2.0 million a year due to high cost medication and maintenance for their condition, that person could move from the EPO plan one year to the CDHP, then back again, and

the actuary would not be able to underwrite the EPO plan correctly. Therefore, the experience for the member moved between plans and the blended underwriting of the risk pool created more stability and enhanced the credibility of the claims experience. Regardless, PEBP would pay for claims and the amount a member paid out-of-pocket would not change going forward with the new plan designs. She noted that AON wanted to stabilize the amount so that fluctuations were not seen when members moved between plans. Ms. Messier stated that AON did not want a participant to accidently choose a plan thinking it would be better for them, but the plan had a $7,000 out-of-max copay versus only having $4,000 on the CDHP, because a $3,000 shift in their out-of-pocket maximum would have a huge impact. In addition, AON wanted to increase the stability of the plans and help members because they were aware that health plans were complicated. She added that another benefit of the new plans were they would provide some normalization by having the same out-of-pocket maximum regardless of the plan chosen.

Senator Kieckhefer asked if the network providers would mirror what was currently available on the high deductible health or EPO plan.

Ms. Rich replied that the network was currently up for bid and the solicitation was in the negotiation process and would be presented to the PEBP Board in January 2021. The network, regardless of plan, would be the same. The network chosen would be applied to all the plans with the exception for HMO, which was a fully insured product.

Senator Kieckhefer asked if it was a single network of providers across all plans regardless of which proposal was chosen, and Ms. Rich concurred.

Vice Chair Carlton asked if there were any significant changes to the HMO, and Ms. Rich replied that currently, the HMO plan was also in the solicitation process. PEBP had seven significant request for proposals (RFP) in the solicitation process, which included the HMO. The negotiations and award were confidential until presented to the PEBP Board at its January 2021 meeting.

Vice Chair Carlton asked if there were any significant proposals to the plan change for the HMO, or would the HMO remain the same and the member would pay a certain amount each month for premiums and copays. Ms. Rich replied there would be minor changes to the HMO and the plan would have a small deductible, which HMO members were not familiar with. She referenced page 40, Exhibit A, which showed the proposed changes to the EPO/HMO and typically, those plans mirrored each other. Previously, the HMO in Southern and Northern Nevada did not have deductibles. However, in order to meet the budgetary requirements and not have three identical plans, the low deductible plan was a hybrid of both the EPO/HMO plans and PEBP introduced a $500 deductible. She noted that all plans had a higher out-of-pocket maximum as well.

Vice Chair Carlton stated that HMOs do not have deductibles and asked the reason the deducible was implemented on the HMO. She believed the idea of an HMO was because the care was managed to protect state employees from having to pay a deductible and

employees made the decision to pay more per month instead of paying a deductible. She thought the deductible was counter intuitive to an HMO.

Ms. Rich agreed, and said that historically, the PEBP HMO did not have a deductible. However, deductibles on HMO plans were standard in the commercial market. She said PEBP had to make changes to all three plans in order meet the budgetary requirements implemented by the Governor. Originally, when PEBP presented its budget, the HMO did not have a deductible, but the 12% proposed cuts forced PEBP to look at all the benefit levels and make some changes.

Vice Chair Carlton stated, in essence, there would be no "safe plan" in the future, so families would have to budget to cover their medical costs and PEBP would add a cost to the HMO, which typically did not have a deductible.

Ms. Rich replied, conversely, the HMO rates were reduced and with the policy instituting flat contributions, the HMO plan now was essentially funded at the same levels as all the other plans. Therefore, there were no increases and the rates were flat, or lower on the HMO because of the policy change.

Vice Chair Carlton stated that families would have to meet a deductible on the HMO so there was an impact to employees. Ms. Rich concurred that the employee would have to meet the deductible; however, the employee rate was also projected to be lower.

Ms. Messier clarified, deductibles for the HMO do not apply to copays when families were going to the doctor or filling prescriptions. For example, if a member had diabetes, or asthma and needed to see their primary care provider every year, in addition to a specialist, they were still accessing care in the same way members on the HMO received today. The participants were not paying a deductible before they met the copay and the visits were on a copay basis. She stated that certain services like high-level imaging, such as an MRI, would be applied to the deductible before moving into coinsurance. Therefore, for a broad percentage of the population on the HMO, they were just accessing care through a doctor, or pharmacy, and those services would remain the same because those services were on a copay basis.

Vice Chair Carlton said she understood what Ms. Messier explained and it helped make the point that in an emergency, families would be impacted with a deductible. She noted the reason many families chose the HMO was because they could pay a set amount for an emergency service rather than having to meet a deductible.

Assemblywoman Miller asked for clarification and referenced the chart on page 40, Exhibit A, which showed that the deductible for the HMO, plus an additional cost had to be met for emergency room and inpatient hospital services in PY 2022. Assemblywoman Miller thought the deductible would have a financial impact on families with children who required frequent emergency room visits.

Ms. Messier replied that the copay applied to services except for emergency care, so people who were going to the doctor for routine care throughout the year, which was a large percentage of the population, the HMO would perform as it had in the past. Similarly, there was a $50 copay if a person needed to take their child to urgent care. She noted when the plan design changes were discussed for the HMO with the vendor, it was recommended to add the deductible with a copay to emergency room and inpatient hospital care, which was shown on the chart on page 40, Exhibit A. Therefore, it was a $500 deductible plus the $750 copay, so essentially, a $1,250 copay for the first emergency room visit. If a secondary emergency room visit was required in the same plan year, the deductible was already met and only the copay was applied. She added that it was the second design of the plan after the additional budget cuts were implemented.

Vice Chair Carlton thanked the presenters for the information because health insurance was complicated and hard to navigate and were difficult decisions for families, especially for future budgeting.

Continuing, Ms. Rich directed the Committee to page 38, Exhibit A, Fiscal Year 2022 and Fiscal Year 2023 plan designs. Typically, the November PEBP Board meeting was designed to provide the Board with recommendations on cost savings opportunities and plan design options for the following year. However, on November 3, the GFO issued a memo to all state agencies indicating that unfortunate economic conditions and declining revenues were expected, and as a result, agencies were asked to formulate proposed budget reserves of 12%. For PEBP, 12% was the equivalent of approximately $72.0 million for the biennium. To meet this requirement, PEBP would have to consider significant benefit reductions in a tight timeframe. Therefore, PEBP and its vendors were forced to work quickly to complete the analysis and provide feasible recommendations to the PEBP Board at it November 23 meeting. She noted that the GFO originally imposed a deadline of November 20; however, knowing that PEBP was in a different situation because it had a Board that made decisions, the timeline was extended to November 24, which was the day after the Board meeting. After decisions were made, PEBP staff had to essentially change and compose a new agency request budget to submit to the GFO the following day. Ms. Rich said it was not an easy task for PEBP because of the short timeframe to come up with different options, because a $72.0 million reduction would have a detrimental impact to the program.

Ms. Rich said, PEBP had to change the plan design and the Board approved a transition to 140% of Medicare pricing model to negotiate out-of-network claims. Fair Health maintained a database of billed charges by service code and zip code to determine typical charges for the service area for out-of-network claims. The Board chose to move to the 140% pricing model by taking what Medicare paid and PEBP would pay 140% of that. Ms. Rich stated that PEBP believed most plans were moving toward the 140% pricing model because it was a familiar reference-based approach. Providers recognized the Medicare pricing model and using the 140% Medicare pricing model would save the plan almost $2.0 million. Moving to the changes to the pharmacy network, she noted the Committee may recall in Fiscal Year 2019, PEBP implemented the Smart 90 pharmacy

network for the CDHP, which was for 90-day maintenance medications. The Smart 90 network narrowed the pharmacy network and excluded two major pharmacies, CVS and Walgreens. By eliminating those pharmacies from the network, the plan and members shared a significant savings because the network was narrowed and it was volume-based savings. She added that all but 34 members would have access to a participating pharmacy within four miles of their home. Although it was not a huge impact to members, and already implemented on the CDHP, the Smart 90 network was added to the EPO and low deductible plan. In addition, PEBP implemented a 30-day express advantage pharmacy network and was taking a similar action for 30-day medications as well. The express advantage excluded CVS and Walgreens by narrowing the pharmacy network to participating express advantage pharmacies. She noted members had the option of continuing to fill their prescription at a non-participating pharmacy by paying an additional $10 to the price of their medication. She added that both of the pharmacy options added $1.5 million in savings with a minor impact to the members. The plan design changes achieved almost $20.0 million of the necessary $36.0 million savings. The Board chose to reduce the Medicare HRA contributions from $13 per year of service to $11 per year of service. She stated that over the last several years, PEBP was able to raise the Medicare HRA contributions from $11 to $13 but was now looking to reduce it to $11 per year of service. Therefore, instead of the maximum of $260 for a Medicare Exchange member with an HRA, the member would be topped at $220. In addition, PEBP reduced the basic life insurance benefit from $25,000 for an active employee and $12,500 for a retiree, which was part of the core benefit package, to $10,000 for an active employee and to $5,000 for a retired member. PEBP did not want to eliminate the life insurance benefit totally and the logic for the reduction was it was still enough to cover a burial or funeral. In addition, PEBP reduced the long-term disability from a 60% benefit to a 50% benefit level, which saved the plan $1.5 million. Lastly, another change was the unbundling of the dental premium. Currently, dental premiums were embedded into the overall premium. Members enrolling in a medical plan automatically received dental coverage and Medicare Exchange retirees could purchase the dental plan separately. The unbundling of dental benefits separated the two premiums and allowed members to opt out of dental, or pay a separate premium to enroll into dental. The benefits were the same but the dental benefit becomes optional. Ms. Rich added that the numbers in the chart on page 40, Exhibit A, were premature numbers and illustrative rates to provide PEBP with guidance. PEBP was early in the plan year with many variables and the rates could change drastically. In the dental premium, members who chose to opt out of the dental would see a reduction in their premium of $5, or $10 for an employee with spouse or child, or $15 for a family. Therefore, having the dental benefits embedded with the health benefits was the difference of $5, $10 or $15, depending on the tier, or if the employee choose the option of dental benefits. She said the thought was that PEBP would continue to make the default as in opt in and members could choose to opt out. She noted that PEBP had to change the plan design from what was proposed in July because of the 12% budget cuts. She reiterated that a $72.0 million reduction was a large number to achieve and PEBP had to revisit the plan design proposed in July to make significant changes in order to achieve the savings that PEBP needed. PEBP had to add the deductible to the EPO/HMO and increase the out-of-pocket maximums. PEBP preferred to leave the deductibles the same because it was first dollar coverage.

However, PEBP had to make cuts to reach the required 12% budget cut level, and unfortunately, the changes were drastic for the program.

Ms. Rich moved to the variables of the program, page 41, Exhibit A. She stated the actuaries could get close to what they thought would happen, but the current budget cycle was somewhat of an anomaly and there were outstanding variables that would ultimately play a critical role and affect the overall experience of the plan. She said that PEBP had seven contracts expiring in 2021, with several of those being major contracts, which had a significant budgetary impact. The biggest contract expiring was the network, which essentially impacted the costs of the claims and a majority of the PEBP budget. She noted, depending on the vendor awarded the contract, the rates could definitely swing one way or the other. In addition, there were COVID-19 costs and at the beginning of the pandemic, the Board approved 100% coverage for all COVID-19-related testing and care. PEBP has been covering those costs knowing there were CARES Act reimbursement and Corona Virus relief funds that PEBP was due to receive. However, the CARES Act funds were expiring at the end of the year and there were no additional stimulus agreements on the federal level, so the program would be required to absorb the costs moving forward. She said that PEBP worked with its actuaries and AON applied significantly more aggressive trend for Plan Year 2022 and Plan Year 2023. However, the COVID-19 trend seemed to change day-to-day and the vaccine could change the scenario and landscape when it becomes available. Also, there was the unknown utilization when a new plan was introduced. AON used its experience-based methodology to assume migration into the plan, but utilization was not as high as normal the first one or two years after a new plan was introduced. In addition, utilization could shift the other way with a lot of utilization, so there was the unknown utilization level when a new plan was introduced. Also, new legislation affected health care, employee benefits, or PEBP funding could have an impact on the program. Ms. Rich stated the PEBP budget was in the Governor-recommendation phase, so it was the PEBP proposed budget, which was submitted to the GFO. However, as with most agencies and budget cycles, the GFO had the authority to make changes and could propose something entirely different from the budget submitted, which was a variable that could come into play.

Lastly, Ms. Rich stated that page 42, Exhibit A, showed PEBP's timeline that it had to adhere to before open enrollment. Immediately after the November 2020 Board meeting, PEBP starting preparing for open enrollment that began on May 1, 2021. When the plan decisions were made, PEBP had operational and IT needs that were necessary to coordinate with its vendors. For example, if the dental carve out was something that the GFO chose to retain in the PEBP budget, a significant IT project would be associated with the plan because PEBP would have to introduce the new plan to allow members to opt out of dental. In addition, on the backend there was a lot of member communication that PEBP had to update, such as guides, masterplan documents, which were legal documents that had a vetting process. Any plan design changes made later in the process eventually caused a slowdown for members as well, which could possibly delay the output of member communication. She noted that the day after the November Board meeting, PEBP's vendors would input the approved rates into the system. PEBP staff would test the rates and the system, so it was up and ready by open enrollment on May 1.

She noted it was already a tight timeframe if rates were approved at the end of March, to get the rates into the system and tested in time for the May 1 open enrollment date.

Senator Kieckhefer stated that PEBP was given a directive from the GFO and at that point, PEBP had to figure out how to make it work within the PEBP budget. He asked how PEBP made the decision to choose relatively stable premiums versus reduced benefit levels and if it was more beneficial to have enhanced costs within the benefit structure versus overall increases in premiums.

Ms. Rich replied that PEBP struggled with the decisions and several different plan options were introduced at the November 23 PEBP Board meeting. She added that the chart on page 40, Exhibit A, was the option approved. She said there were two more options that were presented and discussed at the meeting; both options retained the benefits to a certain degree, and did not reduce benefits. Essentially, the two options put the burden on the premiums, which caused them to skyrocket. If the benefit levels were retained as they were today, because there were different levers PEBP had to work with, then rates would increase, which was an option discussed by the Board. Ultimately, the Board chose to retain the premiums at relatively stable levels, although there would still be an increase in premiums, but they were relatively stable compared to the other two options. A choice had to be made to either retain the benefits or increase premiums and there were arguments for both sides. As heard in public comment earlier in the meeting, reducing benefits would be detrimental for certain members. She added there was talk and concerns among some of the entry-level staff at PEBP that even minor increases to the monthly premiums were very impactful to those employees, to the point where some of the employees said they could not afford those increases. Therefore, there was concern that some employees may chose not to elect health insurance if the premiums were too high. She noted there were arguments for both sides and she could not speak whether one was right or wrong. She did not think either option was great, but when there were such significant cuts to make, something had to give in the end. She stated the decision came down to the Board choosing to keep the rates relatively stable and reduce benefits versus the opposite way.

Senator Kieckhefer asked Ms. Rich what the premiums would be if one of the other plan options were chosen.

Ms. Rich replied that real-time decisions were being made at the Board meeting and actuaries took the very complex scenarios and input the information into its system before it went through a series of peer reviews, which was not happening because of the live scenario of the Board meeting and the condensed timeline. The rates that were being shown may not be entirely correct because the assumptions the actuaries used as place holders were not exactly correct. The option of leaving things as is would have the employee premium about $110, or higher, because of the head count assumptions that PEBP had to reduce that would have increased those rates. Currently, the employee only premium was $45.

Ms. Messier recalled the employee only premium was approximately two and one-half times what current employees paid. Because the state accepted a large portion of the rates, anything that went above those rates becomes highly leveraged in terms of the employee cost once the rate was kept flat. Therefore, when there were no benefit changes, it was pushed on to the $40 rate and the reason for the large increase. In terms of what the state paid, it would be a lower percentage and the state kept its amount flat and any extra that went above the flat rate, if benefits were not reduced, gets pushed on to the employee portion so the $45 became nearly two and one-half times what members currently paid, which was a significant amount.

Assemblywoman Miller stated that she appreciated that PEBP understood that even a $5 change could have a huge impact on an employee. When discussing benefits, the unknown was each individuals' needs. She was concerned with the basic life insurance reduction and if $5,000 or $10,000 was enough to cover a funeral. She was unsure $5,000 would cover a month of bills for some households. She understood the reason the basic life insurance had to be reduced and thought some of the additional plans could be optional, so the employee who needed the higher life insurance benefit had the option to choose that benefit.

Ms. Rich replied the cuts that were made were focused on benefits that had other options available. For example, the basic life insurance comes as part of the core benefit package, which was offered to both active members and retirees through PEBP's voluntary benefit platform. Therefore, life insurance and long-term disability was an option and could be purchased independently.

Assemblywoman Miller asked if the rates were increasing for the voluntary products offered by PEBP, and Ms. Rich replied that a vendor for PEBP provided the rates, which was the same vendor that offered basic life insurance. She said that to her knowledge, those rates have not increased, and the rates were group-rated and based on age.

Assemblywoman Miller asked Ms. Rich if there was an impact to vision coverage, and Ms. Rich replied that vision coverage was imbedded into the medical plan. She added there was a $25 copay for a yearly vision checkup for members on the CDHP, but outside of that, the plan does not provide many vision benefits, such as glasses. She said the HMO plan differed slightly for vision benefits, but the vision benefits for all plans would remain the same.

Vice Chair Carlton asked Ms. Rich to expand on the life insurance benefit, which has been taken away and added back over the years. She and it had a financial impact on families, especially for members close to retirement. Purchasing life insurance at 55 years of age was different and more costly than for a 35-year old employee. She added, she recently heard from state employees who were frustrated with the changes and would like PEBP to stick with the changes for a while so they could make plans for themselves and for the future of the family.

2. 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 independent audit of the Self Insurance Trust Fund and the State Retirees' Health and Welfare Benefits Fund was performed by Casey Neilon, page 51 (Exhibit A). The audit, which covered the period through June 30, 2020, assessed PEBP's financial statements to ensure it complied with generally accepted auditing principles and standards. She stated that the report showed 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.*

3. Report on utilization of PEBP by participants for the plan year ending June 30, 2020, including an assessment of the actuarial accuracy of reserves, pursuant to NRS 287.0425.

Ms. Rich referred the Committee to page 107 (Exhibit A) displaying the Executive Summary for the Consumer Driven Health Plan (CDHP) and the PEBP Premier Plan (EPO). As mentioned earlier in the meeting, she stated that costs and utilization have been steadily rising in the last few plan years and PEBP was projected to spend through its excess reserves based on this. She said the utilization reports were very similar to what the Committee has seen in the last several years, so instead she wanted to touch on the impact of the COVID-19 pandemic and what really happened in the last quarter of Plan Year 2020. She said when the pandemic began in March 2020, the Governor issued an emergency regulation requiring fully insured plans that were regulated by the Division of Insurance to cover all COVID-related costs and testing at no cost to members. She said that PEBP did not fall under that category in the emergency regulation because it was not a fully insured product and not regulated by the Division of Insurance. The PEBP Board met and decided to align with the emergency directive and provide 100% COVID-related coverage. Since then, the plan has incurred several million dollars in COVID costs and PEBP would request approximately $5.2 million in Corona Relief Fund reimbursements at the next IFC meeting. Conversely, the plan also experienced what PEBP called "claim suppression" and in April and May 2020, as the state and the nation starting shutting down, there was a sudden drop in medical claims. Members were not going for routine dental cleanings and elective procedures were being cancelled, or postponed, which caused a significant lag in claims. For example, the surge that was happening in the nation, and especially in Nevada with testing and COVID-related illnesses, PEBP might not see those claims for many months or even years. Therefore, the information that was contained in the utilization report does not necessarily capture what happened with COVID because of the delay in claims. In the end, COVID swung PEBPs total medical trend by almost 5%, and to a degree, the claim suppression would continue to occur in the next plan year. She said that AON projected very low trend through the current plan year and even through the subsequent plan year as well. In addition, Ms. Rich added that the vaccine would affect utilization as well and the vaccine

was expected to be covered at 100%. However, similar to flu shots, there was an administrative fee for the vaccines that the plan paid for, which was approximately $22 for each vaccine moving forward. Therefore, although the vaccine was no cost to members, it still would be a cost burden for PEBP moving forward. She reiterated that the Committee has seen the report many times and it has not changed much since the last meeting and trend and experience was very similar.

Vice Chair Carlton stated that she thought the general categories in the utilization report could be broken down in more detail to help the Committee really see where the state was regarding mental health issues as a result of the pandemic. The mental health issues were significant and if the issues were not measured they could not monitored. She thought that monitoring mental health issues would be helpful in the future to see the actual effects the COVID-19 virus had on utilization and the long-term costs. She added that in recent conversations with medical professionals, their concerns were people were putting off routine doctor visits and health needs making their health situations worse, and as a result, PEBP would have to spend more to address those issues in the future. She noted that was a discussion the Committee had years ago in reference to the deductibles, because people did not want to pay the deductible. However, at this time it was more in reference to actual access to services and fear of exposure to the virus.

Ms. Rich replied that PEBP could provide a detailed breakdown in the utilization report related to the health issues from the pandemic. She added that PEBP and the medical community would be closely monitoring the impact and effects of the pandemic for many years.

4. 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 189 to 204 (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 outcomes. In recent years, PEBP tried to ramp up its communication with members and leveraged many different resources. PEBP reached out to larger employers, such as the Nevada System of Higher Education (NSHE), to ensure PEBP's communication was better disseminated among all of its membership. In addition, PEBP worked closely with the Retired Public Employees of Nevada (RPEN) to ensure retirees were not overlooked. Page 199, showed the Communication Schedule, and the communication produced by PEBP, including member material, surveys, webinars, and newsletters and was an all-inclusive list of what has happened during the plan year. However, in the upcoming plan year, PEBP would be very busy as it anticipated the need for major communication given all the potential policy changes, whether a new plan, new vendors and it anticipated a significant outrage from members in the next six months. Ms. Rich stated, although PEBP only had 34 staff members in the office, many of those people were dedicated to helping with the development of communication for members. Therefore, PEBP has taken many measures to ensure it expanded education and

communication with its members. 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.

Senator Kieckhefer asked about the timing for the significant policy decisions in terms of preparing the communication for members in order keep to pace with a smooth rollout of updated plans and communication strategies.

Ms. Rich replied that there was no good answer because all plan decisions would have a budgetary impact, which would affect rates. Therefore, any changes to the plan benefit design has an overall change to rates. The actuaries developed those rates based on the plan benefit design. For example, outside of the deductibles and out-of-pocket maximums, there were things like life insurance, which was part of the administration load and that load added to the rates. Therefore, if the life insurance was reinstated, while the communication part was fairly easy to change, it also changed the rates and PEBP's overall budget. When changes were made it created a problem on the rates side. The rates were developed in February, presented and approved by the PEBP Board in March, then immediately loaded into PEBP's enrollment and eligibility system and tested so they ready for the May 1 open enrollment date. Hence, any rate change would impact open enrollment. PEBP would have to adjust the rates with the actuaries to ensure they were actuarial sound and solvent and then load the rates into the enrollment and eligibility system and there would be no way to do that if a change was made April 15 and the open enrollment date was May 1. In addition, there were noticing requirements as well that PEBP had to be exempt from, which created a shorter enrollment window and members would only have two weeks to enroll in a plan. The shorter enrollment would create a lot of chaos and confusion among members since it was a plan year with a lot of potential plan changes.

Senator Kieckhefer asked, if the life insurance benefit was part of the administrative load, if it had to go to back to underwriting, and Ms. Rich replied that was no longer the case. She said that AON developed the rates, and PEBP tacked on administration fees to the rates, which essentially made the math no longer accurate and the rates no longer actuarially sound. The Board made a decision to change that policy, so actuaries were involved in the process and the life insurance rate was adjusted accordingly. For example, PEBP broke down the rate to a per member per month type rate that was part of the overall rate per tier.

Ms. Messier added, in terms of the underwriting rate, if the rate was set and PEBP switched to a higher life insurance rate, the actuaries knew that amount and to some extent the rate was still getting added on. Therefore, to streamline the process, AON not only combined the risk pools and that part of the claims build up, but also tried to eliminate the places where tiering happened. AON would go through the claims, add the administrative fee and then applied the tier, life insurance, and disability and dismemberment amount. Ms. Messier noted, what made the rates tricky was the way PEBP and the state applied the different percentages in terms of dependent subsidies. Therefore, as AON was changing different parts of the rates, even if just changing the last step of adding on the life insurance, disability and dismemberment, because it was a flat

amount regardless of the tier, it should not matter if an employee was covering their family or just themselves and they were getting the same amount for the particular benefit. She said life insurance was a benefit for the employee only and not a benefit for the family, versus medical, where if family benefits were elected, those benefits covered all family members. Therefore, in this particular instance AON was trying to add the same dollar amount to each tier where previously that was not how it was applied. Hence, a flat dollar amount was added to each tier, but a percentage was applied on top of that in terms of dependent subsidies, which shifted the rates, and at that point, it could be the migration assumptions, depending on how many benefits were added back in. If the differential shifted from one plan to the next, the copay plan started to look more attractive and more people would start to move into that plan, and it changed how much the plan paid in claims. She added there were many things that were changed in different parts of the process when adding benefits back in. Ms. Messier said that AON was trying to get PEBP on a more straightforward approach but it had to be mindful of the fact there were decisions that could be made at the end of the process that could take them back and AON wanted to ensure everything was solidified when the final rates were produced.

Vice Chair Carlton stated, there was a process when hearing PEBP's budget during the legislative session and she was committed to resolving the PEBP budget as early as possible to help alleviate the stress for members wondering what their health plan would look like beginning on July 1, 2021.

5. Report on the July 1, 2019, independent actuarial valuation of post-employment health and welfare benefits for current and future state retirees provided by the State of Nevada, pursuant to Statement Number 75 of the Governmental Accounting Standards Board (GASB) for Fiscal Year 2020 (NRS 287.0425).

Scott Syverson, AON, stated that he would provide a summary on the June 30, 2020, actuarial valuation of post-employment and health and life insurance plan. The valuation reflected the financial reporting requirement, pursuant to Statement Number 75 of the Governmental Accounting Standards Board (GASB), and measured the liability or cost of providing health and life insurance benefits to current and future retirees. He indicated that the results were summarized in the report, Tab V.5., Exhibit A. He noted that per the GASB 75 rules, for the fiscal year ending June 30, 2020, the liability for the plan increased about 3% more than expected, which was primarily related to a decrease in the interest rate assumption used in the valuation. Interest rate assumptions were used to present value, or discount future payments. A lower interest rate would result in a higher present value; therefore, a higher liability. The economy rules dictate how the interest rate assumption was determined. For the State of Nevada plan, the interest rate was based on 20-year municipal bond and the market interest rates that varied as the market conditions changed. He noted that looking forward to the next valuation, interest rates continued to decrease and the lower interest rates would result in higher liabilities in the June 30, 2021, valuation, all other inputs being equal.

6. Report on the biennial review of PEBP's compliance with federal and state laws relating to taxes and employee benefits dated October 28, 2020 (NRS 287.0425).

Ms. Rich stated that every other year, PEBP was audited to ensure the program complied with applicable federal and state laws relating to taxes and employee benefits. She said that AON performed the biennial review and no major findings were reported by AON; however, there were a few minor findings. She noted, the majority of the minor changes noted in the report were already updated to better meet federal and/or state law requirements, such as changes to member communication and master plan documents.

V. PUBLIC EMPLOYEES' RETIREMENT SYSTEM (PERS).

1. Report on actuarial valuation for the Public Employees' Retirement System (PERS) as of June 30, 2020.

Tina Leiss, Executive Officer, Public Employees' Retirement System (PERS), directed the Committee to Agenda Item IV.1., beginning on page 297 of the meeting packet (Exhibit A). She introduced Steve Edmundson, Investment Officer, PERS, and Kabrina Feser, Operations Officer, PERS. She stated that page 297 provided an update for the FY 2020 Actuarial Valuation for the Public Employees' Retirement System. The valuation determined the projective liabilities of the plan and contribution rate for the coming biennium on an actuarial reserve basis. The areas analyzed during the course of the valuation included, 1) plan design, or the benefit put in place by the Legislature, 2) member demographics and, 3) and the economic assumptions. Per statute, the statutory contribution rate could change every other year on July 1 of the odd-numbered calendar year if the actuarial rate differs by a certain percentage of the current statutory rate. Therefore, if the actuarial rate for this valuation was more than half a percentage point above the current rate, the rate would change on July 1, 2021. Ms. Leiss stated the ultimate costs of the benefits to be paid by the System were determined by the plan design and future events that were unknown at this point in time. The goal of the actuarial funding was to ensure that PERS had the current and future benefits paid for through current contributions. PERS had to make assumptions about future events that it could not predict, such as length of service, average compensation and the longevity of members to determine the contributions so PERS could pay, prefund and invest those funds in the future. Ms. Leiss said that PERS conducted an experience study on a regular basis to ensure the assumptions used to estimate the future liabilities were accurate. The experience study was conducted to review the assumption against its experience to ensure it stayed in line. She added that PERS never expected the experience to be exactly on the assumptions, because those varied from year-to-year, but it tried to keep those as close as possible. She noted the previous experience study was conducted in 2017, and the next experience study was scheduled for 2021, which would go into the 2021 valuation.

Ms. Leiss noted the charts on pages 301 and 302 (Exhibit A) showed the actuarially calculated contribution rates for FY 2020. She said it was a rate-setting valuation and the calculated rates for 2020 were very similar to 2019; however, based on the statutory

mechanism, if there was a change of more than .5% on both the Police/Fire Fund and the Regular Fund, the rates would increase. The actuarial rate for the Regular Fund was calculated at 29.84% as compared to the current rate of 29.25%, which was a little higher than the .5% threshold. Therefore, per statute, the rate would change on July 1, 2021, to 29.75% for the employer pay rate for the Regular Fund. The employer pay rate was shared with the employee so the employees' half of that rate would either be by a salary reduction, or in lieu of promised pay increase. The Police/Fire Fund had a little different demographic experience, and more of a rate increase. The current statutory rate was 42.5% and the actuarial rate was 43.93%, and per statute, the number was rounded to the nearest 0.25%, which was a statutory rate of 44% for the Police/Fire Fund for July 1, 2021.

Moving to page 302, Exhibit A, Ms. Leiss noted the chart showed the rate on the employee/employer pay side and the difference was the employee contribution was an after-tax deduction from their salary, so an additional half of the rate change would come out of their salaries. Because the employee contribution was refundable, the statutory rate was approximately 1% higher, so there was a total of 31% on the Regular Fund and 45.5% for the Police/Fire Fund under the employee/employer pay plan. The chart on page 303 showed how the actuarially determined contribution rates were broken into by experience categories for the year. The chart showed the average between the employer pay rate and the employee/employer pay rate. It also compared the actuarially determined contribution rate from two years ago with the actuarially determined contribution rate for 2020. The rate showed what was driving the change compared to 2018, so it was a two-year valuation to the current valuation. She noted that the biggest driver of the contribution rate change for both funds was the effect of the payroll growth assumption not being met. Therefore, since the contributions were paid as a percentage of payroll, if there was not the payroll growth assumed, the contributions coming out were less than assumed, which affected the contributions collected and the contributions being invested. In addition, when the payroll growth was not being met, it affected the unfunded amortization payment schedule. Ms. Leiss stated that PERS would look at the payroll growth assumption along with the other assumptions in the experience study in 2021. She noted there were gains and losses that net out in the Police/Fire and Regular Fund rate changes. However, the biggest difference between the two funds was the individual salary experience and the demographic experience, which explained the difference in the Regular Fund contribution rate increase of .5% versus the Police/Fire rate increase of 1.5%.

Ms. Leiss referenced pages 304 and 305, Exhibit A, showing the active membership in the Regular and Police/Fire Fund. The 2020 valuation reflected an overall increase in active membership from 109,161 to 111,815. The noted pages displayed the break out for active membership for the Regular and Police/Fire Fund membership. The active membership for the Regular Fund grew by 2.2% and the active membership for the Police/Fire Fund grew by 3.8%. Pages 306 and 307 displayed the retiree demographics and the number of retirees, average monthly benefits, and the total benefit paid by PERS. Page 307 showed a breakout of the average benefit for the Regular and Police/Fire Fund by service retirees, disability retirees, beneficiaries, and survivors. She noted that

page 308 showed the funded ratios of the System, and for 2020, the actuarial funded ratio increased from 74.9% to 75.7% for the Regular Fund, and increased from 76.5% to 77.5% for the Police/Fire Fund, for a total funded ratio for the entire plan of 76.1%, which was trending in the right direction for the actuarial funded ratio.

Ms. Leiss stated that pages 309 and 310, Exhibit A, provided a comparison of PERS actuarial value of assets versus the unfunded actuarial liability (UAL), and PERS assets and unfunded liability (market value). She indicated that PERS used the actuarial value of assets for funding purposes because it smoothed the data over a five-year period to take in consideration large fluctuations that could be seen in the market. Page 309 provided the asset growth on an actuarial basis and the smoother ride for the assets, but compared to unfunded actuarial accrued liability, it provided an idea of the magnitude and growth between the two assets. Page 310 showed PERS assets and unfunded liability (market value) showing not as smooth of a ride without the five-year asset smoothing. She noted that part of the reason was the market volatility does not have as much an impact on the rates because of the two-year rate setting mechanism in place. Ms. Leiss added, because of the asset smoothing, the System currently had $563.0 million in unrecognized gains under the asset-smoothing period that would be recognized in the next five years, or with any future gains and losses the System may experience on the asset side.

Senator Kieckhefer asked if the chart on page 303, Exhibit A, showed the changes that determined the increases in the rates shown on page 302, and Ms. Leiss confirmed that was correct.

Senator Kieckhefer asked if the effect on existing amortization of payroll growth less than expected for the Regular Fund of 0.36% (page 303), was an increase in the rate due to less payroll growth that was anticipated the last time there was an actuarial valuation, and Ms. Leiss concurred.

Responding to Senator Kieckhefer, Ms. Leiss said, currently the payroll growth assumption for the Police/Fire Fund was 6.5% so PERS expected a 6.5% payroll growth. She said the payroll growth assumption was a combination of salary increases and new membership. She said that PERS was not meeting the payroll growth assumption. It was a combination of not only the salary increases of 4.2%, but new positions were not added at the rate normally expected based on PERS experience during the decades prior to 2007. Therefore, the lack of payroll growth compared to PERS assumption probably had more to do with the overall payroll, not the individual salary increases. She added, with the expansion of the payroll, PERS was not necessarily adding the active membership that would have been expected based on the PERS experience prior to 2007.

Ms. Leiss stated that the payroll growth assumption for the Regular Fund was 5.5%, one percentage point lower than the Police/Fire Fund.

Senator Kieckhefer asked if those assumptions were updated as a part of the experience study, or updated in the rate setting years, or every two years. Ms. Leiss answered that it was part of the experience study. For instance, in the 2017 experience study, those payroll growth assumptions were lowered by a percentage point each. The 2013 experience study for the Police/Fire Fund growth assumption had also been lowered in that timeframe as well. Therefore, PERS would be looking at the experience study and she anticipated a recommendation to lower the payroll growth assumptions. The ultimate result of lowering the payroll growth assumption would have an increasing effect to the contribution rates. If the payroll growth assumption was not met there would be a loss, as seen in the valuation, so it had an increasing effect on the contribution rates. In the experience study, if the Board chose to lower the payroll growth assumption on the advice of the independent actuary, it would have an increasing effect to the retirement contribution rate, so it was a timing issue on contributions as far as the payroll growth assumption.

Senator Kieckhefer asked, in terms of accrued liability, if the payroll growth assumption was not as high, or there was not as much of it on the input, the reverse should be true on the output, and Ms. Leiss agreed. She added that it was not just an offsetting effect, it was a little on the Regular Fund and a bit of an anomaly on the Police/Fire Fund for the two-year period. It depended on how the payroll growth assumption was lowered. If it was lowered because of lower-than-expected salary increases, assuming the individuals would be receiving less salary, there would be an offsetting lowering of future liability because the benefit was based in part on a members' salary. Therefore, when less than expected payroll growth was seen there were some offsetting gains on the individual salary experience, because lower than assumed pay raises meant lower benefits that PERS was ultimately paying out to the members.

Senator Kieckhefer asked Ms. Leiss if she could provide a breakdown of the share of both the assets and unemployment liability that were attributable to the state versus local governments.

Ms. Leiss replied that the employer allocations were part of the Governmental Accounting Standards Board (GASB) 67 valuation that was provided to all the employers for financial reporting purposes. Ultimately, under statute, the System was responsible for the benefits and the employer was responsible for their contributions and the share of their contributions. Hence, their share of the liability was broken out by their proportionate share of the contributions, and PERS had that information for each of the 210 public employers. She added that as a general rule, the state had a tendency to be 20% of the total of the unfunded liability proportion on the breakout. Ms. Leiss stated that she would provide the Committee with the schedule of employer allocations as of June 30, 2019.

Vice Chair Carlton added, the fewer employees the state had, the responsibility was on each of the employees. In the past, when the state had furloughs, it tried to hold PERS harmless, and she believed that would be a valid discussion point since there would be furloughs in the future. She asked Ms. Leiss the impact the furloughs had to the System in the past.

Ms. Leiss replied that there was no impact to the System for the furloughs, because the law was written so the employers and employees were still making contributions for the furlough days; therefore, the employee does not have the loss of service or loss in salary. She reiterated that the furloughs had no impact on the contributions PERS was receiving because the law was written to require the contributions on furlough days.

Vice Chair Carlton said that having a very small state workforce resulted in a smaller group of people contributing and each person bears more of the responsibility.

Ms. Leiss stated, the other effect of the economic downturn was PERS was not sure it was seeing the full effects of the increased retirements. Not only were those members going off the active payroll, but PERS was not seeing the retirees being replaced as much as during better economic times. PERS looked at it from both sides, the effects on the active payroll but also the effects that retirees would have on benefit payroll.

Vice Chair Carlton recalled a conversation with PERS during the 2008-2009 economic downturn and at that time members were waiting months for an appointment with PERS to discuss retirement options. Ms. Leiss replied that she did not think the active membership fully recuperated from the 2008-2009 economic downturn.

Senator Brooks asked Ms. Leiss the factors PERS used when estimating payroll growth assumptions based on new employees. He asked if the payroll growth was based on population of the state, or on what other state governments were as a per capita of their population.

Ms. Leiss replied that the actuary made a recommendation to the PERS Board, so it started with the payroll growth assumption that was in place. She noted that the actuary looked at PERS own experience over 5 to 20 years for the recommended payroll growth assumption. The payroll growth assumption was driven more by past experience and the rate of inflation was also a building block of the payroll growth assumption because inflation was also a building block of salary increases. She did not think the actuary looked at trends, other states, local governments, or any other workforce projections. The actuary looked more at past experience and inflation assumptions in the state as far as the individual salary growth. She added, the State of Nevada had a history of exceeding its payroll growth assumptions because the state grew quickly, which made it difficult for the actuaries. It was difficult for actuaries to figure out the long-term trend and what was more of a shorter-term correction, which was why the actuary recommended slower reduction to the payroll growth assumption to determine if it was something that was going to come back. She did not believe the actuary factored the payroll growth assumption into the current environment. Ms. Leiss stated the payroll growth assumption had more to do with the state's past experience and inflation assumption.

Senator Brooks asked if it was safe to say that the participants in the plan were shrinking as a percentage of population over the decade, and Ms. Leiss replied that she has not

done that calculation, although she was aware that its active membership count did not reach the 2008 levels until about two years ago. Therefore, from 2008 to 2018 there were fewer public employees than in 2007, as far as those who were participating in PERS, which is the lion's share of public employees. She noted as far as the comparison to the state population, PERS has not done that calculation.

2. Report on actuarial valuation for the Judicial Retirement System as of June 30, 2020.

Ms. Leiss stated that page 311 (Exhibit A) provided an update on the FY 2020 actuarial valuation for the Judicial Retirement System (JRS). By policy, the Board performed an annual actuarial valuation to monitor the assets of liabilities associated with the JRS. The JRS was created in 2001 for state elected judges. Originally, it was for district court judges and Supreme Court justices. Later, the Legislature allowed the local governments to elect to cover their municipal court judges and justices of the peace, in addition to appellate court judges. The JRS had a similar contribution rate trigger to PERS, and rates may change every two years based on the actuarial valuation results. Unlike PERS, JRS was a multiple employer plan, which allowed each employer to have a separate contribution rate based on its own demographics. Therefore, it was easy to tell the different liabilities of each employer because they were calculated separately, and the contributions were individual to the employer. The actuarial contribution rate for JRS state judges was paid in two different ways to PERS, through payroll contributions and a lump sum payment. The percentage of payroll contributions, which covered the normal costs for state judges, was 22% of their payroll. The actuarial valuation rate was 22.41%, which was within .5 percentage points. Therefore, the contribution rate as a percentage of payroll for the state judges would not change July 1, 2021, and remain at 22%. Unlike PERS, the state paid a lump sum payment for the unfunded actuarial accrued liability (UAL) for the state judges. She stated that part of the reason for the lump sum payment was when the JRS was created in 2001, the judges' retirement was on a pay-as-you-go plan. Thus, the liability for all retired judges and all service credits prior to 2001 were taken into the plan, so the state created a schedule where it paid a lump sum payment in each July for the UAL.

Continuing, Ms. Leiss noted the lump sum payment was now calculated every two years for the state and the lump sum payment would decrease slightly from $1,337,285 to cover the unfunded payment to $1,322,131 for the current biennium. The JRS aggregate funded ratio also increased from 91.8% to 94.8%. Those percentages are aggregated which meant, it included state and non-state judges. The total unfunded accrued liability decreased from $12.0 million to $8.4 million primarily due to liability gains. Pages 313 to 315, Exhibit A, contained demographic information for the JRS state and non-state judges. She noted page 316 showed the contribution rates and lump sum payments for state judges; however, the page was mistitled JRS non-state judges and should be state judges. Pages 317 to 318 showed the local judges, and as an aggregate, the local jurisdictions were in an overfunded status, which meant there were more in assets satisfied than the actuaries projected were necessary for future liabilities. On an aggregate basis, the actuarial accrued liability for the JRS non-state judges was close to

$4.0 million. Page 318 showed the different contribution rates for the local jurisdictions and the rates varied widely because each jurisdiction had a different active membership. For the most part, the plans were very small and only had one to ten members. In addition, some plans may or may not have retirees and the rates were calculated individually and could vary.

3. Report on actuarial valuation for the Legislators' Retirement System as of June 30, 2020.

Ms. Leiss continued with her presentation on page 319 (Exhibit A), Fiscal Year 2020 Actuarial Valuation for the Legislators' Retirement System (LRS). She stated that the LRS funding was different from PERS and the JRS. The legislators paid 15% of their compensation to fund the employee contribution of the LRS and then the state Legislature made two payments to PERS, one for the employer contribution in a lump sum amount, which covered the cost to provide the benefits minus the employee share. In addition, the Legislature paid PERS for the cost of administration of the System. The LRS was voluntary and the provisions of the LRS allowed legislators to participate, or opt out of participation in the System. Ms. Leiss noted that in FY 2020, active membership decreased from 35 to 32 members, which could be from opting out, or due to retirement. The number of retires remained at 56, while the retired members and beneficiaries increased from 72 to 73. Similar to PERS, the even-numbered valuation would determine the lump sum contribution made by the employer for each year of the biennium. In FY 2018, the payment was calculated as $97,935, which was what the Legislature paid each year as the employer contribution. In the 2019-21 biennium, the amount was $82,846 each year, a decrease in the employer contribution amount. The funded ratio for the LRS increased to 95.9% and the unfunded liability decreased from $201,000 to $199,000, and the LRS was approaching a 100% funding level.

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

Steve Edmundson, Investment Officer, PERS, directed the Committee to the table on page 325 of the meeting packet (Exhibit A), which provided a summary regarding investment portfolios for PERS, the LRS and the JRS. The first column showed the investment performance for all three funds for various time periods ending June 30, 2020. The column on the left side of the page depicted returns for the most recent fiscal year ending, which for obvious reasons was an extraordinary volatile year for financial markets. However, despite the volatility, PERS generated a 7.2% return for FY 2020 and the investment portfolio ended the year with $46.6 billion in assets. For reference, in FY 2019, the median large public pension fund experienced a 2.4% return. Over the last five-year time period, Nevada PERS returned 7.6%, which was an important number since it aligned with the actuarial smoothing period. He noted the last ten years was a great decade to be an investor and Nevada PERS generated a 9.5% return; a 6.3% return over 20 years; and a 9.2% return over the last 35 since inception.

The LRS fund generated a return of 6.4% for the period ending June 30, 2020, with $4.7 million in assets. The JRS produced an annualized return in FY 2020 of 6.3% ending the period with $141.0 million in assets. Mr. Edmundson referenced page 326, Exhibit A, PERS annual performance, which depicted each return for individual fiscal years for the last 36 fiscal years. The line in the middle of the page represented PERS 7.5% long-term actuarial assumed rate of return. He emphasized it was a long-term return assumption and not an expectation for any single year, or necessarily an expectation for short and mid-time period. He said PERS anticipated to see returns fluctuate over time in any individual year, and over short and median time periods. However, the return would fluctuate around the 7.5% actuarial assumed rate of return.

Moving to page 329, Mr. Edmundson said the page showed PERS investment strategy. He noted that PERS investment portfolio was somewhat unique in the industry and the fund embraced a simple approach with a lower cost investment strategy. The System was 100% indexed across all public market trading asset classes, so U.S. and investment stock portfolios, along with PERS fixed income allocation were 100 percent indexed. In addition, PERS deliberately avoided exposure to complex investment strategies such as hedge funds or the use of total fund leverage. He stated that PERS simple approach had advantages and kept costs low relative to industry peers. Nevada annual PERS investment costs were 12 basis points or 0.12% of total fund assets relative to medium to large public pension funds that had an expense ratio of approximately 51 basis points or 0.51% of total fund assets. He noted, PERS estimated annual cost savings was approximately $170.0 million per year compared to a similar-sized public plan, and began the fiscal year with a 40 basis point fee advantage. However, in addition to the low costs, PERS simple investment approach has proven to be highly competitive relative to industry peers. PERS rate of return ranked in the top of the public fund database. He added that PERS did not expect it would be the case every year, and some years it was at the bottom of the database, which he expected to see again. However, PERS believed that its simple disciplined approach would continue to be competitive relative to more complex portfolios over longer time periods looking forward as well.

Concluding, Mr. Edmundson stated that while the material he provided was through the most recent fiscal year ending June 30, 2020, he wanted to provide a quick update on the first half of FY 2021. Currently, the PERS portfolio was up 13.8% fiscal year-to-date with $52.7 billion in total fund assets. He noted it was a great start to FY 2021 and was encouraging; however, with six months remaining, it was not indicative of where PERS would end the year. However, given the current low interest rate environment and relatively lofty valuations in global equity markets, it would not be surprising to see more subdued investment returns over the near and mid-term time periods.

Senator Kieckhefer stated the PERS reduced its expected rate of return in FY 2017, from 8.0% to 7.5%, which other states had done as well. He asked where the 7.5% expected rate of return was compared to the other funds that were consistent with what the state had in investment.

Mr. Edmundson replied, at last check, the median fund investment return assumption was approximately 7.25% to 7.3%, so the Nevada PERS' funds were close. He noted the return assumptions were decreasing over the years and Nevada PERS lowered its return assumption from 8.0% to 7.5%, so it was a meaningful reduction in FY 2017. He believed the reason the return assumptions were decreasing was due to the fact that interest rates were declining fairly dramatically, which put pressure on prospective returns looking out at the five to ten-year time periods and on expected returns. However, it did not necessarily mean that would transpire, but it reduced the expectations. He thought that investment return assumption numbers were important for PERS funding and for contribution rates. The return assumption numbers would be included in the upcoming experience study. The investment return assumption was in an actuarial assumption, and the Board ultimately adopted the recommendation of the independent auditor.

5. 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 333 (Exhibit A). 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 as long as they met the qualifications. She noted that there were teachers remaining in the program because they moved in and out of positions, or in and out of eligibility, but the benefit was slowly winding down and would phase out soon. The report on page 335 showed the amount PERS received from the school districts for calendar years 2019 and 2020 to date for the one-fifth of a year of service purchase for teachers, or other school district employees who were still eligible for the credit. She noted there were 61 purchases in calendar year 2019 for $339,000, and to-date in calendar year 2020, there were 81 purchases for a total of $470,000. Ms. Leiss noted that since inception of the program, the System received over $147.0 million for approximately 41,607 purchases. The chart showed that in calendar year 2019, only Churchill County School District and Clark County School District had employees who were eligible for the benefit. In 2020, only Clark County School and Washoe County School District had eligible employees. The timing of the benefits payments was up to the employer and the fact that they were paid in calendar year 2020 does not mean it matched the school year. The chart showed that the money received in calendar year 2020 for the Clark County School District was for school year 2020-2021. The money received from the Washoe County School District was for school year 2019-2020.

Vice Chair Carlton asked, how close PERS was from phasing out the one-fifth of a year retirement service program. Ms. Leiss replied that PERS could not necessarily anticipate when the program would phase out, because the school districts informed PERS who was eligible for the service credit. However, PERS tracked when employees had five purchases to equal one-year of service. She added that some people, as seen for calendar year 2019 for the Churchill County School District, paid in 2019 for school year

2017-2018, so a little was the timing, but PERS was getting closer to phasing out the program.

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

Ms. Leiss added that before Mr. Edmundson presented this agenda item, she wanted to provide a quick update on the administrative side of the Retired Benefits Investment Fund (RBIF). The law that created the Retirement Benefits Investment Board (Board) authorized the Board to hire staff and to contract for administrative services. The RBIF has grown to over $600 million and was managed as well as could be without specific RBIF employees. At the last Board meeting, the Board decided to contract for part-time administrative services, and was seeking administrative services to help the Board with the RBIF. She noted that the Board hired Mr. Rick Combs to help with administration of the RBIF and she expected him to appear before the Committee in the future.

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 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 of the RBIF was similar to how mutual funds were managed for individual investors. In FY 2020, the RBIF generated a 6.7% annualized return, and since its inception in January 2008, the RBIF has generated an annualized return of 6.7%. Due to the fund's structure, the investment performance for each participating member of RBIF was dependent on their individual contribution date. 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, when it had only one participating employer with less than $16.0 million in total fund assets. Mr. Edmundson indicated that as of June 30, 2020, the RBIF had grown to 13 participating employers with $604.0 million in total assets. He added that compared to other public funds, the RBIF portfolio was no longer a small-sized public pension fund and had grown into a mid-size plan and a sizeable pool of assets with $604.0 million. Similar to PERS, one of the benefits of the structure of RBIF was being able to take advantage of the relationship it had with PERS and with asset managers to get the fees of the RBIF portfolio to an extraordinary low point. Total RBIF investment costs were 1.5 basis points or .015% of total fund assets, which he believed was the lowest institutional investment portfolio fee of that size. Mr. Edmundson stated that statute required the RBIF to be managed in the same manner as PERS; however, due to its smaller asset size of $604.0 million versus $52.0 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 similar with publicly traded assets. Over the last ten years, the more simple structure delivered returns within 0.2% of the larger PERS portfolio, which demonstrated the success in meeting its statutory requirements.

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

Kabrina Feser, Operations Officer, PERS, stated that Agenda Item V.7., page 343, Exhibit A, provided an update on the implementation of the PERS pension administration system. She said the contract with Tegrit Software Ventures, Inc. (Tegrit) was approved by the Retirement Board on November 19, 2020. The project start date was set for February 22, 2021, and PERS decided on a phased approach starting with employer recording and then moving to pension payments. There were seven phases of the project and Tegrit received the highest score of the bidders. Tegrit was familiar with, and dedicated to the unique needs of public pension funds. Ms. Feser stated that the references from past clients were outstanding and the key personnel assigned to the project had ample knowledge and experience with implementing their product, Arrivos 2.0, to multiple pension funds. In preparation of the project, an employer advisory group was established. She said that meetings were valuable to communicate and collaborate with employer representatives as well as to provide project updates. The focus of staff, in addition to the day-to-day operations of Nevada PERS, has been on data management to prepare for the data conversion and the data points that were necessary for the target-staging database.

Vice Chair Carlton stated that the funding for the pension administration system was approved by the 2019 Legislature. She asked why the original estimate was $10.0 million more than the negotiated contract amount. She asked if there were different enhancements involved in the project.

Ms. Feser clarified that the original contract included project management and data cleansing so PERS was working with multiple vendors to ensure the success of the project. The original price was for the additional vendor contracts outside of Tegrit, which were needed for the project.

Vice Chair Carlton asked if the additional vendor contracts were part of the conversation when the funding for the pension administration system was requested for the modernization cleanup.

Lauren Larson, Chief Financial Officer, PERS, clarified that funding was approved for the project for the biennium and the project would take approximately four years. The estimate received from Tegrit, along with the estimates for data management and project management, were in line with the total project. PERS received a portion of the funding in the last biennium and since the project was not expected to start until Fiscal Year 2021, a lot of the funding has not been spent yet.

Vice Chair Carlton thanked the presenters. She wanted to ensure the Committee was aware of the progress of the system and if the expenses were higher than originally planned.

Chair Brooks stated that the overall pension administration system cost was proposed to be $33.0 million and the Tegrit contract was $23.0 million. He asked if the overall system cost would still be $33.0 million with the additional vendors, and Ms. Larson concurred. She stated the total cost for the contract with Tegrit was anticipated to be $23.0 million, and the additional contract for the project and data management would be included in the $33.0 million total system cost.

SENATOR BROOKS MOVED TO APPROVE THE ACCEPTANCE OF THE STATUS REPORT ON THE NEW PENSION ADMINISTRATION SYSTEM.

ASSEMBLYMAN WHEELER SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

VI. PUBLIC COMMENT.

Doug Unger, president, UNLV Chapter, Nevada Facility Alliance, member of UNLV Employee Benefits Programs' Advisory Committee, thanked the Committee for its good questions for Ms. Rich, Executive Officer, PEBP and Ms. Messier, Actuary, AON Consulting. He wanted to note a few things stated at the meeting that he thought were incorrect. The premium versus deductibles and maximum out-of-pocket question from Senator Kieckhefer, the figure reported by the Ms. Messier was two and one-half times if benefits were left as they were. He said that state representatives proposed a compromise at the PEBP meeting, which would have distributed modest changes through three different pathways. The pathways were out-of-pocket maximums and deductibles, and the other through premiums, and at the PEBP Board meeting, the figures showed an individual premium insurance of approximately $38, for $58 to $88 if the compromise solution were accepted. He thanked Vice Chair Carlton for committing to addressing the issue early in the 2021 Legislative Session. In addition, Mr. Unger said he appreciated all the years that Senator Woodhouse served on the Committee and he honored her service by expressing gratitude for her many years of participation and interest in employee benefits and all she did for the employees during her time in the Senate. He thanked the Committee and looked forward to resolving the PEBP issues very early in the Legislative Session.

VII. ADJOURNMENT.

The meeting was adjourned at 12:13 p.m.

Respectfully submitted,

_____

Donna Thomas, Committee Secretary

APPROVED:

_____
Assemblywoman Maggie Carlton, Vice Chair

Date: _____