MINUTES OF THE
NEVADA LEGISLATURE'S
INTERIM RETIREMENT AND BENEFITS COMMITTEE
(*Nevada Revised Statutes* 218E.420)
December 14, 2022

The second meeting of the Nevada Legislature's Interim Retirement and Benefits Committee (IRBC) was called to order at 9:02 a.m. on December 14, 2022, online, and in Room 4401 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. The meeting was videoconferenced to Room 3137 of the Legislative Building, 401 South Carson Street, Carson City, Nevada.

COMMITTEE MEMBERS PRESENT:
Assemblywoman Daniele Monroe-Moreno, Chair
Senator Marilyn Dondero Loop, Vice Chair
Senator James Ohrenschall
Senator Jeff Stone
Assemblywoman Sarah Peters

COMMITTEE MEMBERS EXCUSED:
Assemblywoman Heidi Kasama

STAFF MEMBERS PRESENT:
Sarah Coffman, Fiscal Analyst, Assembly
Wayne Thorley, Fiscal Analyst, Senate
Alex Haartz, Chief Principal Deputy Fiscal Analyst, Fiscal Analysis Division
Adam Drost, Principal Program Analyst, Fiscal Analysis Division
Jaimarie Mangoba, Principal Program Analyst, Fiscal Analysis Division
Eileen O'Grady, Chief Deputy Legislative Counsel, Legal Division
Jessica Dummer, Deputy Legislative Counsel, Legal Division
Tom Weber, Committee Secretary, Fiscal Analysis Division

EXHIBITS:
Exhibit A: Meeting Agenda and Packet
Exhibit B: Public Employees' Benefits Program Presentation
Exhibit C: IRBC Addendum - December 5, 2022, PEBP Board Meeting
Exhibit D-1: Public Comment – Kent Ervin, State President, Nevada Faculty Alliance
Exhibit D-2: Public Comment – Sheila S.
Exhibit D-3: Public Comment – Terri Laird, Retired Public Employees of Nevada

I. ROLL CALL.

SENATOR DONDERO LOOP (Vice Chair):

Chair Monroe-Moreno is participating in the meeting remotely today. She has asked me to chair the meeting.

TOM WEBER (Secretary, Fiscal Analysis Division, Legislative Counsel Bureau [LCB]), called the roll; all members were present except Assemblywoman Kasama, who was excused.

II. PUBLIC COMMENT.

KENT ERVIN (State President, Nevada Faculty Alliance):

The State of Nevada is in the midst of an employment crisis. Agencies across the state, including the Nevada System of Higher Education (NSHE), have extraordinarily high vacancy rates and cannot fill positions. It has come to the point where essential governmental services cannot be provided.

Compensation and benefits for state employees, including NSHE faculty and staff, are not competitive due to years of neglect. After the Great Recession, state employees were hit with furloughs, pay cuts, and cuts to benefits. Those cuts had not been fully restored when state employees were again hit with furloughs and drastic cuts to health care benefits due to the pandemic.

Due to recent high rates of inflation, state employee salaries and wages must increase substantially - by 15% to 20% - to become competitive. Restoring benefits is also essential for recruitment and retention.

The Public Employees' Benefits Program (PEBP) Board has proposed partial benefit restoration using savings from new programs that reduce costs. The PEBP Board now apparently needs Interim Finance Committee approval to make any improvement to benefits, even if those benefits are funded by reductions elsewhere. While the Nevada Faculty Alliance is concerned about any programs that restrict access to care, it recognizes that PEBP is doing as much as possible.

The real problem is that the employer contributions from the state budget have not kept up with medical inflation for years and were cut after the pandemic.

I have more comments about the Public Employees' Retirement System, which I will provide in writing (Exhibit D-1).

With the Economic Forum increasing the state budget by over $2 billion over the current biennium, it is time to treat state employees as the dedicated public servants they are so they can provide full services to citizens. (Exhibit D-1).

SHEILA S. provided public comment for the record (Exhibit D-2).

TERRI LAID (Retired Public Employees of Nevada) provided public comment for the record (Exhibit D-3).

III. APPROVAL OF THE MINUTES OF THE FEBRUARY 8, 2022, MEETING.

SENATOR OHRENSCHALL MOVED TO APPROVE THE MINUTES OF THE FEBRUARY 8, 2022, MEETING.

ASSEMBLYWOMAN PETERS SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY WITH THE MEMBERS PRESENT.

IV. PUBLIC EMPLOYEES' BENEFITS PROGRAM (PEBP).

LAURA RICH (Executive Officer, PEBP):

I am joined today by Cari Eaton, Chief Financial Officer, PEBP. The agency will present a plethora of information pertaining to PEBP, including a presentation of the audited financial statements of the program; utilization reports; communications for the program; and the biennial certified actuarial valuation and review of the program compliance performed by PEBP's actuary.

In addition to those retrospective reports that are required by statute, PEBP staff will present an additional report on what benefits the PEBP Board has approved for the plan year starting July 1, 2023 (PY 2024).

I will begin by providing a brief overview of the program. PEBP covers state active and retired employees, plus their dependents. PEBP also covers non-state active employees and non-state retirees of local governments, municipalities and public sector entities that are part of PEBP. There are two different risk pools, which are rated separately.

PEBP's basic package offers medical, dental, vision and basic life insurance. The program also offers voluntary benefits such as life insurance, long-term disability, accident and critical illness, vision, and home and auto insurance.

PEBP is funded in two ways. Most of the funding is through the legislatively approved employer subsidy. Whatever is not covered by the subsidy is covered by the employee premium. Although PEBP does not receive any General Fund dollars, agencies pay subsidies. Every agency pays a certain amount for each employee covered by PEBP.

PEBP offers three self-funded plans: the statewide Consumer Driven High Deductible Plan (CDHP); the Exclusive Provider Organization (EPO) plan, which is similar to a Health Maintenance Organization (HMO) plan, in Northern Nevada; and the statewide Low-Deductible Plan. The self-funded plans are administered by PEBP and the incoming premiums and subsidies fund the claims that are paid out.

PEBP has one additional offering that is not a self-funded plan. The fully insured plan is an HMO offered in Southern Nevada by Health Plan of Nevada. This plan is regulated under the rules administered by the Department of Business and Industry, Division of Insurance.

Additionally, retirees can enroll in Medicare plans through the Medicare Exchange. The program provides them with a Health Reimbursement Arrangement (HRA) contribution based on years of service up to 20 years. The HRA funds are meant to pay Medicare premiums and out-of-pocket health care expenses.

In 2022, the PEBP Board voted to utilize excess cash. Excess cash is any cash that is over and beyond the program's required reserve categories. Much of the excess cash is due to members deferring care throughout the COVID-19 pandemic. During and after the shutdowns, people were not accessing care like they had been. Elective surgeries were postponed. Consequently, many health plans experienced a reduction in claims.

At its December 5, 2022, meeting, the PEBP Board voted to use the excess cash to restore benefits that were cut in 2020. In addition to the excess reserves that were earmarked for the restoration of benefits, several other expenditures were included in PEBP's budget to fund certain things such as the HRA contributions to retirees. After those items were factored in, $9.5 million in excess reserves remained.

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, 2023 (PY 2024).**

LAURA RICH (Executive Officer, PEBP):

Before I present the PEBP Board's plan design and policy changes, I would like to report on the results of a recent employee survey. A brief survey was developed by a working group comprised of leadership from the Governor's Office, PEBP, the Public Employees' Retirement System (PERS), and the Division of Human Resource Management. The survey was sent to all active state employees, including NSHE and legislative employees. The purpose of the survey was to determine what was important to employees - not just in benefits, but wages and other compensation. Over 7,400 survey responses were received, which is a better response rate than for any past PEBP survey.

There are two survey questions that wanted to highlight (page 6, Exhibit B). The first is question 3, which asked employees to rate which benefits they found most important overall. The most important benefit was higher wages and salary and the second most important benefit was lower health insurance premiums. I found that surprising, because PEBP's premiums are similar to other Nevada public employers. The difference is that state employees' wages are much lower than some of the local governments. There is a disparity in the relationship between the state employee wages and premiums. Other items that ranked high were employer matched 457 retirement plan contributions and more robust health benefits.

Question 4 was specific to PEBP. Again, lower health insurance premiums, deductibles and out-of-pocket cost ranked the highest. Those are “first dollar” expenses. Ultimately, PEBP deduced that people want more money in their pocket, not only in wages, but in lower health premiums and deductibles, which is helpful information.

The first item the PEBP Board approved was an additional one-time HRA or Health Savings Account (HSA) contribution for all active state employees. This one-time contribution was specific to active employees because they contributed the most to the excess reserves, thus there was a sense the funds should be directed back to them.

The PEBP Board approved a contribution ranging between $300 and $350 to be made on July 1, 2023. Members on the CDHP are eligible for an HSA. Under the higher contribution scenario, those individuals would receive an additional $350 plus the $600 HSA contribution that comes with that plan.

Members on the low deductible, HMO and EPO plans would receive up to a $350 HRA contribution. Internal Revenue Service (IRS) guidelines do not allow for HSAs on plans that are not a high-deductible plan.

The one-time benefit will be distributed to anyone enrolled in the plan on or around July 1, 2023, which is the beginning of the plan year.

Another item the PEBP Board addressed was the $1,500 annual dental benefit maximum, which had been in place since 2011. The $1,500 limit is still in line with industry standards, but many plans are considering an increase to $2,000, because the cost of dental care, and health care in general, is rising quickly. The PEBP Board chose to increase the annual maximum to $2,000, with a projected annual cost of approximately $750,000. In addition, the annual benefit limit for pediatric dental was eliminated as a result of a compliance audit finding.

The PEBP Board approved the addition of medically necessary abortion care to the existing travel benefit. PEBP currently offers a travel reimbursement in certain situations; for example, organ transplants or bariatric surgery, which are performed at a Center of Excellence (CoE). The plan reimburses travel costs for individuals who have to travel to a CoE to receive those types of services. Travel is reimbursed at General Services Administration (GSA) rates for items such as lodging and meals.

PEBP does not currently offer coverage for elective abortions but does provide coverage for medically necessary abortions. Members (mainly dependents) may reside in a state where their ability to access medically necessary abortion care is limited and therefore, they must travel outside of that state to receive this service. PEBP projects only a handful of these situations, with a projected cost between $25,000 and $50,000 per year.

The PEBP Board also approved a weight loss program called *Real Appeal* (page 10, Exhibit B), which is currently open to HMO members. This is an interesting weight loss program, and an obesity diagnosis is not required to participate. Anyone over the age of 18 can join the Real Appeal program. The program provides tools such as food scales, weight scales, counseling, etc. The projected annual savings is approximately $170,000 per year based on the cost versus the expected return on investment.

The PEBP Board also approved the addition of a cancer concierge program. Currently, PEBP offers case management services to members for cancer and other kinds of complex care conditions to provide extra assistance with coordination of care and navigating the health insurance system.

Cancer concierge is an enhanced service for members diagnosed with cancer to receive extra help navigating their complex medical situation involving multiple providers offering different types of care. Coordination of care can be time-consuming for someone who does not know how to navigate the system. PEBP will release a request for proposal (RFP) to find a vendor for the services. The program is expected to be implemented by July 1, 2023.

The cancer concierge program is elective. Anyone undergoing cancer care can utilize the service. Opting to use the service does not force anyone into a certain network. Depending on the outcome of the RFP, services could potentially be offered for services such as helping members navigate health insurance bills. For example, determining which expenses apply toward the deductible versus out-of-pocket expenses. The projected annual savings for this enhancement is approximately $1 million to $2 million per year.

The PEBP Board also approved the addition of a medical travel program (page 12, Exhibit B). Medical travel is elective; it is an option, not a requirement. A member with surgery scheduled at a local hospital would have the option to travel to a higher quality, lower cost facility. The member would receive assistance to examine the option to travel for the surgery.

These programs can sometimes be incentivized. For example, reduce or eliminate out-of-pocket costs for members who choose the option to travel to a CoE for the procedure. There could be a cost savings to both the member and the program. In addition, there could be a better outcome, because the member would be traveling to a CoE that has better outcomes for the required medical procedure.

PEBP staff will put out an RFP for this service as well. The projected annual savings for the medical travel program is $1 million to $1.5 million per year.

The PEBP Board has approved the addition of Hinge Health, a virtual musculoskeletal physical therapy program. Hinge Health is an alternative to in-person physical therapy that provides online coaching and guidance either by laptop or phone. Opting to use the program can be incentivized by reducing or eliminating any out-of-pocket costs for members. The annual savings is projected to be $1.4 million to $2.4 million.

Other states that have implemented this program have been very happy with the results. PEBP is very excited about implementing a program like Hinge Health, especially with the provider shortage in Nevada.

SENATOR OHRENSCHALL:

How would the estimated savings of $1 million to $2 million for the cancer concierge program be generated?

MS. RICH:

A PEBP Board member provided the following example of how savings are generated. A family member with cancer is currently in hospice care. When the individual was diagnosed with cancer, she was referred to a gastroenterologist; however, she had great difficulty getting an appointment with the specialist, navigating the system, and coordinating care. Due to the delays, her condition worsened and she required care that may not have been necessary had she been able to receive services in a more timely manner. As a result, the individual experienced many gastrointestinal problems and underwent many surgeries.

In this situation, a team of experts would have assisted the individual through the episode of care and coordinated communication between all the doctors involved in the patient's care. Medical services can be siloed; providers do not always communicate with each other. The person receiving the care is expected to communicate with each of the doctors to coordinate care, which is difficult for many people.

The cancer concierge program ensures that patients are receiving timely care at high-quality, lower cost locations if possible. Not only does that result in a better outcome for the patient, it results in savings for the program, because it could reduce the number of surgeries that may result from delayed care.

SENATOR OHRENSCHALL:

It is projected that only five to ten members will use the out-of-state travel benefit. What would happen if more members needed to travel to a CoE? Would the funds for that benefit be exhausted?

MS. RICH:

The estimate of five to ten members is travel for abortion care. PEBP staff predicts a small number of medically necessary abortions in areas where abortion services are not readily available.

For the medical travel benefit, the number would be higher. The benefit is elective. For example, if a member needed a hip or knee replacement, that would trigger the option to travel to an out-of-state CoE with a higher quality rating that could result in a better

outcome. The benefit covers travel, lodging, and meals for the patient and a travel companion. PEBP would benefit as well because there would be better discounts. That is how those savings would be realized.

ASSEMBLYWOMAN PETERS:

Regarding the survey of PEBP members, was the survey conducted in consultation with the Department of Administration, which has been working on a recruitment and retention plan? I am wondering if that was a duplicative effort.

MS. RICH:

The survey was a collective, coordinated effort between the Department of Administration's Division of Human Resource Management, the Governor's Office, PERS and PEBP.

ASSEMBLYWOMAN PETERS:

Related to some of the added benefits for services, does PEBP conduct any kind of impact assessment of the change to members?

MS. RICH:

PEBP's actuaries analyze the impact of each of these new programs with regard to volume and finances. For example, Hinge Health would address musculoskeletal conditions which are number six on PEBP's cost spend for diagnosis on the medical program. Members are suffering from musculoskeletal conditions at a high rate. Online physical therapy will not just reduce the cost to the member, but there is an additional benefit to the member as well, because there is a shortage of physical therapy providers in Nevada. All the programs approved by the PEBP Board are an enhancement and an option for members. The new programs are not limiting services or directing members to a certain provider or network.

The changes are meant to be helpful to members, while, in many situations, providing a cost savings to PEBP. Better outcomes result in a healthier population.

ASSEMBLYWOMAN PETERS:

Pregnancy-related issues are one of the higher costs for members. I did not see any changes addressing those issues. I would like to see any data PEBP has indicating how these changes affect the consumer.

MS. RICH:

I will share the analysis by the actuaries on the plan changes with the Committee.

ASSEMBLYWOMAN PETERS:

One of the recommendations from the PEBP Board was to opt out of the Mental Health Parity and Addiction Equity Act. Please discuss how the PEBP Board arrived at that decision.

MS. RICH:

I would be happy to address that now; however, that matter will be addressed in another agenda item.

ASSEMBLYWOMAN PETERS:

I will wait until the Committee discusses that agenda item.

SENATOR DONDERO-LOOP:

How does PEBP plan to seek approval from the Interim Finance Committee (IFC) or the Legislature to expend some of the excess reserves?

MS. RICH:

In an odd plan year, if the PEBP Board elects to use excess cash for benefit enhancements, it would go before the IFC for approval. Because we are heading into session, plans for the reserve may be built into the Governor's budget, in which case the request would go through the budget hearing and approval process.

2. Reports from an independent certified public accountant regarding audited financial statements, for the year ending June 30, 2022, 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).

LAURA RICH (Executive Officer, PEBP):

An independent auditor audits PEBP's financial statements for both the active and retiree funds in accordance with the generally accepted accounting principles. The auditors look at internal controls, compliance and accuracy.

PEBP's current auditor, CliftonLarsonAllen LLP, conducted the FY 2021 audit. As with any audit, there were a few findings. Overall, the opinion was that PEBP's financial statements fairly represented the financial position of the program. Overall, there was a favorable determination on PEBP's audited statements.

3. Report on utilization of PEBP by participants for the plan year ending June 30, 2022, including an assessment of the actuarial accuracy of reserves (NRS 287.0425).

LAURA RICH (Executive Officer, PEBP):

Utilization is the core of what is happening in the plan. Utilization drives the program's budget and health insurance costs. PEBP looks to utilization to understand what is happening in its population.

There are several hundred pages of health-insurance-related information. It is a complicated subject containing a lot of data. I have pared it down to the minimum to highlight what happened in the plan in PY 2022 compared to PY 2021.

For the CDHP, PEBP's high deductible plan, enrollment was down significantly due to state vacancy rates. The data shows enrollment through June 30, 2022, and enrollment is even lower today.

Overall plan spend decreased significantly but spending per member increased 16.5% per person. Because enrollment is low, the program has spent less overall, but the program is spending much more per person on health care than last year.

Prescription utilization was similar. Net claims decreased overall, largely due to enrollment. Gross cost was down as well. However, the per member, per month, per person amount the program paid for prescription drugs increased almost 5.0%. The average that the plan was paying per claim was up 5.2%, and the average member share was up about 6.5%.

The plan's emergency room (ER) utilization was up considerably at 27.0%; however, the per visit cost decreased slightly at 6.2%. That is because the pandemic was ending in this period between July 2021 and June 2022. These numbers are being compared to the previous year, when there were many ER visits due to COVID-19. Even though there is higher utilization, the severity of the ER incidents were lower in cost.

High-cost claimants are claimants with costs over a $100,000 threshold on any of PEBP's self-funded plans. High-cost claimants drive the spend on the plan. Just recently there was a one member high-cost claimant of $5.5 million. That is why the program has catastrophic reserves. High-cost claimants on the CDHP were about 43.0% higher than in the previous year . However, compared to the pandemic, the average cost of high-cost claims was down 2.2%. It is notable that inpatient claims or costs for the CDHP rose 14.7%, and outpatient claims decreased 20.5%. The top ten costs by diagnoses are shown on page 18 (Exhibit B).

Earlier, Assemblywoman Peters mentioned pregnancy-related disorders. Pregnancies resulting in neonatal care are very high-cost claims. COVID-19 was still a cause of high-cost claims during this period, and cancer always ranks high in cost. In addition, mental health, musculoskeletal, and cardiac issues are high-cost claims. These are high on the list of claims for all three self-funded options.

For the low deductible plan, it is slightly different. This is the first year PEBP has offered the low deductible plan. For those who have been familiar with PEBP for a while, you may have heard from members that there was a desire to bring back a low deductible plan. Members did not feel they had good choices with CDHP and the EPO/HMO options. They wanted something in the middle, so PEBP reimplemented a low deductible Preferred Provider Organization (PPO) plan. The premiums are slightly more expensive than the CDHP, and there are copays for common services such a primary care, generic medications, etc. Essentially, it is a hybrid between the EPO and the CDHP.

Because this is the first year of the low deductible plan, it cannot be compared to prior year performance. Instead, PEBP compared it to the other plans (page 20, Exhibit B). The average enrollment in the low deductible plan is low compared to the CDHP. In the first year of the low deductible plan, members were either unfamiliar with the plan or hesitant to change to the new plan. Now, more members are changing to the low deductible plan.

The medical cost per member, per month is lower than the CDHP, and significantly lower than the EPO plan. Emergency room visits are comparable to the CDHP, but lower. The average ER claim is slightly higher. Per member, per month, the low deductible plan took up more of the costs for prescription drugs, and the members paid less.

In-network utilization is comparable as well. The low deductible plan uses the same network as the CDHP and EPO plans. Next year more data will be available for comparison. Overall, people seem to be happy with the introduction of the new plan.

On the low deductible plan, cancer is the number one driver of cost, followed by pregnancy. The other conditions on the list are similar to the cost drivers in the other plans.

The EPO is similar to an HMO. It is a regional plan with no out-of-network coverage. The EPO is offered in Northern Nevada. I would note that enrollment decreased, and plan spend decreased significantly overall; however, the plan spend per member decreased only slightly, 1.4%. This plan has the highest number of members with chronic conditions. The EPO plan has higher premiums, but the copays and out-of-pocket expenses are much less compared to the CDHP. People with more chronic conditions are drawn to the EPO plan.

For prescription drug utilization, again, net claims decreased almost 11.0%. PEBP's gross costs decreased about 10.0%, but the per member, per month cost increased slightly, by one-half a percentage point. The average share per claim that the plan paid was up 0.4%, and the average member share per claim was up 2.5%. Overall, it was relatively stable, but that is the way the EPO functions.

Emergency room utilization was similar to the other plans; utilization increased and the per visit cost decreased. The high-cost claimants were 10.0% higher. Not as high as on the CDHP, but there was a jump in high-cost claimants, and the average amount of those high-cost claimants decreased slightly by 4.7%.

COVID-19 was the number one cost driver on the EPO in that plan year. Pregnancy-related disorders, musculoskeletal disorders, and other conditions similar to the other plans are driving the costs.

The last plan is the HMO. This is not a plan that is self-funded by PEBP. PEBP pays the vendor, Health Plan of Nevada, a per member, per month fee, and the vendor provides coverage to the members. This plan is overseen and regulated by the Department of Business and Industry, Division of Insurance.

The data that PEBP receives is slightly different. PEBP is not as concerned overall, because it is not responsible for the claims on this plan. PEBP is responsible for the per member, per month fee, for which the contracted rates rise with the increased cost of health insurance.

Again, overall enrollment dropped slightly, 1.6%, but the medical per member, per month on this HMO increased 35.4%. This plan is spending a lot more per member. I would note the HMO is different because it sets fixed per-member fees with the providers. Typically, the way these models work is providers receive a fixed rate to provide a certain type of service.

The HMO does not experience the same type of impact as the self-funded plans. For example, during the pandemic, claims were being deferred on the self-funded plans because the plan was not spending money on things like elective surgeries, which resulted in excess funds. That did not happen on the HMO because of the fixed-cost model.

Overall, and taking into account medical and prescription drug per member, per month, costs have skyrocketed almost 28.0% on this plan. Emergency room utilization is very similar, and high-cost claimants are up approximately 29.0%. The difference is that the amount per high-cost claimant increased almost 23.0%.

The top ten costs by diagnosis are slightly different for the HMO. Mental health disorders are number one. Mental health is on all the lists, but it is the highest cost for the HMO. Other conditions like hypertension and diabetes made this list. Inpatient claims increased 80.4%, which is a significant increase. Outpatient claims increased only 9.5%, which is a little different than the other plans.

SENATOR OHRENSCHALL:

Is in vitro fertilization (IVF) covered by the PEBP plans?

MS. RICH:

Typically, IVF is not a covered service, but I would have to look in the master plan documents to confirm.

SENATOR OHRENSCHALL:

Does some of the excess reserves savings come from the vacancy rate? If so, I am wondering if that should be counted as savings since the hope is to fill those positions in the future.

MS. RICH:

PEBP is different than PERS in that PERS pays out the same benefit each month to a pool of people. The incoming revenue from current staff is much lower.

PEBP is different, because even though less revenue is coming in from employees because of vacancy rates, less is being paid in claims. Generally, PEBP's revenue and claims rise and decrease at the same rate. However, that also depends on the member population. A member population made up of older, unhealthier people with a higher incidence of chronic conditions would result in the program paying out more claims while bringing in the same revenue. Generally, as long as the type of employee being covered remains steady, the incoming revenue aligns with the claims being paid.

SENATOR OHRENSCHALL:

Will the FY 2022 audited financial statements be shared with the Committee after they are approved by the PEBP Board?

MS. RICH:

Yes, PEBP provided the FY 2021 audited statements and will share the FY 2022 audited financial statements with the Committee as soon as they are released. The financial statements are for the previous year. The most recent financial statements are not usually available before the IRBC meeting.

SENATOR STONE:

You mentioned that the HMO is no risk to the state. Is it a capitated plan?

MS. RICH:

Correct.

SENATOR STONE:

Are more people enrolling in the capitated plan to save money on copays? I realize that it is a more exclusive network. A member cannot go out of network and must stay local. What are the dynamics for growth of the HMO plan?

With all the plans that PEBP offers, is there an investment for preventative care so that in the future there will be a healthier population to insure?

MS. RICH:

The HMO enrollment has been decreasing. It is a complicated formula so I will explain it in a high-level manner. PEBP offers an EPO in the north and an HMO in the south. They are very similar plans. The EPO is self-funded, whereas the HMO is a fully insured product. PEBP blends the two rates. Because the cost of care in Southern Nevada is lower than in the rural areas of the state and Northern Nevada, the cost of that HMO is much lower than the price at which it is being offered. That is because PEBP blends all the other plans. PEBP is a statewide program that does not offer lower reduced premiums to the Southern Nevada population versus the Northern Nevada population. Because of that, the price of the EPO in the north drops slightly, and the HMO in the south increases slightly.

The HMO enrollment has been consistent over the last two years because the program had been seeing a downward spiral in enrollment. When enrollment drops, the risk pool decreases; the smaller the risk pool, the more expensive things get. PEBP made adjustments so that does not happen.

Many people like either the high deductible or low deductible plan. Members on the high deductible plan can contribute to an HSA, which is not available on other plans. The low-deductible plan is very similar to the HMO, without the high premiums. There are people who really like the HMO and will continue to remain on the plan. Much of the draw to the low-deductible plan is coming from the high-deductible plan rather than the HMO.

To answer the question about wellness, in the past PEBP has offered a variety of wellness programs. Prior to my time with PEBP, there was a wellness program in place where members who participated in the program received a premium reduction of $50. Many members on the high-deductible plan essentially received free health insurance.

The funding for that wellness program was cut by the Legislature. As an employee during that time, I was disappointed that the program was eliminated because I was receiving the $50 premium reduction.

In addition, five or six years ago there was an incentive program that funded HSA dollars if members pursued preventive care. To qualify, members needed to have their annual primary care visit and lab work, and annual dental exam and cleaning. That program was eliminated by the Legislature as well.

PEBP is hesitant to implement similar wellness plans because of the aversion by the Legislature in the past. Preventive care is the most important way to keep members healthy.

4. Report on material provided generally to participants or prospective participants in connection with enrollment in PEBP for the plan year beginning July 1, 2022 (PY 2023) (NRS 287.0425).

LAURA RICH (Executive Officer, PEBP):

The PEBP communication plan is a living document. It is something that PEBP consistently works to improve, because communication in the plan is challenging. PEBP covers many types of employees, including active and retired members, as well as members located in Nevada, out of state, and even outside of the United States.

It is difficult to get members to read and comprehend the information provided by PEBP, especially in years when there are many changes, which has been the case over the last few years.

PEBP had RFPs for almost everything in the last three years. Every contract has gone out to bid, which was the result of a legislative audit finding a few years ago. There have been many changes in contracts, vendors, and networks. Consequently, members have received a lot of communication via email, regular mail, and through Human Resources representatives within the agencies. PEBP also works with stakeholder groups like the Retired Public Employees of Nevada to communicate to retirees.

Communication is challenging; sometimes mail is ignored, or email goes to a spam folder. I cannot stress how much of a challenge it has been to encourage members to read the information provided by PEBP. It is also important to be selective about how often communication should be sent to members to avoid overwhelming them with information.

PEBP has distributed a lot of communication over the past few years related to items such as COVID-19 and associated coverage, plan benefit changes, and vendor changes. PEBP regularly strives to improve communication with the members.

During the current plan year, PEBP's eligibility and enrollment system overhaul did not go as planned. The situation was similar to the state's Silver State Modernization Approach for Resources and Technology in the 21st Century (SMART 21) project, in fact, PEBP used the same vendor. PEBP ultimately terminated the contract and reverted to the former eligibility and enrollment system. This resulted in disruption and extra communication to members regarding the challenges that arose during that timeframe.

PEBP holds open enrollment meetings every year. Prior to COVID-19 the meetings were in person; however, they are now held virtually. The meetings are interactive; people can participate and ask questions in real time. PEBP also holds informational sessions for active members or retirees that are moving into the Medicare Exchange. PEBP hosted clinics where flu and shingles vaccines were made available to members. All of this information was communicated to members. PEBP continues to strive to find new and more effective ways to communicate.

5. Report on the July 1, 2022, 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 2022 (NRS 287.0425).

LAURA RICH (Executive Officer, PEBP):

Typically, PEBP's actuary would present this information. However, PEBP recently contracted with new actuaries, and as such, it was not appropriate to ask the new actuaries to present the work of a former contractor. Therefore, I will provide a very high-level overview of the information.

Other Post-Employment Benefits (OPEB) considers the program's long-term liability. The valuation was performed by PEBP's actuarial consultants. The actuaries value a cost to cover employees who are retired from state employment. Many states, including Nevada, have been moving away from offering retiree benefits. Many employers in the public and private sectors are no longer offering these benefits because of the high cost.

The Nevada Legislature determined that state employees hired after December 31, 2011, do not qualify for PEBP retiree benefits. Eventually, PEBP will not be offering retiree benefits.

The OPEB is currently an unfunded liability with no assets to back it up. It is being funded in a "pay as you go" format. This expense is built into the PEBP budget as the Retired Employees' Group Insurance (REGI) account. Agencies pay a percentage of payroll to fund their retiree benefits. There is no fund set aside to cover these benefits.

This would be a difficult benefit to reinstate because there is now a decade of unfunded liability. To reinstate it would require a lot of money. Eventually, that liability will decrease to zero, because eventually, everyone who is eligible for retiree benefits will have retired and passed on.

SENATOR STONE:

Are existing employees who were initially employed after 2011 paying for the OPEB contribution, even though they will not receive any retirement health benefit?

MS. RICH:

Technically it is charged to the agencies. It is state funded through a percentage of payroll that PEBP receives as a state subsidy. It is not necessarily funded by current active employees.

SENATOR STONE:

What is the magnitude of the unfunded liability in this fiscal year? When is it projected to reach zero?

MS. RICH:

That is an actuarial question that I will have to ask the subject matter experts. I will follow up with an answer for the Committee.

6. Report on the biennial review of PEBP's compliance with federal and state laws relating to taxes and employee benefits dated December 5, 2022 (NRS 287.0425).

LAURA RICH (Executive Officer, PEBP):

Per statute, PEBP is required to conduct a biennial compliance review, which covers the program's legal compliance with federal and state laws. PEBP's legal consultants perform a compliance review every two years. The compliance review assesses all new federal and state legislation that has been implemented, and whether PEBP is meeting those requirements. There are many requirements related to health insurance.

There were a few findings in the compliance review. Given all the new legislation and COVID-related changes, PEBP did well. There were a few findings, but overall, the findings were minimal.

The most significant finding was the Mental Health Parity and Addiction Equity Act. This act has been in place for several years; however, additional requirements were implemented within the past two years that require health plans to provide federal reporting and analysis on mental health parity. The Mental Health Parity and Addiction Equity Act ensures mental health benefits are being paid in parity with medical benefits on a health plan.

Self-funded government health plans are allowed to opt out of this. Although PEBP has not opted out, it did not comply with the federal reporting regulations that were implemented within the last two years.

When this was discussed with the PEBP Board, it was agreed that because there is an inherent risk in not opting out – the default is opting in – it potentially puts the program in a position with the federal government to undergo significant and time-intensive audits. The federal government is taking action and audits are happening regularly.

As discussed with the PEBP Board, the program can formally opt out, but continue to act as if it had opted in. Opting out allows PEBP to remove the risk of federal audits and the required administrative reporting, while continuing with the work to show that PEBP is in compliance with the act. The PEBP Board chose to opt out, but PEBP will conduct the non-quantitative and quantitative analysis required to ensure the program is in compliance with the act. PEBP is essentially following the spirit of the law, without putting the program at risk.

The next finding was the Dental Excepted Benefit. Under the Affordable Care Act (ACA), there are ten Essential Health Benefits required, one of which is pediatric dental. Children under the age of 19 are required to have pediatric dental coverage. The plan must adhere to ACA regulations. Typically, there are situations where a plan is considered an excepted benefit – an exception to the ACA. To be an excepted benefit, the benefit cannot be bundled into the medical plan. It must be separate from the medical plan contractually, or members must enroll separately. That is how a health service or plan such as dental can be qualified to not have to comply with the ACA ten Essential Health Benefits.

In PEBP, dental coverage is bundled with medical coverage. This has come up in a prior compliance audit. In the past, PEBP's Deputy Attorney General determined it to be an excepted benefit. Nothing had been done about it previously, but during discussions with PEBP's current Deputy Attorney General, it was agreed that the current dental plan is not an excepted benefit.

To comply, dental coverage could be made an excepted benefit by separating it from medical coverage, which would be quite difficult. PEBP staff would have to separate the premiums and allow members to enroll and disenroll. After all the changes that PEBP has undergone, that would be very disruptive to members. It would be challenging and would be a cost to the program. Ultimately, the PEBP Board opted against this idea. The easier option was to comply with the ACA ten Essential Health Benefits, thus PEBP eliminated the annual maximum of $2,000 for the dental benefit, for children under 19.

Another finding related to nondiscrimination testing, which PEBP is required to perform. PEBP is working with vendors to implement the testing.

In addition, there was a variety of suggested language edits to PEBP's master plan documents. PEBP is actively working with subject matter experts in clinical areas, the third-party administrator, the Pharmacy Benefit Manager, and legal consultants to make changes to the master plan documents. Those changes will be presented to the PEBP Board in January 2023 for final approval so the documents are ready for open enrollment in May 2023.

Another significant finding was the right to continuation of care. The *Nevada Revised Statutes* require PEBP's insurance plans to offer continuation of care if providers become out of network while a member is receiving care. Depending on the situation, there is a timeframe in which a person can continue care through that provider at the in-network rate. A process is in place; however, there is a requirement that the health plan must proactively identify members that meet these criteria. While PEBP does have a process in place to allow members to seek continuation of care, it is not proactive; members must request continuation of care. PEBP is working with the third-party administrator to ensure compliance.

All of the findings in the compliance review should be rectified shortly through some small changes in the program.

ASSEMBLYWOMAN PETERS:

Regarding the decision to opt out of the Mental Health Parity and Addiction Equity Act, mental health care is an area I receive the most complaints about from public employees. The coverage is not adequate to meet their needs, especially for dependent children, which is one of the highest risk populations in the state.

I like the reporting requirement. It is important for the state to set a standard of meeting compliance. If the state does not comply, it is difficult to justify requiring private industry to comply. How will PEBP ensure it is meeting those metrics without opting in for the Mental Health Parity and Addiction Equity Act reporting?

MS. RICH:

PEBP will prepare all the reporting and analysis that is required under the Mental Health Parity and Addiction Equity Act. Those reports will be presented to the PEBP Board in late 2023. PEBP has opted out of the federal requirement but is still conducting all the activities and reports required of that act. PEBP staff is actively working with vendors to start that process.

I agree that mental health is very important. There are provider shortages statewide and nationally. It is not necessarily a network problem, but a shortage of providers in general. It is a major problem in Nevada.

When PEBP switched networks in July, two out-of-network Northern Nevada hospital systems called me directly because their behavioral health units had 100 PEBP patients. I contacted the network to find out what could be done, because those patients did not have an alternative. The network and provider group worked together to address the issue; however, that comes at a cost. When the network contracts with that provider group, they are contracting at much higher reimbursement rates than the market rate. The provider groups can do that because there is a provider shortage.

I would assume the contracted rates with mental health providers will be increasing rapidly. Again, it comes down to supply and demand. There is a low supply of providers and a high demand for services. Mental health services are a high cost on the plan and will continue to increase.

Doctor on Demand, which is a telehealth program, is currently offered through PEBP. In addition to medical care, members can seek psychiatric or other mental health services through Doctor on Demand. The PEBP Board did not approve lowering the copay as an incentive for people to access mental and behavioral health services in a telehealth setting.

After the COVID-19 pandemic, mental health became an even higher item on PEBP's radar, and it should be on the state's radar as well.

ASSEMBLYWOMAN PETERS:

It is difficult to talk about the economic impact of not treating mental and behavioral health issues, and the effect it has on the economic system. People who are not being treated for mental health issues miss time at work and/or are less productive. Providing mental health parity would shift that out of the economic cost burden and into the health care cost burden where it should be addressed.

I would ask that PEBP work with the Committee to ensure the compliance reporting is being performed. The Division of Insurance is held to the same requirement for private insurance plans. I would like to see those reports side-by-side to ensure the industry is using the same types of metrics.

SENATOR DONDERO-LOOP:

I am also concerned about this issue. Where is it written that the reporting will occur if PEBP is not required to report to the federal government? I know current PEBP leadership will provide the reporting, but will the next Executive Director follow the directive of opting out while continuing to provide the reports?

Members should be alerted when there are changes to vendors or approved medications. Mental health drugs are very specific, and it is important that the medication is monitored properly by a doctor.

MS. RICH:

The federal government requires annual reporting, and although PEBP has opted out, the PEBP Board has mandated the reporting requirement be honored. Thus, PEBP will submit the report to the Board upon completion of the analysis. This is one of many annual activities that will continue regardless of the Executive Officer.

ASSEMBLYWOMAN PETERS:

Please explain how the reporting requirement will be documented as a mandate by the PEBP Board.

MS. RICH:

The PEBP Board requested that staff perform the quantitative/non-quantitative testing needed for the reporting. The PEBP Board meeting was on December 5, 2022, so I do not have all the details yet. Conducting the analysis will require vendor coordination to analyze parity between PEBP's medical and mental health care benefits. I do not see it being problematic. PEBP members pay a specialist visit copay for mental health services. The vendor's report contains much more detail so it will take several months to perform the analysis. The analysis and reporting will be performed as if PEBP had opted in to report to the federal government. That information will be then presented to the PEBP Board.

I anticipate the report will be submitted to the PEBP Board in the summer or fall of 2023. PEBP's vacancy rate is between 25.0% and 30.0%, and existing staff is working to implement many items as well as preparing for the 2023 Legislative Session.

I foresee this report will be presented to the PEBP Board at its July or September meeting. In the future, the report will be a recurring agenda item on the PEBP Board's annual schedule. PEBP will have to actively opt out of the federal reporting each year, and that decision must be approved by the Board annually.

ASSEMBLYWOMAN PETERS:

I am sure all the Committee members appreciate PEBP's commitment to meeting its obligations despite the lack of staff. That does not dismiss the Committee's obligations to its constituents, many of whom are PEBP members.

It is my understanding the reporting will not be mandated; it will be addressed by the PEBP Board annually. If it is not requested by the PEBP Board, within the context of opting out from the federal reporting, then it would not have to be reported by PEBP staff.

MS. RICH:

Another idea would be to add this report to the IRBC agenda either in the utilization report or as a separate agenda item. PEBP would be happy to report annually to the Committee on the Mental Health Parity and Addiction Equity Act metrics.

V. PUBLIC EMPLOYEES' RETIREMENT SYSTEM (PERS), JUDICIAL RETIREMENT SYSTEM AND LEGISLATORS' RETIREMENT SYSTEM.

TINA LEISS (Executive Officer, Public Employees' Retirement System [PERS]):

I would like to introduce Steve Edmundson, Chief Investment Officer, PERS; Kabrina Feser, Operations Officer, PERS; and Rick Combs, who will testify on Agenda Item V.6, which is the Retirement Benefits Investment Board, which relates to a separate fund for local governments.

I will begin with a brief overview of PERS. PERS covers all public employers in the State of Nevada, including city, county, state, and school districts. The largest employer is the Clark County School District, and the second largest employer is the State of Nevada. The State of Nevada, including the Nevada System of Higher Education (NSHE), comprises approximately 20% of the fund.

PERS is a cost sharing plan in which all employers and employees participate equally. The benefit provisions and the contribution rates are the same across all employers. That allows employees to move freely between public employers without experiencing any difference in the benefit structure or contribution rates.

1. Report on actuarial valuation for the Public Employees' Retirement System as of June 30, 2022.

TINA LEISS (Executive Officer, PERS):

The actuarial valuations determine the projected liability for the plan and the contribution rates needed to fund the plan. During this process, the actuary considers plan design, member demographics, and economic assumptions to arrive at the valuation of the system.

Pursuant to the Nevada Constitution, the system is governed by the Retirement Board. The Nevada Constitution also requires the Retirement Board to adopt the actuarial assumptions recommended by the actuary. If the actuary recommends an assumption, the Retirement Board is legally required to adopt those assumptions when the actuary prepares the valuation.

By statute, the contribution rates are set based on the rate developed by the actuary. This is legally an automatic process by which the actuary does the valuation, then the statute determines what those contribution rates will be based upon that valuation.

Pursuant to the statute, the contribution rate must change with the first full reporting period on or after July 1 of each odd-numbered year. Thus, the 2022 valuation determines the rates beginning July 1, 2023.

The ultimate cost of benefits to be paid by the system are determined by the plan design, which is set by the Legislature, and future events such as the length of service, average compensation, and longevity of members. The goal of the actuarial funding is to ensure current and future benefits are paid with the appropriate levels of employer and employee contributions and the investment earnings on those contributions.

To project the liabilities, assumptions are made about future events. Because they are future events, those events are unknown. The actuary makes those assumptions in the valuation process, then looks at how the system's experience compared to that assumption. There will be a gain or loss based on how the system performed against the assumptions.

Some of the assumptions about future events include whether the system made more or less than the long-term rate of investment; if members lived longer than assumed or if there were more deaths than expected; and if members had higher or lower salaries than expected. Those factors are used to determine how the system's contribution rates are valued for the two-year period.

Every four to six years, PERS conducts an experience study to make sure those assumptions are tracking with the system's experience. Last year, PERS reported that the 2021 valuation included the changed assumptions from the last experience study in 2021; however, 2021 was not a rate setting valuation. The valuation before the Committee is the first valuation for which the new assumptions based on the 2021 experience study have been implemented and feed into the contribution rates.

The biggest demographic assumption that was changed for the experience study was the mortality tables, which is the longevity of members. The plan moved to a fully generational mortality table, which accounts for future expected growth in longevity or changes in longevity. When it is assumed that people will live longer, the benefit will be paid for a longer period than previously expected. Any such changes to the mortality table will increase costs and increase the unfunded liability.

The assumed rate of investment return was changed from 7.5% to 7.25%. That is a long-term assumption. PERS does not anticipate that the system will make 7.25% each year, but over the longer term, that is the average expected for that long-term rate of assumption.

The other significant change to the experience study was the payroll growth assumption. The regular fund had a payroll growth assumption of 5.5%; it was changed to 3.5% annual growth per year. The police/fire fund changed from 6.5% payroll growth assumption to 3.5%. This assumption is important in paying off unfunded liability. Contributions are a percentage of payroll. The actuary determines the amount of contributions needed as a

lump sum amount and converts it back to a percentage of payroll. If payroll is lower than expected, and payments are being made as a percentage of payroll, ultimately, contributions will be lower than assumed. When the assumed payroll growth assumption is lowered to pay for the unfunded liability, that translates to needing a higher percentage of the payroll, because the payroll is not growing as much as assumed.

I would note that payroll growth assumption is something PERS has been watching since 2008. Prior to 2008, the State of Nevada had extremely high payroll growth in public employment. The state's public employment payroll growth was always the top in the nation. That is interesting because Nevada has historically had the lowest number of public employees per capita; however, because Nevada was a fast-growing state through the 1970s, 1980s, 1990s and the early 2000s, there was very high payroll growth. Contributions were based on a percentage of payroll, and payroll growth was higher than assumed, which resulted in more contributions.

In 2008 and 2009 that reversed resulting in years of negative payroll growth, which resulted in lower contributions. PERS was hesitant to make long-term changes to the payroll growth right after the 2008-2009 timeframe; however, by 2021, when the payroll growth had still not returned in the state, the actuary determined the change was needed because it was looking like a long-term trend versus a short-term issue.

The modifications to the assumptions can have increasing or decreasing effects on contribution rates. In this case, the assumption changes in 2021 primarily had increasing effects to the contribution rates. That will be clearer further into the presentation.

I will comment briefly on changes to the active membership shown in the charts on pages 328 and 329 of the meeting packet (Exhibit A). The 2022 valuation shows an overall increase in active members from 106,930 to 108,635; however, that was not equal between the regular fund and police/fire fund.

The police/fire fund experienced a decrease of 284 active members. The police/fire fund is currently just under 13,000 members. It is a much smaller fund than the regular fund. Active membership in the regular fund increased. The increase or decrease in growth will need to be considered for the payroll growth in the future.

The charts on pages 330 and 331 of the meeting packet (Exhibit A) contain information on the retiree membership and the average monthly benefit, which have grown as anticipated in the last year.

The charts on pages 332 and 333 of the meeting packet (Exhibit A) show the actuarially calculated contribution rates for 2022. These rates reflect both the five-year asset smoothing and a rate impact smoothing that was done using the assumption changes.

When the actuary conducted the 2021 experience study, it recommended that the Retirement Board smooth the impact of those changes, because the changes were significant. The rates reflect half of the impact of the smoothing. That is reflected in the

current statutory rate in the regular fund of 29.75% of payroll. The actuarial rate came in at 33.61%. With the statutory rounding mechanism, that would be 33.5% in the employer pay rate. It is called “employer pay” because the entire contribution is collected from the employer.

About 80% of the membership participates in the employer pay plan. Most local governments can legally offer only the employer pay plan. This is equally shared between the member and the employer. When there is a rate increase, the employer must certify to PERS how the employee is sharing in their half of the increase. The employer can report that it will reduce the employee’s salary for half of the contribution rate increase, which is historically what the state has done with its employees, or the employer can report that it was going to give its employees an equivalent pay increase, but instead will pay the employee portion of the contribution rate increase. This is historically how local governments implement the contribution rate increase.

The police/fire rate is shown on page 332 (Exhibit A). The current statutory rate is 44%. The actuarial rate was 49.95%, which resulted in a statutory rate of 50%, or an increase of 6%.

The causes for the contribution rate increases for the police/fire fund are similar to the regular fund, but they are magnified. The smaller size of the fund makes it more volatile; there are fewer members to spread changes over. Changes to certain functions also have a greater impact on the police/fire fund. The main distinguishing factor between the regular fund benefit provisions and the police/fire fund benefit provisions is that the police/fire fund has earlier retirement. A police/fire member can retire at age 50 with 20 years of service. A regular member can retire at age 60 with 10 years of service.

There is typically a ten-year difference between when police/fire members can retire and when a regular member can retire. If a member is drawing the benefit for ten years longer, that will greatly increase the cost of that benefit. Also, the mortality tables are very similar between the two funds. Drawing retirement ten years earlier generally will mean that they will also be drawing ten years longer. That is what makes that benefit significantly more expensive in the contribution rate.

Page 333 (Exhibit A) shows the employee/employer paid fund. This fund is where the employer pays half of the rate directly to PERS, and the employee pay half of the rate. The employee share is an after-tax deduction, and their contributions are refundable. The refundable employee contributions make this rate about 1% to 1.5% higher historically. Only about 20% of members participate under this program. It is a choice of the member to choose either the employer pay, or employee/employer pay if they are with an agency that can legally allow that. Most of the employees in the employee/employer pay fund are state employees. That is the largest employer that is legally able to offer this plan. An employee on the employee/employer pay can voluntarily switch to the employer pay plan, but once an employee makes that switch, they must stay on the employer pay plan.

The information shown on the table on page 334 gets to the heart of why these rates have changed (Exhibit A). An actuarial valuation is performed every year, but the rates only change every two years. PERS went back to the previous rate setting year of 2020 to get the rate on top. These are the average rates between the two contribution rate plans. They will not completely match with either plan, because the actuary averaged the two as a weighted average. Anything in parentheses on this page is a reduction to the rate, and anything not in parentheses was an increase to the rate.

Even though PERS' fiscal year market investment return was less than the assumed return, the five-year smoothing of assets resulted in an investment gain for the year. The investment gain over the two-year period reduced the contribution rate in the regular fund by 2.36%.

The most significant impacts to the increase are the effect of the payroll growth being lower than assumed, meaning PERS is not getting contribution rates in at the level that had been assumed. Approximately 2% of the rate increase for the regular fund and approximately 3% of the rate increase for the police/fire fund is due to post-retirement benefit increases being greater than assumed. PERS' long-term assumption for inflation is 2.5%. Inflation has been higher than that in the last year or so. PERS' post-retirement benefit increases are capped by the rate of inflation. Since inflation has generally been higher than the statutory percentages, the plan is paying higher post-retirement increases to retirees, which has led to a significant loss in the last two years. That loss has led to a significant portion of the contribution rate increase.

The Legislature has determined that part of the benefit design is necessary because it allows retiree benefits to keep pace with inflation. These post-retirement benefit increases are paid through the contribution rate. Prior to the high inflationary environment PERS had gains in this area.

On the regular plan, the effect of the changes in the assumptions was 7.92%. That change is primarily from the changes in payroll growth assumption, mortality tables, and retirement rates. Over the last ten years or so the plan has been running losses in rates of retirement. People are retiring earlier and more expensively than assumed. Changes were made to the assumption, which then changed the rate going forward.

The Retirement Board, at the recommendation of the actuary, made a change to the funding policy on the amortization of the unfunded liability. There was a short time period in the amortization of the unfunded liability. The shorter the time period, the more volatile. The Retirement Board made a change to the regular fund that would take the biggest layer of the unfunded liability and leave it on the same time schedule. However, because of the effect the changes had on the rates, it was determined that it was sound funding policy to put the rest of the unfunded liability on a 20-year payment schedule. That had an impact of decreasing the ultimate rate by 1.5% for the regular fund.

For the police/fire fund, the entire unfunded liability was put on a 20-year payment, as recommended by the actuary. Because of the smaller size of that fund and the short amortization period, it was becoming too volatile. That saved about 6.0% on the contribution rate for the police/fire side.

The table on page 334 shows the causes of the rate changes and the effect of the methods the Retirement Board used to reduce some of the volatility of the contribution rates (Exhibit A).

With the change to the amortization period, the effective amortization period for the regular fund is 16.5 years and for the police/fire fund it is 20 years, for an aggregate of 17.3 years. Currently, PERS is on a 17.3-year amortization period, which is very good industrywide. The actuaries become concerned when the amortization period is above 25 years.

Page 335 shows information on the funded ratio of the system (Exhibit A). The funded ratio is based on actuarial valued assets versus actuarial liabilities. The actuarial valued asset is used for funding purposes, because it smooths the five-years of investment gains and losses to reduce the volatility. The actuarial funded ratio for the regular fund decreased slightly from 75.3% to 74.8%, and the police/fire fund ratio decreased from 75.6% to 74.6%. This is mainly due to the assumption changes. Again, changes to the mortality tables will affect the unfunded liability number. The combined actuary funded ratio is 74.7%, which is down from 75.4%.

Page 336 (Exhibit A) shows information regarding actuarial valued assets versus the actuarial liabilities. This is a representation of the growth of the assets versus the growth of the unfunded liability over a ten-year period. Currently, PERS' actuarial valued assets and market value assets are close. There is a small unrecognized investment gain that will be recognized over the next three years.

CHAIR MONROE-MORENO:

You have covered the primary factors that contributed to the proposed increases in contribution rates. Were other options to offset the increases in contribution rates discussed with the Retirement Board?

MS. LEISS:

PERS' legal provisions and funding policy did not allow many options for the Retirement Board. The Nevada Constitution requires the Retirement Board to adopt the assumptions recommended by the actuary. That policy assures the system is realistically funding the plan. In addition, statute requires that the contribution rates be set based on the actuarial valuation results. There is not much discretion for the Retirement Board in setting contribution rates. The Retirement Board has some discretion in the funding policy itself, which always comes on the advice of the actuary.

The Retirement Board opted to phase-in the changes based on the changes to the actuarial assumptions and lengthen the period by which PERS is paying the unfunded liability. Those were really the only two options the Retirement Board discussed.

The Legislature has options. Historically, the Legislature has controlled how the contribution rate mechanism - including the split between the employer and employee - through statute. Nevada is somewhat unique in that the employer and employee split the rate in half, including the payment on the unfunded liability. Changes to those areas would be made by the Legislature.

CHAIR MONROE-MORENO:

How is that done in other states?

MS. LEISS:

Some states are fully non-contributory, which means the employer pays the entire rate. That is not very common. The most common method is for the employee portion of the rate to be set in statute as a certain percentage. The employer contribution rate would fluctuate based on the actuarial results.

A number of states have a statutory rate set as a certain percentage of payroll. The concern with that method is the state may not always be paying the rate the actuary believes is necessary to fund the plan.

SENATOR OHRENSCHALL:

The table on page 334 lists the changes in actuarially determined contribution rates (Exhibit A). The third item is the effect on existing amortization of payroll growth being less than expected. Is the decrease due to the contributing members' payroll not increasing as it had in the past? Is part of that decrease due to state and local government staff vacancies?

MS. LEISS:

The decrease is due to a combination of salaries not increasing and staff vacancies, but it probably has more to do with the number of active members, which is lower due to vacancies. The contribution is based on total payroll and the number of active members.

SENATOR OHRENSCHALL:

Would the projected increases in employee contributions be worse if the contribution smoothing mechanism had not been put in place by the Retirement Board?

MS. LEISS:

The Retirement Board's decision to smooth the phase-in of the actuarial assumption changes definitely decreased the current contribution rate increases. The point was to incrementally add the changes over four years. The change to the amortization period will permanently lower what the rate would have been because it is spread over a long period of time.

SENATOR DONDERO-LOOP:

The 12 entities participating in the Retirement Benefits Investment Fund (RBIF) are listed on page 362 of the meeting packet (Exhibit A). Why are other government entities like the City of North Las Vegas or Clark County School District not participating in the RBIF?

MS. LEISS:

There is a later agenda item on the RBIF. Would you prefer to wait for that discussion? Otherwise, Mr. Combs is available to answer that now.

SENATOR DONDERO-LOOP:

I will wait until the RBIF agenda item.

2. Report on actuarial valuation for the Judicial Retirement System as of June 30, 2022.

TINA LEISS (Executive Officer, PERS):

PERS is also tasked with the administration of the Judicial Retirement System (JRS). Prior to 2001, the judges' retirement was "pay as you go." Judges were not in PERS unless they were prior PERS members. The benefit was promised to them in statute; each legislative session the Legislature would fund the benefits being paid out. There were no contributions made and no investments.

In 2001 the JRS was created. It was funded with an initial payment of $5 million in July 2001. All the judges to whom the state was paying benefits on a pay-as-you go basis were folded into the JRS. That JRS started with paying out benefits to people who had never contributed. The JRS was initially created with an unfunded liability. At that time, it was just for Supreme Court Justices and District Court Judges.

In 2007, the Legislature allowed local jurisdictions to opt to elect to cover their justices of the peace and municipal court judges. Because of the way the JRS was created, it was not a cost-sharing plan. In other words, the actuary performs a mini valuation; one for the state, and one for each local government employer. Each local government employer that has opted to participate has its own contribution rate.

Similar to PERS, the JRS has a mechanism to change rates every two years based on the actuarial valuation. Those rates are viewed both as an aggregate as well as individually employer by employer.

The actuarial contribution rate for state judges is currently 22.0%. That is only for routine costs and administrative costs. It does not include a payment on the unfunded liability. For PERS, the payment on the unfunded liability is included in the total contribution rate. However, for the state judges, PERS receives a lump-sum payment each year to pay the unfunded liability payment. The 22.0% covers what is going forward, then PERS receives a lump sum for the unfunded liability payment.

The rate for state judges came in at 23.33%. They had similar assumption changes as the PERS fund. Demographically, they are a very different group than general employees in PERS. The JRS members tend to come to the plan a little bit older than other employees. Their rounded rate will move from 22.0% to 23.25%. The amortization payment is paid directly to PERS from the Administrative Office of the Courts (AOC) annually in July. That payment will be $1,551,796 each year of the 2023-25 biennium. That is up from $1,322,137 in the current biennium.

The ratio of assets to liability in this fund increased from 92% to 92.2%. The unfunded actuarial liability increased from $14.2 million to $14.7 million. This is on aggregate. Pages 339 to 344 contain demographic information for full state and non-state members (Exhibit A). Page 342 contains the contribution rate for state judges, and pages 343 and 344 contain contribution rate information for local jurisdictions.

There is a large variation in contribution rates for the local jurisdictions because they generally cover a very small number of people. Some local jurisdictions may only have one active member, and some have no active members at this point. Some have retirees and some do not have retirees. For the most part, the local governments were developed without an unfunded liability. For the most part, they are 100% funded on an individual basis.

3. Report on actuarial valuation for the Legislators' Retirement System as of June 30, 2022.

TINA LEISS (Executive Officer, PERS):

The provisions of the Legislators' Retirement System (LRS) allow legislators to either opt out or terminate participation. In 2022, the active membership in this fund decreased from 27 to 25 members; the number of retirees decreased from 55 to 53; while the number of overall beneficiaries, including survivors, decreased from 70 to 69.

Like PERS and JRS, the even-numbered fiscal year valuation for the LRS determines the amount of the lump-sum contribution made by the employer, in this case the Legislature, for each year of the biennium. By statute, the participating legislators contribute 15.0% of their legislative pay as the employee contribution. The employer pays whatever is determined by the actuary above the 15.0% needed to fund the plan.

In this valuation, the employer payment is increasing from $82,846 in the prior biennium to $90,579 in the current biennium, in each year of the upcoming biennium. The assumption changes were also made to the LRS, which is the main reason the payment is increasing.

The funded ratio of the LRS decreased from 98.8% to 97.6%: it is nearly 100% funded. The unfunded actuarial liability is somewhat volatile because of the small size and the very short amortization period of the fund. It increased over the last year from $61,732 to $124,363; however, by comparison, it was $199,000 two years ago. Over a two-year period, the unfunded liability decreased from $199,000 to $124,363.

The demographic information for this plan is on page 346 of the meeting packet (Exhibit A). The amortization period for this fund is only 1.7 years. That is the length of time that is estimated for the LRS fund to be 100% funded. The active membership is dropping because of the opt out and termination features of this plan. I would note the maximum benefit from this plan can no longer be achieved by any individual member due to term limits. It would take 30 years of legislative service to achieve the maximum benefit, and I do not believe that is possible any longer.

4. Update on investment earnings - PERS, Legislators' Retirement and Judicial Retirement Funds.

STEVE EDMUNDSON (Chief Investment Officer, PERS):

I am going to cover the status of the investment program for PERS, LRS and JRS. Page 351, titled *Investment Results*, summarizes performance for all three funds through the FY 2022 (Exhibit A). The column furthest to the left depicts returns for the most recent fiscal year in which Nevada PERS experienced a return of -5.2%.

It was a difficult year for investments, although not unexpected. This represents the fifth negative fiscal year in PERS' history. Throughout the 38 years since the inception of Nevada PERS the investment return has achieved it long-term objective. However, for any individual year PERS expects a lot of volatility around those returns. In fact, looking at 3, 5, 10 and 30-year numbers for PERS, each one of those returns is above PERS' long-term return assumption.

The middle column, the five-year number, is often an important one for valuation in that the actuary utilizes the five-year smoothing period for investment returns. When that number is above the long-term return assumption, that implies that some investment gains will be rolled into the valuations.

The LRS and JRS portfolios returned -9.5% for the fiscal year. The LRS portfolio ended the period with $4.8 million in assets, and the JRS fund ended the period with $163.7 million in assets. The return differences between the large PERS fund and the smaller LRS and JRS portfolios is largely due to the fact that smaller portfolios do not have private market exposures in them. The larger Nevada PERS fund has allocations for private equity and private real estate. Those returns tend to lag behind public markets to some degree. In a single year, there will be some return difference, but over a longer time horizon the risk profiles of those smaller portfolios are designed to roughly align with PERS. Over extended time periods those returns come closer together, as is happening in the current fiscal year. Last fiscal year, private markets were somewhat of a tailwind for the larger PERS portfolio. It would not be surprising to see that phenomenon change next year so that the smaller LRS and JRS funds perhaps outpace the larger PERS portfolio.

Page 352 titled *PERS' Annual Performance Details* shows investment returns for each of the last 38 fiscal years (Exhibit A). The black horizontal line across the middle of the page depicts PERS' long-term investment return assumption, which was reduced by the Retirement Board from 7.5% to 7.25% at the recommendation of the actuary. Looking back over the past 38 years, it is important to note that PERS does not expect any single year to be right at 7.25%. In single years, PERS expects a wide dispersion of returns above and below that rate. The last couple of years are a good example of that. PERS' return for FY 2021 was over 27.0%, but in FY 2022 it was -5.0%. Over the last 38 years, 12 of those years were below that number.

PERS' investment strategy is somewhat unique in the industry in that it employs a much simpler portfolio design, with a larger allocation to high-quality publicly traded stocks and bonds (page 355, Exhibit A). To my knowledge, PERS is the only large public pension fund that is 100% indexed across all publicly traded U.S. stocks, international stocks and U.S. bonds are indexed, which keeps costs low.

There are a number of advantages to the simple structure of PERS, not the least of which is minimizing investment costs. PERS does not know what the future holds for markets every year, but PERS can control costs. There has been a heavy emphasis on cost control on that over the years. PERS' investment costs are among the lowest, if not the lowest, amongst the peer group of large public pension funds. It is estimated the lower fee structure saves the system more than $200 million per year.

In addition to being low cost, the simple portfolio design has also proven to be competitive over time. Over the last 3, 5, 7 and 10-year periods, PERS' investment returns ranked within the top 10th percentile or better amongst its large public fund peer group. Over the last 38 years, since the fund's inception, PERS' returns ranked within the top 15th percentile of large public pension funds.

Similar to single year returns, PERS does not expect its rankings will be at the top of the peer group every year. PERS spends about one-third of any individual year at the bottom end of the data base. Over time, PERS believes its simple low-cost approach will continue to be competitive relative to more complicated portfolios.

Today's report and the provided material covers the period up to the most recent fiscal year. I will provide a quick update on FY 2023. As of this morning, PERS' portfolio is up approximately 3.5%, with approximately $55.7 billion in total fund assets. Thus far, this fiscal year has proven to be very volatile. At one point in the month of July, PERS' total portfolio was up 7.0% fiscal year to date. The portfolio finished the September quarter at -5.2%. Today, the portfolio is up 3.5% fiscal year to date. It is difficult to predict how the fiscal year will end but given the Federal Reserve's current aggressive rate hiking to bring inflation down, additional volatility throughout the rest of the year would not be surprising.

Despite the market volatility over the last 12 to 18 months, there are silver linings specifically for public pension funds. The dramatic increase in interest rates has been making waves across the markets. In March 2020, the yield on ten-year treasury bonds was 50 basis points, or 0.5%. Today, it hovered around 3.5%. Treasury bonds were above 4.0% earlier in the fiscal year. The higher yield for fixed income securities portends a much stronger foundation for future returns for public pension funds. The more normalized interest rate environment is a better and stronger foundation for prospective returns than when rates were at historical lows.

SENATOR STONE:

I can imagine the stress it would cause to endure the market fluctuations over the past 12 months. Interest rates were raised again today, and the market reflects that by declining over 300 points today. Would the prospect of a potential recession change PERS' investment strategy in 2023?

MR. EDMUNDSON:

A recession will not change PERS' long-term approach. PERS tries to maintain a long-time horizon. The Federal Reserve raised rates again today. There is no indication of where the terminal rate will be when the Federal Reserve ultimately stops raising rates; whether there will be a soft landing; or whether the economy ultimately experiences a recession. A recession would certainly impact PERS' return for the current fiscal year, and probably the coming years as well. That is not something that is under PERS' control. However, PERS can control fees by keeping fees low and maintain a disciplined approach through the market cycle. PERS has been able to do those things, with a high degree of success, within its investment portfolio.

PERS does not change its approach through the market cycle. Through the dot com run up in the late 1990s and early 2000s, throughout the financial crisis, PERS deployed a disciplined approach, and will continue that approach in the current environment.

One benefit of PERS' simple structure is there is a lot of liquidity in the portfolio. PERS adheres to a disciplined rebalancing process. PERS sold off and rebalanced risky assets such as stocks after they experienced a large run up. The most recent example of that would be when PERS sold roughly 5.0% equity in the fall of 2021. PERS rebalanced back into equities in June 2022.

The high degree of liquidity in PERS' portfolio makes that an option for PERS. There might be some rebalancing, but from a long-term strategic perspective, PERS does not anticipate making any changes.

SENATOR STONE:

Are there any thresholds that would require PERS to alert the Legislature in the event the market continues a downward slide, and the unfunded liability increases to a point where it becomes a factor? In my prior experience in another state legislature, which had a much larger fund than PERS, there were many instances where the state had to put general funds into the pension system, because it fell below a certain threshold. Has that been an issue in Nevada where the state has had to supplant the pension fund?

TINA LEISS (Executive Officer, Public Employees' Retirement System ([PERS]):

That has never happened in Nevada. PERS is a bit different in that its contribution rates are based on the actuarial valuation. The contributions that are made are the contributions that are supposed to be made. That is not always true in other states that have a statutory rate that does not necessarily meet the actuarial rate.

Also, although the system is in its 75th year, PERS is a bit of a young fund in the sense that it went cash flow negative from the perspective of contributions to benefits, much later than other funds. PERS is fairly liquid. There are no legal thresholds by which PERS would report, other than reporting to the IRBC. PERS has never been close to that type of situation.

SENATOR STONE:

I would like to compliment you. PERS investment strategies have been both robust and conservative. Other private sector funds involved in the market have experienced much larger losses than the PERS fund. Thank you for your astute protection of the public funds.

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.

TINA LEISS (Executive Officer, PERS):

Page 357 of the meeting packet is a report on the benefit provided to certain education employees pursuant to NRS 391.165 (Exhibit A). This benefit was implemented by the

Legislature as an incentive for certain employees to work at schools that have been designated as needing improvement, or at which at least 65% of the pupils are children who are at risk. Additionally, this benefit was available to any teacher who held an endorsement in mathematics, science, special education, or English as a second language, and have met all other requirements. Under this program, if the individual met the qualifications, the employer (school district) would purchase one-fifth of a year of service credit for that teacher for every year that they qualified, up to one year of service credit.

Section 4 of A.B. 1 of the 23rd Special Session repealed this benefit effective July 1, 2007, and phased it out over time. This benefit is still being discussed in 2022 because the benefit was phased out in such a way that if an employee elected to continue in the one-fifth year purchase program, their participation ceased when the employee had received, after the election, one year of service credit. Because people move in and out of being eligible, there are still people who elected to participate in this program prior to 2007 who have not had a full year of service credit purchased for them.

The spreadsheet on page 357 (Exhibit A) reflects purchases from calendar years 2021 and 2022. In calendar year 2021 the system received $266,695 from 44 purchases. In calendar year 2022 the system received $250,153 for 39 purchases. The benefit is phasing out, but there are still some people who are eligible. Currently, those individuals are all within Clark and Washoe Counties.

Since the benefit's inception, the system has received over $148 million for 41,771 purchases. The one-fifth year credit benefit is nearing its end. The last of these reports could be presented over the next few IRBC meetings.

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

RICK COMBS (Contract Administrator, PERS):

I am the part-time Contract Administrator for the Retirement and Benefits Investment Fund (RBIF).

I will provide a brief history about the fund's creation. The RBIF was created in 2007 through a bill that was requested by the Committee on Local Government Finance. The Committee on Local Government Finance had two goals. The first goal was to authorize local governments to create irrevocable trusts in which funds would be held to offset liabilities for other post-employment benefits (OPEB). The second goal was to provide flexibility for local governments to invest in long-term investments, rather than the short-term investments they had been limited to under statute.

As a result, legislation was passed to authorize the local governments to create their own irrevocable trusts to set aside money. These were basically in response to the Government Accounting Standards Board's (GASB) statements that required government entities to reflect the liabilities on their balance sheets. The GASB then stated that if government entities wanted to then offset those liabilities on their balance sheet, those funds that were set aside had to be in an irrevocable trust.

Pursuant to that enabling statute, the RBIF is administered by a board called the Retirement Benefits Investment Board, which is comprised of the same members of the PERS Board. It is a separate legal entity with its own agendized meetings.

The Retirement Benefits Investment Board is authorized to employ staff and enter into contracts for services. The Retirement Benefits Investment Board is authorized to assess reasonable charges against the fund for the cost of staff and contract services.

From its inception until October 2020, PERS staff handled all the administrative services provided for the fund. In October 2020, the Board decided to put the administrative services under a separate contract. PERS staff still provides all investment and accounting services for the fund.

The fund balance as of the close of FY 2022 was $701.5 million. The FY 2022 return was -9.4%, which was similar to the JRS and LRS return. Since its inception in early 2008, the fund has returns on average of 6.7%. Those dollar amounts are included in the tables on pages 363 and 364 of the meeting packet (Exhibit A). Although the funds in the RBIF are managed in the same way as the JRS and the LRS, there is a slight difference in the structure because the RBIF is smaller than PERS. The RBIF does not invest in private equities and real estate investments like PERS.

Notwithstanding that, for the last ten years the return of the RBIF has been within one-half of a percent of the PERS fund. These results can confirm the Retirement Benefits Investment Board's success in meeting the statutory requirement that the RBIF be invested in the same manner as money in the PERS fund.

Page 362 of the meeting packet (Exhibit A) shows the 12 entities currently participating in the RBIF. PEBP removed the remaining small amount of its investment and will no longer invest in the RBIF. The two largest entities in terms of investments are Washoe and Clark Counties.

Senator Dondero Loop asked why more local governments were not listed. When this legislation was passed in 2007, it provided authority for local governments to invest in the RBIF; however, there is no requirement that they participate in the fund. That does not mean the local governments that are not involved in the fund are not handling their liability appropriately. The enabling legislation gave local governments the authority to create irrevocable trusts at the local level. The RBIF is not the only investment allowed. The statute says local governments can invest in any investment that is authorized for a local government under *Nevada Revised Statutes* (NRS) 355.170. That section provides a

long list of short-term investments that local governments can make. It is possible some of the entities not participating in the RBIF are using other types of investments for their funds.

The local governments were also given the authority to invest in any stocks or bonds outside of the RBIF if the Committee on Local Government Finance approved. The regulations of the Committee on Local Government Finance allow entities with more than $100 million to create their own investment strategy if they choose to do so. Local governments with less than $100 million in their trust can present a plan to the Committee on Local Government Finance for approval.

That is my best guess at why other local government entities are not in the RBIF. It is the choice of the local government as to how to address the liability for OPEB benefits. As Ms. Rich stated earlier, the state is no longer contributing to the RBIF. The state is on a "pay as you go" basis. There is a strong possibility that many local governments are doing the same, especially if they have followed the general direction of some government entities in no longer providing OPEB for retirees in the future.

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

KABRINA FESER (Operations Officer, PERS):

This agenda item provides an update on the Public Employees' Retirement Information System (PERIS). Work began with the vendor Tegrit Software Ventures, Inc., on February 22, 2021. There was an in-person project kick-off with the vendor and staff on July 13, 2021.

There are seven phases to project, with a completion date set for January 2025. The milestones that have been accomplished this cycle include phase 4.1, Member Service Requirement.

The main focus has been on employer reporting, which has included the design, development, testing, system readiness, and training and documentation in order for the first group of employers to transition to the monthly retirement report using PERIS starting in February 2023.

Initially this was scheduled for November 2022 but was changed to February 2023 to allow more time for user acceptance testing and the development of training materials for the employers. This changed the payment milestone but did not impact the total cost of the project, since it is a multi-year project.

An employer advisory group has been established ahead of the new pension administration system. This has been a beneficial resource for communication and collaboration. In addition, there were two liaison officer conferences held to give employers exposure to the new system. One conference was held in Carson City and the other in Las Vegas.

Data collecting efforts are also a big part of the new system. This has been ongoing since 2019. In preparation for the transition of the employers to PERIS, 99.99% of the employer data is ready to transition to the new system's staging database.

VI. PUBLIC COMMENT.

KENT ERVIN (State President, Nevada Faculty Alliance):

The Nevada Faculty Alliance is a statewide independent association of professional employees at Nevada's public colleges and universities. I would like to congratulate PERS for meeting its long-term investment return targets and beating the market benchmark in each of the last two years. PERS accomplished this with just two investment professionals on public servant salaries, which is part of its low-cost approach.

In contrast, there is a teachers' pension plan in a large midwestern state with an investment staff of 100 who give themselves bonuses costing millions based on benchmarks they themselves establish.

The PERS Board took the fiscally prudent advice of actuaries an adopted more conservative assumptions last year about future investment returns and payroll growth. As a result, PERS is no longer allowing negative amortization on the unfunded liability, which is also fiscally prudent. However, as a result, the total retirement contribution rate is rising substantially this biennium; it will likely increase again next biennium.

The Legislature and the Governor need to act to offset the increases for employees. That could be done with pay increases in excess of inflation, or the state could permanently cap the employee portion of the retirement contribution for employees, with the state picking up the remainder. Ms. Leiss indicated this is common in other states. That would be more fair for current employees, because a large portion of the contribution goes toward paying off liabilities that have been accumulating since 1984.

Finally, with the Economic Forum increasing the state budget by over $2 billion compared to the current biennium, it is time to treat state employees as dedicated public servants deserve. The state employees should have competitive compensation and benefits so the state can fill position vacancies and provide full service to our citizens.

VII. ADJOURNMENT.

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

Respectfully submitted,

_____
Becky Lowe, Transcribing Secretary

APPROVED:

_____
Senator Marilyn Dondero Loop, Vice Chair

Date: _____