

**MINUTES OF THE  
NEVADA LEGISLATURE'S  
INTERIM RETIREMENT AND BENEFITS COMMITTEE  
(*Nevada Revised Statutes 218E.420*)  
DECEMBER 17, 2024**

Chair Dondero Loop called the second meeting in calendar year 2024 to order at 9:00 a.m. on December 17, 2024, in Room 165 of the Nevada Legislature Office Building, 7230 Amigo Street, Las Vegas, Nevada. The meeting was videoconferenced to Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada.

**COMMITTEE MEMBERS PRESENT:**

Senator Marilyn Dondero Loop, Chair  
Senator James Ohrenschall  
Senator Jeff Stone  
Assemblymember Max Carter  
Assemblymember Bert Gurr

**COMMITTEE MEMBERS EXCUSED:**

Assemblymember Daniele Monroe-Moreno

**STAFF MEMBERS PRESENT:**

Wayne Thorley, Fiscal Analyst, Senate  
Sarah Coffman, Fiscal Analyst, Assembly  
Jaimarie Mangoba, Principal Program Analyst, Fiscal Analysis Division  
Jessica Dummer, Deputy Legislative Counsel, Legal Division  
Basia Thomas, Committee Secretary, Fiscal Analysis Division  
Carla Ulrych, Committee Secretary, Fiscal Analysis Division

**EXHIBITS:**

[Exhibit A:](#) Meeting Packet  
[Exhibit B-1:](#) Public Comment – Terri Laird, Retired Public Employees of Nevada  
[Exhibit B-2:](#) Public Comment – Kent Ervin, Nevada Faculty Alliance – PEBP  
[Exhibit B-3:](#) Public Comment – Kent Ervin, Nevada Faculty Alliance – PERS  
[Exhibit C:](#) Public Employees' Benefits Program Presentation

CHAIR DONDERO LOOP:

Good morning. We are on time today. Welcome to the Interim Retirement and Benefits Committee meeting today. With that, I'll ask, please call the roll.

**I. ROLL CALL.**

BASIA THOMAS (Secretary, Fiscal Analysis Division, Legislative Counsel Bureau [LCB]), called the roll; all members were present except Assemblymember Monroe-Moreno, who was excused.

CHAIR DONDERO LOOP:

Please mark Assemblymember Vice Chair Daniele Monroe-Moreno absent-excused. We will go to the next thing on the agenda, which is public comment. To provide public comment or testimony, please call 888-475-4499 and when prompted, provide Meeting ID 86172603549 and press #. With that, we will go to public comment, number one. Please, go ahead here in Carson City, or there in Carson City, here in Las Vegas. Is there one in Carson City? Okay, go ahead, please.

## II. PUBLIC COMMENT.

TERRI LAIRD (Executive Director, RPEN [Retired Public Employees of Nevada]) provided public comment for the record ([Exhibit B-1](#)).

KENT ERVIN (State President, Nevada Faculty Alliance [NFA]):

Chair Dondero Loop, Vice Chair Monroe-Moreno and members, thank you for overseeing the Public Employees' Benefits Program (PEBP). We have submitted written comments on both PEBP and PERS. We have three major concerns that I'll give here. First, the NFA opposes PEBP's proposed elimination of the Health Maintenance Organization (HMO), EPO [Exclusive Provider Organization] plan option. Many employees depend on the HMO for predictable out-of-pocket cost, and they are willing to pay extra monthly for that security. Especially in Clark County, essential providers, including mental health and other specialties are only available on the HMO network.

Second, after years of generating excess reserves, PEBP had a deficit in mandatory reserves of about \$26 million at the end of FY [Fiscal Year] 2024 and has a projected deficit of about \$66 million for this fiscal year. The budget for PEBP in the next session must maintain current benefits and employee premiums and replenish the reserves.

Third, the PERS retirement system [*sic*] contribution rate increase will reduce our employee paychecks by 1.75%. With inflation running at about 3.0%, cost-of-living adjustments of 5.0% in FY 2026 and 3.0% in FY 2027 are required just to stay even.

At least maintaining healthcare benefits and the value of take-home pay for state employees is critical to keep from falling behind in recruitment and retention—these should be top priorities next session. Thank you.

KENT ERVIN (State President, NFA) provided public comment for the record ([Exhibit B-2](#)) and ([Exhibit B-3](#)).

CHAIR DONDERO LOOP:

Thank you very much. Is there anyone else in Carson City? Seeing none, I will go to Las Vegas again. Seeing none in Las Vegas, we'll go the phone lines. BPS [*sic*], when you're ready.

LCB AUDIO VISUAL AND HEARINGS [AVH] STAFF:

Thank you chair. The public line is open and working but we have no callers at this time.

CHAIR DONDERO LOOP:

Okay, thank you very much. With that we will go on to the approval of the minutes of the January 16, 2024, which seems like eons ago, but we will go to that.

### **III. APPROVAL OF THE MINUTES OF THE JANUARY 16, 2024, MEETING.**

CHAIR DONDERO LOOP:

I will ask for an approval from Senator Stone, second from Assemblymember Carter.

SENATOR STONE MOVED TO APPROVE THE MINUTES OF THE  
JANUARY 16, 2024, MEETING.

ASSEMBLYMEMBER CARTER SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY WITH THE MEMBERS  
PRESENT.

CHAIR DONDERO LOOP:

Thank you very much. We will go on to Agenda Item IV.

### **IV. PUBLIC EMPLOYEES' BENEFITS PROGRAM (PEBP).**

CHAIR DONDERO LOOP:

We'll start with the presentation from PEBP. I believe Ms. Glover is up in Carson City. Nice to see you. We're glad you're back. Go ahead please, when you're ready up north.

CELESTENA GLOVER (Executive Officer, PEBP):

Good morning. I have with me Michelle Weyland, she serves as the Chief Financial Officer for PEBP.

Good morning chair and members of the Committee. Today we're going to present to you an overview of what has been going on with PEBP for about the last year. Many of this...much of this information you have seen in the past, but we will continue to provide that information and update it as it changes.

The first thing you will see on your presentation slides on the screen (page 2, [Exhibit C](#)) is just an overview of what PEBP does. We are obviously the health insurance plan for the state. We offer three self-funded plans, and one fully insured, which is the HMO plan down in Las Vegas.

We also offer a host of voluntary benefits. Some of those listed on your screen (page 2, [Exhibit C](#)) include voluntary life insurance, that's a buy up from what PEBP and the state offers; long-term disability; vision buy up; home and auto insurance; pet insurance; and a host of other voluntary benefits that the members can enroll in during the open enrollment period.

We serve state actives, retirees, and their dependents; we also have a small number of local government employees—at last check there was approximately 8 employees, retirees and their dependents. We have a few thousand of the local government retirees—just under 500 on the self-funded plans in the HMO and the remaining are on the Medicare Exchange.

We are funded through what we refer to as AEGIS [Active Employee Group Insurance Subsidy], which is an active employee group insurance, and then REGI, which is Retired Employees Group Insurance. That funding is determined by PEBP during the budget building process and goes through the budgeting process and ultimately approved by the Legislature during the sessions.

And what we have on the screen (page 3, [Exhibit C](#)) is a little bit more detail on which plans are offered. For the self-funded plans, we have the Consumer Driven Health Plan (CDHP), which is our high-deductible plan; that high-deductible plan complies with IRS [Internal Revenue Service] rules so that we can offer a Health Savings Account (HSA). For those that don't qualify for an HSA and retirees, we offer a Health Reimbursement Arrangement (HRA).

We have the EPO plan, which is the self-funded plan in the north as a counterpart to the HMO in the south. It's not exactly like the HMO; it is a PPO-type [Preferred Provider Organization] plan, but those rates are blended with the HMO. If you're in the HMO in the south or the EPO in the north, you would both pay the same premium for the same tier; single persons, a member with their spouse or family members, each tier is the same rate.

We also recently, and I would say recently in the last three years, have offered the Low-Deductible Plan. We refer to it as a low-deductible PPO plan but in actual fact, there is no deductible associated with this plan at this point in time. That was a change that was made for Plan Year 2023 I believe, and so with that plan, it is exactly what is says; it's a PPO, it's a traditional PPO plan, and that is a statewide plan, as is the CDHP. Those plans are also offered nationwide, so we have retirees and a couple of employees that actually are out of state and those are the two offerings that those individuals would have access to.

Our fully insured plan is an HMO in the south that's offered by Health Plan of Nevada. Then we have the Medicare Exchange. Our Medicare retirees, if they're eligible for Part A free, they move on to the Exchange, and there they're in an individual marketplace and they can opt for any advantage or supplemental-type plans that are offered by the carriers on that Exchange. They are provided an HRA based on their years of service. Currently, that is \$13 a month per year of service, with a max of 20 years.

1. **Presentation on the health (medical, pharmacy, dental) and life insurance plan design and policy changes considered, and adopted, by the Board of the Public Employees' Benefits Program for the plan year beginning July 1, 2025 (PY 2026).**

Agenda Items IV.1 and IV.3 were discussed jointly. Refer to discussion under Agenda Item IV.3.

2. **Reports from an independent certified public accountant regarding audited financial statements, for the fiscal year ending June 30, 2023 (FY 2023), 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).**

Agenda Items IV.2a, IV.2b, IV.4, IV.5, and IV.6 were discussed jointly. Refer to discussion under Agenda Item IV.6.

3. **Report on utilization of PEBP by participants for the plan year ending June 30, 2024 (PY 2024), including an assessment of the actuarial accuracy of reserves (NRS 287.0425).**

CELESTENA GLOVER (Executive Officer, PEBP):

The next slide (page 4, [Exhibit C](#)) will enter into the description of what so far has been approved by the PEBP Board (Board) and is included in our agency request budget. Whether it gets approved or not, is beyond me at this point, so this is what we're asking for and how we get there.

Each year in September, staff will bring ideas to the Board regarding plan design, benefit changes, anything that we believe the Board should consider. We have that analysis done by our consultants and other vendors to make sure that we have as accurate information as possible so that we can present that to the Board.

The analysis recommends...recommendations are brought back to the PEBP Board for their review and approval; that is usually done at the November/December meeting (the November meeting sometimes slides into December). Then finally, once those plan design changes, if any changes are approved, are made, the plan documents are updated. We have to set the rates for those plans, that is based on experience and trend in the marketplace and based on what our plans actually experience. Then open enrollment begins May 1 and ends on May 31, at which time if you choose not to change your plan, you don't have to do anything. If you choose to change your plan, this is the period of time that you have to go in and make those elections.

For the upcoming Plan Year 2026, we are proposing that the life insurance be set at \$25,000 for employees and \$12,500 for retirees, which is consistent with what we have done in the last few years. Currently, a portion of that is paid by the plan with the funding provided and the other portion was supported by General Funds. We're proposing that this all be included in the plan funding rather than splitting up that amount. We've had discussions about trying to keep that life insurance consistent and not always use it as one of the moving targets for plan changes if we're forced into reducing our budgets due to economic downturns and various other reasons where we might have to make budget cuts.

We're also proposing a \$700 HSA or a health reimbursement contribution for the primary member and \$200 per dependent, up to a max of three. This is on the CDHP; the CDHP is the only plan that qualifies for an HSA, so that is the only place we can offer that. This is similar to what we did prior to COVID where we provided funding to dependents, as well as the primary. The Board so far has approved these two items, that was done at the September meeting and that's what we will create rates for in the new plan.

The deductible will increase on the CDHP from \$1,600 for a single person and \$3,200 for a family up to \$1,650 and \$3,300, respectively, and that is due to the IRS rules. We bring it to the Board for approval, but if they want to maintain that plan, they really don't have an option but to comply with IRS rules. These are the minimum deductibles that we're allowed to have on those plans; if we drop below that, then we no longer qualify for an HSA, and we would have to eliminate that offering. The HSA, HRA, and life insurance benefit changes are again dependent on inclusion in the Governor's recommended budget and ultimately, approval of the funding during the 83<sup>rd</sup> (2025) Legislative Session.

The next set of slides (page 8, [Exhibit C](#)) you're going to see are the utilization reports. The utilization reports in your packets starts on page 108 [*sic*] ([Exhibit A](#)). What I have provided in the slides ([Exhibit C](#)) is just a brief summary of what we're seeing in the various self-funded plans, as well as the HMO plan. This first slide (page 9, [Exhibit C](#)) you'll see that we've listed our enrollment in the CDHP. We have seen a decrease in the primary members by approximately 10.0% overall, which would include dependents, a 12.0% decrease. The plan spend per member though, has actually increased at 6.5% for the primary and 8.9% when you consider dependents and primaries both. The total percent...the total spend though actually decreased by 4.1% for the plan and 4.6% for the employee. That was good for both of our groups—the program itself and the employees.

The next table on that slide (page 9, [Exhibit C](#)) gives you the high-cost claimant counts. We look at these because the high-cost claims actually drive the plan cost. These are for...on this particular plan, high-cost claims are considered to be claims over a \$100,000. High-cost claims per 1,000 is at 5.2%, that is a little bit of an increase over the year before. Percent of plan paid, it's the equivalent of 33.6% of the total plan spend, that was actually a little bit of a decrease. That means those high-cost claims were a little bit lower in total, but it's still 33.0% of our claims is significant.

Emergency room visits per 1,000, we saw a slight increase at 5.2% and paid per visit also a slight increase at 5.8%. The utilization for pharmacy—net claims, we saw a 9.4% decrease. This could be a combination of the decrease in the number of members, it could also be a decrease in the need of those members accessing the pharmacy benefits.

The gross cost of those benefits though did increase by 1.3%; the plan on a per member, per month basis, the cost increased by 17.3%; and the average plan share per claim increased 13.6%. The members are paying an additional 5.8%. I went back and looked at the cost of our pharmacy spend, and this is just for claims, no administrative costs were considered, and between 2022 and 2024, the fiscal years, we saw it go from \$59 million in a year to \$89 million, so we've seen a \$30 million increase over three years and that is very significant. Something we are watching, but we have a lot of specialty drugs, new medications come on the market, and none of those are inexpensive.

The next slide (page 10, [Exhibit C](#)) gives you an idea of the spend for our top 10 diagnoses. I won't read all of them, but you'll see that cancer, cardiac disorders, and gastrointestinal disorders are top 3 for the CDHP. This comes from a list of about 25 different disorders or diagnosis categories that are considered, these just happen to be the top spend for this plan. That changes year-over-year depending on the health situation of the members. You'll be able to see the detail on that on page 131 ([Exhibit A](#)) in your packet.

The next slide (page 11, [Exhibit C](#)) gives you the same information as I presented for the CDHP, this however is for the Low Deductible Plan. Again, the high-cost claims are for those claims over \$100,000. You'll notice that enrollment has increased significantly. We're finding that as members are starting to actually research their plans and their options, that we have more and more people that are moving off the EPO, the HMO, and the CDHP and they're moving into the Low Deductible Plan, which is what we expected to see, so that's where you'll see the 35.6% increase for primaries and the 33.7% increase when you look at all members combined.

The plan spend obviously increased as well—as enrollment goes up and people learn how to use their plan, we would expect that cost to go up. It went up 10.2% over the previous year and overall, it's an 11.8% increase over the previous year when you include dependents in the total count. Total spend for the plan was 49.4% higher than previously and the employee spend also 46.1%. Again, that's driven by enrollment and as our members learn how to use their plan, they're accessing care more and more.

We have an increase again in our high-cost claimant and we had an increase in our emergency room (ER) visits, and that table shows you what those increases are. You can find the high-cost claimant enrollment increases on page 152 ([Exhibit A](#)) of your packet and the ER detail—the emergency room visits on 158.

Then you have the spend for pharmacy, again all increases in all categories, this is to be expected as we see more and more members opt to enroll in the Low Deductible Plan; you'll see the detail on the pharmacy spend on page 171 ([Exhibit A](#)) of your packet.

On the next slide (page 12, [Exhibit C](#)), again shows you our ten...our top ten diagnoses and again, those will change year-over-year depending on the medical conditions that our members are going to seek care for. Cancer tends to stay in that top three, top five situation, cardiac also, so, it's not unusual to see these numbers where they are. You'll see that cancer was 8.4% of total spend for this particular plan and the gastrointestinal disorders, which was higher in this plan than it was in the CDHP, it accounted for 8.7% of total plan spend.

Then the next slide (page 12, [Exhibit C](#)) gives you again, the same information for the Exclusive Provider Organization, or the EPO plan. You'll notice that we're seeing decrease in enrollment, again a lot of those members are enrolling in the Low Deductible Plan. Some are going to the CDHP but for the most part, they are going to the Low Deductible Plan. Plan per member, even though enrollments going down, the cost for those members is increasing 6.0% for the primary and 6.5% when you consider dependents. Total spend on the plan though did decrease by 5.0% and the employee went down by 4.2%, part of that is driven by the lower enrollment.

The high-cost claimants, you'll see those were increased, as were the ER visits. Again, this is for those claims that are over \$100,000 for the high-cost claimants and ER visits is exactly that. RX utilization, the net claims was a decrease. Part of that is driven by the enrollment, but the gross cost, the PMPM [per member, per month] for the plan cost, the average plan share per claim, and the member share per claim all increased, and you'll note that the plan cost, PMPM, actually went up 20%. That again, is driven by the cost of medications overall and as I said, we've seen significant increase in spend in our pharmacy benefits.

Then our top ten diagnoses areas (slide 14, [Exhibit C](#)), again cancer is up there in that top five, top three in this case. They are 10.3% of the spend in this particular plan; cardiac is 8.3%, and the gastrointestinal disorders, 8.1% of total spend. You'll note from all three plans that the top three tend to be very similar, it's just who gets the number one spot versus the number three spot.

Then the last one is the HMO. We look for the same information, they provide that data to us. You will find their utilization starting on page 198 ([Exhibit A](#)), the enrollment is on page 201 ([Exhibit A](#)). We're seeing a decrease, again those folks tend to be moving into the Low Deductible Plan. As people are looking for the best bang for their buck, part of that is the cost of the monthly premium and so that often does cause individuals to move over and of course their individual health concerns also would affect their decisions in that area.

The plan spend per member, we're seeing a decrease for the primary and the overall, and that's a pretty significant decrease over the previous year. It's not a decrease to PEBP per se because PEBP pays a premium to Health Plan of Nevada, we don't pay for the individual claims, but that is what the HMO is reporting that its overall, its per member, it's a lower spend. Total spend for the plan: 29% decrease, employee 27.1% decrease; again, this is not claims payments made by PEBP, this is claims payments made by the HMO. The rate that PEBP pays actually went up 12.0% for this current plan year, so we saw double-digit increase.

High dollar claims for them is at \$50,000, so they report their numbers a little bit different than we do for the self-funded plans. We had no change in the number of high-cost claims from the previous year and we saw a 4.6% decrease in the percent of plan paid, but we did see a significant increase in ER visits with a 6.9% when you're considering visits per thousand and the amount paid per visit also went up by 14.6%.

Then their RX utilization, the member enrollment obviously was down because we had a decrease overall enrollment in the plan. Average pay per prescription, the HMO is having a similar concern with the cost of pharmacy and that was an increase of 2.3%. The net paid PMPM was a 4.3% increase, so although enrollment went down, the cost is still going up.

Then the HMO net paid plans for the ten common conditions you will see those on page 211 ([Exhibit A](#)) of your packet. This lists mental disorders as their first one, breast cancer—so another cancer disorder is their third one. We're seeing that the mental disorders in the case of the HMO is 11.0% of the plan spend and then breast cancer is only 0.8% of their total plan spend, but they did spend \$739 PMPM. Again, the HMO reports their data slightly differently than we look at the data for the self-funded plans. With that, I will stop for a minute to see if there are any questions 'cause that was a lot of information.

CHAIR DONDERO LOOP:

Thank you so much. I appreciate you giving us that information. I would see if there are any questions, and we'll go up north first.

SENATOR OHRENSCHALL:

Chair Dondero Loop?

CHAIR DONDERO LOOP:

Thank you, Senator Ohrenschall. Go ahead, please.

SENATOR OHRENSCHALL:

Thank you. With the chair's indulgence, I have a few if I might continue?

CHAIR DONDERO LOOP:

Please, go ahead.

SENATOR OHRENSCHALL:

Thank you, chair. My first question, and thank you for the presentation, the HMO plan seemed like it had a smaller decrease in enrollment compared to some of the other plans, but it also seemed like it had a smaller increase in the pharmacy costs compared to the plans that had a bigger decrease. I just wondered what do you attribute that to? It seems like it's...the pharmacy costs haven't gone up as much even though the others have less enrollment but higher pharmacy costs.

MS. GLOVER:

The only thing I can say is that the HMO plan has the traditional gatekeeper model, so they have more cost saving measures in place that they can use. We do have a smaller population, that is probably our smallest population in total in all of our enrollments. The decreases...seeing that decrease or increase being at a smaller rate isn't surprising. Specifically, what they're being seen for or what is causing the members to access whatever care, that I can't really answer. I would have to come back to you with more data in that area.

SENATOR OHRENSCHALL:

Okay, thank you, I appreciate that. If that's something you can obtain with the chair's permission, I'd sure appreciate that data, if that's okay with the chair.

A couple of follow-ups, with the chair's indulgence. You mentioned on the HMO plan; I think I saw decrease of 3% on the HMO plan. Do you have a breakdown as to whether that decrease may be in Southern Nevada versus Reno, Carson [City], Douglas [County], the rest of the state? Is the decrease uniform throughout, or wonder if you had it broken down either by region or county?

MS. GLOVER:

The HMO plan is only offered down in the Clark County areas, so it is all southern members; they're the only ones that can access that plan. The north, the answer is the EPO plan and that...even with that, there's pretty significant restrictions as to the regional area that that plan is offered.

SENATOR OHRENSCHALL:

Thank you very much, I appreciate you explaining that. I guess the other question I have is can you discuss the viability of continuing the EPO and HMO plans given that decreasing enrollment and the increase that you mentioned in your slides of the per month, per participant costs?

MS. GLOVER:

We have been looking at both the HMO and EPO plans for, well since I came back on in May of 2023. We are consistently seeing enrollment decrease in those plans. We also know that a lot of our sicker members opt to enroll in those particular plans because of the payment structure. We will hear people indicate that they know what their out-of-pocket costs are going to be, so if it's \$50 for a doctor's visit or \$100 for a specialist visit, whatever the actual cost is. That drives them into the plan because of their consistent care that they're looking for versus somebody who goes for an annual visit once a year and doesn't have any major health concerns.

We saw double-digit increases for plan rates. Keep in mind, the EPO is a self-funded plan so that is funded by state dollars and run by our agency, plus our vendors that assist us—so our third-party administrator—we are not a profit-making organization. The HMO also has a profit on top of what our costs are; obviously they need money to stay in business, so we are not surprised by that. Our analysis is showing that these plans are becoming more and more difficult to maintain simply because the enrollment continues to go down, but the costs continue to go up overall. What we pay the HMO, what we pay for claims on the EPO, they're just getting to a point that they're becoming unsustainable.

Where that magic number is, depends on how you look at those numbers. When I speak with my consultants, they say we're already at that enrollment threshold where much more of a drop, we can't sustain it. We typically, what happens is, healthy people tend to subsidize the unhealthy people in a plan. Well, if there's no healthy people opting to stay in those plans because the premiums are too high, they're moving out of that and there's no way to balance it out with the HMO. With the EPO, those folks are rated with our other self-funded plans, but the EPO is not a true HMO plan. It's not a gatekeeper model, it's essentially a PPO, so we are really watching those numbers to see what that looks like. I think we're at a point where as much as we know our members that are on those plans are concerned, we really believe it's getting to a point where it's just not going to continue to be sustainable without some significant, either increased enrollment, so more people that are healthy go into those plans, and the rates coming down.

A member...a single person on the HMO and EPO, which those rates are combined so that they pay the same as I said earlier, they're looking at \$100 a month more in premium for those plans. What we proposed in our September meeting, which the Board is going to look at again in its January meeting, is to structure the payment methodology in the Low Deductible Plan to essentially mirror or mimic the HMO; so there is a definite copay, there's not coinsurance. I am proposing no deductible. A lot of the concerns that members have talked about, knowing what's coming out of their pocket every time they go to the doctor, they would still have that same option but we'd be able to better utilize the dollars that we have available to pay for the cost of those plans if we can bring them down to having the two self-funded plans versus having an HMO in the south and the EPO in the north.

It's...like I said, the last renewal was double-digit, renewal, it was 12%, we were expecting 28% but they were able to crunch some numbers. We do know at some point the HMO isn't going to continue to be able to give us a better rate than what the claims experience really is showing when you look at those numbers. At this point, I think we're at that...we're at that threshold where we need to make that decision, we need to make it soon.

SENATOR OHRENSCHALL:

I appreciate the answer, and I thank you for what you're doing to try to protect members and help their access to healthcare. Chair, thank you very much for those questions.

CHAIR DONDERO LOOP:

Thank you very much. Anyone else up north with a question? Seeing none, we'll come down south. Senator Stone.

SENATOR STONE:

Thank you, madam chair. Merry Christmas to everybody, happy Hanukkah. Thank you for the presentation. It seems like the number one expenditure is for cancer treatments and in Nevada, we have a shortage, as you know, of healthcare professionals, especially in the oncology realm. As an example, if you need a bone marrow transplant if you have non-Hodgkin lymphoma, chances are you need to leave the state and find someplace like Stanford University, Mayo Clinic, to get this state-of-the-art treatment. It seems to be again, the largest expenditure and probably I would imagine some of the higher dollar claims that we have. Do we know what percentage of our cancer patients are seeing professionals domestically here versus going out of state, 'cause I think we could probably control costs within the state but probably outside the state would probably have more difficulty in controlling the cost. Do you have any numbers on that at all?

MS. GLOVER:

I don't have specific numbers on that. I can tell you that we do know, we...Huntsman Institute in Utah is one of our in-network providers and we do know that a number of our members are referred to Huntsman, as well as Stanford and some other facilities. We have recently started a contract, this was a year ago, for essentially oncology concierge services so that our members can be helped with navigating the best place for their care, whether its domestically or out of state. Because depending on the type of cancer, if it's a breast cancer, maybe they're being helped here, but if it's some other more rare form of cancer, the specialist may just may not be here. I don't know specifically what that breakdown is, but I can go back and see if I can't get that data and provide it to staff.

SENATOR STONE:

Well, thank you for that. I assume that the high costs of the cancer treatments is probably a function of also the cost of the pharmaceuticals and the chemotherapy, which takes me to my next question. I think you'll see in the 83<sup>rd</sup> (2025) Legislative Session, that there's going to be some BDRs [bill draft requests] on pharmacy benefit managers (PBMs). Those are the intermediaries between patients, insurance companies, and pharmacies that are getting paid for claims. The PBMs originally were just a switch if you will, a conduit between these entities and when you have 80%, 85% of them controlled by three or four companies, they decided to monetize that and now are multi-billion-dollar companies. The question is, for our EPO plans, do we have one PBM or multiple PBMs and has there ever been an idea to form our own state PBM so that number one, we can control the formulary, and number two, we can get the rebates from the drug companies based on what drugs are put on that formulary?

Thereby, we can reduce what you saw in multiple slides, the increase in the cost of pharmaceuticals to the state and certainly copays to our employees and share those savings and try to reduce the cost of pharmaceuticals rather than every year come here and see the inflationary increases. Understanding that the PBMs are kind of a black box and we don't know what goes on in the inside of that box and, but we do know it is a profit center and we need to make that profit center a part of the State of Nevada for the benefit of the beneficiaries, which is 3.2 million people here that depend on us to try to keep their healthcare cost as low as possible.

MS. GLOVER:

For PEBP, we have one PBM for all three of our self-funded plans. The HMO pharmacy is taken care of by Health Plan of Nevada. The costs obviously are high, they're driven by a combination of what it costs to pay the PBM for the claims and their admin fees, what the pharmaceutical companies are charging, as well as what the pharmacies themselves are charging. I will say that we do get rebates and that does help us fund the plan. Those rebates over time have gone up, so we are seeing an increase in what we're getting back to help us pay for those claims. I believe there has been some talk in the past about the possibility of pooling resources between the various entities within the State of Nevada to try to use our buying power to lower the cost of drugs.

I don't know if there's been any push to create our own PBM so to speak. Having that...one, having the resources and the expertise in that area would be critical to ensure we were getting what we needed. Whether it was rebates or our formulary being what it should be to cover the needs of all of our residents, including the members on PEBP. There's a lot of moving parts. I mean, obviously I'm open to those discussions. That's not something PEBP can do on its own; we're not big enough for one, and for two, we don't have the expertise or the resources within our agency to take that on, but we would be happy to work with any organization that can provide some good ideas in that area.

SENATOR STONE:

Just a follow-up, who is the PBM that we use for those three plans?

MS. GLOVER:

Express Scripts, we refer to them as ESI. They are our PBM, they have been our PBM for several years. We are due to go out to bid again, I believe we're going out in the summer or early fall as that contract expires June of 2026.

SENATOR STONE:

Has there ever been any discussion with Express Scripts as to what the magnitude of the rebates that they receive from the drug companies based on the prescriptions that are dispensed here in the State of Nevada?

MS. GLOVER:

We build into our contracts that we are to get the maximum, actually the full rebate. We also have our consultants go in and do a market check annually and they review what the rebates are for the various drugs that qualify for those rebates and then our contracts are amended to adjust for any increases due to us. In addition to that, we have an independent auditor go in and audit the PBM to see if one, they're paying claims correctly, but two, are they passing all the rebates they are supposed to pass on to PEBP. That happens every single year, so we believe we're getting the maximum rebate. I know we're probably getting rebates that maybe ESI doesn't always agree with but per the terms of the contract, they do pay what is required in that contract and we do have two different checks in place, two different vendors that go in and look at that to make sure we are getting what we're supposed to get.

CHAIR DONDERO LOOP:

Thank you very much, Senator Stone. Assemblymember Carter.

ASSEMBLYMEMBER CARTER:

Thank you. Yes, ma'am, I appreciate your report and I'm going to ask for a little indulgence. I've got extensive experience in the Taft Hartley world, I know this is different than Taft Hartley so if I take in, go down a wrong road, please don't hesitate to correct me. The first question I had was, do we have stop-loss on our self-insured plans and what is the...if we do, what is the attachment point?

MS. GLOVER:

We don't have stop-loss insurance in place on our plans. We do have three different reserve categories that are what we refer to as "restricted reserve." We have the IBNR, which is Incurred But Not Realized, or Reported—it's called both things. Those are for claims that have happened in a previous year that get paid in a subsequent year or should the plan close down tomorrow, we would use that funding in addition to whatever we have in our budget to pay the runout claims. We have a catastrophic reserve in place, that reserve is for rate stabilization and for catastrophic claims—those big claims we weren't expecting that we didn't account for in our operating budget. If we need to tap into those funds, we go there.

We have a HRA for our members and those balances rollover year-over-year. We keep a reserve to cover approximately 75% to 80% of whatever those balances are each year, and that reserve is used for exactly that. If for some reason everybody was to file a claim on their HRA, we would have sufficient funding to cover 85%, or excuse me, 75% to 80% of those claims from the reserve, plus what we have in our budget to pay for routine claims that we expect to see month-over-month, year-over-year. That is what we use in place of that stop-loss insurance.

ASSEMBLYMEMBER CARTER:

Thank you, and with the chair's indulgence, I got two more. We heard it brought up concerns about losing the HMO and impacting mental health benefits. We see that mental health benefits are very important to our population. How are mental health benefits...why are we hearing that there's a lack of providers or lack of access through the self-insured plans?

MS. GLOVER:

The self-insured plans have access to, in a lot of cases, the same providers that the HMO has access to. It depends on the region, city, town, state that those providers are in and that our members are in that need that care. We also have telehealth, so a lot of those counseling visits can be done virtually if the provider and the member are not in the same location. Part of our analysis that will be discussed during the January Board meeting—that meeting is January 23—is to look at disruption. My understanding is that for the most part, the majority of our providers that are on the HMO plan contract with other networks, including our network through UMR, so those providers are accessible by both the HMO members and the self-funded plan members.

I think individuals know that they can get to Dr. Jones in this plan, and they don't always know that Dr. Jones can also be accessed from another plan, that they're not exclusive to one organization. I think in some cases there's a misunderstanding, that doesn't mean there aren't providers out there that are not contracted with our network. Whenever we see that, we have our network try, and they do it on their own whether we ask or not, to work with the various providers out there to get them contracted within the network so our members have access to all the providers possible.

ASSEMBLYMEMBER CARTER:

One last one, and I'm not second guessing your Board. I'm sure that your Board is very, very talented and has a breadth of knowledge. Just out of curiosity, has the Board ever explored onsite or near-site primary care clinics as a way to boost quality of primary care and contain costs?

MS. GLOVER:

We did explore that several years ago, actually before I retired the first time so 2016, 2017, I would say. At the time, the concern was the cost of getting a near-site clinic stood up and then, at least in the north, a bigger concern has been raised, or was raised at the time, that that clinic would be exclusive to PEBP members and that other residents wouldn't have access to those providers that were within that clinic. We don't know if financially we can actually stand up a clinic and everything that goes with it. That is something we briefly talked about recently, but we haven't done anymore more in-depth studies. I think again, it's how spread out our members are—is the clinic in Carson [City], is it down in [Las] Vegas, is it in Elko, is it in Reno, and who has access? If it's in Carson, it may benefit Carson City members, but it's too far for the Elko members to travel to and maybe the Reno members don't want to come to Carson. How we set that up with how geographically spread out we are, that becomes the difficulty in determining if that is the best way to look at providing benefits to our members.

In addition to that, as you've said, and many other folks have said too, that we have a shortage of providers in general. Where are we going to find those providers that are willing to come to this clinic, and if we could figure that out, maybe that is a direction we can go in. That is something we can explore, but at this point, it has been explored in the past. It's been a lot of years since that happened. At the time, it was determined not to really be a viable option; that doesn't mean it isn't a viable option at a future point in time.

ASSEMBLYMEMBER CARTER:

Thank you.

CHAIR DONDERO LOOP:

Thank you very much. I'm going to jump in here because I have a couple questions. One of them is, all of the self-funded plans are in the same risk pool, so does it matter if the sicker members are on a different plan from the healthier members?

MS. GLOVER:

For the self-funded plans, it doesn't matter as much. It does matter for the HMO because they are not rated in the pool with the self-funded members. That continues to make the HMO potentially more and more expensive and no way for us to offset those costs other than to pay the higher premium, unless the HPN [Health Plan of Nevada] wants to give us a lower rate just 'cause, for a lack of a better term. I think where I look at it, it's not just the rating pool itself, it's how can we best use our dollars to provide the best package of benefits to all of our members, not just those in one plan or the other, as far as the self-funded versus the fully insured plan. As I said, the HMO plan also has a profit margin built in because obviously, they have their overhead, where PEBP's overhead is essentially 1.5% to 2.0% and that is not seen in the industry generally speaking.

CHAIR DONDERO LOOP:

Thank you very much. Another question that I had was the employer subsidy is the same for all the plans, so how does the PMPM increase for the HMO and the EPO, how does that impact that?

MS. GLOVER:

The PMPM is the cost of those claims. We take...if we have \$10 in claims and we have ten members, it's a dollar PMPM, but that doesn't mean all ten members are accessing care; that could be one person who cost \$10, so that is where the PMPM comes in. The amount of the subsidy, so the AEGIS and REGI funds that pay in, the more that the state pays into those funds, the more we can offset the amount that the members themselves have to pay. If that subsidy goes down but the rates go up, the difference comes out of the member's pocket regardless of what the claims look like. The rates are determined by what our claims costs—pharmacy, medical, and dental—what that actually is. It also considers life insurance premiums, administrative fees that we pay to vendors to assist us with the plan; as well as our operating costs, which is payroll, buying paper for our copiers, things of that nature. The PMPM looks at kind of a combination of things, but what I've reported here is really what the claims costs themselves are.

CHAIR DONDERO LOOP:

Okay, thank you very much for that information. Then I have one last concern that was brought to me. Someone contacted me and told me that the Carson Tahoe Hospital was going to change taking our PEBP employees...or our PEBP insurance participants, and they said that the reason that was going to happen is because they weren't getting paid timely. I don't know if that's true or false. I was just wondering because we have a lot of state workers in Carson City and so for them to have to go into Reno to a hospital can be a real hardship. I was wondering if that was actually going to happen, if that was hearsay, if you could just shed some light on that please.

MS. GLOVER:

Yes, we're in talks with Carson Tahoe. They have opted not to renew their contract with the United Healthcare Network. They have cited some various reasons for doing...for making that decision; ultimately, it's a business decision on their part. We have the same concerns with our members in the Carson area, and it's not just Carson City residents, it's Reno residents who happen to work in Carson and access providers in Carson City or any of the surrounding areas to Carson City because so many of our folks do work in Carson proper. We have asked our consultants to begin drafting an RFP [request for proposal], which they are doing. We're planning on releasing an RFP hopefully early February, but it looks like it'll be closer to later in February, to have a second network that includes Carson Tahoe as part of their provider offering. That is going to be a requirement because if they don't have Carson Tahoe, there's no point contracting with them because that is the only reason we're going for a second network.

We have asked Carson Tahoe...so their contract right now expires on May 30<sup>th</sup> of 2025. We've asked them, and the Board has asked them, to consider extending their contract to allow us time to get through the RFP process. The RFP process...the way we're situated now, not only do we have to get the RFP on the streets, there's an amount of time it needs to be out there so we can get responses, we have to bring the results of the bids back to the Board in a closed session, so the timing of that could mean we don't see the BOE [Board of Examiners] until April or May, if everything goes smoothly.

The requirement right now of the Board looking at these RFP results in the middle actually can extend our timeline anywhere from two to four months, so that's a consideration. We also have an implementation timeline that we need typically about six months because we need to make sure that that network one, can get...can share files with our enrollment eligibility system and can work with our TPA [third-party administrator] to ensure that claims get paid.

We are working through that process right now because we are trying to do everything we can to avoid this issue. We've been talking to Carson Tahoe for months, as well as representatives from UMR on the network side, to try to come to some agreement for them to resolve their issues, but it appears at this point that Carson Tahoe is not interested in extending - continuing business. Although, they have said that they would look at extending the existing contract to allow us time to complete the RFP process.

CHAIR DONDERO LOOP:

Okay, thank you for that information. Yes, it's a big concern and I understand you're working towards that. You're right, it isn't just Carson City, it's also Minden or wherever people live that they are closest to Carson Tahoe that they may need those services. I appreciate you working on that. Hopefully the RFP might solve some of that, but I appreciate that. I believe we have another question from Senator Ohrenschall up north. Senator.

SENATOR OHRENSCHALL:

Thank you very much Chair Dondero Loop. With your indulgence, I wonder if I can follow up on something that you asked and Assemblymember Carter asked. I'll try to be brief.

CHAIR DONDERO LOOP:

Please, go ahead.

SENATOR OHRENSCHALL:

Thank you. Just a follow up on Chair Dondero Loop's question regarding Carson Tahoe Hospital and the network administrator. Could the PEBP Board meet earlier; post a meeting and just try to see if that RFP could happen earlier rather than wait two to four months?

MS. GLOVER:

The RFP is being written right now and like I said, we're hoping to have it out there for vendors to bid on early February, but like I said it may be closer to the end of February 'cause it does take time to write that RFP. We are trying to, as much as possible, reduce the timeline for how long it's on the streets, how long the analysis gets done, all of that, because there's going to be a cost to pay that vendor to get that network so that we can lease that network. We can request a special meeting; the concern is with session coming up, a lot of our members, Board members, and PEBP staff are going to be busy with the Legislature, so trying to find time to get a quorum so that we can get

them meeting earlier on tends to be an issue, especially with the upcoming session; but we will do everything we can to get that meeting sooner or to get the RFP ready for their review sooner, whatever we need to do to get that done.

SENATOR OHRENSCHALL:

I appreciate that very much and thank you. Certainly, because I guess if folks here in this part of the country can't go to Carson Tahoe, then I guess their options are go down to Douglas County or up to Reno; that certainly presents extra obstacles to them.

Like the chair, I've also been contacted by some members who voiced a concern, and I don't know if it's valid or not, but I wanted to ask that members in the PPO plan have had trouble with behavioral healthcare. That some of the behavioral healthcare providers have had problems with their payments from the network administrator and that they've left that network. Is that something you believe is true or know about, or wonder if you could give us some information about that?

MS. GLOVER:

We've heard similar concerns, but when we actually look at the information we're provided, for the most part I think I've heard of one actually leaving the network, but we haven't seen a mass exodus. Oftentimes, what we're finding is that there's a combination of issues with the payments, either it's documentation that the TPA requires—that's the third-party administrator—requires in order to pay the claim, are they submitting that paperwork correctly and then early on with the TPA that we have currently, there were some definite growing pains (this was before I came back to PEBP) but since then, they have improved their processes to get those payments out more timely. I think a lot of the issues have been resolved, that doesn't mean there aren't problems once in a while, but as soon as we hear about them, obviously, we try to address them as quickly as possible so we can get those resolved.

SENATOR OHRENSCHALL:

Thank you. Then to follow up on one of Assemblymember Carter's questions regarding the HMO plan. You mentioned earlier when I asked you that you felt it's getting to a point of unsustainability and if that plan ends up being eliminated, the concern that's been brought to me is that members feel that they're predictable costs and they're worried about losing their providers. Do you feel that they'll be able to find those same providers in the other plans if the HMO plan is no longer an option and they'll still have that predictability in the cost?

Ms. GLOVER:

Yes, part of the analysis is disruption analysis to determine how many providers are not in the existing network for people to access. We're looking at that number and we're also looking at the restructuring of the Low Deductible Plan to make that payment structure...the cost for provider care...so, if you're going to your GP [general practitioner] for a general visit, those are pretty similar already. We're looking at just restructuring, getting the coinsurance, which is a percent of the cost, to an actual flat rate. We are trying to get that set up so that they have a level of confidence, those members have a level of confidence, that they're going to know what their out-of-pocket costs are when they go for a visit.

SENATOR OHRENSCHALL:

I appreciate that and on that disruption analysis, is there any data announced if the HMO plan is done away with, members will be able to stay with their providers if they migrate to the other plans; what providers are on the other plans as well?

Ms. GLOVER:

That'll be part of that disruption analysis that says how many of those providers won't be there. We'll be looking at how many claims we see from our members on an individual member level not on an individual claim basis, 'cause one member can have 20 claims obviously, to see how many people really are going to be affected by the potential of certain providers not being in the network. I will say that based on the structure of United Healthcare, our TPA, which is UMR, and the HPN, the network information the providers tend to be on both networks. It's not the same as it was in past years where it was definitely a totally separate...if the HMO was out, we lost the entire network. That's not the case today as it was maybe five or ten years ago.

SENATOR OHRENSCHALL:

Thank you and that disruption analysis is not done yet, that's something that...

Ms. GLOVER:

Correct, that will be presented at the January Board meeting.

SENATOR OHRENSCHALL:

Thank you. Assemblymember Carter asked about mandatory reserves, and you answered his question, and I just had a follow up on that. Where is PEBP now in terms of mandatory reserves? Do you feel they're adequate, do you think that they need to be bolstered?

MS. GLOVER:

Currently...in the current plan year, we did have to reduce those reserve levels because the beginning cash, which supports the reserves, was lower than budgeted, but we have included the replenishment of those reserves in the upcoming 83<sup>rd</sup> (2025) Legislative Session. For the upcoming biennium, we'll be back to the level that we believe we require and we believe that's sufficient, barring no major changes to what PEBP looks like today versus what it looks like a couple years from now, that it should be sufficient.

SENATOR OHRENSCHALL:

Thank you very much, Ms. Glover and chair. This will be my final question; I appreciate your indulgence. Do you foresee any substantial rate increases to members over the next biennium?

MS. GLOVER:

I do foresee rate increases across the board on all the plans just based on what I'm seeing in our claims costs right now; how high those rate increases are, I don't know. Again, we've included some assumptions in our budget submission to account for what we're experiencing and what providers in general, or providers of healthcare plans, are seeing in general, so all of that is taken into consideration and has been built into our budget.

SENATOR OHRENSCHALL:

But what those rate increases are, that's not something right now you can comment on? Okay, thank you. Thank you chair, for the indulgence.

CHAIR DONDERO LOOP:

Thank you very much. I think we are out of questions, unless anybody raises their hand. You raise your hand, I'm gonna charge you. Okay, thank you. Ms. Glover, thank you very much. I believe we might be on Section 4, number 4, but if I'm wrong, just keep going wherever you are.

4. **Report on material provided generally to participants or prospective participants in connection with enrollment in PEBP for the plan year beginning July 1, 2024 (PY 2025) (NRS 287.0425).**

Agenda Items IV.2a, IV.2b, IV.4, IV.5, and IV.6 were discussed jointly. Refer to discussion under Agenda Item IV.6.

5. **Report on the 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 Employer Reporting as of June 30, 2024 (NRS 287.0425).**

Agenda Items IV.2a, IV.2b, IV.4, IV.5, and IV.6 were discussed jointly. Refer to discussion under Agenda Item IV.6.

6. **Report on the biennial review of PEBP's compliance with federal and state laws relating to taxes and employee benefits dated November 2024 (NRS 287.0425).**

Agenda Items IV.2a, IV.2b, IV.4, IV.5, and IV.6 were discussed jointly.

CELESTENA GLOVER (Executive Officer, PEBP):

We are on number three in my slide presentation (page 17, [Exhibit C](#)). Essentially, this is the communications to our members and you'll...there is a schedule included in your packet (page 223, [Exhibit A](#)). The schedule only reflects the events that we've had so far in the year and what's been scheduled through the end of December. Pretty much every month we have some sort of communication to our members, either through a training event, whether it's through our...for our agency representatives...or HRA discussions for Medicare Exchange. We have quarterly newsletter that goes out. Then anytime there's a major change that we feel like we need to get out to the members ahead of time in between all these various sessions and the newsletter, then we'll put out additional communication. At the Board meetings, when there are things coming up, I will include that in my Executive Officer report as a reminder to members that something's come up, like the Medicare Exchange. Medicare open enrollment was going on in between October and early part of December so that information comes out continually. The slide on the screen...

CHAIR DONDERO LOOP:

Ms. Glover, Ms. Glover, if I can interrupt you, I'm sorry.

Ms. GLOVER:

Yes.

CHAIR DONDERO LOOP:

For members, in our packet ([Exhibit A](#)), in our book, it is for [Agenda Item] IV.4, so I just wanted to make sure if they wanted to follow along it is IV for us. Don't worry about your slides, we are just on number 4 with the information. Thank you.

Ms. GLOVER:

Thank you. I believe it's on page 223 of the packet ([Exhibit A](#)), give or take.

CHAIR DONDERO LOOP:

Correct. You are correct.

Ms. GLOVER:

The next section is our audited financial statements (page 20, [Exhibit C](#)). What you're going to see in the packet, and it is actually on page 37 ([Exhibit A](#)), it's early in the packet, is our most recent audit that was completed. This audit was presented to the PEBP Board in July of this past year of 2024. Eide Bailly is our auditor, and they are in the process now of scheduling the work to be done. They originally thought they would begin field work in January but now that has been pushed into March. Part of that is because we require certain data to come from the State Controller's Office and with the new ERP [Enterprise Resource Planning] system and everything that's been going on over the last couple of years, they are...they're not ready to complete their entries.

Our auditors are going to delay their field work, but as soon as all the data's available, we'll get that scheduled and we'll present hopefully those financial statements in July of 2025 to the Board meeting at that time. It may be as late as September, depending on when the financial statements can be completed.

The next section is Other Post-Employment Benefits, or OPEB as it is referred to (page 22, [Exhibit C](#)). Other post-employment benefits are retiree benefits other than pension, so in our case, healthcare. The valuation is required to be done, a full valuation, every two years. The in-between years can be a rollover. The one that is in your packet, which I believe is on page 231 ([Exhibit A](#)), is a rollover that is for June 30, 2023, as reported on June 30<sup>th</sup> of 2024.

The OPEB valuations are included as a disclosure in our annual financial statements. It estimates our total OPEB liability, which is the present value of benefits for current employees and retirees. What is considered in this is assumptions about demographics, turnover, mortality, disability, retirement, healthcare trends, and other actuarial assumptions, and it is attributable to the past service of those employees and retirees.

The PEBP plan has opted for a pay as you go option; this is pretty typical with most government plans. Like other states, PEBP has taken steps, the State of Nevada has taken steps to reduce the liability. Part of that, which has been presented in previous IRBC meetings, is that those retirees...those employees that begin employment after December 31, 2011, when they become retirees, they will be able to opt to join the PEBP plan, but they will not receive any subsidy. They would be required to pay the full amount for that plan, which looking at it, those plans are very expensive so I don't know how that will work for those individuals; but a change to that would greatly increase our OPEB liability, so there's been a reluctance to change that rule and so that is where we're left.

Final on my presentation (page 24, [Exhibit C](#)), this year we have the Biennial Compliance Report. That report begins on page 294 ([Exhibit A](#)). [*Nevada Revised Statutes*] NRS 287 requires an independent biennial review to determine whether we're compliant with state and federal law. This particular review, as I said, just finished; it was presented to the PEBP Board at the November board meeting. It considered the documents that were in effect for the current plan year, Plan Year 2025, which is July 1, 2024, to June 30<sup>th</sup> of 2025. It was determined that for the most part, PEBP does cover all required benefits, but what we need to do is really look at our documentation to essentially clarify what we've written, sometimes it's not clear in the documents. There are a lot of master plan documents for the various plans, along with a host of other documents that we provide to members. They're on our website. Oftentimes, when you read those documents, it's not real clear what we're saying you can and can't do within the plan.

None of the findings were unexpected as rule changes at both the federal and state level are consistently changing. It would be amazing if we could get ahead of them, but we would have to know what they were going to do before they did it, so we comply as soon as we're made aware during our legislative sessions. Obviously, we follow the BDRs that have been presented and any bill discussions, and then we also look at what is happening at the federal level to ensure that we are following all of the laws put in place and that we're providing the services we should be providing.

You'll note that there are no comments in the column for PEBP responses. We are looking at that and prioritizing which things we need to address first and then we will present that back to our consultant that did the biennial review, and we'll look at that. We're going to concentrate on notices in our documentation first and then we'll touch everything else after that. With that, I'll take any other questions.

CHAIR DONDERO LOOP:

Would you...you sort of covered this, but would you just confirm that the plan administrator, UMR, is administering the benefits in accordance with the various amendments to NRS 287.04335 that were approved in the 82<sup>nd</sup> (2023) Legislative Session?

Ms. GLOVER:

Yes, they are administering that, and we did update our plan documents to show what our benefits should look like and what we're required to cover to make sure we didn't miss anything. In addition, UMR has a quarterly audit. The auditors...our independent auditors go in and make sure they are in compliance with whatever federal and state law is and whatever our plan design says because we may be covering things that are not necessarily required by law, but we offer it as a benefit option. They're making sure that those claims are paid according to what is approved in our benefits structure and per state and federal law.

CHAIR DONDERO LOOP:

Okay, thank you very much. Unless anyone on the Committee has another question, Ms. Glover is done with her part of the agenda. Thank you very much for joining us here today, thank you for answering our questions, and thank you for...

ASSEMBLYMEMBER GURR:

Madam chair, madam chair.

CHAIR DONDERO LOOP:

Yes, sir?

ASSEMBLYMEMBER GURR:

I have a question, well I'm not sure it's a question, it's a comment more than anything before they leave. I've heard conversations about provider problems inside of the eastern part or western part of the state, somewhat in the southern. I haven't heard anything, nor did I see anything in these documents about anything in the eastern part of the state and if they're having any problems with providers there or how the retirement system's working. One or two things are happening: either it's working perfectly because I've never heard a word, or it doesn't work at all; one or the other. I'm not seeing it addressed, so if you could, talk about the eastern part of the state and the providers and what's going on there.

MS. GLOVER:

I have not been given any specific information about problems with providers in the eastern part of the state any more than any of the rest of the state, and it typically revolves around provider availability. We have a shortage of providers statewide, we have a shortage of providers nationwide, and the eastern part of the state is having similar issues. Obviously, if you're in a rural part of the state, it's harder because we don't have providers in some of those smaller communities and it does require members to travel.

We do provide travel benefits to our members to allow them to get to providers when they have to come into Reno, or Carson, or go to Las Vegas, or go out of state, so we do try to work with those individuals. Having a provider in a small location like a Tonopah or an Austin, although we may have members out there, it is very difficult to convince a doctor, a nurse, or whoever to actually go out to those communities and live and provide those services, so it does require a lot of times for those individuals to have to travel.

ASSEMBLYMEMBER GURR:

Thank you. I pretty much understand that, but I'm impressed that you let them go out of state 'cause that's a whole lot of what happens in the eastern part of the state is Salt Lake City.

Ms. GLOVER:

We know that happens in the east and the west. If you're in a border town, so to speak, or within a couple of hours of the border, that is an option. We do have a Centers of Excellence contract and that may send our members to Arizona, to Utah, wherever the best facility is for the type of care that member needs. We pay for those claims and provide the travel for the member and one companion to go with them so that they have someone with them with those...to help them with...navigate the situation. That is something that is covered in our plans, always has been covered, at least for as long as I've been around with the plan. I've been with the plan since 2012, as far as working for PEBP.

ASSEMBLYMEMBER GURR:

My assumption that nothing's really wrong with it because nobody complains is pretty much right on. One other specific question, is the Northeastern Nevada Regional Hospital a provider, or do you know?

Ms. GLOVER:

I'd have to go back and double check, but I believe they are in-network; for the most part, most of our facilities are in-network. We do have to sometimes do special agreements with those facilities if there's a service there that they provide and they are an out-of-network. We will then try to do one-off agreements as necessary so that our members can get the care they require.

ASSEMBLYMEMBER GURR:

Thank you, I appreciate it. Thank you, chair.

CHAIR DONDERO LOOP:

Thank you very much and thank you for that information. Thank you for joining us today. We will take just a two-minute recess and let PERS [Public Employees' Retirement System] get ready for their presentations and switch some staff around, thank you.

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

**1. Report on actuarial valuation for the Public Employees' Retirement System (PERS) as of June 30, 2024.**

CHAIR DONDERO LOOP:

Okay, I think everybody's ready and in place. Members, we will start with Agenda Item V, and we'll go to number 1 first. Please go ahead when you are ready.

TINA LEISS (Executive Officer, PERS):

Good morning, madam chair, members of the Committee. Also testifying today on later agenda items will be Steve Edmundson, our Chief Investment Officer, and Kabrina Feser, our Operations Officer.

[Agenda] Item V.1, beginning on page 389 of your packet ([Exhibit A](#)) is an update on the FY 2024 actuarial valuation for PERS. Actuarial valuations determine the projected liabilities of the plan, and the contribution rates needed to fund the system on an actuarial reserve basis. Several areas are analyzed during the course of the valuation: including the plan design, the member demographics, and economic assumptions. Pursuant to the Nevada Constitution, the retirement board must adopt the actuarial assumptions that are recommended to it by the independent actuary that is hired by the board. Then by statute, the contribution rates are set based on the actuary rates developed by the actuary.

The contribution rates must change with the first full reporting period on or after July 1 of each even...of each odd-numbered year as determined by the even year's valuation. This year, the 2024 valuation, does affect contribution rates.

The ultimate cost of the benefits 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 our members. The goal of actuarial funding is to ensure that the current future benefits are paid for through appropriate level of employer and employee contributions and the investment earnings on those contributions. To project liabilities of the system and to determine these contribution levels, assumptions are made about future events that may affect the amount and timing of benefits to be paid and the assets to be accumulated.

As part of this valuation process, actual experience is compared against the projected experience, and any deviations are recognized as gains and losses in that year's experience.

The use of appropriate assumptions is important in maintaining the adequate funding and things do change over time. Demographics change over time, economics change over time, and so every four to six years the board does an experience study to make sure that the assumptions are keeping in place with the actual experience.

As you may recall, the last experience study was in 2021. The assumption changes that were required as a result of the recommendations of the independent actuary caused significant increases to the contribution rates for both the regular and police/fire fund. Because of that, the actuary had recommended a four-year phase-in process of the rate changes solely attributable to the assumption changes, not attributable to other experience. This is the last year of the phase-in of those rate changes from the 2021 experience study, so the contribution rate changes in this valuation had been expected since 2021.

The charts on pages 393 and 394 ([Exhibit A](#)) show the changes to active members and the regular police/fire fund. This valuation shows an overall increase in active members to 112,019...from 112,019 to 115,765 overall. We saw an increase of 3.2% in active membership for the regular fund and 4.4% ,for the police/fire fund. The charts on pages 395 and 396 ([Exhibit A](#)) contain information on the retiree membership and the average benefit amounts. On pages 397 and 398 ([Exhibit A](#)) you will see the actuarially calculated contribution rates for 2024. These rates reflect both our assets smoothing process, which is a mechanism in which gains and losses from the investments are smoothed in over a five-year period to help reduce the volatility of the investment markets and it also again, reflects the last year of the phase-in of the contribution rate changes.

The actuary rate for the regular fund came in at 36.75% compared to the current statutory rate of 33.5%. The actuary rate for the police/fire employer pay plan was 58.65% compared to the current statutory rate of 50.0%. The results are similar in the employee/employer pay plan, and as this is a rate setting year, the statute would require the rates to go up in accordance with these rates. Just as a reminder, even though we call the contribution plan the employer-pay plan, this rate is shared equally between the employer and the employee regardless of the plan that they're on or the employer that they have. Under the applicable statute, the employee share is paid either through a reduction of pay or in lieu of an equivalent pay increase. That is, if the employee had been previously promised a pay increase, then they, in lieu of getting that increase, it would go towards the increase in the contribution rate.

Another thing I might want to mention also is the state is currently a little bit under 20% of the active membership of our plan. Clark County School District is our largest employer at close to 30% of the plan and then the state is the second largest.

Now the chart on page 399 ([Exhibit A](#)) shows the change in the actuarially determined rates broken into categories to show the causes of the actuarial rate increases and decreases. The rates shown are the average for the employer-pay and the employee/employer pay, so they don't exactly match up with either, but this is just to illustrate why the rates are changing. The changes are shown over a two-year period rather than a one-year period to have a true comparison with the current statutory rate.

The system recognized the gain in investments in this valuation due to a very strong investment year and also to our policy of smoothing where we had some previous gains that we're smoothing in still, as well as one loss. Due to this, the system has approximately \$2.1 billion in unrecognized gains that will be recognized over the next four years with future years investment gains and losses. Because of the volatility of investment markets year-to-year, asset smoothing in this manner is important for predictability and is a standard practice throughout the public pension industry.

For the regular fund, the investment gains, the changes in normal cost, and the effects of amortizing the unfunded liability over a larger than expected payroll had decreasing effects on the rate. These decreases were offset by increases due to losses in contributions, individual salary increases, and the final year of the phase-in. It's important to note that the actuarial rate increased in an amount less than the phase-in rate, which means that other than the phase-in rate, or if we had not been phasing in, that prior contribution rate increase, the actuarial rate would have decreased somewhat in the regular fund.

The increase to the contribution rate in the police/fire fund has similar causes but it's more magnified. There was a significant difference in the experience on the police/fire side that caused the contribution rate change to be more than the final phase-in amount. Certain experience may have greater impact on the police/fire fund due to the smaller plus size of the fund and differing demographics and benefit provisions. Other than the effect on the contribution rate of the assumption changes, the most significant factor in the contribution rate increase in this fund was that the increases to the liability based on individual salary increases, that is the higher member salary, or if it increases more than we expect, that creates a higher benefit, which creates higher liabilities. Those increases were not fully offset by other gains as they were in the regular fund.

Now the main distinguishing factor between the police/fire fund and the regular fund is that the police/fire fund has earlier retirement provisions and with our post-2015 members, they also have a higher benefit accrual rate than the regular fund. However, the mortality table for the two groups is very similar, not significantly different, which means that the benefits are paid longer out of the police/fire fund, which also impacts the differences in the contribution rate. We pay the benefit longer; it's a higher liability because of that, and we also have a shorter time that we're collecting contributions for that.

Now based on the 2024 valuation, the amortization period, the time in which the current unfunded liability will be paid, is 14.9 years from June 30, 2024, for the regular fund and 18.2 years for the police/fire fund, for an aggregate of 15.7.

Page 400 ([Exhibit A](#)) shows information on the actuarial funded ratio of the system; this is based on the actuarial value of assets. The actuarial funded ratio for the regular fund increased from 75.5% to 75.8%, while the police/fire actuarial funded ratio decreased from 75.2% to 75.0%. The combined actuarial funded ratio increased to 75.6% and on a market value the combined, that is the regular and the police/fire combined, increased from 76.2% to 78.1%. That's all my prepared remarks on the PERS actuarial valuation. I'd be happy to answer any questions.

CHAIR DONDERO LOOP:

Thank you very much. We'll go up north. Any questions up north?

SENATOR OHRENSCHALL:

Chair, may I have a brief question?

CHAIR DONDERO LOOP:

Please.

SENATOR OHRENSCHALL:

Thank you. Thank you very much for the presentation. Sometimes we hear a lot about unfunded liabilities and is PERS solvent, and I appreciate all the data you've given us. I just wonder if you could speak to that—just unfunded liability, solvency of the system?

MS. LEISS:

Sure. The unfunded liability is the comparison of the assets on hand currently, to the liabilities that we project would be paid out over time. The liability itself is paid out over the next 10, 20, 30, 40, 50, 60, maybe even 70 years because if someone enters at say age 20, they may be receiving benefits until they're 90, even 100; so that liability calculation is what we anticipate we'll pay into the future for all current and retired members—active members and retirees. The liability itself that you're looking at is not something that is due today nor could it be paid today because it's not due until each month of a member's retirement, which can be very far off into the future. It is a number that we look at as one measure of a public pension system's health, but it certainly is not the only one and it...trends need to be evaluated as well.

We do not have big swings in our funded ratio, which also shows stability and that we don't have large swings up or down with say investment markets or certain demographic events. I will say that the 2021 experience study strengthened greatly our assumptions, made them more conservative and so, has put us in a much better position going forward and it did so in a way that really didn't affect the funded ratio a great deal. Also, as you see, the funded ratio goes up a little bit when you take our market of value of assets. Given the strength in the...of the assumptions and where the investments are at this point, I think the board's very happy with where the funded ratio is. We certainly, from a solvency perspective, are in no danger of not having the money on hand to pay benefits as they come due.

SENATOR OHRENSCHALL:

Thank you very much for the answer and for all your hard work there at the system. Thank you, chair.

CHAIR DONDERO LOOP:

Thank you very much. I have a question, sort of along the same line. What are the primary factors that contributed to the proposed increases in the contribution rates?

MS. LEISS:

As in the regular fund, it completely due to assumption changes in 2021 which changed the mortality tables to reflect actual experience, and keeping in mind, that the liability is based on the assumptions that we have, and the liability number is not going to be very accurate off into the future if your assumptions aren't matching your experience. Assumptions were changed to match our experience to make sure that we were realistically following the

changes in what our membership is doing and the demographics. The...ultimately, you need to go back to the assumption changes to understand most of the rate increase and that has to do with changes in mortality tables, people are living longer, we have compounding COLAs [cost-of-living adjustments] every year after the third full year in retirement, which means that the liability increases quite a bit when people are living longer and drawing their benefits longer. That I think was the main factor.

The other factor was the change to the payroll growth assumption. We had for decades, had very high payroll growth, high payroll growth leads to higher contributions and then 2009 forward, we had very low payroll growth, sometimes negative payroll growth. That was another assumption that was changed that is contributing to the changes in the contribution rate.

On the police/fire side, the salary increases seen over the last two years have changed the liability enough to impact the contribution rate. There...it was somewhat on the regular side but not to the same extent as the police/fire side, and unfortunately the police/fire side is just, it's a smaller fund and it is more subject to volatility.

CHAIR DONDERO LOOP:

Thank you. Were there any other options that were contemplated or discussed to offset those increases and contributions rates? Why were those options...if that was discussed, why were those options...were they not considered? Can you talk about that a little bit?

MS. LEISS:

Sure. As far as the assumptions themselves, by Constitution, the board is constrained to adopt the actuarial assumptions recommended by the independent actuary. The board does not have discretion there and nor should they, because if you're funding on unrealistic assumptions, you're not really funding. The assumptions have to be realistic to make sure that you're funding and the benefits that our members have earned, will be paid. In the...in 2022, when these rate increases were first...kind of the magnitude were first shown, the board did some work on the amortization period. They made a change to the amortization period for the police/fire fund that did help with the rate increases. The rate increase would of been a little bit higher than it is now had the board not changed the funding period to 20 years for the police/fire fund. That's why you see the difference between the regular and the police/fire.

The 20 years is about as long as you want to go on your unfunded...on your amortization for your unfunded payments because otherwise you get into negative amortization which means that you're not even paying the interest. That was one thing that the board did.

As far as the Legislature, if you will recall, because of the employees paying half, there was some work done. A number of options were looked at and a bill ultimately passed that did not go into effect. Otherwise, and the board has looked at another...other options as well but as far as what the actuary will recommend, there really is nothing but to make sure that we are recognizing the full cost. I will also mention, of course, that the board is in control under Constitution of the assumptions themselves; the Legislature is in control of the plan design and the contribution rate mechanism.

CHAIR DONDERO LOOP:

Thank you. Any additional questions from any of the members? Assemblymember Carter.

ASSEMBLYMEMBER CARTER:

Good afternoon or good morning. Thank you for the report. I had a few questions. The first one is pretty obvious, but are all of the plan design changes that have been put in place, are they accurately provided to the actuary that's doing these calculations? All of the benefit cuts, benefit increases, all of that.

MS. LEISS:

Yes. Each year the actuary looks at all the benefit provisions and then takes into account any changes. You'll see that over the last probably five, six, seven years, I don't know how far back, the normal cost itself of the benefits has been decreasing slightly other than for the police/fire fund this year. That is due to mostly because of the new tiers, but as you're aware, the Legislature changes for new hires only in accordance with case law in the State of Nevada. It takes a long time for changes, for the results to be seen from those changes, because when you're only applying them to new hires you're...the money savings on the benefits is well out into the future.

ASSEMBLYMEMBER CARTER:

Thank you. You said that we're looking at a 20-year amortization period and I see that we're looking at the current rates bring it to 18 point [years] something or other. Why didn't we push that as far as we could to try to ameliorate these pretty drastic contribution increases?

Ms. LEISS:

The board did do that in 2022, that's why you...let me back up. Each year's gains and losses amortize over a 20-year period, and it counts down. We have layers at 20 years, 19 years, 18 years, 17 years, potentially because you're giving that piece its own 20-year period. Each year's piece gets a 20-year period to be paid off. In 2022, there were some layers in the police/fire fund that I think that had gotten down to say 15 years, 14 years, to when they would be paid off.

To help with the contribution rate increase, the board put those all back together and put them on a 20-year schedule and that layer is at 18 years itself, the current year is at 20 years. Because that's already been done in the police/fire fund, moving the entire thing to 20 years wouldn't do much to help with the rate increase now; that work's already been done. If you'll notice on the regular side, it has a average time period of about 14 years because its biggest layer was not redone to 20 years in 2022. For instance, the big layer, I believe, has 10 years left on it. In the regular fund, once that big layer of 10 years gets paid off, assuming it doesn't get rolled back out, then that rate will go down. If we continually put it back out to 20 years, it will never get paid off. I think that's why the board would...we certainly don't want to continue doing that, but that was something I think just with an extraordinary rate increase due to the assumption changes. But again, since we're only at 18 with the police/fire, moving it back out to 20 I don't think would have a lot of effect on this rate change.

ASSEMBLYMEMBER CARTER:

Thank you. For clarification, again gotta disclaimer—I've got a lot of experience in ERISA [Employee Retirement Income Security Act of 1974] plans and in those plans, we try to...they try to stay at that point, that pay off point, 80% funded or whatever to where we just keep pushing that mortgage out. Why are we trying to pay off? I realize that there was a [*sic*] industry change a decade or so ago to go from pay as you go plans to buying down or moderating the unfunded liability. Are we too aggressively moderating the unfunded liability and shouldn't we...could you discuss why we don't keep that mortgage, so to speak, at 20 years?

Ms. LEISS:

Because then it would never be paid off, right? You would be carrying it continually. I'm sorry, excuse me.

ASSEMBLYMEMBER CARTER:

No, I apologize. Then I don't understand that because we're supposed to be working on the full faith and credit of the State of Nevada. State of Nevada is not gonna disappear, so the idea of paying it off really is not how pension funds are supposed to work. There is supposed to be an ongoing, unfunded liability, and why are we dealing with this type of mentality rather than the industry standard of keeping it at a certain funded ratio?

MS. LEISS:

Keeping it at a certain funded ratio. Our goal is 100% funded to make sure that the benefits can be paid. I will agree that the State of Nevada is considered an ongoing concern unlike a private business where you might consider them to go out of business. For instance, a private sector pension plan has different accounting rules to take care of the eventuality that they could say go out of business and then the pension would go out with it.

Yes, I agree that it is an ongoing...we do intend that the state will be ongoing into perpetuity, hopefully; but as far as standards in the public pension world, that would be considered an open amortization period, which would require disclosures in the financial statements because an open period is not within certain standards. I also believe it would affect the state's bond rating if we were not making progress towards making the unfunded payments and paying off certain layers. That would be kind of the answers to that and just to make sure that we have the money on hand to pay the benefits.

ASSEMBLYMEMBER CARTER:

Thank you for that. I'm still very confused and gonna have to dig in more about why we have a goal of 100% funded when in the standard defined benefits world that typically...well, before Pension Protection Act, it was 65% funded and then you were in trouble. Now it's been boosted up artificially unfortunately by that act to 80% to 85% funded in perpetuity.

You mentioned that salary increases are part of the impact on this. Aren't salary increases, because this is a percentage, isn't that built into the system? As salaries go up, contribution rates go up because it's figured as a contri...as a percentage, rather than a hard dollar number.

MS. LEISS:

Yes. There're two impacts on the salary increases. There's the impact it has to the benefits that we pay—to the liability—and also, as you say, the percentage of payroll—the contributions that we get in. There is a difference in the contributions that we get in and the difference to the liability depending on how you're getting more payroll. For instance, whether you're bringing in a whole lot of new members or you're just having the same members but they're getting paid more.

Yes, there is some offsetting effects to the increases...so you have salary increases, then the liability goes up, but as you say, the contributions can also go up because it's a percentage of payroll and that's an actuarial calculation. The regular fund, the extra contributions in essence, more than offset the extra liability. The increased salary actually as a combination, decrease contribution rates a little bit. On the police/fire side, because of the demographics and because of the longer period that their benefits are paid, the salary increases increase the liability by more than the extra contributions coming in. That won't always be the case, but it was in the demographics in this particular year.

ASSEMBLYMEMBER CARTER:

Thank you. Just...finally, I just want to say that we're looking now...we keep talking about retention of state employees and governmental employees. We're looking at a system that has gone from 15% and 25% of somebody's salary going towards the pension plan to where now we're 35% to 40% and over half of the wages going into the plan. It sounds like a lot of it was triggered by changes in the assumptions and stuff. I just want to say, I think that we really need to look at that because in a time when we are hearing...and I see that smoothing impacts that, but that where our state is bragging about our investment returns and our pension plans. We're a national leader in investment returns and...but we're seeing those percentage increases go up and I really think we need to take a good strong, hard look at how we're doing things 'cause I don't see this as sustainable. Thank you.

CHAIR DONDERO LOOP:

Thank you very much. I don't think we have any additional questions. If you want to continue, go ahead, please.

**2. Report on actuarial valuation for the Judicial Retirement System as of June 30, 2024.**

TINA LEISS (Executive Officer, PERS):

Yes, the next agenda item is Item V.2 beginning on page 401 ([Exhibit A](#)) of your packet. That's an update for the FY 2024 actuarial valuation for the Judicial Retirement System (JRS). The retirement board, by policy, conducts an annual actuarial valuation to monitor the assets and liabilities associated with the JRS. Similar to PERS, this is a rate-setting year for the JRS and the contribution rates are adjusted by statute in the same manner as PERS.

The JRS covers both state judges and municipal justices, judges and justices of the peace of local jurisdictions that have opted to participate. But unlike PERS, this is not a cost sharing plan, which means that the various employers have their own actuarial contribution rate calculated and they pay different contribution rates based on their own demographics and their membership.

The actuarial contribution for the state judges consisting of normal cost and administrative expenses is 24.31% as of June 30, which is compared to a statutory rate of 23.25%, which will make the contribution rate for state judges change to 24.25% as of July 1, 2025. The amortization payment for the state's unfunded liability is not included in the calculated contribution rate but is paid by the state as an annual lump sum payment in both years of the biennium. This payment will increase to \$1,716,852 for each year of the next biennium as compared to \$1,551,796 in the current biennium.

The actuarial...the ratio of actuarial value of assets to the liability increased from 92.0% to 94.9% on a total fund basis, and on a market value of assets the funded ratio in aggregate is 99.6%. The unfunded liability in totality decreased from \$16.2 million to \$10.9 million. Pages 403 to 405 ([Exhibit A](#)) contain demographic information for the JRS, both state and non-state members, 406 contains the contribution rate for the state, and 407 and 408 contains contribution information for the local jurisdictions.

You will see a large variety in the contribution rates for local jurisdiction; it's because of the small number of covered members and whether or not the jurisdictions have any retirees. Some of the jurisdictions do not have retirees yet as this plan was created in 2001 and the locals didn't start having participation 'til the mid-2000s. That concludes my prepared remarks on this agenda item, happy to answer any questions.

CHAIR DONDERO LOOP:

Thank you very much. I...up north, any questions?

SENATOR OHRENSCHALL:

No, chair. Thank you.

CHAIR DONDERO LOOP:

Thank you very much. All right, then we will move on.

**3. Report on actuarial valuation for the Legislators' Retirement System as of June 30, 2024.**

TINA LEISS (Executive Officer, PERS):

The next Agenda Item V.3 in your packet beginning on page 409 ([Exhibit A](#)) is the valuation report for the Legislators' Retirement System (LRS). The provisions of the LRS allows legislators to opt out or to terminate participation in the system. In 2024, the active membership decreased from 24 to 21 members, the number of retirees decreased from 55 to 54, while the number of overall beneficiaries decreased from 70 to 69. As this is an even-year valuation, this also will affect contribution rates for the LRS. By statute, the legislators pay 15% of their salary as the employee contribution and the employer contribution is calculated as the total required actuary contribution minus those employee contributions.

In this valuation, the payment is decreasing from \$90,579 per year to \$44,584 per year. The funded ratio of the LRS decreased from 105.5% to 104.0% in this valuation; therefore, this fund is in a surplus. We have surplus management policies with the board to manage that surplus in a little bit different manner than you do in unfunded liability. The actuarial surplus at this point for the LRS is \$202,248. Beginning on page 410 ([Exhibit A](#)) of your packet is the demographic and funding information for this system. I'd be happy to answer any questions.

CHAIR DONDERO LOOP:

Thank you very much. Any questions up north?

SENATOR OHRENSCHALL:

No, chair. Thank you.

CHAIR DONDERO LOOP:

Thank you very much. Seeing no questions down here, we'll move on. Thank you.

**4. Update on investment earnings – Public Employees’ Retirement, Legislators’ Retirement and Judicial Retirement Funds.**

STEVE EDMUNDSON (Chief Investment Officer, PERS):

Yes, good morning, madam chair, members of the Committee. My portion of today’s report under Agenda Item V.4 includes an update on the status of the investment program for Nevada PERS, legislators, and judicial funds. Beginning on page 415 ([Exhibit A](#)) of your material titled *Investment Results*, which summarizes investment performance for all three funds for various time periods through the 2024 fiscal year.

The first column on the left (page 415, [Exhibit A](#)) reflects returns for the year ended June 30. It was a very strong year for investment performance during FY 2024. PERS portfolio generated a return of 12.0% net of fees and ended the year with just over \$64.0 billion in assets. Over the last 40 years, the PERS portfolio has generated a return of 9.3% on average net of fees. The legislators’ fund generated return of 14.6% during the 2024 fiscal year and ended the period with \$5.5 million in assets, and the judicial fund produced a return during the 2024 fiscal year of 14.8% with an asset value of \$208.4 million as of June 30<sup>th</sup>.

The following page, page 416 ([Exhibit A](#)) I believe, titled *PERS Annual Performance*, details PERS investment results for each of the past 40 fiscal years. There’s a horizontal line across the middle of the page which depicts PERS long-term actuarial assumed rate of return of 7.25%. That was one of those return...actuarial assumptions that was changed in the 2020...during 2021 from 7.5% down to 7.25%. It’s always critical to remember when thinking about that return assumption, that is a long-term return assumption, both are actual experience and expectations; we do not expect to achieve 7.25% in any individual year. In fact, we expect returns to vary widely over individual years and our hope and our goal is to get to that 7.25% number over a long time horizon. As we look forward, we can expect...it’s wise to anticipate that over individual years we should expect that variance or dispersion of returns to be pretty wide over single short time periods.

PERS investment strategy, which is depicted on page 419 ([Exhibit A](#)), is somewhat unique in the industry in that we employ a much simpler structure. We have...relative to the rest of the public pension fund industry we have higher allocation to high-quality publicly traded U.S. [United States] stocks, international stock developed countries only in our International Stock Portfolio. Also, you have somewhat unique is that our U.S. fixed income allocation consists of entirely of U.S. government treasury bonds.

In addition to employing that simple structure, we deliberately avoid exposure to more complex and expensive and riskier investment approaches such as utilization of leverage of the total fund level and/or investment strategies such as hedge funds. One of the advantages of this simple structure, I think one of the numerous advantages to our simple structure, is that our investment costs are extraordinarily low. It's something that we spend a lot of time emphasizing with the investment programs, keeping our costs as low as possible. We want to be sure that every dollar available within the system compounds for the benefit of the members and beneficiaries rather than being paid out in investment management fees.

We estimate that PERS investment costs are on average around \$250 million a year lower than the median peer pension fund. If you extrapolate that cost savings out over the course of 10 years, assuming a 7.25% rate of return, that equates to more than \$3 billion in savings over the course of a decade. In addition to being low cost, this simple approach has proven to be effective over long-time horizons.

PERS results and investment returns have ranked in the top 5<sup>th</sup> percentile or better over the last 5, 7, and 10 years and since inception, remain in the top. The last 4 decades, the last 40 years, remain in the top decile of large public pension plans. With that said, we certainly don't expect to be in the top of the database every year. Our experience is somewhat similar to returns relative to that long-term return assumption where we expect returns to be both above and below that line. Our relative returns compared to the industry we expect it to vary somewhat over short-time horizons. Our fund looks a little bit different, so we're going to behave differently during different time periods. Our actual experience has reflected that and about a third of any individual years, we've been in the bottom of the database, but over that longer time period, we remain in the top decile. We expect PERS simple approach will continue to be competitive on a relative basis over long-time horizons.

While my report today provided materials through the 2024 fiscal year, I wanted to take the opportunity to just give you a quick update on returns for the start of the 2025 fiscal year. As we sit here this morning, PERS returns through today for the 2025 fiscal year are up roughly 5.5% fiscal year-to-date, so a strong start to the fiscal year. Again, not necessarily indicative of where we'll end the year, but definitely off to a good start. As we stand this morning, PERS portfolio sits at \$64...or sorry, \$67.4 billion in assets.

Kind of, I guess, looking forward over the long term, one of the silver linings I would say to the higher interest rate environment that everybody's experiencing—anybody going out to take on a mortgage right now is certainly feeling it or an auto loan in this normalized interest rate environment—but one of the silver linings to the higher interest rate environment, or I would call it a more normalized interest rate environment, is that we can expect with ten-year Treasury Bonds, as of this morning, currently yield around 4.4%.

Go back to 2020, ten-year Treasuries were yielding less than 1.0%. That higher interest rate environment implies that we should have a smoother path going forward to trying to achieve that 7.25% long-term return since we're getting higher income out of the safety bucket of the Treasury allocation and in the portfolio. With that said, that concludes my prepared remarks. I'm certainly happy to answer any questions.

CHAIR DONDERO LOOP:

Thank you very much. I appreciate your expertise and thank you very much for doing that. Any questions up north?

SENATOR OHRENSCHALL:

Chair yes, a couple brief questions, if I may

CHAIR DONDERO LOOP:

Please.

SENATOR OHRENSCHALL:

Thank you, Mr. Edmundson and thank you for your judicious work here with the system. My question is, we don't know what the future holds and if there's a bear market ahead, how do you see the system handling that? If we look at the returns that we've had during times of crisis in 2008 and 2009, 2022, going back to 102 [sic]; if something like that happens, how do you see PERS handling that?

MR. EDMUNDSON:

Yes, thank you for the question. We are certainly...we won't be immune to market volatility; however, as part of that silver lining that I was discussing earlier, in regard to the amount of risk that we have to have in the portfolio, one of the benefits of a higher interest rate environment is that we're actually able to maintain an investment approach at this point that has a lower level of expected volatility going forward. During the last fiscal year, PERS board, at a recommendation of staff, we reduced...significantly reduced our risk posture in the portfolio given the higher interest rate environment, and that lower risk posture of the investment portfolio should help buffer returns going forward.

Again, we won't be immune but historically our allocation to, exclusively to Treasury bonds and our fixed income allocation has provided that buffer during volatile time periods. If you go back to 2008 and 2009, PERS results, despite our higher allocation to publicly traded stocks, remained competitive relative to the industry. At the end of the day, we won't be immune over...for...to volatility over short time periods but our lower risk profile at this point, should help smooth the ride going forward.

SENATOR OHRENSCHALL:

Thank you very much. I appreciate that. Chair, with your indulgence, one brief follow-up?

CHAIR DONDERO LOOP:

Please.

SENATOR OHRENSCHALL:

I appreciate the breakdown of investment categories on pages 419 and 420 ([Exhibit A](#)) for the PERS legislator retirement and judicial retirement. What right now is our investment in the cryptocurrencies, virtual currencies? Is that a large part of the investment of PERS or is it minuscule? I just wonder if you could speak to that?

MR. EDMUNDSON:

Yes, thank you for the question. Our exposure is effectively zero, we don't own any cryptocurrency within the portfolio. We will have some exposure to companies in the venture capital space that might have some offset exposure within the industry, but we don't have any direct exposure to the cryptocurrency. One of our, I guess, key tenants of the portfolio is that we won't put anything into the portfolio unless it's at least 5% of total fund assets.

If it's below 5% of total fund assets, it simply won't move the needle to total fund returns. For instance, a 50-basis point or a 1% allocation to say commodities would not provide a meaningful buffer to say an inflation...in an inflationary environment, nor would say a 50-basis point allocation of cryptocurrency do ultimately do much if anything to total fund returns one way or the other. We try to keep our investment approach at...each piece of the investment portfolio's designed to play a role and will play a significant role. Unless we see an asset class that fits in with our high-quality bias within the portfolio, we wouldn't put it in the allocation. To date, we don't have any direct exposure to cryptocurrency.

SENATOR OHRENSCHALL:

Thank you very much, I appreciate the answer Mr. Edmundson and all your hard work. Thank you, chair.

CHAIR DONDERO LOOP:

Thank you very much. I don't think I see any additional questions. Thank you very much. We can go on to the next section. Thank you.

**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):

Madam chair, [Agenda] Item V.5 in your packet on page 427 ([Exhibit A](#)) is an update on the benefit provided to certain education employees pursuant to NRS 391.165. This benefit was designed to be an incentive to certain employees to work at schools that have been designated as needs improvement, or at least 65% of the pupils or children who are at risk. Additionally, any teacher who holds an endorsement of mathematics, science, special education, or English as a second language, and meets all the eligibility requirements and who have been employed for one year in the area of endorsement may be entitled to the benefit as well.

Section 4 of A.B. [Assembly Bill] 1 of the 23<sup>rd</sup> (2007) Special Session repealed this benefit effective July 1, 2007, and phases it out over time. If an employee elected to continue in the one-fifth of a year purchase program, participation ceases when the employee has received after election, one year of service credit under the program. If you think about that, fifth of the year to get one year would take five years; however, because of people moving in and out of positions, we still have some people in 2023 and 2024 that were eligible for this benefit, although it has greatly decreased because of the elimination of the benefit in 2007.

The spreadsheet on page 429 ([Exhibit A](#)) reflects purchases for calendar years 2023 and 2024. In calendar year 2023, the system received \$454,371 for 65 purchases and in 2024, it was \$97,710 for 11 purchases. Since inception, the benefit...the system has received \$149 million for 41,847 purchases. Over the last two years, this has been limited to the Clark County School District and Washoe County School District. I'd be happy to answer any questions.

CHAIR DONDERO LOOP:

Thank you. I have one. When these...did they have to...the people that are still in the system, did they have to designate that they wanted to do this back when they were at the Title I school? In other words, they can't right now say oh, I was at a Title I school in 2007 and I now want to join and do this?

MS. LEISS:

Yes, I think the law provided that they had to opt to remain in the one-fifth of a year program versus some other type of incentive in the 2007 time period, so this is limited to people who made that decision long ago.

CHAIR DONDERO LOOP:

Okay, thank you. I agree, I just wanted that to be clarified. Any questions up north?

SENATOR OHRENSCHALL:

No, chair. Thank you.

CHAIR DONDERO LOOP:

Thank you very much. I don't believe I see any down here so we can move on to the next section. Thank you.

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

STEVE EDMUNDSON (Chief Investment Officer, PERS):

Agenda Item V.6 provides a status report on the administration and investment of the Retirement Benefits Investment Fund (RBIF). Just by a quick way of background, the RBIF and Retirement Benefits Investment Board were created and enacted from Senate Bill 457 at the 74<sup>th</sup> (2007) Legislative Session, which established the board and the RBIF as a vehicle

for government entities that wish to participate in funding future OPEB [Other Post-Employment Benefits] liabilities and provide an investment vehicle for them to do so.

Last fiscal year, the RBIF produced a return of 14.7% and finished the year with \$906.6 million in assets with 12 participating local entities; all local government entities currently participating within the RBIF portfolio. Since our last update, there have not been any changes to the fund administration, which continues to contract out for administrative services. Investment and accounting services are provided by ultimately Nevada PERS.

Since inception, the RBIF, I think interestingly has produced a return of 7.5% given its challenge starting date. The fund...the RBIF structure was adopted ultimately in 2007 and then initially funded in 2008, which if you recall was an acutely difficult time period for markets during the Great Financial Crisis. I think the fact that the fund has produced that 7.5% long-term return given the difficult starting point, is a good illustration of what time horizon...a longer time horizon can produce investment markets and also provides a good touchstone that our 7.25% long-term return assumption remains viable for the PERS fund. With that said, I'm happy to answer any questions about the RBIF portfolio.

CHAIR DONDERO LOOP:

Thank you very much. Any questions up north?

SENATOR OHRENSCHALL:

No, chair. Thank you.

CHAIR DONDERO LOOP:

Thank you. I don't think I see any down here. Thank you, Mr. Edmundson, again. That means we can move on.

**7. Status report on the implementation of PERS' pension administration system.**

KABRINA FESER (Operations Officer, PERS):

Good morning, madam chair and members of the Committee. We would like to provide an update on the status of the new pension administration system, PERIS [Public Employees' Retirement Information System], under Agenda Item V.7. Work began with a software vendor, Tegrit Software Ventures, on February 22, 2021. An employer advisory group was established, and they meet regularly. This has been a beneficial resource for communication and collaboration. Data cleansing efforts have been ongoing

since 2019. In preparation of the new PERIS, 99.996% of the data from our current system, CARSON [Computer Automated Retirement System of Nevada], has been converted to the target staging database.

Several milestones have been accomplished since the last IRBC meeting earlier in 2024. This includes benefit functionality, calculators, workflows, and user interfaces have been tested and are programmed in the PERIS. In addition, staff is working in parallel tracks for retiree services and accounting functionality for this phase of the project. Our first group of employers transitioned reporting their monthly retirement reports in the PERIS in February of 2024. This past year, the focus of phase 3, Employer Reporting, has been on training and transitioning those employers. There are currently 182 employers that are reporting their reports in the PERIS.

The PERIS project has been moving along well; we have received positive feedback from the employers who have transitioned to the PERIS. We even had a group of employers at our recent liaison officer conference that were part of a roundtable discussion regarding the PERIS. There have been some mutually agreed upon changes which have impacted the project timeline; they're...examples include, holding off on transitioning the employers to ensure that their suggestions were programmed and ready prior to the go-live. There was also the opportunity to upgrade to the framework NXT for ease of maintenance and other benefits, as well as making sure that the project is a successful implementation.

Rather than risking quality of the project to meet the original go-live date of January of 2025, staff collaborated with the PAS vendor, Tegrit, along with our project oversight vendor, Provaliant, and proposed a modification to the timeline, deliverables, and payment milestones to the retirement board. The retirement board authorized the change request for the timeline and payments schedule at their May 2024 meeting. This changes the final deployment date from January of 2025 to June of 2026. The overall cost increase is approximately \$4.2 million. Even with this additional cost, the system remains within its original projected budget for the overall project. The overall goal of this project has always been to create a modernized user interface with enhanced functionality to serve our members, retirees, and employers. Those are my prepared remarks. I'm happy to answer any questions the Committee may have.

CHAIR DONDERO LOOP:

Thank you very much and thank you for your hard work on this. Any questions up north?

SENATOR OHRENSCHALL:

Yes, chair. A brief question?

CHAIR DONDERO LOOP:

Please.

SENATOR OHRENSCHALL:

Thank you, chair. Thank you for the presentation. I just wanted to get that date right. The January 2025 startup date of going live is now being pushed to 2026, but I didn't get what month.

Ms. FESER:

That date is June of 2026.

SENATOR OHRENSCHALL:

Okay, thank you. A brief follow-up, madam chair, with your permission.

CHAIR DONDERO LOOP:

Please.

SENATOR OHRENSCHALL:

Thank you. You mentioned some of the challenges in trying to get the system modernization project, the PERIS project working and working with the vendor. Do you feel that...and the June 2026 date and I think the \$4.2 million, that additional cost, that's pretty firm, or is there possibility it might get pushed back further, it might become more costly to try to implement this?

Ms. FESER:

Thank you, Senator Ohrenschall. We had a really hefty goal of transitioning all employers within a year. Until all of those employers have transitioned, and some are taking a little longer based on them being in the middle of their own computer projects and our updates, so we're watching that with the schedule at this time. We're also watching to see if that will impact any cost because there's the chance that once one of these larger employers transition, there may be programming changes that they suggest or they may need prior to go-live. At this time, it's definitely a risk that we are watching and being aware of, but I don't have anything else to report at this time; it's just a risk we are navigating.

SENATOR OHRENSCHALL:

Well thank you, I appreciate all your hard work on the project and certainly trying to get all the new computer systems working. That's a big task, I think, in any organization. Thank you, chair, for your indulgence.

CHAIR DONDERO LOOP:

Thank you very much. I don't think I see any questions down here. Thank you very much. Thank you, Ms. Leiss, for your team and all their expertise. This is an important benefit to all of our public employees, so thank you.

MS. LEISS:

Thank you for your time.

## **VI. PUBLIC COMMENT.**

CHAIR DONDERO LOOP:

Thank you. With that we will go to [Agenda] Item VI, public...second public comment. If you are listening, you may call in at 888-475-4499 and when prompted, put in the Meeting ID 86172603549 and press #. If you have any issues, I guess, let us know, otherwise we will go to public comment in Carson City first.

SENATOR OHRENSCHALL:

Chair, I don't see anyone coming up to the table here in Carson City.

CHAIR DONDERO LOOP:

Thank you very much. Anyone here in Las Vegas? Seeing none, thank you. We'll go to the phone lines, BPS [*sic*] when you're ready.

AVH STAFF:

Thank you, chair. The public line is open and working but we have no callers at this time.

CHAIR DONDERO LOOP:

Okay, thank you very much. We wore everybody out. With that, if there are no other public comments, then we will adjourn. With that, thank you very much.

**VII. ADJOURNMENT.**

The meeting was adjourned at 11:26 a.m.

Respectfully submitted,

\_\_\_\_\_  
Natalia Garzoli, Secretary for the Minutes

APPROVED:

\_\_\_\_\_  
Senator Marilyn Dondero Loop, Chair

Date: \_\_\_\_\_