MINUTES OF THE
NEVADA LEGISLATURE'S
INTERIM RETIREMENT AND BENEFITS COMMITTEE
(*Nevada Revised Statutes* 218E.420)
January 16, 2014

Chairwoman Maggie Carlton called a meeting of the Nevada Legislature's Interim Retirement and Benefits Committee (IRBC) to order on January 16, 2014, at 9:38 a.m. in Room 3137 of the Legislative Building in Carson City, Nevada. The meeting was simultaneously videoconferenced to Room 4401 of the Grant Sawyer State Office Building in Las Vegas, Nevada.

COMMITTEE MEMBERS PRESENT IN CARSON CITY:
Assemblywoman Maggie Carlton, Chair
Senator Debbie Smith, Vice Chair
Senator Joyce Woodhouse
Assemblyman Randall Kirner

COMMITTEE MEMBERS PRESENT IN LAS VEGAS:
Senator David Parks
Assemblywoman Heidi Swank

COMMITTEE MEMBERS ABSENT:
None

STAFF MEMBERS PRESENT IN LAS VEGAS:
None

STAFF MEMBERS PRESENT IN CARSON CITY:
Mark Krmpotic, Senate Fiscal Analyst, Fiscal Analysis Division
Cindy Jones, Assembly Fiscal Analyst, Fiscal Analysis Division
Laura Freed, Senior Program Analyst, Fiscal Analysis Division
Eileen O'Grady, Chief Deputy Legislative Counsel, Legal Division
Becky Lowe, Committee Secretary, Fiscal Analysis Division
Carla Ulrych, Committee Secretary, Fiscal Analysis Division

EXHIBITS:

Exhibit A: Agenda and Meeting Packet
Exhibit B: Letter from Laurie Howard regarding the non-state retiree health insurance premiums
Exhibit C: Letter from George Wennhold regarding the non-state retiree health insurance premiums

Exhibit D: Letter from Mary Swearingen regarding the non-state retiree health insurance premiums
Exhibit E: Letter from Sandra Mix regarding the non-state retiree health insurance premiums
Exhibit F: State of Nevada Other Post-Employment Benefit Liability by the Public Employees' Benefits Program (distributed but not discussed)
Exhibit G: Report to the Retirement Board of the Public Employees' Retirement System of Nevada by AON Hewitt

I. ROLL CALL.

Chair Carlton called the meeting of the Nevada Legislature's Interim Retirement and Benefits Committee to order at 9:38 a.m. The secretary called roll and all members were present.

II. PUBLIC COMMENT.

Janice Florey thanked the Committee for considering the dilemma of non-state retirees concerning increased monthly premiums. Ms. Florey noted that non-state retirees would receive a one-time allocation of $400, and their dependents would receive a one-time allocation of $100, and she thanked the Public Employees' Benefits Program (PEBP) and the Senate Finance Committee for the thoughtful gesture. Ms. Florey continued, stating that no matter how good the benefits were, if an individual could not afford the monthly premiums, an increase in benefits was a moot issue. She noted that although non-state retirees were given the choice to stay with PEBP or return to their previous employer for health care benefits, not all entities were willing to accommodate the change. Ms. Florey indicated this was a particular problem for Clark County School District personnel. She further explained that non-state retirees who chose to leave PEBP would lose life insurance and the opportunity to receive a small subsidy to purchase Medicare Part B insurance. Ms. Florey said she hoped the Committee would help non-state retirees during the next legislative process.

Peggy Lear Bowen thanked the Committee for their concern for the non-state retirees. Ms. Bowen indicated, however, that non-state retirees were often not considered during the decision-making process. For example, she said if legislators had questioned whether premium rates would be flat for all PEBP recipients, they would have learned that the rates were not flat for non-state retirees. Ms. Bowen said the starting rate for non-state retiree premiums, before any subsidy, was $1,000 a month. She indicated that with her subsidy and wellness discount, her monthly premium rate still increased from $181 to $342 per month. She said many non-state retirees were not using the health benefits, because they could not afford them. She suggested that legislators ask more specific questions to get the answers they need to assist the non-state retirees.

Marty Bibb, Executive Director, Retired Public Employees of Nevada (RPEN) thanked the legislators, particularly the money committee members, for the strong message that was sent to PEBP during the 2013 Legislative Session. Mr. Bibb also expressed gratitude that PEBP found additional ways to add funding for those in the plan. He expressed concern regarding the ongoing issue of excess financial reserves within the PEBP program. Additionally, he said it would be helpful if permanent changes could be made to the plan, rather than infusions of money that contributed to the pattern of increased excess reserves. Mr. Bibb concluded that the RPEN looked forward to working with the Committee in the future on these issues.

Marlene Lockard, RPEN, submitted letters of public comment from Laurie Howard (Exhibit B), George Wennhold (Exhibit C), and Mary Swearingen (Exhibit D) regarding non-state retiree premium increases.

A letter of public comment was provided by Sandra Mix regarding non-state retiree premium increases (Exhibit E).

III. APPROVAL OF MINUTES OF THE JANUARY 30, 2012, MEETING.

ASSEMBLYMAN KIRNER MOVED TO APPROVE THE MINUTES OF THE JANUARY 30, 2012, MEETING OF THE INTERIM RETIREMENT AND BENEFITS COMMITTEE. SENATOR SMITH SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

IV. PUBLIC EMPLOYEES' BENEFITS PROGRAM (PEBP).

1. Report on utilization of the Program by participants for the year ending June 30, 2013, segregated by active employees and retirees, including an assessment of the actuarial accuracy of reserves (NRS 287.0425).

This agenda item was taken out of order.

Jim Wells, Executive Officer, Public Employees' Benefits Program (PEBP), explained that during the economic recession in 2010, the Budget Division requested PEBP to cap the subsidy dollars at the previous biennium amount (i.e., 2009 to 2011 biennium). He said the actuaries performed analysis of medical inflation, comprising of expected utilization in growth, enrollment growth, and compliance with health care reform provisions, such as the coverage of dependents through age 26 and delineation of lifetime maximums. The actuaries determined that PEBP needed about $575.7 million to offer the same benefit plan and subsidy. The state responded with a budget of $493.5 million. Mr. Wells said in order to address the shortfall projected by the actuaries and budget restraints, the PEBP Board implemented the following plan design changes:

- Conversion of the Preferred Provider Organization (PPO) plan to the Consumer Driven High Deductible Plan (CDHP).
- Eliminated specific hospital lab coverage's.
- Removed spouses who were eligible for other employer based coverage.
- Life insurance decreased by 50 percent.
- Coverage for Medicare retirees was shifted to the individual market exchange.
- A shift in subsidy, primarily for the Health Maintenance Organization (HMO) participants.

Mr. Wells went on to discuss the fact that the actuaries' projections for medical, dental, and prescription drug inflation were overstated. As a result of both the cost savings measures approved in the 2011 to 2013 budget and the actuaries' overly conservative projections, excess cash reserves were generated.

PEBP instructed the actuaries to review actual utilization patterns and compare it to their previous projections in order to better understand the discrepancy. Mr. Wells said Aon Hewitt's information was not received by PEBP until January 15, 2014, and that a copy would be provided to the IRBC on January 17, 2014. The following were Aon Hewitt's key observations regarding the two year period from July 2011 to June 2013.

- The 1 - 2 percent national inflation increase in health care represented historic lows. Some analysts believed that health care expenses tracked with economic trends, suggesting that lower economic growth produced lower health care costs. Others believed the inflationary reductions were due to payment reform; guiding people to the lowest cost care pathways in order to fulfill the participant's needs while controlling cost at the same time. Some institutions bundled their services so there was one fixed cost involved in the procedure, otherwise known as "bundled payment reform."
- Changes were made to specific plans offered by PEBP. Mr. Wells stressed that implementation of the high deductible plan produced obvious behavioral changes in consumers and there was no indication that participants were deferring care. Mr. Wells said both wellness and disease management plans yielded a return on investment (ROI) in hard dollars, specifically among the diabetic population.
- PEBP improved contract negotiations and saw a reduction in unnecessary care. On July 1, 2011, when changes were made to the CDHP, PEBP replaced its third-party administrator, resulting in a reduction of duplicate claims. In July 2012, PEBP contracted with a new out-of-state network, saving about $3.4 million last year.
- High cost catastrophic in-patient care claims were better off under the current CDHP versus the old PPO plan.

Chairwoman Carlton asked Mr. Wells to define "unnecessary" care. In response, Mr. Wells explained that under the old PPO plan, PEBP experienced a high volume of emergency room utilization without attendant hospital admissions. That indicated an incorrect avenue of provider service was being used by the members.

Chairwoman Carlton said she did not feel comfortable discussing a report that was not in her possession. She felt that the term “unnecessary care” was misleading. She stated that going to the emergency room, instead of a primary care provider, was merely an incorrect route to the access of care. Fixing that was a matter of educating the clientele.

Mr. Wells said, because medical inflation has historically risen faster than the consumer price index (CPI), the cost of health care escalated. He said when PEBP implemented the provisions required under the Affordable Care Act, in 2011, a 2.5 percent increase in inflation was projected. Mr. Wells stated that projection never came to fruition and that PEBP witnessed even a larger inflation reduction than its counterparts. He reported that many self-funded states, organizations, and insurance carriers were building reserves. He reiterated that the PEBP excess reserve was the result of a reduction in inflation, as well as the implementation of significant plan design changes.

Chairwoman Carlton made reference to the CDHP and the large number of claims below $2,000. With the Health Savings Account (HSA) and Health Reimbursement Arrangement (HRA) contributions, and given the $1,900 individual deductible, she estimated that expenses of about $500 were shifted from the state to each participant. She asked if that shift in dollars contributed to the level of reserves.

Mr. Wells said under the old PPO plan, there was an $825 deductible and co-pays that did not contribute to the deductible. Under the current HSA plan, the contributions could be used to defer out-of-pocket costs.

Chairwoman Carlton agreed, but pointed out the $500 cost shift was deleted from PEBP’s liability, which might account for a portion of the reserves. She noted that claims projections had been incorrect for at least three years. She stated that with access to claims history statistics, the projections should be more accurate. Chairwoman Carlton expressed concern that employees would drop insurance coverage for their kids because of the cost.

Mr. Wells made reference to three categories of CDHP users:

- The participants who produced low claims. Many of these people never used the entire HSA contribution that the state deposited annually. These members were better off with the HSA model.
- The participants who submitted catastrophic claims. PEBP was paying a higher percentage of these claims.
- The middle users, or participants who paid more money than the state contributed to the HSA, but still did not meet the out-of-pocket maximum.

It appeared the cost shifts were found in the middle user group and the users were paying more out-of-pocket expenses with this plan versus the old PPO.

Chairwoman Carlton questioned whether the HSA was meeting the state's intention, especially when there was state money sitting in unused HSA accounts. She said the money was meant to be used for health care and not as a savings account. She asked if the HSA money would be better used elsewhere to defer the high cost of insurance for the entire pool.

Mr. Wells explained that all members would eventually acquire medical claims and the HSA funds would minimize the impact. He said the state could contribute more, but that would burden the taxpayers. Mr. Wells acknowledged that there had been a cost shift. He explained that cost shifting was more evident in the pharmaceutical component of the current plan. The old PPO plan paid a higher percentage of drug costs and triggered the industry to migrate to generic formulas. Mr. Wells indicated that he viewed this as more efficient utilization.

In conclusion, Mr. Wells said the more significant driver of the reserves was because PEBP factored in 10 percent inflation, but experienced an 18.6 percent deflation. He felt this was a bigger factor than the cost shift.

Assemblyman Kirner asked about the three categories of CDHP users that Mr. Wells had described. He asked for the participant numbers associated with each group, especially the middle user. Mr. Wells said the catastrophic group represented less than 5 percent of the participant population, the low claim group represented almost 38 percent, and the middle user made up almost 49 percent.

Assemblyman Kirner asked if prescription costs were applied to the deductible. He also asked why the actuary data used for calculating rates was consistently off, and if the miscalculation caused the excess reserves. Mr. Wells confirmed that prescription costs were applied to the CDHP deductible.

Ms. Debbie Donaldson, Vice President, Aon Hewitt, explained that rate setting could happen 16 months prior to the plan year going into effect. She stated that in FY 2012, the first year of the CDHP, she made assumptions based upon the old PPO plan. She calculated relative values based on plan design changes and assumed there would be reduced utilization associated with the CDHP. She said when the FY 2013 rates were set, she only had six months of data under the CDHP, and therefore, she did not anticipate the current pattern. She assured the Committee that FY 2014 rates were determined using one and one-half to two years of good data under the CDHP. Ms. Donaldson explained that the skewed utilization assumptions were related to the prescription drug plans. She had projected an 18 percent reduction would take place in the first year, rather than the actual 40 percent reduction that occurred. In FY 2013, a 19 percent increase in trend was projected when the actuals reflected an 8.75 percent increase.

Assemblyman Kirner asked Ms. Donaldson how she missed the inflationary number. He said that miscalculations lead to higher premiums for the participants.

Ms. Donaldson stated that a study was performed to locate where the differences occurred. The following changes were identified:

- There were changes to the third-party administrator. Negotiated discounts and out-of-network changes were not disclosed to Ms. Donaldson's team, which yielded significant reductions to the PEBP plan. The changes had a dramatic impact on trend.
- Differences in utilization were studied from plan year 2011 to 2012. For plan year 2011, under the PPO plan, 2.5 percent of the participant population had no claims. Typically that number ranged between 15 percent and 25 percent.
- There was a reduction in duplicate claims.

Assemblyman Kirner commented that the inflationary factor missed its projection, and consequently that was costing the participants. He said statistics showed that inflation decreased from 11 percent per year, or greater, down to a marginal number.

Ms. Donaldson stated the 11 percent figure was the trend used to help anticipate the increase in health care costs. She said her team lowered the 11 percent projection to take into consideration the plan design changes and utilization. The net trend that her team used for the current medical plan was 1.2 percent and negative 4.8 percent for prescription drugs.

Chairwoman Carlton requested clarification in regard to previous utilization under plan year 2012 medical claims. Mr. Wells said the 2.5 percent that Ms. Donaldson referred to was from plan year 2011, prior to changing from the PPO plan to the CDHP. The statistics revealed, using the last year under the old PPO co-pay structure, 2.5 percent had no claims filed. Between 2011 and 2012, that number jumped to 21.3 percent, and dropped to 18 percent in 2013.

Chairwoman Carlton reiterated that, under the old PPO plan, 2.5 percent of the participants did not utilize any health care. She did not believe that participants became 18 percent healthier and stopped utilizing their benefits. She asked if the 18 percent of participants who did not file health care claims in 2013 were projected to present high-cost catastrophic claims five years from now. If so, how would those claims affect the utilization numbers?

Mr. Wells shared an example of utilization, comparing the old PPO with the current CDHP. Utilizing the PPO, it was cheaper for an allergy patient to pay the co-pays for the doctor ($20) and prescription ($5), rather than to purchase over-the-counter allergy medication. Under the CDHP, the same patient purchased over-the-counter medication, because it was cheaper than going to the doctor, since the co-pay was eliminated and the prescription cost increased.

Mr. Wells said there was a decrease in utilization between the PPO and CDHP, and was based on the following:

- 2.5 percent of the decrease reflected over-utilization.
- The decrease reflected lower utilization of the emergency room, with no indication there would be claims due to deferral of care.
- There were no spikes in catastrophic claims with the CDHP, and of the claims received, none pertained to deferral care. The claims were due to cancer, significant accidents, and premature births.

Mr. Wells attributed the low utilization statistics to wellness and identification of risk. He said biometric screenings helped guide a member to the care needed to prevent or correct an illness or disease. He said the screenings would be used to capture data, and to determine future programs that would control long-term costs, such as a hypertension or asthma program.

2. Report from independent certified public accountant regarding audited financial statements for the Program, dated October 2013 (NRS 287.0425).

   a) Fund for the Public Employees' Benefits Program (NRS 287.0435)

   Suzanne Olsen, Audit Manager, Casey, Neilon & Associates, referred the Committee to the Auditor's Report of the financial results of the Self-Insurance Trust Fund, year ending June 30, 2013 (page 49, Exhibit A). She said the audit produced a clean opinion, known as an "unqualified opinion," and that the rating was the highest level of assurance provided.

   Ms. Olsen commented on two additional reports that were required by the audit.

   - Internal Control over Financial Reporting (page 66, Exhibit A). No deficiencies were identified.
   - Management Letter. The purpose of this report was to identify significant problem areas of the audit. There were no significant changes in the accounting practices or policies during the year ending June 30, 2013. The auditor had no difficulties performing the audit and faced no disagreements with the management.

   Ms. Olsen referenced the Statement of Net Position (page 55, Exhibit A). Comparing FY 2012 and FY 2013, total assets increased by $37 million and total liabilities increased by $23.2 million. She said the surges were directly attributed to the active employee group insurance subsidy surplus, and could be explained in more detail on pages 59 and 60, NOTE 1, under the "Receivables" section (Exhibit A). Ms. Olsen noted the net position was itemized under two categories: 1) invested in capital assets, and 2) restricted for losses (including the amount set aside for catastrophic reserves).

   Ms. Olsen explained that the Statements of Revenues, Expenses and Changes in Fund Net Position (page 56, Exhibit A), summarized changes in the net position between FY 2012 and FY 2013. Based on the plan design changes, expectations

were for the Fund's net position to decrease rather than increase during FY 2013. The results were attributed to the following:

- The total operating revenues increased by $14 million in 2013, primarily due to an increase in participation.
- The operating expenses remained fairly consistent from 2012 to 2013 (i.e., an increase of $8 million).
- Claims expenditures increased by 1.4 percent and operating revenue increased by 4.4 percent. There was a significant variance in the reserve for loss and loss adjustments, reflected by a reduction in paid claims.
- Other operating expenses were consistent from 2012 to 2013, supporting the Fund's efforts to reduce costs as its operating revenues increased.
- The total non-operating revenues and expenses provided the investment returns for this fund. The total changes in net position increased $13 million from 2012 to 2013.

b) State Retirees' Health and Welfare Benefits Fund (NRS 287.0436)

Ms. Olsen referred the Committee to the Audit Opinion (page 71, Exhibit A). She reported that PEBP State Retirees' Health and Welfare Benefits Fund had a clean, unqualified opinion. The following reports were also required by the audit:

- Internal Control over Financial Reporting (page 82, Exhibit A). No deficiencies were identified.
- Management Letter (page 67, Exhibit A). There were no changes in accounting practices and policies. There were no difficulties encountered, and no disagreements with management during the audit of the fund.

Ms. Olsen referenced the Statement of Plan Net Position for FY 2012 and FY 2013 (page 73, Exhibit A). The statement provided a financial position for the plan in comparative format. She emphasized the following highlights:

- In FY 2013, the net positions for Other Post-Employment Benefits (OPEB) increased from $1.2 million to $4.4 million.
- Cash with Treasurer increased by $2.2 million.
- Investments at fair value remained stable, reflecting an increase from $940,000 in FY 2012 to $1.1 million in FY 2013. The investments were held in the Retirement Benefits Investment Fund (RBIF).
- The Statements of Changes in Plan Net Position (page 74, Exhibit A), reflected a $3.1 million increase in net fund position from 2012 to 2013. The growth was attributed to increases in both employer contributions ($8.8 million) and net investment income ($47,000). The benefit payments reflected payments from the State Retirees' Health & Welfare Benefits Fund to the Insurance Fund, which increased by $1.8 million.

Ms. Olsen said, per *Nevada Revised Statutes*, Casey, Neilon & Associates was required to report on supplementary information (page 81, Exhibit A). The report was based on the OPEB Actuarial Report, provided as of June 30, 2013. In conclusion, she asked the Committee if it had questions in regard to the financial statements for the State Retirees' Health and Welfare Benefits Fund.

Senator Smith questioned why the net position showed a 32 percent increase in the employer contributions (page 74, Exhibit A).

Mr. Wells explained the employer contribution increase was a combination of inflation (more state contribution per retiree) and having more retirees. Contributions to the Retirees' Fund, paid by the State of Nevada, were determined by an assessment on payroll that was paid by each state entity. Mr. Wells said the assessment increased from 2.134 percent in FY 2012 to 2.690 percent in FY 2013. Mr. Wells said these numbers were based on the total payroll of the state and university systems.

Chairwoman Carlton suspected that more money was put into the State Retirees' Health and Welfare Benefit Fund than was needed.

Mr. Wells said when PEBP projected the cost of the assessment, PEBP took into consideration tier selection; number of retirees; years of service obtained per member; and the number of employees who were projected to join the retirement ranks. That data was used to calculate an estimate of dollars needed to fund the projected cost of assessment. That number was converted by the Budget Office and the Legislative Counsel Bureau (LCB) to a percentage of payrolls.

3. Report on the October 2013 actuarial valuation of post-retirement health benefits provided by the State of Nevada pursuant to Statement Numbers 43 and 45 of the Governmental Accounting Standards Board (GASB) (NRS 287.0425).

Mr. Wells said that the Governmental Accounting Standards Board (GASB) required an actuarial evaluation of post-retirement health benefits be provided to the State of Nevada every other year, unless significant changes were made to the plan design. Because there were no changes in FY 2012, the report illustrated valuation results for FY 2011 and FY 2013.

Ms. Donaldson explained that OPEB valuations include both health care plans and life insurance. The definition of health care plans included medical, prescription drugs, dental and vision benefits (page 86, Exhibit A). She said the plans required valuation, because state subsidies were provided to the members. PEBP provided two types of subsidies, "explicit" and "implicit." The explicit subsidy included direct contributions, such as retiree based subsidies. The implicit subsidy was associated with pooling of the rates. Ms. Donaldson explained that active members and pre-Medicare retirees were pooled together in order to calculate premiums for early retirees. The

FY 2013 valuation included plan design changes as of July 1, 2013, and included the additional HRA and HSA contributions approved by the PEBP Board.

In reference to pre-Medicare retirees, Ms. Donaldson said she performed a valuation for the CDHP, including the HRA. The plan required deductibles of $1,900 (employee) and $3,800 (family). She said the HRA annual base contribution was $700, plus a $200 contribution for the spouse. In FY 2014, PEBP modified the plan to include an additional $400 contribution to all state and non-state retirees, and an additional $297 contribution for state retirees. Furthermore, spouses or dependents received an additional $100, both state and non-state, and dependents of state retirees received an additional $115 (maximum of three dependents). In summary, Ms. Donaldson said a CDHP state retiree received an annual HRA contribution totaling $1,397 (individual only coverage tier). A CDHP state retiree with a spouse received $1,812 in HRA contributions. Additional valued changes in FY 2014 included a 25 percent coinsurance (after the deductible was met), dental insurance, and life insurance benefit ($5,000).

Medicare retirees participated in an exchange with an HRA benefit. Ms. Donaldson reported that, as of July 1, 2013, Medicare retirees received a contribution of $11 per month, per year of service, for a maximum of $220. In addition, for FY 2014 and FY 2015, PEBP made a one-time contribution of $2 per month, per year of service. She also performed a valuation for the optional dental plan and a life insurance benefit.

Ms. Donaldson further described the valuation results, comparing fiscal years ending 2011 and 2013.

- Present Value of Benefits (PVB). As of June 30, 2013, the PVB was above $1.9 billion. The PVB represented the total benefit obligation to PEBP for retirees and future retirees. The future retirees accounted for 68 percent of the liability.

- Actuarial Accrued Liability (AAL). The AAL accounted for the major portion of the PVB, representing the PVB accrued to date. By comparing the current service of active employees to their projected years of service, a liability was calculated and a portion was valued. For example, if an active member had 18 years of service, and was anticipated to have 30 years of service at retirement, Aon Hewitt valued 18/30 of that total projected benefit. For retirees, the PVB equaled their AAL, amounting to about $1.2 billion.
- Normal Cost represented $74 million, a portion of the PVB that was accrued for plan year 2013.
- An AAL Report was reviewed from the prior valuation, illustrating a categorical breakdown of changes made since July 1, 2011.
  - Assumption changes included revisions to the Public Employees' Retirement System (PERS) valuations. PERS adjusted its decrement tables that effected demographic statistics, including mortality, retirement, withdrawal, and disability. Therefore, PEBP had to make revisions as well.
  - Plan design included the additional HRA benefits.

  - Excise tax was included, using a 2018 implementation date.
  - Other experience changes.
- Annual Required Contribution (ARC) was an accounting item that represented the normal cost, plus the amortization of unfunded liabilities. That equaled $142 million.
- Annual OPEB Cost (AOC) represented the annual plan expense, consisting of the ARC and ARC adjustments, plus interest adjustments to the Net OPEB Obligation.
- Net OPEB Obligation (NOO) tallied $775 million, representing the change in annual net obligation. This was the difference between the AOC and PEBP contributions and benefit payments that were made to the plan totaling $50 million.
- Excise tax represented a $61 million increase from the prior valuation. Effective in 2018, the tax will be imposed onto any employer that offers employer sponsored coverage with a value over a certain threshold. The tax was equal to 40 percent of the excess over the threshold of $10,200 (self-only) and $11,850 (self-only retirees) for 2018. Participants enrolled as other than self-only would be calculated using threshold rates of $27,500 and $30,050 for qualified retirees.

Assemblyman Kirner asked if the excise tax was associated with the "Cadillac" plan, and if the plans offered by PEBP were considered as such.

Ms. Donaldson said the excise tax was the same as the Cadillac tax. She emphasized that all of PEBP's health care plans would eventually cross the threshold to be subject to the excise tax. She referenced page 103 of the meeting packet (Exhibit A), to illustrate how the threshold dates were projected for the CDHP (2020) and HMO (2018) plans.

Assemblyman Kirner recalled that one objective of the PEBP Board was to avoid the Cadillac label. Ms. Donaldson said the medical trend increased significantly more than CPI, and at some point most plans would cross the excise tax threshold. She confirmed to Mr. Kirner that the excise tax was a new liability for PEBP.

Chairwoman Carlton asked if the excise tax was based on a total cost of the plan and not just what the state or employee contributed. Ms. Donaldson confirmed that the estimate was the total PEBP obligation and was not allocated to the employees. She said she assumed the employer was picking up the total obligation.

Chairwoman Carlton asked if there was a cost differential in the OPEB valuation if the employer did not pick up the total obligation. She asked if that would extend the date on crossing the threshold. Ms. Donaldson stated there would be a cost difference, but in order to reflect a change in the OPEB valuation, there would have to be specific communication that the retirees would be picking up a portion of that liability.

Mr. Wells explained, for purposes of calculating the excise tax threshold, both the employer and retiree portion was included. Once the threshold was met, the difference between the annual premium and the threshold dollar amount was taxed 40 percent,

regardless of who paid the tax. He said the current valuation reflected the employer assuming the tax.

Chairwoman Carlton stated that she wanted on the record that it did not matter who paid what portion of the premium, but when the premium threshold is met, the tax kicks in. She said the key was to stay below the threshold.

Mr. Wells said due to the comingled rates for active members and retirees, the excise tax impacted the OPEB liability and the active employees. He used the following data to set an example: 2020 as a crossing threshold date, a $15,000 per year annual premium (single person, comingled between active employees and retirees), and an $11,000 excise tax threshold. The difference of the annual premium and the threshold equaled $4,000. The state was required to pay to the federal government a $1,600 tax (40 percent of the $4,000 difference) for every person enrolled in the plan, both active employee and retired. Mr. Wells said it would be difficult to not exceed the threshold. He explained there were two significant provisions within the Affordable Care Act: 1) the $10,200 threshold, and 2) a provision that prohibited out-of-pocket maximums from exceeding a certain dollar limit. Mr. Wells said the second provision would prevent the state from shifting costs to the participant, therefore, the state would need to absorb any rising costs.

Chairwoman Carlton stated the cost of care inflated the premiums. Mr. Wells concurred and explained that PEBP's current plan selections were either community rated or self-funded, indicating the premiums were calculated based on the health of PEBP participants.

Assemblyman Kirner stressed the excise tax was currently not accounted for and would have an impact on the state budget. Therefore, he anticipated a discussion about a future spike in premiums during the 2015 Legislative Session.

Mr. Wells explained that the estimated $61 million excise tax was not immediate, but rather spread over the long term. He stated in the year 2020, the $1,600 tax per enrollee would result in an immediate spike and would then become a liability of the state and/or the participants.

Senator Smith asked if the $61 million was an annual liability. Ms. Donaldson explained that $61 million was the present value of the total excise tax, projected into the future. She clarified the $6.1 million total would be the annual cost, effective year 2018 (page 102, Exhibit A).

Senator Smith referenced the OPEB liabilities for FY 2008 – FY 2011, and FY 2013, noting a 45 percent decrease in liability at the time benefits were changed. She noted the excise tax does not go into effect until 2018. She asked what was causing the increase from $1.8 billion to $2 billion.

Ms. Donaldson said her team valued the PVB, and even though the excise tax does not go into effect until 2018, that value had to be included as part of the present value of liabilities. She said the portion of the difference was $61 million. She referenced page 95 of the meeting packet (Exhibit A), to help illustrate the changes in liabilities from one valuation to the next.

Senator Smith expressed concern that the numbers were misleading. The excise tax would not be applied until 2018, yet it was considered an OPEB liability and obligation today. She said she thought it was odd that the OPEB liability had to reflect benefits that could change, or be eliminated, yet the law required that it be included in the liability package.

Chairwoman Carlton echoed Senator Smith's concern as to why the $6.1 million liability had to be accounted for now when it did not apply until 2018. She felt that true numbers were needed so the OPEB valuation would not reveal a huge liability that would not exist for a number of years.

Mr. Wells explained that the PVB reflected all liability that will ever be accrued by employees, as of the valuation date. For example, if an employee worked ten years, as of 2013 (valuation date), and the employee was 30 years old, the PVB assumed that the employee would continue his/her working career until the benefit maxed out at twenty years. The formula assumed longevity of life beyond that ten years. At retirement, the formula assumed that the employee would obtain the subsidy for his/her retiree lifetime, and it projected how long the employee would live into the future. He explained the PVB number was a projected 70-80 years into the future.

In contrast, the AAL was a snapshot of the liability accrued through June 30, 2013. Mr. Wells emphasized that the $61 million excise tax was literally the present value of a much larger number. The OPEB valuation had to reflect all known factors, and right now the excise tax was a known tax. Mr. Wells stated if the excise tax was repealed by Congress, then the tax could be deleted from the OPEB valuation. He said the excise tax was a very complicated component and repeated Senator Smith's comment about how it was possible to make significant changes that affected the total liability.

Chairwoman Carlton asked if the calculations were based on GASB regulations. Mr. Wells confirmed that was correct and added there would be new GASB pronouncements regarding how pension valuations would be reflected in future financial statements. He said that GASB was also working on similar pronouncements for OPEB, expected to be released in 2015.

Senator Smith said she understood Mr. Well's explanation as to why the excise tax was included. She wanted on the record that it was somewhat misleading, but understood that he was reporting the way the law required. She stated that it was an important discussion to have, keeping in perspective where we are now and what to expect in the upcoming years. She asked for clarification in regard to the chart on page 102 (Exhibit A). She noticed there were some blank spaces in the

"Estimated Excise Tax in 2018" column and therefore, did not add to the $61 million threshold.

Ms. Donaldson explained that not all categories reached the threshold in 2018. For example, State Active CDHP would not cross the threshold until 2020, therefore, there would be zero impact in 2018. The estimated $2,560,000 excise impact for the HMO active employees was expected in 2018.

In response to a question from Assemblyman Kirner, Mr. Wells explained that employees hired after January 1, 2010, had to work 15 years before becoming eligible for a state subsidy for retiree health insurance. Employees hired after January 1, 2012, would not be eligible for a state subsidy, but would receive the implicit subsidy when they retire. He said there was some retiree health liability associated with employees hired after January 1, 2012, but the number of employees that fell within the two categories had minimal impact on the OPEB valuation today. However, in twenty years, there would be a significant decrease in the PVB and the AAL.

Chairwoman Carlton asked Mr. Wells to provide the Committee some statistics on how many employees fell into the two different categories. She said the changes that affected employees hired after January 1, 2012, were presented to the Legislature as a future cost saving measure to the state. Chairwoman Carlton wished to monitor the savings to be realized by the state in the future as a result of those decisions.

4. Report from attorney on PEBP's compliance with federal and state laws relating to taxes and employee benefits, dated January 2013 (NRS 287.0425).

Mr. Wells said Aon Hewitt was the contracted consultant that performed PEBP's Biennial Compliance Review, dated September 2012. He said the review was only required in even numbered years, and the next review would be done in fall 2014. He stated the Executive Summary was on page 120 (Exhibit A), and briefly noted PEBP's response to Aon Hewitt's recommendations:

- Federal law required changes to the HIPAA privacy and data security rules and HITECH provisions. PEBP was required to make language revisions to its Business Associate Agreements and was currently collecting the documents from its vendors.
- PEBP fulfilled most of the HIPAA Privacy and Security Compliance Review recommendations through utilizing the services of a health claim internal auditor. The review was completed and PEBP was implementing the policies and procedures to comply with the auditor's findings.
- In regard to COBRA, PEBP made the appropriate changes to the "Notice of Unavailability of Continuation Coverage" and the policies.
- The Patient Protection and Affordable Care Act (PPACA) required changes to reflect current provisions that were already in effect, such as automatic enrollment. An employee now had to manually opt out to decline participation in a health plan. If a base plan was not specified, automatic enrollment for into the CDHP would occur in the individual only coverage tier.

- The PEBP policy stating that coverage could not be obtained until after the first of the month, following 90 days of employment, was in violation of the Affordable Care Act, which required employment of no more than 90 calendar days. The PEBP Board would hold a public hearing on January 16, 2014, to review a regulation that would revise the waiting period to 60 days, effective May 1, 2014, so PEBP would not be in violation when the plan year started on July 1, 2014. The PPACA 90-day waiting period requirement was effective for any plan year that started on or after January 1, 2014.
- Preventative taskforce guidelines were updated annually as part of PEBP's Master Plan Document (MPD).
- Women's preventative health amendments were added to the PEBP 2013 MPD.
- PEBP was required to develop the following forms and procedures to comply with PPACA requirements:
  - PEBP completed and posted a summary of benefits and coverage.
  - The Comparative Effectiveness Fee affected FY 2014, and would be due to the federal government in the fall of 2014.
  - The filing for Employer Quality of Care reports had not been completed yet.
  - The treatment of the medical loss ratio rebates, applied to the HMO plan, must be reported annually and reflect whether the minimum loss requirements were met. To date, PEBP had not encountered any issues with rebates.
  - PEBP implemented a process to report the value of the state's subsidy on employee W-2s provided annually in January.
  - The notice to inform employees of coverage in the Silver State Health Insurance Exchange (Exchange) was done in 2013.
  - The employer reporting of health insurance information was scheduled for 2015.
- The PEBP Board was encouraged to develop a long term strategy with respect to mitigating the impact of the excise tax.
- Two of three provisions regarding nondiscrimination testing were in a holding pattern because the IRS had not set forth any regulations on how to complete them. The Dependent Care Flexible Spending Account had regulations in place, however, there was an issue of defining what constitutes an employer. For the purposes of conducting the nondiscrimination testing, a request was sent to the Attorney General to provide an opinion. PEBP would comply with the testing requirements as soon as instruction was received.
- The Certification of Disabled Dependent Child was revised to reflect that the information was provided under penalty of perjury. PEBP made changes to the Nevada Administrative Code (NAC) last year to align its plan and regulations, especially when related to the appeals process under the Affordable Care Act. Revisions to specific information about retiree enrollment materials were completed and incorporated into the MPD.
- PEBP was required to perform transactional testing to ensure transactions were in compliance with the state and federal law.

In summary, Mr. Wells averred that most of the provisions and recommendations from the 2012 review were implemented, or were on hold because of federal requirements that had not been divulged.

Assemblyman Kirner asked if an employee could seek a subsidized plan through the Exchange if he or she were already insured through PEBP. Mr. Wells said the Exchange would deny that person as soon as subsidized coverage was deemed available through the employer. He confirmed that PEBP met the affordability and coverage requirements set forth by the Affordable Care Act.

Chairwoman Carlton asked about the security of PEBP's confidential data, and whether changes were anticipated to maintain security. Mr. Wells assured every attempt was made, via contractual arrangements, business associate agreements, and internally, to ensure that data remained confidential. PEBP had an e-mail filter that prohibited staff, including himself, from sending correspondence that included a social security number. He said that firewalls blocked specific data when certain files required access, for example, claims data and appeals files. Mr. Wells concluded that PEBP offered limited availability of confidential details to a small number of people.

Chairwoman Carlton asked when the security system was last evaluated and tested, and if the testing included trying to break into the system. Mr. Wells said the system was evaluated last year, but an attempt was not made to break into it. He confirmed that almost all of PEBP's servers, except the backup servers, were located in the EITS facility. He said it was the responsibility of EITS to ensure upgrades were current and the system was maintained. He stated that the EITS staff may have tested the firewall structure, but he was not aware of what that entailed.

Assemblyman Kirner questioned how secure the information was within EITS. He asked if EITS had firewalls to prohibit employees from accessing the sensitive data. Mr. Wells specified that EITS staff provided the over-arching security, but did not have the administrative passwords needed to access individual servers.

5. Summary of consultant report to PEBP regarding focus groups conducted with PEBP enrollees about the Program during October and November 2013 – LAJ Consulting, Leslie Johnstone, Principal.

This agenda item was taken out of order.

Mr. Wells provided background on the focus group process. He explained that after the PEBP Board approved the focus group study, PEBP hired LAJ Consulting to conduct the focus group meetings. He explained that PEBP's Information Technology (IT) staff created an algorithm to generate random lists of numbers based on location, plan design, age ranges, and married versus single. PEBP then sent 475 letters and made 650 phone calls to get 104 participants (PEBP enrollees) to agree to partake in the focus groups. Of the 104 who agreed to participate, 78 actually attended the focus group meetings. The 78 focus group participants consisted of 48 active enrollees (62 percent) which compared to 75 percent of the actual PEBP population. Of the 48 active enrollees, 34 were either state or LCB employees, and the remaining 14 were from the Nevada System of Higher Education (NSHE). Mr. Wells noted that the ratios

of NSHE members in the focus group were a bit skewed; NSHE typically made up about one-third of PEBP's active population.

Mr. Wells explained that 56 participants (72 percent) were enrolled in the CDHP, whereas 66 percent of PEBP's population was actually enrolled in the CDHP. The other 22 participants were enrolled in the HMO plan. He explained that 45 focus group members (58 percent) were enrolled as "participant only," a tier that made up 68 percent of PEBP's population. The "plus spouse" and "plus child" coverage tiers both had 13 focus group members represented (16 percent). He noted that PEBP's population typically reflected 10 percent for plus spouse and 18 percent for plus child. Lastly, there were seven focus group members in the "plus family" tier, representing 9 percent of the focus group, compared to 11 percent of PEBP's total population.

Leslie Johnstone, Principal, LAJ Consulting, presented an overview of the focus group activity that was conducted in the fall of 2013. Ms. Johnstone said the purpose of the focus group was to have a frank discussion to garner the opinions and impressions of the PEBP participants about the program. She said the focus group members discussed the following eight areas of concern:

1. <u>When you think of health insurance, what is most important?</u> Ms. Johnstone reported that provider access, and the quality of those providers, was a major concern among the focus groups. The second concern was the cost of the monthly premium and out-of-pocket costs. Ms. Johnstone said the focus groups were of the same opinion regarding the premiums, stating the premiums would be better tolerated if the out-of-pocket costs were reduced. The third item of importance was related to the scope of benefits. Participants wanted to see improvements regarding vision and dental benefits.

2. <u>How much do you each think you understand your current plan?</u> Ms. Johnstone declared that many of the focus group participants did not understand their plan's benefits, mostly expressed by participants who were actively using their benefits. Some focus group members thought the HSA was hard to comprehend. Ms. Johnstone said the number of plan changes made over the past years made it difficult for participants to keep abreast of the plan particulars. Also, some of the members felt conflicting information was articulated from various vendors, causing complications with understanding the benefit.

   Ms. Johnstone said the focus groups discussed how changes to the plan could be better communicated to the plan members. The participants reported positive comments in regard to the useful information received from PEBP, HealthSCOPE (third-party administrator) and the HMO. However, the participants expressed confusion about the open enrollment process. Some agency liaisons put more effort into training their members than others. Ms. Johnstone said there was strong opinion from the group that robust Internet tools would be beneficial. The participants did not think the PEBP website was particularly helpful when searching for information about their specific situation. Ms. Johnstone said the

focus group members, including the retirees, were Internet savvy. The participants also indicated that more educational group sessions would be helpful.

3. What is your opinion about the current benefit structure? Ms. Johnstone conveyed that the high deductible plan members did not like the level of the deductible. Some members felt there were unexplained hidden costs, such as out-of-network physicians and the uncertainty of costs before the deductible was met. There were mixed emotions in reference to the HSA. Members appreciated the tax preference and the ability to save funding over several years, whereas others thought the eligibility process was too cumbersome. Some participants felt the cost of prescription drugs was too high before the deductible was met. Generally, the individuals were satisfied with the benefit after the deductible was met, however, the formulary did not always meet their need. Diabetes and asthma were provided as examples. With respect to the wellness program, many participants appreciated the premium savings, but overwhelmingly complained that the process was invasive and cumbersome.

   Ms. Johnstone stated discussion of the HMO product brought up many of the same high deductible plan issues. She said wellness and the equity issue, also known as "rate blending," were popular topics in both northern and southern Nevada. Participants in the south cited an unfair rate increase, while those in the north believed the rate reduction was fair. The dental plan's annual maximum was highly criticized, and the focus group members believed the maximum limit needed to be increased.

   Chairwoman Carlton said she heard concerns from both northern and southern Nevada that the HMO plan design was a big issue. Chairwoman Carlton asked what participants thought about the HMO's provider access and plan design. Ms. Johnstone said the southern members expressed no complaints, however, the northern participants pronounced a strong dissatisfaction in regard to their co-pays being higher than the co-pays in the south.

4. Do you think PEBP understands your benefit needs and why do you think that? Ms. Johnstone said members were generally satisfied with PEBP's assistance, although they sometimes experienced a delay in acquiring answers. She said participants thought PEBP understood its populations' needs, but wished for more member advocacy. The southern group (non-state, state, and retirees) were vocal about a lack of representation of their issues.

5. How do you think PEBP does at selecting vendors it contracts with and what has your experience been with them? Ms. Johnstone explained that many participants did not know enough about the selection process to form an opinion. However, she said several members thought PEBP did not take advantage of its size and that procurement costs might be too high. Participants felt there was opportunity for larger economies of scale if partnered with Medicaid or other programs.

6. When it comes to price, how do you feel about the amount you pay? Ms. Johnstone said many participants felt that the premiums were fair, but desired additional benefits in exchange. The retirees acknowledged that not all public and private sector retirees had access to retirement benefits. Ms. Johnstone said there was discussion about the "orphan" group, a term used to describe non-state retirees.

7. One growing trend is for employers to go to a "corporate exchange" model. Do you know what a corporate exchange is and do you think it's something worth PEBP investigating? Ms. Johnstone said half of the focus group members did not know enough about the corporate exchange model to share an opinion. The other half of the group expressed fear of losing their voice regarding benefits. The participants liked the convenience of calling PEBP, the HMO, or the third-party administrator when issues surfaced. Participants felt the corporate exchange would only be considered if the cost savings benefited the state, therefore shifting costs to the participant. Many felt a corporate exchange would dilute PEBP's purchasing power.

8. How do you feel about the idea of going from a premium structure where the state subsidizes a percentage of the cost vs. a structure where the state subsidizes the same amount for everyone? Ms. Johnstone reported that the subsidy concept was hard to explain, because many participants did not understand that the premium and the state subsidy were based upon percentage versus a flat dollar amount. She said once the models were explained to the group, the general reaction was that the subsidy needed to stay as a percentage of total premium cost.

Chairwoman Carlton said it was interesting to learn how the participants utilized and felt about their benefits, especially after the last few years of plan changes. She noted that Elko was a vocal group. Chairwoman Carlton asked if the focus group members broadly and equitably represented the state. Ms. Johnstone assured the Committee that Nevada's diverse regions were well represented and participants did not hesitate to express their opinions.

Assemblyman Kirner asked if Ms. Johnstone proposed action items to PEBP as a result of the focus groups. Ms. Johnstone conveyed that the strict intent of the meetings was to acquire opinions and to relay the responses back to PEBP. Mr. Wells believed that the plan design changes that were approved by the PEBP Board and effective July 1, 2014, were representative of the issues identified in the focus group meetings.

Chairwoman Carlton recognized the wellness program as an essential part of the focus group discussions. She asked about the PEBP Board's decision to continue the wellness program.

Mr. Wells confirmed that continuation of the wellness program was an agenda item at the November 2013 PEBP Board meeting. He said PEBP received 75 - 100 e-mails overwhelmingly in favor of maintaining the program and expressing gratitude about the

premium reduction. He said the flaws with the initial "Live Well, Be Well" prevention plan inspired PEBP to transition into the "NVision" wellness program. The NVision program incentivized the participants based on biometric outputs rather than involvement in online educational programs. The indicators provided the data needed to track the health of the individual participant and gave direction for areas of improvement. The indicators also identified cost prevalent components of the program.

For the record, Chairwoman Carlton clarified that the PEBP Board decided to continue the wellness program due to feedback from the focus group sessions, participant surveys performed in spring 2013, and e-mail correspondence from PEBP members.

Mr. Wells concurred.

6. Report of plan design changes for Plan Year 2015 approved by the PEBP Board at its meeting of November 21, 2013, including fiscal impacts, to include:
   a) Employee/retiree wellness program (NVision Health and Wellness);
   b) Diabetes Care Management program;
   c) Obesity Care Management program;
   d) Co-insurance percentage paid by PEBP after participant deductible;
   e) Dental benefit;
   f) Vision benefit; and
   g) Individual and family deductibles.

Mr. Wells announced there was a recent report, issued by RAND Corporation, in regard to an evaluation of Pepsi Company's seven-year wellness program. He said research found significant ROI for disease management, but a much lower ROI for the wellness program. The programs were not costing the plan money, but the ROI was flat for wellness. Mr. Wells said the State of Nevada was sold on the wellness program prior to his arrival at PEBP, based on the ROI projections. With his current knowledge of the wellness program, he would not have presented the wellness program based on the ROI calculation that was presented to the Legislature.

Mr. Wells explained that medical professionals calculate ROI by identifying cost avoidance. For example, the professionals suggest that the chance of having a heart attack could be reduced by 10 percent if blood pressure was lowered from moderate to low risk. The professionals used simple math to determine the ROI; a heart attack costs $50,000, multiply that by 10 percent and you saved $5,000. Mr. Wells disagreed with that logic, stating there were no guarantees that a heart attack would occur if high blood pressure existed in a patient, and no guarantees that the patient would not have a heart attack if his/her blood pressure was controlled.

Mr. Wells said he shifted his focus to analyzing statistics to determine the overall health of the population. He reviewed biometric outcomes associated with weight, blood pressure, cholesterol, triglycerides, blood sugar, and tobacco usage (page 181, Exhibit A). In every case except for blood sugar, the percentages dropped favorably between the first and second year of involvement in the wellness program.

Mr. Wells said the results were aligned with the biometric outputs of participants who were tested at the beginning and end of the plan year. Mr. Wells explained that PEBP's NVision program required a two-step incentive to educate the participant about possible risks. He said participants would receive a $50 monthly premium discount if the following requirements were fulfilled: 1) complete a health assessment questionnaire and obtain biometric screenings, and 2) get a physical and discuss the results with a primary care physician, and get an annual dental check-up. Both of the services were paid for 100 percent. The last component of the wellness program was to educate the participants as to how the plan benefits worked.

Mr. Wells presented information on the Obesity Care Management (OCM) program, effective July 1, 2012. Specific weight requirements and health conditions must be present in order to participate and continue involvement in the program. He said there were 222 participants in the program and the results revealed an average decrease in blood pressure and body mass index (BMI). The participants lost an average of 18 pounds per person, equating to 3,970 pounds total. Mr. Wells compared statistics of both participants and non-participants who encountered a diagnosis of obesity on a claim (page 221, Exhibit A). Mr. Wells emphasized that the gross plan costs for participants in the OCM plan were almost half the cost of a non-participant diagnosed with obesity. He said some of the OCM members were able to wean off of medications and had overall better health.

Mr. Wells closed his presentation by stating that the wellness and disease management programs were acquired under one contract. When he took the decision to the Board to determine continuance of the programs, he promoted the positive results that were observed and explained that the data collected would be used to create programs that would benefit other chronic diseases.

Leo Drozdoff, Chair, Public Employees' Benefit Program Board, clarified that the information presented by Mr. Wells was based on new information and was not available to the Legislature or the Board during the 2013 Legislative Session. He stated the reason the PEBP Board decided to continue the wellness program, against the recommendation of the Legislature, was due to the large number of people who expressed a strong desire to continue the wellness program, and because of the new, compelling information received. He closed by saying the PEBP Board understood that the Legislature was not against the wellness program, but did not want to "put all of their eggs in one basket." Mr. Drozdoff stated that he believed that the PEBP Board took the advice of the Legislature and improved benefits by reducing costs and deductibles, and by adding more benefits.

Chairwoman Carlton said she felt that during the 2013 Legislative Session, the Legislature was very clear about its position on the wellness program; that it was not the highest priority, given limited resources. She recollected that Speaker Kirkpatrick and Senator Smith were adamant about the priority of the wellness program, compared to other programs that were cut or barely funded. She said the reserves were state dollars and the PEBP Board made a decision contrary to the intent of the Legislature.

Chairwoman Carlton was concerned that the people who voiced their opinion to continue the wellness and disease programs were the few that used it. She was concerned that the intent of the Legislature was not considered by the PEBP Board. She referenced a participant survey that was performed in spring 2013, identifying that wellness may not be what the people wanted.

In response, Mr. Drozdoff stated that after the 2013 Session he held discussions with members of the Legislature in regard to the wellness program. The purpose of the discussion was not to disagree with the Legislature's intent, but to advise the legislators of the new statistical data supporting the wellness program. He explained to the legislators that PEBP was able to lower deductibles and provide better dental and vision care also, in addition to funding wellness. Mr. Drozdoff said that, even though the Legislature denied funding the wellness program, he interpreted the discussions with the money committees during the 2013 Legislative Session to be accepting of the wellness program as a worthwhile endeavor, if the PEBP Board could meet the priorities of the Legislature.

In response to a question from Chairwoman Carlton, Mr. Drozdoff said the PEBP Board approved the continuation of the wellness program at its November 12, 2013 meeting. He indicated that, of the 90 emails received from wellness members, only one was not in favor of continuing the program. He stated the entire PEBP Board attended the IRBC meeting on January 16, 2014, in an effort to enhance communications with the Legislature. He said the national trends were not shifting away from wellness and disease programs, and the new statistical data results were compelling. He noted that the Board's decision to continue the wellness program amounted to a $6 million line item. Mr. Drozdoff said the new information supported an ROI for both the disease management care and the obesity management care programs. He stated the clarity of the overall wellness program was vague, but that the purpose of wellness was to detour people from getting to a diseased state. Mr. Drozdoff reiterated that the PEBP Board was not working at cross-purposes with the Legislature, and honestly thought the PEBP Board was favorably representing the Legislature's intent.

Senator Smith remarked that the issue at hand was about process and communication. She expressed frustration that the process of reviewing, discussing and voting on the PEBP budget during the 2013 Legislative Session, resulted in a legislative decision that was not implemented by the PEBP Board. She theorized that the PEBP Board could have attended an Interim Finance Committee (IFC) meeting to give the joint money committees an update. Senator Smith expressed frustration that decisions would be made without giving the Legislature time to react before those decisions were implemented. She acknowledged the independence of the PEBP Board, but still expected a working relationship and appropriate communication.

Assemblywoman Swank asked about the raw data that was used to generate the percentages in the outcome summaries (page 160, Exhibit A).

Mr. Wells explained that 4,028 PPO members were represented. He said in order to be included in the 4,028, all participants were required to answer every question in the health assessment and had to undergo biometric screenings at the beginning and end of the cycle. Using "overall health risk" as an example, he explained that in the first year 61 percent of the 4,028 members were in the low risk category, 26 percent were in the moderate-risk category, and 13 percent were in the high-risk category. At the beginning of year four, the low-risk category dropped from 61 percent to 54 percent, the moderate-risk category increased from 26 percent to 31 percent, and the high-risk category experienced a climb from 13 percent to 15 percent.

Assemblywoman Swank asked how many members would qualify for the OCM program, based on the entire population enrolled in PEBP. Mr. Wells explained that prospective participants were extracted from obesity claims submitted by the third-party administrator (page 221, Exhibit A). He stated there were 222 participants, and the records indicated another 510 people would have met the criteria to participate in the OCM program.

Assemblywoman Swank observed the number of men (43) participating in the obesity program was significantly lower than the number of women (179). She asked what outreach methods were performed to attract the men, and if that number was representative of the non-participant population of men who would qualify for the program. Mr. Wells did not have that information available, but said he would research the data and determine if it was representative, or if there was an anomaly between the OCM participants and the non-participants.

Assemblyman Kirner said he concurred with the comments made earlier by Senator Smith about the intent of the money committees in regard to the wellness program. He recalled a funding discussion during the 2013 Legislative Session that money would have been better spent addressing the needs of the non-state participant issues instead of wellness. He pointed out that the wellness questionnaire that was used to qualify participants was difficult and asked if the questionnaire was revised to promote better participation. Although he believed good results were obtained from the OCM members, he did not sense a large participation in the program. Assemblyman Kirner said he was not sure the wellness program was the best option versus other needs. He was concerned that the high deductible plan caused employees to defer care because of costs.

Chairwoman Carlton said that she would accept her portion of responsibility if there was miscommunication of the Legislature's intent in regard to the wellness program. She understood the PEBP Board had a responsibility to manage dollars and represent the best interest of the participants, but she also expressed concern over how the reserves were being applied. She noted that information had already been sent out in regard to wellness program enrollment and the continuation of the wellness plan, therefore, it was too late to suspend it for FY 2015.

Mr. Wells verified that the registration period for FY 2015 was scheduled to start February 1, 2014, and preliminary information was sent out indicating the wellness program would be continued.

Chairwoman Carlton asked Mr. Wells if he would be attending an upcoming IFC meeting to present a work program to continue the wellness program. Mr. Wells replied that a work program was not required at this time because PEBP was able to absorb all wellness program costs within the current budget. He added that PEBP staff would attend the IFC meeting to discuss the future intent of NVision and the wellness program as an informational item. He said the PEBP Board submitted a letter to the Budget Office and the IRBC explaining its position on the program (page 169, Exhibit A).

Chairwoman Carlton recalled Mr. Wells' comment that if the money was not spent on wellness, it would possibly be spent somewhere else. She stated the continuation of the wellness program was a zero sum game, and the decision to spend $6.1 million was made by the PEBP Board.

Mr. Wells directed the IRBC to page 170 (Exhibit A). He noted the total cost of the wellness and disease programs for FY 2014 and FY 2015 was about $8.8 million. He said most of the cost was allocated to premium incentives, which represented a reduction in revenues expected in FY 2015.

Chairwoman Carlton assumed that because of the other dollars that were going to be used to extend the wellness program, the PEBP Board would have to appear before the IFC to propose a work program (i.e., in FY 2015). She asked whether the Board had made any contingency plans if the IFC decided not to support the future work program.

Mr. Wells said PEBP was able to absorb the expenses incurred in FY 2014 and FY 2015. However, he stated PEBP might need a work program to satisfy the administrative costs associated with extending the wellness program contract for an additional year. He was not sure whether a work program was needed for FY 2015, because Category 10 of the PEBP budget was based on enrollment.

Chairwoman Carlton closed by stating the discussion would be the first of many conversations about the issue.

Mr. Drozdoff reiterated that the PEBP Board did endeavor to have discussions with members of the Legislature and staff, subsequent to the close of the 2013 Legislative Session and before action took place. He stated that if the action taken was not adequate, then the PEBP Board would learn from that.

Mr. Kirner restated his concern about the high premiums being charged to the non-state retirees group and asked what measures were taken to address the issue. He said the group's rates would continue to increase because the group's population was getting smaller.

Mr. Drozdoff said the Legislature was not able to obtain funding to support the non-state retiree group, but the PEBP Board decided to contribute $400 per person within that group. Mr. Drozdoff cited that one suggestion made to sustain the non-state retiree group was to mix them into the state group. He said that would lower the non-state retirees' costs, but consequently increase the cost for state employees and state retirees. He did not agree that state members of PEBP should be responsible for that burden. However, he said the reserves might be a resource available to cushion the financial impact. In this specific case, Mr. Drozdoff said the PEBP Board was largely absent of legislative direction. He believed the $400 subsidy to the non-state retiree group was a temporary fix, and he expected to have much broader discussions in the future with the appropriate committees.

Chairwoman Carlton said there would be another meeting and the non-state retiree group issue would be a main topic on the agenda.

Assemblyman Kirner observed that the numbers of members of the non-state retiree group were dwindling. He mentioned that the legislation was structured in such a way to encourage the non-state retiree members to join the state program. He favored comingling the state and non-state groups. He knew there were costs associated, but there were reserves available to resolve that problem.

Mr. Drozdoff said there were two choices: 1) comingle the non-state retirees with the state retirees, which would add a burden to the state retirees, or 2) come to the realization that the non-state retiree group was small and use state revenues to solve the problem.

Chairwoman Carlton agreed that the non-state participants were a small group. She said, because the birthdates of the non-state participants were on file, a projection could be made as to when the non-state participant group would phase out of the system and join Medicare.

Mr. Kirner said, in the meantime, the non-state retirees suffered. Chairwoman Carlton agreed.

Mr. Wells closed by adding that the *Nevada Revised Statutes* required the state and non-state to be comingled separately. He said the cash flow statement that PEBP generated illustrated that reserves generated by state employees were already being used by the non-state group. The non-state group was already being subsidized by the state through that process. Mr. Wells mentioned that he drafted a letter to Senator Parks, Chairman of the Senate Government Affairs Committee, at the beginning of the 2013 Legislative Session. He said the letter outlined potential solutions for the non-state group, and suggested that document would be an excellent place to start the discussion.

7. Report on any additional plan design changes contemplated by PEBP Board for Plan Year 2015, including:

   a) Addition of low-deductible self-funding PPO plan option.

   Mr. Wells reported that in November 2013 the PEBP Board contemplated the addition of a low deductible self-funded PPO plan to the current mix of plans. The new plan would have been similar to the PPO plan that existed June 30, 2011. He said because PEBP consisted of a fixed population, there were concerns about how to determine the mix of plan participation. Mr. Wells expressed his apprehension in regard to participants transitioning from the existing plans, stating that members would be looking for lower out-of-pocket costs and bringing along some relatively high expenses. Those additional cost factors would have been considered when setting the plan's premiums. The PEBP Board voted not to add the third plan, and instead, the PEBP Board opted to make plan design enhancements to the existing CDHP. The improvements included lower deductibles, increased state share of co-insurance, improved dental, and including the annual vision checkup as a preventive screening. Mr. Wells noted the spreadsheet on page 243 (Exhibit A) compared out-of-pocket costs between the CDHP and the proposed PPO for individual participants.

   b) Pursuit of private/corporate insurance exchange.

   Mr. Wells explained that a corporate exchange was similar to the Silver State Health Insurance Exchange, but was based on the claims experience of the population served. The independent carriers would use claims information extracted from the existing PEBP database to build the plan designs and rates. The plans would be offered through a private exchange. He explained the mix of plans would be group based and specific to the State of Nevada employees and retirees. Mr. Wells offered the following benefits to using a corporate exchange model:

   - The private carriers were fully insured, accepted all risks, and could offer a wider variety of plans.
   - A variety of plan levels were offered to accommodate a participant's state of health and the level of out-of-pocket costs preferred by a participant.

   Mr. Wells said the PEBP Board voted against adopting the corporate exchange model for the following reasons:

   - The concept was new and had not been tested in any government settings. The PEBP Board thought the timing was too early for PEBP to take the lead in the industry.
   - The infrastructure was in place for the current plans and PEBP did not want to take a risk on the success of the new concept, not to mention there were other unresolved components of the plan design that needed legislative approval.

- Comingling was a problem for some of the vendors to implement.
- Some vendors had "age range bands" of premiums that were systematically defined and could not be ignored.

Mr. Wells said the PEBP staff would continue to analyze the corporate exchange concept and would keep the Board apprised of positive changes or observations for future consideration.

Chairwoman Carlton emphasized PEBP's current buying power and the negotiation power that the members could possibly lose. She said that transitioning to this concept would change the plan benefit from a defined benefit to a defined contribution.

Mr. Wells stated that he had a concern whether PEBP could move away from the defined benefit without legislative approval. He emphasized this was an issue about which the PEBP Board was aware.

V. PUBLIC EMPLOYEES' RETIREMENT SYSTEM (PERS).

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

Tina Leiss, Executive Officer, Public Employees' Retirement System provided an overview of the salary modifications for Fiscal Year (FY) 2015 (page 251, Exhibit A), pending the Committee's approval. Ms. Leiss noted that the PERS Board and the Committee had previously approved a nine-step pay range for the non-classified positions of PERS as listed in the *Nevada Revised Statutes* (NRS). She continued, stating that a tenth step was approved in 2010; however, the increase was not implemented due to the economy. A tenth step was approved again in the most recent budget cycle to mirror what was done for the classified employees of the state. She noted that modifications to all pay ranges reflected adjustments due to PERS' contribution rate change on July 1, 2013. Ms. Leiss also noted all of the positions were mandated under the employer pay contribution plan; therefore, the salaries were reduced for the employees' share of the contribution rate. She said the PERS Board approved and budgeted for a one-step merit increase for each of the seven non-classified positions for FY 2015 only, which was included in the budgeted amount; however, since the budgeting process, PERS had experienced turnover in five of the positions. She noted the merit increase for some of the positions was lower than what was budgeted, because a new employee was in that position rather than the employee the position had been budgeted for. Ms. Leiss added that a recently appointed Administrative Analyst was confirmed at step two and would move to step three in FY 2015, pending the Committee's approval.

There was no public comment on this item.

SENATOR SMITH MOVED TO APPROVE THE PROPOSED EXECUTIVE STAFF SALARIES OF THE PUBLIC EMPLOYEES'

RETIREMENT SYSTEM. ASSEMBLYMAN KIRNER SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

2. Report on actuarial valuation for the Public Employees' Retirement System as of June 30, 2013.
3. Report on actuarial valuation for the Judicial Retirement System as of June 30, 2013.

Ms. Leiss provided an update regarding FY 2013 actuarial valuations for PERS and the Judicial Retirement System (JRS), as well as an actuarial experience study conducted based on experience from 2006-2012 (page 253, Exhibit A). Ms. Leiss said the PERS Board conducts an annual actuarial valuation to monitor the assets and liabilities associated with PERS. She noted that the *Nevada Revised Statutes* only required a biennial valuation, but the Board has found it helpful to have an annual valuation due to the size of the fund. Ms. Leiss said the FY 2013 valuation would not affect contribution rates, because it was not a rate setting year; however, it would be used in the interim to review demographics and funding of the plan. She explained that to project the cost and liabilities of PERS, assumptions were made about future events that could affect the amount and timing of benefits to be paid, and assets to be accumulated. Ms. Leiss further explained that part of the valuation process was a comparison of actual experience to projected experience, and any deviations were recognized as gains and losses in that valuation process. During a rate setting year, gains or losses could ultimately impact contribution rates. Ms. Leiss noted that the use of appropriate assumptions was important in maintaining adequate funding. To review assumptions, the PERS Board conducts an experience study, through its independent actuary, at least every four to six years. In September 2013, PERS' actuarial firm, Segal Consulting, performed an experience study for the period July 2006 through June 2012.

Ms. Leiss explained that based on trends in the data, the actuary recommended certain modifications to actuarial assumptions which the PERS Board adopted at its September 18, 2013, meeting. These assumptions were utilized in preparing the actuarial valuations for 2013. She said the demographic assumptions that were modified included retirement rates, percentage of members with survivor benefits, mortality rates, withdrawal, and disability. Economic assumptions that were modified included individual salary increases and active member payroll. Ms. Leiss stated some assumptions, most significantly the active member payroll, salary and salary increases, were noticeably affected during the past six years. She said overall, the adjustments to the assumptions resulted in increased actuarial contribution rates to the Regular fund and decreased rates to the Police/Fire fund.

Ms. Leiss explained that a number of factors contributed to changes in contribution rates for both funds. She said the factor that most influenced the increase in contribution rates for the Regular fund was changes to the mortality tables.

Ms. Leiss said recent changes to industry actuarial standards required a more conservative stance regarding longevity assumptions. The new mortality assumption built into PERS' actuarial valuation assumed that retirees would live even longer than PERS' current experience in order to account for future improvements in mortality. Continuing, she said the factor that contributed most significantly to the decrease in contribution rates in the Police/Fire fund was a decrease in salary assumptions. The actuary, based on the experience, recommended decreases in expected salary increases. For instance, Ms. Leiss said PERS did not anticipate the same high salary increases in the Police/Fire fund that occurred during the previous six-year period. She said that would have a large impact on the liability calculation, because benefits were based on years of service, service time factor, and salary during the highest three years of service. If the expected salary declined, the benefit level would also decline. That was the reason the changes in assumptions in the Police/Fire fund resulted in a decrease in the rates.

Ms. Leiss said the Regular fund was not impacted in the same manner, because the regular fund had lower salary increase assumptions to begin with. Experience was also studied for the JRS and the Legislators' Retirement System (LRS). She explained modifications to the JRS resulted in a minor cost reduction as a percentage of payroll due to salary modifications. The net impact to the LRS was a small increase, mainly due to mortality changes.

Ms. Leiss noted the 2013 actuarial valuation showed a slight increase in the number of active members in both the Regular and Police/Fire funds from the previous valuation. She remarked this was significant, because over the prior three years there were decreases in active memberships. Ms. Leiss said that the number of active members declined by 6.7 percent in the last 5 years, from a high of 106,123 in 2008 to 99,038 in the 2013 valuation. The multi-year decline in membership was also reflected in total payroll data. From the highest payroll point through 2013, the Regular fund experienced a 5.1 percent decrease in total payroll and the Police/Fire fund experienced a 5.2 percent decrease. The decrease in total payroll resulted in lower levels of contributions collected, because contributions are paid as a percentage of payroll, which could result in increased upward pressure on contribution rates to account for the change. Ms. Leiss said the estimated period of time until both plans were fully funded declined as the funds continued to make progress on paying off unfunded liabilities. Based upon the 2013 valuation, the Regular fund would be fully funded in 22.8 years and the Police/Fire fund in 22.1 years from June 30, 2013. The PERS Board decreased the amortization period from a 30-year closed year-by-year period to a 20-year closed year-by-year period. To make the transition, the PERS Board would amortize new gains and losses over the aggregate average; therefore, a new loss or gain would be amortized over 22 years until it decreased to 20, and then each new gain or loss would be amortized on its own 20-year period. Ms. Leiss said that if 2013 had been a rate-setting year, the Regular fund would have experienced a contribution rate increase. She noted the Police/Fire fund's contribution rate, which experienced a slight decrease in actuarial rate, would have remained the same due to the rounding

mechanism contained in the Retirement Act. The Regular fund experienced a modest decline in funded ratio from the previous valuation, moving from 71.2 percent to 68.9 percent. She said this was mainly because of assumption changes; when assumptions are changed on liabilities, there may be an impact on the unfunded liability. Ms. Leiss indicated that there was an overall gain from the experiences in 2013, but the assumption changes actually resulted in a loss in addition to the unfunded liability. Ms. Leiss said the results of the 2013 valuation showed the JRS funded ratio improved from 68.6 percent to 72.3 percent. The normal cost decreased from 23.26 percent of payroll to 22.31 percent of payroll. The lump sum payment for the amortization of the unfunded liability increased from $2,037,650 in 2012 to $2,061,891 in 2013. Ms. Leiss stated the LRS is only valued once every two years so a valuation was not available for 2013.

Turning to the subject of the new GASB rules, Ms. Leiss noted Rule 67 for the plan itself was required to be implemented in FY 2014, while Rule 68 for employers would not be implemented until the following year. She said the change that involved calculating liability would affect the financial statements. The second thing that would cause a big impact was a "divorce" between funding and reporting. Ms. Leiss said the liability calculation would be similar to the actuarial accrued liability, but calculated differently. The liability calculation would be based on market value of assets rather than the actuarial value of assets. She noted that the liability would be more volatile because of the way it was calculated; therefore, it would be a snapshot in time and for recording purposes only.

Ms. Leiss stated that the more significant change would be the divorce of funding and disclosure. She said that the Annual Required Contribution (ARC), used to track whether a plan was being appropriately funded, would be done away with. Ms. Leiss said one of the most important elements of appropriately funding a plan was whether the plan sponsor and employers were making the required contributions. She said that because the ARC was being eliminated it would be impossible to use financial statements to determine if employers were making their contributions. Ms. Leiss said there would be a new calculation called a "pension expense" number, and it would be based on the year-to-year changes of the liability number. She noted that some changes would be gradual and others immediate.

Ms. Leiss indicated the amortization period was almost down to 20 years. For disclosure purposes, there would be certain things that could be amortized, but for a much shorter period. Actuaries estimated a 7½ year period to amortize gains and losses. Ms. Leiss said that the pension expense would fluctuate significantly year to year, based on demographic and investment changes; therefore, it could not be used to predict funding needs, which was GASB's intention. She commented that GASB's intent was to divorce the funding from the accounting reporting disclosure requirements, because GASB was not involved in the funding aspect. Ms. Leiss said that a lot of education would be required so that people would understand the differences in the numbers.

Ms. Leiss said that another change to the liability calculation would be the discount rate. The long-term rate of return would be used to discount liabilities to the extent that expected assets would cover expected liabilities. Ms. Leiss said that if there were ever a crossover date where expected assets would no longer cover expected liabilities, then a discount rate equal to an index rate on a 20-year municipal bond would be necessary. That would be a blended rate between the municipal bond rate and long-term expected rate of return. She stated that most actuaries believed that if an adequate and appropriate funding policy was in place, then a crossover point would be unlikely, because future contributions for current members would be taken into account. As long as contributions are being made this should not be an issue. However, that will be determined once the changes are implemented.

With respect to cost-sharing allocation, Ms. Leiss said that currently employers did not put anything on their financial statements regarding liabilities or expenses for PERS. Employers had what was called a "contractually required contribution rate," which was the amount the law required them to pay. Going forward, the net pension liability, which was roughly equivalent to the Unfunded Accrued Actuarial Liability, would be divided among all the employers who would then have to record it on their financial statements as a liability, even though the legal liability for payment rests with PERS. She said that would be included on the employers' income statements as an expense number. Ms. Leiss clarified that the number would not be what was paid in contributions. Rather, it would be an allocation of the expense number, which would be volatile from year to year. She added that if an overfunded status were reached, the liability shown on the employers' books could be a negative number, but would not be an asset that could be used by the employers.

Chair Carlton noted that the elements of funding the plan were becoming more confusing instead of less. She said it would be more difficult to understand what was needed to fund the plan in the future.

Assemblyman Kirner asked if bonding capabilities would be affected, because the liabilities would be moved around to each entity. Ms. Leiss answered that was a potential. She clarified that Nevada was a fairly low debt state based collectively on the current bonds.

Ms. Leiss said that in addition to the funding and GASB numbers, there would also be bond numbers. She said that Moody's and others were creating their own set of numbers, which were being recalculated for standardization purposes. Ms. Leiss said based on that information, some of the state's most recent offerings were being apportioned, roughly by membership; therefore, about 17 percent of the liability would be taken into account for the state's bonding.

4. Report on the study entitled, "Retirement Board of the Public Employees' Retirement System of Nevada: Independent Limited Review of Practices, Statistics and Policies" (November 2013).

Ms. Leiss provided an update regarding the results of the independent review of Nevada PERS conducted by Aon Hewitt at the request of PERS Retirement Board (page 261, Exhibit A). She said during discussions related to the 2013 Legislative Session, it was suggested by the Governor's Office that PERS commission an independent review of PERS. The study was designed to provide a review of plan practices, statistics and policies, and compare PERS to other large public pension plans. PERS awarded the contract for the comparison study to Aon Hewitt. Ms. Leiss noted that one of the requirements for the proposal process was to select an actuary that had never worked with PERS in the past. She said the study compared PERS to 126 other large pension plans in areas such as funded status, retirement eligibility, actuarial funding method, and discount rate. Ms. Leiss said the study concluded that PERS was similar to most other large systems in many ways; however, the study also determined that PERS was different, and more conservative, in three unique areas. The first area was the equal cost-sharing mechanism between employers and employees. Ms. Leiss said the PERS' contribution rate was based on the actuarial rate, which could change every biennium. She noted the fact that the employee contribution rate was not static was unique in the country. Typically, employee contribution rates remained static; therefore, if the rate needed to change, the employer was responsible. PERS was unique in that employees and employers shared equally, and employees paid half of the unfunded liability contribution. Ms. Leiss stated the second area was that actuarial gains and losses were automatically reflected in the contribution rate. She said that many states had a statutory rate that was slow to change with contribution needs; however, PERS' contribution rate was changed automatically by statute. Ms. Leiss stated the third area was the PERS Board's decision to shorten amortization periods from 30 to 20 years. Ms. Leiss said that, overall, the study determined that the PERS' funding policy represented a comprehensive, thoughtful and appropriate model. The PERS model constituted a best-in-class policy, which many systems did not have. She noted that PERS, unlike other systems, had always had its own funding policies, which could be modified to meet the needs of the system.

Assemblyman Kirner commented that he was disappointed that the review was limited as opposed to comprehensive, and he would have preferred an analysis instead of a comparison study. However, he did appreciate that a study was done. He said he noticed PERS' contribution rates were among the highest in the nation. Additionally, Assemblyman Kirner noted that Aon Hewitt chose to use 2012 actuarial data provided by Segal Consulting rather than developing their own. With respect to contribution levels, he pointed out that in order to be fully paid off in approximately 20 years the contribution level would have to be 27 percent as opposed to the current level of 25 percent. He said based on that information, there would be another increase in the next legislative session, which had been the trend for most biennium periods since 2000.

Ms. Leiss noted the Police/Fire fund rates were decreasing actuarially; though, she confirmed the valuation rate for the Regular fund would increase. She noted,

however, the biggest driver of rates was payroll growth, and she did not think negative payroll growth would continue for a long period of time. Additionally, Ms. Leiss said the other thing that would affect contribution rates was inflation assumption. Inflation assumption was important for a number of reasons, but most significantly, it was important for the post-retirement increases to the contribution rate, which had a large impact on liability. Lower inflation would mean capping post-retirement increases, which would drive the rates down a little.

Assemblyman Kirner reiterated the contribution level was 25.75 percent instead of the necessary 27 percent, and even with a higher payroll and other assumptions, the state would still be a biennium behind. He said inflation would likely increase along with salaries, and he expressed concern about another increase to a level that was already high. Assemblyman Kirner said the employer/employee contribution plan began in 1973 in lieu of salary increases. He said since that time the employer/employee contribution plan had continued; but salaries had also gradually increased for everyone, except state employees. He said that was an issue with which he and his constituents wrestled.

Ms. Leiss replied that the state uniformly reduces employees' salaries when the contribution rate increases, which was not an uncommon practice.

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

Steve Edmundson, Investment Officer, Public Employees' Retirement System gave an update regarding the status of the investment programs for the PERS, LRS and JRS funds. Mr. Edmundson said PERS generated a 12.4 percent net of fee return during FY 2013 and ended the year with an asset value of $28.7 billion. He noted that was a $2.9 billion increase from FY 2012. Mr. Edmundson said over the last 29 years, PERS generated a 9.4 percent average annual return, net of fees. Continuing, he said the LRS fund generated a return of 12.9 percent and ended the year with $4.6 million in assets. Additionally, the JRS fund return for FY 2013 was 13.2 percent with an ending asset value of $74.9 million. Mr. Edmundson noted that for short and longer-term periods, PERS generated better returns than its peers with less risk. He said that on a fee adjusted basis, PERS total and risk adjusted return ranked in the top 25 percent among large public pension plans for the majority of periods that ended June 2013. For that same 29 year period, PERS ranked in the top 5 percent of all large public funds on a risk adjusted return basis.

Mr. Edmundson went on to explain the LRS and JRS funds were similarly competitive. Since inception, the LRS fund total fee adjusted return ranked in the top 19 percent of its peer group, and the JRS fund ranked in the top 17 percent. Mr. Edmundson indicated that although there were 6 months remaining in FY 2014, returns to date were healthy. He explained that as of January 10, 2014, PERS' asset value was $31.8 billion, which represented a $3.1 billion increase since the end of FY 2012. PERS' 2014 fiscal year-to-date return was 11.3 percent, the LRS fund was 12.1 percent and the JRS fund was 12.2 percent.

Mr. Edmundson pointed out that PERS' investment management fees were 0.10 percent of net assets, which was 80 percent below the average public pension fund's fees. He said that translated into savings for an equivalent size plan of approximately $110 million per year. He noted that in 2012, the Maryland Public Policy Institute published a paper indicating PERS was the single lowest cost externally managed state pension fund in the country. Mr. Edmundson stated that investment success was earned slowly over time, not in short bursts of brilliance. He indicated the key was to have the vision and experience to understand the edge and the discipline to stick with that strategy throughout all market cycles. He noted that PERS' common sense investment approach, combined with simplicity and efficiency, created some of the most cost effective returns in the public fund industry. He said that approach would likely continue to serve PERS well in the future.

Assemblyman Kirner agreed that compared to other funds, PERS' costs were dramatically low, which was reflected on the returns. Turning to the subject of deferred compensation plans, he noted that, among the state's deferred compensation plan choices, there was not an option to invest in PERS. Assemblyman Kirner asked if that would be a feasible option.

Ms. Leiss replied it would need to be looked at carefully to assure the plan was in compliance with the Internal Revenue Code. She indicated that some other public funds had tried something similar; however, it would be fairly unique in the country. Ms. Leiss said she was unprepared to provide an answer today, because regulatory and administrative obstacles might be overlooked. She indicated that the first step would probably be a legislative change. Additionally, she added there were many different 457 plans within the state which had no relationship to each other, each having its own separate vendor and contract.

Assemblyman Kirner concurred that legislation would be necessary, but there was no sense going through the process if there was no real gain to be made. He asked if PERS could perform a cursory review of the issue and provide feedback at the next Committee meeting. Ms. Leiss noted that PERS was a cost-sharing plan among 190 public employers, so it could be difficult to institute something specifically for just one or two employers. However, she said she would work with Committee staff prior to the next meeting to provide preliminary information and identify any possible issues.

Chair Carlton said she would review the preliminary information and decide whether it would be an agenda item at the next meeting.

6. Status report on critical labor shortage exemptions from PERS' reemployment restrictions – Assembly Bill 555 (2001), Senate Bill 439 (2003), Senate Bill 485 (2005), Assembly Bill 488 (2009).

Ms. Leiss gave a status update regarding current reemployment restrictions, the history of the critical labor shortage exemption, and the status of the most recent amendment to the provision passed during the 2009 Legislative Session (page 279, Exhibit A). Ms. Leiss said that A.B. 488 (2009 Legislative Session) significantly restricted the use of the critical labor shortage exemption by changing requirements for declaration of the critical labor shortage. She said as of December 31, 2013, 69 positions had been declared under the new requirements. A total of 159 retirees, out of approximately 47,000, had been reemployed and 96 were re-enrolled in PERS. Ms. Leiss explained the declaration of critical need was position driven, not individual specific; therefore, one position designation may cover more than one position. For example, if the Clark County School District (CCSD) were to designate a special education teacher as a critical labor shortage position, the designation would apply to any of the CCSD's special education teacher positions. Continuing, Ms. Leiss noted that of the 159 retirees reemployed, 129 were employed in the education sector, with the remaining 30 spread among 16 general government employers (page 282, Exhibit A). She stated the critical labor shortage exemption would sunset on June 30, 2015. PERS was required to conduct an experience study of the employment of retired public employees in critical labor shortage positions from July 1, 2009, through June 30, 2014, and submit a report of the findings to the Interim Retirement and Benefits Committee by December 31, 2014.

Senator Smith remarked that she understood the need to have exceptions for hard to fill positions, but she did not think it should ever be used as a way to circumvent the rules prohibiting reemployment of PERS' retirees. She noted some exemptions had been in place for a long time, and asked if positions were reevaluated at some point. Ms. Leiss answered that the governing body was responsible for determining whether there was a critical labor shortage for a position type. She said PERS' responsibility was to review the designating authority's written findings which supported the designation.

Senator Smith asked if the rules required PERS to review the designation after the fact. Ms. Leiss answered that it was dependent upon when the designation was originally made. She explained the statute was originally put in place in 2001, and at that time there was no end date for the designation; therefore, retirees who were reemployed under the provisions of that statute did not require a re-designation. Ms. Leiss further explained that under A.B. 488 positions required re-designation every two years. She said every two years the governing body must reassess the factors, and PERS would require re-designation or the retiree would be subject to a suspension of benefits.

Senator Smith asked if a PERS retiree could work in the field as long as they were not on the actual payroll. She noted that being hired as a consultant or contractor would be a way to circumvent the rule. Ms. Leiss responded that the law indicated a retiree could not accept employment or an independent contract with a public employer, or the retiree would be subject to suspension of benefits. She said if a

retiree were to work for a private entity, for example a temporary agency or a Limited Liability Company, PERS would not be able to suspend the retiree's benefits. Ms. Leiss said that by working for a private entity, the retiree was not technically working for a public employer; therefore, the reemployment laws would not apply. She said audits were performed every three years and rotated among public employers. During the process, the employer's independent contracts were also audited, and if they had an independent contract with a retiree, it would be noted and the proper steps would be taken to suspend benefits. However, if the retiree had a contract with a private entity, that would not impact the reemployment restrictions.

Senator Smith remarked that the state had worked hard to eliminate the practice of "double-dipping" and fix the consultant issues. She understood the importance of having the right people in the right job, but also noted the importance of not hampering training opportunities for current employees. Senator Smith said the school districts were required to provide a report of hired consultants, which could be another avenue for PERS to explore. Additionally, she noted the Board of Examiners must approve all consultant agreements and that could also provide helpful information. Senator Smith encouraged PERS to continue tightening the retiree reemployment restrictions.

7. Status report on one-fifth of a year purchase of service benefit for certain education employees provided under the former provisions of NRS 391.165.

Ms. Leiss provided an update of the benefit provided to certain education employees pursuant to NRS 391.165. Section 4 of Assembly Bill 1 of the 23rd Special Session repealed the benefit effective July 1, 2007, and phased it out over time. She said the school district was still required to purchase 1/5 of a service year credit for those in specific positions, if the employee was under contract with the district prior to July 1, 2007. Ms. Leiss said individuals remained in the program until a full year had been purchased for them. She noted that since five years had passed, most of the people that were eligible for the 1/5 of a year purchase had dropped off of the program. Ms. Leiss said a certain number remained in the program, because they had not yet received the full year of service. She indicated the number of people remaining in the program had decreased significantly and the program would end soon. She said in 2012 there were 3,302 1/5 of a year purchases for about $13.9 million, and in 2013 there were 1,057 purchases for about $4.5 million. Ms. Leiss noted since inception the program resulted in over 40,000 purchases for about $141 million.

Senator Smith asked if there was a time limit for staff to use the program. Ms. Leiss answered the program was for anyone under contract prior to July 1, 2007, and was only made available to individuals who were vested.

Senator Smith asked when the program was expected to be finished. Ms. Leiss replied it was difficult to say without knowing the employment statistics of the

particular school districts. She noted, however, that only three school districts remained in the program, so the program could end within a year or two. Ms. Leiss clarified the program would not sunset, but the 2007 change made it available only to those who were under contract at that time, and only until a full year had been purchased for them. She said if an individual were continuously eligible it would have taken five years. The few individuals remaining eligible must have had gaps in service during the five-year period.

Assemblyman Kirner asked if someone who had not received the full service amount could leave the system for an undesignated period of time, and still come back to collect the remaining service credit. Ms. Leiss replied that based on her understanding, the individual would have had to remain under contract, even if they were not teaching that particular subject for a portion of the time.

Senator Smith said her understanding was that an individual could come back at any time, and the program would continue until the last eligible person was no longer in the system.

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

Mr. Edmundson gave an update on the RBIF. By statute, RBIF is managed by the PERS Board solely as an investment vehicle for public employers who choose to participate in the program to fund Other Post-Employment Benefits (OPEB). Mr. Edmundson noted the decision to invest or withdraw from the program was solely up to each employer. He said in that respect, the structure was similar to how mutual funds were managed for individual investors. Mr. Edmundson said RBIF held $184 million as of June 2013, and generated a FY 2013 return of 12.9 percent net of fees. Continuing, he said the portfolio had experienced an annualized return of 5.5 percent since its inception in January 2008. Due to the fund's structure, the investment performance of RBIF members was dependent on their individual contribution dates. Mr. Edmundson said an investment performance database of health trusts was not available, so similar sized public pension plans (which had similar return objectives as RBIF) were used for peer comparisons. He said compared to institutional funds of similar size, on a fee adjusted basis RBIF ranked in the top 17 percent for the last 3 years, the top 21 percent for the last 5 years and in the top 3 percent since inception. Mr. Edmundson said, because the PERS Board utilized 100 percent index management in RBIF and took advantage of the multi-billion dollar investment management relationships maintained by PERS, the portfolio's investment fees were very low (3 basis points or 0.03 percent of assets). He said the fee level was estimated at 94 percent below that of comparable size investment programs. He further stated that statute required RBIF to be managed in the same manner as the PERS' investment program. Due to its smaller size ($184 million versus $31 billion) there were some differences in structure between the funds, though the overall policy risk allocation for both portfolios was identical. Mr. Edmundson said for the last three years RBIF's return

was within 0.2 percent of PERS, and since inception, the return was within 0.7 percent of PERS. The results confirmed the PERS Board's success in meeting the statutory requirements for RBIF.

9. Report on annual report of investments of money from the Public Employees' Retirement System in scrutinized companies (NRS 286.723).

   Mr. Edmundson provided an update pursuant to the reporting requirements outlined in A.B. 493 of the 2009 Legislative Session. He stated that PERS did not currently own any securities that were on any publicly available lists of scrutinized companies that do business with Iran.

10. Discussion of recent Nevada Supreme Court decision relating to access to PERS' records, PERS v. Reno Newspapers, 129 Nev. Adv. Op. No. 88 (Nov. 14, 2013).

    Chair Carlton stated that out of an abundance of caution, and because the subject may be ongoing, the Committee should keep their comments to a minimum.

    Ms. Leiss provided an overview of the Reno-Gazette Journal's lawsuit against PERS regarding a public records request (page 303, Exhibit A). She said on January 19, 2011, the Reno-Gazette Journal (RGJ) requested PERS provide information regarding every retiree of PERS. Specifically, the RGJ requested the names of all individuals who were collecting pensions, the name of their employers, salaries, hire and retirement dates, and amount of pension payment. Continuing, she said through its deputy attorney general, PERS responded to RGJ's request asserting the records regarding individual retirees of PERS were not public records. Ms. Leiss said the response was in keeping with PERS' consistent, long-term interpretation of the Retirement Act that member and retiree files were declared confidential by law citing NRS 286.110(3) and NRS 286.117. She explained that NRS 286.110(3) provided that the files of individual members or retired employees were not public records. *Nevada Revised Statutes* 286.117 limited who may review and copy files. Ms. Leiss said the RGJ filed a petition on May 27, 2011, in District Court and on December 12, 2011, the District Court ordered PERS to produce a report concerning each retired employee currently receiving a benefit including the name of the retired employee, employer, salary, hire and retirement dates, and amount of benefit payment. Continuing, she said the order found residence addresses, social security numbers, and all other information contained in the files of individual PERS members and retired employees to be confidential and not subject to disclosure. The District Court's order was appealed by PERS to the Nevada Supreme Court in January 2012. Ms. Leiss said on November 14, 2013, the Nevada Supreme Court ruled that the individual files of members and retirees were confidential. The Court also ruled that "[w]here information is contained in a medium separate from the individuals' files, including in administrative reports generated from data contained in individuals' files, such reports or other media is not confidential merely because the same information is also contained in individuals' files." Ms. Leiss said PERS did not have an existing

report containing all items requested by the RGJ in its entirety; however, PERS would provide a monthly payment register pursuant to the Nevada Supreme Court order. Ms. Leiss indicated that retirees would be notified regarding that fact.

In response to a question from Chair Carlton, Ms. Leiss explained the payment register was similar to a check register. It included the name, social security number, gross amount and net amount of anyone who received payment that month. Ms. Leiss stated that social security numbers would be redacted prior to release. She said that was what PERS was instructed to produce pursuant to the Supreme Court order.

Chair Carlton asked how PERS had been impacted. Ms. Leiss answered that the statutes had been in place since the 1970s, and PERS had consistently interpreted it to mean that when the files were confidential, nothing could be released from those files. PERS' members and retirees were of the same understanding; therefore, communication regarding the change would be vital. Ms. Leiss added there were other reports in the member and retiree files that were used to process PERS' business. Therefore, PERS would be challenged with complying with the public records law while maintaining the confidentiality of PERS' members. She said there may be a time when a judgment call would be required to determine whether the confidentiality statute or the public records request applied. Ms. Leiss said that PERS was remanded to the District Court and it was PERS' intention to have certain documents reviewed on camera by the District Court before being released.

VI. PUBLIC COMMENT.

Marty Bibb, RPEN, said the Aon Hewitt study endorsed PERS' performance. He noted Nevada had an equal employee/employer contribution plan; therefore, it was less likely to face problems found within retirement systems without equal contribution plans. Additionally, Mr. Bibb remarked that because contribution rate changes were automatic based on statute, Nevada was able to avoid lengthy delays typical of systems that required an approval process. Continuing, he said the contribution rates were likely higher to compensate for the fact that the state does not pay social security tax. Mr. Bibb noted the investment rates of returns were presented by PERS as net of fees as opposed to gross. He said PERS' fee structure was conservative compared to other retirement systems. Mr. Bibb concluded by expressing concern regarding retiree privacy.

Frank Papaianni expressed concern regarding retiree privacy. He wanted assurance that social security numbers would be redacted from the report provided to the RGJ. Chair Carlton assured Mr. Papaianni that social security numbers would be redacted as stated by Ms. Leiss.

VII. ADJOURNMENT.

The meeting was adjourned at 2:03 p.m.

Respectfully submitted,

_____
Carla Ulrych, Committee Secretary

APPROVED:

_____
Assemblywoman Maggie Carlton, Chair

Date:_____

Copies of exhibits mentioned in these minutes are on file in the Fiscal Analysis Division at the Legislative Counsel Bureau, Carson City, Nevada. The division may be contacted at (775) 684-6821.