MINUTES OF THE
NEVADA LEGISLATURE'S
INTERIM RETIREMENT AND BENEFITS COMMITTEE
(*Nevada Revised Statutes* 218E.420)
January 30, 2012

SUMMARY OF MINUTES

Chairman Steven Horsford called a meeting of the Nevada Legislature's Interim Retirement and Benefits Committee (IRBC) to order on January 30, 2012, at 9:07 a.m. in Room 4412 of the Grant Sawyer State Office Building in Las Vegas, Nevada. The meeting was simultaneously videoconferenced to Room 2135 of the Legislative Building in Carson City, Nevada.

COMMITTEE MEMBERS PRESENT IN LAS VEGAS:
Senator Steven Horsford, Chairman
Assemblyman Marcus Conklin

COMMITTEE MEMBERS PRESENT IN CARSON CITY:
Assemblywoman Debbie Smith, Vice Chairman
Senator Sheila Leslie
Senator Ben Kieckhefer
Assemblyman Randall Kirner

COMMITTEE MEMBERS ABSENT:
None

OTHER LEGISLATORS PRESENT:
None

STAFF MEMBERS PRESENT IN LAS VEGAS:
Mark Krmpotic, Senate Fiscal Analyst, Fiscal Analysis Division
Laura Freed, Senior Program Analyst, Fiscal Analysis Division

STAFF MEMBERS PRESENT IN CARSON CITY:
Rick Combs, Assembly Fiscal Analyst, Fiscal Analysis Division
Eileen O'Grady, Chief Deputy Legislative Counsel, Legal Division
Tracie Battisti, Committee Secretary, Fiscal Analysis Division

EXHIBITS:

Exhibit A: Agenda and Meeting Packet
Exhibit B: Public Employees' Benefits Program Annual Report A.B. 80 (2011) Agenda Item V-4

I. ROLL CALL.

Chairman Horsford called the meeting of the Nevada Legislature's Interim Retirement and Benefits Committee to order at 9:07 a.m. The secretary called roll, all members were present.

II. PUBLIC COMMENT.

Dennis Ellstead, retired teacher from Clark County, commented about the automatic reimbursement system in state insurance. He reported that his monthly supplement check of $150 was mailed to him in several payments throughout the month. He expressed concern with the payment method. Mr. Ellstead also commented on Lieutenant Governor Krolicki working for Extend Health. Mr. Krolicki's staff informed Mr. Ellstead that the Lieutenant Governor had been contracted with Extend Health since December 2011. Mr. Ellstead thought that was a conflict of interest.

Chairman Horsford asked the Public Employees' Retirement System (PERS) or the Public Employees' Benefits Program (PEBP) staff to address Mr. Ellstead's concerns.

III. APPROVAL OF MINUTES OF THE FEBRUARY 2, 2010, MEETING.

Chairman Horsford asked for a motion to approve the February 2, 2010, meeting minutes included in the meeting packet (Exhibit A, page 5).

> ASSEMBLYMAN CONKLIN MOVED TO APPROVE THE MINUTES OF THE FEBRUARY 2, 2010, MEETING OF THE INTERIM RETIREMENT AND BENEFITS COMMITTEE. SENATOR LESLIE SECONDED THE MOTION.
>
> THE MOTION CARRIED UNANIMOUSLY.

IV. PUBLIC EMPLOYEES' RETIREMENT SYSTEM.

Dana Bilyeu, Executive Officer, Public Employees' Retirement System, introduced Tina Leiss, Operations Officer and Ken Lambert, Investment Officer, Public Employees' Retirement System.

IV-1. Report on Actuarial Valuation for the Public Employees' Retirement System as of June 30, 2011.

IV-2. Report on Actuarial Valuation for the Judicial Retirement System (JRS) as of June 30, 2011.

Ms. Bilyeu provided the Committee with a summary and charts of the Public Employees' Retirement System Actuarial Valuations for 2011 (Exhibit A, page 31).

Chairman Horsford asked Ms. Bilyeu to provide a list of reforms from the previous sessions. He also asked Ms. Bilyeu to define the term "lower tier."

Ms. Bilyeu explained that PERS adopted the term of lower tier to differentiate between two groups: individuals hired prior to and individuals hired after January 1, 2010. Chairman Horsford suggested coming up with a different term.

Assemblyman Conklin asked Ms. Bilyeu if she anticipated the trend of the rate increase would continue.

Ms. Bilyeu said PERS used a five-year smoothing period. She said PERS continued bringing in losses from the 2009 market loss, which was a negative 15.8 percent. She said that in the next two years there would be an uneven pattern due to significant gains. After that, the trend should start reversing itself. Ms. Bilyeu said there was the recession in 2001-2002, and in 2005 PERS rates declined and the funded ratio increased.

Senator Kieckhefer referred to the average member profile, which was 46.1 years for the regular fund. He asked if that age was trending upward, or had it remained steady.

Ms. Bilyeu said it was trending upward as the active workforce aged. The public workforce was generally an older workforce than the private sector, and was trending upward over time.

Assemblyman Kirner referred to the average years of service (Exhibit A, page 38). He said the chart implied there were a number of individuals who would leave the system when they were vested, between 5 and 20 years, yet they would still receive some type of benefit.

Ms. Bilyeu replied that was correct. She said the average entry age in the regular fund was 38 years old. An average of 20 years of service would make an individual 60 years old at retirement. If an individual retired prior to that, a penalty would be assessed against them for every year under the age of full eligibility for retirement. Ms. Bilyeu said some individuals retired over the age of 60 with approximately 20 years of service in the regular fund; the police/fire fund was slightly higher due to employment starting at an earlier age of approximately 29 years old.

Assemblyman Kirner said in order to pay the average benefit in the regular fund of $2,539, PERS must include a large group of individuals that received small amounts, and left the system before their 20th year.

Ms. Bilyeu said there were more individuals who received a lesser benefit. She referred to the chart (Exhibit A, page 37) showing the average salary of participants in the program, which directly affected the benefits.

Assemblyman Kirner said in order to arrive at that average there would have been some high wage earners. That amount would be in lieu of Social Security, unless an employee had worked outside the system for 40 quarters. Assemblyman Kirner asked if the pension plan was designed to be a substitute for Social Security or a substitute for Social Security and private savings.

Ms. Bilyeu replied PERS was designed to replace Social Security benefits as well as the defined benefit portion. PERS was designed in 1947 and the components were defined benefit and Social Security replacement.

Assemblyman Conklin speculated there were employees that had worked 20 years versus 30 years and had not received their full PERS benefit; however, they would be supplemented by Social Security. He said the reality was they did not receive their full Social Security benefit either, because there would have been a penalty for receiving the PERS benefit. He asked Ms. Bilyeu if she knew what that penalty was.

Ms. Bilyeu said there were two different penalties associated with Social Security: the Windfall Elimination Provision and the Government Pension offset. Under the Windfall Elimination Provision, which operated on a sliding scale, the more quarters earned in Social Security, the less of an offset there would be. Individuals who were not vested or eligible for benefits prior to January 1, 1983, would have some type of an offset against his or her Social Security benefit.

Ms. Bilyeu provided the Committee with a summary of the Judicial Retirement System (JRS), and the Legislators' Retirement System (LRS) (Exhibit A, page 32).

Assemblyman Conklin asked Ms. Bilyeu to describe the Legislators' PERS benefit program.

Ms. Bilyeu said every Legislator received $25 per month per year, capped at 30 years of service. With the term limits currently in effect, a Legislator could only have 24 years of service. Actively serving Legislators were entitled to survivor benefits that were the same as the regular fund.

Assemblyman Conklin asked, if a Legislator served 24 years would they receive $600 per month at retirement age? Ms. Bilyeu said that was correct.

IV-3. Update on Investment Earnings – PERS, Legislators' Retirement and Judicial Retirement Funds.

Mr. Lambert provided the Committee with an update on investment earnings for PERS, Legislators' Retirement and Judicial Retirement Funds (Exhibit A, page 39).

Referring to page 41 (Exhibit A) Assemblyman Kirner said it appeared over the past 10 years the objective was 8 percent, and the results were 5.4 percent for the PERS program. Mr. Lambert answered, that was correct. Assemblyman Kirner said that was certainly a reflection of the volatile market that they were in.

Assemblyman Kirner asked Mr. Lambert about risk valuation and the volatility of the investments that came from international stocks and international equity. He asked how the system would guard against the volatility of the international equities.

Mr. Lambert said PERS owns asset classes that performed differently from each other over time. PERS mixed asset classes owned high quality assets, which was one of the reasons they did not invest in emerging markets, and invested in European equities. The companies PERS invested in garnished 70 percent of their revenue outside of Europe and much of it from the developing markets. Mr. Lambert said, over time, those assets performed better, then performed worse. That volatility was used to trade or sell those assets when they were doing well, and then buy other asset classes that were doing poorly. That was how they had been able to add value to the plan. PERS added $210 million in the last three years from selling bonds that had done well, and buying international equity that had done poorly. Over time, that generated a stable return stream.

Assemblyman Kirner asked Mr. Lambert if he anticipated maintaining the 8 percent long-term return over the next 5 to 10-year period.

Mr. Lambert said he was comfortable that level of return could be maintained. He recalled that in the late 1990s, conventional wisdom was that PERS' 8 percent return was too low. Other funds were generating up to 18 percent returns per year. Now, the pundits in the economic community say that 8 percent is too high.

Mr. Lambert said, from a valuation perspective, risk assets, primarily equities, were the least expensive they had been in the past 30 years. He explained that the returns were viewed over long periods, such as 20 years. He said that since the beginning of stock trading, there had been 65 20-year periods. In the last 10 years, returns from stock were 2.7 percent. He said, if U.S. stocks generated a 9.5 percent return per year for the next 10 years, the combined 20-year period would be the second worst in the history of publically traded stocks. PERS thought the odds were strongly in favor of risk assets doing well for the next 10 years. That was the reason PERS was comfortable with the 8 percent return assumption.

Chairman Horsford noted in FY 2011, PERS was experiencing growth of 21 percent. He asked what the growth rate would have to be in order to hit the 8 percent objective.

Mr. Lambert said the 21 percent growth was only for FY 2011. Mr. Lambert said when reviewing investments, the rolling periods rolled forward. He said 2001 and 2002 were extremely poor years. In 2012, the year 2001 would drop off, and in 2013, the year 2002 would drop off. The 10-year average could reach up to 9 percent, due to the rolling period. It depended on how the period was defined. For the next 5 years, if PERS generated 12 to 13 percent per year, that 5-year number would grow proportionally. When the negative returns from 2001 and 2002 dropped off, the 10-year average would quickly raise above 8 percent.

Chairman Horsford added that, in dealing with larger areas of the budget and larger policy objectives of the state, being able to see the longer view was critical. Unfortunately, the Legislature only had a 2-year increment for decision-making. He said the 5 and 10-year views were crucial.

Ms. Bilyeu said 2008 and 2009 were two significantly bad years within the last decade. PERS had six years that greatly exceeded the 8 percent number. Ms. Bilyeu said from a pension financing perspective it was hard to make predictions for a 20-year time horizon. No one could say what the market would look like in 20 years. PERS was focusing on the long term. The 27.5-year period was averaged at 9.5 percent. They knew that over long-term periods the diversified strategy that PERS used was successful.

IV-4. Status Report On Critical Labor Shortage.

Ms. Bilyeu provided the Committee with a summary and spreadsheets on the critical labor shortage (Exhibit A, page 53).

Senator Kieckhefer asked Ms. Bilyeu if all the positions listed on page 56, (Exhibit A) were presently employed.

Ms. Bilyeu replied the shaded area on page 61, (Exhibit A) were the individuals that were no longer reemployed in those positions.

Chairman Horsford asked Ms. Bilyeu if the critical labor shortage was reviewed twice a year. Ms. Bilyeu answered a report was provided to the Committee biennially.

Chairman Horsford asked when the requesting agency had to reaffirm that those were critical labor shortage positions. Ms. Bilyeu said the agencies reported once a biennium.

Chairman Horsford said most of the critical labor designations were made in 2009, which was the beginning or the middle of the recession period. Chairman Horsford wanted justification for the positions, but the agencies were only required to report once a biennium, which meant the agencies, would not have to report until 2011.

Ms. Bilyeu said that was correct. Recertifications were coming in, but they slowed down quite significantly going forward. Referring to page 61, (Exhibit A) she noted the Clark County School District, which was the largest employer, had 64 of the positions. She said many of the rural school districts used retirees for the difficult to fill positions, like bus drivers that had 100-mile routes. Ms. Bilyeu said the statute was currently written to require biennia reports.

Chairman Horsford asked about the review process PERS used when it was time for recertification.

Ms. Bilyeu said PERS compiled the information it was given. There was no review to reject the certification, although PERS worked diligently to ensure the agencies followed the steps they were required to follow. An open hearing was held. The employer presented on the record what they had done to recruit for the position, the purpose of the position, and how it would serve the public going forward. PERS required each employer to fill out a form. PERS worked with them to ensure they followed it exactly. She noted when the critical need designation was extended in 2009, PERS was opposed to it because it was a much broader program and it carried with it a cost. The designation was designed to sunset on June 30, 2015. PERS would be conducting another experience study. The reemployment restrictions in the program were viewed as a cost containment measure to allow PERS to stop the payment of benefits if a retiree came back into the active work force.

Chairman Horsford asked if an individual charter school's governing body could have determined a critical shortage themselves without going through their chartering agency, their school district or the state. Ms. Bilyeu said that was correct. Chairman Horsford said there were a number of critical positions that were within education from charter schools.

Assemblyman Kirner asked if the determination to whether there was a critical labor shortage was not under PERS purview, but was done by the local agency. Ms. Bilyeu said that was correct.

IV-5. Status Report on One-Fifth of a Year Purchase of Service.

Ms. Bilyeu provided the Committee with a status report and spreadsheets on one-fifth of a year purchase of service benefit for education employees provided under the former provisions of NRS 391.165 (page 63, Exhibit A). Ms. Bilyeu apologized for an error on page 63 regarding the total number of employees eligible for the program. In 2011, it said 25 members for both 2010 and 2011, and in 2011, 62 members were not eligible for the program. That meant they had already purchased up to 5 years of service, or they were not vested in the program.

IV-6. Status Report on the Retirement Benefits Investment Fund.

Ms. Leiss provided the Committee with a status report and a chart of the implementation of Senate Bill 457 of the 2007 Legislative Session (Exhibit A, page 67).

Mr. Lambert provided the Committee with an update on the Retirement Benefits Investment Fund (RBIF) (Exhibit A, page 68).

Chairman Horsford asked Ms. Leiss to clarify, which local governments were participating in the RBIF.

Ms. Leiss answered Washoe County, Washoe County School District, Truckee Meadows Water Authority and the City of Las Vegas.

Chairman Horsford asked if they were internally administering their investment funds within each of the governmental entities.

Ms. Leiss said the governmental entity created a trust fund, which they designated. At the trust fund level, the system would be run by the local government trust fund that was created separate from their governing board. It was then sent to the RBIF as an investment vehicle only, so they did not control the investments. She said Mr. Lambert did that through the RBIF, but they did control the contributions and the withdrawals from the system.

Chairman Horsford asked if that was done at each individual governmental entity. Ms. Leiss said it was done at the trust fund level for each governmental entity.

IV-7. Status Report on the IRS "NORMAL RETIREMENT AGE" REGULATIONS.

Ms. Bilyeu provided the Committee with a memo on the status of the Internal Revenue Service's implementation of regulations concerning "normal retirement age" (Exhibit A, page 71).

Chairman Horsford asked if PERS was waiting for Congress and the U.S.Treasury to act. Ms. Bilyeu said that was correct.

IV-8. ANNUAL SCRUTINIZED INVESTMENT REPORT.

Mr. Lambert provided the Committee with a report from PERS on investments of money in scrutinized companies in Iran (Exhibit A, page 73).

Chairman Horsford asked if the President or Congress had imposed economic sanctions on the government of Iran. He asked if PERS would be required to divest this portion of investment in a corporation, even though it had a small fraction of its overall operations there.

Mr. Lambert said that was correct. The Office of Foreign Assets Control list had hundreds of companies on it; most of them were small companies that PERS would not have invested in. When the government changes the list, PERS acts immediately to comply.

Chairman Horsford asked if PERS has had to do that.

Mr. Lambert answered they had not and did not expect to. He said most of the companies on the list were directly linked to terrorism. PERS funds could not be invested in those companies. Historically the government had not taken action against larger corporations, but if it chose to in the future, it would be easy for PERS to comply.

There were no further questions.

V. PUBLIC EMPLOYEES' BENEFITS PROGRAM.

Jim Wells, Executive Officer, Public Employees' Benefits Program, introduced Kateri Cavin, Operations Officer and Donna Lopez, Quality Control Officer, Public Employees' Benefits Program and Nicola Neilon, partner, Casey, Neilon & Associates.

V-1A. Self-Insurance Trust Fund (NRS 287.0435).

Ms. Neilon said her firm was the auditor for the Self-Insurance Trust Fund, PEBP and the State Retirees' Health and Welfare Benefits Fund. Ms. Neilon provided the Committee with the independent auditors report. The auditor's opinion was unqualified, which was the highest level of assurance given on a set of financial statements (Exhibit A, page 77).

Senator Kieckhefer asked if there was a target for net assets and how was it calculated.

Mr. Wells referred to the funded reserve for June 30, 2011, the incurred but not reported liability of $33.85 million and the rate stabilization, or catastrophic reserve, of $33.33 million, which was their target (Exhibit A, page 77). He said in that particular year PEBP had $43.3 million in excess reserves. Mr. Wells said PEBP planned to spend down $43.3 million over the biennium, therefore the amount should be zero in June 2013.

Senator Kieckhefer asked how PEBP accumulated $43.3 million in excess reserves while increasing premiums on employees. He did not understand why there was the build-up and then the trickle down.

Mr. Wells said when the actuaries gave them the rates they used many projections. One projection was for double-digit inflation in claims experience, but there was actually a net decrease in the claims experience. Therefore, the rates were built with the assumption that there would be a 10 percent increase in claims. He said the difference between what was projected and the actuality drove those excess reserves.

Senator Kieckhefer concluded that PEBP did not build it up intentionally, it happened because they did not experience the inflation and expenses. Mr. Wells said that was correct, they would never build up excess reserves intentionally.

Chairman Horsford asked what was the response from the actuaries and what the factors were that led to such a sharp decline.

Mr. Wells said PEBP's actuaries informed PEBP that the expenditures in medical cost in the last 12 to 18 months had been significantly lower than what was projected all across the country. Nevada was not the only state government that had built up reserves in its plan. When they looked at the rate setting methodologies in the past there was a factor built in for variability, so they built the rates at a 95 percent confidence that the premiums being built for that year would cover the claims and costs incurred for that year. When the premiums were being set, they discovered their confidence level had been too high. He said 95 percent of the time they met or exceeded the amount that was needed. In the current year, they used a 50 percent factor, which meant that 50 out of 100 years they would meet the amount needed to cover that year's claims and the other 50 years they would not. That was their first attempt to bring down the excess reserves. The other factor that had driven some of the unknown was the plan design changes that the PEBP Board (Board) put in place over the past 3 years, which started with the 2009 plan design changes and the plan year extension from June 2009 to October 31, 2009, a four-month plan extension. That had put some variability into the work that the actuaries had to consider when they were building the rates.

Chairman Horsford asked what the Board was doing to address the excess reserve, what policy reviews or modifications might the Board make, and whether that would have any effect on the plan design changes enacted within the last 18 months.

Mr. Wells answered the Board would set rates at the March 14, 2012, meeting. At that point, barring any changes form the actuaries, the intent was to leave the rates flat in the next plan year. So instead of considering any inflationary measures that would be normal for expected medical costs, they were looking at keeping premiums identical in 2013 as they were for plan year 2012, and that would significantly reduce the excess reserves.

Chairman Horsford asked why.

Mr. Wells said there was continuing inflation in the claims costs and the insurance premiums to the HMO carriers. Therefore, if they did not increase the revenues coming in, those increases in cost would consume the excess reserves.

Chairman Horsford asked how much the inflationary cost to the providers was. He said if the cost was kept at what it was rather than approving a plan design that would draw down the excess reserves, there would be an increase to PEBP's providers. Mr. Wells confirmed that was correct. Chairman Horsford asked where he could find those inflationary projections.

Mr. Wells said although the projections were not included in the packet, PEBP had done projections on a regular basis. In addition, the actuaries had done cost projections based on the nationwide historical trend as they moved through the rate setting process. Mr. Wells said they had received the renewal rates from one of the HMOs, but not the second. Rates were going up almost 9 percent from this year to next.

Chairman Horsford asked Mr. Wells if he would provide information to staff on the cost of claims going forward and the information that PEBP would be submitting to the Board for consideration in March 2012. Mr. Wells said he would.

V-1B. State Retirees Health and Welfare Benefits Fund.

Ms. Neilon provided the Committee with a report on State Retirees Health and Welfare Benefits Fund (Exhibit A, pages 95-107).

V-2. Legal Compliance Report.

Ms. Lopez provided the Committee with a Legal Compliance Report pursuant to A.B. 80 (2011) (Section 3, subsection 2, paragraph b), the biennial legal compliance review is to determine whether the Program complies with federal and state laws relating to taxes and employee benefits (Exhibit A, page 109).

Regarding Aon Hewitt's finding that PEBP needed to perform transactional testing, Chairman Horsford asked for confirmation that PEBP staff would report to the Committee by 2013 on the implementation process of that finding. Ms. Lopez said PEBP would report either the implementation or the results of the testing.

Senator Kieckhefer asked if PEBP was tracking what the Silver State Insurance Exchange was doing in terms of central benefit package and determining potential cost to the plan.

Mr. Wells said PEBP met on a regular basis with the Department of Health and Human Services, the Silver State Health Insurance Exchange, and the Division of Insurance to review the impact of health care reform and review the essential benefit package.

Senator Kieckhefer asked if there was potential that an essential benefit package could be adopted that would instill some significant cost drivers into PEBP.

Mr. Wells said he did not think the essential health benefit package that would be required for the exchange would be required for other employers or the state.

Referring to the transactional testing, Assemblywoman Smith said it appeared that testing had been suggested over a period of time and wondered why PEBP had not complied previously.

Ms. Lopez said it was a budget issue. It would have cost PEBP money to do the tests, and other priorities were more pressing. She said PEBP understood it was time to get it done, and they were adding the testing expense to their budget.

Assemblywoman Smith asked for confirmation that PEBP would complete the transactional testing. Ms. Lopez confirmed.

Regarding nondiscrimination testing, Mr. Wells said they did not have highly compensated individuals, nor did they treat anyone on the plan differently. Therefore, PEBP should not be subject to the nondiscrimination rules.

Chairman Horsford asked for clarification that PEBP would not do the nondiscrimination testing only after they were able to justify PEBP did not discriminate. Mr. Wells said that was correct.

V-3. Governmental Accounting Standards Board (GASB) Valuation.

Chairman Horsford asked for confirmation that, based on the plan design changes and the policy decisions from the last two legislative sessions, they had essentially reduced any prefunded liability to PEBP by more than 45 percent. Mr. Wells answered that was correct. Chairman Horsford said that was a potential loss of $900 million.

Mr. Wells said that the Other Postemployment Benefits (OPEB) valuation was the snapshot picture. Mr. Wells stated the present value of benefits, which was closer to a $1.5 billion reduction, was the number projected to be earned by all existing retirees through the remainder of their working careers.

Mr. Wells said the one assumption in the valuation was the Health Reimbursement Arrangement (HRA) provided to Medicare retirees. There was no HRA inflation factor built in because there was no inflation factor approved. Mr. Wells said this assumption would likely change. He said If PEBP provided additional HRA funds to Medicare retirees, at an inflation factor of 4.5 percent, it would have increased the present value of benefits by $562 million, and increased the unfunded actuarial accrued liability by $251 million. It also would have increased the annual required contribution by $37 million.

Chairman Horsford asked when the Medicare retiree inflation assumption would be determined.

Mr. Wells said PEBP would be submitting its budget to the Governor's Office on September 1, 2012, and as it moved forward to the legislative session they would determine whether the inflation factor would be approved in future years. Once the actuaries knew if there would be an inflation factor, they would then build it into the valuations.

Mr. Wells said the present value of benefits decreased from $4.0 billion to $1.8 billion. If PEBP had built inflation into the Medicare retirees' health reimbursement arrangement at a rate of 4.5 percent that number would decline from $4.0 billion to $2.3 billion.

Chairman Horsford said this demonstrated the part of the plan where the workers had done their part and had made adjustments that significantly affected their ability to have access to quality health care and it demonstrated it clearly in those numbers. Chairman Horsford said nobody expected them to do more than that.

Assemblywoman Smith asked how Nevada's OPEB valuation compared to other states' valuations.

Mr. Wells answered there was a wide range of states' responses to OPEB. The liability could be prefunded, which was similar to what they did with the pension plan. The state had moved down that path in 2007, and that was how the retiree benefit investment fund was established. With the crises that they faced, they had not put money in the trust fund; they had actually taken money out. Washington and Alaska were two states that had high funded rates for their retiree benefits. Other states like Nevada did it through changes in their plan design. Several states recognized it as a liability, but had not done anything to prefund it or trim benefits. In 2010, Idaho removed Medicare retirees entirely; once individuals turned age 65, they were forced out of the group insurance plan and was left on their own to manage the Medicare market. That was the third state to entirely remove Medicare retirees. Right now, every state is struggling with how to manage the long-term liability. The State of West Virginia was looking at a tax to provide a revenue stream to pay and fund the liability.

Assemblywoman Smith asked Mr. Wells if the plan design changes impact on the unfunded liability were significant in the scheme of things. Mr. Wells answered absolutely. Assemblywoman Smith said from what she had read in various publications it appeared that Nevada had made significant strides in comparison to other states.

Mr. Wells said from a benefit change standpoint, the State of Nevada had done more in benefit changes than any other state.

V-4. Assessment of Reserves.

Mr. Wells provided the Committee with a Utilization Report for the year ending June 30, 2011 (Exhibit B).

Chairman Horsford asked if Catalyst was PEBP's prescription drug provider. Mr. Wells confirmed that the pharmacy benefit manager was Catalyst. Chairman Horsford asked who actually owned Catalyst. Mr. Wells responded that Health Extras was the parent corporation of Catalyst RX. Chairman Horsford said that prescription drugs were the area where there continued to be cost increases. He asked what was being done to help mitigate cost increases.

Mr. Wells said they had met with Catalyst once a quarter, and Catalyst provided PEBP with ways to decrease the prescription drug cost. Many of the prescription drug increases were not necessarily being driven by brand names, but by specialty and orphan drugs that were extremely expensive. The only way to offset that was to have extremely high generic utilization. Mr. Wells said there were retroactive reviews to make sure people were taking drugs they needed and not ones that could conflict with other drugs they were taking. They continued looking at different things that would mitigate the inflation increase.

Mr. Wells provided the Committee with a Utilization Report for the year ending June 30, 2011, Claims Summary (Exhibit B, page 14).

Assemblywoman Smith, in summarizing the utilization report, asked for confirmation that the medical cost declined due to lower enrollment and less utilization, possibly driven by higher deductibles and the out-of-pocket expense.

Mr. Wells said the total dollar decrease was based on fewer participants in the plan as well as the utilization component for the individuals who remained. The members still had $20 co-payments for office visits, and the prescription drugs were still driven with the $5 generic and $40 name brand, but PEBP saw some utilization decreases. PEBP had a significant decrease in catastrophic events, which were high cost drivers.

Assemblywoman Smith said she wanted to make sure the cost/utilization discussion was framed correctly. She reiterated that the medical expenses were down because of reasons unrelated to medical cost (i.e., enrollment) but prescription drug costs were up. An individual may decide not to go to the doctor based on cost, but the individuals who were on certain drugs needed to continue taking those drugs.

Mr. Wells agreed. He said once a person was put on a prescription drug to manage a disease state, they generally stayed on that drug. He said PEBP had been asked if individuals were not taking their medications, if people were making their drugs last longer, or if they were not filling prescriptions due to their high deductible. Early indications were the frequency of non-compliance had not changed from the old plan design to the new one. The same percentage of individuals who were taking their drugs consistently under the old co-payment plan continued to comply with their prescription drugs. The Catalyst RX was to provide a report at the March 2012 PEBP Board meeting, which would include further details on the compliance perspective for prescription drugs.

Assemblywoman Smith said that was the point she was trying to make. She said people may decide not to go to the doctor for a follow-up visit, but they would stay on their medications. She assumed on the utilization side, which was driving the medical costs, PEBP had to be experiencing health care deferral since the deductibles and the out-of-pocket expense had changed.

Mr. Wells said they were seeing anecdotal evidence since July 2011 that individuals on the high deductible plan were waiting to see a doctor and perhaps taking over-the-counter medications that could be bought without a prescription.

Assemblywoman Smith said she did not want the perception to be that the costs were down; they were just looking at it in a different way.

Assemblyman Kirner said regarding prescription drugs, it sounded like PEBP was seeing an increase in the use of specialty drugs.

Mr. Wells said the cost of specialty drugs increased 20.4 percent from $9.5 million to $11.5 million from 2010 to 2011. Therefore, PEBP saw larger increases on the specialty and orphan drugs, which treated specific cases.

Assemblyman Kirner asked if they expected that trend to continue.

Mr. Wells answered he expected the use of specialty drugs to continue, since that was where the majority of the research and development for medications that treated rheumatoid arthritis and MS.

Mr. Wells provided information regarding the 2012 plan design. He reported the high deductible health plan had a $1,900 deductible, in which PEBP provided $700 to either a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA). Therefore if an individual met the $1,900 out-of-pocket they would only be out-of-pocket $1,200 of their own money. PEBP had 2,264 individuals as of last week who had met the $1,900 deductible and 1,408 individuals who met the individual deductible within the family. PEBP had three deductibles in its plan: a single deductible, a family deductible and a per person deductible for those within a family. There were 1,408 individuals who met the $2,400 individual family member deductible and 1,422 individuals, or 445 families, who met the $3,800 family deductible. For each dependent that was added to the plan there was an additional $200 put in their HSA or HRA. Active employees were able to contribute to their health savings accounts through payroll deductions on a pre-tax basis. There were 618 individuals who had met the $3,900 single out-of-pocket maximum and there were 891 individuals or 311 families who met the $7,800 family out-of-pocket maximum. There were 10,910 HSAs as of last week, with the average balance of $789 and 11,110 HRAs with the average balance of $511 in those accounts.

Assemblywoman Smith asked about dependent children up to age 26 being able to stay on the plan. She assumed that impact had been low, because she noticed the family size had decreased.

Mr. Wells said the actuaries had told PEBP the financial impact of covering children up to age 26 could be less than 1 percent. Mr. Wells said there were not many participants who put their children back on. Conversely, PEBP noted that some participants moved children to their spouse's plan, which could have had a better cost structure.

Assemblywoman Smith asked about evaluating claims to see if they should be workers' compensation or PEBP claims. She asked Mr. Wells if PEBP tracked those claims.

Mr. Wells said the Third Party Administrator (TPA) looked at claim information as it was received for potential subrogation. The former Risk Manager recently sat on the PEBP Board, and she had expressed concern that there was some overlap between what Risk Management was paying and what PEBP was paying. Mr. Wells said PEBP would continue to monitor both sides for correct payment.

V-5B. Transition to HealthSCOPE Benefits as Third Party Administrator.

Chairman Horsford asked about participant complaints about providers.

Mr. Wells said they had received complaints from participants, but PEBP was the second level of review. He said before a claim denial could be appealed it went through an internal review process with the TPA. Mr. Wells referred to the chart on page 284 (Exhibit A).

Mr. Wells said the appeals process was re-written to comply with the health care reform law. Now there was an independent review organization appeal process, which replaced the Board appeals with an external review. The master plan document changes had been approved, but they had not yet had a request for an external review.

Chairman Horsford asked what steps had PEBP taken to ensure that substantiated complaints were addressed at the provider network level and what efforts had been undertaken to educate PEBP participants.

Mr. Wells said PEBP was not only changing the TPA in July, but also the plan design. He said letters were sent out in late May to the provider network explaining the new plan process, the change in the TPA and how the new plan compared to the old plan. The in-person participant's outreach was started in October 2010.

V-5A. Plan Year 2012 Plan Design Outreach.

Chairman Horsford referred to PEBP outreach efforts and asked Mr. Wells to provide a breakdown of the participants from the active and retiree groups. Chairman Horsford was concerned about the complaints that had been made by plan participants. He asked who determined whether the complaints were substantiated and what efforts were required of the plan network providers to better educate those members of their concerns.

Mr. Wells said he would provide the breakdown to the Committee. He asked Ms. Lopez to address Chairman Horsford's second question, as she oversaw the appeals process.

Ms. Lopez said they had not provided the results from the appeal or the complaints that had been filed by participants. PEBP provided the individuals either a response to their email inquiry or a written response to their letter, explaining the situation, how it occurred and why the decision was made. The first six months had been a learning curve for HealthSCOPE in trying to understanding PEBP's process. Ms. Lopez said 99.9 percent of the appeals and complaints were resolved to the benefit of the participant.

Chairman Horsford asked if the providers were following the plan design as implemented, both the new changes with the high deductible and the previous plan.

Ms. Lopez said the first few months with the high deductible plan had been extremely difficult for staff and the providers. HealthSCOPE had done a lot of outreach, teaching the providers how the plan worked, how to bill properly, how to use the HRA and HSA, and teaching providers how the debit card worked.

Chairman Horsford asked Mr. Wells to continue informing the Committee about complaints or systematic issues and requested assurance that the Board would resolve them in a timely manner.

Mr. Wells said one of their highest priorities was reviewing the complaint log. Once PEBP received a complaint, it was resolved within 24 hours. Those complaints were not included on the annual report to the Insurance Commissioner. The vast majority of complaints were received and resolved within 24 hours.

Chairman Horsford said by the time complaints got to PEBP staff, there could have been many other complaints that the provider had not addressed. Chairman Horsford wanted to make sure providers were accountable to PEBP. Chairman Horsford said it sounded like there could be more transparency from HealthSCOPE.

Mr. Wells referred to Section V-5B, page 232 (Exhibit A). He said a health claim auditor would audit a randomly selected group of claims each quarter to identify systemic issues and problems. Mr. Wells said PEBP stayed on top of any systemic issues and indicated that the Third Party Administrator would address them timely.

Chairman Horsford asked if there were any current systemic issues that the Committee needed to be aware of.

Mr. Wells referred to Section V-5B, (Exhibit A, page 245). He said those were the trends/issues that were identified during the first quarterly audit of HealthSCOPE Benefits. The second quarterly audit was just completed; the Board would receive the second audit at its March 2012 meeting and make sure the previous identified issues had been resolved.

Chairman Horsford asked if there were any systematic issues that had been identified or concerns that needed to be addressed now. Mr. Wells answered not at this time.

Assemblyman Kirner asked about the TPA change, and the different process for adjudication of claims. He asked what would happen if a claim showed up under the old TPA versus the new TPA, which might adjudicate the claim differently, and whether that could result in a complaint.

Ms. Lopez said PEBP had identified some differences between how claims were processed. Ms. Lopez indicated that PEBP still had some issues. She said it would be a long learning curve, and estimated it would be at least one year before HealthSCOPE learned how PEBP's program worked and what PEBP's expectations were of HealthSCOPE.

Assemblyman Kirner asked how they were addressing the change.

Ms. Lopez said the issues that were brought to her attention were resolved within 24 hours. She said they wanted all claims processed as correctly and consistently as possible. However, with the number of claims that HealthSCOPE received, it was impossible. She thought HealthSCOPE had done a good job at listening to the participants and their complaints. Ms. Lopez said when a provider had a justified legitimate concern about how HealthSCOPE processed a claim, and PEBP staff brought it to their attention, HealthSCOPE had been responsive, and resolved the issue immediately. Ms. Lopez said she was impressed with their turnaround time when PEBP brought an issue to their attention. She said some issues took longer than 24 hours to resolve, but she was confident that HealthSCOPE was doing a good job for PEBP's participants and providers.

Chairman Horsford said he appreciated PEBP's dedication; he wanted to ensure that PEBP was owning any process with HealthSCOPE. He said HealthSCOPE was contracted with PEBP, and it was PEBP's responsibility to make sure HealthSCOPE was holding up their end of the contract. Chairman Horsford said after hearing Ms. Lopez he had confidence there was an internal process, and any individual complaints or systematic issues would be resolved. Chairman Horsford referred to the "Claims and System Audit Report for PEBP," Section V-5B, (Exhibit A, page 232). He wanted PEBP to continue reporting any systematic concerns to the PEBP Board and the Legislature as appropriate. He wanted the participants to be responded to, and he was glad to hear that was the case 99 percent of the time.

Ms. Lopez said the health plan auditor just completed the second quarterly audit of HealthSCOPE Benefits, and identified some concerns that Mr. Wells would be presenting to the Board in March 2012. She said it was important to conduct the quarterly audits, which they had done consistently for almost 10 years. Ms. Lopez said the audits were a component of the contract requirements along with performance standards guarantees and financial penalties. The health plan auditor was in the process of completing an audit with Catalyst RX, which would also be presented to the Board in March 2012. Ms. Lopez said they asked for an extension of 3 months, as the intent of the audit was to audit the previous 12-month fiscal year. Ms. Lopez asked them to audit the first 3 months of the plan year to make sure Catalyst RX was processing the claims on the high deductible plan correctly, so if any issues were identified they could be resolved before a year passed.

Assemblywoman Smith commented that TPA transitions were often difficult. It was her understanding that TPA claims accuracy often dipped during vendor transitions. She asked PEBP to confirm that HealthSCOPE's accuracy was at or above standard.

Mr. Wells answered yes and referred the Committee to the performance guarantees that had been built into the TPA contract (Exhibit A, pages 235-238).

V-5C. Report on Plan Migration Among Active Employees and Non-Medicare Retirees.

Mr. Wells provided the Committee with detailed information regarding open enrollment activity and plan migration for Plan Year 2012 (Exhibit A, page 287).

In response to a question from Assemblywoman Smith, Mr. Wells explained that a dropped call was when a person hung up before they spoke to a person on the phone.

Chairman Horsford asked Mr. Wells why the rate of self-decline doubled from 838 to 1,601 (Exhibit A, page 292).

Mr. Wells answered they had not tracked the reasons for the declines. He said it could have been individuals who had access to other health insurance or moved to their spouse's plan as a dependent. The 1,600 individuals were all presumed to be active employees that had declined insurance.

Chairman Horsford asked if there was the ability to ascertain such information going forward. He also asked why PEBP eliminated the $200 per dependent contribution as a penalty to participants who did not return a plan selection during the open enrollment period rather than dropping those dependents from coverage.

Mr. Wells answered when PEBP closed its enrollment on May 31 there were about 4,700 people who had not responded to the positive open enrollment. PEBP's Master Plan Document had stated those individuals who had not responded would be defaulted to the employee-only coverage on the base plan, which was the PPO plan with an HRA account. After the May 31 deadline, there were 1,183 participants with dependents who had not responded to the open enrollment, whose dependent coverage would be dropped. Federal law required that PEBP could not change dependents once the plan year had started. In addition, since the plan year ran from July to June, PEBP had two options: one was to remove all of the dependents and the other was to give them a second chance to add back their dependents. PEBP had done a tremendous amount of outreach for those individuals. A letter was sent via first class mail and all 1,183 were called or emailed in attempt to get a response for the second chance enrollment, recognizing their dependents would not have coverage effective July 1. PEBP received 880 responses for the second chance enrollment. However, recognizing their two alternatives, not to insure the dependents or not give them the $200 for the dependents portion of the HRA, PEBP opted for the latter.

Chairman Horsford asked if that was a Board decision.

Mr. Wells said it was not a Board decision it was an internal decision that was supported by the Board after the fact.

V-5D. Plan Year 2012 Medicare Retirees Plan Selection.

V-5F. Medicare Retiree Survey.

Mr. Wells provided the Committee with a report on the transition of the Medicare retirees to the individual Market Exchange and an example of the satisfaction Medicare Retiree Survey (Exhibit A, pages 297and 329).

Assemblywoman Smith asked if they had anything to compare to from prior participant percentage of responses.

Mr. Wells said the 40 percent response rate was extremely high. He had expected approximately 15 percent, which was a good response rate. The fact that they got almost 16 percent of their entire population was good.

Assemblyman Kirner asked if the survey was being sent to all retirees.

Mr. Wells said the survey would be sent out to all retirees who were enrolled in Extend Health.

Chairman Horsford asked how the Medicare plan options detailed in V-5D (Exhibit A) compared to non-Medicare retirees plan design in the PEBP program.

Mr. Wells said if an individual bought a Medicare Supplement Plan F, it would have covered almost 100 percent of the out-of-pocket costs for medical, and the retiree would have no other costs besides the premiums for Part F and Part B of Medicare. It was compared to a non-Medicare retiree who would pay a monthly premium as well as the deductible and co-insurance amounts for PEBP. The prescription drug plan had a deductible or the plan would pay a percentage of the drugs and go through a "coverage gap." Once the participant went through the coverage gap the drugs would be covered approximately 95 percent. The different Medicare drug plans had different coverage inside the coverage gap; some of them would cover generic drugs while others would not. It depended on what prescription drug plan was chosen as to what drugs were covered and what the deductible and out-of-pocket costs were. The health care reform would close the coverage gap between now and 2020 so it no longer existed.

Chairman Horsford asked Mr. Wells if he could provide information in writing that would show that example. He thought it would be helpful for the Committee and policy makers going forward, since there were concerns about the comparability between the two options for retirees.

V-6. Possible Plan Design Changes for Plan Year 2013.

Mr. Wells provided the Committee with a report on the Plan Design Changes for Plan Year 2013, which had already been approved by the Board (Exhibit A, page 333).

Chairman Horsford asked Mr. Wells to explain the benefit on the dental teeth cleanings.

Mr. Wells said in Plan Year 2013 the dental plan would pay 100 percent on teeth cleanings, since it was considered wellness. He said in the current plan year, the amount of the teeth cleaning was charged against the $1,000 individual dental benefit, therefore if a cleaning cost $100 and a participant also needed a root canal, filling or a crown, they would only have $900 left in their dental benefit for the year. For the next plan year, the $100 would be exclusive of the total benefit plan, so the $100 teeth cleaning would not count against the $1,000 annual maximum. It would be an increase in the benefit to the participants on the dental plan.

Chairman Horsford asked Mr. Wells to explain the policy rationale on the Obesity Care Management. He said it seemed overly prescriptive between a doctor and a patient. He asked why PEBP was setting such strict policies.

Mr. Wells said any weight loss plan would be determined between the provider and the patient, not between PEBP and the TPA. PEBP was expanding the benefits to pay some of the weight loss benefits as "first dollar." PEBP would cover claims for medically supervised weight loss at 100 percent for wellness, but PEBP wanted to ensure that individuals were actually engaged and following their weight loss treatment plan. Therefore, PEBP would not be dictating the plan, but it would be dictating that the plan was being followed per the agreement between the patient and their doctor.

Chairman Horsford asked where the policy would specify that.

Mr. Wells said it would be in the Master Plan Document. He explained it limited the eligibility for criteria, it defined "actively engaged," and for those who were actively engaged, the benefit was covered 100 percent.

Chairman Horsford asked whether being "actively engaged" would be determined between the provider and the patient.

Mr. Wells said actively engaged included four steps: 1) participating in the wellness program; 2) regular office visits to the weight loss providers; 3) commitment to a weight loss program, which was determined between the patient and the doctor; and 4) to lose weight as determined by the weight loss providers. Mr. Wells said other than participating in the Wellness Program, those requirements were all specific to the doctor and patient interaction.

Chairman Horsford stated that ultimately, if people were in shape their health would be better. Chairman Horsford wanted PEBP to allow those decisions to be made between a doctor and a patient.

Mr. Wells said they had a difficult time finding a weight loss program run by a governmental entity. He said a single weight loss program for Carson City might not have worked well in Clark County, Reno or Ely. They did not want to be too prescriptive by only allowing specific providers; they wanted to allow the patient and the doctor to set the program.

V-5E. Update on Health Reimbursement Arrangement.

Mr. Wells provided the Committee with a report on the health reimbursement arrangement (Exhibit A, page 327).

Referring to earlier discussions of plan utilization, Assemblywoman Smith asked Mr. Wells about the high deductible and the numbers he quoted on how many of the state employees had met the two levels of deductible. She stated that was a lot of out-of-pocket money and she was curious as to whether PEBP had anticipated that in its projections.

Mr. Wells said it was a significant amount of out-of-pocket and some of those people probably put money aside in their HSA or saved for it.

Assemblywoman Smith asked if PEBP had anticipated the number of people who reached their deductible amounts and had large of out-of-pocket expense.

Mr. Wells answered that PEBP did not expect to see an effect so quickly, but that was part of the plan design. He said part of the education outreach process during open enrollment was to let people know they needed to start planning so there would be no surprises to the participants. Everything in insurance is a tradeoff. For every person that was worse off, especially in the self-funded plan, somebody else was better off.

Assemblywoman Smith said she looked at the relatively small number of people who had contributed a lot on the high deductible plan. It appeared to Assemblywoman Smith that it was about $10 million in deductibles from 1,500 people.

Mr. Wells said he had not had a chance to go through the report, but it would certainly be reviewed with the actuaries as they set the rates.

Chairman Horsford said he wanted to commend Mr. Wells and his staff for their outreach efforts. He said when he was out in the rural communities he saw PEBP's notices for informational meetings all over the place. People in every part of the state were impacted by the decisions. There was not a perfect way to educate everyone, but it definitely appeared to him that PEBP's staff was deliberate in how they went about it. Chairman Horsford thanked Mr. Wells and his staff for their presentation and information. He said if there were no further questions, they would take public comment in Las Vegas and Carson City.

VI. PUBLIC COMMENT.

Dr. Jim Richardson, Nevada Faculty Alliance (NFA), said he had testified many times on those issues through the last few sessions, and he wanted to make a few comments for the record. He said they all knew that the plan changes had been dramatic over the last two sessions; they had seen the Board and staff absorb medical inflation without any increased funding. He said it had dramatically affected the health plan both for active employees and retirees, and many people thought it was to the negative. He said Mr. Wells was correct in that the plan was better for some people, but the perception on the campuses was it was hurting many people and they needed to do something to rectify the situation. He had testified before that the establishment of the HSA and HRA were a sound one and should have happened years ago, regrettably it happened at a time when many people had suffered significant salary decreases.

Mr. Richardson said he wanted more information about the dropout issue, and why it was occurring. He saw some data within the University and Community College system that showed the dropout rate was directly related to salary level with higher dropout rate for those on a lower salary. He said there may had been significant numbers of people who worked for the state and went without health care because they could not afford it, they would be doing some surveys within the system to try and find out who those people were. He stated if they saw state employees going on Medicaid they would know they had done something problematic.

Mr. Richardson said utilization seemed to be down, had it meant people were not in need of medical care or needed drugs or had it meant that some of them had not met their deductible yet. It was hard to tell exactly what that number meant, but he applauded the Board and the staff for saying on the record that the plan would spend that money down. The participants in the state health plan had suffered mightily in terms of cuts of benefits and increased cost. In addition, he applauded the proposal that was made to maintain the premium levels at the same level for the second year of the biennium. He trusted the funds would be expended in ways to assist the participants in the plan. The Board had the authority to increase contributions to the HRA and HSA funds if they ended up with more funds toward the end of the year. He said he was glad the survey regarding the shift to the Medicare exchange was being sent out; he said many of those people would find that they were better off being on Medicare than on Nevada's Health Plan. He was glad there was a serious effort being made to survey all of the retirees that had been shifted. Mr. Richardson had heard shortly after individuals had signed up their premiums would be going up 19 to 20 percent within a few months, which was disturbing to him. He encouraged the Legislators to continue with an open mind during the entire process on how the Medicare retirees had been dealt with, and reviewing the possible ways to assist the Medicare retirees in the future. He thanked the Committee for allowing him to make his comments.

Marty Bibb, Retired Public Employees' of Nevada (RPEN), wanted to thank the Legislature, the Money Committees, and both chairs that were represented on the Interim Retirement and Benefits Committee. He said they were thankful for the decision that was made in the closing days of the 2011 Session, on having PEBP report twice per year on the issues of how the Medicare Exchange was working. He said it was a dramatic change for a number of people for whom things like HRAs and HSAs and Part B was difficult to comprehend. He said the staff at RPEN was in the process of developing a questionnaire that would be sent to retired public employees in the PEBP plan. Mr. Bibb said they anticipated receiving some response back to help the university and the PEBP system. He said perhaps some individuals who were on Medicare might be better off in an exchange than in the consumer driven health plan, which was a significant change for not only active but also early retirees. Mr. Bibb said if an individual was moved to the Medicare exchange they lost some of the benefit of being comingled with actives and early retirees and would lose some of the benefit of rate setting. There were many concerns that RPEN had and they were hoping to get some information back that would be shared with PEBP and the Committee in terms of how the health reimbursement accounts were working. He thought the decision of using some of the excess reserves was a good idea. Mr. Bibb said Nevada was the first state to send its Medicare retirees to a Medicare Exchange, although there was a great deal of complexity that went along with it.

Mr. Bibb said he looked forward to working with the Committee through the process and getting out the best information, they could. There were many complex decisions to be made, particularly for Medicare retirees in the plan, due to the age of the membership there could be additional challenges because of the physical deterioration. A large number of the individuals were older than 80 and many did not have computers; therefore, the challenge would be more complex.

Mr. Bibb said they were heartened to hear of the healthy investment return PERS had received in the past fiscal year. They thought it was a sound system, efficient and well balanced. Nevada was 1 of 13 states whose retirement systems did not include a Social Security component, the health of the system was extremely important, the system returned approximately $1.0 billion a year to the state's economy. Mr. Bibb thanked the Chair and the Committee, and said he would answer any questions.

Assemblywoman Smith requested that the Committee receive a re-cap of the survey that Mr. Bibb was doing with their members. Mr. Bibb said he would and anticipated receiving results within a month.

Jack Harris, Retired Public Employees of Nevada, referred to the Health Reimbursement Arrangement, he said each individual was implementing the process a little different. He submitted his co-pays to see how and if the process was working correctly, and it was. He submitted a request at 11:58 pm on a Sunday night and received a response back Monday morning stating it would be credited by Tuesday, and it was. He had not submitted any request on his prescription drugs because in the past it had been a budgeted item. Mr. Harris said he was keeping the excess in his account in case there was a substantial catastrophic event.

Mr. Harris said the main reason he wanted to speak was to tell the Committee about an issue that came up before the Board. He referred to Medicare, the non-state, non-Medicare, pre-Medicare pool that was being impacted. In December 2011, those individuals received a letter from the Board reminding them if they chose to return to their previous employee insurance program it would have to be done in an even numbered year, and the dead line was January 31, 2012. If an individual had not made the change, they would have remained in the PEBP program. When the Medicare retirees were moved to the Medicare Exchange it greatly reduced the number of members in the pool. Mr. Harris said the retired public employees had a Legislative Insurance Committee and he was the Insurance Executive. PEBP requested they contacted their former employees, and when they did, they found out that the cost to them would be substantially greater than what it was currently. The problem they encountered was not knowing the new rates that would not be set until March 2012. Mr. Harris said Aon stated at the January Board meeting the trend for the active members were at a 4 percent increase the trend for the non-state, non-Medicare and pre-Medicare were at a 24 percent increase. Therefore, their premiums could go up 24 percent, they only had two choices, either the rates went up according to the trend or they kept the rates and used the excess reserve to help stabilize the rates.

Mr. Harris said in 2009 individuals who were in other entities or state employees were given the option to join the PEBP insurance program, which established a state pool and a non-state pool. According to the author of the legislation, it was never his intent to continue the two pools, that over a period it would be comingled, he said when the Medicare was taken out the comingling of the non-state retirees had greatly reduced to 330 members. It was a pool that would not be increasing in membership, but would become smaller and smaller, and the increase of premiums would go up substantially each time the rates were set. Another question that came up was legislation considering taking the non-state retiree pool and comingling them in the future with state employees, non-state employees, non-Medicare and pre-Medicare.

Mr. Harris said that suggestion had been presented to PEBP, who was addressing it. He said we would like it to be considered by the Committee as an informational item as we move forward into the Legislative Session.

Chairman Horsford thanked Mr. Harris for his input.

Peggy Lear Bowen, speaking as an individual, referred to the health care of retirees and the health care program as provided by the State of Nevada. She said when she began her 35-year teaching career in the State of Nevada one of the benefits provided was PERS. She said she honored and respected the state by being an honorable employee as long as she served the state. She said state benefits or money that was paid to retirees was often interpreted as a gift, and she thanked Senator Horsford for saying it was an earned benefit.

Ms. Bowen said with direction and guidance from PEBP staff the Board provided a new program, so new it did not exist for any other state in the union. She said it was experimental to the point that the Board included the caveat "if this does not work we could rescind," out of the formula they took out competition, and going out to bid. She knew individuals that were choosing not to seek medical care or not to take their medication that were in the program as A and B Medicare recipients. Individuals chose to pay their rent, buy food and clothes over taking medications that kept them alive. There were people going to the meetings for eight years who were not here today because they had given up.

She said Senator Horsford wanted direction regarding the obesity and the complexity of how they were handling the obesity plan. The disabled had disabilities that kept them from doing certain things, such as exercise. The Board was presented with a benefit of membership to a health club, PEBP considered it as a members benefit, and it was denied. She credited the Board for continuing to work on that issue. She said overweight people could do things to make their conditions better, osteoporosis, bone density increase, cholesterol lowered, and their heart rate brought down. She said the plan was more micro managed then it appeared. She was opposed to signing a four-year contract, she wondered how many people would not take their medications, how many people would not go to the doctor.

Ms. Bowen said the whole program was predicated on one concept and that was the Governor said the spending had to be reduced, that far exceeded what the PEBP program was asked to reduce their expenses by. Ms. Bowen said in today's meeting she heard the reserves would be brought down as the insurance premiums went up. She said people would not go to the doctor because they could not pay the initial deductible even though they received a credit card for $700 to help. There was outreach to the individuals on A and B Medicare, but where was the outreach for the people who remained. She said the pool was smaller, so it would cost individuals more to have an insurance program with the state. Ms. Bowen asked what happened to the state in control of their benefits, costs and their program.

Ms. Bowen said if PEBP wanted to continue with the Medicare Exchange, if they wanted to continue to divide pools, if PEBP wanted to be an employer who provided a benefit to their employees and their retirees, then they needed to include markets, comparisons, and competition. There was not a waiver given to anyone who was age 65 or on A and B Medicare. Ms. Bowen said she was one of the few people that came to the meetings to speak, she asked how many people do not know who to call, would not call, or afraid to call.

Ms. Bowen said Nevada needed to take back the reins of their plan and be in control. She said Nevada was a great state and employers chose to provide benefits to their employees and their retirees. Ms. Bowen said when she heard on the "Today Show" that PERS was among the top five retirement programs in the nation and that Nevada would never run out of money, while other states were going broke, she knew that Nevada had done it right. She knew the Committee had Nevada and its workers in their heart and in their best interest. She thanked the Committee for their patience and for listening to her comments.

Chairman Horsford thanked Ms. Bowen for her comments. He said on behalf of the Committee, many of the decisions that had been made by the Board, the Governor and the Legislature over the last couple of years had been difficult. Chairman Horsford said one of the reasons the Committee existed was to ensure they understood any impact, positive, negative or unintended consequences. He said it was part of the reason the review was so thorough and why the PERS and PEBP Board and management were asked to be at the meeting. He said he would encourage any person who was listening or participating in the meeting, an employee who had a concern, issue, complaint or unintended consequence of the policy to come forward, to complete the surveys and make sure their voice was heard. Chairman Horsford said they could not fix something without hearing directly from those who were impacted. He said the Committee and the next Legislature would do everything they could within the parameters they had available to ensure they correct any unintended consequences of Legislation or policy that was enacted. He appreciated their voice and the voices from the public. He asked everyone to complete the surveys that the system and RPEN had put out and any other organization that was trying to hear from the needs of state employees including the American Federation of State, County and Municipal Employees (AFSCME).

Chairman Horsford asked if there were any other comments from members of the Committee. Chairman Horsford thanked everyone and the LCB staff for their help in the coordination of the meeting, and the presenters.

VII. ADJOURNMENT.

Chairman Horsford adjourned the meeting at 1:09 pm.

Respectfully submitted,

_____
Tracie Battisti, 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.