MINUTES OF THE MEETING
OF THE
ASSEMBLY COMMITTEE ON GOVERNMENT AFFAIRS

Seventy-Ninth Session
February 9, 2017

The Committee on Government Affairs was called to order by Chairman Edgar Flores at 8:30 a.m. on Thursday, February 9, 2017, in Room 4100 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4404B of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/App/NELIS/REL/79th2017.

COMMITTEE MEMBERS PRESENT:

Assemblyman Edgar Flores, Chairman
Assemblywoman Dina Neal, Vice Chairwoman
Assemblywoman Shannon Bilbray-Axelrod
Assemblyman Chris Brooks
Assemblyman Richard Carrillo
Assemblyman Skip Daly
Assemblyman John Ellison
Assemblywoman Amber Joiner
Assemblyman Al Kramer
Assemblyman Jim Marchant
Assemblyman Richard McArthur
Assemblyman William McCurdy II
Assemblywoman Melissa Woodbury

COMMITTEE MEMBERS ABSENT:

Assemblywoman Daniele Monroe-Moreno (excused)

GUEST LEGISLATORS PRESENT:

None

STAFF MEMBERS PRESENT:

Jered McDonald, Committee Policy Analyst
Jim Penrose, Committee Counsel
Patricia Keyes, Committee Secretary
Lori McCleary, Committee Secretary
Carol Myers, Committee Secretary
Cheryl Williams, Committee Assistant

OTHERS PRESENT:

Jeffrey Fontaine, Executive Director, Nevada Association of Counties
Dagny Stapleton, Deputy Director, Nevada Association of Counties
Tina M. Leiss, Executive Officer, Public Employees' Retirement System
Steve Edmundson, Investment Officer, Public Employees' Retirement System
Christopher G. Nielsen, General Counsel, Public Employees' Retirement System
Damon Haycock, Executive Officer, Public Employees' Benefits Program
Kent M. Ervin, Legislative Liaison, Nevada Faculty Alliance
Priscilla Maloney, Government Affairs Retiree Chapter, American Federation of State, County and Municipal Employees, AFL-CIO, Local 4041
Marlene Lockard, representing the Retired Public Employees of Nevada
Kevin Ranft, Labor Representative/Lobbyist, American Federation of State, County and Municipal Employees, AFL-CIO, Local 4041
Vicky Cameron, Private Citizen, Las Vegas, Nevada
Peggy Lear Bowen, Private Citizen, Reno, Nevada

Chairman Flores:
[Roll was called and rules and protocol were explained.] I would like the Nevada Association of Counties to please come up for their presentation.

Jeffrey Fontaine, Executive Director, Nevada Association of Counties:
It has been my honor to have served the Nevada Association of Counties (NACO) as their Executive Director for the past ten years. With me this morning is Dagny Stapleton, who is our Deputy Director. She has done an amazing job in representing NACO at the Legislature since 2013.

I would like to give you some background on NACO and our counties and then talk about our 2017 legislative priorities. Nevada Association of Counties was formed in 1924 as a Nevada association of county commissioners. Today, all 17 counties are members. We are the state association for county government officials and their staff. We are also an affiliate of the National Association of Counties. They represent the nation's 3,069 counties. Nevada has two representatives on the national board. We are also very well represented on various policy steering committees at the national level that set the American County Platform.

At NACO, it is our belief that county government, being closest to the people, has the best opportunity to make a positive change and lead our communities into the future. We work to provide our counties with the resources to achieve this end.

This is the makeup of our NACO Board [page 3, Exhibit C)]. It consists of a commissioner from each county. The commissioners who represent Nevada on the national association's board and the Western Interstate Region Board are also on our board. We also have representatives of our affiliate county associations, such as the assessors and treasurers. They are an integral part of NACO. Our leadership team this year, which is really our executive committee, is made up of commissioners representing both urban and rural counties. Lastly, I would be remiss if I did not recognize our former NACO President from Elko County, Assemblyman John Ellison.

This is a list of our statutory committees [page 4, (Exhibit C)]. They include members either appointed by NACO, nominated by NACO, or appointed by the Governor.

Nevada Association of Counties staff represent counties on numerous committees. These committees have a direct impact on county services in our communities. This is a list of some of those committees [page 5, (Exhibit C)].

I will cover the highlights of what we do at NACO. There is outreach to policymakers, such as yourselves, and the public to provide information about county programs and services. This is done through our website, social media, weekly e-news, and other forms. Collaboration with various federal and state agencies is an important activity and a vital role that we play at NACO on behalf of our counties. As an example, on the federal level we collaborate very closely with federal land management agencies, so counties can have an opportunity to be more effective in influencing land management decisions within their borders. On the state level, we work closely with the Department of Health and Human Services, the Nevada Hospital Association, and others. We do this to maximize the use of county tax revenues to leverage additional Medicaid dollars that can then go out as supplemental payments to hospitals in our communities.

Advocacy on behalf of our counties is our core duty. This includes our work with the Legislature, and work on federal issues. We coordinate with our congressional delegation and the National Association of Counties to monitor and weigh in on proposed legislation and agency rulemaking at the federal level. I am proud to say that NACO members and staff have been invited to testify before congressional committees on a variety of issues.

Lastly, NACO provides leadership development training for county elected officials and their staff. Some examples include our annual educational conference, various workshops that we conduct, and a county commissioner handbook that we issue. We also partner with Extended Studies at the University of Nevada, Reno to offer a Certified Public Official Program.

Nevada's counties are diverse in geography, economy, and culture. They make up the fabric of our great state. There is a stark contrast in the size and economies of our counties, which

create challenges in crafting policies that are both workable and effective in all counties. In the past, the Legislature has used population caps to address disparities amongst counties. The vast amount of public lands in some of our rural counties presents challenges to their sustainability. Even though the economies in our counties vary, we are happy to see that this year unemployment is lower in all of our counties compared to this time last year. Population is up in nine counties, including our two urban counties, Clark and Washoe. However, we do see declining population in eight of our rural counties. Those are primarily mining counties.

Nevada Counties Matter (Exhibit D) is a part of our outreach effort to educate people about county services. I want to highlight three of the points. Note that under "Transport," Nevada's counties maintain more than 65 percent of the state's roads. Under "Keep Nevadans Healthy," counties invest more than $882 million in community health and hospitals. Under "Fund and Conduct Elections," counties oversee over 550 polling places for federal, state, and county elections.

The page listing state and county service providers (Exhibit E) is here to emphasize the important role that counties have as well as to illustrate their partnership with the state in the delivery of a variety of services.

This slide [page 10, (Exhibit C)] lists the combined revenues and expenditures in aggregate for all counties, shown from largest to smallest. Property taxes are the largest source of revenue. Counties collectively spend most of their money on public safety. In some counties the consolidated tax distribution may generate more revenue than property tax. What I want to emphasize about county revenues is that they are relatively flat—most notably property taxes. By almost any metric, property taxes are now less than what they were prior to the Great Recession. At the same time, there is population growth and higher demand for services, which is driving expenditures upward.

Every year NACO develops a priority list of issues. We will share this 2017 list [page 11, (Exhibit C)] with our congressional delegation during our Capitol Hill visits in March. We will continue to work on these priorities with our congressional delegation during the year.

That brings us to our 2017 legislative priorities [page 12, (Exhibit C)]. Preventing unfunded mandates and cost shifts is important. This is our mantra every session, but I wanted to bring it up this year because counties are still paying the tens of millions of dollars in costs shifted to them in 2011. The result of this has been, in many counties, a reduction in county services. I am here to say that the counties cannot afford to take on any new unfunded mandates or cost shifts. Some of our legislative priorities include trying to roll back some of those cost shifts enacted in 2011.

Maintaining county authority is important for counties. It gives them the flexibility to be effective and efficient. We certainly appreciate the Legislature approving Senate Bill 29 of the 78th Session which gave counties limited, functional home rule.

Pursuant to that measure, we provided you with a report on how the counties have used this additional authority to be more responsive to their constituents (Exhibit F).

There are three NACO bills for this legislative session [page 13, (Exhibit C)]. As I mentioned, property tax revenue is one of the largest, if not the largest, revenue source for each county. In many counties it is nearly flat despite rising property values. This fiscal year, six counties will have property tax caps of 0.2 percent. This is due to issues with a formula that determined what the annual caps on property taxes are. Assembly Bill 43 revises the threshold to which the amount of the cap cannot drop to 3 percent. It also adds a rolling average to the Consumer Price Index, which is used to calculate the secondary cap. Assembly Bill 43 does not remove or increase the 3 percent or 8 percent caps, nor does it change the property tax rate.

Assembly Bill 16 is in regard to the University of Nevada Cooperative Extension program. This program is through the University of Nevada, Reno (UNR). Nevada's counties pay about 40 percent of the cost of the program. That is the largest funding source for cooperative extension. The state contribution is far less than the county contribution since it was cut by over 70 percent in 2009. In light of this and to ensure that the program is prioritized, NACO would like to have UNR provide a report regarding a funding plan for cooperative extension as well as other elements of the program that are important to the counties. The counties believe that there should be a funding parity between the county contribution and contributions from the Nevada System of Higher Education as the program is as much, or more, of a university program than it is a county program.

Lastly, is Senate Bill 8. One of the cost shifts enacted in 2011 requires Nevada counties to pay for 70 percent of the cost of producing presentence investigation reports (PSI). These reports are prepared by the Department of Public Safety. They are used by district court judges; however, we believe that the realistic benefit to the counties is much less than the 70 percent of the cost they are paying. A more representative portion of the use by the district court judges of the PSI is 30 percent. Furthermore, there are instances where the state is not completing these PSI reports on time, which requires individuals to remain in jail, and increases the cost to counties. Senate Bill 8 proposes to change the rate paid by counties to cover the costs of preparing those reports from 70 percent to 30 percent. It also authorizes the county to prepare PSI reports at its own expense or enter into a performance agreement with the state if it pays the total cost of the PSI.

There are other legislative matters that are important to the counties that we will be following. I am going to highlight three of them. Indigent legal defense: We are seeking to reduce the costs for counties to provide legal defense for the poor. This is a significant and growing cost that has been shifted to the counties over time even though the provision of indigent legal defense is a constitutional obligation on the state. Recreational marijuana: Now that Question 2 legalizing recreational marijuana was passed by the voters, we want to make sure the impact to counties is considered in any subsequent funding decisions and the policies that may be considered this legislative session. Lastly, transportation infrastructure: Funding for roads in the rural counties where there is no motor vehicle fuel indexing is

a major concern. The backlog of roads that require maintenance is growing which, if not addressed, will result in higher costs to the taxpayers for reconstruction.

That concludes our presentation this morning.

Chairman Flores:
I would like to remind our members that we are going to have an opportunity to fully vet every bill they mentioned. I would prefer that we restrain from asking questions about specific bills until they are before our Committee. However, any other questions pertaining to the presentation or something that you would have liked to have seen and you did not or you would like to bring up, now is the time to take the opportunity to do that.

Assemblyman Ellison:
Do you think the payment in lieu of taxes (PILT) program will stay the way it currently is when it is heard in the congressional session? It has been funded over the past many years, but I am unsure if it is on a five-year funding cycle. Where is PILT funding right now?

Jeff Fontaine:
The PILT program was fully funded last year. It is an annual appropriations process. There is no full funding for PILT authorized beyond the annual appropriations process. We understand that PILT is in the continuing resolution to be funded at the same level as last year, but again, it is subject to annual appropriation.

Assemblyman Ellison:
When does that come up?

Jeff Fontaine:
I am not exactly sure where they are at in the federal budget process. We will get back to you on that.

Assemblyman Ellison:
The PILT program is going to be important this year mostly for some of the rural counties. Have you received any data about whether any county is using home rule right now? Can I get a copy of where they used home rule, how they used it, and how it came out?

Jeff Fontaine:
That report was provided (Exhibit F). We will be available to answer any questions you may have now or at a later date.

Assemblywoman Bilbray-Axelrod:
I have a question about the Cooperative Extension program. The exhibit page referred to UNR. I was under the assumption that because it is a Cooperative Extension program, it was a joint venture between UNR and the University of Nevada, Las Vegas (UNLV). Was the exhibit just pointing out that it was the least restored existing program at UNR or do we refer to it as a UNR program?

Jeff Fontaine:
The Cooperative Extension program is actually housed at UNR because it is the land grant institution. To what extent there are some programs in cooperation with UNLV is something that we will need to get back to you about. The program is housed at UNR, the land grant institution.

Assembly Bilbray-Axelrod:
There is a bit of a discrepancy in that UNLV is also a land grant institution. We do have a campus cooperative extension with very healthy programming. I would beg to differ that we, too, are a land grant institution.

Jeff Fontaine:
I do know that has been a subject of debate, and that there is a cooperative extension office in southern Nevada. There is one in practically every county. I am not taking a side on that debate. I am just letting you know that, as far as we are concerned, for the purposes of our bill, it is at UNR.

Assemblywoman Neal:
In reference to your page on expenditures, I would like to delve into that further. In terms of public safety expenditures, what is the difference in the growth between 2010 and 2015, and what are the anticipated expenditures in 2017? Do you know the percentage? How you have grown or not grown?

Jeff Fontaine:
I was unable to gather that information because we are still in the current fiscal year. In 2015, the chart indicates public safety expenditures in the range of 35 to 36 percent of county budgets. I will gather the information you are requesting and provide it to you.

Chairman Flores:
I have had an opportunity in other presentations to talk about federal funding and grants. Could you give me more insight on what we are doing: where we are; who is in charge; and how many people do we have trying to go after federal dollars?

Jeff Fontaine:
The biggest issue as far as federal funding is concerned for the counties collectively is the PILT program that Assemblyman Ellison referred to. When that program is fully funded, it is about $26 million a year to Nevada's counties. For some of our rural counties, it means the difference between them being able to balance their budgets or not. We spend a lot of time lobbying and advocating and working with the National Association of Counties and our congressional delegation to make sure that those dollars are approved for our counties. Beyond that, NACO does not actively seek federal grants. We do provide information to our counties about the federal grant process, but for most of our rural counties, they do not have the capacity to apply for federal grants. We help them if we can. There are a couple of programs through the U.S. Federal Highway Administration. Through these programs, we

have been able to get some dollars to some of our rural counties and to other areas including Clark County and Carson City. The funding was for transportation project improvements on federal lands and things of that nature. Beyond PILT and a few of those minor grant programs, we are not actively seeking federal grants. We just do not have the capacity to do that at NACO. Again, our rural counties really do not have the capacity either.

Chairman Flores:
Do our counties share information on federal dollars they are getting? In other words, County A applied for a grant, and it worked out. Do they share that information with other counties to let them know that there was an opportunity that they took advantage of, and they recommend that all the other counties take advantage of that? Is that information being shared?

Jeff Fontaine:
Probably not in a formal way. Through our association and at our board meetings and in information that we provide, either informally or formally through our weekly newsletter, we may highlight some of those grants. I think it is being done but not in a formal way.

Assemblywoman Neal:
I have a question on the home rule report (Exhibit F) about the portion where Clark County used home rule in order to address graffiti abatement. The report says that they also addressed civil infractions for sidewalk violations and annexations. Can you give me more information? What were the end results? Were there fines? Last session we heard two bills, Assembly Bill 493 of the 78th Session and Senate Bill 56 of the 78th Session, related to home rule and restitution that would be paid to mitigate the cost of cleaning up graffiti. What were the outcomes of home rule specifically as it relates to graffiti?

Dagny Stapleton, Deputy Director, Nevada Association of Counties:
I compiled the home rule report (Exhibit F) and can answer some questions. The summary on the ordinance that Clark County passed was provided to us by their district attorney. Beyond what you see here and in terms of what the outcomes were and the effects of that ordinance, we can get you that information. I will have to defer to Clark County staff on that. I would be happy to answer any other general questions you have about this report, or the home rule exercised by the counties.

Assemblywoman Neal:
If you could please provide that. I want to make sure that there was not an activity that occurred through the use of home rule where there was a bill that we did not necessarily favor, how graffiti was going to be treated.

Chairman Flores:
We will have Clark County here next week. It will be easier to get at some of the questions pertaining to them at that time. I know that home rule down south has served a different role and it has played out differently, and the interaction has been different as opposed to other counties. I think that conversation will be interesting. Are there any other questions? As a reminder to everybody, make sure that you keep their contact information. They are going to be a great resource to you throughout this Committee for the next 117 or 116 days that we have. Would the Public Employees' Retirement System please come up.

Tina M. Leiss, Executive Officer, Public Employees' Retirement System:
I am the Executive Officer of the Public Employees' Retirement System. With me, to my left is Steve Edmundson; he is the Investment Officer. To my right is Cheryl Price; she is the Operations Officer.

The Public Employees' Retirement System (PERS) was created by the Legislature in 1947 to fill a void in our state. Public employees in our state had no retirement program. In 1947, public employees, as today, could not participate in Social Security. This was because the federal government felt that they could not tax state treasuries, so there was a prohibition against public employees in Social Security. Today it is because Nevada has chosen to keep our employees out of Social Security.

In 1947, the Legislature created PERS and gave us our mission [page 2, (Exhibit G)]. That mission still holds true today. We have essentially three jobs that we are charged to do. The first is to provide public workers and their dependents with a retirement program that provides a reasonable base income for retirement or for periods where disability has removed their earning capacity. The second portion of our mission is to encourage workers to enter into public service and remain in public service. We call this the attract-and-retain portion of our mission. This gives the people of our state the full benefit of the worker's training and experience. As you are probably aware, turnover is very costly in a lot of our public sectors. We want to be able to keep good people on the job once they are trained. Finally, we also provide an orderly method of promoting and maintaining a high level of service through an equitable separation process. Once the time comes for retirement, we want to be able to ensure that our members are financially able to retire. This also allows for promotion up through the ranks for our younger workers.

Funding of PERS is governed by the *Nevada Constitution* (Article 9, Section 2). We have a couple of provisions that pertain to us [page 3, (Exhibit G)]. The *Nevada Constitution* created PERS as a trust fund. Our money is segregated, and our money may only be used for the purpose of paying our benefits and administering the program. It cannot be used for any other purposes. The protections that PERS has within the *Nevada Constitution* were the result of bipartisan efforts made during the 65th and 67th Legislative Sessions. In 1996, 70 percent of Nevada voters approved the constitutional amendments. These amendments ensure that PERS money can never be loaned to the State of Nevada, and we can never buy any obligations of the state. This means that we cannot purchase state bonds.

The other part has to do with the governance of the system. The *Nevada Constitution* dictates that we be governed by a Public Employees' Retirement Board, and the board shall employ an executive officer that serves at the pleasure of the board. Another important requirement is that the board employs an independent actuary and adopts actuarial assumptions based on the recommendations of the independent actuary. This is important. It ensures that our funding process stays appropriate, and we remain uninvolved in any political processes.

What is Nevada PERS [page 4, (Exhibit G)]? We are a constitutionally created trust fund for the purpose of paying retirement benefits to our public employees. We are a multiple employer, cost-sharing, defined-benefit plan. All of the public employers in the state of Nevada participate in our plan equally, and they share the cost. The benefit structure is the same. We have police and fire in one fund, and we have the regular fund. The police and fire have a different benefit structure. Otherwise, all of our employees have the same benefit structure. They are pooled together. That is important because in 1947 when we were created, we did not have a lot of public employees, and we did not have the ability to put the system together very economically unless we were able to pool all public employees. At this point, we are all still pooled together. "Cost sharing" means that we all pay the same costs, and we all have the same liability. Every public employer pays the same contribution rate, as does every public employee. "Defined benefit" means that the benefit paid to the member is specifically defined. That benefit is a monthly benefit paid to the member for their entire life. They cannot outlive their savings. That is very important because our people do not have Social Security. Finally, PERS is a human resource tool. We give our employers a way to design a program that best attracts and keeps their employees.

The benefits are based on a statutory formula that includes the member's length of service, their average compensation, which is the average of their highest 36 consecutive months of compensation (typically, their last three years of employment), and a service time multiplier. As an example, a public employee with a membership date of 2010 with 10 years of service will receive a 2.5 percent multiplier for every year of service. This will provide the public employee with a benefit that is 25 percent of their average compensation. It is a lifetime benefit.

We do have vesting requirements. Our members vest after five years. Once they attain certain service levels or age, they can retire and collect a lifetime benefit. Our members also have the ability to name a beneficiary. If a member names a beneficiary to receive a benefit after they pass away, their benefit is reduced. This ensures that the member pays for the beneficiary coverage.

I would like to briefly talk about some changes that were made to the benefit structure in Senate Bill 406 of the 78th Session. In general, this bill enacted benefit reductions to the program. I do not want there to be misconceptions about that because a lot of what the bill did was, essentially, roll back some benefit improvements that had been made starting in the

late 1980s, into the 1990s, and up to 2001. Senate Bill 406 of the 78th Session put our structure back to where we were in the late 1980s. When those benefit improvements were put into place, they were not necessarily funded in the contribution rate.

We now have the benefit structure that we thought was appropriate in the 1980s, and it is completely funded within the contribution rate. What S.B. 406 of the 78th Session did was change eligibility. It raised retirement age. In the regular fund, anyone hired prior to July 1, 2015, can retire at any age with 30 years of service without benefit reduction. That was a provision that came into place in 1989. Prior to that, a member could retire with 30 years of service at age 55. Senate Bill 406 of the 78th Session took it back to age 55 with 30 years of service. A member may also now retire at any age with 33 1/3 years of service. Extending a public employee's career was the intent behind the legislative changes. It should be noted that because longevity is increasing for our membership, the length of time a person receives a benefit is going to be about the same. People are living a little longer. If they retire a little later, they are in a retirement period for a similar length of time as earlier retirees who do not have as much longevity.

The next component used in determining the monthly benefit is the service time multiplier. For service earned on or after July 1, 2001, the service time multiplier is 2.67 percent per year for every year of service. In 2010, the service time multiplier decreased to 2.5 percent. A public employee who first became a member on or after July 1, 2010, has a benefit based on the 2.5 percent service time multiplier. In 2015, the service time multiplier was reduced to 2.25 percent. A public employee who first became a member on or after July 1, 2015, has a benefit based on the 2.25 percent service time multiplier. With the 2.5 percent service time multiplier, it took 30 years to attain the maximum 75 percent benefit. With the 2.25 percent service time multiplier, it takes 33 1/3 years. Again, this change effectively extends a public employee's career and ensures that we are keeping people on the job longer.

Purchase of service was also changed. A member may purchase up to five years of service. With the 30-and-out provision that we had prior to 2015, you could purchase 5 years of service and retire without an early retirement reduction after 25 years of service. Now purchased service does not count towards retirement eligibility. Service may be purchased to increase the benefit but cannot be used to allow a member to retire earlier.

The 2015 plan changes included a salary cap. The cap on the salary is $200,000. That is the maximum amount that can be reported to us and on which a member's average compensation can be based.

Post-retirement increases that we pay our retirees after retirement were also reduced to levels more akin to what we saw in the 1990s. There was also a benefit forfeiture provision for certain felonies committed by public employees and public officials related to their jobs. The forfeiture is specific to job-related felonies. This particular bill, S.B. 406 of the 78th Session, unlike the changes in 2010, also applied to the two other retirement systems that we administer, the Judicial Retirement System and the Legislators' Retirement System.

Two other provisions I wanted to mention from S.B. 406 of the 78th Session were not benefit reductions. Everyone has a survivor benefit. If a member is killed prior to retirement, their eligible survivors, generally a spouse or, if unmarried, a designated survivor beneficiary and minor children, would receive a benefit. The issue that came up with those killed in the line of duty is that they do not necessarily have a lot of service credit. The survivor benefit is calculated the same as service retirement. We were seeing instances where the service credit the member had at the time of job-related death was low. This factor resulted in a low base survivor benefit. An enhanced benefit provides the spouse or survivor beneficiary of members who are killed in the line of duty with a threshold benefit of 50 percent of the member's average compensation. They may also elect to receive the calculated benefit based on total service credit and monthly average compensation or elect a lump-sum payment. Generally, for those with lower service credit, the 50 percent of salary benefit is greater. Since this law went into place, we have had a couple of work-related deaths. The benefit paid to each of the beneficiaries was triple what the benefit would have been had the deaths occurred prior to the plan change. Fortunately, there are very few people that this applies to, so the benefit change did not have any funding impact.

The other plan enhancement is related to critical labor shortages. Within our statute is a provision that allows our public employers to designate certain positions that are difficult to fill, as critical labor shortage positions [*Nevada Revised Statutes* (NRS) 286.523]. If they designate a position as such, then the employer is able to hire our retirees into that position. Otherwise, if they hire a retiree, the retiree's benefit would be suspended. Under the critical labor shortage position statute, an employer can hire a retiree if they have no other options. We see this used mostly in the education field. Rural bus drivers, special education teachers, and math teachers are typically the positions that are designated as critical labor shortage positions. Statutory provisions regarding critical labor shortage positions were scheduled to sunset on July 1, 2015. Senate Bill 406 of the 78th Session extended the critical labor shortage provision within our statute permanently.

Next we will talk about our cost sharing structure [page 8, (Exhibit G)]. The approximately 105,000 members of the system pay half of the contribution rate, which is represented as one-half of the circle. The public employers are represented on the other half of the circle. The largest slice on the employer's side is the Clark County School District. They have about twice the number of employees as the State of Nevada, which is the next largest employer. Washoe County School District is the third largest employer followed by Clark County then the Las Vegas Metropolitan Police Department. The final portion of employer contributions are paid by the remaining 197 employers who participate in our system. As represented by this chart, half the contributions are paid by the members and the other half are paid by the public employers, which are represented on a relative basis.

Here is a brief profile of our membership [page 9, (Exhibit G)]. As of June 30, 2016, when we did our last valuation, the regular fund had 93,000 members, up from a little over 91,000 members the year before. This is important to us. We receive contributions as a percentage of payroll. As the membership increases, the contributions we receive as a percentage of payroll increase. That is part of our funding assumptions. From about 2008

until two years ago, our active membership had been declining each year. We still have fewer members than we had in 2008, but we are close to the level that we saw in 2008. The average age of a regular member is about 46 with about 9.9 years of service. We did see the average salary increase from 2015 to 2016. That was the first year in many years that we have seen an increase in salaries. Before we were seeing yearly salary decreases.

The Police and Firefighters' Retirement Fund is for police officers and firefighters as specifically defined within our act [NRS 286.061 and NRS 286.042]. The purpose of this fund is to allow earlier retirement for those members of our public workforce who are responsible for protecting the public from physical harm. The goal of this fund is to allow early retirement, so we have a more youthful and vigorous front line public safety force. As noted, our police and fire members have a lower average age and a higher average years of service [page 10, (Exhibit G)]. It is a much smaller fund. The regular fund has about 93,000 members; the police and fire fund has about 12,000 members. The average salary of a police and fire member is quite a bit higher. One misconception we have is that we have early retirement for police and fire members as a reward for their hazardous duty. That is not the case. The reason for early retirement is to protect the public. Police officers and firefighters are compensated for hazardous duty in the salaries they are paid by their public employers.

We pay four different types of benefits from each fund [page 11, (Exhibit G)]. In the regular fund, a service retiree is generally a person who works 20 to 30 years and then retires. We have about 45,000 service retirees currently receiving monthly benefits. The average age of a service retiree is 69.5 years old with an average benefit of $2,800 per month. We have a disability program for those people that are still on the job but are unable to perform their job duties. They receive just their calculated benefit, which is based on total service credit and monthly average compensation. These are the same factors used when calculating service retirement. The disability benefit that a member receives is not reduced for early retirement. We have about 2,500 disability retirees. The average disability retiree is 59 years old with an average monthly benefit of $2,000. The disability benefit is generally lower because disability retirees tend to have less service credit when they retire. We pay approximately 3,600 beneficiaries. These are people who were named as a beneficiary at the time a member retires. The payment to the beneficiary begins the month following the retiree's death. We pay about 1,900 survivors. A survivor is the spouse, designated survivor beneficiary, and/or minor children of a public employee who died prior to retirement.

We pay the same four types of benefits from the police and fire fund [page 12, (Exhibit G)]. It is a much smaller fund. You will note they have the same benefit categories. They do tend to have a little bit higher benefit because the benefit is based on years of service and average compensation. Police and fire members have slightly higher salaries; they tend to work longer; and they retire with more years of service. You will see that reflected in the benefits that are paid out of the police and fire fund.

Just briefly, I will explain how the benefits are funded [page 13, (Exhibit G)]. The top of the triangle shows the benefit costs. That is our funding goal. We make sure that when

a member retires, we have the money available to pay them out into the future. What drives the benefit costs is the plan design. The plan design is what is in the control of the Legislature. The Legislature determines what they feel is an appropriate plan design for our public employees, and we then calculate how we will pay the benefits based on the plan design. Essentially, there are two ways that we get money to pay for those benefit costs. Firstly, the contributions that we receive during a member's career prefund future retirement benefits. Secondly, the money that we receive through investment returns on those contributions is a big component of how we fund the benefits. We have a funding horizon much different than an individual might have. We have a very long funding horizon. For instance, we often tell the story of our favorite retiree. We only say that she is our favorite retiree because she was with us for so long. Even though we were created in 1947, we took in the service credit of people who worked in public prior to 1947. This particular retiree was born in 1902. She started working in 1922 as a teacher. She retired in 1962. She died on Christmas Day 2012. So essentially, she was in the system from when she started working until we paid her final payment, which was the month of her death. That is a period that spanned from 1922 to 2012, which is 90 years. Her retirement benefit was paid from 1962 to 2012, which was 50 years. That is why we say that we have a very long funding horizon. We may receive contributions from someone for a long time and then, of course, we may be paying benefits to that member and the member's beneficiary for a long time.

Just briefly, I will show you the funded ratio [page 14, (Exhibit G)]. This is basically a calculation in which the actuary considers all the information we have on every person in the system and calculates the liability that we are going to have to that person until they pass away. We calculate out how much we assume we are going to pay our benefit recipients out into the future, and then we discount that back and determine our liability. Our liability number includes future payments that we assume we are going to pay. We take our assets and our liabilities and determine our funded ratio. You can see that there is a different pattern between the regular employees and the police and fire employees. There are many factors that account for the difference. For instance, in the year 2009, the regular fund was a little bit better funded than the police and fire fund, but then when you get to 2016, that had reversed itself. The police and fire fund is now slightly better funded than the regular fund. That has to do with demographics. Each fund has different demographics. The characteristics of the members of the fund, as this shows, play a big role in the funding. In 2009, we had a very poor investment market year. On the funded ratios chart, 2009 is the year with the lowest investment returns. The chart reflects how we have come back from that particular investment cycle. We have seen some improvement of the funded ratio over the last two or three years. We expect to see slow improvement in the funded ratio in the coming years. We believe that slow and steady wins the race. We do not want to see big swings. We do not want our investment returns to be volatile. That would impact our employee and employer contribution rates. We want to make sure that we are paying for our benefits, but we also want to make sure that we are doing it in as level a manner as possible.

Our next chart begins our investment strategy. For this portion of the presentation, I will turn it over to Steven Edmundson, who is our Investment Officer.

Steve Edmundson, Investment Officer, Public Employees' Retirement System:
The Public Employees' Retirement System has a distinct investment strategy [page 15, (Exhibit G)]. The Nevada PERS investment portfolio is known throughout the industry as being a very straightforward, simple investment approach. To some extent, we are known as much for what we do not do as for what we do. For instance, we do not utilize hedge funds. We do not incorporate derivatives into our portfolio. We do not use leverage. We do not have high yield or junk bonds in the portfolio. In addition, I believe we are the only fund in the country that is 100 percent indexed across our public market asset classes. All of our stock and bond portfolios are 100 percent in index mandates. As an intentional by-product of that, our investment costs have been and continue to be very low, amongst the lowest in the industry. We pay 11 basis points on the total fund assets. That low cost structure equates to roughly $140 million a year savings over a comparable-sized average public pension plan. If you compound those savings over a decade, the savings amount to billions of dollars.

In addition, we have been fortunate that this investment structure has produced returns that are competitive in the industry. Not only are we investing at a low cost, but our returns on both an absolute and risk-adjusted basis have been near the top of the public pension fund universe, over just about every meaningful time period ending on June 30, 2016.

At the end of fiscal year 2016, the fund had $34.9 billion in assets. This morning our asset total was $36.6 billion. We manage three other funds in addition to the large PERS fund [page 16, (Exhibit G)]. They are the Legislators' Retirement Fund which had $4.5 million in assets as of June 30, 2016; the Judicial Retirement System, which was just north of $100 million in assets at the end of last fiscal year; and the Retirement Benefits Investment Fund which is a pool of assets that we manage for participating entities that are used to fund post-retirement health care benefits. As of June 30, 2016, total assets in that portfolio are nearly $360 million.

This chart details PERS investment returns for various time periods, ending with the most recent fiscal year [page 17, (Exhibit G)]. For the current fiscal year, we are up 5.6 percent with assets right at $36.6 billion as of this morning. The final slide shows the asset growth over time [page 18, (Exhibit G)]. If you were to go out to where we stand today, the bar would be at the $36.6 billion asset mark.

Assemblyman Marchant:
Most pension plans around the country have their assumed rate at 8 percent. Is that where yours is now?

Steve Edmundson:
Yes. Our current investment return assumption is 8 percent.

Assemblyman Marchant:
Some of them have lowered that. Have you considered lowering that?

Steve Edmundson:
Yes, that is something that has been discussed. The Board has been discussing it at considerable length. It is a question that is being discussed throughout the industry. What is the appropriate assumed rate of return for a public pension plan with risk assets approximately between 70 to 75 percent? What would be the appropriate long-term assumed rate of return? Currently, most public funds are between 7.5 and 8 percent. Some have been lowering that number over recent time periods largely due to the current environment, which is a very low interest rate environment.

The question that defined benefit public plans face when they are deliberating rate of return is one of time horizon. You take the current low-rate environment and look out the next few years and there is no doubt that when risk-free assets are returning 2 percent that an 8 percent hurdle is going to be more difficult over a near-term period. However, it is reasonable to assume that we will see some level of interest rate normalization over the years.

Over a longer time horizon, that return assumption may very well look different. That is something that pension plans are grappling with right now. How much do you let those shorter term predictions influence your assumptions? As Tina Leiss mentioned, PERS has a very long funding horizon. Should you alter an investment return assumption that discounts liabilities 30, 40, or 50 years into the future based on a 5 to 7 year investment return prediction? Our board has determined that during the 2017 calendar year, PERS will undergo an actuarial experience study. The study will include a review of all the underlying assumptions of the fund, including the investment return assumption. I think that will be a really healthy discussion for the board and actuary to have. I am fully confident that whatever comes out of that process will be the right decision.

Assemblyman Marchant:
If you do lower the assumed rate, will the expense that we incur be something you would like this Legislature to maybe address for the future?

Tina Leiss:
As Steve said, we are doing that experience study. When you change assumptions, be it the investment return assumption or the mortality assumption, any assumption change does change your funding structure. There is a possibility that it will increase your contribution rate. There is also the possibility that it increases what we have already determined to be the unfunded liability. In this instance, if the investment rate of return were lowered, we do know from our experience, that it would immediately raise our contribution rates because you are essentially assuming that less money is coming in from investments.

If you go back to that triangle, if less is coming from investments, more is going to have to come from contributions because your benefit costs would not change. Yes, if the investment rate of return is lowered, that potentially would raise contribution rates. The current statutory mechanism is an automatic process. Essentially, the rates are set every two years based on what the actuary says we require to fund the system. Currently, that

would be automatic. So the next session, if we change that investment return assumption rate and the rates were to go up, that would need to be funded by the legislature into the State budget and local government budgets. There could be other offsetting changes as well.

One of the other big cost factors is the rate of post-retirement increases or cost-of-living adjustments (COLAs). Generally, if you lower your rate of return assumption, you are also going to lower how much you assume you are going to pay in COLAs, because we have an inflation assumption that assumes that we are going to pay more in COLAs than we are paying right now. There is a cap on COLAs based on the Consumer Price Index. There is a possibility that a contribution rate increase may happen, but as I said, that is an automatic process. I will note that in most states that is not the case. Most states have a capped statutory rate, so if they change their rate of return assumption, it may not necessarily change the contribution rates. What would then occur would be a situation where their contribution rates would not be actuarially sufficient to fund their benefits into the future.

Assemblyman Brooks:
Are there any social or environmental guidelines on the investment decisions within your portfolio?

Steve Edmundson:
We do not incorporate social or environmental guidelines in our investment policies. I know that is something that other plans do. However, in Nevada, our task is to invest for the sole benefit of our members and their beneficiaries. That is the only consideration we can have when making investments. Our investments are made 100 percent for the sole benefit of our members and their beneficiaries.

Assemblyman Daly:
As the chairman of a defined benefit pension plan myself, good job. You mentioned that you are going through an actuarial study. Do you do an actuarial study every year?

Tina Leiss:
Yes. By statute we are required to do a valuation every other year and that valuation is what sets the contribution rates. By board policy, we do a valuation every year so that we keep track of the assets and liabilities and where our trends are going. By board policy, we do an actuarial experience study every four to six years. That is what we undertake to compare the experience we have had over generally about a five-year period to ensure that our experience is tracking with our assumptions. If our experience is departing from our assumptions, then the actuary will make a recommendation to potentially change those assumptions. We are on the four-year end of that cycle. The last experience study was done in 2013. That was on a six-year cycle. We are going to a four-year cycle this time.

I expect the actuary will make some recommendations. Most typically, it could be on mortality, which is a big issue with actuaries. It could be on payroll growth because we have not seen payroll growth. Nevada had some extremely high payroll growth when our state was growing so fast. We saw payroll growth higher than almost any other public pension in

the 1970s, 1980s, 1990s, and up until about 2007. Then our payroll growth, in one sense, went off the cliff. That is another area where I would expect to see some recommendations. It could be in any of those areas. It could be economic, as well, like the investment rate of return assumption. It could be the inflation assumption. Recommendations made by our actuary will be associated with the experience study that is done on a four- to six-year cycle.

Assemblyman Daly:
Growth is good, and I am glad we are heading back in a different direction. I was going to point out, as well, there are a half dozen or more assumptions that are made: mortality; rate of return; and other variables that you mentioned. Do you have a similar program as they do on the private side? Your actuary looks at this, and reviews it every year pursuant to your policy, every two years by statute, and every four years on the expanded review. Do they give you a certification like they do on the private side? Do they give you a recommendation or some background to say that the assumptions that you have are reasonable? I know that is required on the private side. The actuary signs that they certify that the assumptions that are made by the plan are reasonable by their third-party independent standards. When you are making decisions, it is not out of thin air, and there is third-party backup. I just wanted to make that point.

Tina Leiss:
The public side actuaries also do a lot of private side work, and they are subject to the same actuarial standards of practice. That would be one part of the actuarial standards; that the assumptions are reasonable. They will not sign a valuation unless it is valid. This is a part of their professional standards.

Assemblyman Daly:
I was just trying to make the point that the assumptions that are used are backed up by a third-party, noninterested party, who has their accreditations and standards to comply with before they sign off and certify that your assumptions are reasonable in that universe.

Assemblywoman Neal:
Two of my questions relate to S.B. 406 of the 78th Session. You mentioned that there were supposed to be some cost savings that occurred after 2015 over a period of time. Have you made projections about that?

Tina Leiss:
When we originally did the fiscal note for that bill, the actuary did make projections over the long term as to how that would reduce the contribution rate. The assumptions take into account how quickly you roll in the members that are on the July 1, 2015, benefit plan. We have seen a small reduction in what we would call the normal cost, which is the cost of benefits going forward. I will caution that the full cost savings should be significant over the long term, but it will take 20 to 30 years to fully recognize those savings, as we roll in those new members and then go out into retirement.

Assemblywoman Neal:
Has anybody had to forfeit the rights to benefits under the felony provision, or *nolo contendere* provision?

Tina Leiss:
No, but keep in mind that those affected are people who were hired on or after July 1, 2015.

Assemblywoman Neal:
In your assets you have U.S. bonds, which amount to roughly 30 percent of the monies invested, regardless of the fund. Have you had a discussion around what is happening in the treasury market right now? There have been some serious fluctuations, and there have been some projections based on recent policy decisions that may affect the bond market.

Steve Edmundson:
We use U.S. Treasury bonds as our risk control asset. That is the 30 percent piece of the pie chart that you were talking about [pages 15 and 16, (Exhibit G)]. Diversification is one of those protective strategies, so that when one thing is working in the investment portfolio, the other often is not. That is the nature of diversification. The role of Treasury bonds in our portfolio is to offset our equity market risk. Treasury bonds have been effective in doing this over the years. However, that does not mean, in isolation, there is no risk in owning Treasury bonds. Certainly, over recent time periods, especially since the November election, interest rates have backed up considerably, and there is an inverse relationship between bond prices and interest rates. As interest rates go up, bond prices go down; that will affect the pricing of those bonds over the short term. The up side to that is interest rates resetting higher is ultimately a very good thing for pension funds around the country. As interest rates increase, you can expect total returns over future years to increase as well. There is a little bit of near-term pain in regards to bond pricing, but ultimately, a backup in interest rates is a net positive for pension funds, ourselves included.

Assemblyman Ellison:
I would like to go to the funding ratio [page 14, (Exhibit G)]. If you look at the actual value of the assets from 2009 to 2016, the difference between the regular employees and the police and fire employees in 2009 is 73.4 to 68.9 percent. Are these in different funds? The difference in 2016 is 73.2 to 77.1 percent. Can you explain that?

Tina Leiss:
The assets are pooled for the regular and police and fire funds. They have the exact same investment return. The investment returns are prorated between the funds based on the membership in each fund. All PERS assets are pooled and invested. What you are seeing in the difference in the funded ratio are the differences on the liability side for the police and fire and the regular fund. You see here that they have the exact same investment profile during that time period, but you see very big differences in the way that the funding ratio has gone. That is the liability side and the contribution side. The police and fire fund contains only 12,000 people. They are a little more volatile because they are a much smaller fund.

They also have different assumptions for demographics. They have a different mortality assumption because they do have different mortality. They also have different payroll growth.

The other big factor is the police and fire contribution rate. Contributions increased earlier in the police and fire fund because of their demographics. Prior to the 2009 period, the police and fire contribution rate increased in a manner similar to that of the regular fund. The rate increases just occurred earlier, which increased the contributions we received and were able to invest.

The other big factor is the differences in mortality. The police and fire fund membership generally runs about 90 percent male. The regular fund runs about 52 percent female. There is a large difference in the mortality rates between the two funds because of that.

Assemblyman Kramer:
I have seen newspaper reports on the lawsuits that have been brought to require PERS to disclose who is getting what from PERS. What has it cost PERS to defend themselves in those lawsuits?

Tina Leiss:
I do not have an exact figure on legal fees. Chris Nielsen, our General Counsel, has come to the table and he can address the legal fees. I would also say that this is ongoing litigation. Our statute provides that our records are public except for the individual files of our members and their beneficiaries. In our prior lawsuit, the Supreme Court of Nevada did reiterate that our member files are confidential. We are caught in a situation between what we can release as public records and what is confidential member information. That point is not well understood in media reports related to these lawsuits. Those reports do not address the fact that we have a confidentiality provision.

We want to make sure that we are not violating our duties under the law that the Legislature has given us in relation to those confidential files. What is currently being released is, for instance, a monthly payment register, which shows the name of each benefit recipient and the amount that they are receiving. It is a bit like the checkbook that we have to send to the bank every month: It includes the benefit recipient's name and benefit amount. That was being released prior to this lawsuit. What is also being released is the actuarial data that goes to our actuary to value the plan. We create that without names because our actuary does not require names. That is what is currently being released. Then we have the competing interest between the two statutes. I know, however, that you did not refer specifically to the substance of the lawsuits. Your question was more to the cost. I just want you to know what is driving the cost.

Christopher G. Nielsen, General Counsel, Public Employees' Retirement System:
I do not have the cost figures you have requested, but I can provide them to you later today.

Chairman Flores:
Next on the agenda is the Public Employees' Benefits Program.

Damon Haycock, Executive Officer, Public Employees' Benefits Program:
I will provide you with an overview of our agency that includes our agency goals and an overview of our plan. I will also discuss our eligibility, benefit offerings, the various plans that we have, and a budget overview. I recognize that this is not a budget committee, but I think it is important to understand the inputs that go into the policies that we make. Those inputs are primarily financial and provide benefits to our members through health care insurance, life insurance, and other compassionate resources. We will also talk about the Governor's recommended budget. I am going to go into this today because there may be decisions that this Committee makes on additional bills that are brought before it that may have an effect on the Public Employees' Benefits Program (PEBP). We want to help you understand how your decisions may affect the participants of our program who are employees, retirees, and their families. It is important that you understand how we are set up financially and where we are looking to go in the next biennium. I will talk about our other post-employment benefits liability and our Governmental Accounting Standards Board valuation. I will also talk about what occurred last session and give you a brief overview of what we see for this session.

We are primarily an employer-sponsored group health and life insurance program [pages 4 and 5, (Exhibit H)]. We provide benefits to approximately 43,000 participants, employees and retirees, along with 27,000 dependents for a total of 70,000 covered lives. We are governed by NRS Chapter 287 and overseen by a ten-member board appointed by the Governor. Our board-approved mission is simple but impactful. We recognize the fiduciary responsibility of the board. We recognize that the program shall design and manage a group health and life insurance program centered around the people we serve, promote a healthy population, and protect members from medical-related catastrophic financial loss. We employ a staff of 32 full-time employees who are responsible for enrollment and eligibility, member services, public information, quality control, fiscal services, and information technology. We are funded by a combination of employer contributions, what we call the subsidy, and employee and retiree premium payments. We do not receive any direct allocation from the State General Fund. Any General Fund monies we receive are indirect as they are paid to us by General Fund agencies as employer contributions.

We have three basic goals. It is our goal to provide access to our benefits. We want to provide the highest quality of benefits, and we try every day to make those benefits affordable. This is in line with our PEBP Board's designated values that they have approved and are very proud of; we strive to be innovative. We believe that protection from catastrophic health care expense is core to the program. In addition, personal responsibility is a cornerstone of the health and welfare of our members. We are committed in providing tools to assist participants in managing their health care resources. We also wish to maintain transparency regarding the operation and finances of our plan and our program. We are committed to clear communication of our program design. We also provide options for voluntary benefits in addition to our base-level benefits.

We have specific individuals who can participate in our program [page 7, (Exhibit H)]. They are active state employees as well as retirees that are eligible at the time of retirement or who re-enroll during an annual open enrollment period. We also have non-state participants from local jurisdictions. Active non-state employees can participate in the program if their employer participates. Eligibility for non-state retirees was frozen for those who were enrolled as of November 30, 2008, except for retirees from any participating non-state entity. This is an all-in or all-out policy. Senate Bill 544 of the 74th Session specified that a local government or local jurisdiction could cover their retirees through our program only if they also enroll their employees. In health insurance, lower-cost, younger, healthier folks offset the higher cost of older, unhealthier folks. This makes premium costs more affordable for everybody. I do have information regarding the history of that process.

Our current benefit offerings [page 8, (Exhibit H)] include medical coverage, including prescription drugs to active employees and non-Medicare retirees through a couple of different plan options. We have a self-funded consumer driven health plan (CDHP) that is a high-deductible health plan. This plan is coupled with a health savings account (HSA) or a health reimbursement arrangement (HRA). Both are pretax dollars that can be used for first-day coverage in a plan where participants must satisfy a high deductible.

For retirees who are eligible for premium-free Medicare Part A, we also offer Medicare Advantage plans and Medicare supplement plans and Part D prescription plans through a private-market Medicare exchange. This is offered through Willis Towers Watson. We have had that plan in place since 2011.

Dental coverage is provided to all participants equally: state and non-state employees, retirees, those on our CDHP, those that are in our health maintenance organization (HMO) plans, and those that are in the Medicare exchange.

We provide basic life insurance. Coverage is a set amount that is paid to a designated beneficiary(s) when a participant passes away [page 9, (Exhibit H)]. We also offer long-term disability and a cadre of other voluntary products. These products include flexible spending accounts for medical-limited purpose and dependent care. Flexible spending accounts are pretax accounts that are authorized through the Internal Revenue Service (IRS) and can be used to pay for medical or dependent care expenses under certain circumstances or situations throughout the year. We also offer additional life insurance. People have the opportunity to purchase up to $500,000 of voluntary life insurance if they are eligible and they meet certain criteria. We also offer long-term care, short-term disability, and access to home and auto insurance. We are able to offer these voluntary products because we can leverage the entire group to get the best discounts for our participants.

Here is a summary of CDHP design enhancements for 2017 [page 10, (Exhibit H)]. I will not get into detail here but will return to it if the Committee has any questions. We basically have certain levels of benefits. We had an initial implementation of this health plan five years ago, and we were able to create this high-deductible plan with coinsurance and specific benefits. We have been able to enhance the plan because we have been fortunate

enough to experience good years and have been able to maintain a level of additional reserves. Those reserves have been put back into the plan to benefit the participants that actually built the reserves through their premium payments to PEBP. We have used the reserves to enhance the benefits accordingly. Some highlights include a decrease to the high deductible, an increase in coinsurance, an increase in the maximum dental benefit, a one-time contribution to the HRA for those who are on the Medicare exchange, and an increase in the life insurance coverage amounts.

We also have an HMO plan that is put alongside the CDHP as another enrollment option for our employees, retirees, and their families. There are two separate HMO plans that have some differences in their designs. We outsource our HMO plans to fully insured products through Hometown Health Plan in the north and Health Plan of Nevada in the south. We have done so for a number of years. You will see that there is a difference in plan benefit designs which some of our participants have said is not equitable. They question why they get paid the same as someone else in another part of the state, but their benefit plan does not appear to be the same. The PEBP Board has addressed this issue through the latest procurement process for HMO plans. We will be presenting an HMO proposal to the State Board of Examiners for their final approval next week. The proposal will address the parity issue and will create one singular statewide benefit design, which will align the overall compensation for everyone regardless of location.

Our budgeted funding level is at just under $480 million for fiscal year 2017 [page 12, (Exhibit H)]. The bulk of our funding is received through employer contributions as well as through some carried-forward funds. We have a series of reserves that we must maintain to ensure the solvency of the plan. We also receive contributions through the payment of premiums from the participants. We spend the bulk of our funds on self-funded plan claims and on fully insured programs. We collect premiums for those programs and send monies to pay claims made to those programs. We have a decent amount of reserves. They account for almost 20 percent of our budget. We also have HSA and HRA contributions. Those are, again, monies for first dollar coverage that we provide to our participants who are on the CDHP or who are on the Medicare exchange. We have a very small amount budgeted for operating. We are budgeted at around 2 percent for operating and another 2 percent for self-funded administration fees. Those fees include payment to our vendors, such as our third-party administrator and dental networks, and to other vendors who provide services in our self-funded program.

What we are looking at, from a high-level perspective in the Governor's recommended budget this session, is about $943 million for the two-year period [page 13, (Exhibit H)]. The 2018-2019 budget reflects the same revenue sources as the previous budget. The budgeted uses are also similar with the same types of splits.

Everything that we do at PEBP initially starts with enrollment. It is similar to a caseload. How many people do we need to serve? How much is it going to cost on a per-participant, per-month, or per-year basis? Here are enrollment projections [page 14, (Exhibit H)]. We have what actually occurred in fiscal year 2016 broken out into the two risk pools that

are comprised of state active employees, retirees, and Medicare retirees; and non-state active employees, retirees, and Medicare retirees. One of the things that I want to draw your attention to, which is going to probably come up later throughout the session if it does not come out today, is the issue of the non-state risk pool. If you look at fiscal year 2016 in the second category, there are 9 non-state employees trying to offset about 7,000 retirees. This is heavily weighted toward becoming a retiree plan. The law states that we must comingle retirees and employees, but we must keep the state and non-state groups separate. As you see, 25,000 active employees are offsetting about 10,000 retirees on the state side. It is dramatically flipped on the non-state side.

We anticipate a modest growth for this fiscal year at just under 2.5 percent. That same growth percentage is carried forward into fiscal year 2018. We project that growth will flatten out in fiscal year 2019. We have worked with the Office of Finance, Office of the Governor in identifying requested new positions. What they anticipate will be approved through the Governor's recommended budget for 2018 will support a 2.5 percent growth increase to our state group. Requested new positions for fiscal year 2019 support the flattening of growth in our state group.

The other big piece to the puzzle for PEBP is our trends It is not just simple inflation. An example of simple inflation is when you go to the grocery store and you buy a gallon of milk today for $3. That same gallon of milk next year will cost you $3.07. Most people can wrap their brain around that. When it comes to health insurance, there is another factor involved in the trend, and that is the projected utilization of those benefits. First, there is the unit cost; how much is that gallon of milk going to go up, and how much milk are people going to drink. Then there is the projection of how many people are going to access the benefits offered. We have to know what they have been doing before, so we can determine what they are going to be doing in the future. We have an independent actuary that does this for us and provides us this information every year to assist us in our building of our rates and premiums.

In fiscal year 2018, we are looking at about a 3.1 percent increase in medical claims, a 7 percent increase in pharmacy claims, and a 2 percent increase in dental claims [page 15, (Exhibit H)]. One of things that may draw your attention is the fiscal year 2018 premium increase percentages for our HMO plan premiums. Premium rates are set through the contractual process with our HMO providers. For fiscal year 2018 we see a 5.4 percent increase in the north and a 17.3 percent increase in the south.

We have worked with our life insurance vendor and based on past experience, they believe that there was no need to increase the premiums. This may not follow from one year to the next, so we have noted a 10 percent premium increase as a place holder in the 2019 fiscal year budget. We will not increase the premiums if our experience shows that the increase is not needed. The same applies to long-term disability premiums. We anticipate a slight increase in medical claims from 3.1 percent in fiscal year 2018 to 3.6 percent in fiscal year 2019. We do not anticipate that pharmacy or dental claims will increase from fiscal year 2018 to fiscal year 2019. For fiscal year 2019, we have built a 4 percent increase

into the premium cost for the HMO plans. To be frank, I do not think that anyone can survive a 17 percent increase year after year. We are going to do everything that we can to ensure that does not repeat itself.

We have been able to maintain employer contributions and state subsidy at about $700 over this last biennium [page 16, (Exhibit H)]. We were provided the opportunity to increase the state subsidy to just over $740 in fiscal years 2018 and 2019. The additional money coming from the state will help to offset the premium costs for state employees. We are very appreciative of that funding. It is going to offset the inflation trend that is built into the plan every year. For the non-Medicare state retirees, the assessments are close to what they have been. That is an average. The amount of money that we are actually provided per retiree is based on each individual retiree's years of service, so we use an average amount for the subsidy bill. We use a similar average to determine the monthly HRA contribution that goes to those folks participating through the Medicare exchange.

We have a couple of enhancement units that are in our budget [page 17, (Exhibit H)]. We are looking to eliminate the continuing education requirement for the PEBP Board members. There is a pending fiscal bill draft request (BDR). Fiscal savings if the requirement is eliminated are about $16,445 in each of the fiscal years. This was supposed to be a companion to Senate Bill 80, which I will talk about later. It was initially intended to be part of that bill, but was not included, so we were asked to submit the statutory change in our BDR. The PEBP Board has approved some benefit enhancements. It is our board's policy decision to approve the continuation of benefit enhancements and various cost containment strategies for the CDHP in fiscal year 2018. These will be funded through the reduction of excess reserves. Our current budget has the benefit enhancements at about $8 million; however, in recent board meetings, we identified additional reserves and have been able to increase the benefit enhancements to about $30 million.

The CDHP benefit enhancements are similar to what we had in plan year 2012 [page 18, (Exhibit H)]. As noted, we were able to reduce the individual deductible down to $1,600 and the family deductible down to $3,200. We placed the coinsurance level at an 80/20 percent split. We have added a $25 copay to the annual vision exam that we were previously providing to our participants at no cost. The dental maximum will be $1,500 for the plan year. We are introducing something new to our HSA and HRA contributions in plan year 2018. We do not have enough reserves to continue the same level of contribution; however, we were able to tie the level of contribution to a wellness or preventive benefit. This is not the same wellness preventive benefit that you may have seen that was discontinued in 2015. There are not a lot of hoops to jump through to get this funding. We just want people to participate in four basic functions of their health care responsibility. Go to the doctor once a year; participate in the lab tests that are ordered from that doctor; go to the dentist once a year; and get your teeth cleaned. All of this is at no cost to the participant. If they perform these four functions then we will deposit or increase the balance of their HSA or HRA by an additional $200 over the base contribution level. Each covered person will still get the base contribution credited to their account regardless of whether they perform the preventative functions or not. We are not trying to eliminate their ability to meet

first-dollar coverage for a high-deductible plan, but rather to support a process that we feel strongly about, which is personal responsibility in actually figuring out what is wrong with you.

At the last PEBP Board meeting, we were able to retain most of the life insurance coverage that we had in the past. The life insurance benefit amount for an employee was reduced from $25,000 to $20,000 and for a retiree from $12,500 to $10,000. The 2018 plan year life insurance benefit amount is still over the life insurance base amount for plan year 2012.

We are also excited to introduce something called a preventive drug list. With a high-deductible health plan, the IRS will not allow an insurance benefit plan to carve out benefits because the participants need to satisfy the high deductible if the benefit plan is going to offer an HSA, which is funded with pretax money. There are rules that the IRS has developed around that benefit. However, this is a plan benefit that adheres to the IRS guidelines. It is a preventive benefit. There will be a drug list that we will be announcing and presenting prior to plan open enrollment. Under the program, folks can obtain the critical maintenance drugs that they need, and they will receive first-dollar coverage. This allows them to avoid the high deductible and go right into cost sharing.

As an example, if the participant is on a drug today that costs $100 a month and it is on the preventive drug list, instead of having to satisfy the full deductible before the plan starts helping out with coinsurance, it goes right into the 20 percent coinsurance, and the participant is charged $20 at the desk. That will help folks that are having issues trying to maintain their health through the use of maintenance drugs. It will allow participants to have them on the first day of coverage. We have a narrower provider network for this program. In order to reduce the cost, not everybody's pharmacy will be in the provider network. However, of the 98 to 99 percent of the pharmacies that are in business today, there will be a participating pharmacy that is either that pharmacy or a similar pharmacy within five miles. We feel that it is not going to be too much of a strain for folks if they have to change pharmacies to receive this excellent, preventive drug benefit.

We also wanted to address the HMO plan design issue where we had different benefits in different regions of the state. We all get paid the same based on our job title regardless of where we work. Why should we not have the same compensation package? The HMO has a preferred plan benefit design [page 19, (Exhibit H)]. That is what we built into the request for proposal through the procurement notice we released last summer. We were successful in negotiating that plan design with the two vendors that we selected. It just so happened to be Hometown Health Plan in the north, and Health Plan of Nevada in the south. Our goal was to provide the same benefit in the north and south, so each employee and retiree has the same overall compensation package. You will see that the copays are the same. This parity in benefit coverage results in a copay increase for HMO participants in southern Nevada. The prescription drug costs have changed. This is the result of the high cost of prescription drugs that affect our nation and our state today.

Another great enhancement, especially for those down south, is that there will be no primary care physician referrals anymore in the HMO plan. If you want to see a dermatologist, you can call and make an appointment. You do not have to make an appointment with your primary care physician, wait a few weeks or a month or whatever the time is, and then repeat the process for your specialist visit. This opens up some additional access which ties back to our goal of access that I mentioned earlier in the presentation.

We are also looking to provide an alternate HMO plan design. The alternate plan design on this HMO plan is a supplement plan. It is not a replacement plan. The standard HMO plan that we have been offering, and the one that we will be offering again in July, is going to experience high rate increases of 5 percent and 17 percent. When you blend them, and you make the same rate across the state, it is roughly an 8 to 9 percent increase depending on what tier of coverage you are in. This may be potentially unaffordable for some of our members. We worked with both of the HMO providers that we have contracted with and have negotiated an alternate plan design to try to provide some monthly premium relief while still adhering to the HMO model of copays and no deductibles. What you see here is a similar table of benefits [page 20, (Exhibit H)]. The second column is the preferred plan benefit design we are going to have beginning in July. The alternate plan design is shown in the last column. You will see that the alternate plan design heavily weights costs towards emergency room visits, in-patient services, and retail pharmacy. We asked the two vendors to come up with a singular design, again, because we did not want to have different benefits north and south or anywhere else, but we wanted them to lower the monthly premium rate.

The way that they could do it was twofold. The first was by changing the overall plan benefit design. The second was to limit coverage in northern Nevada only to areas where the HMO provider can use their cost-containment strategies. The HMO alternate plan benefit design will not be available in all counties across Nevada. This was not something that we did purposely. It was done solely to get the premium rate down.

In the plan year beginning in July 2017, we will offer a minimum of two different coverage plans. Each participant will be able to enroll in an HMO plan or in a high-deductible health plan, which is our preferred provider organization plan, or CDHP, which are synonymous. Those are the plans that they will have, which is similar to what they have today. In certain counties, we also offer the HMO alternate plan design. The HMO alternate plan design will be offered in six counties in northern Nevada and three counties in southern Nevada. The bulk of the participants within Nevada reside in these counties.

One of the other cost containment strategies that I want to highlight on the alternate plan design is that this plan will require a referral process. Again, that referral, the gatekeeper model, is the traditional HMO model, which is designed to lower costs, so people do not self-diagnose and self-refer to high-cost specialists when their primary care physician could have handled the problem in their office. The referral process will only apply to the alternate

plan benefit design. In no way are we looking to steer people into one plan benefit design or another. We are simply providing choices that meet the affordability criteria of each of our participants, individually and as a whole.

We have some priorities and performance-based budgeting data [page 21, (Exhibit H)]. We have expense and claims loss ratios, generic drugs utilization, and network utilization. Participants who use our provider networks receive in-network discounts. We do not want people to have to make appeals because they do not agree with our coverage decisions. We mitigate that possibility by making the right decisions. We want people to participate in some of our disease management programs because it helps them manage their lives and gets them back on the road to recovery. We also want people to be able to manage chronic diseases, like diabetes. We want them to have a dental visit. We want them to receive a preventive office visit. Only about 35 percent of the population on our CDHP actually go and see a doctor every year. What about the other 65 percent? We feel that it is important for people get that preventive office visit. It is free to them, so we want to drive more folks to it. It ties back to the HSA and HRA opportunity to achieve a $200 payment by satisfying the preventive requirement.

A little bit on other post-employment benefits [page 22, (Exhibit H)]. It is the liability of the state to provide the cost of subsidized health insurance to retirees. Basically, how much do we think we are going to need in order to pay retiree subsidies throughout the state. This is something that is important to the state because it is on our financial statements. It is in all of the financial actions that we take as a state. What is our liability? What is showing up on our financial statements? One of the things that I will state about this liability for PEBP is that due to the decisions made by the Legislature to no longer offer a subsidy or contribution to employees who have an initial hire date after January 1, 2012, we are going to see that liability reduced. We already have seen that liability reduced, because there is no future subsidy for employees that are being hired now.

Chairman Flores:
I do not mean to interrupt, but for the sake of time and concern with the floor meeting coming upon us, could I have you stop there? I know that you only have two or three pages left. We will get to them if we have time. Otherwise, I would like to give an opportunity to the Committee members to ask questions at this point.

Assemblywoman Neal:
I have a series of questions starting with your presentation. I am on the page with the inflation assumptions [page 15, (Exhibit H)]. You use the projected utilization of that benefit. What is the average age of the retiree who is using these benefits?

Damon Haycock:
I do not have the average age split out for different segments, but I can get that information to you.

Assemblywoman Neal:
I am concerned that the HMO premiums for the south are projected at a 17.3 percent increase, and the employer contributions are there to offset that inflation. When you look at fiscal year 2017 for the state employees, the rate is a negative 0.35 percent. Then it goes to 6.2 percent in fiscal year 2018; for fiscal year 2019, it is a negative 0.28 percent [page 16, (Exhibit H)]. Why is the rate in the south so high? Even with the subsidy, the inflation rate is still very, very high for those southern retirees. I do not understand how that is sustainable.

Damon Haycock:
That is an excellent question and something that our board and our staff have wrestled with along with everybody else. I can give you a brief overview as to why that has occurred. I will try to break it down into its most simplistic functions because that is how I can understand it the best. As rates increase for a health plan, many people who are financially concerned about paying those rate increases will choose another option. Traditionally, when it comes to health insurance, it is the unhealthy folks that need the benefit. Healthy folks may migrate away from the plan because of the high premium costs. When more healthy folks migrate away from the plan, the pool of available people to pay for claims is reduced, and the types of claims that are left are the expensive ones. It is a spiral that is potentially heading out of control. The rates in southern Nevada are the direct result of folks migrating off of that plan and finding lower-cost insurance. The ones that are staying on that plan really need it and, therefore, elect to continue to pay more money for it every year.

To answer your question about the subsidy, the subsidy itself will have fluctuations from year to year based on a couple of things. If we are going to implement any plan designs or if we are going to have any cost savings strategies that are built into our budget, we want to reflect that so the state, as the employer, gets to save money as well as the participants. In addition, if we have a shortfall or a surplus in the prior biennium, when the Legislature approves the subsidy bill, it approves the subsidy for a two-year period. We do not know what is going to happen exactly with that initial plan year, but there is no mechanism for PEBP to come back to the Legislature to say that we figured out that we need a little more money, or we need a little less money. The difference from fiscal year 2018 to fiscal year 2019 is to make up for a shortfall that we project to have this year and then level it back out again next year as we do not anticipate a shortfall in the first year of the biennium. That is why it is a little different.

I will finally answer the first part where you asked if this is going to cover the inflation. Maybe I overgeneralized when I said it; this subsidy increase is going to take a chunk out of the inflation cost, but obviously, it will not cover all of it. If it could, we would be able to have flat rates on the HMO plan. That is not going to occur.

Assemblywoman Neal:
You phrase it as healthy and unhealthy, so I will use those terms to simplify my question. When looking at the HMO plan design for fiscal year 2017 and then comparing the HMO plan design for fiscal year 2018, which is based on the Governor's recommended budget,

I am thinking about the unhealthy folks. Why did we lean towards the higher emergency room visit copay of $300, and the higher hospital in-patient services copay of $500 per admission? This is pretty pricey. If I am sick, and I need to go in and get a biopsy which may require I stay over, and I am age 65, I am now hit with a $500 copay where before I had a $300 per admission copay. Now if I need to go to the emergency room, I will have a $300 copay. What we know to be true is that, more often than not, when you are hit with an emergency and you are older, typically, you go to the emergency room. You are not showing up at urgent care. I want to talk about the implication of those two issues, and I will have a follow-up question.

Damon Haycock:
First, when we were looking to create one singular plan benefit design, we wanted to make sure that it would be affordable, and we would get flat or low percentage increase rate proposals. The HMO plan comparison shows the regional coverage disparities [page 11, (Exhibit H)]. If you look at the emergency room visits and the $150 copay increase to a $300 copay, you will see that it is generally easier and less costly to ask a richer plan to become less rich than it is to ask a less rich plan to become more rich. If we would have asked the northern Nevada cohort of proposers to try to meet the southern Nevada lower copay costs for emergency rooms or in-patient visits, they would have naturally increased the rates on their end, which would have been blended among everybody. We were attempting to create an opportunity that was level across the state while also mitigating increased rates.

Assemblywoman Neal:
Basically, you had two insurers playing in this field. One is more healthy financially and can sustain some increases versus the other plan that is kind of unhealthy?

Damon Haycock:
What we have are two distinct regions with two distinct levels of providers. There are access issues. In northern Nevada you have fewer providers than in southern Nevada, but access to the providers in northern Nevada is easier because you do not have a significant population all vying for the same providers like there is in southern Nevada. You also have different types of health plans that have managed to develop different types of cost-containment strategies.

A capitation model where you pay a certain dollar amount per person through health insurance is what is utilized by the HMO plan down south. They have been able to do that because they have a significant market share. They also own their own facilities. Not to give a plug to any specific company, but Health Plan of Nevada is part of UnitedHealthcare, who owns Southwest Medical Associates, so they pay their doctors a salary. They do not have to outsource services and then pay a profit markup. Therefore, they have more cost-containment strategies down south. Generally speaking, their rates are less expensive than up north because they are allowed to close access down and control where they do their referrals because it is all in-house. It is typical supply chain management. It is not about healthy or unhealthy because, traditionally, they are both at roughly the same risk. They both have the same types of people who participate in their plans.

What is also making the southern Nevada costs increase is that we blend the rates. We blend the rates because we do not want someone who makes a certain dollar amount to have to pay more in one region than another because it is part of the overall compensation package. The rates by themselves submitted to PEBP through this process are actually less in the south and more in the north. We tried to do a statewide plan, but when we got the statewide proposals, they were all more costly— every one of them, even if we were to marry up the two regional proposals. Therefore, we did look at trying to solve the problem that way as well.

Assemblywoman Neal:
You mention cost containment strategies and the supply chain that exists in the south. I will use these two terms to ask about the HMO alternate plan for fiscal year 2018 [page 20, (Exhibit H)]. If there are cost containment strategies in the south, we see that the alternate plan benefit design takes the emergency room visit from a $300 copay to a $500 copay. The hospital in-patient services copay goes from $500 to $1,000 per day for the alternative plan benefit design. Is the alternative plan design going to be used? When is this triggered? Or is it even going to be triggered? Is this in one of your bills?

Damon Haycock:
This is not one of our bills. This is part of the contractual process that was ratified by our board at the January 19, 2017, meeting. This is not a replacement of the standard plan. This plan is not for everybody, and we recognize that. I would personally not suggest a frequent user of emergency room services enroll in the alternate plan benefit design. I do not have a problem saying that publicly. There are significant costs that are associated with going to the emergency room. Those costs continue to rise, and there are significant costs that are a part of hospital in-patient services.

I will give you a couple of examples. We have folks on our plan who have babies born prematurely. We had one baby born last plan year that had to spend four and one-half months in the neonatal intensive care unit. She was then able to go home with her parents. The total cost of her care was just under $661,000. If I were to call those parents and ask if they would want to spend $1,000 to take their child home, they would do so over and over. If we ask that person to pay back PEBP and the state, it would take them 250 years if they paid it back at the premium rate. We offer significant catastrophic benefits to folks. If you think about it, the emergency room is when you have an emergency. It is often because of a car accident; or you are having a baby; or you have an episode where the need for care is immediate. That emergency room access has a cost to it. Whether we put some more of it onto the participant or the plan pays for it and then we ask the state to help subsidize it, that cost still has to be paid. It is a cost across the nation that is extremely high. I agree that this is not a plan where you are going to elect to use the emergency room a lot. My question is: What can we do collectively to try to help people not get to the point where they have to go to the emergency room? We cannot stop emergencies like car accidents, but some of the other utilization issues are what we are working on.

Chairman Flores:
I would like to continue with the information regarding the HMO plan design [page 11, (Exhibit H)] and the HMO alternate plan design [page 20, (Exhibit H)]. Every time we talk about health care, one of the obvious discussions we always have is how quickly can I get to Doctor A or Specialist A because sometimes I am waiting weeks or months. In that scenario, a person may get tired of waiting and, out of desperation, find themself going to the emergency room. It is the only way they can get immediate care today. How many individuals who are under either plan are going through a primary care physician or a specialist in comparison to individuals using the emergency room? My fear is that we are punishing individuals who are getting tired of waiting weeks or months and, out of desperation, are going to the emergency room to get the care they need. Not intentionally, but the costs are $700 more through the alternate plan benefit design and $150 more through the preferred plan design. If you could, help me untangle that and correct me where my logic is wrong, because it may be.

Damon Haycock:
Your logic has merit. People get frustrated due to the lack of access to care when they need it. As a parent of young children years ago, I did not want to wait three or four days before I took my kids to the doctor because they were suffering. There are times when you need to go to the emergency room. You need to go to urgent care. From a personal story, my wife rides horses and got thrown. That is not one of those things that you make a primary care visit for. You need to go and get x-rayed and see how badly you are hurt. We recognize that folks should not be punished for that.

I want to change the terminology. We are not punishing people by asking them to pay a portion of their health care. We are paying the lion's share of their health care. You are paying the lion's share of the health care costs as taxpayers through the subsidy that comes to PEBP through employer contributions. It is not a punishment to ask someone to pay a portion of that. It is a privilege. How much is affordable is up to everybody's situation. We have emergency room and urgent care reports, and we do have some folks that are using these services who could have been using some other lower-cost service.

More toward what you are talking about. Why do we not have a mechanism that allows a person to get the care they need, so they do not get fed up and go to the emergency room? We do have that mechanism for certain types of services. We have something that we implemented at the beginning of the last plan year. It is a telemedicine, virtual visit-type of process. On your phone, computer, or tablet, you can talk with a licensed doctor in the state of Nevada 24 hours a day, 7 days a week, and 365 days a year. It costs each participant $40 to use. If you satisfy your high deductible, you only pay 20 percent of that, so it costs you $8. That doctor can see you and ask you questions. You can turn the camera on your device around and show the doctor inside your throat to see if you have a problem there or in your mouth. The doctor can prescribe you a drug, and you can go to the pharmacy and pick it up and avoid the entire urgent care or emergency room process. That does not work for broken bones or large lacerations and some of those other issues that you need to go to the emergency room or urgent care for, but we do have this process. We have it contracted

through our third-party administrator, Doctor on Demand. It is something that we have available on our website, with a complete walk-through on how to utilize it. We do not have heavy utilization because it is new, and it is hard getting the word out, but we have that opportunity available to folks. It works very well. Some of my staff and my own spouse have used it. It took my spouse ten minutes when she had a nasal infection. She was able to go get the drugs she was prescribed within a half hour. She totally avoided the whole system of care but still got the treatment she needed. We do have it. It is not perfect. Nothing is, but again, the big issue about access to care is bigger than PEBP. It is a national issue. It is not having enough providers for the people that need care. We are not out to punish anybody; we are just trying to make sure that everyone is putting a little of themselves into this decision, so they do not make a decision without thinking about it.

Chairman Flores:
I used the word punishment, but I think you are right in saying that is not the correct term. I was worried that we were doing it just as deterrents because I know that people often use the emergency room when they do not necessarily have to, but because they are tired of waiting. I would appreciate data on what individuals end up using the emergency room and, if in fact, they did not have to because it was not, per se, an emergency. I would appreciate it if you have any data on that. I appreciate what you just mentioned about the opportunity to speak with a doctor over the phone. I know that there is an issue with technology. Some populations are not very comfortable with it. Other individuals are just in a situation where they did not grow up with it, so they do not touch technology. What is the educational component that we have? You stated that it was so new. What are we doing to educate some of the members of our communities so that they can use that service?

Damon Haycock:
We use a multi-pronged approach. We actually sent out notices. We sent out newsletters. We have our call center provide information to our participants when they call in. The call centers at our third-party administrator do so as well. It is also on our website pebp.state.nv.us: "Doctor on Demand - Never Wait for a Doctor Again!" There is a frequently asked questions section and a flyer for more information. We distribute these. What is it? What are they used for? What types of services are available? How to go ahead and download it. We actually have a walk-through process. We have folks that are out at our flu shot clinics and open enrollment meetings from Doctor on Demand to answer questions. We have received some great feedback from it. It is just one of those things that is not used enough for it to be a household name, but it is our goal to make it one.

Assemblyman McCurdy II:
How is the targeted marketing going to disseminate that information so that more people are aware of how they can get access to that program?

Damon Haycock:
We have a pretty robust communication process. We developed a communication plan that identifies all of our stakeholders and the different types of mediums that we feel will resonate with them. As the Chairman mentioned, some people did not grow up with technology or do

not feel comfortable with it. We still utilize good old-fashioned mail. We still mail out a lot of notices. We also partner with other groups like the American Federation of State, County and Municipal Employees (AFSCME) or the Retired Public Employees of Nevada (RPEN) to get the word out through them and through their notices. I am fortunate enough to have a column on RPEN's quarterly newsletter where we share information. I believe, and I will go back and look, that when this was first launched, we did that as well.

We look at multiple methods to try to get the information out. Mostly, it is just repetition. It is just getting it out there. I will be the first person to say that before I worked for PEBP I did not always read my PEBP notices, so I recognize that not everybody does. We need to get creative and come up with additional opportunities. We are looking at exploring social media aspects.

Again, that takes care of the more technologically-minded individuals. We recognize that there are folks who just need to get the word through face-to-face meetings, which is why we have also implemented a face-to-face program when it comes to helping people enroll in the Medicare exchange or having any of their HRA questions answered. We do retirement meetings, aging-in, open enrollment meetings, and new-hire meetings. All of these are opportunities to get the word out. We are just going to keep doing that until it sticks.

Assemblyman McCurdy II:
Is there any information as to how many people utilized that?

Damon Haycock:
I wish I had better news, but it is only a couple hundred folks right now. However, the satisfaction of using it is very high. I know personally from my contacts with other folks around the state, that those who use it, love it. I wish they were here to give a big presentation to say how much it has helped them and their families. We are looking at potentially doing some case studies to work with them. Again, it is tough. The population in Nevada is spread over a vast area, which can make face-to-face communication difficult. We are fighting the good fight every day.

Assemblywoman Neal:
From the minutes of a PEBP Board meeting held April 21, 2016, you were having a conversation about the potential budgetary bill draft request (BDR). There were some options that were presented about how to make the plans work. Options included an appropriation from the Legislature to pay for the cost in the next biennium, or to have the retiree return to their former employer or go to the exchange and retain the subsidy in accordance with existing language. I do not know what return to your former employer would be. I need to understand that. I am hoping that is not in your bill draft request.

Damon Haycock:
There is no BDR addressing this issue. This issue is strictly discussing the situation of increased premium costs for our non-state retirees. It is a risk pool that does not include those employees needed to offset the covered retirees, so their costs are going up every

month. It does not affect the state retirees. I just want to make sure that we understand the bucket we are talking about. There have been definite options that have been presented in various legislative sessions, and they have not changed all that much.

What can we do? The statute allows a non-state retiree to return to their former employer to participate in their retiree health care coverage. The problem with that, for many of them if not all of them, is there is not a retiree subsidy requirement, so they would have to pay the full cost for the coverage. I am going to give you some bad numbers here, so please do not quote me on them. If the overall rate costs $900 and their non-state employer is paying $600 to PEBP, we are charging the retiree $300. If that similar plan is offered at the non-state employer's location, that retiree may have to pay the full $900, so it is not an attractive option for them even though their rates keep going up on PEBP. There are different options.

Another option was looking at helping those people move onto the individual marketplace, similar to how we have a Medicare exchange. Our Medicare exchange is all individual plans: Medicare gap, supplement, and advantage plans. The individual marketplace in Nevada, Nevada Health Link or the Silver State Health Insurance Exchange, does offer individual plans that could meet the needs of retirees. The problem is if they have a financial burden that allows them to obtain a federal subsidy, then they will not be eligible for a state subsidy. So they run into the problem of where does the money come from and is it enough?

Individual plans on the Silver State Health Insurance Exchange are age-banded, so the costs of a plan for a 21-year-old is tripled for the cost of a 64-year-old. If it is a $300 plan for a 20-year-old, it is a $900 plan for a 64-year-old with no plan changes. It is not necessarily a great option for these folks because it could drastically increase their costs, or they could drastically reduce their benefits by not understanding that they are basically enrolling in a bronze-level or catastrophic-level plan with a mega-high deductible and out-of-pocket maximums.

Assemblywoman Neal:
I appreciate that response. When I read that, I wondered why would a former employer take back a 64-year-old when that would increase costs for them? It seemed like an irrational option.

Damon Haycock:
I just want you to know it is because they have to. The law (NRS Chapter 287) says that their last public employer has to take them back on every even year, if the retiree wants to reinstate. The former employer does not get the option of offering reinstatement; they have a requirement to do so.

Assemblywoman Neal:
My question is in regard to the CDHP design enhancements [page 10, (Exhibit H)]. You spoke of the coinsurance applied to the preventive and maintenance drugs. How do those particular drugs get on the drug list?

Damon Haycock:
The drug list is provided by our pharmacy benefits manager who provides these types of lists to all of their book of business that has been vetted through the IRS. It is less of a PEBP decision, and more of a what will the IRS allow us to utilize this opportunity for. This includes drugs such as cholesterol drugs, high blood pressure drugs, and asthma or chronic obstructive pulmonary disease (COPD) drugs—those types of things. We should have a finalized list shortly. I have seen a draft of the list. There are still some questions about the list. We will ensure that we will get the word out. We will be marketing it very strongly once we have the final list to announce.

Chairman Flores:
We have time for you to go through your final pages and summarize the information before we conclude the presentation.

Damon Haycock:
There were legislative actions taken in 2015 [page 24, (Exhibit H)]. One was Senate Bill 505 of the 78th Session. This was a Department of Administration bill. The bill provided for a two-month suspension in the collection of employer contributions from state agencies/entities. There was Senate Bill 471 of the 78th Session where we added TRICARE eligibility for the HRA subsidy. Right now if you are a Medicare-eligible retiree, you go to the Medicare exchange, but veterans who served our country honorably who have TRICARE coverage in addition to Medicare coverage do not want to have to purchase a plan on the exchange. This bill allowed this group of individuals to get the subsidy and remain on their TRICARE coverage. Senate Bill 472 of the 78th Session reduced the waiting period required for eligibility and enrollment in PEBP in accordance with the Affordable Care Act, which requires that the waiting period be 90 days or less. We ended up backing it down to 0 to 30 days to assist one of our large employers with their recruitment efforts to hire folks and provide them with first-day coverage. Those were the three major bills that affected PEBP last session.

This session, we do not have any policy bills [page 25, (Exhibit H)]. We will come back and respond to other BDRs, but we will not be presenting any ourselves. We do have that BDR that I spoke of earlier that removed the costs associated with continuing education credits for our board. There is a non-PEBP bill that affects PEBP dramatically. It is Senate Bill 80. I am not here to present it or give an overview of it. It effectively restructures PEBP under the Department of Administration and reclassifies the PEBP Board from governing to advisory. Other major policy issues affecting PEBP were the non-state group issue and what the collective is going to do about the ever-increasing premiums for this population within PEBP. I have a full presentation with historical information going back to the 1960s that documents the decisions that were made to allow non-state entities to participate and some of the clean-up decisions that were made up to where we are today. There are options, but really no great option, because someone has to pay for this group. It is just who should pay and what type of solution should be presented. That is my presentation today.

Chairman Flores:
We have finished the three presentations scheduled for today. I would like to now go to public comment. We will start with Carson City and then go to Las Vegas. For the purposes of efficiency and time, please limit your comments to two minutes.

Kent M. Ervin, Legislative Liaison, Nevada Faculty Alliance:
I represent the Nevada Faculty Alliance. We are a statewide association of the faculty at all eight Nevada System of Higher Education institutions. I came to talk about PEBP, but I wanted to give a shout-out to PERS and refer to a marketwatch.com article on October 28, 2016, titled "How One Man in Nevada is Trouncing Harvard Endowment." The one man at PERS who was here, Steve Edmundson, has beat the similarly-sized fund, Harvard Endowment, over a five-year period by 1.8 percent per year. It is pretty amazing. We have one man, they have 200, many from Goldman Sachs doing all of those hedge fund things. Nevada PERS is also beating the California Public Employees' Retirement System (CalPERS) over one, three, five, and ten years. Just a context for PERS.

We are concerned about the impending benefit cuts at PEBP. Although many of the benefits have not been reduced as much as they could be because of excess reserves, they are still projecting cuts for the coming year. For a family of four, you are talking about a net increase of $500 to $700 per year out-of-pocket. For an administrative assistant, that is going to wipe out the 2 percent COLA. I just want to say that it is not all rosy, and more troubling is that by 2019, PEBP projects not keeping these so-called "enhanced benefits" which are just partial restorations of the cuts made back in 2011. Going back to those base levels would mean really dramatic cuts in benefits for the high deductible plan. The good news is that both PEBP and PERS are in good shape as far as current reserves for the anticipatable things coming up. We are really concerned about the new employees who will have no retirement benefit. There needs to be a plan in place to start funding the future retirement health care costs of these employees. Now is the time to develop a plan that will mitigate the possibility of unfunded liabilities 25 to 30 years from now.

Chairman Flores:
I will remind all of you who are here providing public comment, feel comfortable providing your remarks to our secretary and please send some of the information to our Committee members. It is instructional and a great resource for all of us.

Priscilla Maloney, Government Affairs Retiree Chapter, American Federation of State, County and Municipal Employees, AFL-CIO, Local 4041:
Like Dr. Ervin, I would like to give a quick shout-out to PERS. I know that the former Chair, Assemblyman Ellison, and Assemblywoman Neal and others had to sit through numerous hearings on proposed plan changes to PERS in the 2015 Session. We spent hours and hours of hearing time, both in this house and the Senate, with numerous exhibits submitted. In March 2015, we had a very noted labor economist, Dr. Teresa Ghilarducci, who has worked with multiple administrations, both at the state level in California, for example, and with the Obama Administration she jumped in at the request of the administration in 2008 during the fiscal crisis and came here to help us have some good

discussions on the plan design for PERS. She did an editorial, I believe, on March 16, 2015, that I can get to the Committee. Dr. Ghilarducci said that the Nevada PERS design was one of the best and most solid in the country.

We already have several bills and at least one BDR and one bill, Assembly Bill 71. The sponsor of BDR 23-843 is Senator Roberson. The sponsor on A.B. 71 is the State Controller.

On PEBP, as Dr. Ervin said, the AFSCME retirees do have concerns about the budgetary issues that will ultimately be resolved through the plan design changes that are built into the budget. There are no BDRs, per se, but we do have an objection to Senate Bill 80. We will wait until that bill travels to this Committee.

Marlene Lockard, representing the Retired Public Employees of Nevada:
There is so much to comment on and now is not the time or place. We will be coming back to talk at length about some of the issues you heard about in the presentations. I want to emphasize the point that words do matter. When you are looking at enhancements in the benefit plan design, please keep in mind that those, in my view and our view, are not enhancements. They are a partial restoring of cuts made in 2011. As all of you know, state employees took the brunt of the economic downturn and many of those cuts in 2011. Particularly, health care for retirees has not been restored. I do want to put on the record that PEBP is going to have a meeting to adopt plan changes for the next fiscal year in March. As it stands right now, they have increased the cost to Medicare seniors by another $60 per year on top of previous cuts. We will have an opportunity to talk about that. We are vehemently opposed to Senate Bill 80 and will outline our concerns at a future date.

Kevin Ranft, Labor Representative/Lobbyist, American Federation of State, County and Municipal Employees, AFL-CIO, Local 4041:
To understand the details behind PEBP and PERS is not an easy task. Our international union out of Washington, D.C., is here and has opened up their research department. We are looking forward to working with all of you to answer some questions regarding not only the national trends, but what is going on here in Nevada. I am a labor representative with AFSCME who works on a day-to-day basis with state employees. They bring a lot of personal stories about what is going on with their health care and their families. We know that it is not easy for state employees to be here because they are working at the same time the session is happening, but we are looking forward to having some of those state employees meet you one-on-one. We want to let you know that we appreciate your time, and we respect everything that you do.

Vicky Cameron, Private Citizen, Las Vegas, Nevada:
I am a retired public employee. I am a non-state, non-Medicare retiree, and I am one of the dwindling few orphan retirees. I want the Committee to understand that on April 21, 2016, the PEBP Board unanimously voted that they would come back with a BDR to address the orphan issue. They have not done that. They have not made any effort to do that, and they continue to ignore the problem and ignore trying to find a fix.

Peggy Lear Bowen, Private Citizen, Reno, Nevada:
Two quick concerns but very deep concerns. When you heard the list of drugs that they are including when working with the providers, did you note that there were no drugs pertaining to diabetes? The insurance companies are getting out of the serving-people-with-diabetes business. It has followed up that we have people, and I speak directly to those people who have bought and sold the A and B Medicare, who were transferred without their permission, without their consent, or without pre-knowledge that they were going to be sold by the State of Nevada to an insurance company in Utah. I thought slavery went out with Lincoln, and you did not sell groups of people. I am questioning whether or not that was even a good thing to do or a legal or constitutional thing to do. But in fact, because they were insured and covered by A and B Medicare plans from other jobs other than serving the state they were taken from our state plan, although we are still a part of the conduit that our plan serves to get money to Utah to pay for them. Removing coverage to a third-party vendor brings me to a question. What would have happened if the State of Nevada had maintained them or allowed them to ask the question, if this does not work can they come back to Nevada? When the question regarding returning coverage to Nevada was asked, Mr. Jim Wells responded on the record, "Maybe." Well that "maybe" turned out to be "no." Once you sell a car you do not get to say what you want to have done to the car later. These people, because they are using A and B Medicare, are hitting the doughnut hole. I am not one of those people. Non-state retirees who went to the insurance company in Utah no longer had any control over the fact that another job was paying for their medical insurance through their 40 quarters earned in A and B Medicare. When they hit the doughnut hole, as an example, in March, that means that there are no more benefits for them until next January. They have come and testified how they are dying, and obituaries have been written because of the changes in the plan. Deaths were hastened because they have no coverage. Please consider a way to make a bill so that there is money that can be transferred from Nevada to cover the point when the doughnut hole is hit, so these people can still get their medical and prescription coverage because they served Nevada. Please do something to cover people with diabetes because they have been written out of pretty much most of the plans, and they are dying because they cannot afford their insulin.

Chairman Flores:
Thank you to everybody who participated in the public comment. Thank you for your passion and your interest. Please make sure that you reach out to our members. The meeting is adjourned [at 11:01 a.m.].

RESPECTFULLY SUBMITTED:

Patricia Keyes
Committee Secretary

APPROVED BY:

Assemblyman Edgar Flores, Chairman

DATE:

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is a copy of a PowerPoint presentation titled "Presentation to the Assembly Committee on Government Affairs," dated February 9, 2017, presented by Jeffrey Fontaine, Executive Director, Nevada Association of Counties.

Exhibit D is a document titled "Nevada Counties Matter," submitted by Jeffrey Fontaine, Executive Director, Nevada Association of Counties.

Exhibit E is a document titled "State and County Service Providers," submitted by Jeffrey Fontaine, Executive Director, Nevada Association of Counties.

Exhibit F is a document titled "Report on the Implementation of SB29, Functional Home Rule for Counties," submitted by Jeffrey Fontaine, Executive Director, Nevada Association of Counties.

Exhibit G is a copy of a PowerPoint presentation titled "Briefing on the Public Employees' Retirement System," dated February 9, 2017, presented by Tina M. Leiss, Executive Officer, Public Employees' Retirement System and Steve Edmundson, Investment Officer, Public Employees' Retirement System.

Exhibit H is a copy of a PowerPoint presentation titled "Public Employees' Benefits Program," dated February 9, 2017, presented by Damon Haycock, Executive Officer, Board of the Public Employees' Benefits Program.