Public Employees' Benefits Program

Legislative Session Bill Tracking

Updated: 3/27/2017

Bill Number & Description	Impact to PEBP & Board Position	Bill Status
AB249 (BDR 38-858) Requires the State Plan for Medicaid and all health insurance plans to provide certain benefits relating to contraception. This bill proposes the following changes: • Requiring all public health insurance plans in this State to provide coverage for certain benefits relating to contraception without any copay, coinsurance or a higher deductible. • Requiring certain additional forms of contraceptive drugs, devices and services to be covered by a health insurance plan, including, without limitation, up to a 12-month supply of contraceptives or its therapeutic equivalent, insertion or removal of a contraceptive device, education and counseling relating to contraception, management of side effects relating to contraception and voluntary sterilization for men and women. • Prohibiting the use of a program of step therapy or prior authorization requirement relating to the contraceptive drugs, devices and services required by this bill. • Require a health insurance plan to provide coverage for certain therapeutic equivalent drugs and devices relating to contraception when a therapeutic equivalent covered by the plan is deemed to be medically inappropriate by a provider of health care. • Require that benefits provided by a health insurance plan relating to contraception which are provided to the insured must also be provided to the spouse or dependent of an insured. **Effective Date**: January 1, 2018 (Upon Renewal for PEBP – July 1, 2018)	If passed, PEBP's CDHP would be required to provide a 12-month supply of contraceptives (versus 30-90 days today), cover voluntary male sterilization at 100% (after deductible), and eliminate coinsurance requirements for multi-source contraceptives. PEBP's HMO plans will be required to eliminate copays for contraceptives and male sterilizations. Additionally, no plan can impose any other restrictions or delays on the access of an insured to any such benefits, including, without limitation, a program of step therapy or prior authorization. **Board Position** Neutral (3/23/17) *Previously Opposed on 3/9/17* **Fiscal Note** PEBP is unable to determine the cost, however, expects the impact to be minimal.	3/6/17 – Heard by the Assembly Committee on Health & Human Services No future meetings scheduled at this time.

Bill Number & Description	Impact to PEBP & Board Position	Bill Status
AB331 (BDR 34-28) Creates the Nevada System of Community Colleges. This bill proposes the following changes: • Creates the State Board for Community Colleges and provides for the appointment by the Governor of the members of the Board. • Creates the Nevada System of Community Colleges, consisting of each community college administered under the direction of the Board and provides that the System is operated under the direction and control of the Board. • Provides the Board with similar powers and duties relative to the supervision and control of the Nevada System of Community Colleges as those exercised by the Board of Regents under existing law. • Creates a board of trustees for each community college within the System and provides for the appointment by the Governor of the membership of a board of trustees. • Amends NRS 287.041 to include an additional PEBP Board member who is a professional employee of the Nevada System of Community Colleges appointed by the Governor upon consideration of any recommendations of organizations that represent employees of the Nevada System of Community Colleges. • Amends NRS 287 to include the proposed Nevada System of Community Colleges in multiple areas similar to the Board of Regents and Nevada System of Higher Education. **Effective Date:** Upon passage and approval for the purpose of adopting any regulations and performing any preparatory administrative tasks necessary to carry out the provisions of this act; and, On January 1, 2018, for all other purposes.	If passed this bill separates out a new Nevada System of Community Colleges to be treated similar to the Board of Regents and Nevada System of Higher Education in PEBP. The PEBP Board would also increase from ten members to eleven with a new appointment for this new agency. **Board Position** No Position (3/27/17) **Fiscal Note** No Fiscal Impact	3/20/17 – Read First Time. 4/3/17 – Will be heard by the Assembly Committee on Education.

Bill Number & Description	Impact to PEBP & Board Position	Bill Status
AB352 (BDR 57-592) Provides for continued coverage for health care for certain chronic health conditions. This bill proposes the following changes: • Prohibits an insurer from requiring prior authorization or other preconditions for coverage, or from denying coverage, for a chronic condition for which approval for coverage had previously been provided either by the present insurer or by the immediately preceding former insurer. • Authorizes the imposition of a civil penalty for certain insurers who violate such requirements. **Effective Date:** July 1, 2017	If passed this requires PEBP to accept the decisions on pre-authorizations or other pre-conditions of coverage from another insurer without the ability to reassess those decisions. Patient safety is in jeopardy and cost controls are nullified with this bill. In effect, the bill prevents PEBP from managing its own health plan. This will also affect the HMO plans for PEBP participants coming on to their plans from outside PEBP plan sources. **Board Position** Neutral (3/23/17) **Fiscal Note** FY 18 = $4,480,089 FY 19 = $4,659,293 Future Biennia = $9,885,155 Higher Costs will be paid through increased employer and employee contributions or a reduction in plan benefits.	3/20/17 – Read First Time. 3/31/17 – Will be heard by the Assembly Committee on Commerce & Labor.

Bill Number & Description	Impact to PEBP & Board Position	Bill Status
AB381 (BDR 57-698) Revises provisions governing prescription drugs covered by policies of health insurance. This bill proposes the following changes: • Prohibits an insurer from moving a prescription drug from a lower cost tier to a higher cost tier before the expiration of the policy of health insurance, while expressly authorizing such a move upon renewal of the policy. • The insurer may move a prescription drug from a lower cost tier to a higher cost tier upon renewal of the policy of health insurance. **Effective Date:** July 1, 2017	PEBP's Pharmacy Benefits Manager will change tiers mid-year for certain drugs with alternatives that increase in cost dramatically. This occurs when a drug is purchased by a company and increased dramatically, or when a drug manufacturer increases the cost mid-year. This bill prevents PEBP from managing the health plan by forcing PEBP to keep all drugs in the tiers they were designated at the beginning of the plan year through to the end. **Board Position** Neutral (3/23/17) **Fiscal Note** FY 18 = $282,766 FY 19 = $894,151 Future Biennia = $332,801 This fiscal note reflects the cost for those brand name drugs losing patent protections by 2021.	3/20/17 – Read First Time. No future meetings scheduled at this time.

Bill Number & Description	Impact to PEBP & Board Position	Bill Status
AB382 (BDR 40-570) Establishes provisions governing payment for the provision of emergency services and care to patients. This bill proposes the following changes: • An out-of-network hospital with 100 or more beds that is not operated by a federal, state or local governmental agency or an out-of-network independent center for emergency medical care that is operated by a person who also operates such a hospital shall accept as payment in full for the provision of emergency services and care to a patient, other than services and care provided to stabilize the patient, a rate in accordance with subsection 2 if the patient: a) Was transported to the out-of-network hospital or out-of-network independent center for emergency medical care for the provision of emergency services and care by an ambulance, air ambulance or vehicle of a fire-fighting agency which has received a permit to operate pursuant to chapter 450B of NRS; and b) Has a policy of insurance or other contractual agreement with a third party that provides coverage to the patient for emergency services and care provided by more than one hospital and independent center for emergency medical care in this State other than the hospital or independent center for emergency medical care to which the patient was transported. • The out-of-network hospital (above) shall accept as payment in full for such emergency services and care a rate which does not exceed the greater of: a) The average amount negotiated by the third party with in-network hospitals in this State for the same or similar emergency services and care, excluding any deductible, copayment or coinsurance paid by the patient. b) One hundred twenty-five percent of the average amount paid by Medicare • These rules apply to out-of-network physicians on medical staff of out-of-network hospitals or centers for emergency care as well at the same level of payments described above. • Where disagreements occur, there are rules to mediate. **Effective Date:** Upon passage and approval for the purpose of adopting any regulations and performing any preparatory administrative tasks necessary to carry out the provisions of this act; and, On January 1, 2018, for all other purposes.	If passed, this bill will require payments to be accepted for emergency services for out-of-network hospitals and their physicians at the greater of in-network negotiated rates or 125% of Medicare. This bill may assist PEBP participants with balance billing of high cost out-of-network emergency services. **Board Position** No Position (3/27/17) **Fiscal Note** LCB has not requested a fiscal note for this bill.	3/20/17 – Read First Time. No future meetings scheduled at this time.

Bill Number & Description	Impact to PEBP & Board Position	Bill Status
AB408 (BDR 38-957) Revises provisions relating to Medicaid and health insurance. This bill proposes the following changes: • Aligns Nevada law with federal law and require all insurers to offer health insurance coverage regardless of the health status of a person and prohibits an insurer from denying, limiting or excluding a benefit or requiring an insured to pay a higher premium, deductible, coinsurance or copay based on the health status of the insured or the covered spouse or dependent of the insured. • Requires all insurers to extend coverage for the covered adult child of an insured until such child reaches 26 years of age to align Nevada law with federal law. • Requires all health insurance plans to include coverage for maternity and newborn care aligning Nevada law with federal law. • Requires all health insurance plans to include coverage, without any higher deductible or any copay or coinsurance, for certain preventive health care services for women, adults and children, including, without limitation, screenings and tests for certain diseases, counseling, contraceptive drugs, devices and services as well as vaccinations aligning Nevada law with federal law. • Requires the Director of the Department of Health and Human Services to adopt regulations specifying the preventive health care services which are required to be covered by insurers and that these requirements must include, without limitation, the preventive health care services currently required by federal law. • Insurers cannot discriminate on various protections. **Effective Date:** Upon passage and approval for the purpose of adopting any regulations and performing any preparatory administrative tasks necessary to carry out the provisions of this act; and January 1, 2018, for all other purposes.	This bill in effect ensures the State of Nevada has the same provisions of the Affordable Care Act (ACA) if the ACA is repealed in part or in full. PEBP already supports the provisions of this bill and sees no additional impact. **Board Position** Neutral (3/23/17) **Fiscal Note** No Fiscal Impact	3/20/17 – Read First Time. No future meetings scheduled at this time.

Bill Number & Description	Impact to PEBP & Board Position	Bill Status
SB80 (BDR 18-243) Makes various changes relating to the Public Employees' Benefits Program and the Deferred Compensation Program. This bill proposes the following changes: • Creates the Employee Benefits Division of the Department of Administration. • Requiring the Director of the Department of Administration to appoint the Administrator of the Employee Benefits Division. • Converting the Board of the Public Employees' Benefits Program into an advisory board and removing the requirement that the Board award certain contracts and requires the Advisory Board to advise the Administrator concerning the administration of the Program. • Providing for the Administrator to assume certain powers, duties and functions of the Board and the Executive Officer of the Public Employees' Benefits Program. • Provides that the Administrator assumes: (1) the authority of the Executive Officer to appoint staff; and (2) the duties of the Executive Officer to submit certain reports and receive continuing education. **Effective Date:** January 1, 2018 (Upon Renewal for PEBP – July 1, 2018)	If passed, PEBP would transition to the Department of Administration, the PEBP Board would transition from governing to advisory, and the agency and the Executive Officer would be replaced with the Administrator, who would report directly to the Director of the Department of Administration. The Quality Control Officer would work at the pleasure of the Executive Officer with no additional Board oversight. PEBP would no longer have a Purchasing exemption to procurement processes in NRS 333. **Board Position** No Position (3/27/17) **Fiscal Note** No Fiscal Impact for the current biennium.	2/20/17 – Notice of Eligibility for Exemption. No future meetings scheduled at this time.

Bill Number & Description	Impact to PEBP & Board Position	Bill Status
SB139 (BDR 40-679) Makes various changes to provisions relating to patient-centered medical homes. This bill proposes the following changes: • Requiring the Advisory Council on the State Program for Wellness and the Prevention of Chronic Disease to establish an advisory group comprised of interested persons and government entities to study the delivery of health care through patient-centered medical homes. • Requiring the Commissioner of Insurance, in consultation with the advisory group established by the Advisory Council, the Director of the Dept. of Health and Human Services and other interested persons and governmental entities, to adopt regulations prescribing standards concerning certain payments to and incentives for patient-centered medical homes. • Incentives that are authorized by those regulations and by federal law are not considered unfair methods of competition or unfair or deceptive trade practices. • Requiring plans of health insurance that provide coverage for a service rendered by a patient-centered medical home, including plans of health insurance provided by state and local governmental entities to their employees and Medicaid managed care plans, to provide any such payments or incentives as applicable. **Effective Date:** January 1, 2018 (Upon Renewal for PEBP – July 1, 2018)	If passed, PEBP would have to build incentives into reimbursing patient-centered medical homes in Nevada, without knowing what those incentives will be until approved by an advisory group that may or may not include PEBP's input on those incentives. Depending on the costs, the impact can be minimal to massive. These required incentives will need to be passed on to participants in the form of rate increases. PEBP's HMO plans will also need to incur these incentives and will increase rates accordingly. **Board Position** Neutral (3/23/17) **Fiscal Note** Fiscal impact is dependent upon the amount of the incentives and the number of members participating. Range provided of $60,000 annually to $33,937,200 annually. A proposed amendment would eliminate mandatory incentives. Should the bill pass as amended the fiscal impact would be none.	2/28/17 – Notice of Eligibility for Exemption. 3/27/17 - Heard by the Senate Committee on Health & Human Services; Amend and do pass as amended. Amendment provided by Nevada Primary Care Association.

Bill Number & Description	Impact to PEBP & Board Position	Bill Status
SB233 (BDR 38-817) Requires the State Plan for Medicaid and health insurance plans to provide certain benefits. This bill proposes the following changes: • Requiring all public and private health insurance plans made available in this State to provide coverage for certain preventative services without any copay, coinsurance or a higher deductible. • Requiring certain additional forms of contraceptive drugs, devices, supplies and services to be covered by a health insurance plan, including up to a 12-month supply of contraceptives or a therapeutic equivalent, insertion or removal of a contraceptive device, education and counseling relating to contraception and voluntary sterilization for men and women. • Requiring all public and private health insurance plans in this State to provide coverage for hormone replacement therapy without any copay, coinsurance or higher deductible. • Requiring a pharmacist to dispense up to a 12-month supply of contraceptives or their therapeutic equivalent upon the request of a patient who has a valid prescription. **Effective Date:** January 1, 2018 (Upon Renewal for PEBP – July 1, 2018)	If passed, PEBP would be required to provide a 12-month supply of contraceptives (versus 30-90 days today), cover voluntary male sterilization at 100% (after deductible), and eliminate coinsurance requirements for multi-source contraceptives. PEBP's HMO plans will be required to eliminate copays for contraceptives and male sterilizations. Additionally, no plan can impose any other restrictions or delays on the access of an insured to any such benefits, including, without limitation, a program of step therapy or prior authorization. This bill also includes the requirement to provide hormone replacement therapy (which PEBP does today) but eliminating the step therapy and prior authorization which PEBP has in place currently through a pre-certification requirement. **Board Position** Opposed (3/9/17) **Fiscal Note** FY 18 = $314,336 FY 19 = $336,372 Future Biennia = $745,030	3/6/17 – Heard by the Senate Committee on Health & Human Services; no action. 3/6/17 – Assembly Committee on Health & Human Services; mentioned, no jurisdiction. No future meetings scheduled at this time.

Bill Number & Description	Impact to PEBP & Board Position	Bill Status
SB265 (BDR 40-809) Revises provisions concerning prescription drugs. This bill proposes the following changes: • Requiring the manufacturers of certain expensive prescription drugs or prescription drugs that have increased in price to submit to the Dept. of Health and Human Services a report providing justification for the price or price increase, as applicable. • Requires a manufacturer to reimburse the purchaser of a drug that is included on the list of essential diabetes drugs compiled by the Department of Health and Human Services if: (1) the wholesale acquisition cost of the drug exceeds the highest price paid for the drug in certain foreign countries; or (2) the manufacturer increases the wholesale acquisition cost of a drug during a calendar year by more than a prescribed amount. • Requires an insurer, including a state or local governmental entity that insures its employees, that receives such a reimbursement to refund (to the extent of such reimbursement) any deductible paid by an insured for the drug in an amount that does not exceed the amount of the reimbursement. • Requiring an insurer, including a state or local governmental entity that insures its employees, that uses a formulary to publish before each open enrollment period a notice of all drugs that have been removed from the formulary or will be removed from the formulary during the current plan year or the next plan year. **Effective Date:** January 1, 2018 (Upon Renewal for PEBP – July 1, 2018)	If passed PEBP will need to coordinate with our Pharmacy Benefits Manager (Express Scripts) to ensure we post formulary changes on diabetes drugs on our website no later than 30 days before open enrollment (April 1) of each year. Additionally, if PEBP receives a reimbursement from manufacturers for diabetes drugs under section 6 of the bill, PEBP would need to refund a participants' deductible (but not coinsurance) applied to the purchase. These requirements would also be implemented for PEBP's HMOs. **Board Position** No Position (3/27/17) **Fiscal Note** FY 18 = ($1,074,329) FY 19 = ($1,289,195) Future Biennia = ($3,403,474) The requirements of the bill may result in a reduction to revenue from RX rebates requiring an offsetting increase in employer and employee contributions.	3/14/17 – Read First Time. 3/29/17 – Heard by the Senate Committee on Health and Human Services; no action.

Bill Number & Description	Impact to PEBP & Board Position	Bill Status
SB289 (BDR 57-675) Requires certain policies of health insurance to cover services provided by an out-of-network physician. This bill proposes the following changes: • If an insurer offers for sale in this State a policy of health insurance that provides coverage through a network plan, the insurer shall provide for the reimbursement of services provided by an out-of-network physician to a person covered by the policy of health insurance upon submission of a claim by the physician. • The insurer shall provide reimbursement to the physician within 30 days after receipt of a claim in an amount equal to the lesser of: o The amount billed by the physician in the claim submitted by the physician; or o The 80th percentile for the particular service in the geographic area where the service was provided as reported in the database selected by the Commissioner. o The Commissioner shall, by regulation, adopt a database containing benchmarks for charges for services provided by a physician. • An insurer who offers or issues a policy of group health insurance which provides coverage through a network plan shall include in the policy of group health insurance: o A notice that the provisions of this act apply to health care services received from an out-of-network physician while covered by the policy of group health insurance; and o A procedure for the recovery of a copayment, deductible or coinsurance from a person covered by the policy of group health insurance for any reimbursement paid. **Effective Date:** Upon passage and approval for the purpose of adopting any regulations and performing any preparatory administrative tasks necessary to carry out the provisions of this act; and January 1, 2018, for all other purposes.	PEBP maintains multiple networks of providers with guaranteed discounts to control costs for the state. If this bill is passed, out-of-network physicians will be reimbursed at higher rates than in-network physicians, incentivizing a migration of physicians away from the networks altogether. The 80th percentile in effect could potentially become a 20% off traditional billed charges. PEBP currently averages 62.8% in-network discount with 96.4% utilization. PEBP is developing a fiscal note to show impact of out-of-network incentivized payments. These requirements also apply to HMOs. HMOs do not traditionally provide care outside of their networks unless it is urgent or emergent. Therefore, these requirements also force HMOs to act like PPOs. Their costs could increase dramatically. **Board Position** Neutral (3/27/17) **Fiscal Note** FY 18 = $12,900,000 FY 19 = $13,416,000 Future Biennia = $28,463,386 Higher Costs will be paid through increased employer and employee contributions or a reduction in plan benefits.	3/16/17 – Read First Time. 4/3/17 – Will be heard by the Senate Committee on Commerce, Labor and Energy.

Bill Number & Description	Impact to PEBP & Board Position	Bill Status
SB366 (BDR 38-927) Revises provisions relating to Medicaid and the release of health insurance claims data under certain conditions. This bill proposes the following changes: • Requires an insurer which provides health insurance coverage pursuant to a contract with the Public Employees' Benefits Program to provide either: (1) all claims data relating to the enrollees of such coverage to the Board of the Program once every 3 months; or (2) sufficient data for the Board to calculate the cost of providing certain medical services through the insurer, including, without limitation, data relating to patient demographics, drug prescriptions, office visits with a provider of health care, inpatient services, outpatient services and certain other data required for an insurer to comply with certain sections of the Patient Protection and Affordable Care Act (Public Law 111-148, as amended). ○ Requires this data to: (1) be free of any personally identifiable information; (2) comply with all other federal and state laws concerning privacy; and (3) be easily accessible. **Effective Date:** July 1, 2017	If passed, this bill will require health plan PEBP contracts with to provide similar data to PEBP and the Board as our Third Party Administrators (HealthSCOPE and Express Scripts) do today for our CDHP. It would affect both HMO plans we have contracted through 2021. **Board Position** In Support (3/27/17) **Fiscal Note** LCB has not requested a fiscal note for this bill, however, as written PEBP anticipates there will be no fiscal impact.	3/20/17 – Read first time. 4/5/17 – Will be heard by the Senate Committee on Health and Human Services.

Bill Number & Description	Impact to PEBP & Board Position	Bill Status
SB394 (BDR 38-950) Revises provisions relating to Medicaid managed care and required coverage provided by health insurers. • Prohibits an insurer from establishing eligibility rules for a health care plan based on certain health status factors, including, without limitation, preexisting conditions, claims history or genetic information, and also prohibits an insurer from charging a higher premium, deductible or copay based on these health status factors. • Requires that all insurers offer health insurance coverage regardless of the health status of a person and prohibit an insurer from denying, limiting or excluding a benefit or requiring an insured to pay a higher premium, deductible, coinsurance or copay based on the health status of the insured or the covered spouse or dependent of the insured. • Requires an insurer that offers or issues a policy of group health insurance shall include in each policy coverage for all essential health benefits and shall not place an annual, lifetime or other maximum limit on coverage for such essential health benefits. Such essential health benefits must include, without limitation: (a) Outpatient services; (b) Emergency care; (c) Hospitalization; (d) Pregnancy, maternity and newborn care; (e) Services relating to mental health and substance use disorders, including, without limitation, treatment for behavioral health and inpatient services for behavioral and mental health; (f) Prescription drugs; (g) Rehabilitative and habilitative services and devices; (h) Laboratory services; (i) Preventive and wellness services and management of chronic diseases; (j) Pediatric services, including, without limitation, oral and vision care for children; (k) Contraceptive drugs, devices and services; and (l) Breastfeeding support, counseling and supplies. • Requires an insurer that offers or issues a policy of group health insurance which provides coverage for dependent children shall continue to make such coverage available for an adult child of an insured until such child reaches 26 years of age. • This bill does not require an insurer to make coverage available for a dependent of an adult child of an insured. **Effective Date:** Upon passage and approval for the purpose of adopting any regulations and performing any preparatory administrative tasks necessary to carry out the provisions of this act; and January 1, 2018, for all other purposes.	This bill in effect ensures the State of Nevada has the same provisions of the Affordable Care Act (ACA) if the ACA is repealed in part or in full. PEBP already supports the provisions of this bill and sees no additional impact. **Board Position** No Position (3/27/17) **Fiscal Note** No Fiscal Impact	3/20/17 – Read first time. 4/5/17 – Will be heard by the Senate Committee on Health and Human Services.

Bill Number & Description	Impact to PEBP & Board Position	Bill Status
SB404 (BDR 57-467) Revises provisions relating to health insurance coverage of certain cancer treatment drugs. • Authorizes the use of a drug approved by the United States Food and Drug Administration for the treatment of metastatic cancer, including, without limitation, cancer identified as advanced or stage four, without the insured having to first fail to respond successfully to a different drug or prove a history of failure of such drug. • Prohibits an insurer, carrier, hospital or medical services corporation, health maintenance organization and managed care organization from requiring prior authorization for the mandated benefits. **Effective Date:** July 1, 2017	If passed, this bill forces PEBP to disregard step therapy and pre-certification for certain cancer treatments. The concern is treatments that are considered experimental or investigational are often extremely expensive and still may pose a risk for patient safety. This bill also appears to modify the definition of standard of care. **Board Position** No Position (3/27/17) **Fiscal Note** PEBP believes the requirements of this BDR will result in an overall increase in claims costs requiring an increase to employer and employee contributions or a reduction to plan benefits. Although there will be a fiscal impact PEBP is unable to determine the cost.	3/20/17 – Read first time. No future meetings scheduled at this time.

Bill Number & Description	Impact to PEBP & Board Position	Bill Status
SB436 (BDR 57-996) Prohibits certain discriminatory designs for prescription drug benefits in health benefit plans. This bill proposes the following changes: • Requires certain public and private policies of insurance and health care plans to: (1) provide, in each level of coverage provided by such policies, that at least 25 percent of those policies apply a copayment before the payment of a deductible to the entire prescription drug benefit; and (2) not place all prescription drugs within a given class within the highest cost tier provided by the policy or plan. **Effective Date:** July 1, 2018	If passed, PEBP would be required to either 1) offer another plan alongside the CDHP to meet the requirement of providing a RX benefit with copays, 2) eliminate the HSA and carve out the RX benefit to provide RX copays, or 3) eliminate the CDHP and replace with a standard PPO plan with RX copays. All 3 options above would significantly change the program of benefits and require actuarial analysis, MPD revisions/creations, and increase the costs to PEBP. **Board Position** None at this time. The Board has not yet deliberated on this Bill. **Fiscal Note** FY 18 = $43,689,636 FY 19 = $45,050,550 Future Biennia = $95,758,925 Higher Costs will be paid through increased employer and employee contributions or a reduction in plan benefits.	3/27/17 - Read first time. 4/3/17 – Will be heard by the Senate Committee on Commerce, Labor and Energy.

Bill Number & Description	Impact to PEBP & Board Position	Bill Status
SB502 (BDR 18-979) Makes various changes relating to the Public Employees' Benefits Program and the Public Employees' Deferred Compensation Program. This bill proposes the following changes: • Transitions the Public Employees' Benefits Program and the Public Employees' Deferred Compensation Program to the Department of Administration. • Requiring the Director of the Department of Administration to appoint, with the concurrence of the Governor, the Executive Officer of the Public Employees' Benefits Program. • Converting the Board of the Public Employees' Benefits Program into an advisory board and transfer the powers, duties and function of the Board relating to the administration of the Program to the Executive Director of the Program. • Reduces the size of the Board from ten members to seven, changes the composition of the Board and removes the requirement that the Governor provide certain notice upon removing an appointed member of the Board. • Eliminates the requirements that the Executive Officer and the Board of the Public Employees' Benefits Program complete certain continuing education requirements relating to the administration of group benefits for public employees. **Effective Date:** July 1, 2017	If passed, PEBP would transition to the Department of Administration, the PEBP Board would transition from governing to advisory and be reduced from ten members to seven members, eliminates the continuing education requirements of the PEBP Executive Officer and the PEBP Board members. The PEBP Executive Officer would report directly to and serve at the pleasure of the Director of the Department of Administration. **Board Position** None at this time. The Board has not yet deliberated on this Bill. **Fiscal Note** No Fiscal Impact	3/27/17 - Read first time. No future meetings scheduled at this time.