From: Debbie Pattni [redacted]
Sent: Friday, July 23, 2021 8:12 AM
To: Wendi Lunz <wlunz@peb.nv.gov>
Subject: Unfair cuts to UNLV benefits

Dear Advisory Board,

I have witnessed many of my family members and friends leaving jobs to take higher paying, remote and flexible jobs with better benefits than we get as state employees. While I have always been paid remarkably less than those in the private sector, I would justify the salary caps by experiencing better vacation accrual and better healthcare benefits.

Now not only did we experience a hiring freeze, salary cuts in the form of furloughs, no increases in COLA in the next year, we also had our parking permits increase in cost and our healthcare costs go up and require more out of pocket costs. There is literally NO reason not to start looking at the private sector for jobs now, except that I really care about the future of higher education and the impact I can make on our students.

All UNLV faculty, administrative included, have multiple degrees and are highly educated. I personally can make 50% more in salary and likely stay remote if I chose since there are so many jobs hitting my Linked In, but I ask you instead to return our furlough cuts to us now that things have improved, and please consider increasing our HSA and other cuts the state took. We sacrificed financially when things were down, but when things improve, why do state employees not benefit?

I worked hard 8 hours per day all through the furlough just to make sure the students are-enrolled into classes and had helpful information while they navigated a climate of uncertainty. I will do this no matter what you decide. However, now that my goals for students to return to campus are nearly realized, don't you want to reward our hard work to keep UNLV vibrant and a strong community partner?

Thank you for your time.

Debbie Pattni, MBA, MHA, M.Ed
[redacted]
Web • Twitter • Facebook • Instagram • YouTube
Top 3 percent nationally in research activity.

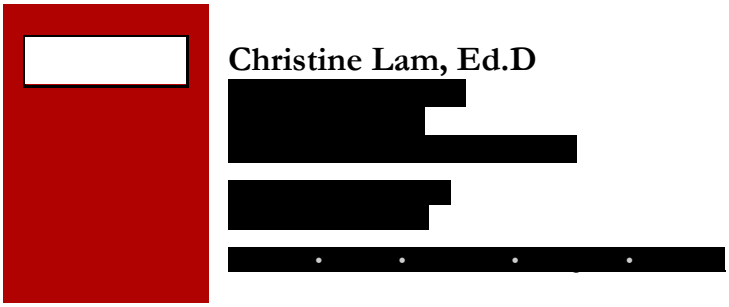
From: Christine Lam [redacted]
Sent: Friday, July 23, 2021 8:19 AM
To: Wendi Lunz <wlunz@peb.nv.gov>
Subject: RE: Written Public Comment for Next PEBP Meeting (7/29)

Hello,

Here is my comment about the PEBP Benefits:

Deductibles are already high in this state and to raise them again is unjust and irresponsible. Employees with state health benefits should have one of the best insurance options and instead we have the worst. I came from NJ where state employees have one of the best insurance plans. I went from having a $100 deductible to having one that is more than 10 times that amount here in Nevada. I am hesitant to go to the doctor because I am afraid of the bill I will receive post-visit. Decreasing the HSA funds only made matters worse. Also, changing healthcare providers from Hometown Health to Aetna, I can't find a provider in-network near me. In some cases, I have found it is cheaper to pay out of pocket using a doctor's office "no insurance discount offers/cash patient plans" than it is to use my own insurance.

Best,
Christine



From: [redacted]
Sent: Friday, July 23, 2021 8:31 AM
To: Wendi Lunz <wlunz@peb.nv.gov>
Cc: [redacted]
Subject: Healthcare Stories to the PEBP Board

Good Morning,

My name is [redacted] I am a member of the UNLV Graduate College staff and a proud alumni of the UNLV Creative Writing bachelor's program. I would appreciate if my name remained anonymous in any publications or meetings concerning my health status, due to any discrimination that I may face. Besides that, I want to share my situation with you.

I have been living with [redacted] since 2008. Thanks to medication, I am able to live without fear of my health deteriorating or passing along the virus to others. This medication is extremely expensive. It costs over $1000 a month before insurance and co-pay assistance. Last year, our insurance and the co-pay assistance was unable to pay for this medication throughout the course of the year and I was left needing to pay about $1500 to my pharmacist ($500 for 3 months of medication). This was extremely difficult for me to pay as I live on a tight budget to begin with.

Knowing now that our deductible has changed and that this will potentially increase the cost of my medication's out of pocket for me, this scares me deeply. My medication literally keeps me alive, but now I have to face a deepening burden to my budget due to these changes in our health benefits. If there is any way PEBP or the UNLV Employee Benefits Advisory Committee can help UNLV employees like myself who are in this situation, I would greatly appreciate it. I wish you all the best and hope you all have a wonderful day.

Thank you,

[redacted]

Jay F. Cafferata
[redacted]

7/22/2021

To Laura Freed and the Members of the PEPB Board:

Today (Thursday, July 22nd) I received a phone call from Express Scripts – the preferred pharmacy of my state employee's Consumer Driven Health Plan – regarding one of the medications I have been prescribed by my physician, Dr. Colleen Kriss. The message I received was automated but told me that one of my medications had been denied. That medication is testosterone.

I have been prescribed testosterone under the care of Dr. Kriss for the last three years. She has been my primary care provider for over a decade. Prior to this denial of care, I have not been required to receive specialized treatment from an endocrinologist or mental health provider to gain access to treatment. Primary care is transgender care. If I am the consumer and driving the cost of my care – then a primary care physician will always be the lowest cost and the greatest value in the continuity of care for me.

Historically, this medication has been prescribed by this physician – not just for me but others as well – this is impacting only one group of her patients – transmasculine and non-binary patients. AETNA has introduced an arbitrary standard for prescribing testosterone that affects a specific population; transgender and gender non-conforming people.

The explanation for the denial given to Dr. Kriss's office is that only an endocrinologist or a physician who specializes in transgender care can prescribe testosterone for gender dysphoria. Unless a primary care physician cannot prescribe testosterone to any patient – then this is plainly discrimination based on my transgender status and not based on the physician's skill, training, or ability. If I were seeking hormone replacement therapy for my experience with menopause, I doubt that AETNA would require me to see a specialist physician. My primary physician also prescribes my thyroid hormone replacement medication with no requirement to see an endocrinologist.

Please look for yourself – in Northern Nevada - a provider that "specializes in transgender care" is not listed under AETNA's available providers. There are NO transgender care specialists or medical providers identified by AETNA as "in-network". This is an unjustifiable requirement that arbitrarily creates a barrier to care for one of the most vulnerable populations of patients in the state of Nevada.

By requiring me to seek specialized care, I will be forced to find an OUT OF NETWORK medical provider, pay for a new patient exam, travel, reveal my transgender status that puts me at risk for discrimination

and harm as well as take time away from my job and my family. My insurance benefits do not pay for out of network providers by simply having a large "out-of-network deductible". These mandatory requirements are discriminating provisions/conditions for receiving basic healthcare that targets one group of people by AETNA – the health insurance provider which you selected.

Here is the plan document: Page 58

Explanations and Limitations Gender Reassignment Surgery for the Treatment of Gender Dysphoria

This Plan provides certain benefits to individuals seeking medical services for the treatment of gender dysphoria. • Benefit coverage includes related mental health, hormone therapy, prescription drug therapy, and gender reassignment surgery. • ***Benefits are conditioned*** *upon adherence to the requirements listed in this Plan document such as obtaining precertification for applicable services. Other* ***mandatory requirements*** *include a mental health evaluation and mental health treatment to confirm a diagnosis of gender dysphoria. •* ***Precertification is required for all services*** *related to gender dysphoria (excluding mental health services). The precertification requirement applies to medical treatment related to hormone therapy and prescription drug therapy* ***by the pharmacy benefit manager****.*

Hormone Therapy Coverage page 59

Hormone therapy coverage requires precertification. Benefits for oral and self-injectable hormone replacement treatment therapies must be obtained through an In-Network pharmacy or mail order pharmacy. Hormone therapy for individuals preparing for gender reassignment surgery is medically necessary when all the following criteria are met: • Persistent, well-documented Gender Dysphoria. • Capacity to make fully informed decision and to consent for treatment. • Must be at least 18 years old (age of majority). • ***Demonstrate knowledge of what hormones can and cannot do as well as their social benefits and risks.*** *• Document real-life experience of at least three months prior to the administration of hormones; or • Undergo a period of psychotherapy of a duration specified by a mental health professional whose specialty is working with individuals with gender dysphoria (usually a minimum of three months)*

This does not follow your own policy nor Nevada Law. And since AETNA has no providers that offer this "specialty of working with individuals with gender dysphoria" – this condition is not achievable within the plan coverage limits. I would have to seek outside medical care to meet the "conditions" for treatment coverage according to the plan as written.

This new and arbitrary barrier to accessing medically necessary health care for transgender people is contrary to the inclusive PEBP policy that began on July 1, 2015 and has helped transgender employees that are entitled to benefits as part of standard state employee compensation. Altering access after six years of positive experience is detrimental to both the physical and mental health of those that have been historically accessing this medically necessary treatment. And to be clear – not every person who is transgender or non-binary has gender dysphoria or is seeking surgical treatment options, which may require a higher degree of evaluation. This is another example of denying services to a patient based on a company's business decision about what constitutes appropriate medical care for trans and non-binary patients and does not follow ethical clinical guidelines. It is apparent that the person who agreed to this section of the plan is not a medical provider that specializes in the treatment of transgender or non-binary patients.

I do not know what "document real-life experience of at least three months" is referring to – are you required to document real life experience with ANY medical condition before you can receive medically appropriate care? This amounts to a 90-day waiting period to receive healthcare specifically and only for the treatment of gender dysphoria. Documentation of "real life experience" for hormone therapy is not part of any recommendations of major medical associations, including the American Medical Association, the American Academy of Pediatricians, the Endocrine Society, and many others. The mandatory requirement that a patient be able to *demonstrate knowledge of what hormones can and cannot do as well as their social benefits and risks* is not required for similar hormones – I do not need to demonstrate knowledge about how the Thyroid functions or the social benefits and risks associated with taking thyroid hormone replacement medication.

There is also the question of why years of documented hormone therapy doesn't qualify as "pre-certification" by AETNA, as abrupt discontinuation of hormone therapy has dangerous medical outcomes. At what point after 4 years of a medically necessary and appropriate lifelong treatment plan – such as for the treatment of diabetes or hypothyroidism - requires a re-evaluation by a pharmacy benefit manager? Are all pharmacy benefit managers providers that specialize in the care of transgender and non-binary patients? This is my medical history – there was no interruption of care until I was denied access to hormone therapy by this plan document and your decision to accept it.

AETNA's policy also runs contrary to the policies and practices of Nevada Medicaid, which follows the "informed consent" model for hormone therapy, allowing for primary care practitioners (physicians, nurse practitioners, and physician assistants) to begin hormone therapy for transgender patients without prior 'gatekeeping' by a mental health provider or 'real life experience.' It should go without saying that simply continuing a prescriptive treatment of hormone therapy is well within the guidelines of approved care under Medicaid.

AETNA's plan documents regarding treatment for gender dysphoria (the underlying diagnosis for transgender people) appear to violate NRS 613.330 *Unlawful employment practices: Discrimination on basis of race, color, religion, sex, sexual orientation, gender identity or expression, age, disability, national origin or discussion of wages; interference with aid or appliance for disability; refusal to permit service animal at place of employment; consideration of criminal history without following required procedure.* Because health benefits are part of employee compensation, requiring a different set of standards for hormone treatment of transgender people is a violation of law.

Federal law also comes to bear on this issue, under Title VII. The *Bostock* ruling from June 15, 2020 makes amply clear that an employer treating a transgender employee differently than a cis-gender employee is discrimination on the basis of sex. A cis-gender man is permitted to have a primary care physician prescribe testosterone without the barriers outlined by AETNA for a transgender man as it defines a different level of approval than for a cisgender man or a cisgender woman.

It is within the Board's power to override these illegal and inappropriate clauses in AETNA's policy. It is imperative that this action take place immediately to prevent further harm to myself and to other transgender employees. Transgender people are a protected class and any policies that affect only this group of employees, or their beneficiaries must meet a level of "heightened scrutiny" which the AETNA policy does not.

I wish to thank you for your consideration of this issue and look forward to your speedy actions to comply with state and federal law, as well as to meet the medically necessary needs of transgender employees.

Respectfully,

Jay F. Cafferata

cc: Governor Steve Sisolak

Richard Whitley, Director of Health and Human Services

Tina Dortch, Program Manager, Nevada Office of Minority Health and Equity

From: Eileen Quinn [redacted]
Sent: Sunday, July 25, 2021 3:35 PM
To: Wendi Lunz <wlunz@peb.nv.gov>
Subject: PEBP Board - Written Public Comment

To the PEBP Board,

I'd like to share my personal impact that the changes of the Employee Insurance benefits will have on me and my spouse.

My Primary Care Physician's Health Organization: P 3 Medical Group - They were not re-contracted with our employee benefits plan this year. This is a disadvantage for me. I have been going to my Primary Care Physician for 3 years now and do not wish to seek out a new doctor. I do not want to pay Out of Network prices. My husband is retired and on Medicare and I will be retiring, possibly within the next 2 years. This is a difficult time for me to have a change now.

Also, the increases in the deductible and out of pocket expenses are going to prove to be difficult; again as this is the beginning of a transition period for us within the next two years. My husband had a difficult year of medical expenses last year and it took until the latter part of the year to get to the point of us being able to pay co-pays; we had difficulty meeting the deductibles and the medical businesses all expected their bills to be paid immediately, putting a strain on our monthly income.

I am thankful and grateful to have the Employees Insurance Benefits. I wonder the reasons for the increases in the deductibles and out of pocket expenses.

Thank you for listening to my personal situation. I know you have a big job meeting the needs of all your employees.

Sincerely,

[redacted]

Eileen Quinn, M. Ed
Program Coordinator
Department of Early Childhood, Multilingual, and Special Education
[redacted]

From: Robin Wood [redacted]
Sent: Monday, July 26, 2021 9:20 AM
To: Wendi Lunz <wlunz@peb.nv.gov>
Subject: Benefits changes

Good morning,

I am extremely disappointed with the newest changes to our benefits. Not only are the costs higher and the Health Savings amount lowered, but my doctor is no longer in our network. I looked up other doctors who specialize in the same field on the new network, and all have VERY low ratings! I now have to pay out of network prices to go to the doctor I know and trust. That is beyond unfair, especially with the decrease in the Visa amount. Most of the time I roll with the punches when it comes to the benefits changes, but this time it is too much.

Please let me know if you have any questions.

Thank you,

Robin L. Wood

From: Bonnie Brucato [redacted]
Sent: Monday, July 26, 2021 11:30 AM
To: Wendi Lunz <wlunz@peb.nv.gov>
Subject:

The increase in the deductible and decrease in HRA funds have hindered my ability to postpone seeking medical treatment for my health issues. All doctors, imaging centers, hospitals etc. in Las Vegas require payment up front before services are rendered if you have not met your deductible requirements. I don't have extra dollars to pay medical costs upfront with the decrease in HRA funds. The deductible is so high that it will be difficult to meet therefore, postponing medical treatment. It's unfair to raise healthcare costs and our retirement contribution when employees at UNLV have not received a pay increase. I sincerely hope leadership will revisit this situation and decrease the health insurance deductible and increase HRA funding to enable myself and many others to seek medical treatment sooner rather than postpone it due to financial constraints.

Thank you very much!

From: Jessica Ogens [redacted]
Sent: Monday, July 26, 2021 6:53 PM
To: Wendi Lunz <wlunz@peb.nv.gov>
Subject: RE: PEBP Board Public Comment - Healthcare Story for Meeting on 7/29

Hello PEBP Board,

It is advised that our *deductibles are increasing*, our *out of pocket maximums are increasing*, yet you are *decreasing the amount of funds we receive in our Health Savings accounts*? If true and approved, this is an appalling and inhumane action after we have all suffered a year of furlough, while contending with a disastrous, ongoing pandemic and its financial consequences for ourselves and our loved ones. Wonderful timing + our wages are not going to increase to counteract these pokes and jabs...

People are forgoing seeking medical care because of the consequences and expense of doing so, myself included. For example, after a year of neglecting a condition that has worsened each month I finally sought medical help in June because of a terrifying experience with my heart and to check for hormone imbalances. The women in my family have almost all experienced heart failure by 40 years old - it is congenital. I chose not to seek emergency medical care when the stressful and scary event was happening because I knew the testing and bills, especially in an emergency setting, would be crushing. I waited two weeks before breaking down and seeing an urgent care doctor (EKG / exam - over $300) and was advised I need an event monitor and further testing, which I will not and cannot pursue because I need to focus on other medical expenses right now, basic needs like vision and dental. The heart and hormones seem like the more important item to focus on, right? I think so too, but I cannot take the risk of seeking medical help when every cent counts. It may be a couple bucks to you, but for many of us, crumbs and pennies must add up to satiate our needs and get by.

It isn't news that most of us cannot afford basic housing or to pay the totality of living expenses from food to transportation these days. You know this. This action will further our financial and physical hurt.

At this point it is easier dying than drowning financially for medical testing and care. What is the point of trying to be healthy and survive when we're going to be crushed by medical debt we cannot pay off anyway? For individuals with children and spouses who suffer, I feel for even more. I choose the roof I am barely affording to keep over my head and a pair of glasses to see each day, rather than seek the medical attention I truly need to live well.

Shame on you for considering to decrease our HS funds while simultaneously raising our costs. I wish those who make the big decisions choose to put people first instead of lining their pockets this time, next time, and beyond.

Regards,

Jessica Ogens
Senior Academic Advisor
College of Education Student Services Center
University of Nevada, Las Vegas
[redacted]

From: Pam Viton [redacted]
Sent: Tuesday, July 27, 2021 8:06 AM
To: Wendi Lunz <wlunz@peb.nv.gov>
Subject: Healthcare concern

Hello,

I am writing to share my concerns/annoyances with the new provider - Aetna. Since the plan switched over, we have lost access to 2 of our specialists that we have been going to for years. One for 15 and another for 20! Will there be any efforts made to contract with doctors who are with Optum Care.

Also, I'd like to mention that I think Express Script is a complete waste as far as I'm concerned. There is no real advantage to using them except that we can get 3 month's worth of scripts at a time. And now they've switched up the preferred pharmacies away from the most common and nationally recognized? They should stop spending so much money with their constant letters in the mail asking people to get their scripts from them, and apply it to more savings for the consumer.

Pam Viton

From: Me [redacted]
Date: July 27, 2021 at 12:39:59 PM PDT
To: [redacted]
Subject: New AETNA Insurance Plan for Carson City

Laura-

I am contacting you because you are the Chair of the PEBP Board.

I'd like to make you aware of two things I have learned about the new AETNA plan, for northern Nevada, specifically pertaining to Carson City.

First, this morning, my in-network doctor, here in Carson City, referred me to Carson Tahoe Imaging to get an X-ray of my ankle/foot (they are located upstairs from the Carson Tahoe Physicians Clinic). Before I saw them, I looked on my phone to see if they were listed as an "in-network provider" on the CDHP for Northern Nevada. I did not find them listed and only saw X-ray locations listed for Reno. I called PEBP's to confirm what I found; I spoke with Angela, who confirmed she was finding the same thing. She transferred me to Healthscope Benefits, who also confirmed there are no "in-network providers" to get an X-ray in Carson City. If what we have all found is correct (and I hope it is wrong) it must be an oversight. The gal from Healthscope Benefits also looked for Great Basin Imaging, the former name of Carson Tahoe Imaging, both affiliated with Carson Tahoe Hospital; she didn't come up with anything.

Second, the first week of July I had lab work done for a wellness visit. Fortunately, the night before my appointment, I looked up the lab I have gone to for years, the Renown lab in Carson City, and found they are no longer listed as an "in-network" provider. When I checked the PEBP website for providers before the start of the new fiscal year, they were listed as an "in-network provider" for the new fiscal year. I then looked up which lab I could go to in Carson City and discovered there are ONLY TWO APPROVED labs that are in-network providers in Carson City.....Lab Corp on W. Washington, and Quest Diagnostics on North Carson Street.

I am hopeful you will look into this, and discuss it, to resolve the matters at the upcoming Board meeting.

Thank you,

Suzanne Sturtevant
Retired State Employee
[redacted]

Thank you for this opportunity to provide written public comment on today's agenda, especially agenda items numbers 6 and 8. The UNLV Employee Benefits Advisory Committee (UNLV EBAC) represents *all* employees at the University of Nevada, Las Vegas, with representatives from academic faculty, administrative faculty, and classified staff. (The author of this public comment is Shaun Franklin-Sewell, a co-chair of the UNLV EBAC.)

Regarding agenda item number 8, we urge the PEBP Board and other interested parties to do whatever they can to restore the cuts to our benefit programs. **Others have submitted public comment outlining the real damage these cuts may do to employees' health.** In November 2020, we submitted public comment begging leaders to avoid cutting our plan. We were ignored. Now is the time to restore benefits since the state is or will be flush with cash from both the increased projection by the Economic Forum and the American Rescue Plan funding.

Our rankings of the options presented in item 8 follow.

(1) Revert deductibles and out-of-pocket maximums to pre-pandemic levels, revert co-insurance to 0% on the EPO plan, and revert co-pays to pre-pandemic levels. (4 options ranked together)
(2) Revert deductibles and out-of-pocket maximums to the leaner alternative. (2 options ranked together)
(3) Restore basic life insurance.
(4) Restore long-term disability coverage.

We have chosen not to rank the option of receiving a $44/mo. premium credit. An annualized premium credit of $444, while better than nothing, will also not come close to making employees whole. (As a reminder, an individual on the CDHP could pay $1,100 more this year; a family could pay twice that.)

Further, a philosophical disagreement about such credits exists. The idea that employees want their premiums kept low while benefits continue to be cut is not born out by our lived experiences. More than that, cutting benefits to maintain low premiums leads to a vicious cycle in which employees ultimately have no benefits at all. Additionally, medical and dental inflation happens every year; forcing insurance plans to live with "flat" budgets inevitably means further cuts. Employee morale around this issue is already suffering; it may only get worse. Recruitment efforts are hampered by our inferior benefit package when compared to other states.

We would also suggest one option not presented in the document for item 8: a restoration of the cut to our Health Savings Account funding. Many employees utilize the max amount of their funding each year to pay for health care; that money will be paid out more quickly this year - forcing them to pay more out of pocket.

Regarding agenda item number 6, releasing a request for proposals seems to provide staff the ability to thoroughly review and compare different drug distribution models. Generally, the UNLV

EBAC desires lower costs on all prescription drugs for members. If joining the consortium meets that goal, we would support it.

Thank you, again, for providing the opportunity to provide written public comment. We continue to acknowledge Executive Director Rich's commitment to working with advocacy groups and on behalf of all members. We also want to acknowledge the commitment board members undertake by serving on this board.