From: steph parker [redacted]
Sent: Friday, May 20, 2022 9:32 AM
To: Wendi Lunz <wlunz@peb.nv.gov>
Subject: Public Comment 5/26/22 PEBP Meeting

My name is Stephanie Parker and I am a member of AFSCME Local 4041 and a state employee. I wanted to make comment for the record that I am happy that this board has seen they have made a mistake with changing to AETNA in the beginning and it is no secret the hardships that have been experienced by employees. The last year caused mental anguish and negative health related impacts to PEBP members, the same members that count on you to protect their interests. We all know that making a change is a burden on everyone and the continued increase in premiums, decrease in healthcare coverage does not make it any more palatable.

I want you to confirm that you have verified that we will not end up with the same mess effective 7/1/22 where we will have unclear directions on what labs we will be able to utilize, our doctors will not have to jump through hoops for 9-10 months to continue providing care for us, and our prescription coverage will not be diminished again. It takes more than 2 weeks to learn about the new plan providers and we are hoping we don't have to cancel more doctor appointments and find new providers.

I ask that this Board continue to demand that ARPA funds be used to cover the shortfalls that resulted in higher premiums, increase the HSA contribution and provide a mechanism for HMO/EPO plans to ease the burden. Demand that they make us whole! Most of us are not members of the 6-figure club, we barely make it from paycheck to paycheck. We want affordable healthcare benefits that we can use.

Sincerely,
Stephanie Parker
Carson City, Nevada

May 23, 2022

Public Employees Benefits Program (PEBP) May 26, 2022, Meeting
Public Comment

To the Board Members of the Public Employees Benefits Program (PEBP),

I am writing this letter to the Board due to my concerns with the Public Employees Benefits Program lack of coordination with retired State of Nevada retirees who have become Medicare eligible.

Switching from State of Nevada Insurance with PEBPs to Medicare, Drug Coverage and Supplemental Insurance is unnecessarily complicated. This process needs to be streamlined. I would suggest an advocate be appointed to assist us during this process.

When I started with the State of Nevada in 1976, the employees' benefits package included health insurance until our death. This was changed and now retirees and Medicare eligible persons like me are forced to go to Medicare and deal with Via Benefits. If we do not go through Via Benefits, we will lose our HRA Funding, which is based on the number of years we worked. If a retiree worked 25 years or more, we receive $260 per month for the HRA Funding.

As State of Nevada retirees who are Medicare eligible to have health insurance, we must create a Social Security Account, a Medicare Account, chose Part D for our prescription drug coverage and Part G for our supplemental insurance, which is more complicated than when we were State of Nevada retirees.

I became Medicare eligible on May 1, 2022, and these are the issues I have encountered:

PEBP's is backlogged and is currently transmitting February records to Via Benefits, is dealing with a staffing shortage, is in the middle of open enrollment period and had a computer conversion that failed in December, which caused a large amount of employees' information to be lost. These issues are directly affecting the State of Nevada retirees who are Medicare eligible.

PEBP's is only meeting with individuals on Thursday after an appointment has been made. This backlog and staffing shortage is creating unnecessary complications.

When an individual calls PEBPs, the telephone system puts you in a phone tree depending on the option chosen. My experience took me around in a circle and left me with no ability to leave a message.

As a State of Nevada retiree who is Medicare eligible, Via Benefits will not talk to me unless PEBPs has transmitted my records. And PEBPs does not want to talk to me because I am Medicare eligible and no longer have State of Nevada Insurance. Who do I talk to regarding my concerns? This is an example where an advocate would be beneficial.

State of Nevada retirees who are Medicare eligible must pay their Medicare premiums three months in advance and their HRA Funding is not available until 12 weeks after they are Medicare eligible, which means that for six months we are on our own financially to maneuver through this maze. As retirees and Medicare eligible we are on a fixed income, this can place a financial burden on State of Nevada retirees who are Medicare eligible.

Via Benefits is misinforming State of Nevada retirees who are Medicare eligible by communicating to us that our HRA funding would be available on the first day that we are Medicare eligible. I was informed this information is not correct and is on the PEBP's website after you click on the Medicare eligible employees' link on Page 32. Let me repeat that last sentence. This information is on page 32.

Via Benefits is informing State of Nevada retirees who are Medicare eligible to contact the Human Resources Department of PEBPs if they are not eligible to access their HRA Funding. Via Benefits needs to be informed that there is no Human Resources Department with PEBPs. They further need to be instructed that the State of Nevada retirees who are Medicare eligible records need to be electronically transmitted to Via Benefits from PEBPs, and this process may take 12 weeks.

Via Benefits is informing State of Nevada retirees who are Medicare eligible that they may not be eligible for their HRA Funding because they have a spouse. How would Via Benefits know if the employee had a spouse since the employee record has not been transmitted to Via Benefits from PEBPs. Via Benefits needs to be informed that spouses have no relevance to whether a person qualifies for HRA Funding.

On May 19, 2022, I was so frustrated with all of this that I went to the PEBP's Office in person and was given Case ID 220518-21. A PEBPs staff member suggested I use the Public Comment Section to voice my concerns to the PEBP's Board Members. I appreciate the suggestion to communicate with the Board of PEBPs. However, this situation needs immediate intervention.

Please contact me at [redacted] if additional information is needed.

Thank you.

Lona M. Domenici

Lona M. Domenici

From: Brian Miller [redacted]
Sent: Monday, May 23, 2022 4:43 PM
To: Wendi Lunz <wlunz@peb.nv.gov>
Subject: Public Comment from Brian Miller, Alt VP for NV AFSCME

Hello,

My name is Brian Miller. I am a state employee with UNR/NSHE and a member of AFSCME 4041.
Thank you for the opportunity to provide public comment.

I have worked for the State of Nevada for over 22 years. I want to voice my disappointment in the PEBP board's choice to increase premium costs for PEBP members.
In March 22, only one member voted against the already climbing increase for PEBP. In addition to this increase service has declined within PEBP, giving short notice in increase and enrollment to both patients, families and medical coverage and medical providers. I understand that over the years some increases may have been necessary. However; with PEPB it has hardly been a mild increase nor a mild slide down the slope of what was at one point very good insurance. Many people whom have been employed with the state for a significant amount of time can attest to the fact one of the reasons we had applied for the state was in part due to the, at the time, good health care insurance for workers and their families, retirees', ect. It has become so bad that I am paying for PEBP but can not afford to use it, let alone if my family needs to use it.

In order to "prioritize" and choose whom gets to use insurance and funds first, I have had to put off imaging for myself, pulmonary specialist exams, and am still paying off (monthly) the cost from a sleep test performed over 2 years ago. This was all done with full coverage for me within PEBP. Even the HSA card had been cut in half with out being given significant warning that would be the case and was cut down to $600 total for me and my family, half of what it was the year before, and three times less then it was three to four years ago.

I understand that funds are appropriated by analytical forecast and other factors. I also understand from the March 22 meeting that there had been "data entry errors" combined with other errors, upward to sums in the millions. Whom is accountable for these errors, and do workers under PEBP, "eat the expense" in subtle yet blanketed increase?

It is my opinion that apart from the member who had voted against an increase, the board hardly has the workers that PEBP provides for as a priority. One may yield a conclusion that sadist rather than empathy driven individuals heads the board of PEBP, with a negative bias directed at the state workers. This may not be the case, but considering many of the decisions including recently voted down, proposed by the PEBP board ideas of unconstitutional "would be surcharges" to, the recently voted in increase of cost in premiums, to the blatant inept handling of provider care and client coverage in the forms or "data entry error". It would appear my personal opinion may not be far off from fact.

What good is insurance, mandatory for some, if we cannot afford to use it? When only one board member votes AGAINST an increase in costs perhaps its the inept out of touch leadership within PEBP that needs to go rather than what use to be decent healthcare insurance provision.

Thanks,
Brian Miller

From: Lorayn Walser [redacted]
Sent: Tuesday, May 24, 2022 9:22 AM
To: Wendi Lunz <wlunz@peb.nv.gov>
[redacted]
Subject: Public Comment 5/26/22 PEBP Meeting

To the PEBP Board:

I am a 20- year State of Nevada employee, and am submitting my written comment for the meeting on 05/26/22.
I am definitely disappointed by the decreasing affordability of our health insurance.

Specifically, there has been an increase in premium costs to employees. Many of us have selected the EPO/HMO plans because we cannot afford to pay 20% until reaching our deductible with the PPO.

Our health coverage continues to have related costs shifted to employees. Many of us are unable to fully access lifesaving healthcare because we can see a doctor but not obtain treatment that is recommended secondary to the shift of costs of the plan to the employee.

I am also asking the PEBP Board to fight in order to have ARPA funds utilized to restore benefits to our healthcare plans.

Additionally, I am not aware of any email sent to state employees informing them of this meeting. Why would this be kept from the very people whose lives are being impacted? If EITS can manage to send a statewide email, so can PEBP. This probably is the worst obstacle we are facing - a lack of transparency on things which we may want to have input. The only way I even knew about this meeting was through notification from AFSCME 4041.

Lorayn Walser

From: Noah Fischel [redacted]
Sent: Tuesday, May 24, 2022 11:21 AM
To: Wendi Lunz <wlunz@peb.nv.gov>
Subject: PEBP Meeting Written Comments

Good morning,

My name is Noah Fischel. I am an employee with the Department of Employment, Training, and Rehabilitation and an AFSCME member. The stability of state employment has changed my life for the better. It's allowed me and my spouse to settle down, make a home together, and are now expecting our first child. Both her and I work for the State, and even with the great pay, the health insurance premiums are what hurt our checks every other week.

It makes no sense that State employees are forced to pay exorbitant amounts, increasing each year, when the municipalities, the cities and Clark County itself, provide 100% EMPLOYER PAID HEALTHCARE, plus an additional 50% PER DEPENDENT.

I could go work for one of the cities or the county, and have the healthcare covered for myself, my wife, and my child, for the price of 1 person.

We already basically get 1/3rd of our check removed per pay period, and you expect us to keep paying more? This is not fair to the hundreds, if not thousands, of people who keep the state government, and its various departments, running every single day.

-**Noah Fischel**

From: Paige Menicucci [redacted]
Sent: Tuesday, May 24, 2022 12:03 PM
To: Wendi Lunz <wlunz@peb.nv.gov>
Subject: Public Comment for May 26th PEBP meeting I would like to be read into the record
Importance: High

Hello members of the Board. My name is Paige Menicucci, I'm an Administrative Assistant III for the Bureau of Safe Drinking Water.
I'm concerned why the board members continue to place these burdens and costs on the State of Nevada employees. We haven't had a Comp and Class study done in 20 years± Governor Guinn was in office last time this was done. With inflation rates at 47% and rising and not our paychecks this puts a tremendous hardship on state employees, some who are working 2 or 3 jobs to make ends meet because of the disparity in income working for the State of Nevada. Last year I paid 15 thousand out of pocket due to lack of coverage for treatment. That's huge when your only making $18.82 an hour and with all the other fees that come out of my paycheck, I make just a little over $1000.00 every 2 weeks. This is not sustainable and NOT a livable wage.
Have you considered reaching out to local and county governments statwide to see if you can piggyback on the health insurance to give us a bigger "Pool" to lower our rates and give us better coverage at a lower cost? I believe thinking outside the box and working with other governments could potentially save money and get us better insurance.
We are paying much more for less insurance coverage than the years prior, and you are supposed to be working for **our** benefit not against us! We the State of Nevada employees have had enough, and it shows with the number of people who are leaving state service!
We have a shortage of doctors, and your provider list is shrinking daily! PEBP must notify state employees when significant changes are made to our provider lists and covered treatments. Due to provider shortages, we make appointments well in advance and must start the process over when we learn the provider is no longer in our network.

I ask you to vote no on any rate increases to state employee health insurance.

Paige

D. Paige Menicucci
[redacted]

To: State of Nevada, Public Employees' Benefits Program Board

May 24, 2022

Written Public Comments for the May 26, 2022, Board Meeting

Re: Consent Agenda Item 4.3

Members of the Board;

Lying before you is a request to approve PEBP Master Plan Documents for Plan Year 2023, which includes the Consumer Driven High Deductible Plan, the Low Deductible Plan, and the Exclusive Provider Organization Plan. There are specific modifications of these plan that address previous inadequacies of coverage for medically necessary treatments for Gender Dysphoria. The direction these modifications take is a positive step forward, however, there are specific issues that are non-compliant with both Federal and State employment laws that leave the plans exposed to legal actions that due to the discriminatory restrictions applied only to those patients who happen to be transgender and seeking health care that specifically treats the issues manifested by the particular effects of Gender Dysphoria. It's unfortunate that these policies were not made available, earlier, for review by those employed by the State of Nevada who have been instrumental in the creation of inclusionary policies. This would have obviated the need to halt the approval of these plans at this meeting.

Cursory examination of the new language reveals fatal flaws in the administrative language that pertains to services related to treatment for Gender Dysphoria. I have excerpted passages from the plans which are the modifications subject to approval at this meeting and subsequently note (in red italic) the ramifications these arbitrary restrictions cause. Approval of this language leaves the Board liable for current and future claims of discrimination.

- 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. *This precertification is illegal as it treats transgender patients differently than cisgender patients. For example, a cisgender woman needs no precertification for Hormone Replacement Therapy if her provider diagnosis her as entering menopause. Likewise, a cisgender man needs no precertification for testosterone if diagnosed with low testosterone by his provider. Diagnosis by a qualified provider is sufficient for prescribing Hormone Therapy for a transgender patient under the Informed Consent model and has been for over 20 years.*

- Precertification for genital reassignment surgery must be completed by the UM company to determine medical necessity. Refer to the Utilization Management section for more information. *There is no perceived issue with this requirement.*

- When reviewing services for appropriateness of care and medical necessity, the UM company may refer to guidelines published by organizations such as the World Professional Associations for Transgender Health (WPATH), Aetna, Cigna, United HealthCare, Medicare, and Blue Cross/Blue Shield.

  Coverage of transgender services by health insurance providers has long been a contentious issue. Guidelines from Aetna, Cigna, United HealthCare, and Blue Cross/Blue Shield have not been made available for review by the public or by policy holders. This places an enormous amount of power on private companies and their non-medical administrators that have a primary mission of making profits as opposed to providing the best comprehensive medical coverage for a long-misunderstood area of healthcare. WPATH Standards of Care and Medicare policy are open, transparent, and perceived as best practices in the delivery of care for transgender patients.

- Pre-certification is required
  - The UM Company will explain the required criteria that must be met and documented in the medical record; and
  - May assist with identifying providers who specialize in surgeries to treat gender dysphoria.
  - A nurse case manager will be assigned to the participant and will assist with the complex medical services to ensure continuity of care.

  This is perceived as appropriate and helpful for gender affirming surgeries.

Mental Health Services

If a member is diagnosed with gender dysphoria and prior to submitting a recommendation for hormone and surgical treatment, the mental health professional's evaluation should document the following for the gender reassignment patient:

• The member's general identifying characteristics.

• The initial and evolving gender, sexual, and psychiatric diagnosis of the member.

• Details regarding the type and duration of psychotherapy or evaluation the member underwent.

• The mental health professional's rationale for hormone therapy and surgery.

• The degree to which the member has followed the standards of care and likelihood of continued compliance.

• Surgery to treat gender dysphoria must be pre-authorized.

Mental health coverages do NOT require precertification.

Benefit coverage includes transgender and associated co-morbid psychiatric diagnoses provided as any other outpatient mental health service under the Plan.

The evaluations stated as required here do not comply with WPATH Standards of Care, which most surgeons required prior to performing certain surgeries. Having two separate mandated requirements are onerous for both the transgender patient and the patient's providers. Additionally, there are procedures that are considered medically necessary that may not require such a level of pre-authorization and will be perceived as unjustified "gate-keeping" from life-affirming, medically necessary treatment. A Mental Health professional's rationale for hormone therapy is non-compliant with federal and state laws, as previously noted.

To determine which procedure may or may not be covered, the member should consult with their nurse case manager who works for this Plan's UM company.

Hormone Therapy Coverage

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 surgeries to treat gender dysphoria 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).

An arbitrary age denial is inappropriate and can be detrimental to a transgender adolescent in certain cases. Age of medically informed consent is 16. Certain cases of gender dysphoria have been appropriately treated under medical necessity as is consider typical with the onset of puberty in cisgender girls, around the age of 14. These cases need to be determined as appropriate or inappropriate by the medical providers treating and patient (endocrinology, primary care, behavioral health providers) and parents. Administrative denials based on arbitrary age cutoffs lack justification.

• 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).

A Mental Health professional's rationale for hormone therapy is non-compliant with federal and state laws, as previously noted.

Reversals of surgery to treat gender dysphoria will not be covered.

There is no perceived issue with this requirement.

The definition of Medically Necessary found in the Key Terms and Definitions portion of the MPDs should suffice for determination of transgender specific procedures, without the imposition of additional administrative barriers and procedures that intentionally discriminate access to health care for transgender employees. Here is the plan's definition excerpted for ease of reference:

Medically Necessary: A medical or dental service or supply will be determined to be "medically necessary" by the Plan Administrator or its designee if it:

• Is provided by or under the direction of a physician or other duly licensed health care practitioner who is authorized to provide or prescribe it (or dentist if a dental service or supply is involved); and

• Is determined by the Plan Administrator or its designee to be necessary in terms of generally accepted American Medical and Dental standards; and

• Is determined by the Plan Administrator or its designee to meet all the following requirements:

• It is consistent with the symptoms or diagnosis and treatment of the illness or injury; and

• It is not provided solely for the convenience of the patient, physician, dentist, hospital, health care provider, or health care facility; and

It is an appropriate service or supply given the patient's circumstances and condition; and

• It is a cost-efficient supply or level of service that can be safely provided to the patient; and

• It is safe and effective for the illness or injury for which it is used.

A medical or dental service or supply will be appropriate if:

• It is a diagnostic procedure that is called for by the health status of the patient and is: as likely to result in information that could affect the course of treatment as; and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.

• It is care or treatment that is likely to produce a significant positive outcome; and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.

• A medical or dental service or supply will be cost-efficient if it is no costlier than any alternative appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply. The fact that your physician or dentist may provide, order, recommend or approve a service or supply does not mean that the service or supply will be medically necessary for the medical or dental coverage provided by the Plan. A hospitalization or confinement to a health care facility will not be medically necessary if the patient's illness or injury could safely and appropriately be diagnosed or treated while not confined. A medical or dental service or supply that can safely and appropriately be furnished in a physician's or dentist's office or other less costly facility will not be medically necessary if it is furnished in a hospital or health care facility or other costlier facility:

• The non-availability of a bed in another health care facility, or the non-availability of a Health Care Practitioner to provide medical services will not result in a determination that continued confinement in a hospital or other health care facility is medically necessary.

• A medical or dental service or supply will not be considered medically necessary if it does not require the technical skills of a dental or health care practitioner or if it is furnished mainly for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any dental or health care practitioner, hospital, or health care facility.

I recommend to the Board to direct the plan to be amended, eliminating the arbitrary and unnecessary administrative reviews of treatments to used to mitigate Gender Dysphoria and simply apply the definition of Medically Necessary already defined within the plans, along with the WPATH Standards of Care, Version 7, and updating to Version 8, once it is published, later this year. This will ease the burden on State Employees that need these crucial, life saving treatments and procedures while relieving the Board from the liability caused by the current, discriminatory policies that are in this draft of the plan documents.

Respectfully,

Brooke Maylath

From: Stephanie Dube [redacted]
Sent: Tuesday, May 24, 2022 8:49 PM
To: Wendi Lunz <wlunz@peb.nv.gov>
Subject: Public comment

- My name is Stephanie Dube. I am an AFSCME Local 4041 member. I ask you to vote no on any rate increases to state employee health insurance.

  PEBP continues to increase health insurance rates while cutting services.

  We are paying more for less insurance coverage than the year before, and the year before that. PEBP must notify state employees when significant changes are made to our provider lists and covered treatments.

  Due to provider shortages, we make appointments well in advance and must start the process over when we learn the provider is no longer in our network. I must start over to find all new providers in my network. The providers that I have used for almost 5 years are now not available to me.

  I hope that you remember the people that you make decisions for. There are many of us. We are tired. We are tired of having insurance that we fear using because of the out-of-pocket costs. We all deserve affordable healthcare.

Stephanie Dube
Region 4 Vice President
Co-chair Political Action Committee
Desert Chapter President
Steward for Local 4041