JOE LOMBARDO
Governor

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
3427 Goni Road, Suite 109, Carson City, Nevada 89706
Telephone 775-684-7000 | 702-486-3100 | 1-800-326-5496
https://pebp.nv.gov

CELESTENA GLOVER
Executive Officer

JOY GRIMMER
Board Chair

MEETING NOTICE AND AGENDA – Amended 5/21/25

Name of Organization:	Public Employees' Benefits Program
Date and Time of Meeting:	May 22, 2025 9:00 a.m.
Video Conferencing:	**This meeting will be available by means of a remote technology system pursuant to NRS 241.023 using video- and tele-conference. Instructions for both are below. This meeting can be viewed live over the Internet on the PEBP YouTube channel at https://www.youtube.com/live/HEaqXFaqjmg**

To submit written public comment, please upload your document to the *Public Comment Upload Form* located under *Contact Us* on the PEBP website, *https://pebp.nv.gov*, no later than two business days prior to the meeting.

To listen to and view the PEBP Board Meeting please click on the YouTube Link located in "Video Conferencing" field above.

There are two agenda items designated for public comment. If you wish to provide verbal public comment during those agenda items, please follow the instructions below:

Option #1 **Join the webinar as an attendee https://us06web.zoom.us/j/85889212901**

This link is only for those who want to make public comment. If you are just listening to the webinar, please use the YouTube Link located in the "Video Conferencing" field above.

Option #2 **Dial: (669) 900-6833. When prompted to provide your Meeting ID, please enter: 858 8921 2901 then press #. When prompted for a Participant ID, please enter #.**

Participants that call in will be muted until it is time for public comment. A moderator will then unmute callers one at a time for public comment.

To resolve any issues related to dialing in to provide public comment for this meeting, please call (775) 684-7016 or email jcrane@peb.nv.gov

AGENDA

1. Open Meeting; Roll Call.

2. Public Comment.
   Public comment will be taken during this agenda item. No action may be taken on any matter raised under this item unless the matter is included on a future agenda as an item on which action may be taken. Public comments to the Board will be taken under advisement but will not be answered during the meeting. Comments may be limited to three minutes per person at the discretion of the chairperson. Additional three-minute comment periods may be allowed on individual agenda items at the discretion of the chairperson. These additional comment periods shall be limited to comments relevant to the agenda item under consideration by the Board. The total time allotted to public comment may be limited to one hour at the discretion of the chairperson. As noted above, members of the public may make public comment by using the call-in number provided above. Persons unable to attend the meeting in person or by telephone and persons whose comments may extend past the three-minute time limit may submit their public comment in writing by uploading your document to the *Public Comment Upload Form* located under *Contact Us* on the PEBP website, *https://pebp.nv.gov,* no later than two business days prior to the meeting. **If you need ADA accommodation, please let us know by 4:00 pm two days before the board meeting so that we may make appropriate arrangements**. Persons making public comment need to state and spell their name for the record at the beginning of their testimony.

3. PEBP Board disclosures for applicable Board meeting agenda items. (Radhika Kunnel, Deputy Attorney General) (Information/Discussion)

4. Consent Agenda. (Joy Grimmer, Board Chair) (**All Items for Possible Action**)

   Consent items will be considered together and acted on in one motion unless an item is removed to be considered separately by the Board.

   4.1 Approval of Action Minutes from the March 7, 2025, March 20, 2025, and April 7, 2025 PEBP Board Meetings.

   4.2 Receipt of quarterly staff reports for the periods ending March 31, 2025:

   4.2.1 Q3 Budget Report

   4.2.2 Contract Status Report

   4.3 Receipt of quarterly vendor reports for the period ending March 31, 2025:

   4.3.1 Q2 UMR Performance Guarantees

   4.3.2 Q3 WTW's Individual Marketplace (VIA Benefits) Enrollment and Performance Report

   4.3.3 Q3 Amplifon Performance Report

   4.3.4 Q3 Doctor on Demand Engagement Report

5. Executive Officer Report. (Celestena Glover, Executive Officer) (Information/Discussion)
6. Discussion and possible action regarding the appointment of Nik Proper as Interim Executive Officer of PEBP upon the retirement of Celestena Glover. (Joy Grimmer, Board Chair) **(For Possible Action)**
7. Discussion and possible action on recommended changes and updates to the Master Plan Documents for Plan Year 2026 (July 1, 2025 – June 30, 2026). (Leslie Bittleston, Quality Control Officer) (**For Possible Action**)
8. Discussion and acceptance of Claim Technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Plans administered by UMR for the period of October 1, 2024 – December 31, 2024. (Joni Amato, Claim Technologies Incorporated) (**For Possible Action**)
9. Discussion and possible action regarding 2025 Legislative Bills that may impact the Public Employees' Benefits Program. (Celestena Glover, Executive Officer) (**For Possible Action**)
10. Public Comment.

    Public comment will be taken during this agenda item. Comments may be limited to three minutes per person at the discretion of the chairperson. Persons making public comment need to state and spell their name for the record at the beginning of their testimony.
11. Adjournment.

The supporting material to this agenda, also known as the Board Packet, is available, at no charge, on the PEBP website at https://pebp.nv.gov/Meetings/current-board-meetings/ (under the Board Meeting date referenced above). Contact Jessica Crane at PEBP, 3427 Goni Rd, Suite 109, Carson City, NV 89706 (775) 684-7020 or (800) 326-5496
An item raised during a report or public comment may be discussed but may not be deliberated or acted upon unless it is on the agenda as an action item.
All times are approximate. The Board reserves the right to take items in a different order or to combine two or more agenda items for consideration to accomplish business in the most efficient manner. The Board may remove an item from the agenda or delay discussion relating to an item on the agenda at any time.
We are pleased to make reasonable efforts to assist and accommodate persons with physical disabilities who wish to participate in the meeting. If special arrangements for the meeting are necessary, please notify the PEBP in writing, at 3427 Goni Rd, Suite 109, Carson City, NV 89706, or call Jessica Crane at (775) 684-7020 or (800) 326-5496, as soon as possible so that reasonable efforts can be made to accommodate the request.
Copies of both the PEBP Meeting Action Minutes and Meeting Transcripts, if such transcripts are prepared, are available for inspection, at no charge, at the PEBP Office, 3427 Goni Rd, Suite 109, Carson City, NV 89706 or on the PEBP website at https://pebp.nv.gov. For additional information, contact Jessica Crane at (775) 684-7020 or (800) 326-5496.
Notice of this meeting was posted on or before 9:00 a.m. on the third working day before the meeting on the PEBP website at https://pebp.nv.gov, at the office of the public body and to the public notice website for meetings at https://notice.nv.gov. In addition, the agenda was mailed to groups and individuals as requested.

1.

1. Open Meeting; Roll Call.

2.

2. Public Comment.

3.

3. PEBP Board disclosures for applicable Board meeting agenda items. (Radhika Kunnel, Deputy Attorney General) (Information/Discussion)

4.

4. Consent Agenda. (Joy Grimmer, Board Chair)
(**All items for possible action**)

4.1 Approval of Action Minutes from the March 7, 2025, March 20, 2025, and April 7, 2025 PEBP Board Meetings.

4.2 Receipt of quarterly staff reports for the period ending March 31, 2025:

4.2.1 Q3 Budget Report

4.2.2 Contract Status Report

4.3 Receipt of quarterly vendor reports for the period ending March 31, 2025:

4.3.1 Q2 UMR Performance Guarantees

4.3.2 Q3 WTW's Individual Marketplace (VIA Benefits) Enrollment and Performance Report

4.3.3 Q3 Amplifon Performance Report

4.3.4 Q3 Doctor on Demand Engagement Report

4.1

4. Consent Agenda. (Joy Grimmer, Board Chair) (**All Items for Possible Action**)

4.1 Approval of Action Minutes from the March 7, 2025, March 20, 2025, and April 7, 2025 PEBP Board Meetings.

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
BOARD MEETING

Video/Telephonic Open Meeting
Carson City

ACTION MINUTES (Subject to Board Approval)
March 7, 2025

MEMBERS PRESENT	Ms. Joy Grimmer, Board Chair
VIA TELECONFERENCE:	Ms. Michelle Kelley, Vice Chair
	Dr. Jennifer McClendon, Member
	Mr. Jim Barnes, Member
	Ms. Theresa Carsten, Member
	Ms. Janell Woodward, Member
	Ms. Laura Rich, Member
MEMBERS EXCUSED:	Ms. Bepsy Strasburg
FOR THE BOARD:	Ms. Radhika Kunnel, Deputy Attorney General
FOR STAFF:	Ms. Celestena Glover, Executive Officer
	Mr. Nik Proper, Operations Officer
	Ms. Michelle Weyland, Chief Financial Officer
	Ms. Brandee Mooneyhan, Lead Insurance Counsel
	Ms. Leslie Bittleston, Quality Control Officer
	Ms. Jessica Crane, Executive Assistant
OTHER PRESENTERS:	Stacie Weeks, DHCFP

1. Open Meeting; Roll Call

    - Board Chair Grimmer opened the meeting at 10:00 a.m.

2. Public Comment

    - Kent Ervin – NV Faculty Alliance
    - Doug Unger – NV Faculty Alliance
    - Terri Laird - RPEN

3. Discussion and possible action regarding 2025 Legislative Bills that may impact the Public Employees' Benefits Program, as reflected in the attached Bill Tracking table. (Celestena Glover, Executive Officer) (**For possible action**)

BOARD ACTION ON ITEM 3
MOTION: No action taken.

4. Presentation and discussion regarding Nevada Health Authority. (Stacie Weeks, DHCFP Administrator) (Information/Discussion)

5. Public Comment

6. Adjournment

    - Board Chair Grimmer adjourned the meeting at 11:09 a.m.

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
BOARD MEETING

Video/Telephonic Open Meeting
Carson City

ACTION MINUTES (Subject to Board Approval)
March 20, 2025

MEMBERS PRESENT	Ms. Joy Grimmer, Board Chair
VIA TELECONFERENCE:	Ms. Michelle Kelley, Vice Chair
	Dr. Jennifer McClendon, Member
	Mr. Jim Barnes, Member
	Ms. Theresa Carsten, Member
	Ms. Janell Woodward, Member
	Ms. Laura Rich, Member
MEMBERS EXCUSED:	Ms. Bepsy Strasburg, Member
FOR THE BOARD:	Ms. Radhika Kunnel, Deputy Attorney General
FOR STAFF:	Ms. Celestena Glover, Executive Officer
	Mr. Nik Proper, Operations Officer
	Ms. Michelle Weyland, Chief Financial Officer
	Ms. Brandee Mooneyhan, Lead Insurance Counsel
	Ms. Leslie Bittleston, Quality Control Officer
	Ms. Jessica Crane, Executive Assistant
OTHER PRESENTERS:	Richard Ward, Segal

1. Open Meeting; Roll Call

    - Board Chair Grimmer opened the meeting at 9:00 a.m.

2. Public Comment

    - Kent Ervin – NV Faculty Alliance
    - Doug Unger – NV Faculty Alliance
    - Terri Laird – RPEN

3. PEBP Board disclosures for applicable Board meeting agenda items. (Radhika Kunnel, Deputy Attorney General) (Information/Discussion)

4. Consent Agenda (Joy Grimmer, Board Chair) (**All Items for Possible Action**)

    Consent items will be considered together and acted on in one motion unless an item is removed to be considered separately by the Board.

    4.1 Approval of Action Minutes from the January 23, 2025 PEBP Board Meeting.

    4.2 Receipt of quarterly staff reports for the period ending December 31, 2024:

    4.2.1 Q2 Budget Report

    4.2.2 Q2 Utilization Report

    4.2.3 Contract Status Report

    4.3 Receipt of quarterly vendor reports for the period ending December 31, 2024:

    4.3.1 Q2 UMR – Obesity Care Management

    4.3.2 Q2 UMR – Diabetes Care Management

    4.3.3 Q2 Sierra Healthcare Options – Utilization and Large Case Management

    4.3.4 Q2 Sierra Healthcare Options and UnitedHealthcare Plus Network – PPO Network

    4.3.5 Q2 Express Scripts – Summary Report

    4.3.6 Q2 Express Scripts – Utilization Report

    4.3.7 Q2 UnitedHealthcare Basic Life Insurance

    4.3.8 Q2 WTW's Individual Marketplace (VIA Benefits) Enrollment and Performance Report

    4.4 VIA Benefits Data Request

BOARD ACTION ON ITEM 4
MOTION: Motion to approve the consent agenda item except for item 4.3.8.
BY: Vice Chair Michelle Kelley
SECOND: Member Jim Barnes
VOTE: Unanimous; the motion carried

BOARD ACTION ON ITEM 4.3.8
MOTION: Motion to accept agenda item 4.3.8 as presented.
BY: Vice Chair Michelle Kelley
SECOND: Member Laura Rich
VOTE: Unanimous; the motion carried

5. Executive Officer Report. (Celestena Glover, Executive Officer) (Information/Discussion)
6. Discussion and possible action to include approving Plan Year 2026 rates for State and Non-State employees, retirees, and their dependents for the Consumer Driven Health Plan (CDHP), Low Deductible Plan (LD), Exclusive Provider Organization Plan (EPO), and Health Maintenance Organization Plan (HMO). (Celestena Glover, Executive Officer) (**For Possible Action**)

    A. Plan Year 2026 Rates Table

    B. Plan Year 2026 Comparison Table

    6.1 Segal PY25 Trend Report

BOARD ACTION ON ITEM 6
MOTION: Motion to approve rates as laid out in scenario two, staff's recommendation.
BY: Vice Chair Michelle Kelley
SECOND: Member Laura Rich
VOTE: Ayes – 6, the motion carried
Abstained – Jim Barnes

7. Discussion and possible action on recommended changes and updates to the Master Plan Documents for Plan Year 2026 (July 1, 2025 – June 30, 2026). (Leslie Bittleston, Quality Control Officer) (**For Possible Action**)

BOARD ACTION ON ITEM 7
MOTION: Motion to approve item.
BY: Member Laura Rich
SECOND: Vice Chair Michelle Kelley
VOTE: Unanimous; the motion carried

8. Discussion and possible action regarding the permanent appointment or recruitment of the PEBP Executive Officer. (Joy Grimmer, Board Chair) (**For Possible Action**)

BOARD ACTION ON ITEM 8
MOTION: Motion to table the Executive Officer Recruitment and include it at a future board meeting.
BY: Vice Chair Michelle Kelley
SECOND: Member Theresa Carsten
VOTE: Unanimous; the motion carried

9. Discussion and possible action regarding 2025 Legislative Bills that may impact the Public Employees' Benefits Program, including the following:

   *Assembly Bills

   *Senate Bills

   *Bill Draft Requests

   (Celestena Glover, Executive Officer) (**For Possible Action**)

   *Due to time constraints inherent in the legislative process, a list of specific bills or bill draft requests, if applicable, on which PEBP staff will seek direction from the Board during this meeting will be posted at https://pebp.nv.gov/Meetings/current-board-meetings/ by March 17, 2025.

BOARD ACTION ON ITEM 9
MOTION: No motion.

10. Public Comment.

11. Adjournment

- Board Chair Grimmer adjourned the meeting at 10:58 a.m.

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
BOARD MEETING

Video/Telephonic Open Meeting
Carson City

ACTION MINUTES (Subject to Board Approval)
April 7, 2025

MEMBERS PRESENT	Ms. Joy Grimmer, Board Chair
VIA TELECONFERENCE:	Ms. Michelle Kelley, Vice Chair
	Dr. Jennifer McClendon, Member
	Mr. Jim Barnes, Member
	Ms. Laura Rich, Member
	Ms. Janell Woodward, Member
	Ms. Theresa Carsten, Member
MEMBERS EXCUSED:	Ms. Bepsy Strasburg, Member
FOR THE BOARD:	Ms. Radhika Kunnel, Deputy Attorney General
FOR STAFF:	Ms. Celestena Glover, Executive Officer
	Mr. Nik Proper, Operations Officer
	Ms. Michelle Weyland, Chief Financial Officer
	Ms. Brandee Mooneyhan, Lead Insurance Counsel
	Ms. Leslie Bittleston, Quality Control Officer
	Ms. Jessica Crane, Executive Assistant
OTHER PRESENTERS:	Gideon Davis, Nevada State Purchasing Division

1. Open Meeting; Roll Call

    - Board Chair Grimmer opened the meeting at 2:00 p.m.

2. Public Comment

    - Kent Ervin – NV Faculty Alliance
    - Terri Laird - RPEN

3. PEBP Board disclosures for applicable Board meeting agenda items. (Radhika Kunnel, Deputy Attorney General) (Information/Discussion)

4. Discussion and possible action to rescind and or substitute the Board's November 2024 directive to issue a Request for Proposal for a second medical network to include Carson Tahoe Health providers. A portion of this item may be conducted in a closed session to consult with legal counsel and to allow the Board to prepare a request for a proposal or other solicitation for bids under NRS 287.0415(4). Any action will be in an open meeting in accordance with NRS 287.04345(5), including cancelling the request for proposals, or modifying and reissuing the request for proposals. (Celestena Glover, Executive Officer, Gideon Davis, Administrator, State Purchasing Division) (For Possible Action)

BOARD ACTION ON ITEM 4
MOTION: Motion to rescind the November 24th Board decision to release an RFP for the secondary Network.
BY: Member Theresa Carsten
SECOND: Member Michelle Kelley
VOTE: Unanimous; the motion carried

5. Discussion and possible action regarding 2025 Legislative Bills that may impact the Public Employees' Benefits Program. (Celestena Glover, Executive Officer) (**For Possible Action**)

BOARD ACTION ON ITEM 5
MOTION: No action taken.

6. Public Comment

7. Adjournment

    - Board Chair Grimmer adjourned the meeting at 3:16 p.m.

4.2

4. Consent Agenda. (Joy Grimmer, Board Chair) (**All Items for Possible Action**)

    4.1 Approval of Action Minutes from the March 7, 2025, March 20, 2025, and April 7, 2025 PEBP Board Meetings.

    4.2 Receipt of quarterly staff reports for the period ending March 31, 2025.

4.2.1

4. Consent Agenda. (Joy Grimmer, Board Chair) (**All Items for Possible Action**)

4.2 Receipt of quarterly staff reports for the period ending March 31, 2025:

4.2.1 Q3 Budget Report

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CELESTENA GLOVER
Executive Officer

JOY GRIMMER
Board Chair

AGENDA ITEM

[X] Action Item

[ ] Information Only

Date: May 22, 2025

Item Number: 4.2.1

Title: Chief Financial Officer Budget Report

Summary

This report addresses the Operational Budget as of March 31, 2025, to include:

1. Budget Status
2. Budget Totals
3. Claims Summary

Budget Account 1338 – Operational Budget – Shown below is a summary of the operational budget account status as of March 31, 2025, with comparisons to the same period in Fiscal Year 2024. The budget status is reported on a cash basis and does not include incurred expenses and income owed to the fund.

The budget status report reflects actual income of $367.6 million as of March 31, 2025, compared to $323.4 million as of March 31, 2024, or an increase of 13.6%. Total expenses for the period have increased by $42.0 million or 12.7% for the same period.

The budget status report shows Realized Funding Available (cash) at $101.1 million. This compares to $120.7 million for the same period last year. The table below reflects the actual revenues and expenditures for the period.

Operational Budget 1338

	FISCAL YEAR 2025			FISCAL YEAR 2024		
	Actual as of 3/31/2025	Work Program	Percent	Actual as of 3/31/2024	Fiscal Year 2024 Close	Percent
Beginning Cash	106,429,030	106,429,030	100%	128,062,282	128,062,282	100%
Premium Income	321,677,343	433,139,318	74%	286,894,528	400,716,314	72%
All Other Income	45,878,784	39,183,809	117%	36,532,369	34,220,617	107%
Total Income	367,556,127	472,323,127	78%	323,426,897	434,936,931	74%
Personnel Services	2,359,106	3,020,415	78%	1,881,318	2,722,805	69%
Operating - Other than Personnel	1,942,915	3,095,546	63%	1,993,266	2,825,959	71%
Insurance Program Expenses	368,377,696	498,972,422	74%	326,805,745	455,467,372	72%
All Other Expenses	163,417	214,039	76%	124,009	172,381	72%
Total Expenses	372,843,134	505,302,422	74%	330,804,338	461,188,517	72%
Change in Cash	(5,287,007)	(32,979,295)		(7,377,441)	(26,251,586)	
REALIZED FUNDING AVAILABLE	101,142,023	73,449,735	138%	120,684,840	101,721,813	119%
Incurred But Not Reported Liability	(33,509,499)	(33,509,499)		(52,874,000)	(52,874,000)	
Catastrophic Reserve	(30,845,956)	(30,845,956)		(38,212,000)	(38,212,000)	
HRA Reserve	(9,094,280)	(9,094,280)		(20,600,889)	(20,600,889)	
NET REALIZED FUNDING AVAILABLE	27,692,288	-		8,997,951	(9,965,076)	

Current Budget Projections

The following table represents projections for FY 2025. The projection reflects total income to be more than budgeted by 2.6% ($594.0 million vs $578.8 million), total expenditures are projected to be less than budgeted by 1.1% ($500.0 million vs $505.3 million); and total reserves are projected to be more than budgeted by 28.3% ($94.3 million vs $73.4 million).

State Subsidies are projected to be more than the budgeted amount by $15.0 million (4.6%), Non-State Subsidies are projected to be less than budgeted by $0.8 million (3.9%), and Premium Income is projected to be less than budgeted by $6.2 million (7.5%). The overall increase in budgeted revenue is due in part to an increase in state subsidies because of actual state active enrollment compared to budgeted enrollment and a change in the mix of plan and tiers. The mix of participants is as follows:

- 4.51% more state actives,
- 7.99% less state non-Medicare retirees,
- 38.89% more non-state actives,
- 15.44% less non-state, non-Medicare retirees
- 4.37% less state Medicare retirees, and
- 7.62% less non-state Medicare retirees

Budgeted and Projected Income (Budget Account 1338)					
Description	**Budget**	**Actual 3/31/25**	**Projected**	**Difference**	
Carryforward	94,373,969	94,373,969	94,373,969	0	0.0%
State Subsidies	330,044,762	249,707,452	345,062,503	15,017,741	4.6%
Non-State Subsidies	20,452,623	14,933,304	19,654,448	(798,175)	-3.9%
Premium	82,641,933	57,036,587	76,445,956	(6,195,977)	-7.5%
COVID Funds	0	0	0	0	18.2%
Appropriations	12,055,061	12,055,061	12,055,061	0	2.6%
All Other	39,183,809	33,823,723	46,333,162	7,149,353	18.2%
Total	578,752,157	461,930,096	593,925,099	15,172,942	2.6%
Budgeted and Projected Expenses (Budget Account 1338)					
Description	**Budget**	**Actual 3/31/25**	**Projected**	**Difference**	
Operating	6,330,000	4,465,438	6,523,058	(193,058)	-3.0%
State Insurance Costs	444,141,837	333,784,030	445,655,766	(1,513,929)	-0.3%
Non-State Insurance Costs	8,021,212	4,411,425	6,557,980	1,463,232	18.2%
Medicare Retiree Insurance Costs	46,809,373	30,182,240	40,927,241	5,882,132	12.6%
Total Insurance Costs	498,972,422	368,377,696	493,140,986	5,831,436	1.2%
Total Expenses	505,302,422	372,843,134	499,664,044	5,638,378	1.1%
Restricted Reserves	73,449,735	73,449,735	90,270,839	(16,821,104)	-22.9%
Differential Cash Available	0	15,637,227	3,990,216	(3,990,216)	
Total Reserves	73,449,735	89,086,962	94,261,055	(20,811,320)	-28.3%
Total of Expenses and Reserves	578,752,157	461,930,096	593,925,099	(15,172,942)	-2.6%

Expenses for Fiscal Year 2025 are projected to be $5.6 million (1.1%) less than budgeted when changes to reserves are excluded. Operating expenses are projected to be more than budgeted by $0.2 million (3.0%). Employee and Retiree insurances costs are projected to be less than budgeted by $5.8 million (1.2%) when taken in total (see table above for specific information).

Recommendations

None.

4.2.2

4. Consent Agenda. (Joy Grimmer, Board Chair) (**All Items for Possible Action**)

    4.2 Receipt of quarterly staff reports for the period ending March 31, 2025:

        4.2.1 Q3 Budget Report

        4.2.2 Contract Status Report

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AGENDA ITEM

[X] Action Item

[ ] Information Only

Date: May 22, 2025

Item Number: 4.2.2

Title: Contract Status Report

Summary

This report addresses the status of PEBP contracts to include:

1. Contract Overview
2. New Contracts for approval
3. Contract Amendments for approval
4. Contract Solicitations for approval
5. Status of Current Solicitations

1. Contracts Overview

Below is a listing of the active PEBP contracts as of May 09, 2025

PEBP Active Contracts Summary

Vendor	Service	Contract #	Effective Date	Termination Date	Contract Max	Current Expenditures	Amount Remaining
Eide Bailly	Financial Auditor	27703	7/11/2023	12/31/2026	$ 386,500.00	$ 145,500.00	$ 241,000.00
Health Plan of Nevada Inc	Southern Nevada HMO	23802	7/1/2021	6/30/2025	$ 192,093,848.00	$ 171,546,286.37	$ 20,547,561.63
Diversified Dental Services Inc.	Dental PPO	23810	7/1/2021	6/30/2026	$ 1,601,613.00	$ 1,227,561.63	$ 374,051.37
Lifeworks/Telus Health	Benefits Management System	25935	5/10/2022	12/31/2026	$ 6,145,600.00	$ 4,044,761.14	$ 2,100,838.86
Express Scripts, Inc.	Pharmacy Benefit Manager	25582	5/10/2022	6/30/2026	$ 332,109,496.00	$ 258,403,577.29	$ 73,705,918.71
*Willis Towers Watson (VIA)	*Medicare Exchange	16468	7/1/2015	6/30/2025	$ 1,546,000.00	$ 1,233,741.92	$ 312,258.08
HSABank	HSA/HRA Account Manager	25213	7/1/2022	6/30/2026	$ -	$ -	$ -
United Healthcare Insurance	Group Basic Life Insurance	25607	7/1/2022	6/30/2026	$ 12,824,248.00	$ 13,045,583.56	$ (221,335.56)
Brown & Brown of Massachusetts	Health Plan Auditor	24030	4/13/2021	6/30/2027	$ 1,581,662.00	$ 734,822.00	$ 846,840.00
Segal Company, Inc.	Consulting Services	25557	7/1/2022	6/30/2027	$ 4,285,410.00	$ 2,281,160.00	$ 2,004,250.00
Capitol Reporters	Court Reporting	27029	2/1/2023	6/30/2025	$ 31,932.00	$ 14,172.00	$ 17,760.00
Carrum Health	Centers of Excellence	28745	2/12/2024	6/30/2028	$ 4,000,000.00	$ 477,095.54	$ 3,522,904.46
Carrum Health	Oncology Concierge	29053	5/14/2024	6/30/2028	$ 1,490,000.00	$ 231,283.03	$ 1,258,716.97
UMR, Inc.	TPA and Other Services	25155	7/1/2022	6/30/2028	$ 65,413,106.00	$ 9,345,082.04	$ 56,068,023.96

*As of July 1, 2019 Willis Towers Watson no longer charges PEBP an administrative fee.

Recommendation

No action necessary

2. New Contracts

EXPECTED TO BE APPROVED AT THE JUNE 10TH BOARD OF EXAMINERS MEETING:

Health Plan of Nevada – Southern HMO

Extend Health – Medicare Exchange (Willis Towers Watson-VIA Benefits)

Recommendation

No action necessary

3. Contract Amendment Ratifications

CARRUM HEALTH – AMENDMENT TO UPDATE NEVADA BUSINESS LICENSE NUMBER AND ADD BUSINESS ASSOCIATE AGREEMENT.

Recommendation

Approve contract amendment as stated above.

4. Status of Current Solicitations

The chart below provides information on the status of PEBP's in-progress solicitations:

Service	Anticipated/ Actual RFP release date	Anticipated/ Actual NOI	Winning Vendor	Anticipated PEBP Board Contract Approval
Eligibility & Enrollment	01/27/2025	05/2025	TBD	09/2025
Pharmacy Benefit Manager	06/2025	09/2025	TBD	09/2025
Dental Network	08/2025	TBD	TBD	TBD
Life Insurance	09/2025	TBD	TBD	TBD
HSA/HRA	09/2025	TBD	TBD	TBD

4.3

4. Consent Agenda. (Joy Grimmer, Board Chair) (**All Items for Possible Action**)

4.3 Receipt of quarterly vendor reports for the period ending March 31, 2025:

- 4.3.1 Q2 UMR Performance Guarantees
- 4.3.2 Q3 WTW's Individual Marketplace (VIA Benefits) Enrollment and Performance Report
- 4.3.3 Q3 Amplifon Performance Report
- 4.3.4 Q3 Doctor on Demand Engagement Report

4.3.1

4. Consent Agenda. (Joy Grimmer, Board Chair) (**All Items for Possible Action**)

4.3 Receipt of quarterly vendor reports for the period ending March 31, 2025:

4.3.1 Q2 UMR Performance Guarantees

PEBP Performance Guarantees

		2024									2025								
			Result				Variance					Result				Variance			
Ref. #	**Performance Guarantee Claims Administration**	**Target**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Target**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
1.4	Claim Adjustment Time (7 cal or 5 bus days)	95.0%	93.1%	94.5%	94.3%	97.8%	-1.9%	-0.5%	-0.7%	2.8%	95.0%	93.1%	96.0%			-1.9%	1.0%		
1.5	Call Answer Time (30 Seconds)	85.0%	90.3%	97.8%	92.2%	92.8%	5.3%	12.8%	7.2%	7.8%	85.0%	94.4%	96.8%			9.4%	11.8%		
1.6	Call Abandonment	3.0%	1.1%	0.1%	0.5%	0.6%	1.9%	2.9%	2.5%	2.4%	3.0%	0.5%	0.3%			2.5%	2.7%		
1.7	First Call Resolution	95.0%	93.8%	91.0%	95.8%	96.3%	-1.2%	-4.0%	0.8%	1.3%	95.0%	97.5%	97.3%			2.5%	2.3%		
1.8	Time CSR To Close Open Inquiry (% Within 48 Hours)	90.0%	94.7%	95.2%	98.0%	98.4%	4.7%	5.2%	8.0%	8.4%	90.0%	98.5%	98.5%			8.5%	8.5%		
1.8	Time CSR To Close Open Inquiry (% Within 5 Days)	98.0%	95.5%	95.5%	99.2%	99.6%	-2.5%	-2.5%	1.2%	1.6%	98.0%	98.9%	99.3%			0.9%	1.3%		
1.9	CSR Audit or Quality Scores (Call Handling)	97.0%	95.5%	96.8%	97.0%	97.5%	-1.5%	-0.2%	0.0%	0.5%	97.0%	98.1%	98.6%			1.1%	1.6%		
1.1	CSR Call Back Performance (Within 24 Hours)	90.0%	85.0%	76.9%	100.0%	100.0%	-5.0%	-13.1%	10.0%	10.0%	90.0%	100.0%	100.0%			10.0%	10.0%		
1.11	Emails Return Time (% Within 8 Hours)	90.0%	100.0%	100.0%	100.0%	100.0%	10.0%	10.0%	10.0%	10.0%	90.0%	100.0%	100.0%			10.0%	10.0%		
1.11	Emails Return Time (% Within 24 Hours)	95.0%	100.0%	100.0%	100.0%	100.0%	5.0%	5.0%	5.0%	5.0%	95.0%	100.0%	100.0%			5.0%	5.0%		
1.12	Member Satisfaction Service Survey	95.0%	N/A	N/A	N/A	95.6%	N/A	N/A	N/A	0.6%	95.0%	N/A	N/A			N/A	N/A		
1.13	Account Management - Satisfactory To PEBP	AGREE	MET	Met	Met	Met	Met	Met	N/A	N/A	AGREE	Met	Met			Met	Met		
1.14	Eligibility Processing (2 Business Days)	98.0%	100.0%	100.0%	100.0%	94.2%	2.0%	2.0%	2.0%	-3.8%	98.0%	100.0%	100.0%			2.0%	2.0%		
1.15	Data Reporting (100% Within 10 Business Days)	MET	N/A	N/A	100.0%	100.0%	N/A	N/A	N/A	N/A	100.0%	100.0%	100.0%			0.0%	0.0%		
1.16	Implementation Satisfaction	MET	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A			N/A	N/A		
1.17	ID Card Production (10 Business Days)	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	100.0%	100.0%			0.0%	0.0%		
1.18	Subcontractors Disclosure (30 Calendar Days)	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	Met	Met			N/A	N/A		
1.19	PHI	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	Met	Met			N/A	N/A		
	Network Administration																		
2.1	EDI Claims Re-Pricing Turnaround Time (3 Business Days)	97.0%	98.0%	99.5%	99.0%	99.5%	1.0%	2.5%	2.0%	2.5%	97.0%	99.5%	99.5%			2.5%	2.5%		
2.1	EDI Claims Re-Pricing Turnaround Time (5 Business Days)	99.0%	100.0%	99.5%	99.5%	99.5%	1.0%	0.5%	0.5%	0.5%	99.0%	99.5%	99.8%			0.5%	0.8%		
2.2	EDI Claims Re-Pricing Accuracy	97.0%	98.3%	97.9%	97.8%	99.5%	1.3%	0.9%	0.8%	2.5%	97.0%	98.9%	99.5%			1.9%	2.5%		
2.3	Data Reporting (Within 10 Business Days)	MET	N/A	N/A	N/A	100.0%	N/A	N/A	N/A	N/A	100.0%	100.0%	100.0%			0.0%	0.0%		
2.4	Subcontractors Disclosure	100.0%	N/A	N/A	N/A	100.0%	N/A	N/A	N/A	0.0%	100.0%	Met	Met			N/A	N/A		
2.5	Provider Directory (Within 10 Business Days)	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	Met	Met			N/A	N/A		
2.6	Website 99% Of Time	99.0%	99.9%	100.0%	100.0%	100.0%	0.9%	1.0%	1.0%	1.0%	99.0%	100.0%	100.0%			1.0%	1.0%		
	UM/CM Management																		
3.1	Date Reporting (10 Calendar Days)	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	100.0%	100.0%			0.0%	0.0%		
3.2	Notification Of HCC (5 Business Days)	100.0%	100.0%	92.3%	100.0%	100.0%	0.0%	-7.7%	0.0%	0.0%	100.0%	100.0%	100.0%			0.0%	0.0%		
3.3	Pre-Cert Requests (5 Business Days)	98.0%	N/A	N/A	N/A	100.0%	N/A	N/A	N/A	2.0%	98.0%	99.9%	100.0%			1.9%	2.0%		
3.4	Concurrent Hospital Reviews (2 Business Days)	98.0%	N/A	N/A	N/A	100.0%	N/A	N/A	N/A	2.0%	98.0%	99.7%	100.0%			1.7%	2.0%		
3.5	Retrospective Hospital Reviews (5 Business Days)	98.0%	N/A	N/A	N/A	100.0%	N/A	N/A	N/A	2.0%	98.0%	100.0%	100.0%			2.0%	2.0%		
3.6	Implementation - Tasks	98.0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	98.0%	N/A	N/A			N/A	N/A		
3.7	Implementation - Problem Resolution	98.0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	98.0%	N/A	N/A			N/A	N/A		
3.8	Hospital Discharge Planning (3 Business Days)	95.0%	N/A	N/A	N/A	98.1%	N/A	N/A	N/A	3.1%	95.0%	95.7%	95.8%			0.7%	0.8%		
3.9	Large Case Management	95.0%	N/A	N/A	N/A	95.0%	N/A	N/A	N/A	0.0%	95.0%	95.0%	95.0%			0.0%	0.0%		
3.1	Utilization Management Med Nec & COE Usage	98.0%	N/A	N/A	N/A	100.0%	N/A	N/A	N/A	2.0%	98.0%	100.0%	100.0%			2.0%	2.0%		
3.11	Return On Investment ROI UM/CM	100.0%	N/A	N/A	N/A	100.0%	N/A	N/A	N/A	0.0%	100.0%	N/A	N/A			N/A	N/A		
3.12	Disclosure Of Subcontractors (60 Calendar Days)	100.0%	N/A	N/A	N/A	100.0%	N/A	N/A	N/A	0.0%	100.0%	Met	Met			N/A	N/A		
3.13	Unauthorized Transfer of PEBP Data (60 Calendar Days)	100.0%	N/A	N/A	N/A	100.0%	N/A	N/A	N/A	0.0%	100.0%	Met	Met			N/A	N/A		

4.3.2

4. Consent Agenda. (Joy Grimmer, Board Chair) (**All Items for Possible Action**)

4.3 Receipt of quarterly vendor reports for the period ending March 31, 2025:

4.3.1 Q2 UMR Performance Guarantees

4.3.2 Q3 WTW's Individual Marketplace (VIA Benefits) Enrollment and Performance Report

Public Employees Benefit Program

Quarterly Update – 3rd Quarter Plan Year 2025

WTW's Individual Marketplace (Via Benefits)

April 29, 2025

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 3rd Quarter Plan Year 2025

Executive Summary

Plan Enrollment:

- At the end of FY Q2 2025, PEBP's total enrollment into Medicare policies through WTW's Individual Marketplace decreased slightly to 11,314. Since PEBP started with Via Benefits back on July 1, 2011, 124 carriers have been selected by PEBP's retirees with current enrollment in 2,352 different plans.
- Medicare Supplement (MS) plan selection remained consistent at 83% of the total population with the majority of participants selecting AARP and Anthem BCBS of Nevada as their insurer; each carrier holds plans for 5,805 and 1,557 enrollees respectively. The average monthly premium cost for MS plans remained consistent at $147.
- The percentage of Medicare Advantage (MA or MAPD) plans selected remained consistent at 17%. Top MA carriers include Aetna with 622 individual plan selections and Humana with 354 individual plan selections. The average monthly premium cost to PEBP participants remained consistent at $7.

Customer Satisfaction:

- In Q3 2025, PEBP participant satisfaction with Enrollment Calls had an average satisfaction score result of 4.5 out of 5.0 based on 29 surveys returned.
- For Q3 2025, the average satisfaction score for Service Calls was 4.3 out of 5.0 based on 224 surveys returned.
- The combined average satisfaction score for Enrollment Calls and Service Calls was 4.3 out of 5.0 for Q2 2025.

Health Reimbursement Arrangement:

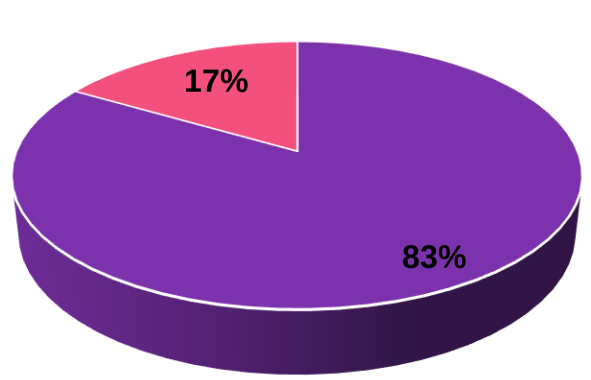
- At the end of Q3 2025 there were 13,256 Health Reimbursement Arrangement (HRA) accounts for PEBP participants.
- There were 125,018 claims processed in Q3, with 84.3% being submitted via Auto-Reimbursement, meaning that participants did not have to manually submit 105,373 claims for Premium Reimbursement.
- The total reimbursement amount processed for Q3 was $8,559,513 paid from 46,157 payments for an average of $185.44 per claim payment.

Summary of Retiree Decisions and Costs

Retiree Plan Selection Through 12/31/2024		Previous Qtr.
Total enrolled through individual marketplace	11,314	11,353
Number of carriers**	124	124
Number of plans**	2,352	2,338

Plan Type Selection Through 12/31/2024		Previous Qtr.
Medicare Advantage (MA, MAPD)	1,877	1,931
Medicare Supplement (MS)	9,451	9,459

Medical Enrollment



"The percentage of Medicare Advantage plans selected by PEBP's retiree population is slightly below the average for WTW's Book of Business.

Plan Type	Number Enrolled	Average Premium
Medicare Supplement (MS)	9,451	$150
Medicare Advantage (MA,MAPD)	1,877	$6 / $17
Part D drug coverage	5,350	$26
Dental coverage	840	$35
Vision coverage	1,668	$11

** Reflects total carriers and plans that PEBP participants have enrolled in nationwide, since inception.

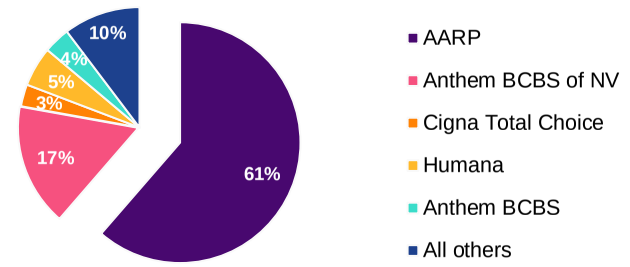
The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 3rd Quarter Plan Year 2025

Summary of Retiree Carrier Choice

Top Medicare Supplement Plans	Total
AARP	5,805
Anthem BCBS of NV	1,557
Humana	506
Cigna Total Choice	280
Anthem BCBS	336

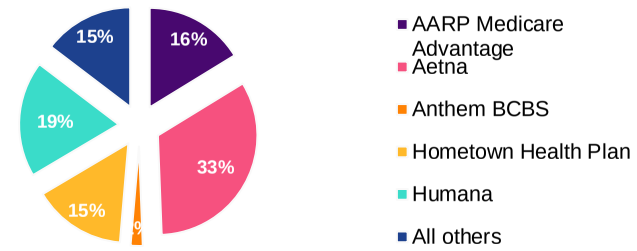
Medicare Supplement Carrier Choice



Cost Data For MS Plans	Cost
Minimum	$22
Average	$147
Median	$140
Maximum	$464

Top Medicare Advantage Plans	Total
Aetna	622
Humana	354
AARP	305
Hometown Health Plan	284
Anthem BCBS	37

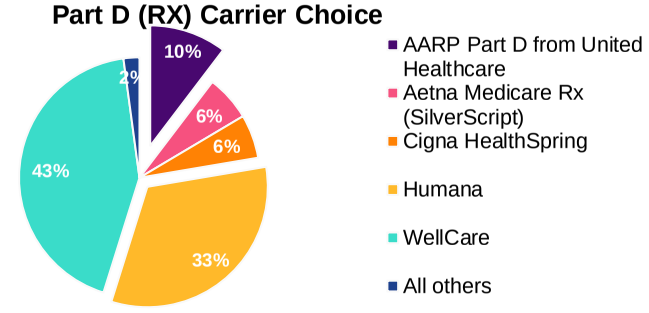
Medicare Advantage Carrier Choice



Cost Data For MA Plans	Cost
Minimum	$0
Average	$7
Median	$0
Maximum	$230

Top Medicare Part D (RX)	Total
WellCare	2,302
Humana	1,739
AARP Part D from United Healthcare	554
Aetna Medicare Rx (SilverScript)	327
Cigna HealthSpring	314

Part D (RX) Carrier Choice



Cost Data For Part D (RX)	Cost
Minimum	$0
Average	$18
Median	$15
Maximum	$156

The Public Employees Benefit Program Executive Dashboard

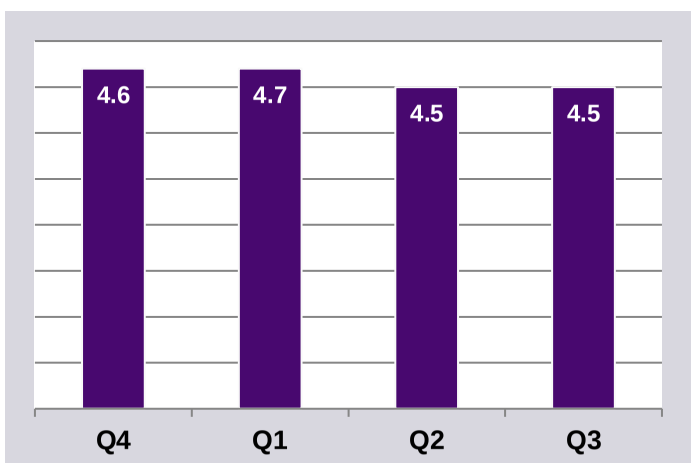
Quarterly Update – 3rd Quarter Plan Year 2025

Customer Service – Voice of the Customer (VoC)

Individual Marketplace conducts phone and email surveys of all participant transactions. Each survey contains approximately 12-16 questions. Responses are scanned by IBM Mindshare Analytics which expose trends within an hour, alerting Individual Marketplace of issues and allowing for real-time feedback and adjustments

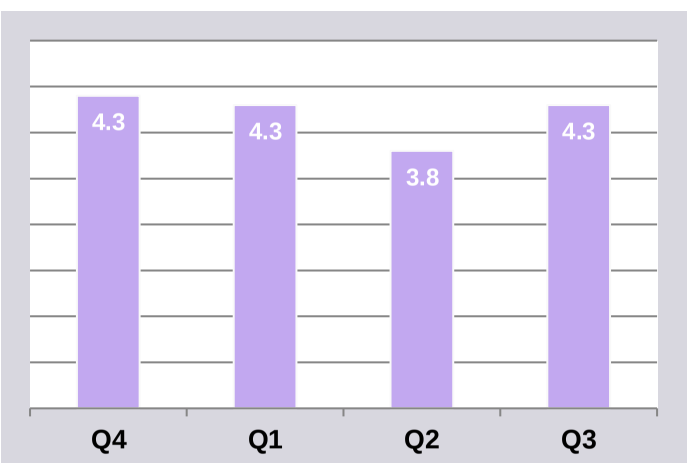
Q3 Enrollment Satisfaction

CSAT score	Count	%
5	19	66%
4	4	14%
3	6	20%
2	0	0%
1	0	0%
	29	**100%**



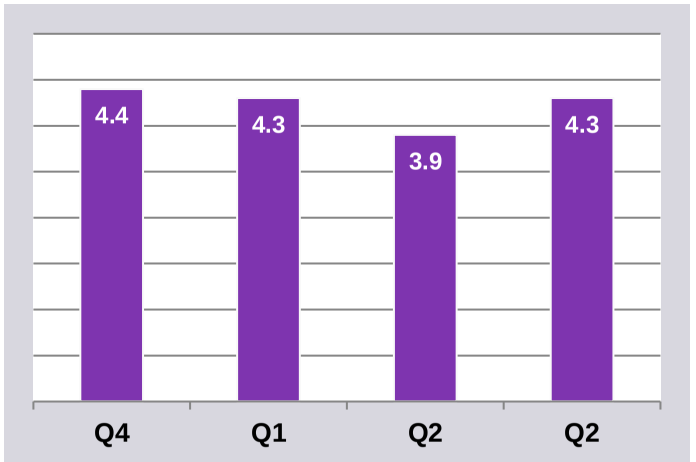
Q3 Service Satisfaction

CSAT score	Count	%
5	142	63%
4	37	17%
3	24	11%
2	7	3%
1	14	6%
	224	**100%**



Q3 Enrollment & Service Combined

CSAT score	Count	%
5	161	64%
4	41	16%
3	30	12%
2	7	3%
1	14	5%
	253	**100%**

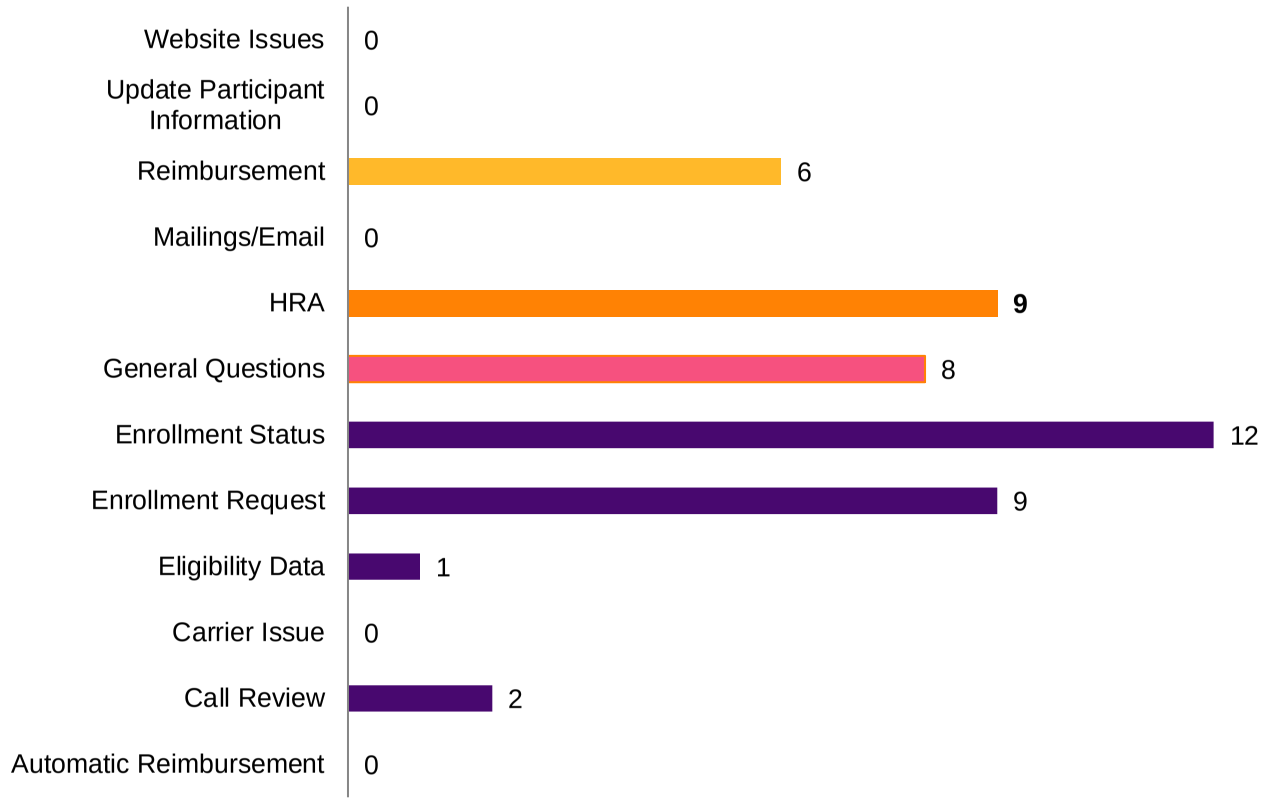


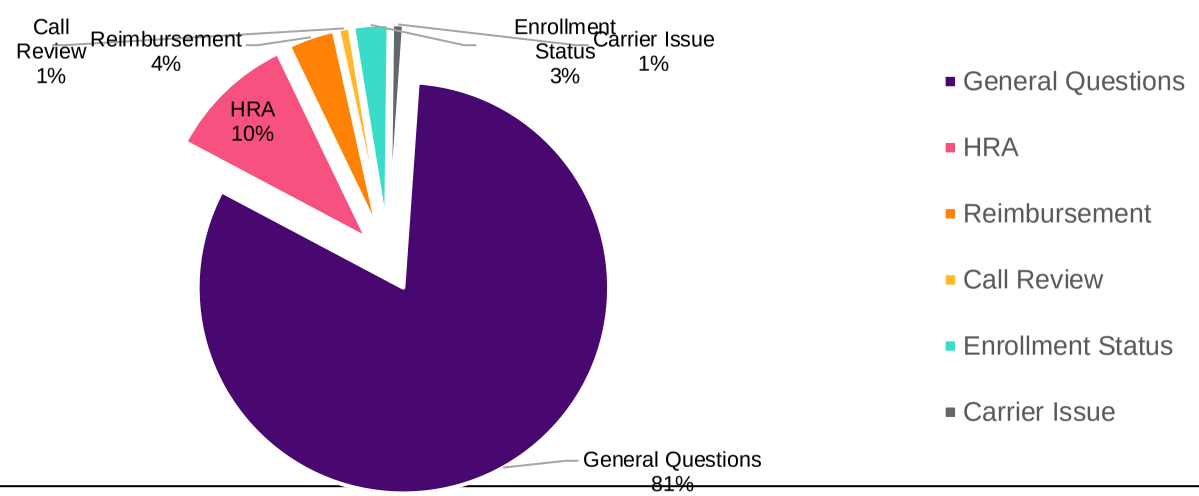
The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 3rd Quarter Plan Year 2025

Customer Service – Issues Log Resolution

Each quarter a certain number of participant inquiries are received by both PEBP and WTW that require escalation to Individual Marketplace Issues Log. Items on the Issues Log are carefully evaluated and continuously monitored by seasoned WTW staff until resolution is reached. The total number of inquiries reviewed during Q2-PY 2025 is 46 and are associated with the following categories:





Health Reimbursement Account (HRA)

Claim Activity for the Qtr.	Total
HRA accounts	13,256
Number of payments	46,157
Accounts with no balance	8,230
Accounts with Direct Deposit	10,204
Percentage of Accounts with Direct Deposit	77%
Claims paid amount	$8,559,513

Claims By Source	Total
A/R file	105,373
Mail	7,980
Web	7,754
Mobile App	3,911
TOTAL	125,018

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 3rd Quarter Plan Year 2025

Performance Guarantees*

Category	Commitment	Outcome	PG MET
Claims Turnaround Time	≤ 2 days	0.15 Days	Yes
Claim Financial Precision	≥ 98%	99.8%	Yes
Reports	≤ 15 business days	Met	Yes
HRA Web Services	≥ 99%	99.0%	Yes
Benefits Administration Customer Service Avg. Speed to Answer	≤ 2 min. in Q1 ≤ 90 sec in Q2 and Q3 ≤ 5 minutes in Q4 Note - Quarters listed are based on calendar year.	1 minute 35 seconds	Yes
Benefits Administration Customer Service Abandonment Rate Annual	≤ 5%	4.92%	Yes
Customer Satisfaction	≥ 80%	91.7%	Yes
Disclosure of Subcontractors	100%	100%	Yes
Unauthorized Transfer of PEBP Data	100%	100%	Yes

*Please note that the performance guarantees are ultimately measured based on the annual audit period.

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 3rd Quarter Plan Year 2025

Operations Report

Spring Retiree Meetings:

WTW and Nevada PEBP held virtual retiree meetings on April 2 and 3, with a live attendance option at the PEBP offices in Carson City. The meetings were designed to help age-in participants and employees who are 65 or older who are considering retiring get educated on the transition to Medicare as well as assist those who are already enrolled through Via Benefits with Medicare and the HRA. Recordings of meetings are now available on the Nevada PEBP Via Benefits website at https://my.viabenefits.com/PEBP.

HRA Available Balance Cap of $8,000:

Effective May 30, 2025, we will process the annual $8,000 HRA Available Balance Cap reduction on accounts with a balance of more then $8,000. (Note that May 31, 2025 is on Saturday so the process this year will occur on the last business day of May.) Nevada PEBP has sent communications related to the Available Balance Cap to 824 participants with balances of $7,000 or greater as they are expected to be the ones who will potentially be impacted by the Cap this year. The goal of the communication is to remind participants to submit claims against their balance to reduce it below the $8,000 threshold so they do not lose any of their HRA balance. Once funds are removed because they are over the $8,000 cap, they cannot be added back.

Outbound Call Campaign to Accounts with Large Balances:

In April, Via Benefits completed an outbound call campaign to Nevada PEBP participants with large available balances to try to help educate participants on how to effectively utilize their HRA accounts. The campaign was completed for 807 participants with a success rate at of contact of 23%. Educational material about how to utilize the HRA is also available on the Nevada PEBP Via Benefits website at https://my.viabenefits.com/PEBP.

4.3.3

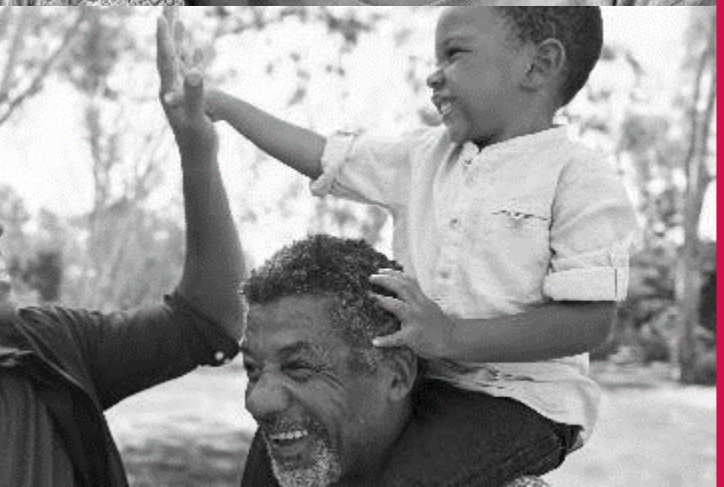
4. Consent Agenda (Joy Grimmer, Board Chair) (**All Items for Possible Action**)

4.3 Receipt of quarterly vendor reports for the period ending March 31, 2025:

4.3.1 Q2 UMR Performance Guarantees

4.3.2 Q3 WTW's Individual Marketplace (VIA Benefits) Enrollment and Performance Report

4.3.3 Q3 Amplifon Performance Report



amplifon Hearing Health Care

Performance Report

Nevada Public Employees' Benefit Program
January 1st through March 31st, 2025

Amplifon Updates

AMPLIFON CONTINUES GROWING RAPIDLY

We now work with 50+ health and insurance partners. In just 24 months, we've doubled our Medicare Advantage business, doubled our Medicare Supplement business, and doubled our commercial client business

CONCIERGE-LEVEL SERVICE EXCELLENCE

Amplifon continues to focus on exceptional member service through our focus on education and engagement, our hearing-dedicated Patient Care Advocates, and enhancements to our member journey via virtual tools

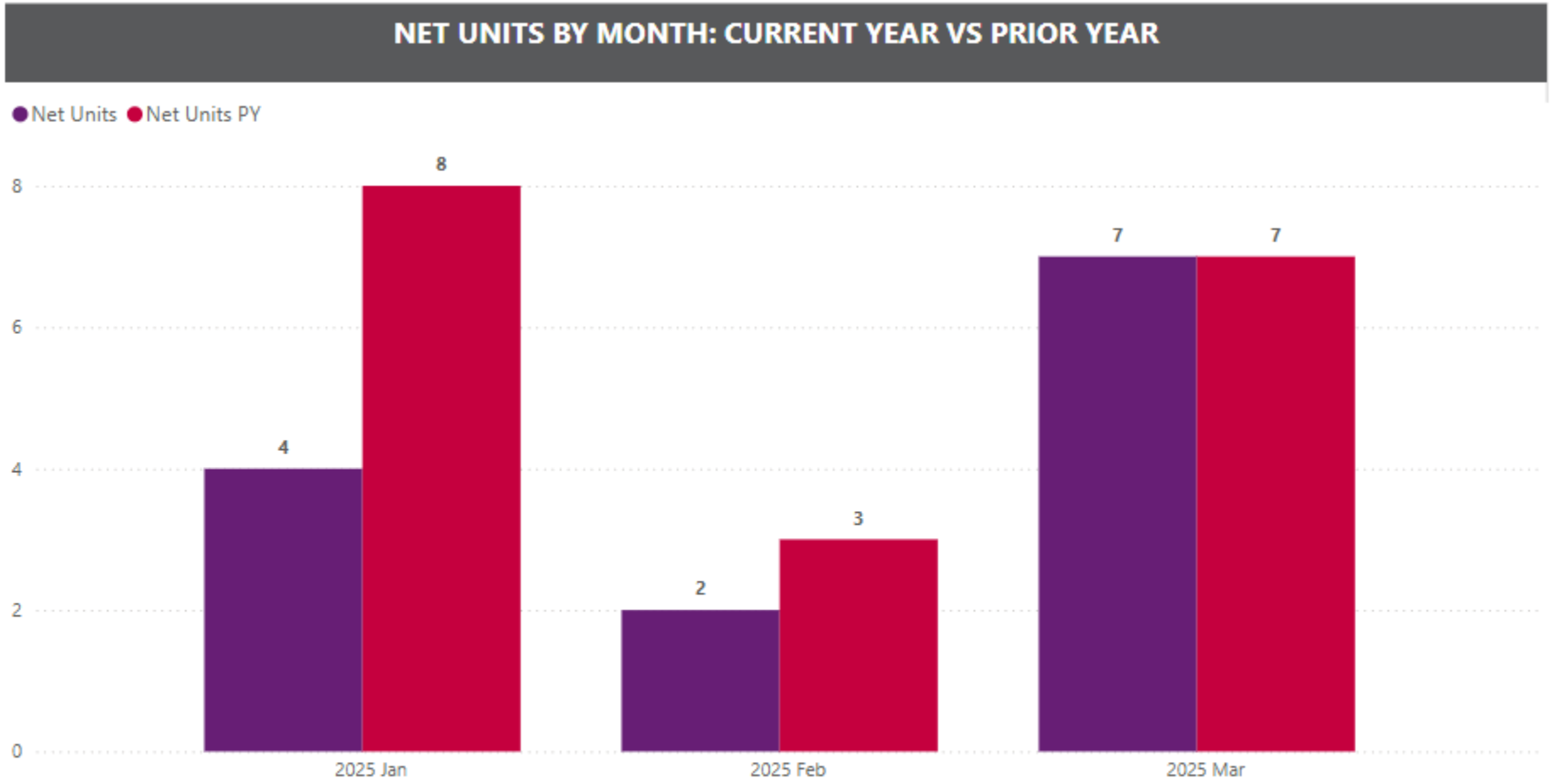
A FOCUS ON NETWORK ACCESS

Amplifon continues to expand our network and will soon exceed 6,000 nationwide locations. We remain the only hearing health administrator with Miracle-Ear® locations in network

UNIFORM PROVIDER REIMBURSEMENT

Amplifon continues to be the only hearing health administrator with a universal provider reimbursement focused on quality of care vs. a graded reimbursement that rewards providers for selling more expensive HAs

Hearing Aid Purchases



MEMBERS SERVED

7

10 PY

-30.00% %YOY

HEARING AIDS DISPENSED

13

18 PY

-27.78% %YOY

RETURN RATE

16.67 %

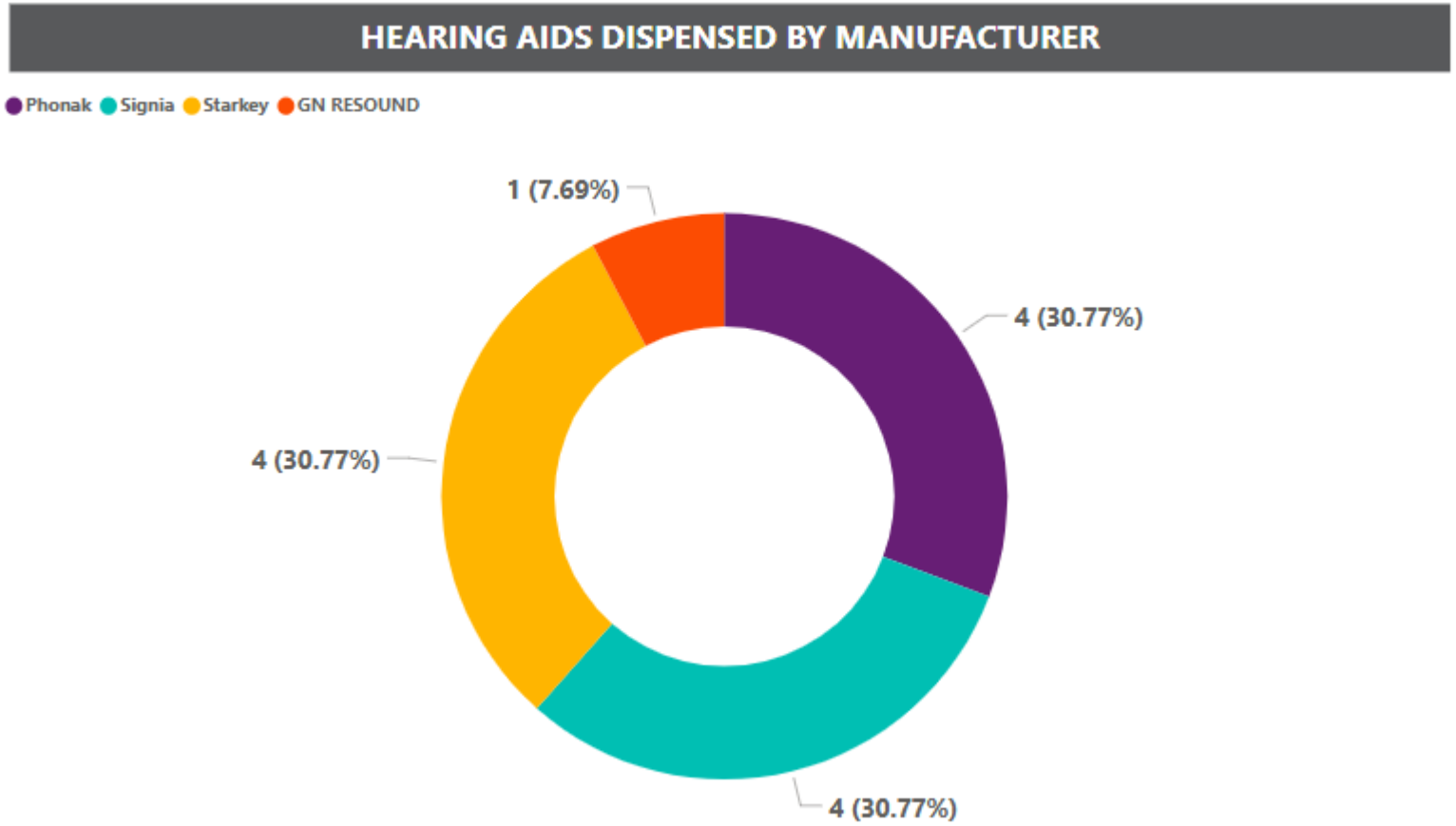
5.88% PY

183.33% %YOY

Why do members return hearing aids?

Typically, members return hearing aids due to issues with comfort. For example, a member may feel they want an invisible in-the-ear-canal model but realize it's uncomfortable. They may request to return their hearing aids and switch to an over-the-ear model.

Hearing Aids Dispensed by Manufacturer



THE IMPORTANCE OF CHOICE

Since Amplifon is the only major hearing administrator not owned by a manufacturer, our program is designed to provide your members substantial member choice.

Why is choice of hearing aids important?

- Most providers do not offer all manufacturers. Most only offer 1 to 2 brands of hearing aids
- For members who may already wear hearing aids, they often prefer not to switch manufacturers because they are comfortable with their existing brand
- Some models by manufacturers may be better suited for different lifestyle, technology and hearing healthcare needs

What do providers think?

In a recent Amplifon survey, 90% of providers indicated they prefer having the option to dispense the hearing aid brand and model best suited for the members' lifestyle, technology and hearing needs.

Hearing Aids Dispensed by Technology Tier

UNDERSTANDING TECHNOLOGY TIERS

PREMIER
For **dynamic** lifestyles. Typically includes: 20+ frequency channels, beam forming, wind/echo reduction, impulse noise reduction, and binaural processing

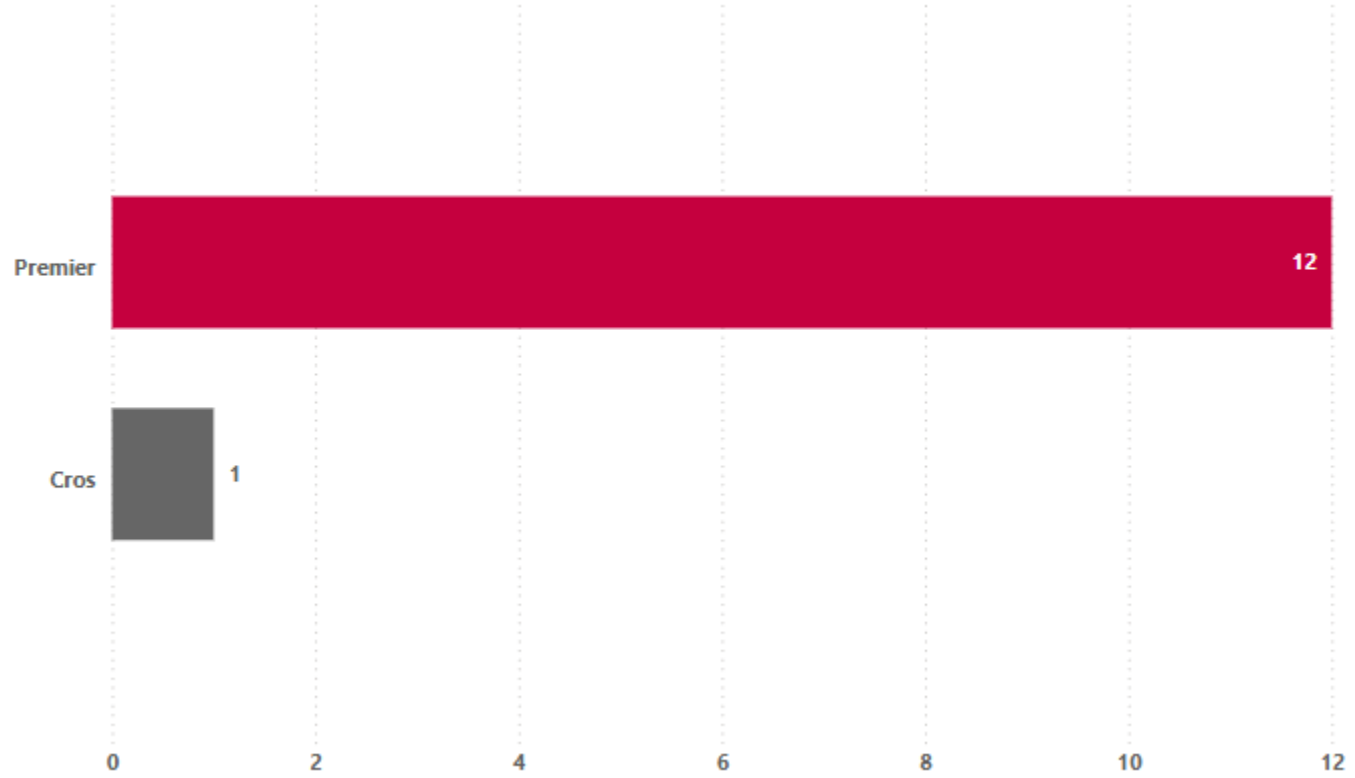
SIGNATURE
For **very active** lifestyles. Typically include: 16 frequency channels, beam forming (limited), wind/echo reduction, impulse noise reducing and binaural processing

ADVANTAGE
For **moderately active** lifestyles. Typically include: 12 frequency channels without other features listed above

PLUS AND BASIC
For **casual or quiet** lifestyles. Typically includes 8 or fewer frequency channels without other features listed above

CROS
A **specialized** hearing aid whose microphone picks from the "poor side" and sends it via wireless connection into a conventional hearing aid on your better ear

HEARING AIDS DISPENSED BY TECHNOLOGY TIER



100%

Percent of Your Members Purchased Rechargeable Hearing Aids
What's the primary difference between disposable and rechargeable hearing aid batteries? Rechargeable hearing aids eliminate the time, stress, and cost of dealing with disposable batteries. Take note: two digital hearing aids eat up an average of 300 (or more!) batteries in a 3-year span.

Savings Analysis

$77,550 =

TOTAL SAVINGS YEAR TO DATE

We're on our way to another successful year. Think of the impact you're making on your members quality of life!

	HAs PURCHASED	AVR MSRP	AVR MBR COST	TOTAL SAVINGS
Premier	12	$8,495	$2,195	$75,595
Cros	1	$3,850	$1,895	$1,955

Average MSRP Per Aid

$8,137

$7,831 PY | 3.9% %YOY

Average Cost Per Aid

$2,172

$2,101 PY | 3.40% %YOY

Total Cost of Aids Purchased

$28K

$37.81K PY | -25.32% %YOY

Average Cost Per Purchase

$3,974

$3,738 PY | 6.31% %YOY

Network Access

Member Utilization: Top Counties

COUNTY	STATE	UTILIZATION YTD	PRIOR YEAR
CARSON CITY	NV	2	9
CLARK	NV	2	1
WASHOE	NV	2	0
SALT LAKE	UT	1	

Member Utilization: Top Providers

PROVIDER	UTILIZATION YTD	PRIOR YEAR
My Hearing Centers	1	
Sharp Hearing	1	
Southern Nevada Audiology	1	
Sierra Nevada Hearing Aid Center	2	4
Silver State Hearing and Balance	2	-1

The Importance of a Uniform Provider Reimbursement Schedule

Rewarding providers with larger dispensing fees (right) leads to unnecessary upselling and greater expense.

FACT: Amplifon is the only hearing health administrator with a universal provider reimbursement rate.

FOCUS: QUALITY OF CARE

Amplifon	
Premier	$$
Signature	$$
Advance	$$
Plus	$$
Basic	$$

Competitors	
Premier	$$$$$
Signature	$$$$ ⬆
Advance	$$$ ⬆
Plus	$$ ⬆
Basic	$ ⬆

FOCUS: MAXIMIZING PROVIDER ROI

Thank you!

4.3.4

4. Consent Agenda (Joy Grimmer, Board Chair) (**All Items for Possible Action**)

4.3 Receipt of quarterly vendor reports for the period ending March 31, 2025:

4.3.1 Q2 UMR Performance Guarantees

4.3.2 Q3 WTW's Individual Marketplace (VIA Benefits) Enrollment and Performance Report

4.3.3 Q3 Amplifon Performance Report

4.3.4 Q3 Doctor on Demand Engagement Report

Included HEALTH

dr+ on demand by Included Health

Virtual Care Engagement Monthly Report

UMR-UMR - UMR-State_of_Nevada

Reporting Period

2025-01-01-2025-02-01

Member Engagement

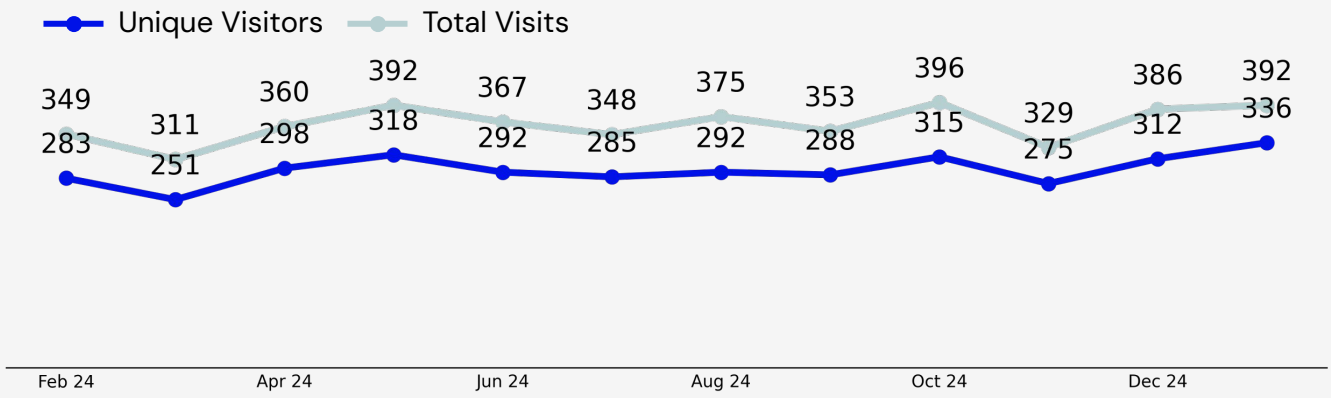
56	336	392
Registrations This Month	Unique Visitors This Month	Total Visits This month

This section highlights how many members have engaged with our services, as measured by registrations and visits. Registration is a leading indicator of program health, as it opens the door to continuous engagement with members and supporting them when clinical needs arise. Monitoring monthly engagement is key to program success; changes in engagement can result from marketing initiatives or seasonality (e.g. cold and flu).

New Registrations (Year to Date)

0	4,645	0.0%
Total Covered Lives	Registrations Lifetime to date	Registration Rate Lifetime to date
-	56	0.0%
Employee Covered Lives	Registrations Year to Date	Registration Rate Year to Date

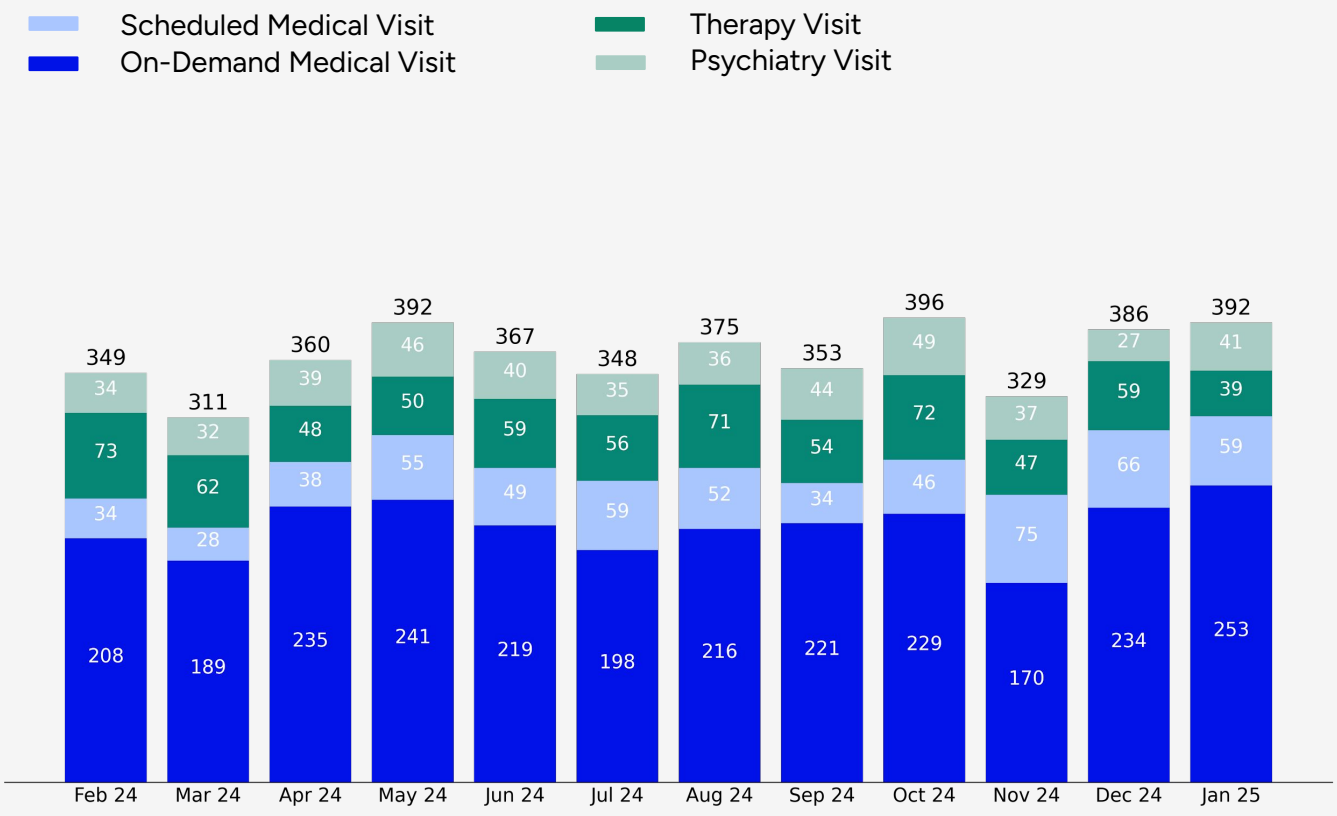
Visits Last 12 Months



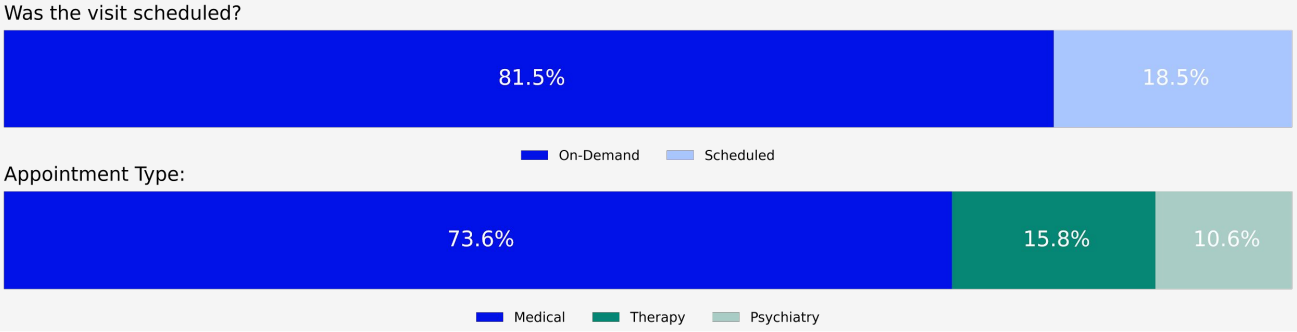
11,039	3,786	2.9	0.0%
Visits Lifetime to Date	Unique Visitors Lifetime to Date	Avg Visits Per Visitor Lifetime to Date	Engagement Rate (Visitors/Lives) Lifetime to Date
392	336	1.2	0.0%
Visits Year to Date	Unique Visitors Year to Date	Avg Visits Per Visitor Year to Date	Engagement Rate (Visitors/Lives) Year to Date

Member Engagement

Medical & Behavioral Health Visits (Rolling)



Member Demand by Visit Type Year to Date



Most Popular Day for Visits Year to Date

Thursday

Most Popular Time for Visits Year to Date

10AM - Noon

*Most popular day and time metrics are adjusted to time zone local where the visit was initiated

Member Access

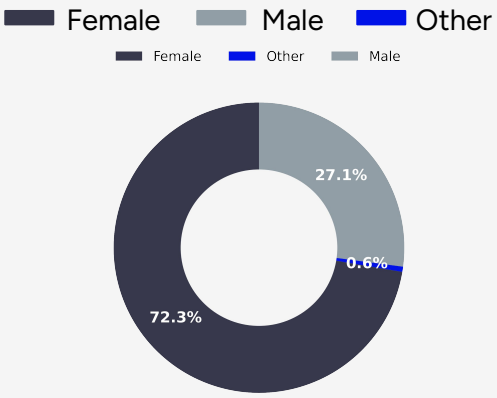
This section highlights our impact on increasing members' access to appropriate medical and behavioral health care, and their satisfaction with our services. We improve access to care by seeing members after hours (when brick & mortar providers are closed) and by making it easier to visit with a provider during business hours.

Without Included Health, where would you have gone?

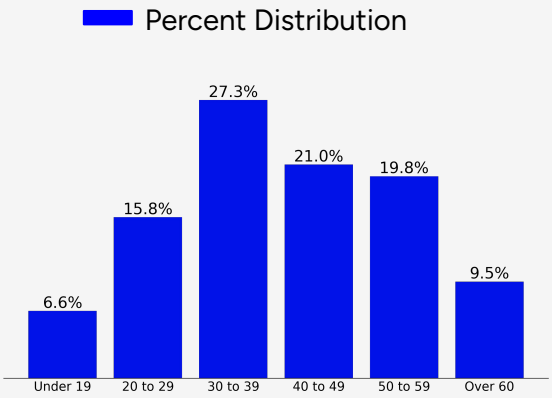
Percent Response Year to Date

We help members avoid unnecessary in-person visits by treating their needs virtually.

Visits by Reported Gender Year to Date



Visits by Age Year to Date



Member Experience Metrics	January	Year to Date
Average Member Rating	0.0 / 5 (N = 0)	0.0 / 5 (N = 0)
Median Wait Time for On-Demand Medical Appointments	19.6 min	19.6 min
Median Days to Scheduled Appointment (MD & BH)	2.0 days	2.0 days

Member Clinical Needs

This section highlights the range of clinical conditions that we treat through virtual care services. The program addresses comprehensive physical and behavioral health needs, and chronic and acute conditions. Examining the top needs of your population can inform more targeted clinical interventions and programs.

Member Reported Visit Reasons

Top 10 Visit Reasons

Visit Reasons	Visits Year to Date
Cold	49
Cough	39
Urinary tract infection (UTI)	21
Other injury	18
Sore throat	17
Eye issue	17
Fever	11
Nasal congestion	11
Rash	11
Anxiety	9

Member Conditions

Top 10 Diagnoses

ICD-10 Diagnoses	Visits Year to Date
Other upper respiratory infect..	117
Anxiety disorders	62
Mood disorders	34
Administrative/social admission	23
Urinary tract infections	23
Inflammation; infection of eye..	19
Cough, unspecified	18
Other upper respiratory disease	18
Viral infection	13
Adjustment disorders	12

Clinical Service Delivery

Our clinical team can provide a wide range of clinical services to help address members' needs. Our team has a focus on prescribing and labs to ensure our efficacy meets or exceeds that of in-person care through connections with pharmacy benefits and top lab networks.

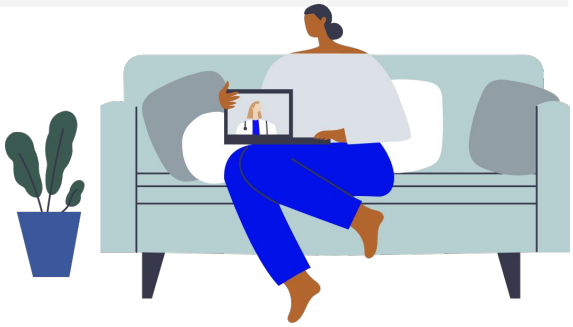
Prescriptions and Testing Summary

407	70.7%	60	1.8%
Prescriptions This Month	of visits resulted in a prescription order Year to Date	Lab Orders This Month	of visits resulted in a lab order Year to Date

Top Prescriptions and Testing Orders

Top Prescriptions	Count (YTD)
amoxicillin and clavulanate potassium	27
ipratropium bromide	23
prednisone	19
fluticasone propionate	19
albuterol sulfate	17
benzonatate	16
nitrofurantoin (monohydrate/macrocrystals)	14
oseltamivir phosphate	13
ondansetron	12
sertraline hydrochloride	12

Top Labs	Count (YTD)
HbA1c (hemoglobin A1c), blood	4
lipid panel, serum	4
CMP, serum or plasma	2
urinalysis complete, reflex culture	2
TSH + free T4, serum	2
TSH, serum or plasma	2
CBC w/ auto diff	2
culture, urine	1
C diff toxin A+B, qual IA, stool	1
testosterone, total, serum	1



For any questions regarding the reporting, please feel free to reach out to your respective client success lead. Thank you.

Data & Metric Definitions

Metric	Definition
Behavioral Health Visit	Behavioral Health visits refer to scheduled appointments with our multidisciplinary team of therapists, psychologists, and psychiatrists. Our integrated Behavioral Health solution delivers highly-accessible, virtual-first therapy and psychiatry to members to address every member need from subclinical to clinical. Therapy visits are 25 or 50 minutes in length depending on the patient's needs. Initial Psychiatry visits are 45 minutes in length and all follow up psychiatry visits are 15 minutes in length.
Covered Lives	Total count of member lives (employees and dependents) eligible for Included Health services.
Employee Lives	Total count of employee lives eligible for Included Health services.
Engagement Rate	Total number of unique visitors as a percentage of eligible lives.
Medical Visit	Medical visits refer to on-demand and/or scheduled encounters with our multidisciplinary team of clinicians. **Urgent Care:** Our Everyday & Urgent Care solution offers accessible video-first care for acute needs. Our multidisciplinary team of employed clinicians provide 24/7 care on demand or by appointment to improve access to care and deliver a better care experience. Providers are cross-trained in behavioral health, primary dermatology, and geriatric medicine, to treat a wide range of everyday & urgent care and behavioral health needs including cold, flu, UTIs, sinus infections, along with anxiety and depression **Virtual Primary Care -** With Primary Care, we provide 24/7 care across the full continuum of member needs, including physical - acute, preventive and chronic - and behavioral for engaged members.
ICD-10 Code and Description	Describes the top international classification of diseases for diagnoses, symptoms, and procedures recorded by our clinicians as a result of the visit.
Member Rating	Average visitor rating of 1-5 stars submitted upon visit completion.
Patient Reported Symptoms	Describes the top symptoms selected by the patient during visit intake. A patient may select more than one symptom per visit.
Registration	A member is considered "registered" when they digitally accept the Included Health TOS. Registration rate is the total number of individuals registered as a percentage of eligible lives.
Reported Age and Gender	Describes the patient's age and gender category as provided by the member's insurance carrier or reported by the patient. Note, these demographics describe the patient, not the visitor.
Visit	A visit describes a member's encounter with an Included Health provider. Visits can be classified as: Medical or Behavioral (Therapy, Psychiatry)
Visitors	A member that initiates a visit with Included Health. Unique visitor counts is determined by the member that initiates the visit, not the patient seen by the provider. For example: A patient that initiates a visit for herself and a separate visit for her child is counted as one unique visitor.

Included HEALTH

dr+ on demand by Included Health

Virtual Care Engagement Monthly Report

UMR -

UMR-State_of_Nevada

Reporting Period

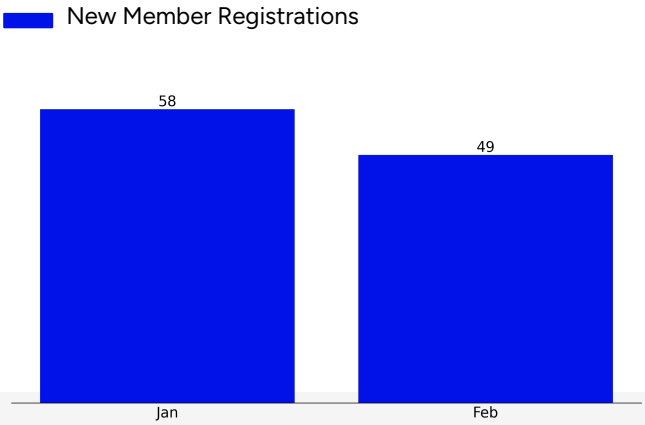
2025-02-01-2025-03-01

Member Engagement

49	299	360
Registrations This Month	Unique Visitors This Month	Total Visits This month

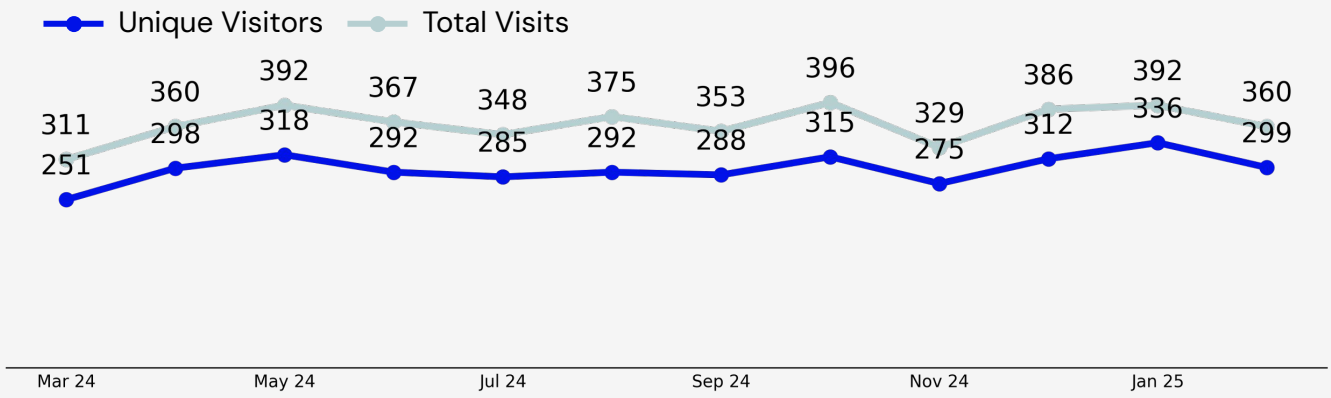
This section highlights how many members have engaged with our services, as measured by registrations and visits. Registration is a leading indicator of program health, as it opens the door to continuous engagement with members and supporting them when clinical needs arise. Monitoring monthly engagement is key to program success; changes in engagement can result from marketing initiatives or seasonality (e.g. cold and flu).

New Registrations (Year to Date)



0	4,792	0.0%
Total Covered Lives	Registrations Lifetime to date	Registration Rate Lifetime to date
-	107	0.0%
Employee Covered Lives	Registrations Year to Date	Registration Rate Year to Date

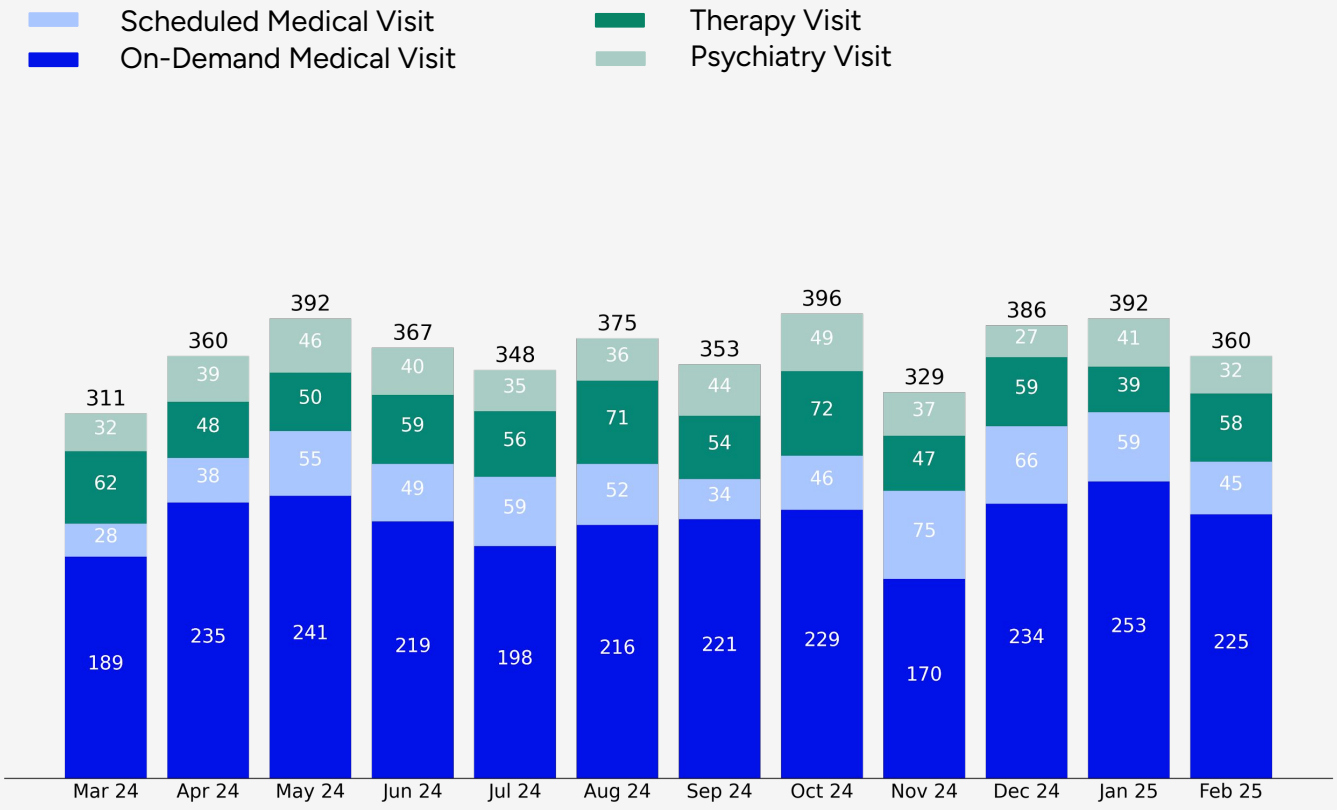
Visits Last 12 Months



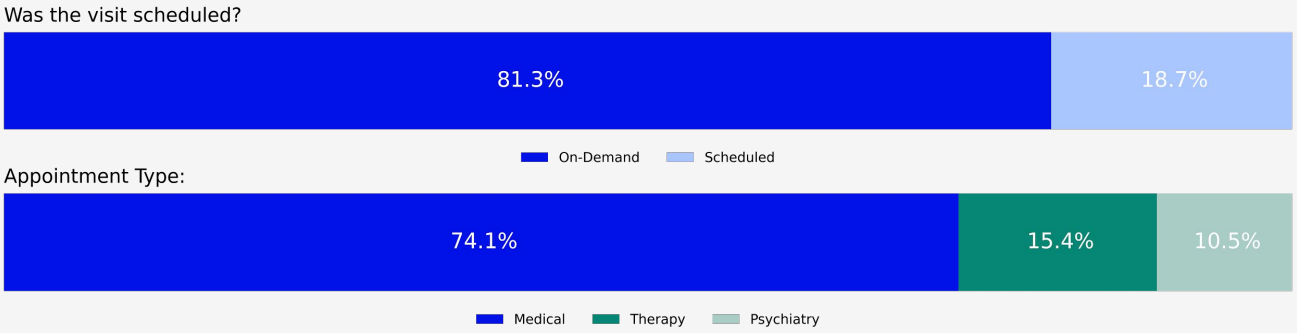
11,399	3,860	3.0	0.0%
Visits Lifetime to Date	Unique Visitors Lifetime to Date	Avg Visits Per Visitor Lifetime to Date	Engagement Rate (Visitors/Lives) Lifetime to Date
752	564	1.3	0.0%
Visits Year to Date	Unique Visitors Year to Date	Avg Visits Per Visitor Year to Date	Engagement Rate (Visitors/Lives) Year to Date

Member Engagement

Medical & Behavioral Health Visits (Rolling)



Member Demand by Visit Type Year to Date



Most Popular Day for Visits Year to Date

Wednesday

Most Popular Time for Visits Year to Date

8AM - 10AM

*Most popular day and time metrics are adjusted to time zone local where the visit was initiated

Member Access

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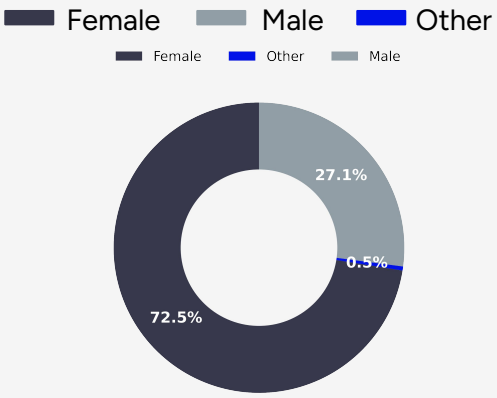
Without Included Health, where would you have gone?

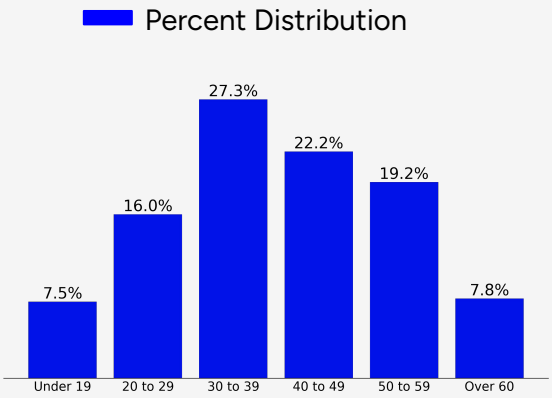
Percent Response Year to Date

We help members avoid unnecessary in-person visits by treating their needs virtually.

Visits by Reported Gender Year to Date



Visits by Age Year to Date



Member Experience Metrics	February	Year to Date
Average Member Rating	0.0 / 5 (N = 0)	0.0 / 5 (N = 0)
Median Wait Time for On-Demand Medical Appointments	14.7 min	17.3 min
Median Days to Scheduled Appointment (MD & BH)	2.0 days	2.0 days

Member Clinical Needs

This section highlights the range of clinical conditions that we treat through virtual care services. The program addresses comprehensive physical and behavioral health needs, and chronic and acute conditions. Examining the top needs of your population can inform more targeted clinical interventions and programs.

Member Reported Visit Reasons

Top 10 Visit Reasons

Visit Reasons	Visits Year to Date
Cold	98
Cough	61
Urinary tract infection (UTI)	44
Sore throat	34
Eye issue	29
Other injury	29
Anxiety	23
Fever	21
Influenza	20
Nasal congestion	20

Member Conditions

Top 10 Diagnoses

ICD-10 Diagnoses	Visits Year to Date
Other upper respiratory infect..	210
Anxiety disorders	128
Mood disorders	65
Urinary tract infections	44
Administrative/social admission	38
Cough, unspecified	34
Inflammation; infection of eye..	31
Adjustment disorders	29
Attention-deficit conduct and ..	29
Viral infection	29

Clinical Service Delivery

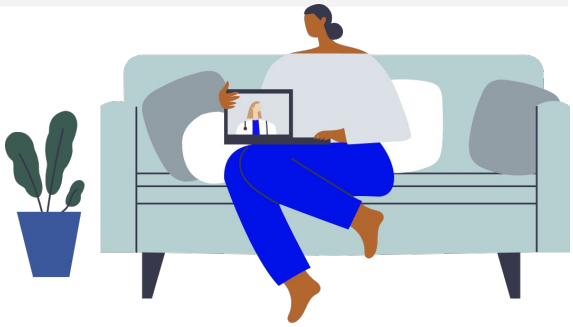
Our clinical team can provide a wide range of clinical services to help address members' needs. Our team has a focus on prescribing and labs to ensure our efficacy meets or exceeds that of in-person care through connections with pharmacy benefits and top lab networks.

Prescriptions and Testing Summary

314	64.9%	16	1.5%
Prescriptions This Month	of visits resulted in a prescription order Year to Date	Lab Orders This Month	of visits resulted in a lab order Year to Date

Top Prescriptions and Testing Orders

Top Prescriptions	Count (YTD)
amoxicillin and clavulanate potassium	42
fluticasone propionate	39
prednisone	36
ipratropium bromide	31
albuterol sulfate	30
benzonatate	27
nitrofurantoin (monohydrate/macrocrystals)	27
oseltamivir phosphate	27
ondansetron	25
methylprednisolone	18



Top Labs	Count (YTD)
HbA1c (hemoglobin A1c), blood	5
lipid panel, serum	5
CBC w/ auto diff	4
TSH, serum or plasma	3
CMP, serum or plasma	3
culture, urine	2
TSH + free T4, serum	2
urinalysis complete, reflex culture	2
CT + NG RNA, PCR, unspecified specimen	1
mycoplasma genitalium DNA, qualitative, PCR	1

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Included HEALTH

dr+ on demand by Included Health

Virtual Care Engagement Monthly Report

UMR-State of Nevada

Reporting Period

2025-03-01-2025-04-01

Member Engagement

49	364	451
Registrations This Month	Unique Visitors This Month	Total Visits This month

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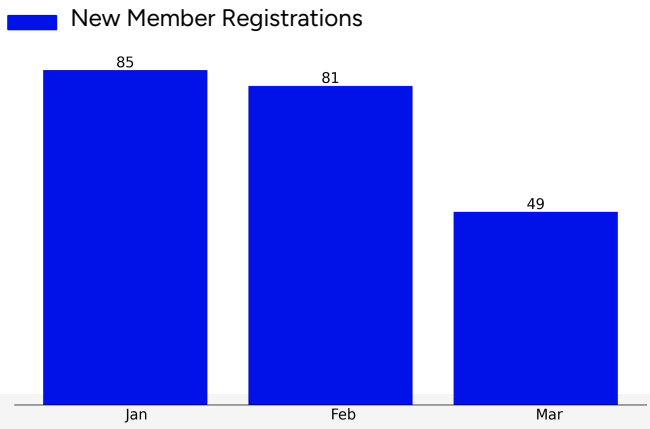
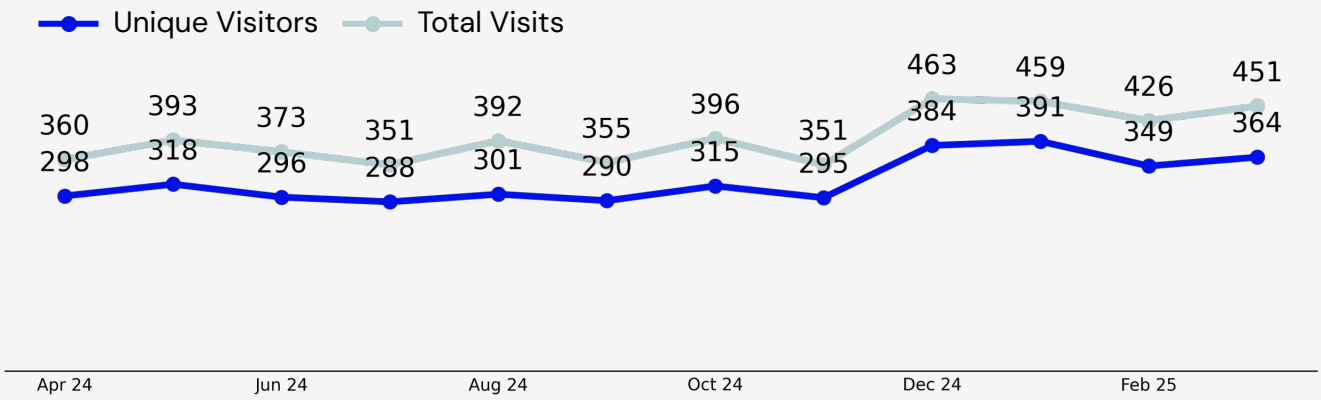
New Registrations (Year to Date)



48,935	13,491	27.6%
Total Covered Lives	Registrations Lifetime to date	Registration Rate Lifetime to date
-	215	0.4%
Employee Covered Lives	Registrations Year to Date	Registration Rate Year to Date

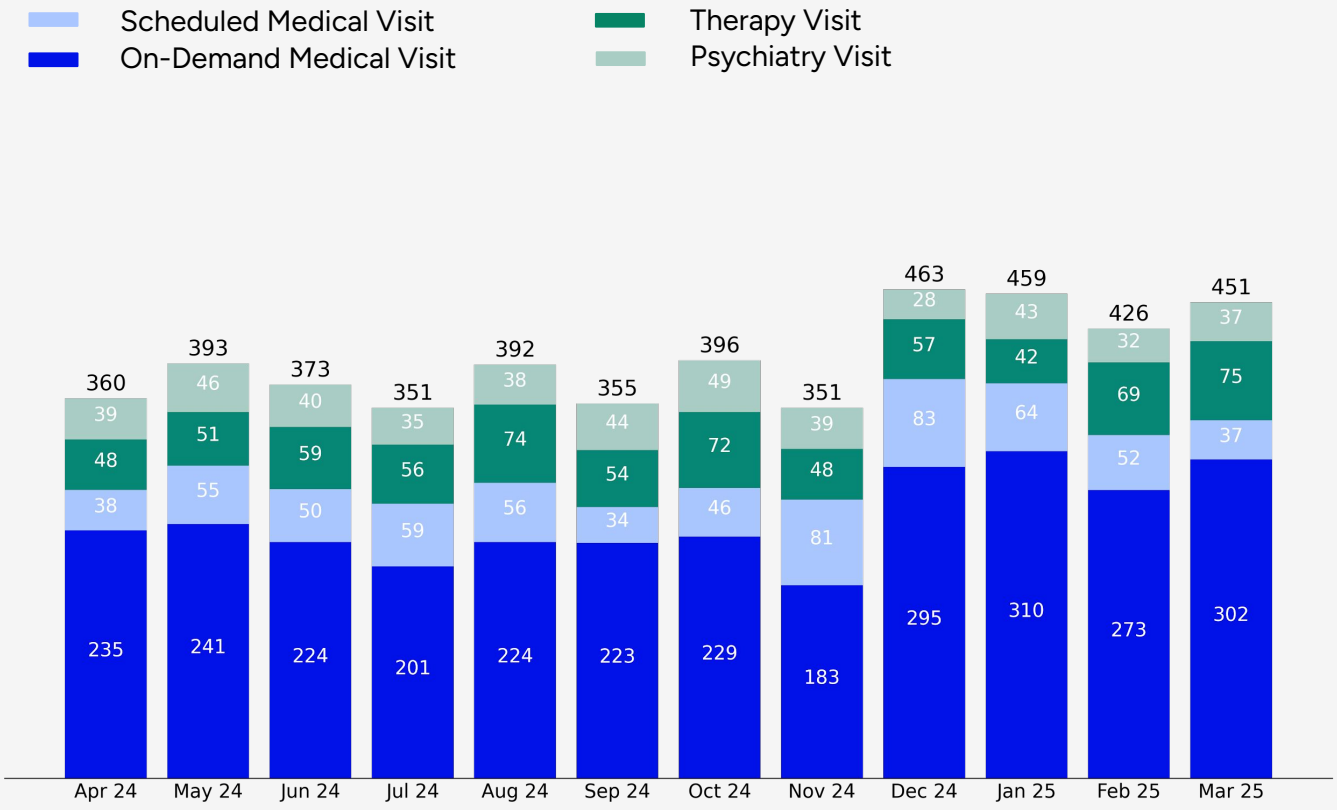
Visits Last 12 Months



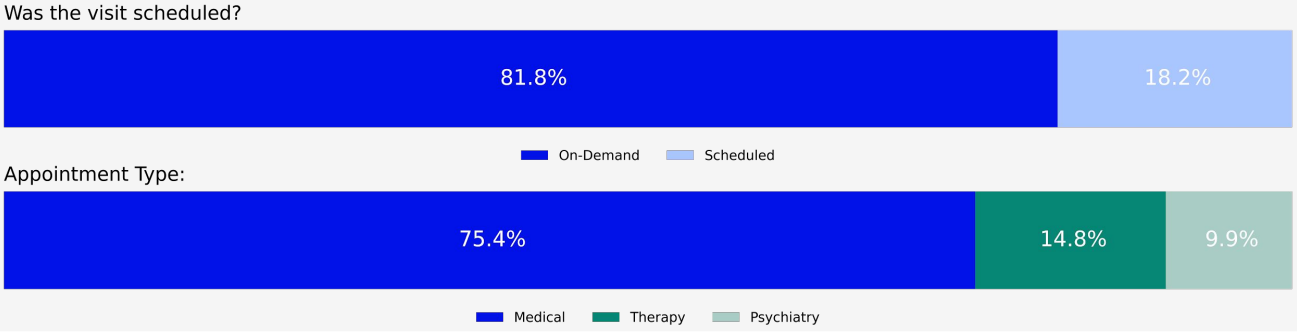
24,058	7,852	3.1	16.0%
Visits Lifetime to Date	Unique Visitors Lifetime to Date	Avg Visits Per Visitor Lifetime to Date	Engagement Rate (Visitors/Lives) Lifetime to Date
1,336	909	1.5	1.9%
Visits Year to Date	Unique Visitors Year to Date	Avg Visits Per Visitor Year to Date	Engagement Rate (Visitors/Lives) Year to Date

Member Engagement

Medical & Behavioral Health Visits (Rolling)



Member Demand by Visit Type Year to Date



Most Popular Day for Visits Year to Date

Monday

Most Popular Time for Visits Year to Date

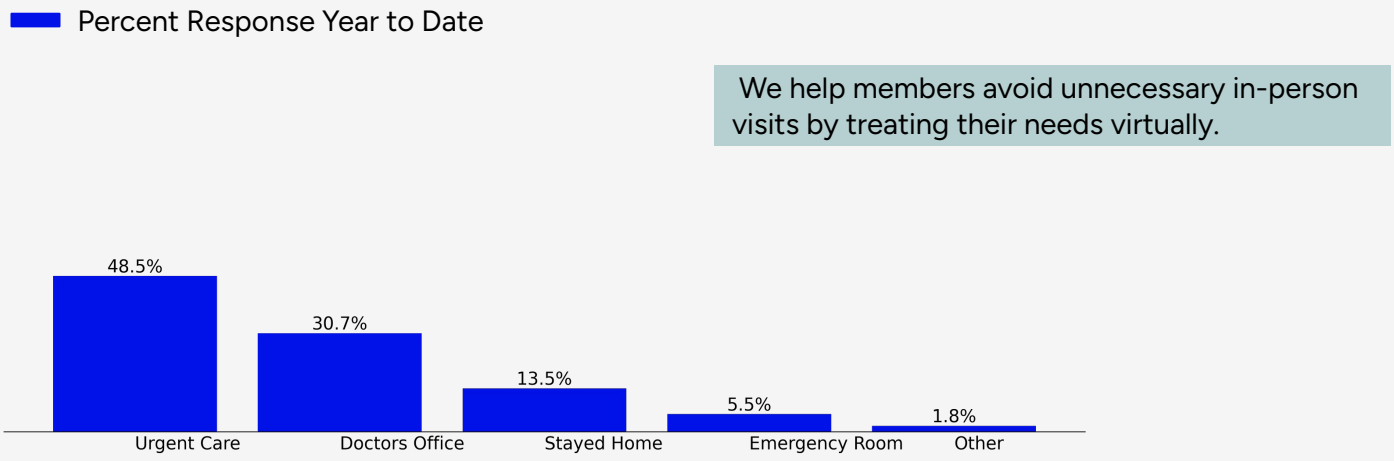
10AM - Noon

*Most popular day and time metrics are adjusted to time zone local where the visit was initiated

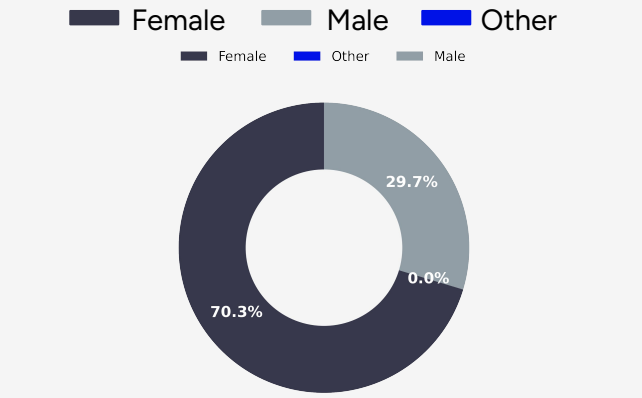
Member Access

This section highlights our impact on increasing members' access to appropriate medical and behavioral health care, and their satisfaction with our services. We improve access to care by seeing members after hours (when brick & mortar providers are closed) and by making it easier to visit with a provider during business hours.

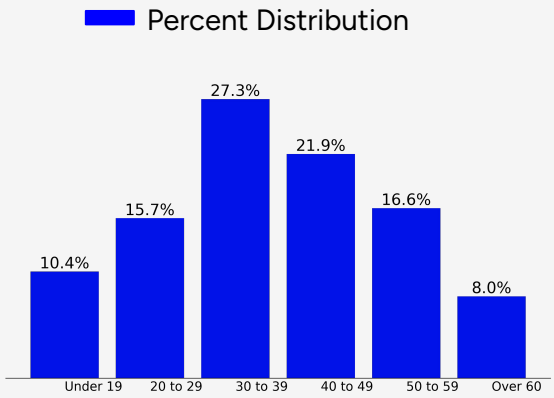
Without Included Health, where would you have gone?



Visits by Reported Gender Year to Date



Visits by Age Year to Date



Member Experience Metrics	March	Year to Date
Average Member Rating	4.9 / 5 (N = 189)	4.9 / 5 (N = 206)
Median Wait Time for On-Demand Medical Appointments	3.0 min	7.8 min
Median Days to Scheduled Appointment (MD & BH)	3.0 days	2.0 days

Member Clinical Needs

This section highlights the range of clinical conditions that we treat through virtual care services. The program addresses comprehensive physical and behavioral health needs, and chronic and acute conditions. Examining the top needs of your population can inform more targeted clinical interventions and programs.

Member Reported Visit Reasons

Top 10 Visit Reasons

Visit Reasons	Visits Year to Date
Cold	148
Cough	103
Urinary tract infection (UTI)	87
Eye issue	64
Sore throat	60
Other injury	57
Anxiety	44
Influenza	42
Fever	40
Nasal congestion	37

Member Conditions

Top 10 Diagnoses

ICD-10 Diagnoses	Visits Year to Date
Other upper respiratory infect..	337
Anxiety disorders	214
Mood disorders	108
Urinary tract infections	83
Inflammation; infection of eye..	71
Administrative/social admission	65
Cough, unspecified	64
Adjustment disorders	58
Viral infection	56
Attention-deficit conduct and ..	50

Clinical Service Delivery

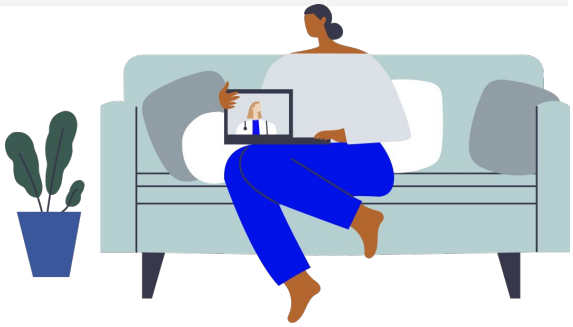
Our clinical team can provide a wide range of clinical services to help address members' needs. Our team has a focus on prescribing and labs to ensure our efficacy meets or exceeds that of in-person care through connections with pharmacy benefits and top lab networks.

Prescriptions and Testing Summary

378	63.2%	19	1.4%
Prescriptions This Month	of visits resulted in a prescription order Year to Date	Lab Orders This Month	of visits resulted in a lab order Year to Date

Top Prescriptions and Testing Orders

Top Prescriptions	Count (YTD)
prednisone	70
fluticasone propionate	69
amoxicillin and clavulanate potassium	68
albuterol sulfate	55
oseltamivir phosphate	50
nitrofurantoin (monohydrate/macrocrystals)	48
ondansetron	46
ipratropium bromide	40
benzonatate	38
methylprednisolone	32



Top Labs	Count (YTD)
urinalysis complete, reflex culture	5
RPR (rapid plasma reagin), serum	4
culture, urine	3
HIV 1+2 Ab + HIV1 p24 Ag, quantitative immunoassay, serum	3
TSH + free T4, serum	3
mycoplasma genitalium DNA, qualitative, PCR	3
CT + NG RNA, PCR, unspecified specimen	2
trichomonas vaginalis RNA	2
CBC w/ auto diff	2
CMP, serum or plasma	2

For any questions regarding the reporting, please feel free to reach out to your respective client success lead. Thank you.

Data & Metric Definitions

Metric	Definition
Behavioral Health Visit	Behavioral Health visits refer to scheduled appointments with our multidisciplinary team of therapists, psychologists, and psychiatrists. Our integrated Behavioral Health solution delivers highly-accessible, virtual-first therapy and psychiatry to members to address every member need from subclinical to clinical. Therapy visits are 25 or 50 minutes in length depending on the patient's needs. Initial Psychiatry visits are 45 minutes in length and all follow up psychiatry visits are 15 minutes in length.
Covered Lives	Total count of member lives (employees and dependents) eligible for Included Health services.
Employee Lives	Total count of employee lives eligible for Included Health services.
Engagement Rate	Total number of unique visitors as a percentage of eligible lives.
Medical Visit	Medical visits refer to on-demand and/or scheduled encounters with our multidisciplinary team of clinicians. **Urgent Care:** Our Everyday & Urgent Care solution offers accessible video-first care for acute needs. Our multidisciplinary team of employed clinicians provide 24/7 care on demand or by appointment to improve access to care and deliver a better care experience. Providers are cross-trained in behavioral health, primary dermatology, and geriatric medicine, to treat a wide range of everyday & urgent care and behavioral health needs including cold, flu, UTIs, sinus infections, along with anxiety and depression **Virtual Primary Care -** With Primary Care, we provide 24/7 care across the full continuum of member needs, including physical - acute, preventive and chronic - and behavioral for engaged members.
ICD-10 Code and Description	Describes the top international classification of diseases for diagnoses, symptoms, and procedures recorded by our clinicians as a result of the visit.
Member Rating	Average visitor rating of 1-5 stars submitted upon visit completion.
Patient Reported Symptoms	Describes the top symptoms selected by the patient during visit intake. A patient may select more than one symptom per visit.
Registration	A member is considered "registered" when they digitally accept the Included Health TOS. Registration rate is the total number of individuals registered as a percentage of eligible lives.
Reported Age and Gender	Describes the patient's age and gender category as provided by the member's insurance carrier or reported by the patient. Note, these demographics describe the patient, not the visitor.
Visit	A visit describes a member's encounter with an Included Health provider. Visits can be classified as: Medical or Behavioral (Therapy, Psychiatry)
Visitors	A member that initiates a visit with Included Health. Unique visitor counts is determined by the member that initiates the visit, not the patient seen by the provider. For example: A patient that initiates a visit for herself and a separate visit for her child is counted as one unique visitor.

5.

5. Executive Officer Report. (Celestena Glover, Executive Officer) (Information/Discussion)

JOE LOMBARDO
Governor

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
3427 Goni Road, Suite 109 | Carson City, Nevada 89706
Telephone 775-684-7000 | 702-486-3100 | 1-800-326-5496
https://pebp.nv.gov

CELESTENA GLOVER
Executive Officer

JOY GRIMMER
Board Chair

AGENDA ITEM

☐ Action Item
☒ Information Only

Date: May 22, 2025

Item Number: 5

Title: Executive Officer Report

SUMMARY

This report provides the Board, PEBP members and other stakeholders information on agency operations.

REPORT

OPEN ENROLLMENT

PEBP's annual open enrollment began on May 1, 2025, and will continue through May 31, 2025. As in past years, information was provided to members through the 4th Quarter newsletter, email to those members with email addresses within PEBP's system and via a statewide email sent to employees. As of (5/14/25) there have been 1217 events in progress, and 2534 open enrollment events completed. This is on track as last year there were 1151 in progress, and 2285 completed events by 5/12/23.

Plan Enrollment as of 5/14/25 – Total Lives Covered

Plan	PY2024 Enrollment	Current PY2025 Enrollment	Current elections for PY2026
CDHP	23,861	23,068	22,823
LD	20,108	23,946	24,558
EPO	5,562	5,078	4,939
HMO	6,123	5,985	5,869
Dental	10,309	10,226	10,216
Declined	2,587	2,914	2,945

CARSON TAHOE HEALTH UPDATE

In 2024, Carson Tahoe Health had notified PEBP and members that their contract with United Healthcare was due to expire on May 30, 2025, and that they would not be renewing their contract. After numerous discussions, CTH indicated that they would consider extending their contract to the end of the calendar year. On April 15, 2025, PEBP received confirmation via email that they had executed an agreement to extend the contract until December 31, 2025. CTH has included notifications to this fact on their website (see link below).

https://www.carsontahoe.com/unitedmembershipupdate.html

PEBP is continuing to research options to address this issue. However, we are also preparing for the worse case scenario in that CTH will be an out-of-network provider effective January 1, 2026.

6.

6. Discussion and possible action regarding the appointment of Nik Proper as Interim Executive Officer of PEBP upon the retirement of Celestena Glover.
   (Joy Grimmer, Board Chair) (**For Possible Action**)

7.

7. Discussion and possible action on recommended changes and updates to the Master Plan Documents for Plan Year 2026 (July 1, 2025 – June 30, 2026). (Leslie Bittleston, Quality Control Officer) (**For Possible Action**)

JOE LOMBARDO
Governor

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CELESTENA GLOVER
Executive Officer

JOY GRIMMER
Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: May 22, 2025

Item Number: 7

Title: Plan Year 2026 Documents Update and Plan Year 2026 Amendments for Approval

Plan Year 2026 Master Plan Documents Update

The following documents were revised and posted to the PEBP website.

- Consumer Driven Health Plan Master Plan Document and Summary of Benefits and Coverage
- Low-Deductible PPO Master Plan Document and Summary of Benefits and Coverage
- Exclusive Provider Organization Master Plan Document and Summary of Benefits and Coverage
- Dental Plan and Life Insurance Master Plan Document
- Flexible Spending Account Master Plan Document
- Retiree Health Reimbursement Arrangement Master Plan Document

The following documents were not updated (with the exception of dates) and posted to the PEBP website.

- Medicare Health Reimbursement Arrangement Master Plan Document
- Section 125 Master Plan Document

The following documents were combined into one document titled "Health and Welfare Wrap Document" and posted to the PEBP Website.

- Health and Welfare Wrap for Actives
- Health and Welfare Wrap for Retirees

The following documents were removed from the website.

- Enrollment & Eligibility Master Plan Document – Will become an internal policy.
- Health Reimbursement Arrangement Summary Plan Document – No longer needed (One time funding).

Plan Year 2026 Summary Documents Update
The following documents were revised and posted to the PEBP website.

- 2026 Benefit Guide
- 2026 Rate Guide
- 2026 Plan Comparison
- 2026 Dental Rates and Monthly HRA Contributions
- 2026 PEBP and Medicare Guide
- 2026 Summary of Benefits Coverage: Consumer Driven Health Plan
- 2026 Summary of Benefits Coverage: Low Deductible PPO
- 2026 Summary of Benefits Coverage: Exclusive Provider Organization Plan

The following documents were not updated as nothing has changed.

- Qualifying Life Events
- Commonly Used Health Coverage and Medical Terms
- HRA FAQs for State Active Employees

HPN Documents.
Pending new documents from HPN to upload to the PEBP website.

Plan Design Changes: The following are changes to plan design; for board approval. These changes will be an amendment with an effective date of July 1, 2025.

#	Change Type	Proposed Change	Justification	Section
1	Enhancement	Add a dollar limit for wigs.	PEPB Recommendation	Master Plan Documents for the EPO, CDHP, and the LDPPO
This item was intended to be presented at the March Board meeting but was accidentally missed. *New language in red:* New Language: *"Patients undergoing chemotherapy may be eligible for 1 wig, any type, synthetic or not, per Plan Year, up to $350 (excluding sales tax).*				
2	Enhancement	Prior authorization for Ketamine.	Q2FY25 UMR Findings Report Observation	Master Plan Documents for the EPO, CDHP, and the LDPPO
CTI Audit Results: "CTI recommends the either require prior authorization or be submitted through the prescription drug plan. Administration of this drug requires monitoring of the patient for two hours due to potential serious side effects". *Side effects include, but are not limited to: sedation, dissociation, respiratory depression, cognitive impairment, and abuse/misuse.*				
3	Enhancement	Vision Therapy	Q2FY25 UMR Findings Report Observation & UMR Staff Clarification	Master Plan Documents for the EPO, CDHP, and the LDPPO
Vision therapy (orthoptics) is an excluded service in the MPDs, however, PEBP instructed this service to be covered via memo by previous QC Officer, Tim Lindley. Based on review of claims with UMR and research, the following is recommended: Vision therapy must be prior authorized. Covered conditions include lazy eye, convergency insufficiency, and stroke recovery. Excluded conditions include learning disabilities, reading disorders, and dyslexia.				
4	Enhancement	HRA Plan Design	Via Benefits & PEPB Recommendation	Via Benefits Materials
HRA Plan Design will include the requirement for all HRA claims to be reimbursed via direct deposit. Currently, Via Benefits currently allows the option of direct deposit or a mailed paper check. Current stats.				

- *76% direct deposit*
- *24% mailed check*

Direct deposit takes roughly 3 days to process while a mailed check takes 7 -10 days. Direct deposit is safer, faster, and more convenient. It reduces the risk of loss, theft, and fraud.

Direct deposit is currently required for deposit of PEBP retirement and deposit of social security.

Will take between 3-4 months to go into effect once approved.

Clarification The following are being clarified. These changes will be an amendment with an effective date of July 1, 2025.

#	Change Type	Proposed Change	Justification	Section
1	Telehealth	Out of network providers	UMR Staff Clarification	Master Plan Documents for the EPO, CDHP, and the LDPPO
EPO and CDHP do not cover out of network services, but LDPPO does at 50% coinsurance. Intent is no coverage out of network. *Note: Further clarification is requested by UMR staff regarding reimbursement for all providers as in network as the member is either located in a medical office or at home which will be vetted internally and may be brought back to the board at a later board meeting.*				
2	Mammograms for Men	Age requirements	UMR Staff Clarification	Master Plan Documents for the EPO, CDHP, and the LDPPO
This was brought to the March board meeting for women. Added men, but did not include age requirements for men. *1. Mammograms begin at age 20 if BRCA mutations are present.* *2. Mammograms begin at age 30 if there is a 20% chance or greater of developing breast cancer.*				
3	DME	Parameters for purchase of DME	Executive Staff Recommendation	Master Plan Documents for the EPO, CDHP, and the LDPPO
MPDs currently state: *1. Durable Medical Equipment (DME): Limited to one purchase, repair, or replacement of a specific item of DME every 3 years. DME rental to purchase in accordance with Medicare guidelines. The purchase or rental of DME, including oxygen-related equipment in excess of $1,000 requires prior authorization, and* *2. Oxygen provided while traveling on an airline and portable oxygen concentrators that are supplied for purchase or rent specifically to meet airline requirements are excluded.* *Suggested Revision to replace the current #2:* *An additional purchase of DME cannot be made sooner than 3 years after a previous purchase of the same item, generally for convenience.*				
4	HRA/HSA Proration (CDHP)	HRA/HSA contributions for dependents	PEPB Recommendation	Master Plan Documents CDHP and HRA/HSA
Current MPDs state that HRA/HSA contributions are prorated for new hires and dependents mid-plan year based on hire date. *Current MPDs are silent on HRA/HSA contributions for a mid-plan year change based on a qualifying life event for dependents.*				

Update on PLAN for MPDs: The long-term plan for the master plan documents is to consolidate what can be consolidated and to revise/update what is remaining. It is anticipated that this will be done in stages over the next two years. The following highlights this long-term proposal.

Current Document	New Document	Status
Consumer Driven Health Plan Master Plan Document	Master Plan Document for Health, Dental, and Basic Life Insurance	Not yet started
Low-Deductible PPO Master Plan Document		
Exclusive Provider Organization Master Plan Document		
Dental Plan and Life Insurance Master Plan Document		
Enrollment & Eligibility Master Plan Document	Enrollment & Eligibility Policy (This will no longer be public facing – rather the Qualifying Life Events Guide and the Benefit Guide provides all information the public needs to know)	In process
Health and Welfare Wrap for Actives	Health and Welfare Wrap Document	Completed for Plan Year 26
Health and Welfare Wrap for Retirees		
Health Reimbursement Arrangement Summary Plan Document	Health Reimbursement and Flexible Spending Accounts Master Plan Document	Not yet started
Flexible Spending Account Master Plan Document		
Medicare Health Reimbursement Arrangement Master Plan Document		
Section 125 Master Plan Document	Section 125 Master Plan Document	Completed for Plan Year 26

Recommendation from PEBP Staff:

- Approve PEBP Staff's proposed changes, as presented.
- Allow for technical adjustment as necessary.

8.

8. Discussion and acceptance of Claim Technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Plans administered by UMR for the period of October 1, 2024 – December 31, 2024. (Joni Amato, Claim Technologies Incorporated) (**For Possible Action**)

Comprehensive Claim Administration Audit

QUARTERLY FINDINGS REPORT

State of Nevada Public Employees' Benefits Program Plans

Administered by UMR

Audit Period: October 1, 2024 – December 31, 2024
Audit Number 1.FY25.Q2

Presented to

State of Nevada Public Employees' Benefits Program

May 22, 2025

CLAIM TECHNOLOGIES INCORPORATED

TABLE OF CONTENTS

EXECUTIVE SUMMARY

This ***Quarterly Findings Report*** is a compilation of the detailed information, findings, and conclusions drawn from Claim Technologies Incorporated's (CTI's) audit of UMR's (UMR's) administration of the State of Nevada Public Employees' Benefits Program (PEBP) medical and dental plans.

Scope

CTI performed an audit for the period of October 1, 2024 through December 31, 2024 (quarter 2 (Q2) for Fiscal Year (FY) 2025). The population of claims and amount paid during the audit period reported by UMR:

Medical and Dental	
Total Paid Amount	$68,305,570
Total Number of Claims Paid/Denied/Adjusted	237,292

The audit included the following components which are described in more detail in the following pages.

- Quarterly Performance Guarantees Validation and Review of Self-Reported Results
- 100% Electronic Screening with 50 Targeted Samples
- Random Sample Audit of 200 Claims

Auditor's Opinion

Based on these findings, and in our opinion:

1. UMR met all 27 self-reported performance guarantees in which CTI reviewed UMR's summary reports.
2. UMR met the service objective for Financial Accuracy, Overall Accuracy and Claim Turnaround Time and no penalty is owed.
3. CTI recommends UMR should:
   - Review errors identified in our Random Sample audit as well as the additional observations and determine if procedures, system changes, or claim processor training could help reduce or eliminate errors of a similar nature in the future.
   - Review the 100% Electronic Screening with Targeted Sample results and focus on the most material findings.
   - Where appropriate, verify claim processor coaching, feedback, and retraining has occurred because most errors were manually processed.

Random Sample Audit Performance Guarantee Summary

Based on CTI's Random Sample Audit of 200 claims, UMR met its target for Financial Accuracy, Overall Accuracy and Claim Turnaround Time in Q2 FY2025 and no penalty is assessed.

Quarterly Metric	Guarantee	Met/Not Met	Penalty	Calculated Penalty
Financial Accuracy	99.4%	Met – 99.99%	NA	$0.00
Overall Accuracy	98.0%	Met – 99.0%	NA	$0.00
Claim Turnaround Time	92% in 14 Days 99% in 30 Days	Met – 95.6% Met – 99.3%	NA NA	$0.00 $0.00
		Total Penalty	NA	$0.00

The following table presents a summary of UMR's historical performance against the quarterly metrics based on CTI's random sample audit results for the last four quarters. Results shown in red represent where UMR missed the agreed upon metric.

Measure	Guarantee	FY 2024		FY 2025	
		Quarter 3	Quarter 4	Quarter 1	Quarter 2
Financial Accuracy	**99.4%**	98.47%	96.41%	98.68%	99.99%
Overall Accuracy	**98.0%**	98.5%	97.5%	98.0%	99.0%
Claim Turnaround Time	**92% in 14 Days**	94.0%	93.3%	94.2%	95.6%
	99% in 30 Days	98.5%	99.5%	99.0%	99.3%

AUDIT OBJECTIVES

This report contains CTI's findings from our audit of UMR's administration of the State of Nevada Public Employees' Benefits Program (PEBP) plans. We provide this report to PEBP, the plan sponsor, and UMR, the claim administrator. A copy of UMR's response to these findings can be found in the Appendix of this report.

CTI conducted the audit according to accepted standards and procedures for claim audits in the health insurance industry. We based our audit findings on the data and information provided by PEBP and UMR. The validity of our findings relies on the accuracy and completeness of that information. We planned and performed the audit to obtain reasonable assurance claims were adjudicated according to the terms of the contract between UMR and PEBP.

CTI specializes in the audit and control of health plan claim administration. Accordingly, the statements we make relate narrowly and specifically to the overall effectiveness of policies, procedures, and systems UMR used to pay PEBP's claims during the audit period. While performing the audit, CTI complied with all confidentiality, non-disclosure, and conflict of interest requirements and did not receive anything of value or any benefit of any kind other than agreed upon audit fees.

The objectives of CTI's audit of UMR's claim administration were to determine whether:

- UMR followed the terms of its contract with PEBP;
- UMR paid claims according to the provisions of the plan documents and if those provisions were clear and consistent; and
- members were eligible and covered by PEBP's plans at the time a service paid by UMR was incurred.

QUARTERLY PERFORMANCE GUARANTEE VALIDATION

As part of CTI's quarterly audit of PEBP, we reviewed the Performance Guarantees included in its contract with UMR. The results for Q2 FY2025 follow.

	Metric	Service Objective	Actual	Met/ Not Met
CLAIMS ADMINISTRATION – SERVICES AND PERFORMANCE GUARANTEES				
1.4	**Claim Adjustment Processing Time:** measured from the time a prior claim submission requiring an adjustment is identified through the date the claim adjustment is processed by service facility personnel.	95.00% 7 Calendar/ 5 Business Days	96.0%	Met
1.5	**Telephone Service Factor:** Defined as the percentage of the Client telephone inquiries answered by facility Customer Service Representatives (CSRs) within 30 seconds. Measured from the time the caller completes the prompts of the automated telephone system to the time the caller reaches a CSR.	85.00% Calls answered within 30 seconds	96.8%	Met
1.6	**Call Abandonment Rate:** total number of participant and provider calls abandoned, divided by the total number of calls received by the facility's customer service telephone system.	3.00%	0.3%	Met
1.7	**First Call Resolution Rate:** the percentage of telephone inquiries completely resolved within a 'window period' of time. A call is considered 'resolved' when the same participant or a family member under the same subscriber ID has not contacted the administrator's customer service facility again regarding the same issue within 60 calendar days of the initial call.	95.00%	97.3%	Met
1.8	**Open Inquiry Closure:** addresses the time taken in hours and/or days by CSRs at the administrator's service facility to close open inquiries placed by participants of PEBP to the facility.	90.00% 48 Hours 98.00% 5 Business Days	98.5% 99.3%	Met Met
1.9	**CSR Audit, or Quality Scores:** determined by the process used to evaluate the effectiveness and accuracy of participant telephone call handling at the administrator's customer service facility.	97.00%	98.6%	Met
1.10	**CSR Callback Performance:** measured from the CSR commitment data in hours and/or days to the time the actual callback was placed to the participant.	90.00% Within 24 Hours	100%	Met
1.11	**Participant Email Response Performance:** measured from the time an email is received by the administrator's response team to the time in hours or days to the time the actual email response is sent to the participant.	90.00% Within 8 Hours 95.00% Within 24 Hours	100% 100%	Met Met
1.13	**Account Management – Plan will guarantee that the services provided by the TPA's team during the guarantee period will be satisfactory to PEBP. Areas of satisfaction will include:**			
	Knowledge/Capabilities – Account representative demonstrates competence in getting issues and problems resolved.	Agree	5	Met
	Responsiveness – All calls returned within at most 24 hours; along with an alternate person identified who can assist with service issues when account representative is unavailable.			
	Ability to meet deadlines – Supplying all requested materials accurately and in a timely manner, along with all necessary documentation (i.e., enrollment kits, rate confirmations, plan performance work plans, group contracts, ZIP code file, etc.).			
	Professionalism – Demonstrates objectivity and empathy with customer problems.			
	Flexibility – Ability to meet client-specific needs.			

	Metric	Service Objective	Actual	Met/ Not Met
	Participation in periodic meetings – Attendance at all required client meetings or conference calls.			
	Guarantee measured with staff responses to internal questionnaire. A scale from 1 to 5 will be used to measure performance, where 1 means 'very dissatisfied' and 5 means 'very satisfied'; and 2 through 4 are defined, respectively.			
	Periodic program reports will be provided and presented with recommended actions. Standard program reports, within 30 days to quarter-end. Year-end activity report, within 45 days of program year end.			
	Open Enrollment Support: Accurate materials will be provided at least 60 days prior to the open enrollment period starting on April 1 each year. Representative will be available, if requested, for up to 5 employee benefit fairs.			
	Service Objective (out of a score of 5 on internal questionnaire):	350		
1.14	**Eligibility Processing:** Confirm daily and weekly eligibility and enrollment within specified business days of the receipt of the eligibility information, given that information is complete and accurate.	98.00% 2 Business Days	100%	Met
1.15	**Data Reporting:** Offeror will provide PEBP with 100% of the applicable reports (within 10 business days for standard reports and within 10 business days of Plan year-end for Annual Reports and Regulatory documents).	100% 10 Business Days	100%	Met
1.17	**ID Card Production and Distribution**	100% 10 Business Days	100%	Met
1.18	**Disclosure of Subcontractors:** Offeror will provide the identity of the subcontractors who have access to PEBP member PHI. Provide identity of subcontractors who have access to PHI within 30 calendar days of the subcontractors' gaining access.	100% 30 Calendar Days	No new subcontractors	Met
1.19	**PHI:** Offeror will store PEBP member PHI data on designated servers. Must remove PEBP member PHI within 3 business days after offeror knows or should have known using commercially reasonable efforts that such PHI is not store on a designated server.	100% 30 Business Days	No changes	Met
NETWORK ADMINISTRATION – SERVICES AND PERFORMANCE GUARANTEES				
2.1	**EDI Claims Re-Pricing Turnaround Time:** At least 97% of medical claims covered under the PEBP Medical PPO Network must be electronically re-priced within business 3 days and 99% within business 5 days.	97.00% 3 Business Days 99.00% 5 Business Days	99.5% 99.77%	Met Met
2.2	**EDI Claims Re-Pricing Accuracy:** At least 97% of claims re-priced by the PPO Network must be accurate and must not cause a claim adjustment by PEBP's TPA.	97.00%	99.5%	Met
2.3	**Data Reporting – Standard Reports (Quarterly reporting to include Service Performance Standards, Guarantee, Method of Measurement, Actual Performance Results, and Pass/Fail indicator.)** Standard reports must be delivered within business 10 days of end of reporting period or event as determined by PEBP.	100% 10 Business Days	100%	Met
2.4	**Subcontractor Disclosure:** 100% of all subcontractors used by vendor are disclosed prior to any work done on behalf of PEBP. Business Associate Agreements completed by all subcontractors.	100%	No new subcontractors	Met
2.5	**Provider Directory:** Best efforts to resolve 100% of complaints within 10 business days. Provider Directory issue resolution log maintained by Vendor and periodically reviewed with PEBP.	100% 10 Business Days	No complaints filed	Met
2.6	**Website:** A website hosting a reasonably accurate and updated Provider directory must be available and accessible on all major browsers 99% of time.	99.00%	100%	Met

	Metric	Service Objective	Actual	Met/ Not Met
UTILIZATION MANAGEMENT/CASE MANAGEMENT – SERVICES AND PERFORMANCE GUARANTEES				
3.1	**Data Reporting – Standard Reports (Quarterly reporting to include Service Performance Standards, Guarantee, Method of Measurement, Actual Performance Results, and Pass/Fail indicator.)** Standard reports must be delivered within calendar 10 days of end of reporting period or event as determined by PEBP.	100% 10 Calendar Days	100%	Met
3.2	**Notification of potential high expense cases. High expense case is defined as a single claim or treatment plan expected to exceed $100,000.00.** Designated PEBP staff will be notified within 5 business days of the UM/CM vendors initial notification of the requested Service.	100% 5 Business Days	100%	Met
3.12	**Disclosure of Subcontractors:** All subcontractors who have access to PHI or PII data and physical locations where PEBP PHI or PII data is maintained and/or stored must be identified in this contract. Any changes to those subcontractors or physical locations where PEBP data is stored must be communicated to PEBP at least 60 days prior to implementation of services by the subcontractor. Implementation will not be in effect until PEBP has provided written authorization.	100% 60 Calendar Days	No new subcontractors	Met
3.13	**Unauthorized Transfer of PEBP Data:** All PEBP PHI or PII data will be stored, processed, and maintained solely on currently designated servers and storage devices identified in this contract. Any changes to those designated systems during the life of this agreement shall be reported to PEBP at least 60 calendar days prior to the changes being implemented. Implementation will not be in effect until PEBP has provided written authorization.	100% 60 Calendar Days	No changes	Met

100% ELECTRONIC SCREENING WITH TARGETED SAMPLE ANALYSIS

Objective

CTI's Electronic Screening and Analysis System (ESAS®) software identified and quantified potential claim administration payment errors. PEBP and UMR should discuss any verified under- or overpayments to determine the appropriate actions to correct the errors.

Scope

CTI electronically screened 100% of the service lines processed by UMR during the audit period for both medical and dental claims. The accuracy and completeness of UMR's data directly impacted the screening categories we completed and the integrity of our findings. We screened the following high-level ESAS categories to identify potential amounts at risk:

- Duplicate payments to providers and/or employees
- Plan exclusions and limitations
- Patient cost share
- Fraud, waste, and abuse
- Timely filing
- Coordination of benefits
- Large claim review
- Case and disease management

Methodology

We used ESAS to analyze claim payment and eligibility maintenance accuracy as well as any opportunities for system and process improvement. Using the data file provided by UMR, we readjudicated each line on every claim the plan paid or denied during the audit period against the plan's benefits. Our Technical Lead Auditor tested a targeted sample of claims to provide insight into UMR's claim administration as well as operational policies and procedures. We followed these procedures to complete our ESAS process:

- ***Electronic Screening Parameters Set*** – We used your plan document provisions to set the parameters in ESAS.
- ***Data Conversion*** – We converted and validated your claim data, reconciled it against control totals, and checked it for reasonableness.
- ***Electronic Screening*** – We systematically screened 100% of the service lines processed and flagged claims not administered according to plan parameters.
- ***Auditor Analysis*** – If claims within an ESAS screening category represented a material amount, our auditors analyzed the findings to confirm results were valid. Note using ESAS could lead to false positives if there was incomplete claim data. CTI auditors made every effort to identify and remove false positives.
- ***Targeted Sample Analysis*** – From the categories identified with material amounts at risk, we selected the best examples of potential under- or overpayments to test. As cases were not randomly selected, we did not extrapolate results. We selected 50 cases and sent your administrator a questionnaire for each. Targeted samples verified if the claim data supported our finding and if our understanding of plan provisions matched UMR's administration.

- ***Audit of Administrator Response and Documentation*** – We reviewed the responses and redacted the responses to eliminate personal health information. Based on the responses and further analysis of the findings, we removed false positives identified from the potential amounts at risk.

Findings

We are confident in the accuracy of our ESAS results. It should be noted that dollar amounts associated with the results represent potential payment errors and process improvement opportunities. To substantiate the findings, CTI would have to perform additional testing to provide the basis for remedial action planning or reimbursement.

Categories for Process Improvement

The ESAS Findings Detail Report shows by category the line items where exceptions were noted. PEBP should work with its TPA, UMR, to examine areas of concern. A CTI auditor reviewed UMR's responses and supporting documentation. The administrator responses shown in the ESAS Detail Findings Report on the following pages were copied directly from UMR's reply to audit findings. **It is important to note that even if the sampled claim was subsequently corrected prior to CTI's audit, we have still cited the error so PEBP can discuss how to reduce errors and re-work in the future with UMR.**

For each potential error, we sent an ESAS Questionnaire with an identification number (QID) to UMR for written response. After review of the response and any additional information provided, CTI confirmed the potential for process improvement.

Manually adjudicated claims were processed by an individual claim processor. Auto-adjudicated claims were paid by the system with no manual intervention.

ESAS Findings Detail Report				
QID	**(Under)/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
Duplicate Payments				
45	$91.00	Agree.	Procedural deficiencies and overpayments remain. UMR paid duplicate charges.	☐ M ☒ S
49	$207.20			☐ M ☒ S
50	$491.48			☒ M ☐ S
Service Not Authorized				
37	$800.00	Agree. Prior authorization was not on file for CPT code 97151.	Procedural deficiency and overpayment remain. The applied behavioral analysis (ABA) services required prior authorization, which was not done. The ABA services should have been denied as not authorized.	☒ M ☐ S
Plan Exclusions				
Liposuction (Cosmetic Surgery)				
42	$3,710.25	Agree. The charges for 15877 and 15878 should have been reviewed for medical necessity before payment. UMR will request medical records for post payment review prior to pursing overpayment recovery.	Procedural deficiency and overpayment remain. Per page 92 of the EPO MPD, cosmetic procedures were excluded by the plan. The charges for lipectomy (procedure codes 15877 and 15878) were not prior authorized or reviewed for medical necessity prior to payment. The charges should have been denied.	☒ M ☐ S
Incorrect Preferred Provider Discount Applied				
21	$578.15	Agree. The claim should have taken a discount.	Procedural deficiency and overpayment remain. The provider discount was not applied to the claim.	☒ M ☐ S

Copay Application				
Office Visit - PCP				
15	$30.00	Agree. The copayment applies per visit not per day. $30.00 copay should apply to this claim per the plan benefits.	Procedural deficiency and overpayment remain. The MPD states copays are per visit and not per day.	☒ M ☐ S
Office Visit – Specialist				
17	($11.94)	Agree. Specialty copay of $40.00 should have applied.	Procedural deficiency and underpayment remain. The service should have had a $40.00 copay applied instead of coinsurance.	☒ M ☐ S
Preventive Services				
With Coinsurance Applied				
6	($20.50)	Agree. The coinsurance on this claim was applied in error. The claim should have paid at 100% of cost share. This claim will be adjusted at the completion of the audit.	Procedural deficiency and underpayment remain. The member cost share should have been waived for this preventive service.	☒ M ☐ S

Additional Observations

During the focused Audit, our auditor observed the following procedures or situations that may not have caused an error on the sampled claim but may impact future claims or overall quality of service.

QID Number	Observation
39	Per page 109 of the CDHP MPD, vision therapy (orthoptics) was specifically excluded by the plan and should have been denied. UMR provided a memo where PEBP instructed UMR to allow expenses for vision therapy. PEBP should verify their coverage intent for vision therapy and ensure the MPD reflects that intent as well as communicate any change to UMR.

RANDOM SAMPLE AUDIT

Objectives

The objectives of our Random Sample Audit were to determine if medical and dental claims were paid according to plan specifications and the administrative agreement, to measure and benchmark process quality, and to prioritize areas of administrative deficiency for further review and remediation.

Scope

CTI's statistically valid Random Sample Audit included a stratified random sample of 200 paid or denied claims. UMR's performance was measured using the following key performance indicators:

- Financial Accuracy
- Claims Payment Accuracy
- Overall Accuracy

We also measured claim turnaround time, a commonly relied upon performance measure.

Methodology

Our Random Sample Audit ensures a high degree of consistency in methodology and is based upon the principles of statistical process control with a management philosophy of continuous quality improvement. Our auditors reviewed each sample claim selected to ensure it conformed to plan specifications, agreements, and negotiated discounts. We recorded our findings in our proprietary audit system.

When applicable, we cited claim payment and processing errors identified by comparing the way a selected claim was paid and the information UMR had available at the time the transaction was processed**. It is important to note that even if the sampled claim was subsequently corrected prior to CTI's audit, we have still cited the error so PEBP can discuss how to reduce errors and re-work in the future with UMR.**

CTI communicated with UMR in writing about any errors or observations using system-generated response forms. We sent UMR a preliminary report for its review and written response. We considered UMR's written response, as found in the Appendix, when producing our final reports. Note that the administrator responses have been copied directly from UMR's reply.

Financial Accuracy

CTI defines Financial Accuracy as the total correct claim payments made compared to the total dollars of correct claim payments that should have been made for the audit sample.

The total paid in the 200-claim audit sample was $2,855,721.25. The claims sampled and reviewed revealed no underpayments and $125.00 in overpayments. This reflects a weighted Financial Accuracy rate of 99.99% over the stratified sample. This is an increase in performance from the prior period. Detail is provided in the following table, Random Sample Findings Detail Report.

UMR met the Performance Guarantee for PEBP in Q2 FY2025 of 99.40% for this measure.

Claims Payment Accuracy

CTI defines Claims Payment Accuracy as the number of claims paid correctly compared to the total number of claims paid for the audit sample.

The audit sample revealed 1 incorrectly paid claim and 199 correctly paid claims. This is an increase in performance from the prior period. Detail is provided in the table below, Random Sample Findings Detail Report.

Total Claims	Incorrectly Paid Claims		Frequency
	Underpaid Claims	Overpaid Claims	
200	0	1	99.5%

Overall Accuracy

CTI defines Overall Accuracy as the number of claims processed without errors compared to the total number of claims processed in the audit sample.

Performance increased from the prior period. UMR met the Performance Guarantee for PEBP in Q2 FY2025 of 98.00% for this measure. Detail is provided in the table below, Random Sample Findings Detail Report.

Correctly Processed Claims	Incorrectly Processed Claims		Frequency
	System	Manual	
198	0	2	99.0%

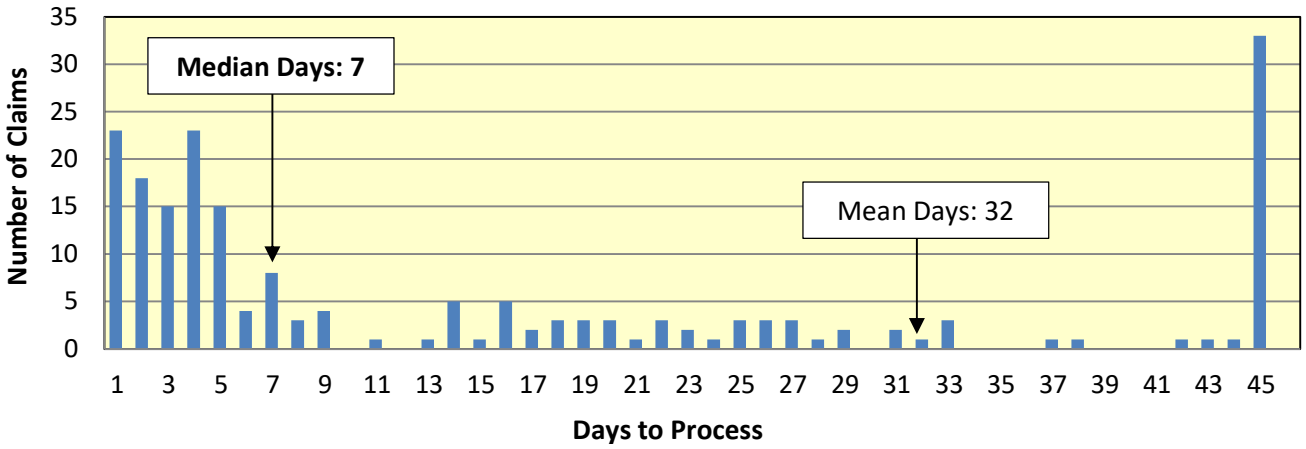
Random Sample Findings Detail Report				
Audit No.	Under/ Over Paid	UMR Response	CTI Conclusion	Manual or System
PPO Discount				
1038	$125.00	Agree. The processor allowed $150.00 for code S9379 and should have allowed $25.00. This results in a $125 overpayment.	Procedural error and overpayment remain. An incorrect PPO discount was applied to the sampled claim.	☒ M ☐ S
Paid Ineligible Procedure				
1114	NA	Agree. Gingival dental work is excluded on the Low Ded. Plan. This claim was allowed in error by the Customer First Representative.	Procedural error and overstatement of $100.55 to the deductible remains. This claim for dental services was not eligible for benefits based on page 96 of the plan document.	☒ M ☐ S

Claim Turnaround

CTI defines Claim Turnaround as the number of calendar days required to process a claim – from the date the claim was received by the administrator to the date a payment, denial, or additional information request was processed – expressed as both the Median and Mean for the audit sample.

Claim administrators commonly measure claim turnaround time in mean days. Median days, however, is a more meaningful measure for administrators to focus on when analyzing claim turnaround because it prevents just a few claims with extended turnaround time from distorting the true performance picture.

Median and Mean Claim Turnaround



UMR met the Performance Guarantees for PEBP in Q2 FY2025 of 92% processed within 14 days and 99% processed within 30 days. The performance of both measures improved from the prior period and there is no penalty due.

Additional Observations

During the Random Sample Audit, our auditor observed the following procedures or situations that may not have caused an error on the sampled claim but may impact future claims or overall quality of service.

Audit Number	Observation
1083, 1091	CTI identified two claims in the random sample audit where payment for Esketamine nasal spray (Spravato) was allowed without prior authorization. Administration of the drug requires monitoring of the patient for two hours due to potential serious side-effects. Based on the medical claim data, PEBP spent in excess of $140,000 for this drug in FY2025. CTI recommended administration of this drug should require prior authorization. PEBP and UMR have since discussed and agreed prior authorization will be required going forward for coverage of Esketamine through both the medical and prescription drug plans.

CONCLUSION

UMR met all the performance metrics in the second quarter of FY2025. No penalty is owed.

We consider it a privilege to have worked for, and with, the PEBP staff and its administrator. Thank you again for choosing CTI.

APPENDIX – ADMINISTRATOR RESPONSE TO DRAFT REPORT

Your administrator's response to the draft report follows.

Additional information submitted to CTI from the administrator in response to the draft report is reviewed and observations may be removed prior to the final report being published. While a removed observation will not be included in the final report, it may be referenced in the administrator's response to the draft report.

115 West Wausau Ave
Wausau, WI 54401

CLAIM TECHNOLOGIES INCORPORATED
100 COURT AVENUE SUITE 306
DES MOINES, IA 50309

March 18, 2025

Joni,

Thank you for the opportunity to respond to the recent review of the State of Nevada Public Employees' Benefit Program Q2Y25 audit draft report. The following is our response to the draft report completed by CTI.

ESAS Targeted Sample Analysis

Duplicate Payments

QID 45 – Dental claim 24291261705 is a duplicate to previously processed claim 24291261625. This results in a $91.00 overpayment. Adjustment was completed on 3-13-2025.

QID 47 – After further review, UMR disagrees with this duplicate payment error. The provider of service also confirmed this is not a duplicate billing. Patient had D0220 (X-Ray) and D9910 done on each tooth, # 2 and #3.

QID 50 – Medical Claim 24291266170 is a duplicate to previously processed claim 24282416643. This results in a $491.48 overpayment. Adjustment was completed on 1-23-2025.

QID 49 – After further review, Dental claim 24338017408 is a duplicate to previously processed claim 24277382456. Services for tooth # 7, an anterior tooth (lateral) was billed for procedure D2332 (3 surface resin-based composite, not an amalgam). UMR received two separate billings with the same code and billed amount. This results in a $207.20 overpayment. Adjustment was completed on 3-18-2025.

Services Not Authorized

QID 37 – After further review, UMR agrees with this finding. Prior authorization was not on file for CPT code 97151. This was a Customer First Representative (CFR) processing error. The claim was adjusted on 3-13-2025 and results in a $800.00 overpayment.

Plan Exclusions – Orthoptics (Vision Therapy)

QID 39 – UMR disagrees with this finding. Claims are reviewed based on the services billed. Procedure and Diagnosis selections are coded in the UMR system to identify the services and plan benefits. This claim is processed correctly.

Plan Exclusions – Experimental /Investigational

QID 40 – UMR disagrees with this finding. Claims are reviewed based on the services billed. Procedure and Diagnosis selections are coded in the UMR system to identify the services and plan benefits. This claim processed per the provider's UHC contract and case rate methodology. This claim is processed correctly.

715-841-7262 www.UMR.com Julie.Frahm@UMR.com

Plan Exclusions – Liposuction (Cosmetic Surgery)

QID 42 – UMR disagrees with this finding. Claims are reviewed based on the services billed. Procedure and Diagnosis selections are coded in the UMR system to identify the services and plan benefits. This claim processed per the provider's UHC contract and surgical case rate methodology. This claim is processed correctly.

Incorrect Preferred Provider Discount Applied

QID 21 – UMR agrees with this finding. The provider discount was omitted at the time this claim was processed. This was a CFR processing error. This claim was adjusted on 2-11-2025 and results in a $578.15 overpayment.

Copay Application – PCP

QID 15 – After further review, UMR agrees with this finding. The copayment applies per visit not per day. $30.00 copay should apply to this claim per the plan benefits. This claim was adjusted on 3-13-2025 and results in a $30.00 overpayment.

Copay Application – Office Visit – Specialist

QID 17 – UMR agrees with this finding. A $40.00 copay should apply for a specialist office visit. This claim was adjusted on 03-14-2025 and results in a $11.94 underpayment.

Preventive Services – With Coinsurance Applied

QID 6 – UMR agrees with this finding. Coinsurance was applied to this claim in error. This was a manual processing error. The claim was adjusted on 3-13-2025 and results in a $20.50 underpayment.

Random Sample Findings

PPO Discount

Sample 1038 – UMR agrees with this finding. An incorrect allowed amount was entered for code S9379. This claim was adjusted on 3-13-2025 and results in a $125.00 overpayment.

Paid Ineligible Procedure

Sample 1114 – UMR agrees with this finding. This service is excluded on the plan and was allowed in error by the CFR. The claim was adjusted to deny on 3/11/2025.

UMR is dedicated to improving the overall experience for the State of Nevada PEBP members and will continue to work diligently on addressing any issues highlighted by this review. Coaching and ongoing training is held with our dedicated processors. We continue to meet with the staff daily to go over quality reports, identifying trending errors, initiating refresher training for skill gaps, and using this data to improve the overall quality of the staff.
If you have any questions or concerns regarding our responses, please feel free to contact me at 715-841-7262.

Sincerely,

Julie Frahm
Sr. UMR External Audit Coordinator

Claim Technologies Incorporated representatives may from time to time provide observations regarding certain tax and legal requirements including the requirements of federal and state health care reform legislation. These observations are based on our good-faith interpretation of laws and regulations currently in effect and are not intended to be a substitute for legal or tax advice. Please contact your legal counsel and tax accountant for advice regarding legal and tax requirements.

CLAIM TECHNOLOGIES INCORPORATED

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9.

9. Discussion and possible action regarding 2025 Legislative Bills that may impact the Public Employees' Benefits Program. (Celestena Glover, Executive Officer) (**For Possible Action**)

JOE LOMBARDO
Governor

CELESTENA GLOVER
Executive Officer

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
3427 Goni Road, Suite 109 | Carson City, Nevada 89706
Telephone 775-684-7000 | 702-486-3100 | 1-800-326-5496
https://pebp.nv.gov

JOY GRIMMER
Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: May 22, 2025

Item Number: 9

Title: Legislative Update

SUMMARY

This report provides the PEBP Board and the public with information regarding new legislation proposed in the 2025 session of the Nevada Legislature.

REPORT

PEBP staff is tracking all bills that may affect PEBP, including those addressing the conduct of open meetings, public records requests, and preparation of state agency budgets. However, the attached spreadsheet lists only those measures likely to affect the benefits offered to members and/or those that may have a significant fiscal impact on PEBP.

The bills that appear most consequential are:

Assembly Bill 188 – In part, this bill proposes to, under certain circumstances, provide a subsidy to pay for a portion of premium costs for retirees who were initially hired on or after January 1, 2012; raises the cap on HRA balances for retirees enrolled in Medicare; and requires a legislative study of various aspects of PEBP during the 2025-2026 interim. PEBP estimates that passage would incur an immediate increase in its OPEB liability of 12.26% ($179 million) in the first year and approximately 3.5% per year thereafter; additionally, passage would require additional staff members to manage the resulting increased workload, as well as increased administrative costs, totaling approximately $1 million in Fiscal Year 2027, and $2.5 million in the next biennium. This does not account for claims costs which are dependent upon the number of retirees and the plan and tier those retirees elect as well as the health concerns of both the retirees and their dependents. Claims costs are difficult to determine, however initial estimates of costs are approximately $1.1 million in FY2027 and $5.6 million in the next biennium.

Assembly Bill 583 – Establishes the subsidies to be paid to PEBP, consistent with the Governor's Recommended budget.

Senate Bill 494 – This bill was introduced in the Senate on May 15, 2025, and reflects the reorganization previously presented to the Board by Stacie Weeks, Administrator of the Division of Health Care Financing and Policy, to include placing PEBP within the Nevada Health Authority (which is created by the bill) and authorizing the Board to use certain Nevada Health Authority services, including procurement services.

CONCLUSION

PEBP staff will continue to track legislation and provide updates as appropriate to the PEBP Board through the close of the session.

Bill Tracking 83rd (2025) Session							
BILL #	**Summary**	**Description**	**Sponsor**	**Tracking**	**Comments**	**Fiscal Note Requested**	**Fiscal Impact**
AB52	Revises provisions relating to the payment of claims by providers of health care	AN ACT relating to insurance; requiring the Commissioner of Insurance to establish programs to inform providers of health care and insureds under health insurance policies of certain information relating to the payment of claims; revising provisions governing the payment of claims under policies of health insurance; establishing certain administrative penalties; requiring a health carrier to provide certain information to participating providers of health care and covered persons; requiring a health carrier to establish certain procedures for challenging the denial of a claim; and providing other matters properly relating thereto.	Commission on Minority Affairs	YES	**4/24/25: To Assembly Committee on Ways and Means** Amends NRS 689B.255 and NRS 695G.230, which apply to PEBP via NRS 287.04335, to set forth requirements for denial of claims submitted by providers, including reasons for denial, criteria for determination, and summary of procedure to challenge denial; adds new provisions regarding approving and paying or denying claim within 21 days if submitted electronically, setting other timelines for requesting further information and resolving claims after receipt, requiring payment of interest on late-paid claims, and annual report to DOI re: compliance.	Yes	$177,709 in Year 1 $370,736 in Year 2 $790,073 in future biennia
AB169	Revises provisions relating to insurance.	AN ACT relating to insurance; requiring that certain health insurance policies and health plans include coverage for certain forms of speech-language pathology as treatment for stuttering for persons who are less than 18 years of age; prohibiting certain limitations on such coverage; and providing other matters properly relating thereto.	Assemblymember Yeager	YES	**4/23/25: To Assembly Committee on Ways and Means** Section 15 amends NRS 287.04335 to require coverage for habilitative/rehabilitative speech-language pathology as treatment for stuttering for persons under 26; and to prohibit imposing a maximum annual limit on such coverage, limiting coverage based on cause of stuttering, or imposing medical management techniques on such coverage.	Yes	$3.3 Million in 2027 $8.1 Million in future biennia
AB186	Revises provisions relating to health care.	AN ACT relating to pharmacy; authorizing a registered pharmacist to prescribe drugs and devices to treat certain health conditions; authorizing a registered pharmacist to administer drugs; authorizing a registered pharmacist to engage in certain activity relating to laboratories and laboratory testing; and providing other matters properly relating thereto.	Assemblyman Orentilicher	YES	**4/23/25: To Assembly Committee on Ways and Means** Amends NRS 695G.1705, which applies to PEBP via NRS 287.04335, re: insurance coverage for certain services performed by registered pharmacists.	Yes	Cannot Be Determined
AB188	Revises provisions relating to public employment.	AN ACT relating to the Public Employees' Benefits Program; requiring the Board of the Public Employees' Benefits Program to report certain information relating to the costs of health insurance for certain retirees; revising provisions relating to the subsidy paid for certain health and welfare benefits for certain state employees who have retired with state service; revising requirements for certain retired public officers and employees to reinstate insurance under the Program; and providing other matters properly relating thereto.	Assemblymember Carter	YES	**5/15/25: Referred to Assembly Committee on Ways and Means** Revises NRS Chapter 287 to provide subsidy to retirees initially hired on or after 1/1/12 under certain circumstances and provisions related to such subsidies; raises cap on HRA balances for retirees enrolled in Medicare; requires Joint Interim Standing Committee on Government Affairs to conduct a study during the 2025-2026 interim concerning various aspects of PEBP.	Yes	$179 million increase to OPEB liability, Additional Staff, Administrative Fees and Claims Costs $2.5 million in future biennia based on 3.55% inflation and only 73 new retirees initially enrolled
AB259	Revises provisions relating to health care.	AN ACT relating to health care; prohibiting certain actions related to pricing and reimbursement for certain drugs; creating a cause of action for violating such prohibitions; and providing other matters properly relating thereto.	Assemblywoman Considine	YES	**4/21/25: To Assembly Committee on Ways and Means** Prohibits entities that purchase drugs subject to a maximum fair price (the price negotiated by the US Sec'y of Health & Human Svcs. for Medicare recipients) from paying more than that price or seeking reimbursement higher than that price.	Yes	$921,024 each year without consideration for drug inflation or effect on rebates.

Bill Tracking 83rd (2025) Session							
BILL #	**Summary**	**Description**	**Sponsor**	**Tracking**	**Comments**	**Fiscal Note Requested**	**Fiscal Impact**
AB290	Revises provisions relating to health care.	AN ACT relating to insurance; imposing requirements governing prior authorization for medical or dental care; prohibiting an insurer from requiring prior authorization for covered emergency services or denying coverage for covered, medically necessary emergency services; requiring an insurer to publish certain information relating to requests for prior authorization on the Internet; requiring an insurer and the Commissioner of Insurance to compile certain reports; and providing other matters properly relating thereto.	Assemblymember Nguyen	YES	**4/24/25: To Assembly Committee on Ways and Means** Section 23 amends NRS 287.04335 to remove requirement for PEBP to comply with NRS 687B.723; and to require that PEBP comply with NRS 687B.225(1); (2)(b), (c); (3), (4) and (5); and sections 2 to 18 of the act, all of which provide requirements related to prior authorizations.	Yes	Cannot Be Determined
AB340	Requires health insurance to cover certain screenings and assessments.	AN ACT relating to insurance; requiring certain health insurance to include coverage for the screening, assessment and diagnosis of attention deficit hyperactivity disorder, fetal alcohol spectrum disorders, intellectual disabilities and specific learning disabilities for certain persons; establishing certain administrative sanctions for failure to provide such coverage; and providing other matters properly relating thereto.	Committee on Health and Human Services	YES	**4/17/25: To Assembly Committee on Ways and Means** Section 14 amends NRS 287.04335 to comply with section 11 of the act, which requires coverage of screening for and the assessment and diagnosis of attention deficit hyperactivity disorder, fetal alcohol spectrum disorders, intellectual disabilities and specific learning disabilities for insureds under 18 years or, if enrolled in high school, until the the age of 22.	Yes	$59,951 in 2027 $127,192 in future biennia
AB428	Makes revisions relating to health care.	AN ACT relating to insurance; requiring certain health plans to include coverage for certain procedures or services for the preservation of fertility of insureds who have been diagnosed with breast or ovarian cancer; providing certain exceptions for insurers affiliated with religious organizations; and providing other matters properly relating thereto.	Assemblymember Flanagan	YES	**4/24/25: To Assembly Committee on Ways and Means** Section 14 amends NRS 287.04335 to require compliance with section 11 of the act, which requires coverage for certain procedures or services that are medically necessary to preserve fertility for an insured who has been diagnosed with breast or ovarian cancer if (1) the cancer may directly or indirectly cause infertility; or (2) the insured in expected to receive medical treatment for the cancer and the treatment could directly or indirectly cause infertility.	Yes	$216,707 in 2027 $495,058 in future biennia
AB463	Revises provisions relating to health care.	AN ACT relating to insurance; imposing requirements governing prior authorization for medical or dental care; prohibiting an insurer from requiring prior authorization for covered emergency services or denying coverage for covered, medically necessary emergency services; prohibiting an insurer from requiring prior authorization for certain other medical care; requiring an insurer to publish certain information on the Internet website of the insurer; requiring an insurer and the Commissioner of Insurance to compile and submit certain reports; and providing other matters properly relating thereto.	Assemblymember Backus	YES	**4/24/25: To Assembly Committee on Ways and Means** Section 31 amends NRS 287.04335 to require compliance with 687B.225(1)(b), NRS 687B.225(2), and sections 2 through 26 of this act, all of which provide requirements related to prior authorizations.	Yes	$5.6 million in 2027 $11.1 million in future biennia

Bill Tracking 83rd (2025) Session							
BILL #	**Summary**	**Description**	**Sponsor**	**Tracking**	**Comments**	**Fiscal Note Requested**	**Fiscal Impact**
AB522	Revises provision relating to health care.	AN ACT relating to health care; requiring health insurers to allow the covered adult child of an insured to remain covered by the health insurance of the insured until 26 years of age; requiring health insurers to provide coverage for certain preventive health care for children, persons who are pregnant, women and adults; prohibiting insurers from imposing certain costs and taking other actions with respect to certain preventive health care; requiring health insurers to provide coverage for screenings for colorectal cancer; requiring health insurers to provide coverage for maternity and newborn care; prohibiting health insurers and providers of health care from engaging in certain discriminatory actions; and providing other matters properly relating thereto.	Assembly Committee on Health and Human Services	YES	**4/24/25: To Assembly Committee on Ways and Means** Section 106 amends NRS 287.04335 to remove requirements to comply with NRS 695G.167 (orally administered chemotherapy), NRS 695G.1675 (exemptions for step therapy), and NRS 695G.170 (medically necessary emergency services); and to add requirement to comply with sections 90 to 94 of act, which requires coverage of children to age 26, adds coverage for additional preventive health care services not currently covered under existing law with no copay/coinsurance, and addresses postpartum hospital stays; section 107 amends NRS 287.04337 to add requirement to cover diagnostic imaging test for breast cancer under certain conditions, without charging higher deductible, copay, or coinsurance for such imagine.	Yes	Cannot Be Determined
AB583	Establishes for the 2025-2027 biennium the subsidies to be paid to the Public Employees' Benefits Program for insurance for certain active and retired public officers and employees.	AN ACT relating to programs for public personnel; establishing for the 2025-2027 biennium the subsidies to be paid to the Public Employees' Benefits Program for insurance for certain active and retired public officers and employees; and providing other matters properly relating thereto.	Assembly Committee on Ways and Means	YES	**5/15/25: To Assembly Committee on Ways and Means**		
SB192	Revises provisions relating to health care.	AN ACT relating to public health; imposing requirements relating to birth in a hospital or freestanding birthing center; requiring health insurance to include certain coverage; requiring the governing bodies of public schools to adopt policies to prevent sudden cardiac arrest during the participation of pupils in certain sports; requiring an independent psychiatric evaluation of certain children in the custody of a child welfare agency; prohibiting a health insurer or health insurance administrator from providing health care services; prohibiting a hospital from taking measures to restrict certain providers of healthcare; prohibiting the use of race-based health formulas and race-based care standards in certain circumstances; requiring patients to be provided information relating to stem cell treatment, storage and donation in certain circumstances; revising provisions governing the prescribing and dispensing of controlled substances; prohibiting a health insurer from engaging in certain discrimination against solo practitioners; providing for a study of certain disparities relating to health care; providing a penalty; and providing other matters properly relating thereto.	Senator Neal	YES	**4/25/25: To Senate Committee on Finance** Section 18 amends NRS 287.04335 to require compliance with section 61 of act, which requires coverage of doula services and inclusion of doulas in network; section 42 amends NRS 687B.692, which applies to PEBP through NRS 287.04335, to prohibit denial of a request to include a provider in a network because provider is a solo practitioner; section 64 amends NRS 695G.1717, which applies to PEBP through NRS 287.04335, to extend current coverage for hormone replacement therapy to include testosterone replacement therapy for menopausal women; and section 67.5 requires insurers like PEBP to submit to the Insurance Commissioner a plan for complying with this requirement by January 1, 2026.	Yes	$306,750 in Year 2 $613,500 in future biennia

Bill Tracking 83rd (2025) Session							
BILL #	**Summary**	**Description**	**Sponsor**	**Tracking**	**Comments**	**Fiscal Note Requested**	**Fiscal Impact**
SB217	Revises provisions relating to women's health.	AN ACT relating to health care; prohibiting a governmental entity from substantially burdening certain activity relating to assisted reproduction under certain circumstances; authorizing a person whose engagement in such activity has been so burdened to assert the violation as a claim or defense in a judicial proceeding; authorizing a court to award damages against a governmental entity that substantially burdens such activity in certain circumstances; providing certain immunity from civil and criminal liability and administrative sanctions for certain persons and entities involved in the provision of assisted reproduction; providing that a fertilized egg or human embryo outside of a human uterus is not a person for legal purposes; requiring certain health insurers to authorize a pregnant person to enroll in a health plan during a specified period; requiring certain public and private health insurers to provide certain coverage for the treatment of infertility and fertility preservation; providing a penalty; and providing other matters properly relating thereto.	Senator Cannizzaro	YES	**4/22/25: To Senate Committee on Finance** Section 13 amends NRS 287.04335 to comply with new provisions requiring coverage for treatment of infertility, including (a) at least three but not more than five completed retrievals of oocytes, (b) at least three but not more than five transfers of embryos, (c) at least five years of standard fertility preservation services; also prohibits imposition of conditions, including cost-sharing, prior auths, and waiting periods on infertility treatment/fertility preservation if such conditions are not required for similar benefits that are not related to fertility.	Yes	$3.2 million in Year 1 $3.7 million in Year 2 $9 million in future biennia
SB337	Revises provisions relating to health care.	AN ACT relating to health care; requiring certain health care facilities and certain providers of health care to provide patients with a form for a non-opioid directive and offer patients treatments that do not utilize an opioid under certain circumstances; requiring the Division of Public and Behavioral Health of the Department of Health and Human Services to create a form for a non-opioid directive; requiring the Administrator of the Division to appoint an advisory board to monitor compliance with laws and regulations relating to the non-opioid directive; requiring certain policies of health insurance to include coverage for at least one drug that is an alternative to opioids; requiring certain insurers to provide the form for a non-opioid directive to new insureds; revising the manner by which money in the Fund for a Resilient Nevada allocates money to projects and grants; and providing other matters properly relating thereto.	Senator Lange	YES	**5/15/25: Heard Senate Committee on Finance/No action** Section 28 amends NRS 287.04335 to require compliance with provisions of section 53 of the act, which requires the plan include coverage for at least one alternative to an opioid that is effective for the purpose for which an opioid is commonly used and is available; and prohibits requiring prior authorization or other requirement for such alternative if prior authorization or other requirement is not required for an opioid under the same circumstances.	Yes	$97,333 in 2027 $207,702 in future biennia
SB344	Revises provisions governing health care.	AN ACT relating to insurance; requiring certain health insurance to cover certain screenings for genetic disorders in a fetus or the parents of a fetus; and providing other matters properly relating thereto.	Senator Cannizzaro	YES	**4/10/25: To Senate Committee on Finance** Section 15 amends NRS 287.04335 to require coverage for noninvasive prenatal screening, i.e., drawing blood to test DNA for the purpose of detecting chromosomal abnormalities in the fetus, at any time during pregnancy without requiring prior authorization	Yes	$124,448 in 2027 $273,822 in future biennia
SB494	Makes revisions relating to health and human services.	AN ACT relating to state government; creating the Nevada Health Authority; creating certain divisions and offices within the Authority; providing for the appointment of officers and the employment of staff for the Authority; establishing requirements governing procurement by the Authority; creating the Nevada Health Authority Gift Fund; prescribing the duties of the Authority and its divisions and officers; transferring to the Authority the responsibility for operating various programs and administering various provisions; revising the name of certain agencies; revising certain terminology; eliminating the Division of Health Care Financing and Policy of the Department of Health and Human Services; revising provisions governing the operation of the Public Employees' Benefits Program; revising the membership and duties of the Board of Directors of the Silver State Health Insurance Exchange; and providing other matters properly relating thereto.	Senate Committee on Finance	YES	**5/15/25: Introduced; referred to Senate Committee on Health and Human Services** Sections 68 through 74 revise provisions governing the operations of PEBP, including placing PEBP within the newly created Nevada Health Authority (NHA); revising the procedure governing the appointment of PEBP Board members; transferring responsbility for appointing PEBP's Executive Officer from the Board to the NHA Director; requiring the submission of annual report regarding the administration and operation of the Program to the NHA; providng that the appointment of PEBP officers and unclassified employees is subject to the approval of NHA Director; and authorizing the Board to use certain NHA services, including procurement services.		

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10. Public Comment.

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11. Adjournment.