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In The Matter Of:

*PUBLIC EMPLOYEES' BENEFITS PROGRAM BOARD
VIDEOCONFERENCED OPEN MEETING*

January 26, 2024

*Capitol Reporters
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Original File 012624pebpOP_1.txt

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PUBLIC EMPLOYEES' BENEFITS PROGRAM BOARD

TRANSCRIPT OF PROCEEDINGS

VIDEOCONFERENCED OPEN MEETING

FRIDAY, JANUARY 26, 2024

CARSON CITY AND LAS VEGAS, NEVADA

The Board: JACK ROBB, Chairperson
MICHELLE KELLEY, Vice Chair
JIM BARNES, Member
BETSY AIELLO, Member(Absent)
LESLIE BITTLESTON, Member(Absent)
JENNIFER MCCLENDON, Member
JANELL WOODWARD, Member
STACIE WEEKS, Member
BEPSY STRASBURG, Member
APRIL CAUGHRON, Member

For the Board: RADHIKA KUNNEL, Deputy
Attorney General
BRANDEE MOONEYHAN, Lead
Insurance Counsel

For Staff: CELESTENA GLOVER
Executive Officer
NIK PROPER
Operations Officer
MICHELLE WEYLAND
Chief Financial Officer
TIM LINDLEY
Quality Control Officer
JESSICA CRANE
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FRIDAY, JANUARY 26, 2024, 9:00 A.M.

---oOo---

CHAIRMAN ROBB: Good morning, everyone. This is the January 26th meeting. We'll call the meeting to order.

MS. CRANE: We will start roll call. Chair Robb.

CHAIRMAN ROBB: Here.

MS. CRANE: Michelle Kelley.

MEMBER KELLEY: Here.

MS. CRANE: Betsy Strasburg.

MEMBER STRASBURG: Here.

MS. CRANE: Jim Barnes.

MEMBER BARNES: Here.

MS. CRANE: Stacie Weeks.

MEMBER WEEKS: Here.

MS. CRANE: Jennifer McClendon.

MEMBER MCCLENDON: Here.

MS. CRANE: Janell Woodward.

MEMBER WOODWARD: Here.

MS. CRANE: April Caughron.

MEMBER CAUGHRON: Here.

MS. CRANE: And then Betsy Aiello and Leslie Bittleston are absent today. We do have a quorum. Please remember to state loudly and clearly and state your name for our transcriber. Thank you.

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1 CHAIRMAN ROBB: Thank you. We will move on to
2 Agenda Item Number 2, public comment. Public comment will be
3 taken during this agenda item and no action may be taken on
4 matters raised under this item. Do we have public comment?

5 MR. ERVIN: Kent Ervin, E-r-v-i-n, Nevada Faculty
6 Alliance. Good morning. My colleagues from the south have
7 submitted comments on the UMR remediation plan. I will speak
8 to the master plan document with regard to Agenda Item Number
9 10.

10 For transplant surgery at an approved Center of
11 Excellence, travel reimbursement should be made for
12 pre-surgery evaluation or treatments and post-surgery
13 follow-up visits that are medically necessary and must be
14 done on site. Obviously PEBP isn't paying for spa vacations.
15 But this is not that. And it doesn't make sense to provide
16 travel for pre and post-surgery visits for knee replacements
17 and hip replacements but not for transplants. That's
18 arbitrary and unfair.

19 Next, the change of the name from low deductible
20 plan to just -- Sorry -- low deductible PPO plan to just PPO
21 plan is confusing since the high deductible health plan is
22 also a PPO plan. The real problem is that the low deductible
23 plan was changed to have zero deductible for reasons that
24 remain unclear. The low deductible plan was meant to give a
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1 choice between the high deductible PPO and the HMO or EPO
2 plan, reducing the deductible of the low deductible plan to
3 zero, while adding a deductible to the HMO and EPO, which
4 traditionally had no deductibles, blurs those distinctions
5 and is confusing to the participants. That's what should be
6 fixed, rather than the names.

7 Finally, the PEBP employer contributions with
8 adjustments in FY 2024 are in violation of PEBP's own written
9 policy that the state's contributions will be identical for
10 all three plans within a given dependent tier. Allowing that
11 deviation from policy to continue when you set rates in March
12 will further skew the distinction and pricing for employee
13 premiums between the three plans, further confusing
14 participants for what they mean. The policy was set for good
15 reasons with due deliberation and the policy should be
16 followed. Thank you.

17 CHAIRMAN ROBB: Thank you.

18 Next public comment in Carson.

19 MS. BONER-WELCH: My name is Leanne, L-e-a-n-n-e,
20 Boner Welch, B-o-n-e-r dash W-e-l-c-h. I am a member.

21 It is disappointing, bordering on disgust, that
22 I'm here before you today to tell you about a UMR PEBP appeal
23 process that has been useless, never addressing the reason
24 for the appeal.

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1 In early 2023, I submitted a non-assigned medical
2 claim. I called routinely to see if it had a preferred
3 provider. UMR could never provide me a preferred provider
4 list.

5 On April 19, 2023, UMR paid the claim at 50
6 percent. I called to inquire how that was determined. I had
7 spent months not getting that information. The response was
8 swift. I received a phone call after hours from a supervisor
9 from UMR explaining that the claim had been reversed by a
10 claims manager and I would be required to return the check
11 that was already being processed or they would pursue
12 collection. I was told in this call that the option was to
13 start the appeals process on the basis of a plan document
14 exception.

15 When the first appeal was denied by UMR, that,
16 too, was an insult. The request for an exception was never
17 addressed.

18 They had turned it over to a physician. He noted
19 an incorrect diagnosis and ignored the information on letter
20 of medical necessity.

21 In the appeals process, each step was met with no
22 acknowledgment of the request for an exception but rather
23 repeating that it's not covered.

24 Let me be specific. The PEBP plan document
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1 covers the medical device annually for patients who
2 experience the temporary side effect to the treatment of
3 cancer. They do not cover the device for the actual
4 diagnosis, which is a permanent condition. As the appeals
5 process progressed, I used capital letters, bold font. I
6 even told them what they could do. They could pay the claim
7 at 80 percent because they don't have a preferred provider or
8 they can address why they will not make the exception.

9 UMR denies responsibility for exceptions. PEBP
10 denies responsibility for exceptions. No one will take
11 responsibility. How convenient for PEBP, don't take
12 responsibility, give the runaround so the member gives up.

13 Keep in mind, members and their dependants are
14 experiencing health issues. They have much higher priorities
15 than to deal with all of this stress, often insulting
16 process.

17 Lastly, I see that Express Scripts is on your
18 agenda. They, too, are dishonest, extremely difficult, and
19 often incompetent. It is unbelievable to me that PEBP has
20 such incompetent providers and a total lack of
21 accountability. Thank you.

22 CHAIRMAN ROBB: Thank you.

23 Next public comment, please.

24 MR. WELCH: Good morning. For the record, my
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1 name is Bill Welch, B-i-l-l W-e-l-c-h, and I am the husband
2 to Leanne, the party who just spoke with you under public
3 comment. I appreciate the opportunity to speak with you
4 today.

5 Now that my wife has described the issue which
6 has, unfortunately, brought us to you today, my focus will be
7 to request action by this board to help bring our request for
8 the planned benefit exception to coverage hopefully to a fair
9 and equitable resolution. And I'm going to apologize in
10 advance because I'm going to repeat plan benefit exception to
11 coverage because it has never been addressed in any of our
12 communications to date.

13 As you heard from my wife's public comments, it
14 appears that neither PEBP nor UMR staff have the authority to
15 make a determination on our request for plan benefit
16 exception to coverage.

17 So, with that in mind, I respectfully am asking
18 you, the board of the directors of the Public Employees
19 Benefits Program, to consider our request for the plan
20 benefit exception to coverage. Please note the exception we
21 are asking for is to provide the same benefit of coverage
22 from medical device provided annually to other patients under
23 the PEBP benefit plan who experience a similar condition to
24 the patient in question such as the result of the medical

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1 diagnosis of cancer. We certainly support their coverage of
2 the medical device and strongly believe our request for a
3 plan exception to coverage in our situation is reasonable and
4 should be approved without hesitation.

5 The diagnosis in question with the patient that
6 we're referring to is alopecia totalis and the condition is
7 total loss of hair, the same thing that a cancer patient and
8 other types of patients will experience in their treatment of
9 their medical condition.

10 Understanding this matter cannot be addressed by
11 you today because it is not on your agenda for this meeting
12 and cannot be considered under public comment, I'm requesting
13 that you formally consider this matter at your next board
14 meeting. Further request that this matter be considered at
15 your board meeting in a manner which does not compromise the
16 patient's confidentiality so as not to cause any further
17 duress to the patient. Please direct staff to notify us of
18 how and when this matter will be considered by the board so
19 we may be present.

20 My wife and I are available to you and/or your
21 staff as may be necessary to help bring this matter to
22 resolution. Thank you for your consideration.

23 And, on one last note, I would just like to
24 reenforce what my wife had indicated about the process. We
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1 have made over a hundred calls, multiple letters, multiple
2 e-mails, and still have never had the specific issue that we
3 have presented and was directed to present considered. I
4 would encourage this board to seriously review PEBP staff and
5 UMR's process for handling plan members' claim dispute
6 issues. Thank you.

7 CHAIRMAN ROBB: Thank you. As you noted, we
8 cannot discuss this item today. But I will work with
9 Ms. Glover and we will be in contact to see where we can get.

10 MR. WELCH: Thank you, Mr. Robb.

11 CHAIRMAN ROBB: Any other public comment in
12 Carson?

13 MS. OSBORNE: Good morning. Good morning, Board.
14 My name is Margaret Kelly Osborne. I came to you last month
15 to discuss the transplant process travel reimbursements or
16 travel payment for transplant patients. I appreciate you,
17 the board, allowing GSA rates to be considered for travel
18 reimbursement for transplants at Centers of Excellence. I
19 appreciate you looking in to that. This is a great first
20 step.

21 I am here to address -- Let's see. I don't have
22 this in front of me. Agenda item Number 10 when it talks
23 about the master plan document as it relates to pre-surgery
24 appointments at Centers of Excellence, my question is why are
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1 you not allowing reimbursement for travel expenses for
2 pre-surgery appointments for transplant patients but you are
3 allowing them for hip replacements, for knee replacements.

4 I left -- Last time I was here, I left a handout
5 here as educational material, what is required of transplant
6 patients, lung transplant patients. Evaluation and testing
7 needs to be conducted at these Centers of Excellence. Not
8 just blood tests. Blood typing, general labs, serology,
9 tissue typing, PFTs, six-minute walk tests, CT scans, chest
10 x-rays, EKGs, echocardiograms, cardiac catheterizations,
11 abdominal ultrasounds, 24-hour urine testing, bone density
12 scans.

13 When I talked to a PEBP member here a couple of
14 months ago, he stated that all of this is done so they can
15 make money. Not for the transplant patient to survive this
16 surgery and to have a quality of life but so the Center of
17 Excellence can make money. I take exception to that. I
18 believe the Center of Excellence would probably take
19 exception to this.

20 To allow payment for reimbursement for
21 pre-surgery evaluations for hip and knee replacements seems
22 to be -- and not for transplant patients seems to be unfair.

23 What about dry runs? You know, most transplant
24 patients don't receive the first set of lungs. So it's

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1 possible that I could have to go to San Francisco three,
2 four, five times before they find a set of lungs for me.
3 That's three, four, five times that I'm going to have to go
4 to San Francisco and pay \$330 for lodging, only to have to
5 come back home and turn around and do this all over again.
6 This is money out of my pocket. And it's just not fair.

7 Same for counseling. The Centers of Excellence
8 requires inpatient -- in-person counseling for very good
9 reasons. And there's all kinds of literature out here why
10 they require it. And this isn't a spa treatment. This
11 isn't -- This is people's lives. And I just would appreciate
12 you reconsidering this. Thank you for your time.

13 CHAIRMAN ROBB: Okay. Thank you.

14 Any further public comment in Carson City?

15 Seeing none, do we have any public comment on
16 line?

17 MR. HOPKINS: We have comment on line. As a
18 reminder, Zoom is used for public comment only. This meeting
19 is streaming live on the PEBP YouTube channel if you want to
20 watch the board meeting there. The YouTube link is located
21 on the agenda. For those who have joined for public comment,
22 your name or last four digits of your phone will be announced
23 and you will be advised that you have been unmuted. Please
24 slowly state and spell your name for the record. Then

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1 proceed with your comments.

2 Douglas Unger, you have permission to speak.

3 Please slowly state and spell your name for the record.

4 MR. UNGER: Doug Unger, D-o-u-g U-n-g-e-r,
5 President, UNLV Chapter, Nevada Faculty Alliance and Chair of
6 Government Affairs Committee.

7 Thank you to Director Robb and the PEBP board for
8 your service and consideration.

9 The NFA and UNLV Employee Benefits Advisory
10 Committee express our concern that the audit report for UMR
11 still concludes that there are ongoing failures to meet PEBP
12 contractual service objectives for financial accuracy,
13 overall accuracy, and claim turnaround time. We believe some
14 progress has been made to address these issues. And I can
15 confirm, anecdotally, that we've heard fewer complaints.
16 Still, we do hear about delayed claims, wrongly-coded claims
17 hung up in appeals, and inaccurate payments. We appreciate
18 UMR's remediation plan and encourage its speediest possible
19 implementation.

20 Our major and most pressing concern is access to
21 providers and providers shortages. This is at crisis levels,
22 especially for mental health. UMR's list of mental health
23 providers is reported to us to contain several who no longer
24 take UMR insurance. As well, many primary care physicians
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1 and specialists in the network are so booked that they no
2 longer take new patients. It would be helpful if this could
3 be somehow indicated, perhaps by providers reporting no room
4 in our practice periodically.

5 Provider shortages constitute a much larger
6 crisis affecting our whole state that seems to be getting
7 worse. We hope UMR will join us in advocacy to the governor
8 and legislature to increase exponentially state support for
9 residencies, also for other incentives to attract new
10 physicians to Nevada.

11 We also remind UMR leaders that they made a
12 commitment to add the UMR logo to the published claims PEBP
13 members must download from the claims search function in
14 order to forward them to their flexible spending accounts for
15 reimbursement. FSAs do not reimburse claims without the
16 logo. So, PEBP members waste time adding them as they can,
17 which is messy. This is a small, inexpensive software change
18 UMR committed to make.

19 All this said, we appreciate the improving
20 communications with UMR staff and administrators. We see
21 positive steps. Still, we urge UMR to redouble its efforts
22 to comply fully with its contract service obligations as the
23 83rd legislative session fast approaches. We also hope UMR
24 and its industry partner representatives can join faculty

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1 professionals and other state employee advocates to address
2 with state leaders the serious provider shortages now
3 negatively affecting our state and its future health. Thank
4 you.

5 CHAIRMAN ROBB: Thank you.

6 Any further public comment on line?

7 MR. HOPKINS: That concludes public comment,
8 Chair Robb.

9 CHAIRMAN ROBB: Okay. We will close Agenda Item
10 Number 2 and go to Agenda Item Number 3, PEBP board
11 disclosure of applicable board meeting agenda items. Radhika
12 Kunnel.

13 MS. KUNNEL: Good morning, Chair Robb. Thank
14 you. This is Radhika Kunnel, Deputy Attorney General, for
15 the record.

16 This agenda item is to allow me to make a
17 disclosure regarding conflicts of interest on behalf of the
18 board members who are eligible for PEBP benefits. Pursuant
19 to NRS 281.420, on behalf of the board members who are
20 eligible for PEBP benefits or whose families are eligible for
21 PEBP benefits, I offer this disclosure, that they will be
22 voting on these items that may affect the benefits available
23 to them or their family members.

24 The law does not require abstention from voting
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1 merely because the board member or their family member is
2 eligible for PEBP benefits.

3 At this time, I invite any member of the board
4 who has any additional disclosure, to make it now. Thank
5 you.

6 CHAIRMAN ROBB: Thank you. Do we have any
7 further board disclosures at this time?

8 Seeing none, we'll close Agenda Item Number 3 and
9 move to Agenda Item Number 4, consent agenda. Items on the
10 consent agenda will all be considered together and acted on
11 in one motion unless an item is removed to be considered
12 separately by the board. And we have the list of items on
13 consent agenda attached in your report packet. Is there any
14 items that any member would like to pull for further
15 discussion?

16 We're all good. I'll take a motion.

17 MEMBER KELLEY: I'll make a motion to approve the
18 consent agenda as listed.

19 MEMBER STRASBURG: Second.

20 CHAIRMAN ROBB: Okay. We have a motion and a
21 second. Any further discussion?

22 (The court reporter interrupts)

23 MEMBER STRASBURG: Betsy Strasburg.

24 CHAIRMAN ROBB: Sorry about that. Any further
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1 discussion? Seeing none, I'll call for the vote. All of
2 those in favor, signify by saying aye.

3 (The vote was unanimously in favor of the motion)

4 CHAIRMAN ROBB: All of those opposed. Motion
5 passes unanimous.

6 We'll move on to Agenda Item Number 5,
7 presentation and possible action on the status and approval
8 of PEBP contracts, contract amendment, and solicitations.
9 With respect to a new proposed contract with Carrum Health to
10 maintain a network of National Centers of Excellence, the
11 board previously reviewed the results of the evaluation of
12 the proposals for the contract in closed session pursuant to
13 NRS 287.04345(4) in its December 7th, 2023, meeting. To the
14 extent that additional consideration of the contract requires
15 the board's discussion of confidential material related to
16 the contract prior to the notice of award being issued, see
17 NRS 333.335(7), such portions of this meeting may be
18 conducted in closed session pursuant to NRS 287.04345(4).
19 All actions on the contracts will occur in open session
20 pursuant to NRS 287.04345(5). Ms. Weyland.

21 MS. GLOVER: This is Celestena Glover for the
22 record. I want to just make one comment before I turn it
23 over to Michelle. We do have one contract that if there are
24 questions on that contract we will need to close the session.
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1 If there are no questions, then we can move on to the vote.
2 Any discussion on the contract will be confidential until the
3 contract becomes public.

4 CHAIRMAN ROBB: Thank you. She just clarified
5 what I just read.

6 MS. WEYLAND: Michelle Weyland for the record.
7 Item 5.1, contracts overview. Please note, I did add a note
8 on the Willis Towers Watson contract as effective July 1st,
9 2019, that was no longer charged per member per month fee, so
10 it is a zero dollar contract as of July 1st, 2019.

11 5.2, Centers of Excellence travel concierge. Is
12 there any questions on this contract? Do we need to close
13 this meeting?

14 CHAIRMAN ROBB: Any board members have any
15 questions on that portion of the contract?

16 MEMBER KELLEY: I'm sorry to be the person.
17 Michelle Kelley for the record. I would like to review the
18 contract. I think -- I don't have any burning questions, but
19 I think I would like to hear you talk about the contract, if
20 that's possible.

21 CHAIRMAN ROBB: And so we will have to close the
22 session. But, instead of closing the session right now, I
23 want to know if we're going to have more sections that we're
24 going to close the session for instead of closing. So we
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1 will table that discussion for right now and move on to the
2 next one and see if we have to close for multiple items. And
3 we'll let the public know what items we're closing for and
4 then close them and come back.

5 MS. WEYLAND: All right. 5.3, there are no
6 contract amendments.

7 5.4, there are no solicitation ratifications.

8 5.5, current solicitations. We will be getting
9 negotiations on the oncology management program soon. We are
10 working through the red line contract agreement that they
11 had -- the vendor has provided. And then the staff
12 recommends that the contract for Centers of Excellence travel
13 concierge with Carrum Health be approved. So, at this point,
14 we can close the session.

15 MEMBER KELLEY: Chair Robb, I have some questions
16 regarding the 5.1.

17 MS. WEYLAND: Okay.

18 MEMBER KELLEY: That doesn't need to be closed, I
19 don't think. Michelle Kelley for the record. So I just
20 wanted to ask about the Willis Towers Watson contract. I
21 understand it's a zero contract. So I have a couple of
22 questions. How are they making their money is my first
23 question?

24 MS. WEYLAND: That would be a question for Willis
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1 Towers Watson.

2 MEMBER KELLEY: Okay. And then I believe that
3 this contract has never actually been put out for RFP; is
4 that correct?

5 MS. WEYLAND: It would have had to have gone out
6 for RFP.

7 MS. GLOVER: So, this is Celestena Glover, for
8 the record. When Towers Willis Watson first came on, they
9 were Extend Health. At that time, we did have a solicitation
10 waiver. So an RFP was not conducted. It was pretty new at
11 the time. And that contract did get extended. When it's
12 time for the RFP, which is coming up soon, we will be going
13 out to bid.

14 MEMBER KELLEY: Okay. Thank you. So that was
15 actually linked right in to my next question. This is,
16 obviously, a very complex product offering, the way the
17 providers are reimbursed, just I'm sure the negotiations in
18 general. So I'm wondering when -- I see it's 6-30-25. But I
19 also know that often we leave these things to the last minute
20 and don't give ourselves appropriate amounts of time for a
21 complex RFP. So I'm just wondering when will that be
22 released.

23 MS. WEYLAND: Well, we're actually working with
24 Segal on the current RFP needs, and that is on my white board
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1 in my office with a big old exclamation point. Michelle
2 Weyland for the record. Sorry.

3 MEMBER KELLEY: Okay. I mean, has Segal
4 indicated how long might be appropriate for the first
5 evaluation of this kind of contract?

6 MS. WEYLAND: Not to me. But we can certainly
7 ask Segal to come to the table if you would like.

8 MEMBER KELLEY: Yeah. I think I would like to --
9 I am worried about this contract. We get a lot of feedback
10 from retirees about Willis Towers Watson and we always have.
11 It doesn't matter the name. So just I think it's important.

12 MR. WARD: Hi. Richard Ward with Segal for the
13 record. The procurement and the process might be a little
14 more straightforward than you might think, because the
15 services are for the enrollment and -- for the enrollment and
16 the education of the retirees. These exchanges provide
17 access to the individual market. And those policies and
18 plans are available and filed and renewed independent of
19 these exchanges. So, it would be probably three or four
20 months.

21 MEMBER KELLEY: I have another question. So then
22 what will the RFP be evaluating? Just generally.

23 MR. WARD: Uh-huh. It will be evaluating the
24 exchanges, the different bidders' capabilities to
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1 communicate, educate, and support the retirees in accessing
2 the MA -- the Medicare advantage and Medicare supplement
3 plans in the individual market. So it's more of -- I'm
4 sorry. It's more of a service and education type of
5 contract. They won't be contracting with providers. That's
6 happening separately. It's just providing access to the
7 market that already exists.

8 MEMBER KELLEY: And so where does the HRA or
9 administration of the HRA for retirees fall in to this?

10 MR. WARD: I'm sorry. I'm considering that part
11 of the administration and the education and access.

12 MEMBER KELLEY: So that will be part of it?

13 MR. WARD: Yes.

14 MEMBER KELLEY: And what are the -- what
15 difficulties do plan sponsors have, generally, evaluating and
16 choosing? How many providers are there in this space that
17 are capable, I guess, of managing -- That's a more specific
18 question -- that are capable of managing a PEBP size plan?

19 MR. WARD: Low single digit.

20 MEMBER KELLEY: Okay. Low single digit.

21 MR. WARD: Well, because it's a large group.

22 There are a number of exchanges in the market, but they have
23 different levels of capability and they serve different group
24 sizes and they excel in different sections of the market or
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1 with different types of plans. And you're correctly noting
2 that with a large state plan that requires a certain amount
3 of breadth and depth and expertise.

4 MEMBER KELLEY: Okay. Thank you.

5 MR. WARD: And may I answer a question that you
6 asked earlier? These exchanges, generally, their
7 compensation and their revenue comes from -- comes from
8 commissions that are built in to the individual policies.

9 MEMBER KELLEY: So then do the commissions differ
10 based on if it's an exchange or if it's kind of an individual
11 selling Medicare plans --

12 MR. WARD: Generally no.

13 MEMBER KELLEY: No. So the commission structure
14 is kind of built in to the insurance?

15 MR. WARD: Yeah, generally, yes. Richard Ward
16 for the record. Generally, with these bids, the evaluation
17 is focused on the scope of services and the capability of
18 providing that scope of services and performance guarantees,
19 rather than the financial aspect.

20 MEMBER KELLEY: So one more question, just a
21 general question, thinking about one of the public comments
22 that I read. So why don't these exchanges have contracts
23 with all of the different providers? And is that a piece
24 that we should be evaluating as part of the RFP? Because I
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1 read a comment that said, you know, the plan that we're in
2 wasn't covered by -- under the exchange. And, when they
3 tried to get it under the exchange, they couldn't. So I'm
4 just wondering -- Access, obviously, is always a big deal in
5 Nevada. So that will be part of kind of looking at what
6 companies are going to be --

7 MR. WARD: Right. And that access will be at the
8 insurance carrier level. So it will be whether it's United
9 or Aetna or Humana or whomever, that's -- the contracts are
10 at that level between the insurance carriers and the
11 exchanges.

12 MEMBER KELLEY: And, generally, once they have a
13 contract, they would offer all of it in this offering or --

14 MR. WARD: Generally speaking, that's correct.
15 Individual policies in the market that they've already filed
16 with the feds, which vary by county or can vary by county.

17 MEMBER KELLEY: Okay. Thank you.

18 MEMBER WEEKS: Stacie Weeks for the record. Are
19 you drafting this RFP?

20 MR. WARD: We're drafting it in conjunction with
21 PEBP staff.

22 MEMBER WEEKS: Stacie Weeks for the record. Can
23 we review the RFP before it's posted to give feedback?

24 MS. GLOVER: This is Celestena Glover for the
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1 record. Yes. Because we will be asking for board members to
2 be part of the evaluation committee in addition to staff and
3 whoever else we need to include.

4 MR. WARD: I look forward to working with you on
5 it.

6 MEMBER WEEKS: Stacie Weeks for the record. I
7 would love to be part of that. Procurements are a big part
8 of what we do at Medicaid. And, for the record, I think that
9 some things I'm hearing just feels a little bit like we can
10 do some things maybe differently.

11 MEMBER KELLEY: I know it's way early, but okay.

12 MS. GLOVER: Remember that when we start.

13 MS. WEYLAND: For the record, you're both
14 already --

15 CHAIRMAN ROBB: What Board Member Weeks is saying
16 is she's really not busy enough.

17 MEMBER WEEKS: I know. My staff have already
18 yelled at me.

19 CHAIRMAN ROBB: Any further questions on 5.1?

20 Seeing none, thank you.

21 Now, we have to go 5.2. We will have a closed
22 session. I really want to give a target. It's 9:33 now.
23 I'm hoping we can wrap up the closed session by 10:00
24 o'clock. But, for the people that we're going to ask to be
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1 excused, plan on being back at 10:00 o'clock. If we go a
2 little bit longer, we will relay that. But let's plan to
3 readjourn the meeting at 10:00 o'clock.

4 (Recess was taken to move to a closed session)

5 (Closed session was reported and put into a separate
6 transcript)

7 CHAIRMAN ROBB: Okay. It is 10:15. We will
8 bring the meeting back to order. We are still on Agenda Item
9 Number 5, and it is for possible action. I just remind the
10 board members that anything discussed in closed session not
11 be part of your motion or part of any further discussion. So
12 I will entertain a motion at this point.

13 MEMBER KELLEY: Michelle Kelley for the record.
14 I'll make a motion to approve the contract for Carrum Health
15 for the Centers of Excellence travel concierge program.

16 MEMBER CAUGHRON: April Caughron for the record.
17 I'll second.

18 CHAIRMAN ROBB: I'm sorry.

19 MEMBER CAUGHRON: I said April Caughron for the
20 record. I'll second.

21 CHAIRMAN ROBB: Okay. We have a motion and a
22 second. Any further discussion?

23 MEMBER KELLEY: I just have a comment. I just
24 want to thank staff for all the effort that has gone in to
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1 this new contract, new product offering. I just, for the
2 record, I urge our participants once this contract is up and
3 running to really investigate and take advantage of the
4 services that are going to be offered through it. Because
5 I -- adding these programs to the plan really is for
6 participants. So, please use it, once it's up and running.
7 And thank you to the staff and the consultants for doing such
8 a -- and purchasing for doing such a thorough job. So thank
9 you.

10 CHAIRMAN ROBB: Any further discussion? Seeing
11 none, I'll call for the vote. All of those in favor, signify
12 by saying aye.

13 (The vote was unanimously in favor of the motion)

14 CHAIRMAN ROBB: Those opposed? Motion passes
15 unanimous.

16 We will move on to Agenda Item Number 6,
17 Executive Officer report. Celestena Glover, Executive
18 Officer, for information and discussion.

19 MS. GLOVER: This is Celestena Glover for the
20 record. Just give me one second. Again, Celestena Glover
21 for the record. This is my executive officer report. It's
22 an information item only.

23 On the 16th, Ms. Weyland and I took the
24 oh-dark-hundred flight to Las Vegas to meet with IRBC.
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1 That's the Interim Retirement and Benefits Committee. They
2 have meetings, essentially, annually. And both PEBP and PERS
3 present to those boards that this is by statute we have
4 certain reports we give them. For us, it's financial
5 statements, the OPEB report, the utilization report. We also
6 provide them updates for any plan design changes the board
7 has approved. And then they may request additional
8 information after we present.

9 And, the only thing we will be sending back to
10 them, per their request, is any additional plan design
11 changes that the board will approve today. And then they've
12 asked to look at what our communication schedule looks like.
13 So, working with our LCB analyst, they agreed to hold off
14 until this meeting was finished and we had all the
15 information so we can give it to them in one packet.

16 They didn't really have any concerns about
17 anything we provided to them. They did ask about our plans
18 for '26 and '27. And I very politely said we're still
19 working on '25 and that we will present '26 and '27 when we
20 have information. But that is coming rapidly because next --
21 in March -- I keep saying next month, but it's a month beyond
22 that -- we will begin the budget building process. We have
23 the budget kick-off meeting. So, at that point, we will be
24 looking at '26 and '27, because we'll need to put it in our
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1 budget bill. So that's coming in upcoming board meetings.

2 Back in September, we worked with UMR and Via
3 Benefits to have the opportunity for members to schedule
4 in-person appointments to discuss their claims, concerns, HRA
5 reimbursement. And we provided information in my board
6 report. We've provided contact information in our
7 newsletter. I provided it to the RPEN newsletter. And, as
8 of the writing of this report, which was about a week ago,
9 the number of appointments with the UMR rep who travels up
10 here and typically spends two days up here, we've had no
11 in-person appointments. With the Via Benefits, they -- their
12 appointments are approximately every other week. The first
13 month they had a scheduled appointment, the person was a
14 no-show. October and November they didn't have anything
15 scheduled. December they had two scheduled. One of them was
16 a no show.

17 So, although we've heard through public comment
18 and through phone calls and other things that people want
19 this service, they are not taking advantage of it. So I
20 don't know is it really a service that a big group of people
21 want or are we talking five or ten people? Obviously, from
22 the results, we're not getting a lot of takers. We are going
23 to continue with this program. But, if in the next couple of
24 months we see no improvement, we may look at reducing the

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1 number of times that we require them to travel here.
2 Because, if all they're getting is phone calls, it can be in
3 their office locations taking those calls. Obviously, if we
4 have somebody who wants to make an appointment, we'll try to
5 accommodate that.

6 So, I put, again, in this report, which is
7 public, the contact information. So, if people want to take
8 advantage, they can call these numbers and schedule
9 appointments.

10 With that, pretty much the only other thing is,
11 so the calendar for board meetings on the 26th of September,
12 that's a tentative date. Right now we have no reason to not
13 stick with that date. Chair Robb has asked that we consider
14 having that board meeting in Las Vegas. In the past, we have
15 done that where we've had meetings in Carson and then
16 alternate meetings in Las Vegas, since we do have a pretty
17 good size employee and retiree contingent down there. So we
18 are looking at that. So something to keep on your calendars
19 that that's a possibility that we may move that meeting down
20 there. Once we know for sure, we'll definitely get that out
21 to the board members.

22 And then, lastly, staffing. When I wrote this
23 report, we were roughly 21 percent vacancy rate. We did get
24 two more positions filled, but we also lost one person, who
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1 is transferring. They got a promotion so they're moving on
2 to another agency. But we have opened the recruitment for
3 that position or we requested that the recruitment be open.
4 So hopefully we can get a replacement in that position in
5 accounting. But, that will leave us -- Once the new person
6 starts, our six person-accounting team will finally have
7 five. We had four. So that will help. But we're going to
8 be looking for one more.

9 That is all I have. I will take any questions.

10 CHAIRMAN ROBB: Board Member Kelley.

11 MEMBER KELLEY: Thank you, Chair Robb. Michelle
12 Kelley for the record. Regarding the IRBC, you know, many
13 years ago, I was around when the -- when that group or our
14 group out of Carson City kind of took great exception to the
15 wellness programs on our plan. Of course, they were
16 canceled. Has there been any interest shown by that group by
17 starting to relook at introducing wellness benefits and
18 comprehensive wellness programs for our members?

19 MS. GLOVER: This is Celestena Glover for the
20 record. I went back to our last IRBC meeting before this one
21 where Laura Rich, the previous executive officer, was asked
22 that question by the board. They got very quiet when she
23 answered that. It was the legislature that made us terminate
24 the program. They did not ask me that question this time.

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1 Surprise. I think that since they are asking the question
2 they have asked in the past, they may be more open. I think
3 it would be incumbent upon PEBP staff and our vendor partners
4 to help us get a program in place that would be well-received
5 by members as well as the legislature. So, what that would
6 look like, I don't know today. But they're not saying no at
7 this point.

8 MEMBER KELLEY: Just to follow up, Michelle
9 Kelley, for the record. If I recall correctly, they took
10 exception to the number of sticks being introduced all at
11 once for our members. And, obviously, we're responsive to
12 members' complaints. So, you know, maybe a separate agenda
13 item. But I would encourage us to start thinking about
14 wellness programs again, because I do think they benefit our
15 employees and maybe take it to one of your sessions or
16 something.

17 MS. GLOVER: This is Celestena Glover for the
18 record. I hope they agree. I think it would be good. We
19 just need to find the right fit for our members.

20 CHAIRMAN ROBB: Okay. Any further discussion?
21 Seeing none, we will close Agenda Item Number 6 and move on
22 to Agenda Item Number 7, acceptance of Claim Technologies
23 Incorporated audit findings for the State of Nevada Public
24 Employees' Benefits Program third party administrator UMR for
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1 FY 2024 Q1, covering the period of July 1 of 2023 through
2 September 30, 2023. Tim Lindley.

3 MR. LINDLEY: Tim Lindley for the record. This
4 audit revealed not only the -- This audit covered the first
5 three performance guarantees and also revealed the other
6 performance guarantees not subject to audits that were
7 reported in this audit report. There were five additional
8 performance guarantees not met, yielding a six percent fees
9 at risks for claims administration, for a total of
10 \$79,578.15. In addition to the penalties in the audit were
11 \$46,420.60, for a total calculated penalty for period ending
12 9-31 2023 -- 9-30 2023, totalling \$125,998.75.

13 We do have CTI on the line who will go over the
14 audit record. After CTI had reviewed the audit report, we
15 will open it so the board can ask questions of CTI.

16 And, in conjunction with this audit -- in
17 conjunction with this agenda item, we do have a UMR
18 remediation plan that was requested in a prior board meeting.

19 And, with that, I'm going to pass it to CTI.

20 MS. AMATO: Good morning. For the record, my
21 name is Joni, J-o-n-i, Amato, A-m-a-t-o. And the scope of
22 the first quarter 2024 UMR audit included claims processed
23 during the periods of July 1, 2023, through September 30th,
24 2023. And, as in prior UMR audits, that included both

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1 medical and dental claims.

2 The medical and dental claims paid during the
3 audit period totaled approximately 55 million dollars and
4 included approximately 218,000 claims.

5 The audit included four components: The
6 quarterly performance guarantee validation, 100 percent
7 electronic screening with 50 targeted samples, a
8 statistically valid stratified random sample of 200 claims,
9 and data analytics.

10 In our auditor's opinion, UMR's financial
11 accuracy and overall accuracy performance decreased this
12 quarter, while claim turnaround time within 14 days improved
13 and claim turnaround time within 30 days remained the same
14 when compared to the prior quarter audit results.

15 Performance guaranteed for claim turnaround time
16 of 92 percent processed in 14 days was met this quarter. The
17 performance guarantees were not met for financial accuracy,
18 overall accuracy, and claim turnaround time of 99 percent
19 processed within 30 days.

20 As Tim mentioned, this results in a 3.5 percent
21 penalty. The administrative fees for the quarter were
22 \$46,420.60. We recommend reviewing the financial errors
23 identified in the random sample audit to ensure the root
24 causes have been identified and a claim process or training
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1 or any system corrections are made where appropriate.

2 Additionally, we recommend the review of the
3 electronic screening and targeted sample results to focus on
4 potential recovery and process improvements in the categories
5 identified with errors noted. Thank you.

6 CHAIRMAN ROBB: Thank you.

7 Any questions from the board?

8 Okay. It is listed for possible action. Do we
9 want to go through the remediation plan before we go to the
10 action?

11 MR. LINDLEY: It would be accept the audit
12 findings and then open it to the remediation plan.

13 CHAIRMAN ROBB: All right.

14 MEMBER KELLEY: I make a motion to accept the --
15 Michelle Kelley for the record. I make a motion to accept
16 the audit findings by Claim Technologies for Q2 -- Q1.

17 CHAIRMAN ROBB: We have a motion.

18 MEMBER STRASBURG: Betsy Strasburg. Second.

19 CHAIRMAN ROBB: Thank you. We have a motion and
20 second. Any further discussion? Seeing none, I'll call for
21 the vote. All of those in favor, signify by saying aye.

22 (The vote was unanimously in favor of the motion)

23 CHAIRMAN ROBB: All opposed? Okay. 7.1, UMR
24 remediation plan.

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1 MR. BRAUN: Good morning. I'm Helmut Braun from
2 UMR. H-e-l-m-u-t B-r-a-u-n. I've got with me Nathan Maier,
3 who is also with our organization, and Darren, who runs our
4 operations for the claim operations.

5 I guess I would just like to start and say, you
6 know, we are deeply committed to this relationship, okay.
7 We've been working hard to try to make progress on the
8 requirements as per the contract. And I think we've made
9 some progress in some areas. Not as much as we'd like in
10 some others, potentially, but we certainly have committed
11 resources to this and continue to meet resource to this.

12 We've had the -- this operation actually in our
13 organization, when you include the acquisition, for, you
14 know, ten plus years at this point in time. And we've had
15 the same team, which Darren has run, who has come along to
16 work with us today or to answer any questions today, working
17 on this same organization and same team in place, okay,
18 during this entire time. Obviously, team members come and go
19 and the team migrates a little bit. But, in general, the
20 core team that's been working on this from a customer care
21 perspective and from a claim payment perspective has remained
22 in place.

23 And, since we've migrated this over on to our UMR
24 platform and our CTS platform, all we've done is sort of add
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1 resources, okay. So we have increased our resources. We
2 were probably somewhere in that 45 to 50 range when it was on
3 HealthSCOPE platform. We're now probably with the 80
4 employees working on this plan.

5 So we have taken on some additional services in
6 that time. We are now actually doing the care management
7 services and all the network services, some of those things
8 that HealthSCOPE didn't do. So we do sort of have the full
9 scope of responsibility.

10 The details are in the report, so I don't know
11 that I need to walk through this sort of on a line-by-line or
12 page-by-page basis. You've all had a chance to see that.

13 And I think at this point I would more than happy
14 and open to questions. I mean, we gave you a little bit of
15 information about the total amount of scope that we do and
16 the number of plans that we process and the number of phone
17 calls that we take. And so you can see it is a very large
18 number of claims. It is a very large number of calls. And I
19 would tell you that, you know, our effort really is to sort
20 of help support and plan and make sure that we keep it cost
21 effective. All right. And so we do have a lot of efforts in
22 place to make sure those plans are well-managed and we have a
23 lot of people focused on making sure those get paid correctly
24 according to the contract.

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1 CHAIRMAN ROBB: Board Member Kelley.

2 MEMBER KELLEY: Michelle Kelley for the record.

3 Can you walk us through what the remediation plan is? I
4 understand you've given us a written document, but I would
5 like to hear you talk about it.

6 MR. BRAUN: You know what, I'm actually going to
7 turn it over to Darren, because he's going to be the one
8 responsible for it, so I'll let him take you through some of
9 the bullet points.

10 MR. ASHBY: If you had an opportunity to --

11 (The court reporter interrupts)

12 MR. ASHBY: Darren Ashby with UMR for the record.
13 D-a-r-r-e-n A-s-h-b-y.

14 If you had an opportunity to look through the
15 remediation plan, you'll see there is some key initiatives
16 outlined, and we'll kind of go through those to kind of talk
17 through what we're doing. As we go through it, you'll see a
18 common theme of various areas that we are putting in
19 additional steps of review from an auditing standpoint. Also
20 looking at adding additional resources to the teams and then
21 also looking at the additional resources and then the
22 auditing.

23 So, as we look at the financial accuracy portion
24 of the remediation plan, the areas that we're looking at
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1 there, we're taking errors that have been identified through
2 our internal audits, as well as errors that have been
3 identified through CTI. And we're taking that and comparing
4 it to additional repetitive-type errors that we may see come
5 through on a daily basis. We have enhanced those audits and
6 increased them.

7 And one of the additional steps that we're taking
8 is we actually have our leadership team that is now looking
9 at those errors that may come through on a daily basis and
10 they're meeting with the staff to go through with counseling
11 sessions. And, then, if they identify that a particular
12 error -- error is happening across multiple claims processors,
13 then we're putting together training modules. And then on a
14 weekly basis we pull the staff together and together go
15 through that training process and going over those errors to
16 make sure that there's an understanding and also to get
17 feedback from the claims processors as to what they need from
18 us in order to better do their job and/or avoid making these
19 errors going forward.

20 As far as claim turnaround time, as Helmut
21 mentioned, we've added additional staff. Originally, we had
22 14 claims processors and -- on the dedicated team. We've now
23 increased that to 20 on the dedicated team.

24 In addition to that, we also have a list of
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1 additional resources to help us to manage that inventory and
2 to make sure that going forward we improve the claim
3 turnaround time.

4 And we have actually already seen results from
5 that and have been able to significantly reduce the overall
6 inventory as well as reduce the turnaround time that it's
7 taking us to get those claims processed.

8 MEMBER KELLEY: Can we ask questions as we go?

9 CHAIRMAN ROBB: Yes, go ahead, please.

10 MEMBER KELLEY: So, with regard to the inventory,
11 it's my understanding that most of the providers would submit
12 digitally all of their bills digitally; is that correct?

13 MR. BRAUN: Yeah. About 92 percent
14 electronically.

15 MEMBER KELLEY: Okay. And so then that's the
16 queue you're referring to. So every claim kind of comes in
17 and it sits in a queue and it needs proctoring? Sorry. I'm
18 trying to understand the process. Once that bill hits the
19 queue, what is the process?

20 MR. BRAUN: So, what happens is, like I said, 92
21 percent come in electronically. The other eight percent come
22 in in some other form, either faxed in, mailed in, those are
23 converted. That usually takes one or two days. And, so,
24 within one or two days, they're in electronic format. And
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1 they all go in to the queue on whichever day they're
2 received. At that point, it goes through a repricing
3 process, so the claim has to get repriced. And then about --

4 MEMBER KELLEY: Is that manual or automatic?

5 MR. BRAUN: It's an automatic repricing process.
6 Now, there are some manual kickouts, okay, but for the most
7 part it's automatic.

8 And then those ones that they can't get processed
9 automatically, we're probably somewhere in that 60 percent
10 they automatically adjudicate, those get kicked out to a
11 processor. They have to look at those and review those and
12 then they approve those claims and they go on through the
13 process.

14 Okay. Now, the payments actually go out, we're
15 probably somewhere in that 85 to 90 percent, go back out
16 electronically to providers as well. And they have several
17 different options for how they can receive their claims or
18 their payments electronically. They can sign up with various
19 clearing houses. Most of them, like I said, are signed up to
20 receive that, as well as their remittance advice, all come to
21 them electronically.

22 MEMBER KELLEY: Thank you.

23 So, then, I'm sorry, coming back to the
24 enhancements. So, the staff, the 14 that have gone to 20,
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1 those staff are reviewing the kickouts?

2 MR. BRAUN: Yes.

3 MEMBER KELLEY: So, the repricing that doesn't
4 happen automatically, they each then go in and -- Why -- What
5 causes kickouts?

6 MR. BRAUN: Well, it could be repricing. It also
7 could be other edits, okay. So maybe it requires a referral
8 or maybe there's an authorization that has to be verified or
9 there is a claim type that we need to do a counter on or go
10 back and review historical claims to make sure something else
11 hasn't occurred that would impact that payment. It may just
12 be a review of the claim. For example, some hospital claims
13 and complex billing situations, and we got to make sure that
14 it's in accordance with the contract and it's more than the
15 computer can do by itself so we have somebody manually review
16 those.

17 MEMBER KELLEY: And so you said -- I think you
18 said about 90 percent go through without kicking back,
19 kicking out?

20 MR. BRAUN: About 60 percent.

21 MEMBER KELLEY: 60 percent. So I'm sorry. Just
22 going back to the report, so I think there was, what, 257,000
23 claims in a quarter of the audit. And so only 60 percent of
24 those go through automatically. And we've got now 20 staff
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1 working on the kickouts. And, so, when something kicks out,
2 what's the process, just the general process, that the staff
3 member would take?

4 MR. BRAUN: It comes to that staff member. So
5 they'll get a queue. Let's just say there will be claims
6 lined up for them to look at. It will come up on their
7 screen. That screen will show whatever edits that claim
8 requires, okay. So it may say you need to find the
9 authorization and match that with an authorization before it
10 gets paid and then they go ahead and say, okay, I found this
11 authorization. They do the match up and they release that
12 claim, okay. Or it may say we need to get additional
13 records, we may need an I-bill from the hospital, before we
14 can pay this claim.

15 MEMBER KELLEY: I-bill, what's that?

16 MR. BRAUN: Itemized bill. But, again, there's
17 various, you know, edits that take place. It may say check
18 for coordination of benefits. You know, so, like I said, I
19 don't know. Do you know how many edits there are, Darren?
20 There's probably thousands.

21 MR. ASHBY: Thousands, yes.

22 MEMBER KELLEY: So, on average, I'm sure you've
23 done the data collection. On average, how long is one staff
24 member spending on one kickout?

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1 MR. BRAUN: So our goal is for staff members to
2 process between 12 and 18 claims per hour. So we say an
3 average of four minutes, all right.

4 MEMBER KELLEY: So that's a lot -- So even though
5 you've added resources, that's still a lot of kickouts for 20
6 staff members.

7 MR. BRAUN: You know, we've added enough
8 resources so that we're able to manage that, okay. That's
9 why we added the resources. I mean, claim inventory, a year
10 ago, we were probably at that 20,000 level. Right now we're
11 probably around 7,000 claims in house and we get about 2,000
12 claims a day. Okay. So we have three and a half days worth
13 of claim and inventory, okay. That's pretty good turnaround
14 time, all right.

15 MEMBER KELLEY: So this report is Q1. What Q are
16 we in now?

17 UNIDENTIFIED SPEAKER: We're in Q3.

18 MEMBER KELLEY: Thank you. So, internally, you
19 would have looked at Q2?

20 MR. BRAUN: Yes.

21 MEMBER KELLEY: Have the additional resources you
22 put to this area, is it making a significant difference that
23 at the next meeting when we get Claim Technologies audit
24 report am I going to be smiling or not or at least neutral?

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1 MR. BRAUN: We've definitely made improvements in
2 the inventory that was on hand, okay. And that should be
3 reflected in the turnaround time as well. Okay. And that
4 inventory has consistently gone down over the course of the
5 last six months.

6 MEMBER KELLEY: So do your matrix show that
7 you're meeting the --

8 MR. BRAUN: I would say that we're likely meeting
9 the ten day or 14 day, okay. But, the challenge, the 99
10 percent in 20 days, that's a very challenging metric for us
11 to hit, just because we have quite a few claims where we have
12 to get bills from hospitals or detailed records from
13 hospitals and review those. And it just exceeds that one
14 percent number. We normally don't agree to 99 percent.
15 Normally we're at 98. That's our typical PG.

16 MEMBER KELLEY: But you agreed to 99.

17 MR. BRAUN: We agreed. And we're striving to
18 meet that. And, if we don't, we pay the penalty. But it's
19 not like we're missing it by ten percent. You know, we're
20 missing it by two percent, three percent. And, again, we're
21 working with the hospitals to make sure we know what our
22 status is on those claims. We have a weekly meeting with
23 Carson-Tahoe. We have a weekly meeting with Renown, okay.
24 So they know where the claims are in the process. But it's
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1 not like they're -- They're not angry because they're not
2 getting paid. They know we're doing our reviews.

3 MEMBER KELLEY: Just a follow-up on that. So I
4 think that many of the complaints -- Well, I'm sure I don't
5 know about the hospital complaints. But what we did hear
6 from were individual providers who do live hand to mouth.
7 And so I think many of those providers, especially out, you
8 know, where there aren't a lot of providers were saying, hey,
9 if we're not getting our bills paid, we can't feed our
10 family, and we're not going to provide services anymore.
11 It's kind of that simple, right. So how about those
12 individuals?

13 MR. BRAUN: I think those have been improved
14 significantly. You know, there were some turnaround-time
15 issues earlier in the year last year. But, towards the end
16 of the year, those have definitely improved, okay. And,
17 again, you know, we're hitting that 93, four, five percent in
18 ten days. Most of those claims are not the complex claims
19 that take a long time. So those should be getting out. Now,
20 again, we can get you some better measures. I know I did
21 look at December and December did show some numbers.

22 Darren, was it 90?

23 MR. ASHBY: In ten days it was 94.2. And then in
24 20 days -- And these are business days -- it was 97 -- 98.71.
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1 MR. BRAUN: Yeah. So we do have some improved
2 numbers. And, what we did, we looked there at claims
3 received in December and then we went with those days and
4 those are the numbers he just blurted out to you. So we
5 would have hit the one metric and missed the other one by
6 three-tenths of a percent.

7 MEMBER STRASBURG: Betsy Strasburg. Thank you
8 for representing the remediation plan. And I do see that you
9 stated that in the last year there's been a vast improvement
10 and thank you for sharing all the processes that you have
11 done.

12 The one thing I would like to ask you is in order
13 to track your improvement over time, do you have internal
14 goals for your staff and are they time-balanced?

15 MR. ASHBY: We do have internal goals for our
16 staff and they are time-balanced. So, basically, we measure
17 our staff on a weekly basis. We receive both quality and
18 turnaround time reports on a regular basis. And that's one
19 of the enhancements that I talked about earlier is that
20 rather than looking at those weekly, we've now started to
21 look at those daily. And so now what we're trying to
22 identify so that we can remediate quicker is what errors are
23 they getting today or from yesterday and what we can do to
24 help to remediate that immediately so that they don't

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1 continue to make that same type of mistake throughout the
2 balance of the week and/or the balance of the month.

3 And so those are the times frames that we have in
4 place right now and that's kind of what we're doing to make
5 sure we look at the inventory on a daily basis. Helmut is
6 part of that. He gets that update every morning as well.
7 And so we have all leadership heavily involved in looking at
8 that inventory on a daily basis, making adjustments where we
9 need to make adjustments, to make sure that we're hitting the
10 numbers that we expect to hit on a daily basis.

11 MEMBER STRASBURG: Thank you.

12 MEMBER CAUGHRON: April Caughron for the record.
13 Just looking at some of these findings, a lot of them are
14 tied to manual processes. What are you doing to reconsider
15 that approach and take more of a systematic approach to
16 eliminate the manual intervention and how has that been
17 considered to see if you can't improve upon those SLAs?

18 MR. BRAUN: We do have a team that is working on
19 automation, okay. And so we're looking at the claims. We
20 categorize them, figure out which claims in certain
21 categories have the most manual processes, and we're working
22 our way down that list trying to improve that number. So,
23 you know, hopefully that 60 percent automated number goes to
24 65 or 70 within the next year and that should help us.

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1 CHAIRMAN ROBB: Board Member Kelley.

2 MEMBER KELLEY: I just had a follow-up. So why
3 are claims manually processed? I'm sorry. I like to start
4 at the beginning. So you've got automated processes. But
5 what causes a claim to have to be manually processed?

6 MR. BRAUN: Well, there are just certain things
7 that need to be looked up that we haven't been able to
8 automate so that the computer does it automatically.

9 MEMBER KELLEY: Is that plan document specific or
10 PEBP plan specific or is it generally?

11 MR. BRAUN: It's a combination of plan document
12 issues and it's a combination of network challenges,
13 sometimes, with the complexity of the network contracts and
14 requirements and how they're paid. Okay.

15 So I will tell you that the automation in the
16 PEBP plan is at the lower end of the spectrum for us. Our
17 average automation is well above 80 percent, okay. And this
18 one is, like I said, in the 60s. And so we are looking
19 specifically at things within the PEBP plan that we can
20 hopefully automate and bring that number up so we get, let's
21 say, hopefully into the 65, 70 percent range within the next
22 12 months.

23 MEMBER WEEKS: Stacie Weeks for the record.

24 Thank you for the presentation. Is there a way for you to
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1 add to your plan here, that automation?

2 MR. BRAUN: We can add a paragraph about that,
3 yeah. Not a problem.

4 MEMBER WEEKS: And then the other question I have
5 just my keeping it simple and high level, when I hear delays
6 like this, I think, oh, we have too many PA's in our system.
7 Because often that is a problem and that is why we -- And so,
8 I'm curious, have you looked at your PA's on some of your
9 services and trends to see are 90 percent of these PA's often
10 just being approved and removing those PA's? Because that is
11 the burden and that creates a lot of delay in payment for
12 providers. And, often, I know plans use PA to sort of
13 control cost sometimes and I would say sometimes that's
14 inappropriate.

15 But I think there's probably opportunity to look
16 at your PA's and think about removing some of them that
17 obviously are delaying processes.

18 MR. MAIER: And those aren't plan specific, so --

19 (The court reporter interrupts)

20 MR. MAIER: This is Nathan Maier, for the record,
21 from UMR, M-a-i-e-r. And so I was just saying that the PA
22 rules are set by PEBP. I know Rhonda works back with our
23 clinical team, we make recommendations back to PEBP staff
24 about, you know, are there things that require authorization
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1 that we see a, you know, approved pretty much on an automatic
2 basis that don't make sense and they create unnecessary
3 delay. So that is a process that I know that we communicate
4 back with PEBP staff as we're looking at plan changes. And
5 so, yes, that is something we can look at.

6 MEMBER WEEKS: Stacie Weeks. One more follow-up.
7 Can we maybe add that to this as well is that you're going to
8 do a look at categories of services and come back to us with
9 recommendations?

10 MR. MAIER: Sure.

11 CHAIRMAN ROBB: Okay. Any further questions?

12 MEMBER KELLEY: We talked kind of about the
13 claims. Michelle Kelley for the record. We talked about the
14 claims, but we didn't talk about customer care. I think that
15 was the next --

16 MR. ASHBY: Yes. Darren Ashby, for the record,
17 UMR. So, for customer care, again, kind of along that same
18 theme of looking at resources, looking at enhancing our
19 quality audits and the number of audits that we do in order
20 to impact change here.

21 So you'll notice that originally we started off
22 with 18 call agents and we increased that to 22. And, as we
23 continued to review the process and the work that was
24 associated with not only the volume of calls coming in but
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1 then the work that that creates when that call does come in,
2 we recognize the need to make adjustments in that staffing
3 model.

4 And so we went through an iteration of 22 then to
5 27. And so we are now sitting at 31 call agents that take
6 calls and also resolve issues that come up from those calls
7 the work that needs to be done. And we are meeting our
8 metrics as a result of that increase.

9 MEMBER KELLEY: Just a follow-up question.
10 Michelle Kelley for the record. So are those dedicated
11 agents to the PEBP plan? So are they trained in the PEBP
12 plan documents specifically, all they do is PEBP? Or are
13 those 31 agents assigned to multiple clients or just it's a
14 general queue?

15 MR. ASHBY: Those 31 agents are dedicated to the
16 PEBP account, servicing the PEBP account.

17 CHAIRMAN ROBB: I'm impressed with your ability
18 to bring on staff. I would like to know how you're doing
19 that. The State of Nevada has not figured that out yet.
20 We're working on that.

21 MR. BRAUN: It is a big job, okay. You know,
22 obviously, we have a pretty large organization and we have a
23 town acquisition team that helps us with that process. And
24 it's planned in advance. And, you know, we sort of predict
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1 how many people are going to leave or transfer in to other
2 positions in advance and so we get classes scheduled and we
3 start planning those classes 60 to 90 days in advance of the
4 time we're going to have class in order to fill those classes
5 with qualified candidates.

6 MEMBER KELLEY: Michelle Kelley for the record.
7 I'm sorry. I feel like I'm ennoblizing this. Please ask
8 questions.

9 So I think there's been a theme in public comment
10 for the last few meetings of the appeals process. And I
11 understand the appeals process is a shared process between
12 UMR and PEBP. So are these 31 agents also dealing with
13 appeals? Or can you talk about the appeal process generally
14 and how it might relate to the contract?

15 MR. BRAUN: So, we have a separate appeals team,
16 okay. So, every appeal that comes in gets assigned a case
17 number, and somebody specifically works on that appeal. We
18 probably have 80 to a hundred people that work on the appeals
19 team. Now, they're not assigned to any specific group or
20 whatever. But those appeals come in and obviously we review
21 those appeals. And, in many cases, you know, it's a question
22 of whether or not the benefit is payable or not payable. You
23 know, obviously, sometimes, we've given misinformation to a
24 member. And, when we do, we correct that or fix that, okay.

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1 In some cases, it requires a plan acceptance. If
2 we get to the point where it needs a plan exception, then
3 we're going to come back and work with the PEBP staff and ask
4 if the plan exception might be available. If not, then we
5 communicate that back to the member.

6 But it's a process that certainly many members
7 who don't get their claims paid and it's not covered by the
8 benefit plan don't feel good about the result.

9 MEMBER KELLEY: So I have just a follow-up. So I
10 had a personal issue where I didn't think my bill was paid
11 per my understanding of the plan document, so I called and
12 said, hey, this is wrong, you know, this is my understanding
13 of the plan document. And, I've got to say, the agent was
14 very nice, very professional. But nothing happened.

15 And so then I just came back from vacation. And
16 this is three months ago. I just went ahead and paid Quest.
17 Of course, it's always Quest, right. I paid my -- the share
18 that UMR was saying that I owed. And I came home to a check.
19 Because, I guess, three months later I didn't know if it was
20 caught in an audit or the appeals process maybe is invisible
21 to me.

22 MR. BRAUN: No. If you didn't file an appeal, an
23 official appeal, then there would not have been any appeal
24 process. Now, you know, maybe you talked to somebody and
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1 they initiated some sort of provider review or some sort of
2 review of that billing process and found something in that
3 process and figured out that it should have been different.
4 But unless you actually initiate an appeal, a member
5 appeal --

6 MEMBER KELLEY: I believe I did. I had --

7 MR. BRAUN: You can do --

8 (The court reporter interrupts)

9 MEMBER KELLEY: Sorry. So Michelle Kelley here.
10 I was just saying I'm pretty sure that I was told there was
11 no repricing anymore and I did have to do an appeal. And I
12 think I did it on line. You know, I mean, honestly it was
13 \$40. It wasn't worth my time. But, as I say, I'm pretty
14 sure I filed that and then I looked out and I couldn't find
15 anywhere where it was listed and --

16 MR. BRAUN: Okay. Well, we can check and see if
17 you did actually file an appeal. And, Jesse, I'm assuming
18 you can look in to that and get her the results of what
19 happened to that --

20 MEMBER KELLEY: Well, I think I got paid, because
21 I got a check that I wasn't expecting.

22 MR. BRAUN: I understand that. But I'm just
23 saying we can make sure -- Normally, if you file an appeal,
24 you would have gotten a letter telling you the results of
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1 that appeal.

2 CHAIRMAN ROBB: Board Member Weeks.

3 MEMBER WEEKS: Stacie Weeks for the record. So
4 it is disturbing to hear some of the complaints. And, I get
5 it, not every time is it going to be perfect. But I do think
6 we need to look at our customer service, not just at your
7 shop but possibly at PEBP. I am concerned. People don't --
8 People just sometimes want someone to listen, to be
9 empathetic, even if the answer is no. And I'm not sure what
10 our transcripts look like for our call centers and how people
11 respond to people. But I'm just wondering if we can do a
12 review or you guys maybe start -- we all start recording
13 somehow some of these conversations. And, when there is a
14 complaint, someone is doing a quality check on that and going
15 back and looking at what went wrong, how maybe the agent
16 could have explained something better, what was the follow-up
17 communication. Sometimes people just want information on
18 why. And, if the answer is still no, if we're not explaining
19 things, people get frustrated. I mean, it's their health
20 care. It's their life.

21 So I think we just need to look at how we're
22 treating our recipients. And I would like to think about
23 recording those or some way we can do a quality check on what
24 actually happened and then train staff to do something

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1 different next time. That's something I think we need to
2 think about, not just at your shop but possibly at PEBP.

3 MR. ASHBY: Darren Ashby for the record. So that
4 actually is part of our process. So, when we do get a
5 complaint that comes in, we do record all of our calls, so we
6 have the ability to go out and pull that call. And the team
7 lead will listen to the call. And, if there is remediation
8 that's needed, we need to talk to the rep about how they
9 handled the call or the information that was provided, that
10 takes place at that time. So that is a process that is
11 currently in place.

12 MR. BRAUN: And we allot a certain number of
13 calls every week. Every week, every agent gets, you know, a
14 couple of calls a week audited, so, you know, eight per
15 month. So each agent is reviewed to make sure that they're
16 handling situations appropriately.

17 MR. MAIER: This is Nathan Maier for the record.
18 We provided some call satisfaction rates for participant
19 calls. And so 97.4 percent of callers were satisfied with
20 the service. So that is a number that we track in addition
21 to the audits.

22 MEMBER WEEKS: Stacie Weeks for the record. So
23 then maybe can PEBP look at their process and what's going on
24 with recipients? Because I'm very concerned about some of
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1 the feedback we've been getting on their experience.

2 MS. GLOVER: This is Celestena Glover for the
3 record. Part of our training process, our calls are also
4 recorded. They always have been. So that is part of our
5 training process.

6 If our members are giving -- our employees are
7 giving out incorrect information, obviously, they're told
8 what the information should have been or how the call should
9 have been handled. So that's been an ongoing process for
10 years.

11 MEMBER WEEKS: Stacie Weeks for the record. I'm
12 sorry, I'm going to hit this one again. But it's not going
13 well. I mean, you can tell by the way people come up here
14 and talk and how their experience has been. We heard it
15 earlier. And I know that's not on the agenda right now, but
16 we have to look at that.

17 Yes, we're not going to cover everything. We
18 can't. We can't afford everything. But I do think the
19 respect and sort of the way we treat the recipients when they
20 call, even when you have to say no. I just -- Something is
21 not going right in that process.

22 CHAIRMAN ROBB: Vice Chair Kelly.

23 MEMBER KELLEY: I just want to follow up on Board
24 Member Weeks. I would actually like to request an agenda
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1 item where the board gets to review the totality of the
2 appeals process, both the UMR side, who is, you know, like,
3 who is responsible for what, including the PEBP's side. And
4 I think that, you know, it's been a continual noise that
5 we're hearing. And I, with your permission, Chair Robb, I
6 think it would really benefit the board to understand from A
7 to Z of the appeals process.

8 MR. BRAUN: We're happy to do that.

9 MEMBER KELLEY: And, just bringing it back to
10 UMR, I'm very pleased to see that the metrics for customer
11 care has improved. And, as I say, the people I have spoken
12 to the few times have been good. And it was with public
13 comment that anecdotally complaints, you know, that pass
14 around campuses from participant to participant, from
15 participant to participant have decreased. So I think some
16 of what you have done has addressed the concerns. So I look
17 forward to continuing to see improved metrics on that.

18 MR. BRAUN: Thank you.

19 CHAIRMAN ROBB: Okay.

20 MEMBER KELLEY: And, with that, I'll make a
21 motion to accept the UMR remediation plan as presented today.

22 CHAIRMAN ROBB: It was not listed for action.

23 MEMBER KELLEY: Oh, we don't even need a motion.

24 MS. GLOVER: It's part of the whole --
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1 CHAIRMAN ROBB: Yeah, it's part of the -- We
2 already took action on Number 7, so the remediation plan.

3 MS. GLOVER: Just to be safe.

4 CHAIRMAN ROBB: We can be safe. We have a
5 motion.

6 MEMBER WEEKS: Can I amend that motion? I asked
7 for a couple of things to be added to the remediation plan.
8 I'm trying to remember what they were. Do you guys take
9 notes?

10 MR. BRAUN: Yeah. Automation was one and prior
11 authorization review.

12 MEMBER KELLEY: We accept the remediation plan
13 with the inclusion of the additional metrics requested by
14 Ms. Weeks.

15 CHAIRMAN ROBB: Okay. So we have a motion and a
16 second.

17 MEMBER WEEKS: Stacie Weeks. I move --

18 CHAIRMAN ROBB: Second with Board Member Weeks.
19 Any further discussion? Seeing none, I'll call for the
20 motion. All of those in favor signify by saying aye.

21 (The vote was unanimously in favor of the motion)

22 CHAIRMAN ROBB: All opposed? Motion carries.

23 We'll move on to Agenda Item Number 8, acceptance
24 of Mental Health Parity and Addiction Equality -- Equity Act
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1 report, including possible action on, but not limited to, the
2 following items. Celestena Glover.

3 MS. GLOVER: This is Celestena Glover for the
4 record. About a year ago, in December 2022, November and
5 December, the Mental Health Parity and Addiction Equity Act,
6 at the time government plans could opt out. That option has
7 changed. And I believe that has been reported in a previous
8 board meeting. PEBP had always intended to comply with the
9 requirements of the act, but they had intended at the time to
10 opt out.

11 Once we determined that we could not opt out,
12 then we requested that a review be done of our plans to
13 indicate where we meet the requirements of the act and where
14 we do not.

15 So, the item coming up, we've asked Segal to do
16 that review. They have completed it. What they have
17 included in the packet is a high level executive summary to
18 tell you where we're good and where we're not, essentially
19 what we're missing and what we need to change here.

20 The agenda item itself is information because the
21 things they bring up are going to come up in the plan design
22 and the MPD document for actual action. So, with that, I
23 will turn it over to you, to Segal.

24 MR. WARD: Richard Ward with Segal for the
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1 record. At the last meeting, the board reviewed a specific
2 plan change and a co-pay for other outpatient services as a
3 result of our review. And what we have here is a further
4 review of clarifications, for want of a better term, the plan
5 document that Executive Officer Glover mentioned will be
6 addressed more specifically in a later agenda item. I'll
7 turn it over to my colleague.

8 MS. DUNN: Thank you. Amy Dunn for the record.
9 Good morning, everyone. Thank you for having us. Today
10 we're here to talk about the key findings of our mental
11 health parity non-quantitative treatment limitations review,
12 also known as NQTL, within the plan documents for the
13 consumer directed health plan, for the low deductible PPO,
14 and the exclusion provider plan or the EPO.

15 And, so, by way of background, the Mental Health
16 Parity and Addiction Equity Act generally requires that group
17 health plans ensure that financial requirements and treatment
18 limitations on mental health or substance use disorder
19 benefits are no more restrictive than those are on medical
20 surgical benefits, so two different areas.

21 Non-quantitative treatment limitations are
22 non-numerical limit on the scope or duration of benefits for
23 treatment, for example, pre-authorization type of
24 requirements. Additionally, although the regulation does not
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1 require plans to cover mental health or substance use
2 disorder benefit, if they do, they must provide mental health
3 or substance use disorder benefits in all classifications in
4 which medical surgical benefits are provided. And those
5 classifications are inpatient, both in and out of network,
6 outpatient, both in and out of network, prescription drugs
7 and emergency care.

8 Now, PEBP is not alone in all of this. Plans
9 throughout the United States are working with their
10 administrators to advance continued compliance with more
11 recent parity requirements, including ensuring comparative
12 analysis are documented, making sure modifications are done
13 and needed to assure that the written descriptions and
14 administrative operations conform with one another, as well
15 as to the parity rules.

16 And now I would like to walk you through some of
17 these key findings that we had within our review.

18 So, in addition to the plan design changes that
19 were approved in December of 2023 to the low deductible and
20 to the EPO plans, our recommendation generally includes
21 following action, modifying or removing certain exclusions or
22 limitations, clarifying certain day limits or visit limits,
23 clarifying certain benefit descriptions, reassigning certain
24 benefit classifications. And I got a group of other

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1 considerations. So I would like to walk you through some of
2 our findings now.

3 So, under modifying or removing certain
4 exclusions or limitations -- And I would say this is where
5 the bulk of our findings fell -- we've made the following
6 recommendations. Under the exclusion for attention deficit
7 disorders, we've recommended removing this exclusion, as
8 there were restrictions on care for this specific diagnosis
9 that are not applied to medical diagnosis. And, as PEBP is
10 covering prescription drug medication for treatment for
11 attention deficit disorder, it must provide coverage in all
12 six of those benefit classifications I just described that
13 are under the regulations.

14 The exclusion for hypnosis or hypnotherapy, we
15 recommended moving this exclusion under general exclusion.
16 Because now it only appears under the behavioral health
17 exclusion, so it's clear that it applies equally to both
18 mental health and substance use disorder benefits as well as
19 medical and surgical benefits.

20 The exclusion for marriage and couples and/or sex
21 counseling, we recommend clarifying the exclusion for
22 marriage and couples counseling that will not limit
23 individual mental health counseling for otherwise covered
24 mental health conditions. We also recommend either
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1 clarifying or removing the exclusion for sex counseling, as
2 sex counseling could be interpreted as an exclusion aimed at
3 gender dysphoria.

4 The exclusion for cognitive therapy, currently
5 plan documents exclude coverage for cognitive therapy unless
6 it's related to short-term services necessitated by
7 catastrophic neurological event to restore functioning of
8 activities of daily living. And we recommend revising the
9 plan documents to include an exception to this exclusion for
10 medically necessary treatment of a mental health or substance
11 use disorder condition.

12 So, about the exclusion for sleep disorders, the
13 plan documents now cover medical treatment for sleep
14 disorders. However, there is exclusion for cognitive
15 behavior therapy for sleep disorders. And so we recommend
16 adding an exception for medically necessary treatment of a
17 medical -- of a mental health or substance use disorder
18 condition.

19 There's an exclusion -- Plan documents have an
20 exclusion for milieu. If you're wondering what that is,
21 milieu therapy is a structured group treatment method for
22 mental health issues using everyday activities and a
23 conditioned environment to help people with interaction in
24 community settings. And, so we recommend clarifying this
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1 exclusion, unless this care is otherwise medically necessary.
2 So just a revision there.

3 When it comes to exclusion for food addiction, we
4 recommend removing this exclusion. Several enforcements
5 generally tend to raise questions about plan provisions that
6 may exclude medically necessary treatment for eating
7 disorders.

8 There's also an exclusion for weight management.
9 The plan documents include a pretty detailed exclusion for
10 weight management. But they include an exception to that for
11 detail -- exception for that in conjunction with medically
12 necessarily treatment of anorexia, bulimia, or acute
13 starvation. That's a narrow list. We simply recommend
14 changing that language to include eating disorders if they
15 are considered -- because they are considered a mental health
16 diagnosis to just rephrasing that to say, you know, for
17 medically necessary treatment of an eating disorder.

18 For speech therapy, the CDHP schedule of medical
19 benefits include benefits for speech therapy for injury or
20 sickness that is other than a learning or mental disorder.
21 And so limiting speech therapy for a mental health diagnosis
22 may cause problems under mental health parity. Speech
23 therapy is commonly used for treatment of mental health
24 conditions, most notably autism.

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1 And if the limitation is only presented in the
2 CDHP plan and it's not in the low deductible or the EPO plan,
3 it's possible that just may have been an inadvertent
4 oversight. So we recommend removing that limitation for
5 speech therapy for a mental disorder.

6 Also for alternative or complimentary health care
7 exclusions focusing on chelation therapy. That has to do
8 with heavy metal toxicity or poisoning. Plan documents
9 exclude coverage for chelation therapy, except as may be
10 medically necessary for treatment for acute arsenic, gold,
11 mercury or lead poisoning or for diseases due to clearly
12 demonstrated excessive copper or iron. It would be
13 appropriate to exclude chelation therapy for all conditions.
14 But it raises mental health compliance concerns to allow it
15 only for certain medical diagnosis, as it can be prescribed
16 for the diagnosis of autism and ADHD. So we recommend adding
17 that to the list of exceptions for medically necessary
18 treatment of a mental health diagnosis.

19 Exclusion for vitamin B-12 injections. Who knew?
20 The plan document excludes vitamin B-12 injections, except
21 under certain medical conditions. For example, one of them
22 is, for instance, anemia and there are others. Allowing B-12
23 injections for a certain medical diagnosis while not allowing
24 them for any mental health diagnosis, for example, such as
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1 anxiety or depression present issues under mental health
2 parity. So we recommend amending this exclusion to make an
3 exception for mental health and substance use disorder
4 conditions.

5 So those were the main ones for that category. I
6 would also say for clarifying certain day limits and visit
7 limits, we note that the EPO plan and the low deductible
8 plans limit the coverage for rehabilitation and
9 rehabilitation facilities to 60 plan days per plan year for
10 physical or occupational and speech therapies. The plan also
11 require recertification for habilitative and rehabilitative
12 therapy visits exceeding 90 combined visits per plan year.
13 Since the visit limits and the day limits don't appear to
14 apply again to substantially all medical surgical benefits,
15 it would not be permissible to have a visit limit imposed
16 with respect to services provided in this classification for
17 the treatment of mental health and substance use disorder
18 conditions. And so we recommend adding a consistent
19 exception throughout all three of the plan documents to state
20 the visit limits will not apply to medically necessary
21 treatment of mental health or substance use disorders.

22 We want to also clarify certain benefit
23 descriptions. Like, for example, for case management, the
24 plan documents describe a case management program. And so we
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1 recommend revising this plan language to make clear that a
2 disability resulting from mental health or substance use
3 diagnosis will be covered under the case management program.
4 We note that this is a voluntary program. But the plan
5 document does not clearly indicate that case management is
6 available for mental health or substance use disorder. It
7 doesn't exclude it either. So we just think that enhancing
8 that language would be helpful.

9 For rehabilitation therapy, inpatient and
10 outpatient, the plan documents exclude coverage for speech
11 therapy for conditions of a psychoneurotic origin. That
12 language has been unclear and it excludes treatment for
13 autism or other mental health conditions.

14 So our recommendation is to remove conditions of
15 a psychoneurotic origin to the extent that they may limit
16 mental health conditions.

17 Exclusion for sexual disfunction, the plan
18 documents include an exclusion relating to, among other
19 things, drugs, medicines, procedures, surgeries related to
20 sexual disfunction. However, under the family planning
21 benefits for the schedule of benefits in the CDHP plan, it
22 states that procedures related to sexual disfunction may be
23 covered. So we recommend clarifying this plan language for
24 services and for drugs related to sexual disfunction within
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1 all three of the plan documents consistent with the parity
2 regulations.

3 For enteral formulas and special food products,
4 the plan documents allow enteral formulas and special food
5 products for a person with inherited metabolic disease up to
6 a maximum benefit of \$2500 for plan year. But there's no
7 similar coverage for a mental health condition, such as an
8 eating disorder. So we recommend allowing enteral feedings
9 for mental health diagnosis, without the \$2500 annual maximum
10 per plan year, as plan years are not able to impose a dollar
11 limit on mental health substance use disorder type of
12 diagnosis.

13 One part that we saw we need to reassign a
14 certain benefit classification for partial hospitalization.
15 The plan documents specifically lists partial hospitalization
16 as an inpatient benefit under the pre-authorization
17 requirements of the plan. Partial hospitalization should
18 really be re-assigned as an outpatient benefit and referenced
19 accordingly through the plan document.

20 And, finally, I would call other considerations.
21 And these two are really kind of put together here. I would
22 say that the treatment plan required for the treatment of
23 autism. The plan documents state that any treatment of
24 autism spectrum disorders must be identified in a treatment

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1 plan. And the plan terms are written as required under state
2 law. We're requiring a treatment plan actually in addition
3 to a physician's order and discharge plan under the CDHP plan
4 for behavioral health services when there's no similar
5 requirement for medical services raises federal mental health
6 parity concerns.

7 There is -- The Department of Labor and the
8 Department of Health and Human Services that put out a
9 publication called warning signs on NQTLs. And this
10 specifically mentions this as problematic when there is no
11 similar handling required for medical surgical treatments.

12 I would also say a second part of this is looking
13 at ABA therapy, for example, which is known as the applied
14 behavioral analysis or ABA. Per Nevada statute, that is
15 considered a medical benefit. Federally speaking, a federal
16 auditor may not agree with that approach. They may consider
17 that an actual mental health type of program.

18 So, from here, I think the plan should really
19 coordinate with parties, for example, the administrators,
20 regulators, legal counsel, and perhaps also the Department of
21 Health and Human Services regarding questions as related to
22 is it appropriate condition coordination from federal and
23 state issues and requirements related to autism, which is a
24 mental health benefit subject to federal parity requirements.

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1 And, finally, in closing, I want to point out
2 that last summer, the summer of '23, new proposed rules came
3 out for mental health parity that propose amending existing
4 regulations. And they establish new minimum standards for
5 these NQTLs, including additional documentation and data
6 collection standards. Again, these are now proposed rules.
7 We have not yet heard any final.

8 But this is, like I said, PEBP is in this with
9 everybody else right now. We are all learning. And this law
10 is really evolving and growing. And so stay tuned, I would
11 say, for more updates as we go.

12 CHAIRMAN ROBB: Okay. Thank you for a thorough
13 review.

14 Any questions?

15 MEMBER KELLEY: Of course. I'm sorry. Michelle
16 Kelley for the record. This was very thorough. And, excuse
17 for me for ignorance, because I'm about to ask a question
18 that I'm not actually comfortable with. But, when you are
19 kind of going through each of these items, it jumped out to
20 me that the PEBP plan has limitations for what I would say
21 are medically necessary things, like, you know, specifically
22 looking at physical therapy, right, 60-day limitation. But
23 you're saying that that same limitation can't apply to mental
24 health. And so that seems to me that we're going to get in
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1 to a situation where medically necessarily rehabilitation
2 isn't covered to the same extent that mental health
3 rehabilitation is covered.

4 And so I guess my question is -- I know you're
5 looking specific to this law. But, as you went through, did
6 you turn an eye to equity issues as well just between mental
7 health and regular medical? Because it seems to me like I
8 know we're going to go through the plan document and enact
9 some of these changes. I guess I'm just concerned that we
10 then end up with a plan that's a letter misshapen because we
11 have to comply with the law on one hand, which is -- I would
12 be remiss if I didn't say which is going to cost the plan
13 potentially significant amount of money.

14 But then, on the other hand, we've got medically
15 necessary rehab for structural issues of the body, if you
16 want -- I'm not sure what the right term is -- that aren't
17 going to be covered at the same level. So I just wonder if
18 you can comment on that.

19 MS. DUNN: Amy Dunn for the record. That's a lot
20 to unpack in that question. But, again, nothing that all
21 other plans right now are really looking at and facing. The
22 rules look to see as long as the mental health benefits --
23 Again, there's no requirement to cover mental health
24 benefits, federally speaking. But, if you do, those type of
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1 requirements cannot be held more stringently than those under
2 medical.

3 Where I think it comes up a little bit surprising
4 are where some of these things that you would have to look at
5 from the benefit side of medical to the mental health side,
6 as was just demonstrated from the visit limits per day limits
7 in some of those regards.

8 And so part of that is constantly, I think,
9 looking and re-evaluating not just to see if we're compliant
10 but as we're talking about to say how does this perform
11 ultimately in planned. And part of that is looking at plan
12 design type of issues to see how far does some of this go.
13 And part of that is how rich or perhaps it isn't in certain
14 benefits. It's a complex layered question, I think. I think
15 one of the plans ultimately are reviewing across the board,
16 not just from a compliance perspective, but also, as you just
17 pointed out, equity.

18 MEMBER KELLEY: That didn't help me at all.

19 MS. DUNN: I'm sorry.

20 MEMBER KELLEY: Thank you for your answer. Not
21 your fault.

22 MR. WARD: Richard Ward for the record. In our
23 review there were no -- Well, we reviewed it, as Ms. Dunn
24 mentioned, from the perspective of considering whether the
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1 mental health substance use disorder benefits were in parity
2 with or at least as good as the medical surgical benefits.
3 And we didn't review that as thoroughly or as on a detailed
4 line-by-line basis in the other direction. There were no
5 apparent inequities in the other direction that leapt out at
6 us.

7 MEMBER KELLEY: So just a follow-up. So you
8 don't think that it's an inequity with someone who requires
9 physical therapy for a condition is limited to 60 days versus
10 that same, you know, their friend who has a mental health
11 issue isn't limited. I guess I don't understand how that
12 physical therapy is not considered medical. So I don't
13 really understand. I guess that's my gap.

14 MR. WARD: Richard Ward for the record. Within
15 the comparison, the mental health and substance use disorder
16 benefits are compared against a broader range than just
17 physical therapy. So there are a number of other care
18 situations that the plan provides without limitations.

19 So the fact that there's other medical surgical
20 conditions that are within that same -- the same -- within
21 that same of the six categories that are provided in an
22 unlimited manner, then that's what applies toward the mental
23 health and substance use disorder benefits. It's a policy
24 decision to consider what you're suggesting if the physical

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1 therapy benefits should be applied with a limitation or not.

2 And, customarily, I'll just comment within other
3 plans that we work with, generally, those physical therapy
4 benefits are provided with a limitation, just in the industry
5 with other state plans.

6 MEMBER WEEKS: Stacie Weeks for the record. I
7 really appreciate this analysis. I know it's really hard. I
8 go through a similar process with Medicaid. It's a hard one
9 to do.

10 But I think what I hear you saying is that we're
11 not giving folks who have behavioral health needs better
12 benefits. We're just making sure that the same similar
13 medical component, that they're treated similar, like, with
14 equity, right. So it's not like we're improving -- We're
15 improving them to, you know, to be on par as much as we can
16 with what someone would be getting on the medical side of
17 that service; is that right?

18 MS. DUNN: Amy Dunn for the record. I would
19 agree.

20 MEMBER KELLEY: I have one specific question and
21 it's kind of the same thing. In the other considerations on
22 page seven, the recommendation, so this relates to kind of a
23 treatment plan as well as kind of the doctor's order, if you
24 will. So, isn't the authorization essentially a treatment

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1 plan? And most of, I think, the -- like, many of the medical
2 stuff we cover requires pre-auth. So I guess what's the
3 difference between pre-authorization and this requirement
4 that a treatment plan be provided, as well as the doctor's
5 note?

6 MS. DUNN: Amy Dunn for the record. I would
7 actually look to see in the plan documents and others from
8 kind of looking at from those definitional type of things.
9 But, to me, it's, I think the treatment plan -- I think prior
10 authorization might be a broader term.

11 MR. WARD: Richard Ward for the record. A prior
12 auth is an up-front review to determine whether the care is
13 appropriate or not. It doesn't automatically come with any
14 sort of follow-through oversight. And a treatment plan is a
15 plan of treatment throughout the course of the -- I need a
16 thesaurus here -- throughout the course of the treatment.

17 MEMBER KELLEY: Okay. Thank you. I understand
18 that.

19 CHAIRMAN ROBB: Any further questions? Seeing
20 none, we'll move on to Agenda Item Number 9, discussion and
21 possible action on potential plan design changes for plan
22 year 2025, July 1, 2024, through June 30, 2025. Celestena
23 Glover.

24 MS. GLOVER: Celestena Glover for the record.
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1 So, these proposed plan design changes, a number of them came
2 up with the review of our master plan document. We were
3 asked to go back and do some negotiations with UMR for their
4 prescription co-pay maximizer and then, of course, the mental
5 health parity.

6 So the first thing I have on the list is the UMR
7 prescription co-pay maximizer. And, in a very simplified
8 nutshell, it's a benefit, it's a voluntary program to provide
9 co-pay assistance to our members via a coupon program. But
10 it's in the medical setting, not through our pharmacy
11 benefits.

12 Now, the board had asked that I go back and work
13 with UMR on approval of the contract. Those are
14 confidential, so they're not included in this board report.
15 I did provide that to the board members under a separate
16 cover. So, if you have questions, I would really appreciate
17 it if you don't mention those terms.

18 But UMR is here. They can answer specific
19 questions to this plan design change that we're recommending,
20 if there any. We can do that now or we can go through the
21 whole report before we go through, whichever way you want to.

22 CHAIRMAN ROBB: It appears to go as you like.

23 MS. GLOVER: The next thing is the Mental Health
24 Parity and Addiction Equity Act. So, based on the report in
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1 Agenda Item 8, this is kind of -- this is basically a general
2 we want to incorporate all the provisions of that report to
3 ensure that we can make the necessary plan design changes.
4 And then in the next agenda item we will talk about how to do
5 the master plan document. So I just include this item as a
6 general plan design change to ensure we don't miss anything
7 when we actually go through and update our documents.

8 Elimination of prior authorization requirements.

9 I know this has been -- This had come up as one of the
10 things. So, ambulatory surgery centers, I mean, it's not
11 like somebody is just going to go, oh, I think I need a knee
12 surgery without going through their doctor.

13 So, if they're going to our in-network providers
14 and even within our UMR network, we do have Centers of
15 Excellence for some of these services, the recommendation was
16 to remove the prior authorization requirements there.
17 Dialysis also falls under this. I don't know anybody that
18 would voluntarily go in to dialysis without the need.

19 And then the final thing that we are looking at
20 is GSA rates for travel benefits. This has come up -- In the
21 past, we use GSA rates, and then we were told they were
22 taxable. We didn't have a way of doing the 1099s in order to
23 say what was approved beyond or what was reimbursed beyond
24 the rates allowed. So we're proposing that we adopt the GSR

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1 rates -- GSA rates. Excuse me. UMR is going to work with us
2 on how we apply the benefit. Because, in the past, it was
3 subject to cost share. And we can work around that.

4 And then, internally, we're working on a process,
5 because we don't have that many people traveling where we can
6 do the 1099. It will be a manual process. But we'll be able
7 to create the 1099s to submit to the IRS so that whatever
8 portion is actually taxable that we're reporting correctly.

9 There's a couple of things that are listed here
10 as what's allowed for travel: Bariatric, hip and knee, organ
11 tissue transplant, and abortions. And so those just some of
12 the things that are covered now. This hopefully will help
13 some of our members. You know, it's what we can do and still
14 keep us within our scope. And, with that, I'll answer any
15 questions.

16 CHAIRMAN ROBB: Board Member Kelley.

17 MEMBER KELLEY: So I think in public comment
18 there was a very articulate member who talked about her
19 experience or, today, but talking about the pre-transplant
20 meetings and counseling, which are currently excluded. And I
21 probably had jumped ahead, but, I think, since you brought it
22 up, I think section four, there's an enhancement to reinstate
23 the travel benefit, but it is excluding those pre-counseling
24 appointments. And, just from her description, I heard how
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1 complex it is because she's had many of them.

2 But it is concerning that someone who is having,
3 you know, who requires something for life-saving care where
4 those appointments are mandatory, we're not going to cover
5 travel. Can you talk about that? Can the board change that?

6 MS. GLOVER: This is Celestena Glover for the
7 record. The board can change that. I mean, it's at the
8 discretion of the board for what they want to include in the
9 plan or not.

10 MEMBER KELLEY: I wonder why it's excluded right
11 now.

12 MS. GLOVER: You know, I don't have the history
13 on why that's excluded. I would have to go back and look at
14 that.

15 MEMBER WEEKS: Stacie Weeks for the record.
16 Maybe we look at the fiscal impact a little bit too. I mean,
17 if it's not -- If it's negligible, then I think it's
18 something we should. So I agree with Michelle on this.

19 MS. GLOVER: This is Celestena Glover for the
20 record. We can do that. I mean, obviously, anything we add
21 to the plan is going to affect our rates, which affects our
22 members. For the second year of the plan, our employer
23 contribution is set. We cannot adjust that. There's no
24 mechanism for us to go back and ask for more money.

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1 So, from a fiscal standpoint, everything we do,
2 potentially increase rates. We also look at cost-saving
3 measures. So, if this is something the board wants to do, my
4 recommendation would be to include that in the -- the
5 approval of the plan design changes, make that change. And
6 then when we come back with the rates in March, then we can
7 see if there's some way to say, well, adding this back
8 resulted in dollar on to the rate, whatever that is. So it's
9 something we would need to know now because we need to start
10 the rate-setting process. We can't bring it back in March.
11 It's too late.

12 MEMBER KELLEY: So follow-up. Michelle Kelley
13 for the record. I think in an earlier agenda item regarding
14 the concierge services, I think Mr. Lindley indicated that in
15 three years there's been four or five transplants or -- yeah,
16 transplants. So we're not talking a large number. I guess,
17 personally, I think we should add it in. But I also see the
18 complexity in it.

19 So I wonder if the board or perhaps Segal, our
20 consultant, could provide some information on what other
21 people do, how we could structure the pre-appointment,
22 counseling, just to give us some parameters in which to work.
23 Or maybe there are no parameters. I don't know.

24 UNIDENTIFIED SPEAKER: I can do that.
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1 MEMBER KELLEY: Now or --

2 MS. GLOVER: This is Celestena Glover for the
3 record. I don't know what other plans provide as far as
4 travel benefits for the pre-surgery visits. It is something
5 we can go back and look at. But, if it -- if it's a desire
6 of the board that we include it, we can bring it back for
7 informational purposes. But if that's not going to make a
8 difference on what we do to our plan, then I think you could
9 just include that in your motion that we include that portion
10 of the travel for that benefit.

11 MEMBER KELLEY: Yeah. I understand. Okay.
12 Thank you.

13 MEMBER STRASBURG: Betsy Strasburg. I have a
14 question. If the number of incidents of people going through
15 that care is small, can that be handled through an exception
16 process or does it need to be changed in the plan document?

17 MS. GLOVER: This is Celestena Glover for the
18 record. We would prefer it in the plan document. To do an
19 exception would mean we actually potentially put a hold on
20 every situation. Even though it's very limited, you would
21 have to wait for that exception process to be done before
22 that person can move on. And that's not something we hang
23 them up on because they're waiting for me or Tim or Nick to
24 say, yes, you can do this. If we're going to allow it

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1 anyway, it's probably better in a plan document.

2 MEMBER STRASBURG: Thank you.

3 CHAIRMAN ROBB: Yes.

4 MEMBER WOODWARD: Janelle Woodward for the record.

5 Just a question. This has been brought up in previous
6 meetings. But does PEBP ever go and ask for an increase for
7 the second year? Instead of passing that on to the members
8 asking legislature not to just give you one amount for both
9 years but knowing that it always goes up the second year.
10 Can they increase that second year?

11 MS. GLOVER: This is Celestena Glover for the
12 record. When we build our budgets, we include trend and
13 experience, working with our actuaries to determine where we
14 believe rates are going to be two years from now. Obviously
15 we can't be sure. The employer contribution is not the same
16 in both years. It is more in the second year. But,
17 depending on what we do, the plan design, the more in the
18 second year may not be enough to cover it. And that means it
19 goes to the employee and the retiree. So it's not -- But
20 there is no other mechanism outside of legislature for us to
21 get those employer contributions. So we need to be pretty
22 aware.

23 And, keep in mind, once we put something in a
24 plan, it's very difficult to pull that benefit back out, even
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1 if we decide it's not really working well or it's too
2 expensive. And then we will go forward with the budget build
3 with those new plan designs in mind and anything we believe
4 we might anticipate going forward.

5 CHAIRMAN ROBB: Any further questions? Seeing
6 none, it is an action item.

7 MEMBER KELLEY: Michelle Kelley for the record.
8 I would make a motion to accept the -- What are we on?

9 MS. GLOVER: This is Celestena Glover for the
10 record. The recommendations are numbered at the bottom of
11 the report. So you can take them in that order and make the
12 adjustments at the end.

13 MEMBER KELLEY: Oh, okay. So Michelle Kelley for
14 the record. I make a motion to approve recommendations one,
15 two, three, four, as stated in the document. And then should
16 we do a separate one for the travel? So I would make that
17 motion.

18 CHAIRMAN ROBB: We have a motion and a second.

19 MEMBER STRASBURG: Second. Betsy Strasburg.

20 CHAIRMAN ROBB: Thank you. Any further
21 discussion? Seeing none, I'll call for the vote. All of
22 those in favor, signify by saying aye.

23 (The vote was unanimously in favor of the motion)

24 CHAIRMAN ROBB: All of those opposed? Motion
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1 passes unanimous.

2 Second motion.

3 MEMBER KELLEY: Michelle Kelley for the record.

4 I make a motion that we approve the recommendation of
5 Executive Officer Glover to use the GSA rates for
6 reimbursement of allowed travel expenses. However, I move
7 that we include medically-required pre-transplant
8 appointments and counseling as a covered item for the
9 reimbursement of travel. Is that clear?

10 MS. GLOVER: Uh-huh.

11 CHAIRMAN ROBB: We have a motion.

12 MEMBER STRASBURG: Second.

13 CHAIRMAN ROBB: And a second by Board Member
14 Strasburg. Any further discussion? Seeing none, I'll call
15 for the vote. All those in favor, signify by saying aye.

16 (The vote was unanimously in favor of the motion)

17 CHAIRMAN ROBB: Any opposed? Motion passes.

18 We'll move on to Agenda Number 10, discussion and
19 possible action on recommended changes and updates to the
20 master plan documents for plan year 2025, July 1, 2024,
21 through June 30th, 2025. Tim Lindley.

22 MR. LINDLEY: Tim Lindley for the record. This
23 report will go over the benefit changes and updates of the
24 master plan documents and summary of benefits and coverage of
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1 plan year 25 for the consumer driven health plan low
2 deductible PPO, exclusive provider organization EPO plan,
3 dental plan and life insurance, health reimbursement
4 arrangement, flexible spending account, enrollment
5 ineligibility, Medicare health reimbursement arrangement, the
6 health and welfare wrap plans for the actives and retirees,
7 and Section 125 master plan document.

8 Due to file size, the documents have been
9 provided electronically that are posted on line on our
10 website.

11 Throughout the plan year, several intricacies in
12 the plan document verbiage are identified through various
13 methods. These include members notifying PEBP, audit
14 reviews, vendor inquiries, et cetera.

15 PEBP staff and its vendor partners reviewed the
16 master plan documents, summary plan description, and summary
17 of benefits and coverages. The proposed changes stem from
18 input received from subject matter experts. Some changes
19 being simply housekeeping efforts, while others are
20 regulatory and compliance matters.

21 The tables -- The lists and tables below
22 provide -- will review housekeeping changes, board-approved
23 changes, changes required per the Mental Health Parity and
24 Addiction Equity Act, No Surprises Act, plan design changes,
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1 and other changes deemed necessary for board approval.

2 Throughout the document, the changes have been
3 numbered. And, instead of going through over 90 different
4 changes, I would invite the board to have a discussion on
5 specific numbered items. If there is no discussion, of
6 course, the board can make the changes as necessary.

7 With that, I would pass it to the board for
8 discussion, or if they want to discuss a specific item
9 number.

10 CHAIRMAN ROBB: Okay. Any questions from the
11 board?

12 MEMBER KELLEY: Michelle Kelley for the record.
13 So this isn't a question but just a general observation that
14 as I was going through, I noticed some typos and thing that I
15 just couldn't match up. So I do have some questions that
16 it's really kind of busy. It's not going to impact the plan.

17 So, with Executive Officer Glover's permission, I
18 would just like to perhaps communicate with Tim, just some of
19 it, periods and just an understanding with an asterisk, so
20 it's kind of -- what would that be -- punctuation-driven
21 questions and changes, like, nothing that would change the
22 plan design or anything like that.

23 MS. GLOVER: This is Celestena Glover for the
24 record. Typically when we do the master plan document
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1 changes, one of the things we ask for in the approval of the
2 changes is technical adjustments as needed. And that will
3 cover our grammar and all of that. Because we will do a
4 proofread in the team once we incorporate all of those things
5 to make sure that we didn't miss anything in the process.
6 But, if you notice something, let us know.

7 MEMBER KELLEY: Yeah. There are lots of
8 documents.

9 CHAIRMAN ROBB: All right. Any further
10 questions? Seeing none, it is an action item. Oh, so sorry.

11 MEMBER MCCLENDON: It's okay. It was a
12 last-minute hand up. I'm just looking at -- This is Jennifer
13 McClendon for the record. I'm looking at 83 and I'm not sure
14 this is the exact item, but renaming the low deductible plan
15 to a PPO plan. I'm just thinking back to Mr. Ervin's public
16 comments about the confusion between having a PPO plan and an
17 EPO plan that is essentially a PPO plan. The last thing that
18 we need is more confusion, I think, in our documents. And I
19 just -- But I might not understand the rationale that the
20 team had for coming up with that. So that's just a question
21 I guess for Executive Director Glover.

22 MS. GLOVER: This is Celestena Glover for the
23 record. Because there is no deductible, that was the
24 rationale behind changing it. But, of course, the board --

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1 the board can approve everything else and not change the plan
2 name. I think that Tim has some information he wants to
3 bring up.

4 MR. LINDLEY: Tim Lindley for the record. One
5 thing we hear from the quality control side is from our
6 member services unit staff who take calls from new hires,
7 rehires, et cetera. And they also say why is it called a low
8 deductible plan. There is no deductible. And that is a very
9 common thing that we receive when people are trying to select
10 their plans. And so this was a change brought up by members
11 calling PEBP and asking about that. Again, if the board
12 wants to maintain the name low deductible.

13 MEMBER MCCLENDON: Jennifer McClendon again for
14 the record. I'm just wondering if there might be a third
15 option besides, you know, that's maybe a little bit more
16 clear than either low deductible, which it is not, and PPO,
17 which it has in common with other plans. I'm not feeling
18 creative enough to bring up other solutions, so forgive me
19 for even bringing up this point.

20 MEMBER KELLEY: Michelle Kelley for the record.
21 I guess my concern is if we change the name then, you know,
22 depending on plan experience, most likely soon, and I don't
23 have a crystal ball, but most likely soon there will be a
24 deductible. Then we have to change the name again. And so
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1 for the short period there may not be a deductible I kind of
2 feel that we should keep low deductible and have the
3 explanation, because it is unusual for a PPO not to have a
4 deductible. But I will go with whatever the board thinks.

5 CHAIRMAN ROBB: Any further questions or
6 comments? Seeing none, it is an action item.

7 MEMBER KELLEY: I'm kind of motioned out. What
8 item was it?

9 MS. WEYLAND: 83.

10 MEMBER KELLEY: 83, all right. Michelle Kelley
11 for the record. I make a motion that we accept as presented
12 all changes except for number 83 today and technical
13 adjustments going forward.

14 MEMBER STRASBURG: What about four?

15 MEMBER KELLEY: I think we already changed that;
16 right?

17 MEMBER STRASBURG: Do we have to do it again?
18 No.

19 CHAIRMAN ROBB: We have a motion. Do we have a
20 second? Okay. Board Member Strasburg seconds. Any further
21 discussion? Seeing none, I'll call for the vote. All of
22 those in favor, signify by saying aye.

23 (The vote was unanimously in favor of the motion)

24 CHAIRMAN ROBB: All of those opposed? Motion
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1 passes.

2 We'll move on to Agenda Item Number 11, public
3 comment period. Public comment will be taken during this
4 agenda item. Comments are limited to three minutes per
5 person.

6 MR. WELCH: Thank you, Mr. Chair. Again, for the
7 record, Bill Welch, B-i-l-l W-e-l-c-h. First, I would like
8 to acknowledge and thank you all for your time today to hear
9 my wife and myself on our concern.

10 I also want to acknowledge that I did hear the
11 board ask for from both PEBP and UMR staff for a quality
12 review on the appeal process. I would ask that we make sure
13 that it also includes the exception to the plan benefit as
14 part of that review.

15 Having been a health care executive for many,
16 many years until I recently retired, I understand that
17 processes are well-intended and are intended to meet the
18 needs and the objectives of both the plan and also the
19 member. But sometimes they don't always fall -- those plans
20 are not always followed.

21 And, with that in mind, I think the only way you
22 truly get an evaluation is one thing to understand how the
23 process works. But, to understand whether it is working, you
24 might want to also request that part of that review includes
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1 interviewing plan members who have had to go through that
2 planned benefit appeal process or planned benefit exception
3 process to get a real sense from them if the system is
4 working or not. And, so, again, thank you very much. I
5 appreciate your time today.

6 CHAIRMAN ROBB: Thank you for your time.

7 MR. ERVIN: Kent Ervin, E-r-v-i-n, Nevada Faculty
8 Alliance.

9 First of all, thank you for your action on travel
10 reimbursements. I know Ms. Osborne had to leave for actually
11 a medically-related Zoom session. So I hope that message
12 gets to her. And I hope that that goes in to effect
13 immediately or there are plan exceptions for this plan year
14 if need be.

15 Regarding the customer service issues, UMR said
16 their rule is to -- And I think I get this quote right --
17 quote "support the plan and keep it cost effective" end
18 quote.

19 I would hope that UMR and PEBP include the number
20 experience as well as the plan support and cost effectiveness
21 in all of your review. And I appreciate that you're going to
22 review in particular the appeal process in the future. I
23 think that's important and that it covers both UMR and PEBP.

24 Regarding the Medicare exchange contract, you
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1 know, the provider Via Benefits gets kickbacks, excuse me,
2 commissions from your insurance providers. These are not
3 disclosed to Medicare exchange retirees. I haven't seen a
4 report on the gross commission income recently. But, as I
5 recall, it's in the millions of dollars. So the service is
6 hardly no cost.

7 This reminds me of a situation in the retirement
8 plan industry 15 to 20 years ago when providers earned
9 kickbacks, excuse me, revenue sharing from investment
10 managers and told plan sponsors and participants that their
11 services were free or implied that they were free. The
12 retirement industry has since been reformed and revenue
13 sharing has now returned to individual participants and the
14 providers are compensated through transparent contracted
15 fees.

16 It is time for PEBP to demand through the RFP
17 process that providers offer their services for a flat fee
18 per participant and any excess commissions are returned to
19 either participants or to PEBP. And, if you don't ask for
20 that through an RFP process, they aren't going to offer it.
21 But, if you do ask for it, maybe you'll get some proposal
22 from some providers. So that's the suggestion for that RFP
23 process.

24 Finally, this room is inadequate. It has
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1 inadequate ventilation in the post-Coronavirus era. And an
2 outdoor waiting room for the public is really not acceptable.
3 Vendors seem to have somewhere else to go during the break.
4 You have options. The board can use the legislative
5 building. Those meeting rooms are free, outside of session.
6 Or you could perhaps ask to use the PERS board room. And
7 then maybe you could convert this space to consultation rooms
8 so you don't need to meet with participants about medical
9 situations in the public waiting room or outside. Thank you.

10 CHAIRMAN ROBB: Thank you.

11 Any other public comment in Carson City? Seeing
12 none, any public comment on line? We do have public comment
13 on line.

14 MR. HOPKINS: One moment, Chair Robb. I'll get
15 the slide up.

16 For those that have joined for public comment,
17 your name or last four digits of your phone number will be
18 announced, you'll be advised that you have been unmuted.
19 Please slowly state and spell your name for the record and
20 proceed with your comments.

21 Douglas Unger, you have permission to speak.
22 Please slowly state and spell your name for the record.

23 MR. UNGER: Doug Unger, D-o-u-g U-n-g-e-r, Nevada
24 Faculty Alliance and the UNLV Employee Benefits Advisory
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1 Committee.

2 Thank you to the board for your detailed and very
3 productive discussion of the items on the agenda today and
4 particularly detailed questioning about the UMR issues and
5 the audit and also the travel reimbursement.

6 I would like to go back to the customer care
7 experience that was raised by the board during the UMR
8 discussion and the appeals process and just inform the board
9 that as a labor representative who hears about these cases,
10 you know, pretty regularly, although fewer this year than
11 last year, often it's the coding from the provider or the
12 hospital or somewhere in the system, not UMR, which has made
13 the mistake, that leads to the very delayed claim and the
14 very frustrating claim process when a claim is denied due to
15 a provider or a hospital error.

16 At this point, the PEBP member is in neophyte,
17 lost in a hieroglyphic world of incomprehensible codes,
18 literally moving from door to door, hospital, physician,
19 PEBP, UMR, lost in infinite recorded phone loops until the
20 patient or the PEBP member gets lucky enough to find a
21 professional who can spot the coding mistake. So the
22 responsibility gets put on the PEBP member to resolve this
23 issue.

24 I would like to propose that there should be an
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1 ombudsperson who recognizes that these coding errors are --
2 happen and that these are the most extreme cases.

3 And, as far as UMR's customer care is concerned,
4 please trust the PEBP member first. Treat the PEBP member as
5 though the PEBP member has a legitimate case first. That
6 will improve the member experience, rather than informing the
7 PEBP member that, no, this, you know, medical service isn't
8 covered, when it really should have been in the first place,
9 except for a coding error.

10 I don't know what this will require in terms of
11 training staff or having a designated staff member to look
12 for that. But that is the most extreme case that I see. And
13 I see it continuing.

14 About the travel reimbursement, I appreciate very
15 much your approval of increased benefits. I would like to
16 ask on a future agenda item that you add another travel
17 benefit and it is for those rare diseases and rare conditions
18 that are not treated in the State of Nevada for which the
19 State of Nevada has absolutely no providers.

20 I speak from personal experience with this. My
21 wife was diagnosed with a very, very rare condition. There
22 were only four places that treated this condition in the
23 entire United States. We could find only one case that had
24 ever been treated in the 154-year-old history of the State of
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1 Nevada. We were out \$6,000 in travel expenses. Fortunately,
2 the problem was resolved at the Mayo Clinic and we appreciate
3 very much PEBP's support.

4 But, perhaps, an exception for those rare disease
5 and conditions that are not treated in the State of Nevada
6 might be added to the travel reimbursement.

7 Thank you very much and for your attention to
8 everything on the agenda today.

9 CHAIRMAN ROBB: Do we have anybody else on the
10 line?

11 MR. HOPKINS: There's one more, Chair Robb.
12 Would the caller with the name Chris, please slowly state and
13 spell your name for the record and then you can make public
14 comment. I think they just dropped out.

15 Chair Robb, that concludes public comment.

16 CHAIRMAN ROBB: Okay. We will close Agenda Item
17 Number 11 and we will adjourn. Thank you for everybody's
18 time today.

19 (Hearing concluded at 11:57 a.m.)

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1 STATE OF NEVADA)
2)ss.
3 CARSON CITY)

4

5 I, CHRISTY Y. JOYCE, Official Court Reporter for
6 the State of Nevada, Public Employees' Benefits Program
7 Board, do hereby certify:

8 That on Friday, the 26th day of January, 2024, I
9 was present, via Zoom, for the purpose of reporting in
10 verbatim stenotype notes the within-entitled public meeting;

11 That the foregoing transcript, consisting of pages
12 1 through 98, inclusive, includes a full, true and correct
13 transcription of my stenotype notes of said public meeting.

14 Dated at Reno, Nevada, this 8th day of February,
15 2024.

16

17

18

19

CHRISTY Y. JOYCE, CCR
Nevada CCR #625

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