In The Matter Of:

PUBLIC EMPLOYEES' BENEFITS PROGRAM BOARD VIDEOCONFERENCED OPEN MEETING

January 26, 2024

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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 Executive Assistant
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A G E N D A

FRIDAY, JANUARY 26, 2024, 9:00 A.M.

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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: Bepsy 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.

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

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

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

Next, the change of the name from low deductible plan to just -- Sorry -- low deductible PPO plan to just PPO plan is confusing since the high deductible health plan is also a PPO plan. The real problem is that the low deductible plan was changed to have zero deductible for reasons that remain unclear. The low deductible plan was meant to give a

choice between the high deductible PPO and the HMO or EPO plan, reducing the deductible of the low deductible plan to zero, while adding a deductible to the HMO and EPO, which traditionally had no deductibles, blurs those distinctions and is confusing to the participants. That's what should be fixed, rather than the names.

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

CHAIRMAN ROBB: Thank you.

Next public comment in Carson.

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

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

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

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

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

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

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

Let me be specific. The PEBP plan document

covers the medical device annually for patients who experience the temporary side effect to the treatment of cancer. They do not cover the device for the actual diagnosis, which is a permanent condition. As the appeals process progressed, I used capital letters, bold font. I even told them what they could do. They could pay the claim at 80 percent because they don't have a preferred provider or they can address why they will not make the exception.

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

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

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

CHAIRMAN ROBB: Thank you.

Next public comment, please.

MR. WELCH: Good morning. For the record, my

name is Bill Welch, B-i-l-l W-e-l-c-h, and I am the husband to Leanne, the party who just spoke with you under public comment. I appreciate the opportunity to speak with you today.

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

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

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

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

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

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

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

And, on one last note, I would just like to reenforce what my wife had indicated about the process. We

have made over a hundred calls, multiple letters, multiple e-mails, and still have never had the specific issue that we have presented and was directed to present considered. I would encourage this board to seriously review PEBP staff and UMR's process for handling plan members' claim dispute issues. Thank you.

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

MR. WELCH: Thank you, Mr. Robb.

CHAIRMAN ROBB: Any other public comment in Carson?

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

I am here to address -- Let's see. I don't have this in front of me. Agenda item Number 10 when it talks about the master plan document as it relates to pre-surgery appointments at Centers of Excellence, my question is why are

you not allowing reimbursement for travel expenses for pre-surgery appointments for transplant patients but you are allowing them for hip replacements, for knee replacements.

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

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

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

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

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

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

CHAIRMAN ROBB: Okay. Thank you.

Any further public comment in Carson City?

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

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

proceed with your comments.

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

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

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

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

Our major and most pressing concern is access to providers and providers shortages. This is at crisis levels, especially for mental health. UMR's list of mental health providers is reported to us to contain several who no longer take UMR insurance. As well, many primary care physicians

and specialists in the network are so booked that they no longer take new patients. It would be helpful if this could be somehow indicated, perhaps by providers reporting no room in our practice periodically.

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

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

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

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

CHAIRMAN ROBB: Thank you.

Any further public comment on line?

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

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

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

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

The law does not require abstention from voting

merely because the board member or their family member is eligible for PEBP benefits.

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

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

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

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

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

MEMBER STRASBURG: Second.

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

(The court reporter interrupts)

MEMBER STRASBURG: Bepsy Strasburg.

CHAIRMAN ROBB: Sorry about that. Any further

discussion? Seeing none, I'll call for the vote. All of those in favor, signify by saying aye.

(The vote was unanimously in favor of the motion)

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

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

MS. GLOVER: This is Celestena Glover for the record. I want to just make one comment before I turn it over to Michelle. We do have one contract that if there are questions on that contract we will need to close the session.

If there are no questions, then we can move on to the vote. Any discussion on the contract will be confidential until the contract becomes public.

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

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

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

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

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

CHAIRMAN ROBB: And so we will have to close the session. But, instead of closing the session right now, I want to know if we're going to have more sections that we're going to close the session for instead of closing. So we

will table that discussion for right now and move on to the next one and see if we have to close for multiple items. And we'll let the public know what items we're closing for and then close them and come back.

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

5.4, there are no solicitation ratifications.

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

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

MS. WEYLAND: Okay.

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

MS. WEYLAND: That would be a question for Willis

Towers Watson.

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

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

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

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

MS. WEYLAND: Well, we're actually working with Segal on the current RFP needs, and that is on my white board

in my office with a big old exclamation point. Michelle Weyland for the record. Sorry.

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

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

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

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

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

MR. WARD: Uh-huh. It will be evaluating the exchanges, the different bidders' capabilities to

communicate, educate, and support the retirees in accessing the MA -- the Medicare advantage and Medicare supplement plans in the individual market. So it's more of -- I'm sorry. It's more of a service and education type of contract. They won't be contracting with providers. That's happening separately. It's just providing access to the market that already exists.

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

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

MEMBER KELLEY: So that will be part of it?

MR. WARD: Yes.

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

MR. WARD: Low single digit.

MEMBER KELLEY: Okay. Low single digit.

MR. WARD: Well, because it's a large group. There are a number of exchanges in the market, but they have different levels of capability and they serve different group sizes and they excel in different sections of the market or

with different types of plans. And you're correctly noting that with a large state plan that requires a certain amount of breadth and depth and expertise.

MEMBER KELLEY: Okay. Thank you.

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

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

MR. WARD: Generally no.

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

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

MEMBER KELLEY: So one more question, just a general question, thinking about one of the public comments that I read. So why don't these exchanges have contracts with all of the different providers? And is that a piece that we should be evaluating as part of the RFP? Because I

read a comment that said, you know, the plan that we're in wasn't covered by -- under the exchange. And, when they tried to get it under the exchange, they couldn't. So I'm just wondering -- Access, obviously, is always a big deal in Nevada. So that will be part of kind of looking at what companies are going to be --

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

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

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

MEMBER KELLEY: Okay. Thank you.

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

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

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

MS. GLOVER: This is Celestena Glover for the

record. Yes. Because we will be asking for board members to be part of the evaluation committee in addition to staff and whoever else we need to include.

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

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

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

MS. GLOVER: Remember that when we start.

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

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

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

CHAIRMAN ROBB: Any further questions on 5.1?

Seeing none, thank you.

Now, we have to go 5.2. We will have a closed session. I really want to give a target. It's 9:33 now. I'm hoping we can wrap up the closed session by 10:00 o'clock. But, for the people that we're going to ask to be

excused, plan on being back at 10:00 o'clock. If we go a little bit longer, we will relay that. But let's plan to readjourn the meeting at 10:00 o'clock.

(Recess was taken to move to a closed session)

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

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

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

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

CHAIRMAN ROBB: I'm sorry.

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

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

MEMBER KELLEY: I just have a comment. I just want to thank staff for all the effort that has gone in to

this new contract, new product offering. I just, for the record, I urge our participants once this contract is up and running to really investigate and take advantage of the services that are going to be offered through it. Because I -- adding these programs to the plan really is for participants. So, please use it, once it's up and running. And thank you to the staff and the consultants for doing such a -- and purchasing for doing such a thorough job. So thank you.

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

(The vote was unanimously in favor of the motion)

CHAIRMAN ROBB: Those opposed? Motion passes unanimous.

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

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

On the 16th, Ms. Weyland and I took the oh-dark-hundred flight to Las Vegas to meet with IRBC.

That's the Interim Retirement and Benefits Committee. They have meetings, essentially, annually. And both PEBP and PERS present to those boards that this is by statute we have certain reports we give them. For us, it's financial statements, the OPEB report, the utilization report. We also provide them updates for any plan design changes the board has approved. And then they may request additional information after we present.

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

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

budget bill. So that's coming in upcoming board meetings.

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

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

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

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

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

And then, lastly, staffing. When I wrote this report, we were roughly 21 percent vacancy rate. We did get two more positions filled, but we also lost one person, who

is transferring. They got a promotion so they're moving on to another agency. But we have opened the recruitment for that position or we requested that the recruitment be open. So hopefully we can get a replacement in that position in accounting. But, that will leave us -- Once the new person starts, our six person-accounting team will finally have five. We had four. So that will help. But we're going to be looking for one more.

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

CHAIRMAN ROBB: Board Member Kelley.

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

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

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

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

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

CHAIRMAN ROBB: Okay. Any further discussion? Seeing none, we will close Agenda Item Number 6 and move on to Agenda Item Number 7, acceptance of Claim Technologies Incorporated audit findings for the State of Nevada Public Employees' Benefits Program third party administrator UMR for

FY 2024 Q1, covering the period of July 1 of 2023 through September 30, 2023. Tim Lindley.

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

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

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

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

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

medical and dental claims.

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

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

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

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

As Tim mentioned, this results in a 3.5 percent penalty. The administrative fees for the quarter were $46,420.60. We recommend reviewing the financial errors identified in the random sample audit to ensure the root causes have been identified and a claim process or training

or any system corrections are made where appropriate.

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

CHAIRMAN ROBB: Thank you.

Any questions from the board?

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

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

CHAIRMAN ROBB: All right.

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

CHAIRMAN ROBB: We have a motion.

MEMBER STRASBURG: Bepsy Strasburg. Second.

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

(The vote was unanimously in favor of the motion)

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

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

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

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

And, since we've migrated this over on to our UMR platform and our CTS platform, all we've done is sort of add

resources, okay. So we have increased our resources. We were probably somewhere in that 45 to 50 range when it was on HealthSCOPE platform. We're now probably with the 80 employees working on this plan.

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

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

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

CHAIRMAN ROBB: Board Member Kelley.

MEMBER KELLEY: Michelle Kelley for the record. Can you walk us through what the remediation plan is? I understand you've given us a written document, but I would like to hear you talk about it.

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

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

(The court reporter interrupts)

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

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

So, as we look at the financial accuracy portion of the remediation plan, the areas that we're looking at

there, we're taking errors that have been identified through our internal audits, as well as errors that have been identified through CTI. And we're taking that and comparing it to additional repetitive-type errors that we may see come through on a daily basis. We have enhanced those audits and increased them.

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

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

In addition to that, we also have a list of

additional resources to help us to manage that inventory and to make sure that going forward we improve the claim turnaround time.

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

MEMBER KELLEY: Can we ask questions as we go?

CHAIRMAN ROBB: Yes, go ahead, please.

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

MR. BRAUN: Yeah. About 92 percent electronically.

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

MR. BRAUN: So, what happens is, like I said, 92 percent come in electronically. The other eight percent come in in some other form, either faxed in, mailed in, those are converted. That usually takes one or two days. And, so, within one or two days, they're in electronic format. And

they all go in to the queue on whichever day they're received. At that point, it goes through a repricing process, so the claim has to get repriced. And then about --

MEMBER KELLEY: Is that manual or automatic?

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

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

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

MEMBER KELLEY: Thank you.

So, then, I'm sorry, coming back to the enhancements. So, the staff, the 14 that have gone to 20,

those staff are reviewing the kickouts?

MR. BRAUN: Yes.

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

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

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

MR. BRAUN: About 60 percent.

MEMBER KELLEY: 60 percent. So I'm sorry. Just going back to the report, so I think there was, what, 257,000 claims in a quarter of the audit. And so only 60 percent of those go through automatically. And we've got now 20 staff

working on the kickouts. And, so, when something kicks out, what's the process, just the general process, that the staff member would take?

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

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

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

MR. ASHBY: Thousands, yes.

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

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

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

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

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

UNIDENTIFIED SPEAKER: We're in Q3.

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

MR. BRAUN: Yes.

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

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

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

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

MEMBER KELLEY: But you agreed to 99.

MR. BRAUN: We agreed. And we're striving to meet that. And, if we don't, we pay the penalty. But it's not like we're missing it by ten percent. You know, we're missing it by two percent, three percent. And, again, we're working with the hospitals to make sure we know what our status is on those claims. We have a weekly meeting with Carson-Tahoe. We have a weekly meeting with Renown, okay. So they know where the claims are in the process. But it's

not like they're -- They're not angry because they're not getting paid. They know we're doing our reviews.

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

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

Darren, was it 90?

MR. ASHBY: In ten days it was 94.2. And then in 20 days -- And these are business days -- it was 97 -- 98.71.

MR. BRAUN: Yeah. So we do have some improved numbers. And, what we did, we looked there at claims received in December and then we went with those days and those are the numbers he just blurted out to you. So we would have hit the one metric and missed the other one by three-tenths of a percent.

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

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

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

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

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

MEMBER STRASBURG: Thank you.

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

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

CHAIRMAN ROBB: Board Member Kelley.

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

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

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

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

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

MEMBER WEEKS: Stacie Weeks for the record. Thank you for the presentation. Is there a way for you to

add to your plan here, that automation?

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

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

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

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

(The court reporter interrupts)

MR. MAIER: This is Nathan Maier, for the record, from UMR, M-a-i-e-r. And so I was just saying that the PA rules are set by PEBP. I know Rhonda works back with our clinical team, we make recommendations back to PEBP staff about, you know, are there things that require authorization

that we see a, you know, approved pretty much on an automatic basis that don't make sense and they create unnecessary delay. So that is a process that I know that we communicate back with PEBP staff as we're looking at plan changes. And so, yes, that is something we can look at.

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

MR. MAIER: Sure.

CHAIRMAN ROBB: Okay. Any further questions?

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

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

So you'll notice that originally we started off with 18 call agents and we increased that to 22. And, as we continued to review the process and the work that was associated with not only the volume of calls coming in but

then the work that that creates when that call does come in, we recognize the need to make adjustments in that staffing model.

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

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

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

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

MR. BRAUN: It is a big job, okay. You know, obviously, we have a pretty large organization and we have a town acquisition team that helps us with that process. And it's planned in advance. And, you know, we sort of predict

how many people are going to leave or transfer in to other positions in advance and so we get classes scheduled and we start planning those classes 60 to 90 days in advance of the time we're going to have class in order to fill those classes with qualified candidates.

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

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

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

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

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

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

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

MR. BRAUN: No. If you didn't file an appeal, an official appeal, then there would not have been any appeal process. Now, you know, maybe you talked to somebody and

they initiated some sort of provider review or some sort of review of that billing process and found something in that process and figured out that it should have been different. But unless you actually initiate an appeal, a member appeal --

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

MR. BRAUN: You can do --

(The court reporter interrupts)

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

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

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

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

that appeal.

CHAIRMAN ROBB: Board Member Weeks.

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

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

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

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

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

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

MEMBER WEEKS: Stacie Weeks for the record. So then maybe can PEBP look at their process and what's going on with recipients? Because I'm very concerned about some of

the feedback we've been getting on their experience.

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

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

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

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

CHAIRMAN ROBB: Vice Chair Kelly.

MEMBER KELLEY: I just want to follow up on Board Member Weeks. I would actually like to request an agenda

item where the board gets to review the totality of the appeals process, both the UMR side, who is, you know, like, who is responsible for what, including the PEBP's side. And I think that, you know, it's been a continual noise that we're hearing. And I, with your permission, Chair Robb, I think it would really benefit the board to understand from A to Z of the appeals process.

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

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

MR. BRAUN: Thank you.

CHAIRMAN ROBB: Okay.

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

CHAIRMAN ROBB: It was not listed for action.

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

MS. GLOVER: It's part of the whole --

CHAIRMAN ROBB: Yeah, it's part of the -- We already took action on Number 7, so the remediation plan.

MS. GLOVER: Just to be safe.

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

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

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

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

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

MEMBER WEEKS: Stacie Weeks. I move --

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

(The vote was unanimously in favor of the motion)

CHAIRMAN ROBB: All opposed? Motion carries.

We'll move on to Agenda Item Number 8, acceptance of Mental Health Parity and Addiction Equality -- Equity Act

report, including possible action on, but not limited to, the following items. Celestena Glover.

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

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

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

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

MR. WARD: Richard Ward with Segal for the

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

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

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

Non-quantitative treatment limitations are non-numerical limit on the scope or duration of benefits for treatment, for example, pre-authorization type of requirements. Additionally, although the regulation does not

require plans to cover mental health or substance use disorder benefit, if they do, they must provide mental health or substance use disorder benefits in all classifications in which medical surgical benefits are provided. And those classifications are inpatient, both in and out of network, outpatient, both in and out of network, prescription drugs and emergency care.

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

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

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

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

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

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

The exclusion for marriage and couples and/or sex counseling, we recommend clarifying the exclusion for marriage and couples counseling that will not limit individual mental health counseling for otherwise covered mental health conditions. We also recommend either

clarifying or removing the exclusion for sex counseling, as sex counseling could be interpreted as an exclusion aimed at gender dysphoria.

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

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

There's an exclusion -- Plan documents have an exclusion for milieu. If you're wondering what that is, milieu therapy is a structured group treatment method for mental health issues using everyday activities and a conditioned environment to help people with interaction in community settings. And, so we recommend clarifying this

exclusion, unless this care is otherwise medically necessary. So just a revision there.

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

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

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

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

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

Exclusion for vitamin B-12 injections. Who knew? The plan document excludes vitamin B-12 injections, except under certain medical conditions. For example, one of them is, for instance, anemia and there are others. Allowing B-12 injections for a certain medical diagnosis while not allowing them for any mental health diagnosis, for example, such as

anxiety or depression present issues under mental health parity. So we recommend amending this exclusion to make an exception for mental health and substance use disorder conditions.

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

We want to also clarify certain benefit descriptions. Like, for example, for case management, the plan documents describe a case management program. And so we

recommend revising this plan language to make clear that a disability resulting from mental health or substance use diagnosis will be covered under the case management program. We note that this is a voluntary program. But the plan document does not clearly indicate that case management is available for mental health or substance use disorder. It doesn't exclude it either. So we just think that enhancing that language would be helpful.

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

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

Exclusion for sexual disfunction, the plan documents include an exclusion relating to, among other things, drugs, medicines, procedures, surgeries related to sexual disfunction. However, under the family planning benefits for the schedule of benefits in the CDHP plan, it states that procedures related to sexual disfunction may be covered. So we recommend clarifying this plan language for services and for drugs related to sexual disfunction within

all three of the plan documents consistent with the parity regulations.

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

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

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

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

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

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

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

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

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

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

Any questions?

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

to a situation where medically necessarily rehabilitation isn't covered to the same extent that mental health rehabilitation is covered.

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

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

MS. DUNN: Amy Dunn for the record. That's a lot to unpack in that question. But, again, nothing that all other plans right now are really looking at and facing. The rules look to see as long as the mental health benefits -- Again, there's no requirement to cover mental health benefits, federally speaking. But, if you do, those type of

requirements cannot be held more stringently than those under medical.

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

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

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

MS. DUNN: I'm sorry.

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

MR. WARD: Richard Ward for the record. In our review there were no -- Well, we reviewed it, as Ms. Dunn mentioned, from the perspective of considering whether the

mental health substance use disorder benefits were in parity with or at least as good as the medical surgical benefits. And we didn't review that as thoroughly or as on a detailed line-by-line basis in the other direction. There were no apparent inequities in the other direction that leapt out at us.

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

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

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

therapy benefits should be applied with a limitation or not.

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

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

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

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

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

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

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

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

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

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

MS. GLOVER: Celestena Glover for the record.

So, these proposed plan design changes, a number of them came up with the review of our master plan document. We were asked to go back and do some negotiations with UMR for their prescription co-pay maximizer and then, of course, the mental health parity.

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

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

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

CHAIRMAN ROBB: It appears to go as you like.

MS. GLOVER: The next thing is the Mental Health Parity and Addiction Equity Act. So, based on the report in

Agenda Item 8, this is kind of -- this is basically a general we want to incorporate all the provisions of that report to ensure that we can make the necessary plan design changes. And then in the next agenda item we will talk about how to do the master plan document. So I just include this item as a general plan design change to ensure we don't miss anything when we actually go through and update our documents.

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

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

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

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

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

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

CHAIRMAN ROBB: Board Member Kelley.

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

complex it is because she's had many of them.

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

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

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

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

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

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

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

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

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

UNIDENTIFIED SPEAKER: I can do that.

MEMBER KELLEY: Now or --

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

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

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

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

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

MEMBER STRASBURG: Thank you.

CHAIRMAN ROBB: Yes.

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

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

And, keep in mind, once we put something in a plan, it's very difficult to pull that benefit back out, even

if we decide it's not really working well or it's too expensive. And then we will go forward with the budget build with those new plan designs in mind and anything we believe we might anticipate going forward.

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

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

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

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

CHAIRMAN ROBB: We have a motion and a second.

MEMBER STRASBURG: Second. Bepsy Strasburg.

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

(The vote was unanimously in favor of the motion)

CHAIRMAN ROBB: All of those opposed? Motion

passes unanimous.

Second motion.

MEMBER KELLEY: Michelle Kelley for the record. I make a motion that we approve the recommendation of Executive Officer Glover to use the GSA rates for reimbursement of allowed travel expenses. However, I move that we include medically-required pre-transplant appointments and counseling as a covered item for the reimbursement of travel. Is that clear?

MS. GLOVER: Uh-huh.

CHAIRMAN ROBB: We have a motion.

MEMBER STRASBURG: Second.

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

(The vote was unanimously in favor of the motion)

CHAIRMAN ROBB: Any opposed? Motion passes.

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

MR. LINDLEY: Tim Lindley for the record. This report will go over the benefit changes and updates of the master plan documents and summary of benefits and coverage of

plan year 25 for the consumer driven health plan low deductible PPO, exclusive provider organization EPO plan, dental plan and life insurance, health reimbursement arrangement, flexible spending account, enrollment ineligibility, Medicare health reimbursement arrangement, the health and welfare wrap plans for the actives and retirees, and Section 125 master plan document.

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

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

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

The tables -- The lists and tables below provide -- will review housekeeping changes, board-approved changes, changes required per the Mental Health Parity and Addiction Equity Act, No Surprises Act, plan design changes,

and other changes deemed necessary for board approval.

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

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

CHAIRMAN ROBB: Okay. Any questions from the board?

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

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

MS. GLOVER: This is Celestena Glover for the record. Typically when we do the master plan document

changes, one of the things we ask for in the approval of the changes is technical adjustments as needed. And that will cover our grammar and all of that. Because we will do a proofread in the team once we incorporate all of those things to make sure that we didn't miss anything in the process. But, if you notice something, let us know.

MEMBER KELLEY: Yeah. There are lots of documents.

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

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

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

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

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

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

MEMBER KELLEY: Michelle Kelley for the record. I guess my concern is if we change the name then, you know, depending on plan experience, most likely soon, and I don't have a crystal ball, but most likely soon there will be a deductible. Then we have to change the name again. And so

for the short period there may not be a deductible I kind of feel that we should keep low deductible and have the explanation, because it is unusual for a PPO not to have a deductible. But I will go with whatever the board thinks.

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

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

MS. WEYLAND: 83.

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

MEMBER STRASBURG: What about four?

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

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

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

(The vote was unanimously in favor of the motion)

CHAIRMAN ROBB: All of those opposed? Motion

passes.

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

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

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

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

And, with that in mind, I think the only way you truly get an evaluation is one thing to understand how the process works. But, to understand whether it is working, you might want to also request that part of that review includes

interviewing plan members who have had to go through that planned benefit appeal process or planned benefit exception process to get a real sense from them if the system is working or not. And, so, again, thank you very much. I appreciate your time today.

CHAIRMAN ROBB: Thank you for your time.

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

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

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

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

Regarding the Medicare exchange contract, you

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

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

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

Finally, this room is inadequate. It has

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

CHAIRMAN ROBB: Thank you.

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

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

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

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

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

Committee.

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

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

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

I would like to propose that there should be an

ombudsperson who recognizes that these coding errors are -- happen and that these are the most extreme cases.

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

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

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

I speak from personal experience with this. My wife was diagnosed with a very, very rare condition. There were only four places that treated this condition in the entire United States. We could find only one case that had ever been treated in the 154-year-old history of the State of

Nevada. We were out $6,000 in travel expenses. Fortunately, the problem was resolved at the Mayo Clinic and we appreciate very much PEBP's support.

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

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

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

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

Chair Robb, that concludes public comment.

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

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

STATE OF NEVADA)
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CARSON CITY)

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

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

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

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

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CHRISTY Y. JOYCE, CCR
Nevada CCR #625

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