JOE LOMBARDO
Governor

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

CELESTENA GLOVER
Executive Officer

JACK ROBB
Board Chair

January 26, 2024

RICHARD WHITLEY, MS
DIRECTOR OF DHHS
OFFICE OF CONSUMER HEALTH ASSISTANCE
400 W KING ST STE 300
CARSON CITY NV 89703

Re: Public Employees' Benefits Program (PEBP) Appeals and Complaints
Summary Report Calendar Year 2023

Dear Mr. Whitley:

In accordance with NRS 695G.310, PEBP presents to the Office of Consumer Health Assistance, under the Aging and Disability Services Division of the Department of Health & Human Services, its annual Appeals and Complaints Summary Report for Calendar Year 2023.

Specifically, the name of the employee(s) responsible for appeals, descriptions of notification procedures, and an explanation of rights are set forth below, followed by a narrative summary of the attached appeals and complaints log. A graph showing the number of appeals and complaints resolved in Calendar Years 2017 through 2023 has been included for historical comparison purposes.

Pursuant to NRS 695G.200, the "name and title of the employee[s] responsible for the system for resolving complaints" are:

Tim Lindley, Quality Control Officer, PEBP
Gina Reynolds, Quality Control Analyst, PEBP
Allison Walker, Quality Control Analyst, PEBP

Additionally, pursuant to NRS 695G.200, a description of the system for resolving appeals and to notify an insured of the decision regarding their appeal and a "copy of the explanation of rights and procedures" provided to insureds:

PEBP has contracted with UMR located in Las Vegas, Nevada, to provide third-party administration services for PEBP's self-funded plans: the Consumer Driven Health Plan (CDHP), Low Deductible PPO (LD-PPO), and the Exclusive Provider Organization (EPO). As PEBP's claims administrator, UMR receives claims from physicians, dentists, psychiatrists, laboratories, and other providers. UMR reviews the claims and processes them in accordance with provisions in the applicable plan year PEBP Master Plan Document. Included at the bottom of every

explanation of benefits (EOB) notice sent by UMR to participants is a statement that describes the first level of appeal available to a participant:

> **What if I have questions about this claims decision?**
> If you have any questions about this explanation of benefits, please call the toll-free number on your ID Card.
>
> **What if I don't agree with this claim decision?**
> If your claims has been denied in whole or in part, you may file an appeal by sending a written request and pertinent information (eg: office notes, lab results, operative notes/reports, and medical history) within 180 days from the date of this notice, or the period otherwise established by your plan. Be sure to also check your benefits booklet for information about claim determination and your plan's specific appeal process.
>
> **How do I file an appeal?**
> If you are not satisfied with this decision, either you or your authorized representative can start the appeal process by sending a written request to:
>
> Claims Appeal Unit
> P.O. Box 30546
> Salt Lake City, UT 84130-0546
>
> Or the member can submit an appeal electronically through the UMR appeals portal. Please log into UMR.COM and click on submit an appeal/or as otherwise set out in your benefit plan book within 180 days of receipt of this explanation of benefits (unless a longer term is permitted by your plan). Please note that if you choose to designate an authorized representative, you must make this designation to us in writing.
>
> **Your rights and other resources**
> If we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party after exhausting the internal appeal process. You must make the request within 4 months or within the period as specified in your plan documents. Contact us at the phone number on your ID card to find out how to start an external review.

The written request for appeal is either mailed to the address listed on the EOB or electronically filed through the member's UMR portal. The Third-Party Administrator's (UMR) decision on the Level 1 Claim Appeal is mailed to the PEBP participant in writing. If the TPA approves the appeal, they reprocess the related claim(s). If the TPA denies the Level 1 Claim Appeal, the denial letter to the participant includes instructions on how to proceed to a Level 2 Claim Appeal, if the participant deems necessary.

Level 2 Claim Appeals are adjudicated by PEBP, and decisions are sent to participants in writing. If the Level 2 Claim Appeal is denied, the denial letter to the participant may include instructions on how to proceed to an External Review. External Reviews are managed by the Nevada Office of Consumer Health Assistance (OCHA):

> If you are not satisfied with this decision, you may have the right to request a separate external review. This means you have the right to have the claim determination reviewed by an independent health care professional.
>
> To file an external review, you must contact the Nevada Governor's Office for Consumer Health Assistance (GOVCHA) and file your request for an external review within 4 months after the date of receipt if this letter. A standard external review request form is available in the PEBP website at www.pebp.state.nv.us or the GOVHA website at http://dhhs.nv.gov/Programs/CHA.
>
> Office for Consumer Health Assistance
> 3320 W. Sahara Ave, Suite 100
> Las Vegas, NV 89102
> Phone: (702) 486 -3587, (888) 333-1597
> Website:
> https://adsd.nv.gov/Programs/CHA/Office_for_Consumer_Health_Assistance_(OCHA)/

The claim appeal process described in PEBP's Master Plan Document complies with the requirements of the Patient Protection and Affordable Care Act of 2010 (PPACA) and Chapter NRS 695G of the Nevada Revised Statutes. Forms for completing the various levels of review are available by accessing their E-PEBP Portal at https://pebp.nv.gov/ or by calling the PEBP office.

Summary Narrative

The Complaints and Claim Appeals Summary Report for calendar year 2023 lists 36 Level 2 Claim Appeals, 13 External Reviews, and 79 Complaints totaling 128 resolved. Complaints are categorized by vendor and complaint type. This compares to 5 external reviews, 22 Level 2 Claim Appeals, and 79 complaints totaling 106 resolved in 2022.

When compared to 2022, the 2023 Appeals and Complaints have increased overall for external reviews, Level 2 Claim Appeals, and complaints. Members who exercise their right to an External Review saw roughly 70% of decisions upholding either the Utilization Management or Claims determination. Meanwhile, the increase in Level 2 Claim Appeals saw approximately 58% of appeals upheld by PEBP.

Of the complaints resolved in 2023, 32% were directed at UMR, 20% were directed at Express Scripts, 13% were directed at VIA Benefits. UMR experienced 25 complaints, mostly focused on claims processing and claims payments. Express Scripts (ESI) experienced an increase in complaints with 16 in 2023 compared to 11 in 2022. The majority of ESI complaints centered on the price of prescriptions. Willis Towers Watson's VIA Benefits experienced a decrease to 10

complaints in 2023 compared to 11 complaints in 2023, with most complaints relating to customer service.

The number of complaints for PEBP and other vendors, such as Corestream, Health Plan of Nevada, HSA Bank, Network, etc. experienced an increase in 2023, from 25 overall complaints in 2022 up to 28 for 2023. Most of these complaints (13) are related to PEBP for administration and eligibility determinations.

Sincerely,

Tim Lindley
Quality Control Officer
Public Employees' Benefits Program
775-684-7000

Enclosure(s): Appeal and Complaint report (3 pages)

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Board Chair

January 26, 2024

SCOTT KIPPER
NEVADA DIVISION OF INSURANCE
1818 E. COLLEGE PARKWAY, SUITE 103
CARSON CITY, NV 89706

Re: Public Employees' Benefits Program (PEBP) Complaints Summary Report Calendar Year 2023.

Dear Commissioner Kipper:

In accordance with NAC 287.750, PEBP presents to the Nevada Division of Insurance, under the Department of Business and Industry, its annual Complaints Summary Report for Calendar Year 2023. Specifically, the name of the employee(s) responsible for appeals, descriptions of notification procedures, and an explanation of rights are set forth below, followed by a narrative summary of the attached complaints log.

Pursuant to NAC 287.750(1)(a), the "name and title of the employee[s] responsible for the system for resolving complaints" are:

Tim Lindley, Quality Control Officer, PEBP
Gina Reynolds, Quality Control Analyst, PEBP
Allison Walker, Quality Control Analyst, PEBP

Additionally, pursuant to NAC 287.750, below is a "description of the procedure used to notify an insured of the decision regarding his or her complaint" provided to insureds:

A complaint may be made to the PEBP by any participant, provider, vendor, etc., regarding any PEBP process or service. It is recognized that complaints may be in person, over the phone, by e-mail, or other method of communication. Complaints must be in writing for appropriate consideration.

1. The Compliance Division staff member will respond to the participant either by mail, e-mail, or phone within 2 business days to acknowledge receipt of the complaint. Generally, complaints will be acknowledged in the same method as submitted to PEBP.
2. The Compliance Division staff will log the Complaint for tracking and reporting purposes with the pertinent details of the complaint. The Compliance Division staff review complaint documents to determine a response.
3. If the complaint is addressed to QCO, or the PEBP, the Compliance Division staff will draft a response and review with the QCO for approval prior to mailing.

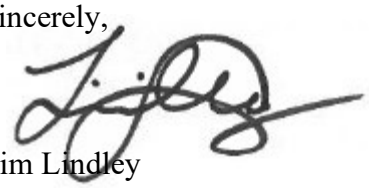
4. The Compliance Division staff will respond to the participant with determination of complaint findings within 7 business days. In the event further time is needed to completely research and review the complaint, the Compliance Division staff will contact the member as needed to provide status updates.
5. A final complaint response, including signed written response from the Compliance Division, are mailed to the member.
6. For PEBP Operational purposes, the Compliance Division staff may note the participant's account in the current PEBP internal Client Relations Management Tool and will not include participant's Personal Health Information (PHI).

Summary Narrative

The Complaints Summary Report for calendar year 2023 lists 79 Complaints resolved. Complaints are categorized by vendor and complaint type. This compares to 79 complaints resolved in 2022. Of the complaints resolved in 2023, 32% were directed at UMR, 20% were directed at Express Scripts, 13% were directed at VIA Benefits. UMR experienced 25 complaints, mostly focused on claims processing and claims payments. Express Scripts (ESI) experienced an increase in complaints with 16 in 2023 compared to 11 in 2022. The majority of ESI complaints centered on the price of prescriptions. Willis Towers Watson's VIA Benefits experienced a decrease to 10 complaints in 2023 compared to 11 complaints in 2023, with most complaints relating to customer service.

The number of complaints for PEBP and other vendors, such as Corestream, Health Plan of Nevada, HSA Bank, Network, etc. experienced an increase in 2023, from 25 overall complaints in 2022 up to 28 for 2023. Most of these complaints (13) are related to PEBP for administration and eligibility determinations.

Sincerely,



Tim Lindley
Quality Control Officer
Public Employees' Benefits Program
775-684-7000

Enclosure(s): Complaint report (1 page)

Level 2 Claim Appeals														
Plan and Appeal Outcome	**Jan-23**	**Feb-23**	**Mar-23**	**Apr-23**	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Year Totals**	**% of Total**
CDHP-PPO	**3**	**1**	**1**			**5**	**1**		**2**	**2**	**1**	**1**	**17**	**47%**
Addt'l Docs Req.	1					4							5	
Overturned										1	1		2	
Untimely									1				1	
Upheld	2	1	1			1	1		1	1		1	9	
Exclusive Provider (EPO)	**2**					**2**	**1**		**1**	**1**	**1**		**8**	**22%**
Addt'l Docs Req.	2												2	
Overturned						1			1	1			3	
Upheld						1	1				1		3	
Low Deductible-PPO	**1**	**1**	**2**		**1**		**1**	**1**	**1**	**1**	**2**		**11**	**31%**
Overturned								1		1			2	
Upheld	1	1	2		1		1		1		2		9	
Year Totals	**6**	**2**	**3**	**0**	**1**	**7**	**3**	**1**	**4**	**4**	**4**	**1**	**36**	**100%**

External Review Appeals														
Plan and Appeal Outcome	**Jan-23**	**Feb-23**	**Mar-23**	**Apr-23**	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Year Totals**	**% of Total**
CDHP-PPO	**1**			**2**			**2**		**2**		**1**		**8**	**62%**
Overturned	1						1		1				3	
Upheld				2			1		1		1		5	
HMO						**1**							**1**	**8%**
Upheld						1							1	
Low Deductible-PPO				**1**		**1**				**2**			**4**	**31%**
Overturned										1			1	
Upheld				1		1				1			3	
Year Totals	**1**	**0**	**0**	**3**	**0**	**2**	**2**	**0**	**2**	**2**	**1**	**0**	**13**	**100%**

Complaints														
Vendor and Complaint Type	**01/2023**	**02/2023**	**03/2023**	**04/2023**	**05/2023**	**06/2023**	**07/2023**	**08/2023**	**09/2023**	**10/2023**	**11/2023**	**12/2023**	**Grand Total**	**% of Total**
Corestream							**2**	**1**			**1**		**4**	**5%**
Administration							1						1	
Claim Processing								1					1	
Voluntary Benefits/Products							1				1		2	
ExpressScripts		**1**	**3**	**2**	**1**	**2**	**3**		**1**	**1**	**2**		**16**	**20%**
Administration											1		1	
Claim Price Payment Dispute			2										2	
Customer Service									1		1		2	
Enrollment & Eligibility							1						1	
Network Provider Access				1		1							2	
Prescription		1			1		1						3	
Prescription Pricing			1			1	1			1			4	
Prior Authorization				1									1	
Health Plan of NV						**1**							**1**	**1%**
Administration						1							1	
HealthSCOPE Benefits				**1**	**1**								**2**	**3%**
Administration				1									1	
Claim Price Payment Dispute					1								1	
HSA Bank	**1**				**1**	**3**		**1**				**1**	**7**	**9%**
Administration												1	1	
Claim Denial					1								1	
Claim Processing						1							1	
HSA/HRA/FSA	1					2		1					4	
Network-UHC Choice Plus/SHO/BHO								**1**					**1**	**1%**
Voluntary Benefits/Products								1					1	
Public Employees' Benefits Program		**1**		**1**	**1**	**1**	**1**	**2**	**3**	**1**	**1**	**1**	**13**	**16%**
Administration								2	2	1		1	6	
Enrollment & Eligibility		1		1			1		1				4	
HSA/HRA/FSA											1		1	
Network Provider Access					1								1	
Voluntary Benefits/Products						1							1	
UMR	**1**	**1**	**6**	**2**	**2**	**4**	**3**	**1**	**2**	**1**	**2**		**25**	**32%**
Administration	1	1	1										3	
Carrier Issues			3										3	
Claim Denial					2	1							3	
Claim Price Payment Dispute			1	1		1	1				1		5	
Claim Processing						2	2	1	2	1	1		9	
HSA/HRA/FSA			1										1	
Plan Design				1									1	
VIA Benefits (Willis Towers Watson, O	**1**	**1**		**1**			**1**			**2**	**1**	**3**	**10**	**13%**
Administration											1		1	
Claim Processing										1			1	
Customer Service										1		3	4	
HSA/HRA/FSA	1			1			1						3	
Network Provider Access		1											1	
Grand Total	**3**	**4**	**9**	**7**	**6**	**11**	**10**	**6**	**6**	**5**	**7**	**5**	**79**	**100%**

PEBP Complaints and Appeals History Comparison
2017 - 2023