To whom it may concern,

I am a soon-to-be divorced parent of 2 adult children. Neither of my children have affordable and accessible health insurance through their employment, so my coverage also supports their health care needs.

And we are generally healthy individuals who try to keep up on our yearly primary preventative care. But it's not always that straightforward.

My daughter was in a car accident last fall and received the minimum care through the [redacted] She owes the hospital $750.

My son went to the emergency room [redacted] we owed the hospital $700, which I paid out of pocket. I used $200 from my HSA account to cover the hospital request for a deposit. $500 additionally came out of pocket.

In addition, the guidance on using HSA is not very clear. I found no instruction on how to submit expenses to HSA and collected receipts to submitted through my tax filing. and I recently received an aggressive letter from HSA informing me that I would have to pay if I did not send my receipts to them. It was accusatory and with an unnecessary "or else" tone. This was prefaced by a statement that they had previously contacted me and this was my last notice – I had never received any contact from them previously. No letter, no email, no phone call. I don't want to be made to feel suspect for using these funds when I need them.

I am a state employee for the Division of Health Care Financing and Policy. I have a better understanding of health care than maybe others. I feel that raising state employee's premiums is a disservice to those that choose to be civil servants. It's not like the pay alone is incentive to become a state employee. There is a desire to help the residents of Nevada. I don't appreciated being treated like some one is trying to take advantage of the state of Nevada.

Why is PEBPs choosing to further take away from those employees that give back every day through the work that they do for the state of Nevada?

I understand the economics of health care somewhat. And I understand Nevada's economy somewhat. It just doesn't add up to me.

Sincerely,

Carin Fox Hennessey

[redacted]

To the PEBP Board-

I am writing to submit a public comment regarding coverage options for Obesity Management. I know that you are currently considering benefit coverage and I would like to you consider including the new medications the have had tremendous success for obese patients. The new medications such as Wagovy and Zepbound have been researched and shown to help those who have struggled with chronic obesity lose weight and maintain a healthy weight.

For many of us who have had to deal with obesity for most of our lives, this new medication can be a miracle and help us manage the host of other health issues that arise from obesity. Diet and exercise can help to support long term healthy habits but many people and having dramatic results by adding this medication.

Right now, the cost of this medication prohibits and discriminates against many of us who are not able to afford it. By approving this additional medication management along with your other obesity management support, we may be able to have a huge life changing impact for so many people struggling with this chronic disease.

It is time that we stop shaming people for being obese, telling them that all they need to do is move more and eat less. Please consider offering this through our benefit package.

Thank you

Jamie

To: Board of PEBP

From: Larry & Jacqueline Gavuzzi

Member ID: [redacted]

Re: hsabank debit card

I would like to voice our concern about the hsabank debit card usage and process. “Every time “ we use our debit card for our medical deductibles we are contacted by hsabank to provide them with an EOB from the provider. This has become an extreme inconvenience as most of the time it takes a week or two for the provider to generate the EOB for billing , then we have to contact the provider and then mail the EOB to the bank for proof. The bank will not

accept the receipt which clearly shows the medical provider and amount . Hsabank said they need the EOB for IRS purposes.

I don’t understand why the proof of burden is put on the members, it’s our money and benefit and it clearly shows that it goes to medical !!!.

The past benefit debit card prior to hsabank we never had to do this.

I am also speaking on behalf of all our friends and family members and medical staff whose spouses and friends that are members of PEBP who are not pleased with this procedure.

Please take in consideration of making changes with hsabank debit card requirements and procedure process in the future.

Thank you

Regards

Carson City

April 22,2024

To The PEBP Board

Re: Carson Tahoe Health and United Healthcare Insurance Company (UMR).

Hello,

My name is Danilo Dragoni and I have been with the State of Nevada for 12 years. I live in Carson City and had used, and still use, Carson Tahoe Health (CTH) services and doctors. Recently, CTH sent a message stating that they had issues with reimbursements from UMR and that they may discontinue the contract with this insurance company. I do believe that this will cause a substantial disruption and burden to many employees and ask the Board to do everything is possible to avoid such situation.

Regards,

I am copying the message I received, for reference,

March 1, 2024

Dear Valued Patient,

For nearly seventy-five years, Carson Tahoe Regional Healthcare ("CTH") has stood as a cornerstone of our community, providing essential healthcare services. We are deeply committed to maintaining the highest standards of care, which requires access to well-trained staff, the latest equipment and technology, which in turn requires reimbursement for the services we provide to our patients.

For many years, CTH has been contracted with United Healthcare Insurance Company, and its affiliates, Northern Nevada Health Network, Inc. and Optum (together, "United") for reimbursement for services CTH has provided to Members and Customers of United. Unfortunately, CTH has
experienced ongoing payment issues with United such that CTH has given notice of its intent to terminate its contracts with United. Although CTH has continued to deliver services to United Members and Customers, a significant number of claims for services already provided remain unpaid or underpaid, therefore, CTH will be forced to end its relationship as an in-network provider of United.

While we are doing everything in our power to avoid any potential disruptions, if a resolution is not

soon reached with United, you may no longer be covered by United for healthcare services at CTH.

As a Nevada non-profit organization dedicated to enhancing the health and well-being of our community, we will not turn anyone away who needs our service. However, as an independent, community-based hospital, we depend on payment from those able to pay, and we rely on our contracted payors to honor their obligations.

In the event CTH is unable to reach an agreement with United and our contracts with United are terminated, it will be necessary for you to find a healthcare provider within the United network to maintain your coverage. In such an event, you or your new provider should submit a request for your medical records to be sent to your new provider, allowing at least 30 days for processing time.
With so many changes taking place within the healthcare industry, making the best choice for you or your family can be difficult. If you have any questions or concerns about your health insurance options, please talk to your health insurance agent or representative for guidance.

We are grateful for your support throughout the years and we sincerely hope to continue serving you and our community.

Sincerely,

Michelle Joy
President and CEO
Carson Tahoe Health

I want to formally file a public complaint about the 3excuse that is claimed to be HSA BANK those income pent fools did not give me the opportunity to be in compliance with federal law with regard to their notifications. Furthermore, they did not tell who to contact to complain about their utter incompetence. I encourage PEBP to look for another organization to serve the government employees of Nevada. HSA Bank is not tolerable in my opinion. I have cut up my card a year ago and I refuse to deal with them.

May 7, 2024

PEBP Board
PEBP Executive Officer Celestina Glover
3427 Goni Road, STE 109
Carson City, NV 89706

RE: Public Comments 5/9/2024 Meeting

I was a member of the PEBP Board when the Board adopted the SaveOnSP program.

I am writing regarding the declaration in the Master Plan Designs (MPD) that "**copayment assistance for specialty drugs will not apply toward your deductible and Out-of-pocket Maximum**" and to indicate that I believe the master plan designs incorrectly state the intent of the Board and may create issues because of the way the language in the MPD's have been written. This letter provides background on the adoption of the SaveOnSP program, why the MPD language is wrong, and suggested changes to the language in the MPD.

At the time the SaveOnSP program was adopted, the Board did not vote to disallow copay assistance for specialty drugs in totality. The purpose of using the SaveOnSP program was to allow PEBP participants to access these specialty drugs at no cost to them, while maximizing the amount of copay assistance to the plan to offset that benefit. The intent was to disallow <u>direct</u> copay assistance from pharmaceutical companies from applying to accumulators.

As explained when the SaveOnSP program was presented, the PEBP plan became the beneficiary of any pharmaceutical copay assistance, and the plan participant paid $0 for the medication. The copay assistance collected by the SaveOnSP program would not apply to the deductible or out of pocket maximum because the plan participant received the medication with no out-of-pocket cost. This left the accumulators in place and the participant would be responsible for all other medical costs that would generally apply to the deductible and out of pocket maximum.

The reason for this change was the pharmaceutical copay assistance was usually GREATER than the out-of-pocket maximum incurred by the member, therefore the actual cost to the plan was less by offering this plan in this manner.

During the March 31, 2020 Board meeting where the SaveOnSP program was approved, there was discussion about patient assistance programs <u>for non SaveOnSP medications</u>. The information provided to the Board was that patient assistance programs could still apply. In other words, patient assistance could apply to the deductibles and copays for drugs not on the SaveOnSP program.

The transcript statement on page 91 on that March 31, 2020 date reads:

MS. DALY: So that's on slide seven and there would be and there are some members that are on a specialty drug with co-pay assistance that are not a part of Save-On. So some of the members will not be participating in Save-On again because of the targeted list. But if they are using the co-pay assistance programs they can continue to do that. Those dollars will not go away and our specialty pharmacy will continue to encourage members to sign up for those dollars if they are available.

COPAYMENT ASSISTANCE

There are many kinds of copayment assistance including direct and indirect. Some indirect patient assistance providers are funded in part by pharmaceutical companies, but users must apply to receive them. This type of assistance is indirect copayment assistance. It's not a coupon anyone can use.

Some of these indirect patient assistant programs include funding from the National Organization for Rare Disorders (NORD) and MedMonk. These programs are indirect patient assistance programs which generally have qualification requirements (need based, or other criteria). These are not direct pharmaceutical coupons but is specifically approved funding placed into an account on behalf of a patient that can be accessed by a specialty pharmacy to cover the bills for certain specialty drugs.

Direct copayment assistance is more in the line of pharmaceutical coupons or direct to consumer incentives or payments that come directly from manufacturers.

When a member participates in the SaveOnSP program, they enroll into it and the plan follows a specific method to capture the copayment assistance for the benefit of the plan. There is a specific agreement between the PEBP plan and the enrolled participant.

There are several patient assistance programs that assist plan members with the costs of drugs that are NOT on the SaveOnSP program.

Absent a specific agreement for the plan to capture the copayment assistance on behalf of a participant, how can the plan possibly take non-direct copay assistance used to pay a medical bill on behalf of participant without applying it to the amount owed by the participant?

The way the PEBP Board has structured the language in the SPD, a participant could qualify for $20,000 in patient assistance funding from NORD because of financial need, and as this indirect copay assistance was applied to the bills from the specialty pharmacy, the plan would simply take the money without giving credit to the bills the participant is responsible for paying, leaving the participant to pay the bills for the specialty drugs again.

This practice, in my opinion, violates the intent of the Board when the SaveOnSP plan was adopted. I also believe that the application of disallowing non-direct copay assistance from applying toward a deductible or OOP for specialty drugs that are not part of the SaveOnSP program would be arbitrary and capricious and perhaps unlawful. Certainly, such a practice would violate the affordable care act.

I request that PEBP and the PEBP Board clarify/change the currently overbroad statement in the master plan design from:

"copayment assistance for specialty drugs will not apply toward your deductible and Out-of-pocket Maximum"

To read:

"copayment assistance for specialty drugs that are part of the SaveOnSP program will not apply toward your deductible or Out-of-pocket Maximum. Direct copayment assistance from pharmaceutical companies such as discounts or coupons will not apply toward your deductible or Out-of-pocket Maximum. Indirect copayment assistance will apply toward your copays, deductible and Out-of-pocket Maximum."

A change such as this would align with the intent of the Board that adopted the SaveOnSP program, would clarify to Accredo and UMR when to allow or disallow copayment assistance from applying to accumulators, and would not create an issue for the plan or plan members when indirect copayment assistance is applied when non-SaveOnSP specialty medications are provided by Accredo.

I request that this be clarified in writing before the end of Open Enrollment as it makes a difference on the choices participants make.

Please feel free to reach out to me with any questions.

Sincerely,

[redacted]