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AGENDA ITEM

Action Item

Information Only

Date: October 9, 2008

Item Number: VI

Title: 2009-11 Budget Reduction Decision Unit

Summary

As discussed during recent PEBP Board meetings, the Program has been instructed by the Budget Office to submit its Agency Budget Request for the next biennium with specific limits in the amount of State subsidy. After accounting for normal cost trends and enrollment growth, the amount by which the State subsidy must be reduced, compared to what is required to sustain current benefits and cost sharing policies, is approximately **\$55 million**.

At the August meeting, the PEBP Board reached a general consensus on three significant points:

1. That focus be maintained on providing financial protection to the participants against catastrophic health conditions;
2. That focus be maintained on encouraging participants, through the provision of "wellness benefits", to achieve a healthy lifestyle; and
3. That budget reductions to meet the target be considered evenly between cost shifting the contributions/premiums and reducing benefits paid by the plan.

At the September meeting, the Board considered various options to shift funding from the State subsidy to the employee/retiree. To be clear, the impact of shifting the share of cost from the State subsidy to the contribution/premium means increased costs to the participants, above and beyond what would otherwise occur. Each of the cost shifting options considered by the Board were projected to save \$27.5 million over the next biennium in State subsidy (using the current plan design). The following cost shift approaches were approved by the Board:

1. Continue the Board's current policy regarding use of Reserve for Rate Stabilization.
2. Reduce the percentage of cost paid by the State subsidy in all tiers in the non-base plans only.
3. Allocate the Medicare Part D subsidy revenue between the plan and the Medicare retirees.
4. Propose a legislative change regarding the State subsidy for retirees that eliminates State subsidy for individuals who retire after June 30, 2010 with less than 15 years of service.

Today's agenda item is intended to provide various options to the Board for implementing the plan benefit reductions. "Plan benefit reductions" refers to health services that will either no longer be covered by the plan or will require a larger participant cost share when services are received. In this context, "health services" includes any medical, dental, vision, prescription services or materials provided by the plan. Unlike last month's agenda item regarding cost shifting, reducing plan benefits will have an impact only on those participants who actually access the plan benefits. Each of the benefit reduction options discussed in this report is projected to save approximately \$27.5 million over the next biennium in State subsidy (using the current cost sharing policy).

As with the cost sharing options discussed in September, the Board is asked to take action based upon the basic approach to each plan benefit reduction. At the November 6, 2008 meeting, staff will present a consolidation of the cost shift approach approved in September and the approach to benefit reductions approved today. This consolidation will reconcile the two components for a total savings in State subsidy of approximately \$55.0 million during the upcoming biennium.

Report

When planning for this agenda item, staff referred to several sources for suggestions. These included a ten-year PEBP plan comparison (see a summary in Attachment A), the 2007 Plan Comparison conducted by PEBP, and Aon's familiarity with several other state benefit plans. What makes the selection of plan design reductions difficult is the magnitude of the savings needed. In order to achieve \$27.5 million in savings in State costs over such a short timeframe, the plan design reductions are drastic. The focus of this agenda item will be the budget target, but the Board and all stakeholders in the plan should also know that PEBP staff will continue to pursue other plan options that would achieve administrative efficiencies, cost effective changes in utilization patterns or improved provider payment arrangements.

PEBP staff started its analysis with a list of individual plan design reduction ideas that were estimated to have a significant impact on costs (see Attachment B). After

preliminary cost impacts were developed by Aon, three basic groups of options (i.e. bundled options) were developed for presentation to the Board. Each bundled option takes a different approach to achieve the required savings. The number of individual plan changes varies by option and should be viewed as a connected group. In addition, some of the options include changes with long term policy implications.

PEBP staff is aware that effectively communicating the final decisions to the participants will be difficult. It will be necessary to explain why the changes are necessary and what approach was used to determine the final set of changes. Then, as normally occurs with health insurance, the participants will likely focus on the direct impact on their own expected usage of the plan. The fewer the number of individual changes, the easier this process will be. However, fewer changes require more severe plan changes in order to achieve the requested savings.

The long term policy implications fall generally in the area of establishing a policy to “automatically” adjust certain out-of-pocket cost shares paid by the participant. Examples of this are to index the annual deductible, copayments, and/or annual out-of-pocket maximum. These types of plan changes help to distribute future cost increases in a consistent manner between the plan and the participants. However, because they would in effect, mean a plan change each year, they could be viewed as an annual source of dissatisfaction on the part of plan participants.

Most of the discussion in this agenda item will focus on the self-funded plan. Currently about 71% of all PEBP participants are enrolled in the self-funded plan. The two health maintenance organization (HMO) plan vendors have been asked to propose plan changes that would hold premiums in FY 2010 at the FY 2009 level. The normal approach with the HMO’s is to receive any premium adjustments in January of each year for inclusion in the next year’s rates. It will be PEBP staff’s intent to work with each vendor to achieve the target growth in FY 2010 and to communicate any plan changes necessary to the Board at the February 2009 meeting. Preliminary plan options from each vendor to be considered are included in Attachment C.

Certain benefit areas were not considered in meeting the Budget Office subsidy target. Those benefit areas included the following:

- Plan changes that would generate a relatively small savings and do not have any long term cost sharing policy implications
- Prescription benefit changes that may create a barrier to patient compliance - the general concern would be inadvertently causing an increase in medical utilization for conditions that may have been better addressed through prescription drug adherence
- Dental, vision and life insurance benefits – cost increases for these benefits are generally limited to more moderate inflationary increases (there are generally not cost pressures caused by changes in utilization patterns)

- Wellness benefits currently provided in the self-funded plan – PEBP intends to continue working towards overall improved health condition of the participants and therefore will not be proposing any reductions to this benefit.

The following sections describe three approaches for Board consideration that would result in approximately \$27.5 million savings in State subsidy over the next biennium. As indicated, the cost impact has been based upon the current cost sharing policy. The cost share approach approved last month and the plan design approach approved today will be reconciled for the November Board meeting to achieve the total \$55.0 million savings requested by the Budget Office.

Aon was asked to consider the impact on the Reserve for Rate Stabilization under each approach. In response, staff has been advised that “the impact to the reserve for each of these scenarios would be small relative to the impact/reduction on expected claims. While the expected claims are being reduced (which directionally reduces the needed reserve), the further a plan is from first dollar coverage, the higher the volatility in plan paid costs typically (which directionally increases the needed reserve).” Therefore, no change to the Reserve for Rate Stabilization would be recommended with any of these approaches. Any impact on projected Incurred but not Reported (IBNR) reserve levels will be incorporated into the November reconciliation of cost shift and plan design approaches.

Approach #1

The priority of Approach #1 is to retain the two self-funded plan options at their current deductible levels. With that goal in mind, several other significant plan design reductions would be required. When developing this option it became apparent that, without changing the deductible levels, it is very difficult to achieve the requested savings without a further contribution/premium cost shift from the State to the participants. Benefit reductions that would be included in this approach are as follows:

1. Remove the Health Assessment Questionnaire (HAQ) and the associated incentives

- a. High deductible stays at \$2,000 individual / \$4,000 family
- b. Low deductible stays at \$500 individual / \$1,000 family

Current plan design:

The High Deductible can be reduced by 50% to \$1,000 individual / \$2,000 family with the completion of the HAQ. The Low Deductible can be reduced by 50% to \$250 individual / \$500 family with the completion of the HAQ. The plan year maximum dental benefits payable for any individual covered under this plan is increased from \$1,500 to \$2,000 for services performed in-network if the HAQ is completed.

2. Eliminate out-of-network benefits

This change would eliminate any benefits paid by the plan, except under certain conditions, when services are received from an out-of-network provider. Conditions under which out-of-network services would be paid as in-network would not change (refer to exceptions under the “Current plan design” section below). This change would make the PEBP self-funded plan inconsistent with statutory requirements of fully insured preferred provider health plans. However, those statutory requirements do not apply to the PEBP plan. Consideration was given to requiring pre-certifications before out-of-network services could be covered, but the cost savings was significantly less and would have required an even greater reliance on cost shifts from the State subsidy to the participant. Typically, health maintenance organization (HMO) plans only provide out-of-area benefits for emergency services.

Current plan design:

Out-of-network (i.e. non-network) health care providers have no agreements with the plan and are generally free to set their own charges for the services or supplies they provide. The plan will reimburse the plan participant for the Usual and Customary Charge (as defined in the Master Plan Document) for medically necessary services or supplies, subject to the plan’s deductibles and co-insurance (on non-discounted services) or copayments, subject to the limitations and exclusion of the plan. The co-insurance benefit paid by the plan is generally 50% compared to in-network services with an 80% co-insurance benefit. Non-network health care providers may bill the

plan participant for any balance that may be due in addition to the amount payable by the plan, also called balance billing.

Out-of-network providers may be paid as in-network providers under the following circumstances:

- In the event of a life-threatening emergency in which a participant uses an out-of-network provider, benefits will be paid at the in-network benefit level.
- For services or supplies by non-PPO¹ providers when such services or supplies are not available from PPO providers within 50 miles of the participant's residence, even if the services are provided for wellness, weight loss, or second opinion. (This exception only applies to those individuals who are covered under an eligible PPO network.)
- If a participant travels to an area serviced by the participant's elected PPO network, the participant must use an in-network provider in order to receive benefits at the in-network benefit level.
- If a participant travels to an area not serviced by the plan's PPO network, benefits for an out-of-network provider will be paid at the in-network level.
- If a participant travels to an area and cannot access a PPO provider, and is experiencing an urgent, but not life-threatening, situation, and uses an out-of-network urgent care facility, benefits may be paid as in-network.
- If there is a specialty that is not available inside the participant's eligible PPO network, benefits may be paid as in-network.

3. Index annual out-of-pocket maximum by 50% of medical trend effective July 1, 2010

This item is an example of a long-term policy decision for the Board. The annual out-of-pocket maximum has not been adjusted since 2003. As a result, now in cases where this limit is reached, the plan is subject to a higher percentage of overall costs than it would have been in the past. The option presented would be to use an annual index equivalent to half of the medical inflation projected by the plan's actuary. The rationale for using half of the medical inflation is recognition that this benefit has typically been a cornerstone for the plan's policy of protecting participants against financial hardship when catastrophic health conditions occur. For developing the cost impact, a 4.5% index factor was used (given that medical inflation is projected to run about 9% per year). Staff would not consider this change to be inconsistent with the Board's policy of protecting participants against catastrophic situations due to the relatively modest annual adjustment that would occur in this era of considering a claim to be "large" when billed charges exceed \$100,000.

In this bundled approach, with out-of-network benefits eliminated, there would also no longer be an out-of-network limit. The implementation approach would be to

¹ PPO refers to Preferred Provider Organization

apply the increase beginning July 2010. This date was selected because of the severity of other benefit changes during the first year of the biennium.

Current plan design:

Each plan year, after an individual or family has incurred a maximum out-of-pocket cost for co-insurance, no further co-insurance will apply to covered eligible medical expenses. As a result, the plan will pay 100% of all covered eligible medical expenses, except for specified out-of-pocket expenses that are incurred during the remainder of the plan year, after the out-of-pocket maximum has been reached. The out-of-pocket maximums are as follows:

In-Network:	Out-of-Network:
\$3,500/individual	\$10,000/individual
\$7,000/family	\$20,000/family

The family out-of-pocket expense is a combination of out-of-pocket expenses met by each covered family member. The family out-of-pocket maximum cannot be met by just one person.

4. Eliminate ADD/ADHD² psychotherapy and neurotherapy benefits.

Psychotherapy and neurotherapy benefits for ADD/ADHD were added to the self-funded plan effective July 1, 2008. While the removal of this benefit would be inconsistent with previous Board action, the extreme nature of the fiscal targets given to PEBP warrant a reconsideration of whether the benefit should be continued at this time.

Current plan design:

Outpatient behavioral health (including ADD/ADHD psychotherapy and neurotherapy) services subject to pre-certification after the 20th visit.

5. Increase premium cost shift \$4.1 million over two years to meet overall subsidy target

Plan changes described in items 1-4 above achieve approximately \$23.5 million in subsidy savings over two years. As a result, a significant increase in the amount of contribution/premium cost shift would be necessary to reach the total subsidy savings target of \$55 million. As a result, a shift in costs from the subsidy to the participant would make up approximately 57% (\$31.7 million) of the targeted reductions, rather than the 50% (\$27.5 million) originally intended by the Board. The Board's approach

² ADD/ADHD refers to Attention Deficit Disorder / Attention Deficit and Hyperactivity Disorder

approved in September would be applied to calculate the impact on the percentage of costs subsidized to generate this additional cost shift.

Approach #2

The priority in creating Approach #2 was to make one major change along with a few smaller ones. This option retains the two plan model under the self-funded plan but at higher deductible levels. The most significant change in this option is to increase the deductible levels. One modification is made to the high deductible structure for primary physician office visits to be changed to a \$20 copayment. As with Approach #1, the HAQ and its incentives are discontinued.

1. Remove the HAQ and the associated incentives, increase deductible levels and modify the high deductible design

- a. Change high deductible to \$2,900 individual / \$5,800 family.
- b. Change low deductible to \$725 individual / \$1,450 family
- c. For the high deductible option, change primary care physician visits to the same co-payment as in the low deductible option (currently \$20)³

Current plan design:

The high deductible is currently \$2,000 individual/\$4,000 family. The high deductible can be reduced by 50% to \$1000 individual/ \$2000 family with the completion of the HAQ.

The low deductible is currently \$500 individual/\$1,000 family. The low deductible can be reduced by 50% to \$250 individual/ \$500 family with the completion of the HAQ.

The plan year maximum dental benefits payable for any individual covered under this plan is increased from \$1,500 to \$2,000 for services performed in-network if the HAQ is completed.

2. Index annual out-of-pocket maximum by 50% of trend effective July 1, 2010

This item is an example of a long-term policy decision for the Board. The annual out-of-pocket maximum has not been adjusted since 2003. As a result, now in cases where this limit is reached, the plan is subject to a higher percentage of overall costs than it would have been in the past. The option presented would be to use an annual index equivalent to half of the medical inflation projected by the plan's actuary. The rationale for using half of the medical inflation is recognition that this benefit has typically been a cornerstone for the plan's policy of protecting participants against financial hardship when catastrophic health conditions occur. For developing the cost impact, a 4.5% index factor was used (given that medical inflation is projected to run about 10% per year). Staff would not consider this change to be inconsistent with the Board's policy of protecting participants against catastrophic situations due to the

³ "Primary Care Physician (PCP)" means a physician in family practice, internal medicine, obstetrics and gynecology and pediatrics. Currently in the high deductible plan, those services are subject to the annual deductible and then are paid at 80% for in-network services.

relatively modest annual adjustment that would occur in this era of considering a claim to be “large” is when billed charges exceed \$100,000.

In this bundled approach, with out-of-network benefits continued, there would continue to be an out-of-network limit. The proposal would be for the out-of-network maximum to be indexed annually at the same rate as the in-network maximum. The implementation approach would be to apply the increase beginning July 2010. This date was selected because of the severity of other benefit changes during the first year of the biennium.

Current plan design:

Each plan year, after an individual or family has incurred a maximum out-of-pocket cost for co-insurance, no further co-insurance will apply to covered eligible medical expenses. As a result, the plan will pay 100% of all covered eligible medical expenses, except for specified out-of-pocket expenses that are incurred during the remainder of the plan year, after the out-of-pocket maximum has been reached. The out-of-pocket maximums are as follows:

In-Network:	Out-of-Network:
\$3,500/individual	\$10,000/individual
\$7,000/family	\$20,000/family

The family out-of-pocket expense is a combination of out-of-pocket expenses met by each covered family member. The family out-of-pocket maximum cannot be met by just one person.

3. Adopt policy to index deductibles and all co-payments at medical trend effective July 1, 2010

This item is an example of a long-term policy decision for the Board. The annual deductible levels have not been modified since Plan Year 2006. The co-payment levels have not been modified since Plan Year 2003. For projecting the impact of this proposal, an annual medical trend of 9% was used. Staff would intend to round annual deductible calculations up to the nearest \$25 and co-payments to the nearest \$5 when adjustments are made (on a cumulative basis for the index factor). All medical, dental and prescription deductibles and co-payments would be indexed. The implementation approach would be to apply the increase beginning July 2010. This date was selected because of the severity of other benefit changes during the first year of the biennium.

Current plan design:

Annual deductibles and co-payments are reviewed as part of the plan rate development process each year. The current deductible options are describe above in item 1 and co-payment levels for the most common services are listed in Attachment A for the low deductible plan. Generally, there are no co-payments under the high deductible plan as most services are paid at a co-insurance level after the annual deductible has been met.

4. Eliminate ADD/ADHD psychotherapy and neurotherapy benefits

Psychotherapy and neurotherapy benefits for ADD/ADHD were added to the self-funded plan effective July 1, 2008. While the removal of this benefit would be inconsistent with previous Board action, the extreme nature of the fiscal targets given to PEBP warrant a reconsideration of whether the benefit should be continued at this time.

Current plan design:

Outpatient behavioral health (including ADD/ADHD psychotherapy and neurotherapy) services subject to pre-certification after the 20th visit.

Approach #3

The priority in developing Approach #3 was to keep the plan changes to a very limited number and to leave all other benefits alone. There are no long term cost mitigation policies included in this approach.

1. Implement single deductible option for the self-funded plan

Currently, 90% of self-funded plan participants enroll in the low deductible option and the remaining 10% enroll in the high deductible option. Under this approach, there would no longer be a deductible option and the deductible level necessary to meet the budget target would be \$925 individual / \$1,850 family. Plan benefits would be structured the same as the current low deductible plan (e.g. co-payments, co-insurance, in-network, vs. out-of-network). There would be no HAQ or associated incentives. No other plan changes are included in this approach.

Current plan design:

The high deductible is currently \$2,000 individual/\$4,000 family. The High Deductible can be reduced by 50% to \$1,000 individual/ \$2,000 family with the completion of the HAQ.

The low deductible is currently \$500 individual/\$1,000 family. The low deductible can be reduced by 50% to \$250 individual/ \$500 family with the completion of the HAQ.

The plan year maximum dental benefits payable for any individual covered under this plan is increased from \$1,500 to \$2,000 for services performed in-network if the HAQ is completed.

Recommendation

It is difficult to suggest that any one of these approaches should be “recommended”. However, given the subsidy target from the Budget Office, staff has a responsibility to the Board in this regard. In that context, Approach #2 would be the “recommended” option for implementation if additional funding is not available. There are two primary reasons for this “recommendation”:

- Some semblance of choice is retained regarding the self-funded deductible levels. The PEBP participants cannot be generalized in terms of their financial ability to address increases in the deductible against adjustments to their contributions/premiums.
- Long term policies would be implemented to index the annual deductible, the annual out-of-pocket maximum, and co-payments. Staff considers this a critical component of the plan’s ability to address expected future cost pressures.

Benefit	Calendar 1998 Core Plan	Fiscal 2009 Low Deductible ⁴
	Participant Share	
Medical Deductible - Individual	\$250	\$250
Medical Deductible – Family	\$500	\$500
Out-of-Pocket maximum / year	\$1,500/person	\$3,500 / person \$7,000 / family
Lifetime maximum	\$2,000,000 / person	\$2,000,000 / person
Physician – primary	\$10 copayment	\$20 copayment
Physician – Specialist	20% after deductible	\$30 copayment
Urgent Care	20% after deductible	\$45 copayment
Emergency Room	20% after deductible	\$70 copayment and 20% co-insurance
Ambulance	20% after deductible	20% after deductible
Outpatient Lab & X-ray	20% after deductible	20% after deductible
Outpatient Hospital Services	20% after deductible	20% after deductible
Inpatient Hospital Deductible	\$-0-	\$105 / admission
Inpatient Hospital Co-insurance	10%	20%
Prescription Deductible - Retail	\$25	\$50 (Preferred Brand only)
Prescription Deductible – Mail Order	\$-0-	
Prescription – Retail	30% co-insurance after deductible	\$5 generic \$40 Preferred Brand 100% Non-Preferred Brand
Prescription – Mail Order	\$15 copayment for brand \$5 copayment for generic	\$10 generic \$70 Preferred Brand 100% Non-Preferred Brand
Dental Deductible	\$100 lifetime Basic & Major	\$50 / person annually
Dental – Preventative	0%	0%
Dental – Basic	20%	20%

⁴ Assumes completion of the Health Assessment Questionnaire

Benefit	Calendar 1998 Core Plan	Fiscal 2009 Low Deductible ⁴
	Participant Share	
Dental – Major	50%	50%
Dental Annual Maximum	\$1,500	\$1,500
Vision Deductible – Services	\$10	\$-0-
Vision Deductible – Material	\$25	\$-0-
Eye Exams	\$10	20% of U & C
Vision material	\$25	\$125 / 24 months
Life insurance	\$40,000 active \$20,000 retirees	\$20,000 active \$10,000 retirees

Self-funded Plan Changes Considered	Subsidy Savings (millions)
1. Remove HAQ and associated incentives	\$11.7
a. High deductible stays at \$2,000/\$4,000	
b. Low deductible stays at \$500/\$1,000	
2. Remove HAQ and modify deductible design	\$6.6
a. Change high deductible to \$1,750/\$3,500	
b. Change low deductible to \$400/\$800	
c. Change primary physician visits to \$20 copayment in high deductible plan (replaces the deductible)	
3. Remove HAQ, modify deductible design, and	\$8.1
a. Change high deductible to \$1,750/\$3,500	
b. Change low deductible to \$400/\$800	
c. Change primary physician visits to \$20 copayment in high deductible plan (replaces the deductible)	
d. Adopt policy to index deductibles and all co-payments at trend effective 7/1/10	
4. Eliminate out-of-network benefits (50 mile rule not changed)	\$4.3
5. Reduce out-of-network benefits by 50% if not pre-authorized and	
a. 0% with pre-authorization	\$2.8
b. 25% with pre-authorization	\$2.3
c. 50% with pre-authorization	\$2.3
d. 75% with pre-authorization	\$0.9
6. Index annual out-of-pocket maximum by 50% of trend effective 7/1/10	\$0.4
7. Implement single deductible level at \$925/\$1,850; plan benefits structured same as current low deductible plan	\$21.9
8. Eliminate ADD/ADHD psychotherapy and neurotherapy benefits	\$1.1
9. Change Rx mail order co-payment to straight 3 months for 2 co-payments	\$0.3
10. Establish annual maximum dollar benefit for physical therapy services	\$0.3

* Savings may be reduced when certain options are combined.

Health Plan of Nevada	<i>Current Plan Benefits</i>	Alternative Option	Alternative Option
	State of Nevada HPN 15	HPN HMO C15	HPN HMO D20
Medical Services			
Non Specialist Office Visit	\$15 per visit	\$15 per visit	\$20 per visit
Specialist Office Visit	\$15 per visit	\$30 per visit	\$40 per visit
Hospital Services			
In-Patient	\$200 per admission	\$300 per admission	\$400 per admission
Out-Patient	\$50 per admission	\$50 per admission	\$50 per admission
Physician Surgical Services			
In-Patient	No Charge	\$50 per surgery	\$100 per surgery
Out-Patient	No Charge	\$25 per surgery	\$50 per surgery
Physicians Office	No Charge	\$15 per visit	\$20 per visit
Anesthesia	No Charge	\$100 per surgery	\$150 per surgery
Emergency Services within the Service Area			
Physician Services	\$25 per visit	\$25 per visit	\$50 per visit
Emergency Room	\$50 per visit	\$50 per visit; waived if admitted	\$50 per visit; waived if admitted
Ambulance	No Charge	\$50 per trip	\$50 per trip
Urgent Care Facility	\$15 per visit	\$20 per visit	\$25 per visit
Emergency Services outside the Service Area			
Physician Services	\$25 per visit	\$50 per visit	\$75 per visit
Emergency Room	\$50 per visit	\$75 per visit; waived if admitted	\$75 per visit; waived if admitted
Ambulance	No Charge	\$50 per trip	\$50 per trip
Urgent Care Facility	\$15 per visit	\$40 per visit	\$40 per visit
Diagnostic			
Routine Lab	No charge	\$15 per visit	\$20 per visit
Routine X-Ray	No charge	\$15 per visit	\$20 per visit
Prescription Drug	\$7/\$30/\$50	\$7/\$30/\$50	\$7/\$30/\$50

State of Nevada
Hometown Health HMO
Rate Hold Analysis Summary Worksheet

Benefit Category	Benefit Limits & Comments	Auth	Current Plan HMO 15-200 A	Alternative Plan 2009 Standard EOC HMO 20-400 D
Medical Benefits -				
Out-of-Pocket Co-Pay Maximum -				
Single			\$3,500	\$6,500
Family			\$7,000	\$13,000
Physician Office Visits –				
Primary care			\$15 co-pay / visit	\$20 co-pay / visit
Primary care - wellness visit			\$15 co-pay / visit	\$20 co-pay / visit
Obstetrics and gynecology			\$15 co-pay / visit	\$20 co-pay / visit
Specialty care			\$15 co-pay / visit	\$40 co-pay / visit
Hospital Inpatient Services –				
Acute care hospital		x	\$200 co-pay / admit	\$400 co-pay / day*
Outpatient observation		x	\$200 co-pay / admit	\$400 co-pay / day*
Skilled nursing facility	30 days per calendar year	x	\$200 co-pay / admit	\$400 co-pay / day*
Rehabilitation facility	30 days per calendar year	x	\$200 co-pay / admit	\$400 co-pay / day*
Urgent Care & Emergency Services				
Urgent Care Center Services			\$15 co-pay / visit	\$40 co-pay / visit
Emergency Room Services			\$75 co-pay / visit	\$100 co-pay / visit
Ambulance (ground)			\$100 co-pay / trip	\$100 co-pay / trip
Ambulance (air and water)			\$100 co-pay / trip	\$200 co-pay / trip
Imaging & Diagnostic Testing –				
Computer Tomography (CT) scan			\$50 co-pay / procedure	\$100 co-pay / procedure

State of Nevada
 Hometown Health HMO
 Rate Hold Analysis Summary Worksheet

Benefit Category	Benefit Limits & Comments	Auth	Current Plan	Alternative Plan
			HMO 15-200 A	2009 Standard EOC HMO 20-400 D
Positron Emission Tomography (PET) scan			\$75 co-pay / procedure	\$100 co-pay / procedure
Magnetic Resonance Imaging (MRI)			\$75 co-pay / procedure	\$100 co-pay / procedure
All other imaging services			\$0 co-pay / procedure	\$0 co-pay / procedure
Laboratory Services –				
General laboratory services			\$0 co-pay / visit	\$0 co-pay / visit
Preventative Screenings –				
Mammography screening			\$0 co-pay / visit	\$0 co-pay / visit
Prostate Specific Antigen (PSA) screen			\$0 co-pay / visit	\$20 co-pay / visit
Papanicolaou (PAP) test			\$0 co-pay / visit	\$20 co-pay / visit
Colorectal screening			\$0 co-pay / visit	\$20 co-pay / visit
Outpatient Therapy and Rehabilitation Services –				
Speech therapy	20 visits per calendar year	x	\$15 co-pay / visit	\$20 co-pay / visit
Occupational therapy	20 visits per calendar year	x	\$15 co-pay / visit	\$20 co-pay / visit
Physical therapy	20 visits per calendar year	x	\$15 co-pay / visit	\$20 co-pay / visit
Wound therapy			\$15 co-pay / visit	\$20 co-pay / visit
Cardiac and pulmonary rehabilitation	40 visits per calendar year		\$15 co-pay / visit	\$20 co-pay / visit
Chemotherapy - Specialist			\$15 co-pay / visit	\$40 co-pay / visit
Infusion therapy - Specialist			\$15 co-pay / visit	\$40 co-pay / visit
Radiation therapy - Specialist			\$15 co-pay / visit	\$40 co-pay / visit
Surgical Services –				

**State of Nevada
 Hometown Health HMO
 Rate Hold Analysis Summary Worksheet**

Benefit Category	Benefit Limits & Comments	Auth	Current Plan HMO 15-200 A	Alternative Plan 2009 Standard EOC HMO 20-400 D
Performed in primary care physician's office			\$15 co-pay / visit	\$40 co-pay / visit
Performed in specialty care physician's office			\$15 co-pay / visit	\$40 co-pay / visit
Performed in outpatient facility	Co-pay applies toward professional and facility charges	x	\$100 co-pay / visit	\$400 co-pay / visit
Performed in same day surgery facility	Co-pay applies toward professional and facility charges	x	\$100 co-pay / visit	\$400 co-pay / visit
Medical Supplies –				
Durable medical equipment (purchase and rental)	\$3,500 maximum calendar year benefit	x	\$0 co-pay / visit	\$0 co-pay / visit
Orthopedic and prosthetic devices		x	\$0 co-pay / item	\$25 co-pay / item
Ostomy care supplies (30 day supply = 1 order)	\$3,600 maximum calendar year benefit		\$0 co-pay / visit	\$0 co-pay / visit
Special food products (30 day supply = 1 order)	\$2,500 maximum calendar year benefit		\$0 co-pay / visit	\$0 co-pay / visit
Alcohol and Substance Abuse Treatment –				
Inpatient treatment	\$9,000 maximum calendar year benefit	x	\$200 co-pay / admit	\$400 co-pay / day*
Outpatient treatment - Specialist	\$2,500 maximum calendar year benefit	x	\$50 co-pay / visit	\$40 co-pay / visit

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Benefit Category	Benefit Limits & Comments	Auth	Current Plan HMO 15-200 A	Alternative Plan 2009 Standard EOC HMO 20-400 D
Withdrawal treatment - inpatient	\$1,500 maximum calendar year benefit (inpatient and outpatient combined)	x	\$200 co-pay / admit	\$400 co-pay / day*
Withdrawal treatment - outpatient	\$1,500 maximum calendar year benefit (inpatient and outpatient combined)	x	\$50 co-pay / visit	\$40 co-pay / visit
Medical Pharmacy –				
Special pharmaceuticals	A separate calendar year out-of-pocket maximum applies: \$2,000 individual, \$6,000 family		\$75 co-pay / item	\$75 co-pay / item
All other medical pharmacy			\$15 co-pay / item	\$40 co-pay / item
Mental Health –				
Inpatient services for severe mental illnesses	40 days maximum calendar year benefit		\$200 co-pay / admit	\$400 co-pay / day*
Partial hospitalization for severe mental illnesses	each day counts a 1/2 day toward the 40 day maximum benefit for severe mental illnesses			
Outpatient visit - general mental health	10 visits maximum calendar year benefit		\$15 co-pay / visit	\$40 co-pay / visit

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Benefit Category	Benefit Limits & Comments	Auth	Current Plan HMO 15-200 A	Alternative Plan 2009 Standard EOC HMO 20-400 D
Outpatient visit - severe mental illnesses	40 visits maximum calendar year benefit		\$15 co-pay / visit	\$40 co-pay / visit
Other Medical Services –				
Alternative Medicine	\$1,000 maximum calendar year benefit		\$15 co-pay / visit	\$40 co-pay / visit
Spinal manipulation	\$1,000 maximum calendar year benefit		\$15 co-pay / visit	\$40 co-pay / visit
Home health care	\$5,000 maximum calendar year benefit		\$15 co-pay / visit	\$20 co-pay / visit
Hospice care	185 days		\$0 co-pay / visit	\$0 co-pay / visit
Kidney dialysis service	\$60,000 maximum calendar year benefit		\$15 co-pay / visit	\$50 co-pay / visit
Genetic counseling and testing	\$2,500 maximum lifetime benefit	x	\$50 co-pay / visit	\$50 co-pay / visit
Temporomandibular Joint Disorder (TMJ)	\$2,500 maximum lifetime benefit		50% co-insurance	50% co-insurance
Vision –				
Vision Exam	1 visit maximum 12 month benefit		\$15 co-pay / visit	\$15 co-pay / visit
Prescription Drugs –			RX \$7/\$30/\$50	RX \$10/\$30/>(\$60,40%)
Formulary Drugs				
Generic drugs			\$7 co-pay per script	\$10 co-pay per script
Brand name drugs			\$30 co-pay per script	\$30 co-pay per script

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Benefit Category	Benefit Limits & Comments	Auth	Current Plan HMO 15-200 A	Alternative Plan 2009 Standard EOC HMO 20-400 D
Brand name drugs with generic alternatives			\$30 co-pay per script, plus ancillary charge	\$30 co-pay per script, plus ancillary charge
Non-Formulary Drugs				
Non-formulary drugs			\$50 co-pay per script	greater of \$60 co-pay per script or 40% co-insurance
Mail Order (90 day supply)				
Generic drugs			\$14 co-pay per script	\$20 co-pay per script
Brand name drugs			\$60 co-pay per script	\$60 co-pay per script
Non-formulary drugs			\$150 co-pay per script	greater of \$180 co-pay per script or 40% co-insurance
Other Pharmacy Benefits				
Special pharmaceuticals			20% co-insurance	20% co-insurance
Generic diabetic supplies (classified as a pharmacy benefit)			\$7 co-pay per script	\$10 co-pay per script
Brand diabetic supplies (classified as a pharmacy benefit)			\$30 co-pay per script	\$30 co-pay per script

* Per day co-payments are applied up to a maximum of 5 days