9. Discussion and possible action including approval of the Draft Overview of the Scope of Work and Scoring Criteria for Request for Proposals. (Damon Haycock, Executive Officer; Kirby Bosley, Aon Hewitt) *(For Possible Action)*

9.1. Health Maintenance Organization (HMO) services; and/or

9.2. Exclusive Provider Organization (EPO) services.
HMO/EPO Discussion

June 17, 2016
Executive Summary

PEBP was tasked by the Board to provide a Scope of Work and Evaluation Criteria for a Health Maintenance Organization (HMO) Request for Proposal (RFP) as well as develop what an Exclusive Provider Organization (EPO) plan may look like.

PEBP is recommending a single HMO RFP that prioritizes statewide services, singular plan benefit design, open access, out-of-area access, and lowest cost/highest value proposals through dedicated evaluation criteria and “bonus points” for PEBP’s priorities.

By developing the RFP this way, and not mandating specific PEBP priorities that prevent bidders from participating, this HMO RFP will allow for all 6 HMO vendors in Nevada the ability to bid and be evaluated equally and fairly on an apples-to-apples comparison.

PEBP is also recommending more time to fully analyze and vet a Self-Insured EPO plan as a possible alternative to HMO offerings in the future if costs become unsustainable.
An HMO gives access to certain doctors and hospitals within its network. But unlike other insurance plan types, there is no out of network care (except for urgent care and emergencies or when care is not available in the network).

Key features include:

- Some plans may require the member to select a primary care physician (PCP), who determines what treatment is needed. This is the classic HMO model.
- With capitated HMOs, a PCP referral is required for specialist treatment to be covered. Capitations are prepayments to PCPs, and provide incentives for the PCP to efficiently manage patient care.
- If a member opts to see a doctor outside of an HMO network for non-urgent/non-emergent services, there is no coverage, meaning the member will pay the entire cost of medical services.
- Generally (outside of PEBP), premiums are lower for HMO plans, particularly capitated plans, and benefits are based on copayments rather than deductibles and coinsurance.
Definition – Preferred Provider Organization (PPO)

PPO plans provide more flexibility when picking a doctor or hospital. They also feature a network of providers at discounted rates, but unlike HMOs, there is coverage (at a lower reimbursement rate) for non-network providers.

Key features include:

• Members can see a doctor or specialist without needing a PCP referral.
• Members can obtain medical services outside the network, and still be covered. However, benefits will be less expensive if using network providers.
• Premiums tend to be higher than classic, capitated HMO plans, and benefits typically have a deductible and coinsurance reimbursement after the deductible is met. However, in PEBP today, the premiums for our Consumer Driven Health Plan (PPO) are lower than the HMOs.
Definition – Exclusive Provider Organization (EPO)

Similar to an HMO, with an EPO the member **must** use network providers - doctors, hospitals and other health care providers - that participate in the plan. The only exception is for urgent and emergency care or for services not available in the network. Unlike an HMO, members may not need to select a Primary Care Physician, nor do they need a PCP referral to access specialists.

Key features include:

- EPOs are often self-funded and utilized by large employers.
- EPOs are non-capitated: therefore, providers have no financial incentive to manage care with overall less costs to the health plan.
- EPO plan design is similar to HMO plan design (copayments).
- EPO networks are narrower than PPO networks, and may include more benefit cost containment features.
# Side-By-Side Comparison: HMO vs. EPO

<table>
<thead>
<tr>
<th>Activity</th>
<th>Traditional HMO</th>
<th>Traditional EPO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Select a Primary Care Provider</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Require Referral to See a Specialist</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Out-of-Network Providers</td>
<td>Only Urgent / Emergency Services</td>
<td>Only Urgent / Emergency Services</td>
</tr>
<tr>
<td>Deductibles</td>
<td>No</td>
<td>Maybe (if so, low &lt;$1250)</td>
</tr>
<tr>
<td>Copays</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Capitation*</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Fully-Insured</td>
<td>Yes</td>
<td>Typically self-insured</td>
</tr>
</tbody>
</table>

**Capitation***
Insurer pays a physician or group of physicians a set amount for each enrolled person whether or not that person seeks care. Physicians or physician groups have an incentive to use services efficiently.
Current Decisions Facing the PEBP Board

- Regional Plans vs. Statewide Plan
- Access to Specialists / Out-of-State Services
- Singular Statewide Plan Design
- Fully Insured HMO(s)
- Promote Cost Controls (e.g. Capitation)
- Retain vs. Lose Sierra Healthcare Options Network

- Degree of Disruption: Changes in Network
- Rate Increases & Subsidy Levels
- Self-Insured EPO(s)
- Blended vs. Regional Rates

Access to Specialists / Out-of-State Services
Singular Statewide Plan Design
Degree of Disruption: Changes in Network
Promote Cost Controls (e.g. Capitation)
Rate Increases & Subsidy Levels
Self-Insured EPO(s)
Blended vs. Regional Rates
Retain vs. Lose Sierra Healthcare Options Network
HMO Considerations

Regional
Current Vendors
Current Design
Capitated

Statewide
New Vendors
Hybrid Design
Non-Capitated

Disruption
Nevada’s Large Group HMO Market

In Nevada, there are currently 6 Insurance Carriers licensed to provide HMO services to large group employers (Anthem, Aetna, Hometown Health, Health Plan of Nevada, Humana, and Prominence).

Market Analysis*:

- 2 of the 6 (33%) carriers are licensed to offer statewide HMO services (a 3rd is willing to expand their certificate of authority statewide)
- 2 of the 6 (33%) carriers contract with all hospitals in northern Nevada
- 1 of the 6 (16.67%) carriers contract with all hospitals in southern Nevada
- 0 of 6 (0%) carriers offer it all: statewide HMO services; all service areas in Nevada; and contract with all hospitals in northern and southern Nevada

There is no “one carrier fits all” for access across the state.

*Analysis performed by AON Consulting
PEBP, in coordination with Purchasing, will develop **one** RFP to ensure HMO services are provided to PEBP’s participants across the entire state. This can occur either through multiple regional offerings or one statewide proposal.

• The start date for this contract(s) will be upon Board of Examiners (BOE) approval (anticipated Jan-Feb 2017) and services will begin on July 1, 2017 (Plan Year 2018).

• PEBP is looking for cost saving measures to reduce rate increases.

• This procurement will follow all rules and regulations outlined in NRS 333 and NAC 333.

• An evaluation committee will be appointed by PEBP and Purchasing to include a minimum of 2 PEBP Board Members, a maximum of 3 PEBP staff, and 1 outside expert from another State agency. Additionally, AON (PEBP’s actuary consultant) will provide financial and disruption analysis.
• PEBP requires, at a minimum, HMO participants to have access to a comprehensive choice of providers within the covered service area as well as outside of Nevada for emergency and specialized care.

• The plan(s) should include a full complement of reputable, qualified professionals, a variety of specialists and include centers of excellence.

• All plans shall include, but not be limited to, the following services and plan provisions:
  • Customer Service
  • Utilization review
  • Concurrent review
  • Disease management
  • Large case management
  • Wellness and preventive services benefits
  • Vision benefits
  • Mandated health benefits

• Dental benefits are offered through PEBP’s self-funded PPO dental plan and will not be included in this RFP.
• The Affordable Care Act (ACA) currently has provisions that charge health plans a 40% tax on all plan costs (premiums) that exceed a specific threshold beginning in 2020 regardless of who pays/subsidizes the total premium. The state is looking for creative ways to reduce overall plan costs to ensure participants are not liable for the 40% tax. Information on the Excise Tax can be found at: http://www.irs.gov/pub/irs-drop/n-15-16.pdf.

• PEBP will prioritize plan benefit design, cost, access, and statewide services (see evaluation criteria later in the slides) through additional weighting and other scoring criteria.
Per NRS 333.335: In making an award, the chief of the using agency, the Administrator of the Purchasing Division or each member of the committee, if a committee is established, shall consider and assign a score for each of the following factors for determining whether the proposal is in the best interests of the State of Nevada:

(a) The experience and financial stability of the person submitting the proposal;
(b) Whether the proposal complies with the requirements of the request for proposals as prescribed in NRS 333.311;
(c) The price of the proposal; and
(d) Any other factor disclosed in the request for proposals.

The chief of the using agency, the Administrator of the Purchasing Division or the committee, if a committee is established, shall determine the relative weight of each factor set forth in subsection 3 before a request for proposals is advertised. The weight of each factor must not be disclosed before the date proposals are required to be submitted.
A defined preferred HMO plan benefit design will be utilized to ensure an apples-to-apples comparison. Vendors have the right to take exception to any part of the RFP and creative solutions will be accepted.

Other Evaluation Criteria to be Disclosed in the RFP:

1. Additional weighting/scoring for meeting or exceeding the PEBP preferred Plan Benefit Design;
2. Additional weighting/scoring for Statewide versus Regional Proposals;
3. Additional weighting/scoring for Open Access versus Closed Access Proposals;
4. Additional weighting/scoring for Access to out-of-area HMO Services; and
5. Additional weighting/scoring for the Best Overall Value*

*PEBP recognizes the inverse relationship between additional access and lower costs. State of Nevada employees, retirees, and their dependents are very price sensitive. All proposals should recognize PEBP’s fiduciary responsibility.
HMO RFP Development Timeline

**June**
- Board approves RFP Overview, Scope, and Evaluation Criteria
- Vendor Meetings
- Finalize HMO RFP Development with Purchasing

**July**
- Release Participant Survey
- Release HMO RFP

**September**
- Proposals Received

**October**
- Evaluation Committee Meets and Selects a Winning Vendor(s)

**November-December**
- Division of Insurance Review
- Contract Negotiations
- Board Ratification of Vendor Contract(s)

**January-February**
- BOE Approval
- Implementation Kick Off

**March**
- PEBP Development and PEBP Board Approval of Rates

**April - July**
- Communications to Participants
- Open Enrollment
- Plan Year Start
# High Level Plan Design

<table>
<thead>
<tr>
<th>Plan Feature</th>
<th>HPN PY 2017</th>
<th>HTH PY 2017</th>
<th>PEBP Preferred Plan Benefit Design</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP Visit</td>
<td>$15</td>
<td>$25</td>
<td>$25</td>
</tr>
<tr>
<td>Specialist Visit</td>
<td>$25</td>
<td>$45</td>
<td>$45</td>
</tr>
<tr>
<td>Emergency Room Visit</td>
<td>$150</td>
<td>$300</td>
<td>$300</td>
</tr>
<tr>
<td>Hospital In-Patient Services</td>
<td>$300/admit</td>
<td>$500/admit</td>
<td>$500/admit</td>
</tr>
<tr>
<td>Retail Pharmacy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preferred Generic</td>
<td>$7</td>
<td>$7</td>
<td>$7</td>
</tr>
<tr>
<td>Preferred Brand</td>
<td>$35</td>
<td>$40</td>
<td>$70</td>
</tr>
<tr>
<td>Non-Formulary Specialty</td>
<td>$55</td>
<td>$75</td>
<td>$75</td>
</tr>
<tr>
<td>Specialty</td>
<td>$55</td>
<td></td>
<td>$40%</td>
</tr>
<tr>
<td>Out-of-Pocket Limit</td>
<td>$6,000 individual $12,000 family</td>
<td>$6,600 individual $13,200 family</td>
<td>$7,150 individual $14,300 family</td>
</tr>
<tr>
<td>PCP Referral Requirement</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Actuarial Value</td>
<td>93%</td>
<td>87%</td>
<td>87%</td>
</tr>
</tbody>
</table>
Analyzing an EPO Plan

Considerations

Hybrid Design

Mid-Range Design

Cost Sharing

Account for Adverse Selection

Managed by Current Third Party Administrators

Disruption

Medical Network

Loss of Sierra Healthcare Options Network

CDHP Network Search
Conclusion

Recommendation:
PEBP staff recommend the Board approve the following:

1. HMO RFP Overview Concept
2. HMO RFP Scope of Work Concept
3. HMO RFP Evaluation Criteria Concepts
4. Continue to Analyze the EPO Option

PEBP needs flexibility to make technical adjustments to the HMO RFP based on vendor meetings held and additional analysis prior to its release.