

Committee on Health Benefit Plans
Report on the Basic and Standard Plans

Introduction

This report is developed based on the requirements of AB 521 (the Act) passed in 1997. Under the authority of the Commissioner of Insurance provided by Section 179 of the Act, the Committee on Health Benefit Plans (Committee) was convened on August 28, 1997. The Committee's responsibility is to design the Basic Health Plan and the Standard Health Plan for Nevada (Plans). The deadline to complete the recommendation for these plans must be 12/28/97 by statute.

Once approved by the Commissioner of Insurance, The Nevada Basic Health Plan and Standard Health Plan are to be used in three ways:

1. the guaranteed coverage individual carriers must offer to Eligible Persons as defined in Section 10 of the Act.
2. actively marketed to all small groups, and
3. the sole conversion policies offered by all carriers of group plans.

The following provides the Committee's recommendation to the Commissioner of Insurance and the Board of the Nevada reinsurance pools for approval and implementation.

Plan Design

It is noted by Committee members that the development of the Plans are principally to provide an alternate mechanism to fulfill the requirements of the Health Insurance Portability and Accountability Act (HIPAA) passed by the federal government. The federal statute and regulations strongly encourage the development of individual coverage that reflects the most popular plans being purchased by consumers in the current market. The Committee set this same parameter in their effort to design the Standard Health Benefit Plan.

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Design of the Basic Health Plan is based on Section 183 of the Act, an exemption from statutory required coverage of specific services or providers. Using this as a reference, the Committee introduces a Basic Health Care Plan with the intent to provide the lowest possible premium cost to the consumer. While not covering some health care services or providers, the Committee recognizes the value of offering the consumer choice of a low cost plan designed to cover catastrophic losses.

It is the determination of the Committee that these plans meet the requirements of the both the group and the individual market. Therefore, our recommendation is to require the same Basic Health Plan and Standard Health Plan of small group and individual carriers.

Type of Plans Required of Carrier

The Committee recognizes that the market is represented by three different plan types: indemnity only, preferred provider organization (PPO) and health maintenance organization (HMO). An insurance company and medical service plan authorized in the State of Nevada that offers indemnity insurance plans may invest in the development of a preferred provider organization (PPO). These PPO plans must meet the definition of a Restricted Network as found in Section 180 (6) of the Act.

The PPO plan design is an important cost containment feature used by many carriers in all their products. These carriers would be financially harmed by any requirement to offer plans that did not include the PPO benefit features. Conversely, some carriers have not developed PPO plan designs. Therefore, the Committee has determined the need to detail both an Indemnity and PPO version of the Basic and Standard Health Benefit Plans.

As indicated by Section 180 (4) of this Act, the Committee recognizes the need to encourage plans with the most cost control features available. In this regard, the Committee recommends that insurance companies and medical service plans be only required to offer the PPO Plan Basic and Standard Health Benefit Plans. Only those companies who have no PPO plans filed with the state Department of Insurance should be required to market the Indemnity Basic and Standard Health Benefit Plan.

An HMO is authorized under a different part of the insurance code. HMOs typically feature the provision for health care coverage through a defined set of providers. The usual HMO plan has no coverage for providers outside of the network unless an emergent or out-of-area urgent conditions is present. The recommended HMO Basic and Standard Health Benefit Plans adhere to this design while creating an equitable comparison with the indemnity and PPO designs.

The Committee acknowledges that there is a recent development by HMOs to offer point-of-service plans (POS) providing regular coverage of non-network providers. Because this coverage is new and not offered by the majority of licensed HMOs in this state, the Committee recommends against the requirement of a POS Basic and Standard Health Benefit Plan.

A PPO and HMO must use the same network of providers for the Plans that it uses for other policies issued in Nevada. If the carrier offers different provider networks for different

policyholders, a Basic and Standard Health Plan must be available to each network.

The Committee's recommended plan designs are found in Exhibits 1, Nevada Basic Health Benefit Plan, and Exhibit 2, Nevada Standard Health Benefit Plan, attached to this report.

Cost Containment Requirements

Even though Section 180 (4) of the Act provides for cost containment features, the Committee recognizes that carriers use a variety of cost containment and utilization management measures in their plans. In addition, the state actively regulates the use of many utilization measures as specifically found in AB 156 (1997). Therefore, the Committee chooses not to recommend specific cost containment features in the Standard and Basic Health Care Plans.

In the interest of the state to provide for the lowest possible cost of health care plans, the Committee recommends that each carrier be required to include in the Plans their most aggressive cost containment and utilization management efforts as used in any other plans filed with the Department of Insurance. We further recommend adequate disclosure of all cost containment provisions included in the Plans in all marketing materials associated with the Plans.

Exclusions and Limitations

In general, a carrier's exclusions and limitations can provide no more coverage and no less coverage than what is shown in Exhibit 3. The Committee finds that it is important for consumer understanding and industry regulation that this coverage be offered by each carrier without modification. This requirement serves to facilitate the State of Nevada Reinsurance Pool administration as well.

The Committee recommends that carriers be allowed to offer additional, optional benefits at their discretion so long as this offer does not alter the basic right to the core coverage.

The preexisting conditions limitation is an important feature in health plans. The Committee considered the common pre-existing conditions limitations included in many plans. However the Committee recommends any pre-existing conditions limitation that the carrier normally imposes on their coverage so long as their limitation meets the statutory requirements found in this Act and elsewhere.

Timely Implementation

The Committee has worked diligently to design these plans as quickly as possible. We have been aware of a number of individuals who qualify or will qualify as an Eligible Person for guaranteed coverage. The Committee will continue to offer assistance to the Commissioner in any way possible to expedite the implementation of the Basic and Standard Health Benefit Plans. We encourage the Division of Insurance to find ways to streamline the filing and approval process to facilitate the broadest number of carriers possible available by January 1, 1998.

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Exhibit 1

Nevada Basic Health Benefit Plan

Benefit	Basic Indemnity Plan	Basic PPO Plan		Basic HMO Plan
		Network	Non-Network 1	
1. Lifetime Maximum Benefits	\$1,000,000	\$1,000,000		\$1,000,000
2. Annual Deductible Individual Family	\$2,500 N/A	\$ 1,500 N/A	\$3,000 N/A	None None
3. Coinsurance	50% of the first \$10,000 of eligible expenses; 100% thereafter	70% of the first \$10,000 of eligible expenses; 100% thereafter	50% of the first \$10,000 of eligible expenses; 100% thereafter	None
4. Out-of-pocket Maximum Individual Family	\$7,500 N/A	\$4,500 ² N/A	\$8,000 N/A	\$4,000 \$8,000
5. Facility Services Acute Hospital Skilled Nursing /Rehabilitation/Hospice Outpatient and Ambulatory Surgical Facility	50%	70%	50%	\$300/day not to exceed \$900/admission \$300/admission \$200/admission

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6. Emergency Care Emergency facility Urgent care facility Ambulance	50%	70%	50%	\$100/visit \$ 50/visit \$150/trip
7. Physician Services Office visit Preventive Services maximum \$250/person/year (deductible does not apply) Surgery in a facility Other physician services	50%	\$20/visit \$20/visit 70% 70%	50%	\$25/visit \$10/visit \$200/procedure No Charge
8. Outpatient treatment Laboratory & X-ray services All Others	50%	70%	50%	\$10/visit \$25/visit
9. Prescription Drugs	50%	70%	50%	\$15/generic 30 day supply \$30/brand name 30 day supply

Exhibit 1: Nevada Basic Health Benefit Plan (cont.)

Benefit	Basic Indemnity Plan
Features	Basic PPO Plan
	Basic HMO Plan
10. Plan limitations	\$1000 per calendar year

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Durable Medical Equipment	30 days per calendar year
Skilled Nursing/Rehabilitation	30 visits per calendar year
Home Health Care	
Mental Health Services	Not covered
Outpatient	Not covered
Inpatient	
Substance Abuse Services	Not covered
Outpatient	Not covered
Inpatient	
Manual manipulation and subluxation of the spine	Not covered
Transplant	\$100,000/lifetime for non-experimental human-to-human procedures
Maternity	Not covered on Individual plan. Optional coverage must be provided on groups of 2 to 14 lives. Covered for groups of 15 to 50. (complications of pregnancy covered)
Physical, speech or occupational therapy	60 days/calendar year
TMJ (medical treatment only)	\$1,000/calendar year
11. Standard exclusions	See Exhibit 3

1 Non-network expenses accumulate separately from network expenses. 2 Out-of-pocket maximum includes the deductible and coinsurance payments made by the member. This does not include copayments paid (except on HMO plan) and ineligible expenses. 3 Emergency care can be limited to medically necessary care subject to Nevada statute and regulation. 4 Preventive services include annual physical exam, well childcare, related diagnostic testing and immunizations. Pap smears and mammography will not be subject to the calendar year maximum. 5 The PPO office visit copayment includes office visit expenses only. All other services billed during the visit will be applied to the deductible and coinsurance. 6 A prescription drug card may be offered in addition to the Basic Plan prescription benefits. 7 A \$15 generic/\$30 brand name drug card may be substituted by the carrier for deductible and coinsurance

Exhibit 2

Nevada Standard Health Benefit Plan

Benefit	Standard Indemnity	Standard PPO Plan	Standard HMO Plan

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Features	Plan	Network	Non-Network ¹	
1.Lifetime Maximum Benefits	\$1,000,000	\$1,000,000		None
2. Annual Deductible Individual Family	\$1,000 \$3,000	\$ 500 \$1,500	\$1,000 \$3,000	None None
3. Coinsurance	80% of the first \$10,000 of eligible expenses; 100% thereafter	80% of the first \$10,000 of eligible expenses; 100% thereafter	60% of the first \$10,000 of eligible expenses; 100% thereafter	None
4. Out-of-pocket Maximum ² Individual Family	 \$3,000 \$6,000	\$2,500 \$5,000	\$ 5,000 \$10,000	\$2,000 ² \$4,000
5. Facility Services Acute Hospital Skilled Nursing /Rehabilitation/Hospice Outpatient and Ambulatory Surgical Facility	80%	80%	60%	\$100/day not to exceed \$300/admission \$ 50/admission \$100/admission
6. Emergency Care ³ Emergency facility Urgent care facility Ambulance	80%	80%	60%	\$ 75/visit \$ 25/visit \$ 50/trip
7. Physician Services Office visit Preventive Services ⁴ maximum of \$500/person/year	80%	\$10/visit ⁵ \$10/visit	60%	\$10/visit \$10/visit

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(deductible does not apply) Surgery in a facility Other physician services		80% 80%		no charge no charge
8. Outpatient treatment Laboratory & X-ray services All Others	80%	80%	60%	\$10/visit \$10/visit
9. Prescription Drugs	80% ⁶	80% ⁷	60%	\$10/generic 30 day supply \$20/brand name 30 day supply

Exhibit 2: Nevada Standard Health Benefit Plan (cont.)

Benefit Features	Standard Indemnity Plan Standard PPO Plan Standard HMO Plan
10. Preventive Services	Services include an annual physical exam, reproductive exam, child health supervision, immunizations, and related diagnostic testing to a maximum benefit of \$500/calendar year.
11. Plan limitations Durable Medical Equipment Skilled Nursing/Rehabilitation Home Health Care Substance Abuse Services Treatment for withdrawal Treatment when admitted to a facility Mental	No limitation applies 100 days per calendar year 100 visits per calendar year \$2,500 counseling and \$1,500 detoxification per calendar year \$9,000/calendar year

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Health Services	
Outpatient	20 visits/calendar year
Inpatient	30 day inpatient/calendar year
Manual manipulation and subluxation of the spine	10 visits/calendar year
Transplant	\$100,000/lifetime for non-experimental human-to-human procedures
Maternity	Covered as any other illness
Physical, speech or occupational therapy	60 days/calendar year
TMJ (medical treatment only)	\$1,000/calendar year
12. Standard exclusions	See Exhibit 3

1 Non-network expenses accumulate separately from network expenses.
 2 Out-of-pocket maximum includes the deductible and coinsurance payments made by the individual or family. This does not include copayments paid (except on HMO plan) or ineligible expenses. This amount will not exceed 200% of premium for federally qualified HMO plans.
 3 Emergency care can be limited to medically necessary care subject to Nevada statute and regulation.
 4 Preventive services include annual physical exam, well child care, related diagnostic testing and immunizations. Pap smears and mammography will not be subject to the calendar year maximum
 5 The PPO office visit copayment includes office visit expense only. All other services billed with the office visit will be applied to the deductible and coinsurance.
 6 A prescription drug card may be offered in addition to the Standard Plan prescription benefits.
 7 A \$10 generic/\$20 brand name drug card may be substituted by the carrier for coinsurance.

Exhibit 3

Required Exclusions

Nevada Basic and Standard Health Benefit Plan

The following services are not covered.

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1. Services for which coverage is not specifically provided, complications resulting from non-Covered Services, or services which are not Medically Necessary, whether or not recommended or provided by a Provider.
2. Personal comfort, hygiene, or convenience items such as a Hospital television, telephone, or private room when not medically Necessary. Housekeeping or meal services as part of Home Health Care. Modifications to a place of residence, including equipment to accommodate physical handicaps or disabilities.
3. For a private room in excess of the average semi-private room and board rate.
4. Dental or orthodontic splints or dental prostheses, or any treatment on or to teeth, gums, or jaws and other services customarily provided by a dentist. Charges for dental services in connection with temporomandibular joint dysfunction are also not covered unless they are determined to be Medically Necessary. Such dental-related services are subject to the limitation shown in the Benefit Schedule.
5. Except for reconstructive surgery following a mastectomy, cosmetic procedures to improve appearance without restoring a physical bodily function.
6. Third-party physical exams for employment, licensing, insurance, school, camp, sports, or adoption purposes. Immunizations related to foreign travel. Expenses for medical reports, including presentation and preparation. Exams or treatment ordered by a court, or in connection with legal proceedings if not medically necessary or a covered service.
7. For fertility or infertility studies, diagnostic testing, advice, consultation, examination, medication, or for any treatment related to or connected in any way with the restoration or enhancement of fertility or conception by artificial means including Embryo transplants, in vitro fertilization, GIFT and ZIFT procedures and low tubal transfer.
8. For the treatment of sexual dysfunction or inadequacies, including, but not limited to, impotence and implantation of a penile prosthesis. Reversal of surgically performed sterilization or subsequentresterilization Charges for genetic testing, counseling, treatment or therapy.
9. Elective abortions.
10. Surgical or invasive treatment (including gastric balloon) or reversal for reduction of weight regardless of associated medical or psychological conditions, unless determined to be Medically Necessary. Any weight loss programs, whether or not recommended, provided or prescribed by a physician or other medical practitioner.
11. Treatment of chronic marital or family problems; occupational, religious, or other social maladjustments; chronic behavior disorders; codependency; impulse control disorders, organic disorders, learning disabilities or mental retardation.
12. Institutional care which is determined to be for the primary purpose of controlling Member's environment and Custodial Care, domiciliary care, convalescent care (other than Skilled Nursing Care) or rest cures.

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13. Vision exams to determine refractive errors of vision and eye glasses or contact. Coverage is provided for vision exams only when required to diagnose an Illness or Injury.
14. Hearing exams to determine the need for or the appropriate type of hearing aid or similar. Coverage is provided for hearing exams only when required to diagnose an Illness or Injury.
15. Ecological or environmental medicine. Use of chelation, orthomolecular substances; use of substances of animal, vegetable, chemical or mineral origin not specifically approved by the FDA as effective for treatment; electrodiagnosis; Hahnemannian dilution and succussion; magnetically energized geometric patterns; replacement of metal dental fillings; laetrile; gerovital.
16. Services for chronic, intractable pain by a pain control center or under a pain control program.
17. Acupuncture or hypnosis.
18. Treatment of an Illness or Injury resulting from riots, war, insurrection; rebellion; or armed invasion or aggression.
19. Treatment of an occupational Injury or Illness which is any Injury or Illness arising out of or in the course of employment for pay or profit.
20. Travel and accommodations, whether or not recommended or prescribed by a Provider
21. Vitamins, herbal medicines, appetite suppressants, and other over-the-counter drugs. Drugs and medicines approved by the FDA for experimental or investigational use.
22. Any services provided before the Effective Date or after the termination of coverage.
23. Care for conditions that federal, state or local law requires to be treated in a public facility for which a charge is not normally made.
24. Any equipment or supplies that condition the air, arch supports, support stockings, special shoe accessories or corrective shoes unless they are an integral part of a lower-body brace, heating pads, hot water bottles, wigs and their care and other primarily nonmedical equipment.
25. Special formulas, food supplements other than as specifically covered or special diets on an outpatient basis. (Except for the treatment of inherited metabolic disease)
26. Services, supplies or accommodations provided without cost to the Member or which the Member is not legally required to pay.

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27. Milieu therapy, biofeedback, behavior modification, sensitivity training, hypnosis, hydrotherapy, electrohypnosis, electrosleep therapy, electronarcosis, narcosynthesis, rolffing, residential treatment, vocational rehabilitation and wilderness programs.
28. Experimental or investigational treatment or devices.
29. Sports medicine treatment plans intended to primarily improve athletic ability.
30. Radial keratotomy or any surgical procedure for the improvement of vision when vision can be made adequate through the use of glasses or contact lenses.
31. Any services given by a Provider to himself or to members of his family.
32. Ambulance services when a Member could be safely transported by other means. Air ambulance services when a Member could be safely transported by ground Ambulance or other means.
33. Late discharge billing and charges resulting from a canceled appointment or procedure.
34. Care or treatment of an illness or injury caused by or arising out of participation in a riot, war, insurrection, rebellion, armed invasion or aggression; or sustained by a Member while in the act of committing a felony.
35. If you are eligible for Medicare, any services covered by Medicare under Parts A and B are excluded to the extent actually paid for by Medicare (applicable to individual coverage only).