Steve Sisolak
Governor

Richard Whitley
Director

State of Nevada

Department of Health and Human Services

Nevada Public Option Webinar: Preliminary Actuarial Findings

September 23, 2022

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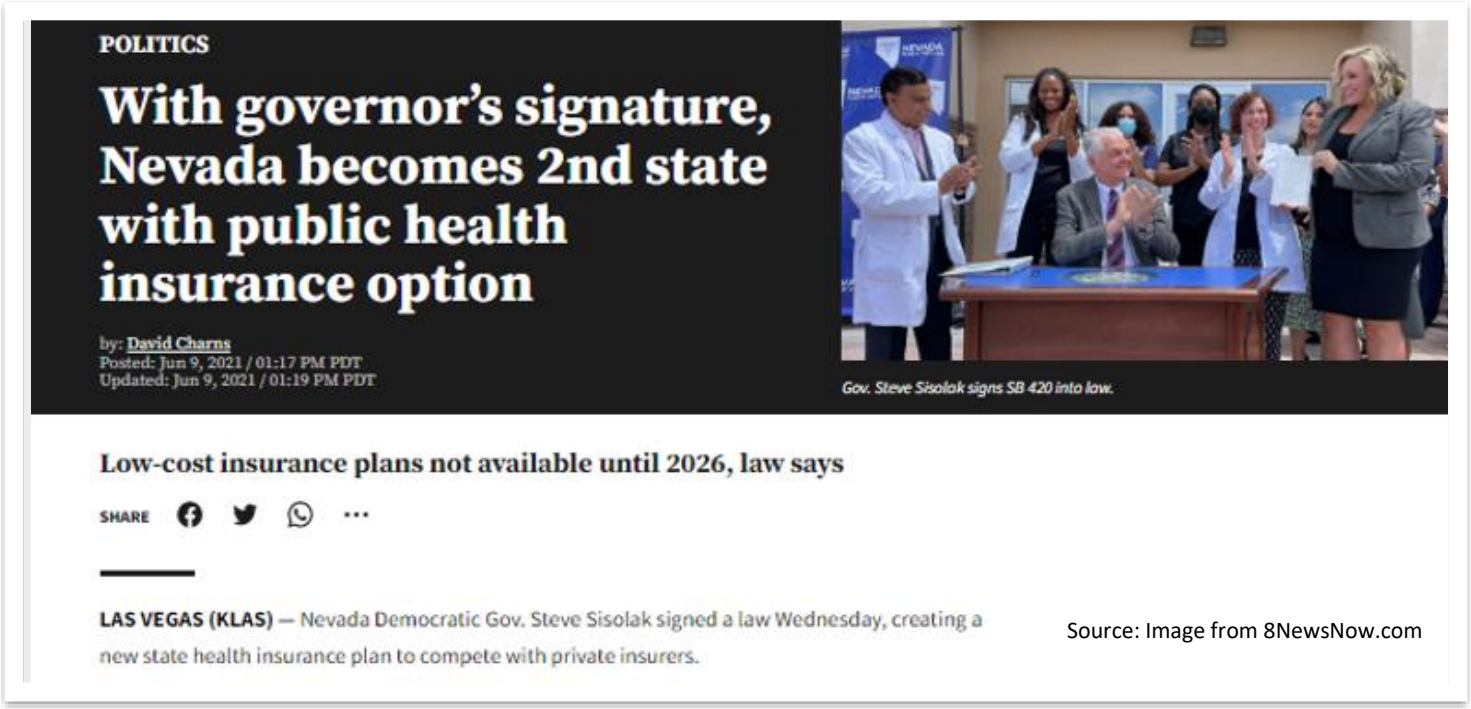
Agenda

- Introduction
  - Please post questions in the chat
- Opening Remarks
  - Governor Steve Sisolak
  - Senate Majority Leader Nicole Cannizzaro
- Background on Nevada's Public Option
- 1332 Waiver Request and Actuarial Report
- Preliminary Findings
- Next Steps
  - Waiver Timeline
  - Public Comment Period

Background

- In 2021, Nevada became second in the nation to establish a Public Option.
- Under the new law, the Director of the Department of Health and Human Services (DHHS) is charged with overseeing implementation and procurement for Public Option products, in consultation with Silver State Health Insurance Exchange and the Division of Insurance.
- Nevada Public Option products launch on January 1, 2026.



POLITICS

With governor's signature, Nevada becomes 2nd state with public health insurance option

by: David Charns
Posted: Jun 9, 2021 / 01:17 PM PDT
Updated: Jun 9, 2021 / 01:19 PM PDT

Gov. Steve Sisolak signs SB 420 into law.

Low-cost insurance plans not available until 2026, law says

SHARE

LAS VEGAS (KLAS) — Nevada Democratic Gov. Steve Sisolak signed a law Wednesday, creating a new state health insurance plan to compete with private insurers.

Source: Image from 8NewsNow.com

The Goals & Approach

State Purchasing & Contracting Strategy

- Nevada Public Option uses a statewide procurement and contracting strategy with health plans to offer low-cost coverage to consumers.
- New state procurement is tied to state's Medicaid managed care procurement to leverage state's largest purchasing power with health plans.

Health Plan & Provider Participation Requirement

- Health plans seeking to participate in Nevada Medicaid managed care program must submit a good faith bid to offer Public Option in state's individual (nongroup) health insurance market, which includes Silver State Health Insurance Exchange.
- Providers in networks for Medicaid, PEBP, and worker's comp. must agree to participate in one Public Option network.

Source
Nevada Revised Statutes, Chapter 695K.

Statutory Goals

- ✓ Improve affordability
- ✓ Improve access and reduce disparities
- ✓ Increase competition
- ✓ Promote value-based health care financing

Product Design

Health plans bidding to contract with state to offer new Public Option products must comply with the following design features in accordance with state law.

Mandatory Design Features

- Nongroup product
- Silver & Gold products
- Nongroup market rules & network adequacy standards
- Qualified Health Plan (QHP) Certification
- State's rate review process for health plans
- Medicare rates as floor for provider reimbursement
- Premium reduction target of at least 15% in first 4 years*

*DHHS will be issuing guidance under Director's revision authority pursuant to subsection 5 of NRS 695K.200 to apply a 4% instead of 5% annual premium reduction target and the Consumer Price Index-Medical (CPI-M) for controlling increases in inflation instead of Medicare Economic Index (MEI).

Product Design, continued

Health plans bidding must also comply with other design features in new procurement and contract process with state for the new Public Option products.

Additional Design Features

- Incentives for Bronze products
- Network alignment with MCO networks
- Value-based provider payment targets
- New caps on administrative load in premiums for health plans participating in Public Option to offset impact of premium reductions on providers
- Others as to be determined by state in consultation with stakeholders*

*DHHS intends to issue a Request for Information for public feedback on the procurement and contracting strategy for Public Option products in Spring 2023.

1332 Waiver & Actuarial Study

- State law requires 1332 waiver to implement premium reductions.
- 1332 waiver allows states to capture federal savings in advanced premium tax credits (APTCs) (i.e., pass-through funds (PTF)).[1]
- States applying for 1332 waiver must include an actuarial analysis and certification.[2]
- Nevada contracted with independent actuarial firm—Milliman—which has experience in evaluating proposals for public option.[3]
- Final actuarial report will provide estimate of resulting federal PTF plus analysis of effect of the provider participation requirement.

The Process

1. Stakeholder input
2. Actuarial study & waiver development
3. Tribal notice
4. Post for state public comment period
5. Federal submission
6. Federal public comment period
7. Completeness review
8. Negotiations/ Federal Decision

Sources

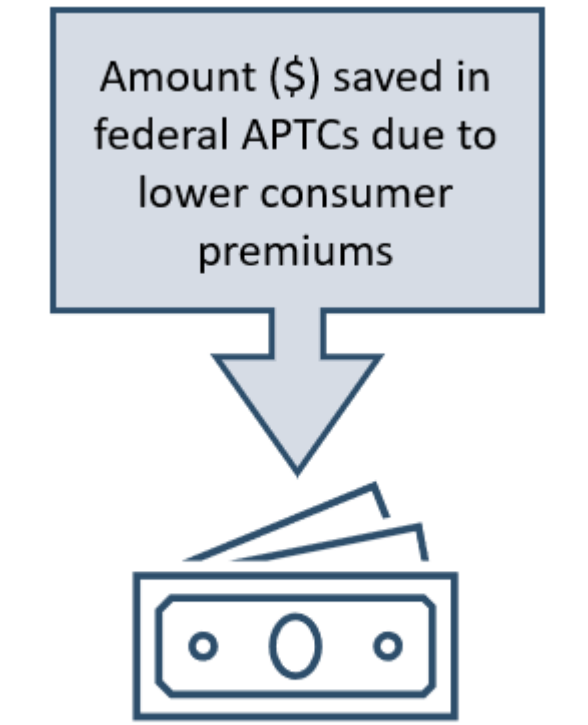
1: NRS 695K.210.

2: 45 CFR § 155.1308.

3. See Fritz Busch & Paul Houchens, *Milliman Report: Evaluation of a Colorado Public Option,* prepared for the Kaiser Permanente, 2019.

New Funds for Affordability Policies

- State law requires federal PTF to be deposited into state trust fund to support state operations and to improve affordability.
- After Year 1, state operations for Public Option will be self-funded by federal PTF.
- Leftover PTF can be used by Director of DHHS to establish new affordability policies:
  - New state premium wraps
  - New funds for supporting enrollment marketing, outreach and assistance (e.g., navigators)



Key Highlights of Actuarial Report

Financial Estimates

- **Potential for up to $341 to $464 million in savings** in the first five years, a significant portion of which could be passed on to State under 1332 waiver depending on use of new funds and Exchange enrollment
- Savings passed on to State in first 10 years estimated **near $1 billion**

Affordability Gains

- Public Option expected to provide more affordable health care coverage to **55,300 Nevadans** in year one and up to **92,500** by year five

Coverage Estimates

- Uninsured eligible for Exchange coverage **decreases by 10-12%** (Yr. 5)

Provider Revenue Impact

- **Minimal impact** as individual market makes up smallest portion of provider payor mix in Nevada
- Revenue decreases partially offset by **higher volume of service utilization** and reductions **in uncompensated care costs**

Actuarial Study Framework

American Rescue Plan Act (ARP) provided additional premium subsidies (enhanced APTCs) for Exchange plans through 2023; these ARP subsidies were recently extended through 2025 under Federal Inflation Reduction Act.

Two Potential Current Law Frameworks

1: With ARP Subsidies Extended: ARP premium subsidy amounts for Exchange plans are made permanent or extended through 2035 by Congress.

2: Without ARP Subsidies Extended: ARP premium subsidy amounts for Exchange plans are not extended beyond 2025 by Congress and, therefore, revert to previous APTC levels under current law in the Affordable Care Act.

Source
1: H.R. 5376, the federal Inflation Reduction Act

1. Actuarial Study Scenarios

For each framework, the full actuarial analysis considers three policy designs and models a total of six scenarios.

Framework	Scenario	Description
With the ARP Subsidies Extended	Scenario 1	Baseline – No Waiver
	Scenario 1A	Trust Fund
	Scenario 1B	State Premium Wrap
Without ARP Subsidies Extended	Scenario 2	Baseline – No Waiver
	Scenario 2A	Trust Fund
	Scenario 2B	State Premium Wrap

- **Scenarios 1 & 2** assume no Public Option & no waiver; “Baseline.”
- **Scenarios 1A & 2A** assume federal PTF generated by 1332 waiver are set aside for future use and reflect total potential PTF; “Trust Fund” scenarios.
- **Scenarios 1B & 2B** assume federal PTF are used to enhance APTCs with new state premium wrap and thereby reduce net premium costs (after all subsidies); “State Premium Wrap” scenarios.

2. Actuarial Study Scenarios

The actuarial study models the design of state premium wraps differently based on whether federal ARP subsidies are extended.

Framework	Scenario	State Premium Wrap Design
With ARP Subsidies Extended	1B State Premium Wrap	State premium wrap builds on extended ARP subsidies, targeted to those earning between 150-400% of federal poverty level
Without ARP Subsidies Extended	2B State Premium Wrap	State premium wrap acts as a backfill to the expired ARP subsidies, targeted to those earning between 0-250% of federal poverty level

Actuarial Study: Preliminary Findings

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Actuarial Study: Purpose

Provide certification that Nevada's 1332 waiver application fulfills federal requirements (four guardrails):[1]

- Consumer protections
- Federal financial obligations

Provide information to State of Nevada to assist with program design decisions:

- Estimate impact on coverage and costs for Nevadans
- Estimate pass-through funding available to offer additional benefits to Nevadans
- Assess overall impact of Public Option's provider participation requirement on provider revenue

Source

1: 31 CFR § 33.108

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Actuarial Study: Premium Impact

The actuarial study estimates the following impact on health insurance premiums over the first five years of the Public Option.

- In each scenario, Public Option premiums below baseline

Table 1: Premium Reductions by Actuarial Study Scenario

Year	1A – ARP Trust Fund	1B – ARP Prem Wrap	2A – No ARP Trust Fund	2B – No ARP Prem Wrap
2026	(4.0%)	(4.0%)	(4.0%)	(4.0%)
2027	(8.3%)	(8.3%)	(8.3%)	(8.9%)
2028	(12.2%)	(12.4%)	(12.2%)	(13.4%)
2029	(16.0%)	(16.2%)	(16.0%)	(17.1%)
2030	(16.0%)	(16.2%)	(16.0%)	(17.1%)

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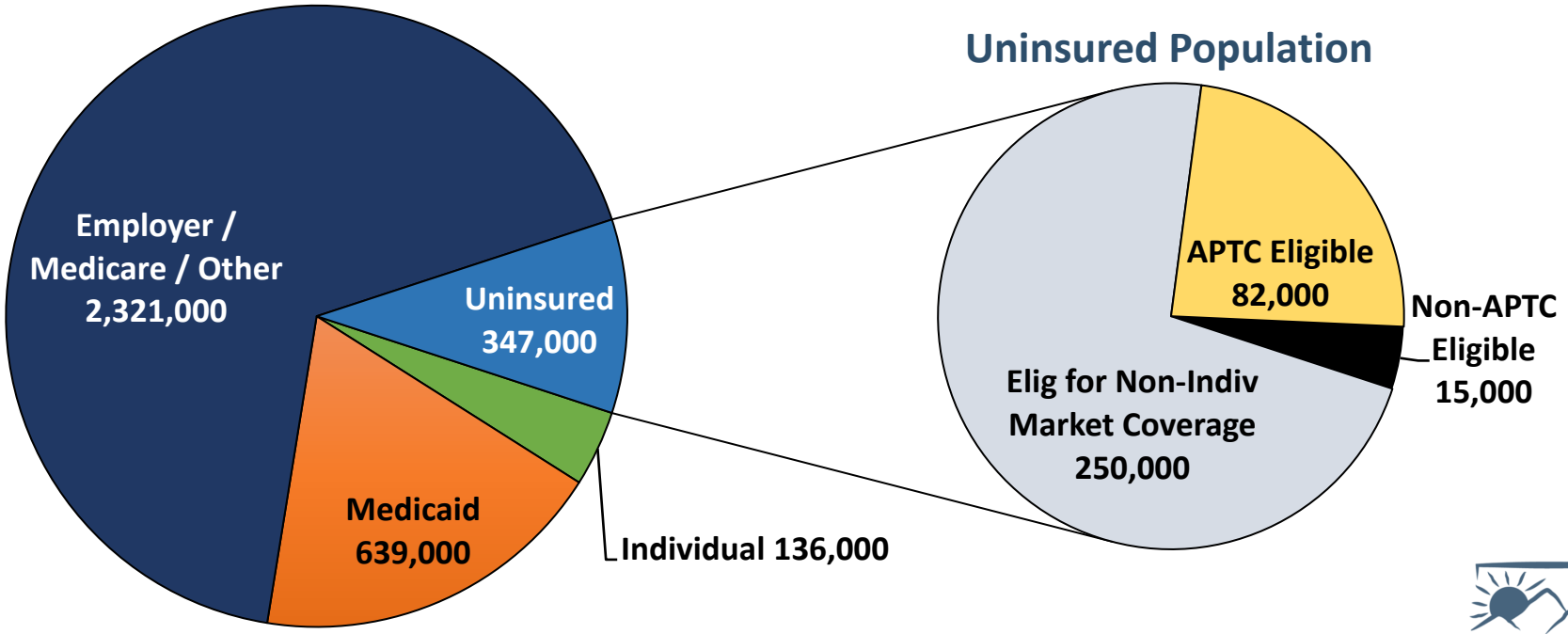
Actuarial Study: Market Enrollment

Many Nevadans who are uninsured are already eligible for more affordable health care coverage through Medicaid or Marketplace tax credits. Nevada is considering various strategies to promote coverage and affordability, like an additional premium tax credit, with new federal funds from Public Option.

Figure 1: Nevada Health Insurance Market - Projected 2026



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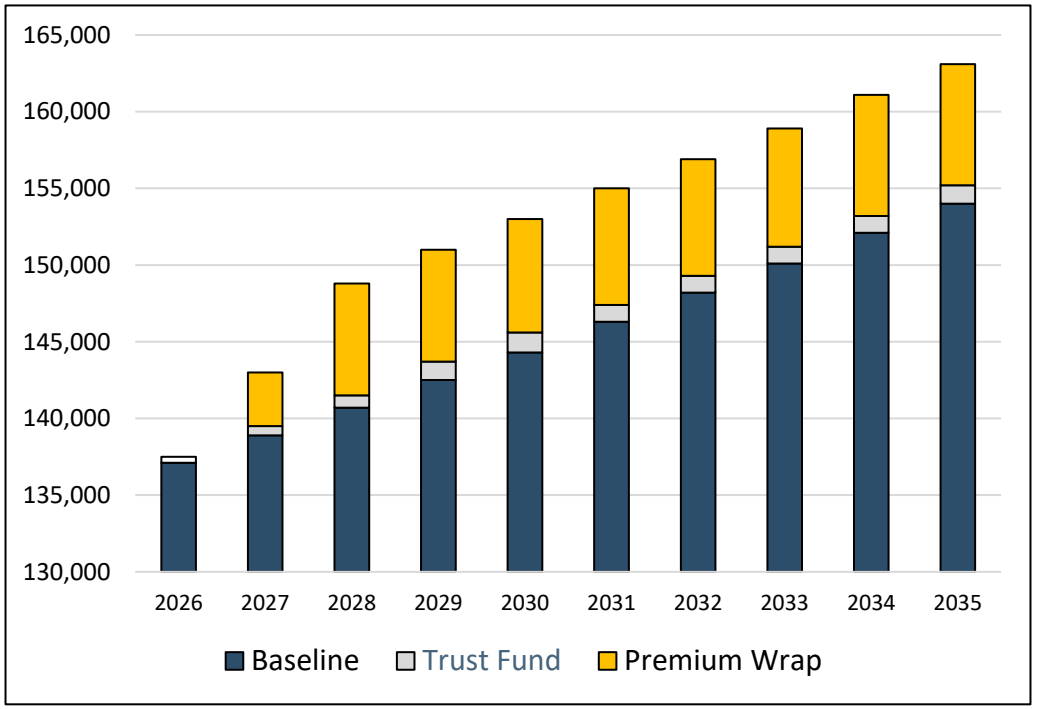
Actuarial Study: Individual Market Enrollment Impacts

Assumes the extension of ARP premium subsidies.

- Preliminary actuarial analysis assumes new state premium wrap is offered, beginning in 2027
- New state premium wrap expected to reduce number of uninsured APTC-eligible individuals

Table 2: Newly Insured due to State Premium Wrap



Note: Baseline enrollment reflects projected individual market enrollment under "No Waiver" scenario

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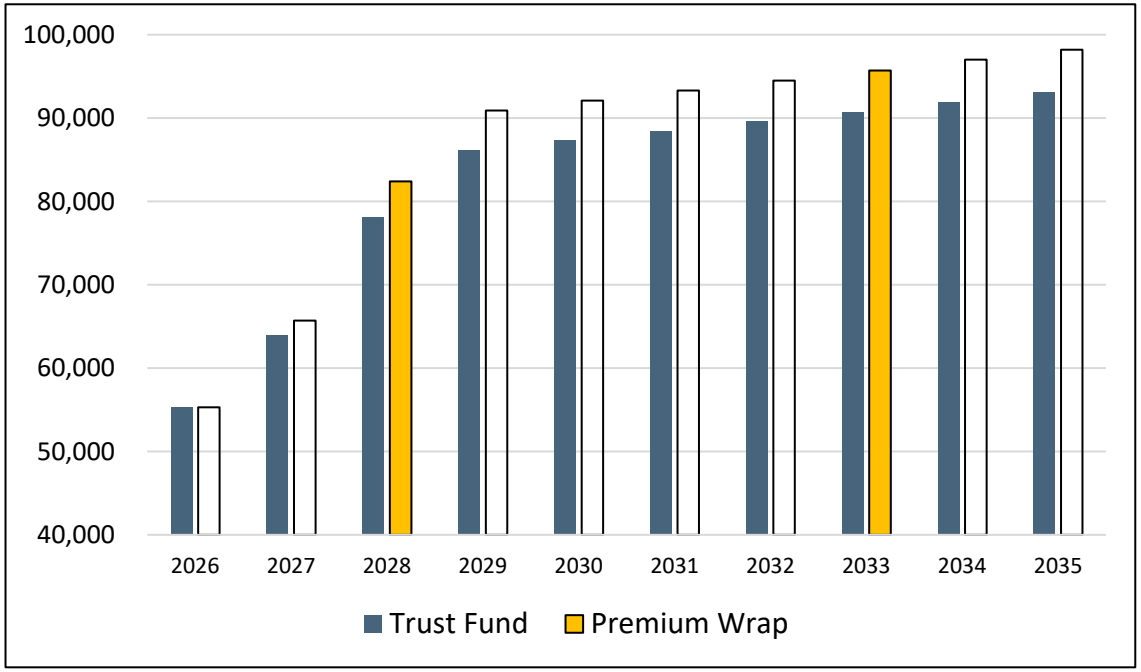
Actuarial Study: Public Option Enrollment Impacts

Assumes the extension of ARP premium subsidies.

- A state premium wrap expected to reach more consumers as size of State's pass-through funding grows over time (see next slide)

Table 3: Number of Individuals Enrolled in Public Option



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Actuarial Study: Pass-through Funds

Assumes the extension of ARP premium subsidies.

- With state premium wraps, Nevada could receive approx. **$344 million** in pass-through funds over first 5 years
- In 10 years, **nearly $1 billion** based on early projections
- If ARP subsidies not extended, State could receive approx. **27% to 45% less** over first 10 years depending on whether new funds are used to pay for state premium wrap to replace ARP (i.e., $341 (trust fund) to $191 million (wrap) in five years; $952 million (trust fund) $540 million (wrap) in ten)

Table 4: Pass-Through Funds With/Without State Premium Wrap

	Year	1A ARP Trust Fund	1B ARP Prem Wrap
Years 1- 5	2026	$28	$28
	2027	$61	$45
	2028	$97	$63
	2029	$136	$102
	2030	$142	$106
	5 Year Subtotal	**$464 M**	**$344 M**
Years 5 - 10	2031	$150	$113
	2032	$158	$119
	2033	$167	$124
	2034	$176	$131
	2035	$185	$138
	10-Year Subtotal	**$1.3B**	**$969M**

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Actuarial Results: Broader Market Impacts

Nevada Public Option is not projected to meaningfully impact provider reimbursement rates and providers are anticipated to participate in public option networks and not expected to exit other state coverage networks because of the provider tying requirement.

Provider Participation Requirement: Providers in networks for Medicaid, PEBP, and workers' comp. must agree to participate in one Public Option network

Marginal impact to overall provider revenue:

- Individual health insurance market, where Public Option will be offered, makes up **3-to-4% of provider payer mix in Nevada**
- Do not expect enrollment to be impacted in large employer-sponsored or self-insured plans in Nevada's group market
- Provider reimbursement reductions expected to be offset partially by **increased utilization of services and reductions in uncompensated care costs**
- **If state applies new caps to administrative load** in premiums for health plans participating in Public Option, this is expected to offset impact of premium reductions on providers

The Nevada Public Option does not dictate how provider rates are negotiated or set.

Instead, state law establishes a **provider reimbursement floor** requiring that health carriers offering Public Option plans pay providers at rates that are no lower than Medicare rates (on the aggregate)[1]

Note: 1: Federally-qualified health centers and rural health centers must receive rates that are comparable to or better than the reimbursement rates established under the applicable Prospective Payment System in Medicare

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Next Steps

1. Public & stakeholder **weekly "office hours"** in October with Nevada Medicaid on Public Option
2. Finalize 1332 waiver application and full actuarial report to **post for 45-day public comment** period in late November 2022
3. Host at least **two public hearings** during public comment period (November-January) plus tribal consultation
4. Incorporate public comments into waiver application
5. Submit 1332 waiver application and actuarial report to federal government (**March 2023**)
6. Begin planning for **procurement and contracting phase** with stakeholder input in 2023 with procurement expected in 2024

Questions & Contact Information

- For today's presentation, please type your questions in the chat.
- For future comments or questions at any point, go to NVpublicoption@dhhs.nv.gov
- For future updates, please visit the State's public option website (https://dhhs.nv.gov/PublicOption/) to receive updates on the State's Public Option FAQ, to learn more about the state's upcoming public comment period and public hearings, and to sign up for the notification email list.