December 21, 2021

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RE: Stakeholder Priorities for the Design of the Public Option (12/22 Mtg)

On behalf of the Nevada Association of Health Plans (NvAHP), we write to offer our comments on Nevada's Public Option Implementation Design session on December 22nd, 2021.

Plan Design

Senate Bill 420 (SB420) remains ambiguous on whether the Public Option Program is intended to be a fully insured product offered by an insurance carrier, or a plan designed and administered by the State of Nevada. The legislation states that the Director shall design, establish and operate a health benefit plan known as the Public Option,[i] and may directly administer the Public Option if necessary.[ii] Additionally, the legislation indicates money received is to be deposited into the Trust Fund;[iii] therefore, the State would assume the underwriting risk and be responsible for losses that exceed premiums.

However, the legislation also references filing rates and supporting information with the Commissioner of Insurance, obtaining certification as a qualified health plan (QHP) through the Silver State Health Insurance Exchange (SSHIX) under provisions of 45 C.F.R. § 155.305, and for direct purchase as a policy of individual health insurance under chapter 689A of NRS and other applicable provisions of the Title.[iv] This is traditionally completed by fully insured products. If the fully insured Public Option plan is offered by an insurance carrier, then the Public Option plan design would be subject to the requirements outlined in the Nevada Insurance Code. Additionally, the insurance carrier is responsible for payment of claims even if the premiums are not sufficient to cover the claims.

If the Public Option plan is designed and administered by the State, similar to a self-funded plan, the State is then responsible for claims that exceed the collected premiums. Additionally, an analysis will need to be completed to determine what Nevada Insurance Code provision would apply to the Public Option plan or the State entity administering the Public Option plan.

Given the lack of clarity and direction in the bill, we recommend that the actuarial analysis evaluate both a fully insured and a self-funded plan design. If statutory changes are needed to clarify whether the plan is a fully or a self-funded product (where the State is ultimately responsible for claims

and administration), then a clear funding source and reserves will need to be accounted for in the State budget.

We believe that determination needs to be addressed prior to making specific recommendations on any specific plan design.

Insurance Requirements

A number of fundamental issues will need to be addressed once a determination is made on the Public Option plan. We have characterized these issues as Insurance Requirements, which are crucial when determining a Public Option plan design and the premium rates associated with a plan.

- **Exchange vs. Off Exchange**
  If the intent is to have an individual and small group Public Option plan available in 2026, a decision needs to be made on whether the Public Option plans will be made available on or off Exchange.

  While the Public Option plan may be made available for small group employers,[v] it is unclear if the intent is to offer the plan on the Exchange as currently only individual plans are offered. If the intent is to include the plan, then the process of building out and the timing to develop a Small Business Exchange needs to be reviewed as part of the Public Option development process.

- **Rate Review/Reserve Requirements**
  The rate review process allows the Division of Insurance to review premium rates to ensure that all individual and small group plans are actuarially sound and that the insurer (whether fully insured or self-insured) is charging an appropriate premium in order to protect individuals enrolled in these plans, the providers who provide services to individuals, and the State who may be ultimately responsible for these claims.

  In the recent past, we have witnessed entities who provide health insurance options for their employees, struggle with paying their providers. Often the funds set aside, or the premiums charged, are insufficient and the reserves inadequate to cover the claims. This often results in providers attempting to get paid for services already rendered or members not able to find coverage.

  While the Public Option is required to meet all state and federal laws and regulations applicable to insurers, to the extent that such laws and regulations are not waived,[vi] the rate review process and reserve requirements are fundamental requirements that should not be waived. Therefore, capitalization and reserve requirements should be met to assure solvency of the plan for the consumers and providers. Additionally, plans should be subject to the same rate review process as other Exchange products.

- **Federal Affordable Care Act**
  We recommend that any plan design be consistent with the Federal Affordable Care Act (ACA) requirements for plans available on the Exchange and that meet the requirements of being an Exchange plan from both an actuarial value requirement and a benefit requirement. NRS Chapter 689A individual health insurance policy requirements apply to the Public Option that include Federal ACA Essential health benefits along with mandated benefits.

- **Provider Network**
  The Public Option plan makes various assumptions on provider networks, reimbursements, and the ability to leverage the buying power of the State in developing a provider reimbursement schedule. We believe that any actuarial analysis review whether those assumptions are feasible. A Public Option network could be very limited if providers opt out or limit which insurer's Public Option plan they will accept.

- **Perform the Actuarial Analysis Mandated by SB420**
  SB420 requires an actuarial analysis on the potential impact of the bill before the next legislative session in 2023. Specifically, the bill:

  - Requires an actuarial analysis of "the impact of the Public Option on the ***markets for health care and health insurance*** in this State and health coverage for natural persons, families and small businesses."[vii]
  - Requires a distinct systemic review of the impact SB420 will have on providers and payers, and whether there will be any effect on Nevadans to access care through their employers or at their chosen doctors or hospitals.[viii]

  This analysis is distinct and separate from the required actuarial analysis that any State must perform per the Affordable Care Act (ACA) Section 1332 state innovation waiver process. We are deeply concerned that the discussion and slides for the first design session meeting failed to recognize this statutory requirement. Slide 18 of the first design session states that the "actuarial analysis will not provide a market analysis of the financial viability of providers with the public option products."[ix] Furthermore, there was no mention that the actuarial analysis would cover the statutorily required areas listed above.

  As indicated during the stakeholder comment period of the first design session meeting, DHHS must conduct this in-depth actuarial analysis to inform policymakers and the public of the range of potential impacts from SB420 on the markets for health care and health insurance as well as Nevadans access to care through their employer-sponsored coverage. This is specifically required by the statute so that a robust analysis can inform the ACA 1332 waiver considerations and other elements of SB420 implementation with an opportunity to refine as needed to ensure that unintended consequences do not materialize from an uninformed implementation. The preliminary actuarial study required by SB420 Sections 11 and 39 was written by lawmakers to ensure that the potential impact of SB420 on the broader health care market be understood prior to the application for any Centers for Medicare and Medicaid (CMS) waiver.

  We want to underscore its importance in understanding how the Public Option may directly, but inadvertently impact access to care for vulnerable Nevadans.

- **Ensure a Robust Dialogue During and Post- Design Sessions**
  We share the common goals of reducing the uninsured, lowering the cost of health care, and ensuring equitable access to care. We believe that SB420 could result in significant changes that would undermine existing sources of coverage for Nevadans. These concerns should continue to be part of any dialogue to inform the design and implementation planning and we respectfully request that the State consider the following:
  - Invite a consultant to share their findings regarding the potential market impacts of SB420 as mentioned during the first design session. An open and transparent dialogue will be critically

important for Nevadans and will help inform but will not substitute to the statutory mandated actuarial analysis described above.

- Review and provide responses to the Nevada health care industry coalition letter submitted on November 23, 2021. This working document is intended to offer a threshold starting point for meaningful review of the potential impact of the Public Option from a specific, Nevada point of view.[x]

We appreciate the opportunity to provide comments and look forward to working with policymakers and other stakeholders to advance policy that makes healthcare more affordable, accessible, and equitable for Nevadans.

Sincerely,

Nevada Association of Health Plans

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[i] Senate Bill 420, Section 10, subsection 1: *The Director, in consultation with the Commissioner and the Executive Director of the Exchange, shall design, establish and operate a health benefit plan known as the Public Option.*

[ii] Senate Bill 420, Section 12, subsection 5: … t*he Director may directly administer the Public Option if necessary to carry out the provisions of sections 2 to 15, inclusive, of this act.*

[iii] Senate Bill 420, Section 12, subsection 7: *The Director shall deposit into the Trust Fund any money received from:*
(a) A health carrier or other person or entity with which the Director contracts to administer the Public Option pursuant to subsection 1 which relates to duties performed under the contract; or
(b) If the Director directly administers the Public Option pursuant to subsection 5, any money received from any person or entity in the course of administering the Public Option.

[iv] Senate Bill 420, Section 10, subsection 2(a): *(a) Shall make the Public Option available: (1) As a qualified health plan through the Exchange to natural persons who reside in this State and are eligible to enroll in such a plan through the Exchange under the provisions of 45 C.F.R. § 155.305;*

[v] Senate Bill 420, Section 10, subsection 2 (b): *May make the Public Option available to small employers in this State or their employees to the extent authorized by federal law.*

[vi] Senate Bill 420, Section 10, subsection 2 (c): *Shall comply with all state and federal laws and regulations applicable to insurers when carrying out the provisions of sections 2 to 15, inclusive, of this act, to the extent that such laws and regulations are not waived.*

[vii] Senate Bill 420, Section 11, subsection 2: *In preparing an application for any waiver described in subsection 1, the Director, the Commissioner and the Executive Director of the Exchange may contract with an independent actuary to assess the impact of the Public Option on the markets for health care and health insurance in this State and health coverage for natural persons, families and small businesses.*

[viii] Senate Bill 420, Section 39, subsection 2: *The actuary must have specialized expertise or experience with state health insurance exchanges, the type of waiver for which the application is being made, measures to contain the costs of providing health coverage, reforming procedures for the purchasing and delivery of government services and Medicaid managed care programs….*

[ix] Nevada DHHS Design Session #1, December 8, 2021.

[x] See letter available at: https://dhhs.nv.gov/Resources/PublicOption/PublicOptionMeetings/