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Nevada Department of Health and Human Services Public Option Implementation

Design Session #1

Wednesday, December 8, 2021

Today's Goals and Agenda

- Public Option Goals and Guiding Principles
- Overview of Legislation (SB420)
- Required Actuarial Analysis
- Background on 1332 Waivers
- Public Option Designs in Other States
- Next Steps

Welcome to Zoom – Meeting Participation Options

Written Comments:
Participants may submit comments and questions through the **Zoom Q&A box**; all comments will be recorded and reviewed by the State. To submit questions or comments outside of today's session, write to: **NVpublicoption@dhhs.nv.gov**

Spoken Comments:
Participants must "raise their hand" for Zoom facilitators to unmute them to share comments; the facilitators will notify participants of the appropriate time to volunteer feedback.

If you logged on via phone-only

Press "*9" on your phone to "raise your hand"

Listen for your phone number to be called by moderator

If selected to share your comment, please ensure you are "unmuted' on your phone by pressing "*6"

If you logged on via Zoom interface

Press "Raise Hand" in the "Reactions" button on the screen

If selected to share your comment, you will receive a request to "unmute;" please ensure you accept before speaking

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Public Comment Opportunities

- Public comment will be taken during the meeting at designated times.
- Public comment will be limited to the total amount of time allocated for public comment on particular issues.
- Individuals will be recognized for up to two minutes and are asked to state their name and organizational affiliation at the top of their statements.
- Participants are encouraged to use the comment box to ensure all feedback is captured or email their comments to **NVpublicoption@dhhs.nv.gov**

Public Option Goals and Guiding Principles

Overview of Implementing Agencies

Department of Health and Human Services (DHHS)

The **Nevada Department of Health and Human Services (DHHS)** promotes the health and well-being of its residents through the delivery or facilitation of a multitude of essential services to ensure families are strengthened, public health is protected, and individuals achieve their highest level of self-sufficiency. Within DHHS is the Division of Health Care Financing and Policy (DHCFP).

Suzanne Bierman
Administrator, Division of Health Care Financing and Policy (Medicaid)

Silver State Health Insurance Exchange

Often referred to as the "Exchange," **Silver State Health Insurance Exchange** is the state agency that oversees and operates the online health insurance marketplace in the state of Nevada, known as Nevada Health Link.

Ryan High
Interim Executive Director

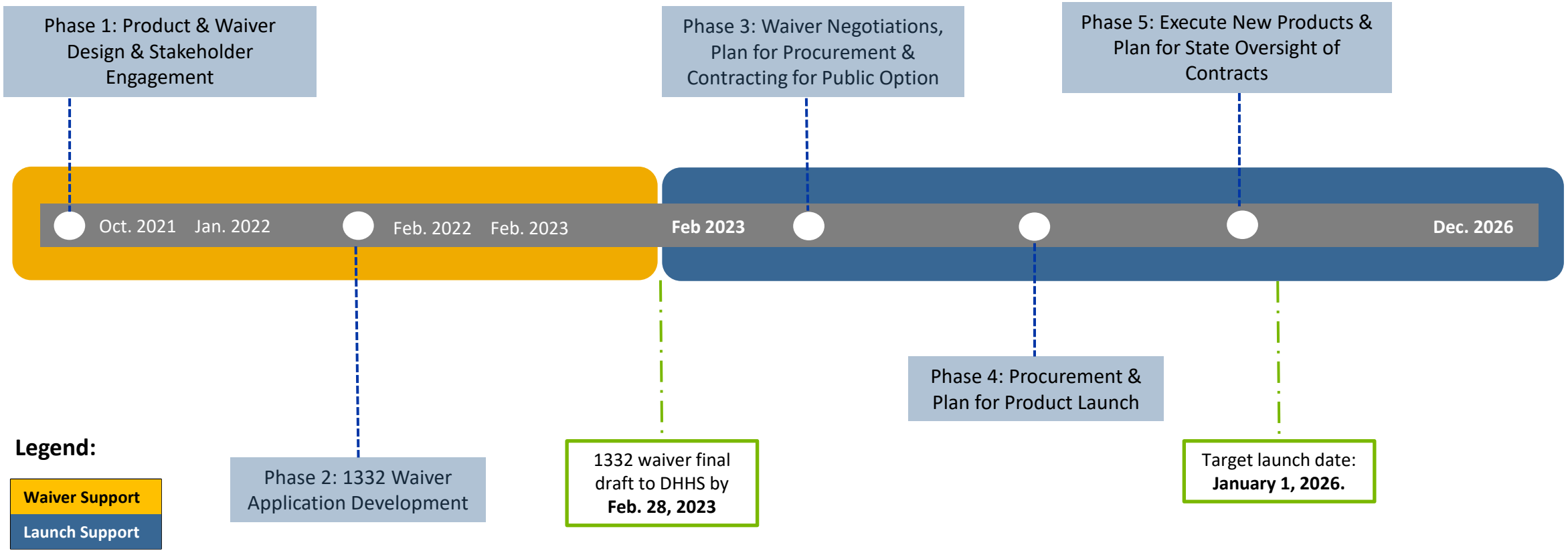
Division of Insurance

The **Insurance Division** is charged with protecting the rights of the consumer and the public's interest in dealing with the insurance industry and is responsible for regulating the insurance industry.

Barbara Richardson
Insurance Commissioner

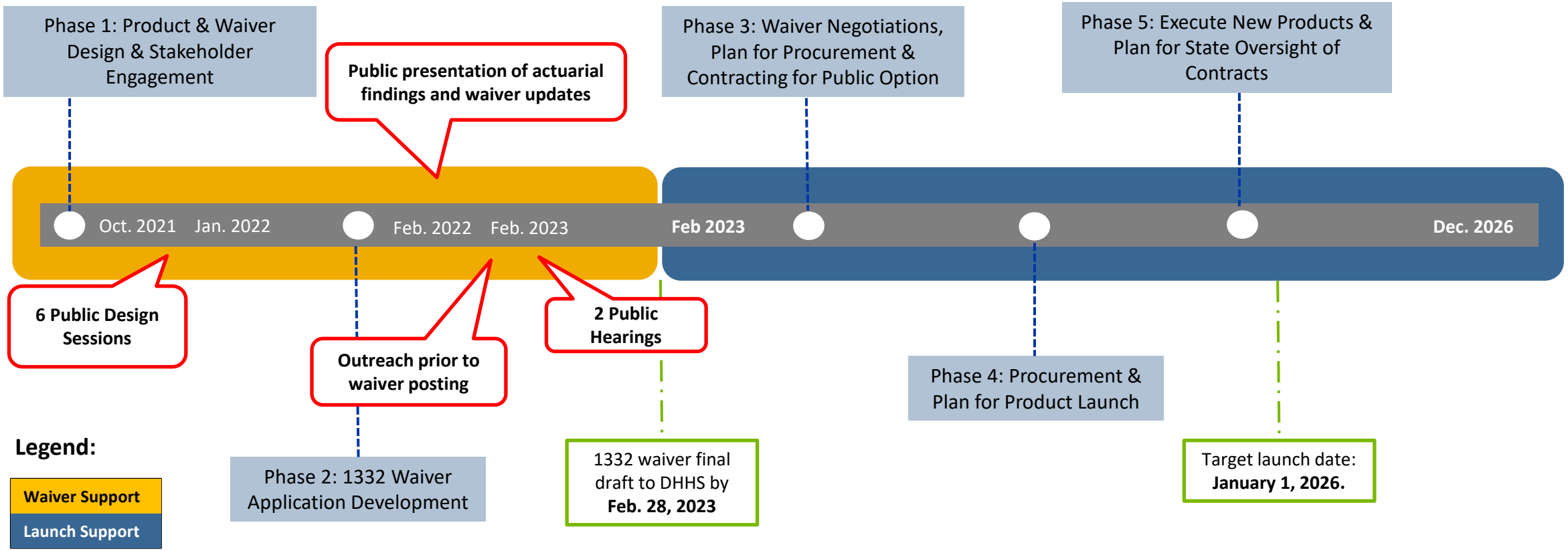
Implementation Timeline

The public option is planned to launch in January 2026, with initial planning occurring over the next year.



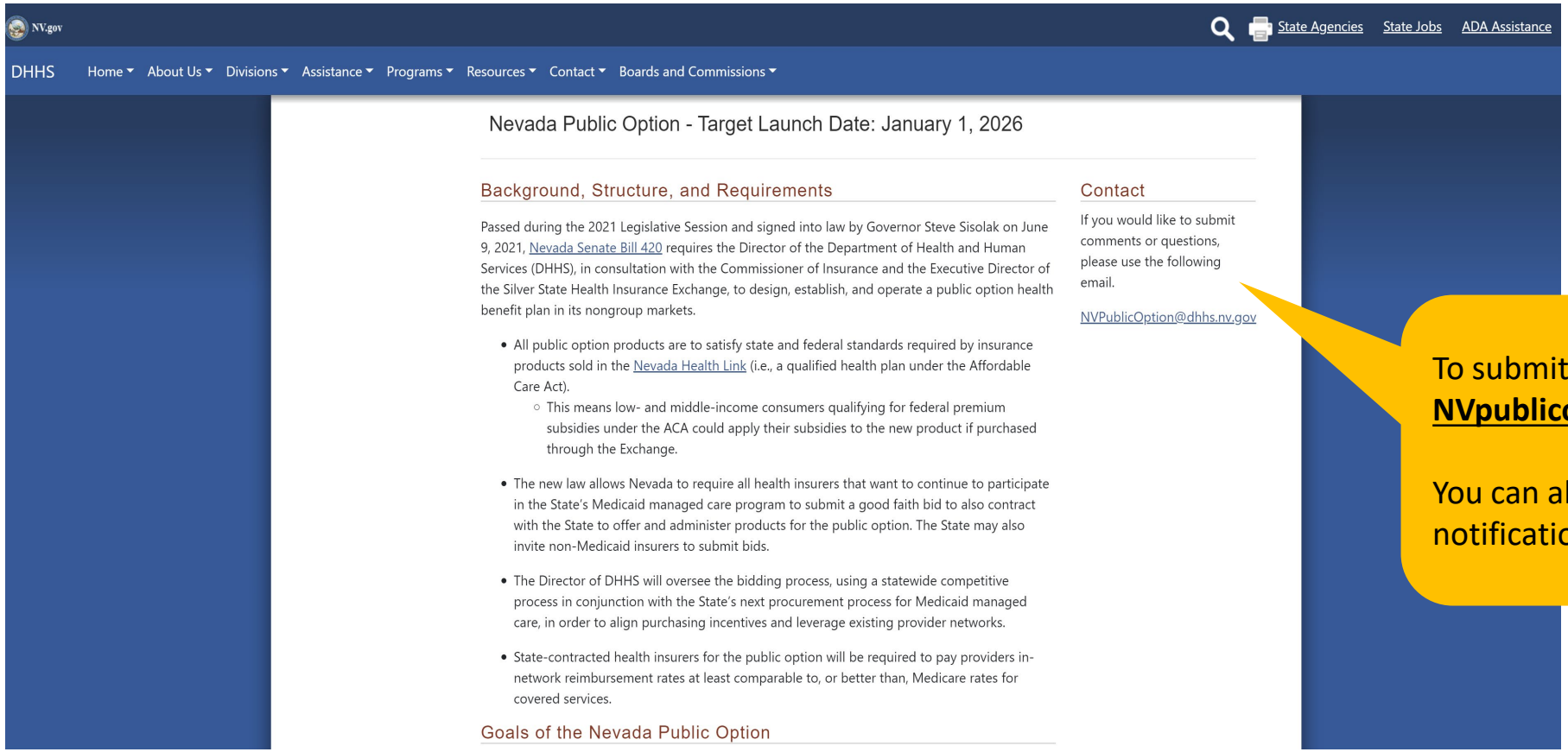
Opportunities for Public Input

The public will have many opportunities for input throughout the multiyear implementation process.



Opportunities for Public Input

Nevada DHHS published a website to provide regular updates on Nevada's Public Option legislation:
https://dhhs.nv.gov/PublicOption/



To submit questions or comments, write to:
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You can also sign up for the email notification list through the website.

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Goals of the NV Public Option

Key goals of the public option plan include:

Leverage state purchasing power to lower premiums and costs for health care for all Nevadans.

Improve access and reduce disparities related to quality of care and outcomes for historically marginalized communities.

Increase competition in individual health insurance rating areas to improve availability of coverage for rural Nevadans.

Promote value-based health care financing.

Design Session Overview

The State will hold six 'design sessions' open to the public for feedback.

These sessions are an opportunity for the public and key stakeholders to provide feedback on and actively participate in the implementation process.

These sessions are not a discussion on the merits of SB420 as passed into state law which took place during the legislative session.

Design Session Sequence and Topics

Session #	Date	Focus
1	**December 8th** 2-3 pm PT	• Goals and guiding principles • Overview of legislation and 1332 waivers • Overview of public option designs in other states
2	**December 22nd** 2-3 pm PT	• Stakeholder priorities for the design of this public option (e.g., affordability, provider networks, access to care, provider reimbursement, etc.)
3	**January 5th** 2-3 pm PT	• Affordability: Cost-sharing and premiums • Health plan rate-setting
4	**January 13th** 1-2 pm PT	• Provider contracting and networks • Value-based payment /cost containment
5	**January 18th** 12-1 pm PT	• Benefits • Strengthening the individual and small group markets • Licensure and oversight
6	**January 28th** 1-2 pm PT	• Recap/open questions • Next steps (actuarial analysis , subsequent opportunities for stakeholder feedback, waiver development)

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NVpublicoption@dhhs.nv.gov

Overview of Legislation (SB420)

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Coverage Challenges

While Nevada has made significant strides in reducing the number of residents without health insurance, it consistently has one of the highest uninsured rates in the nation, with nearly 400,000 Nevadans going without insurance.

The uninsured population is primarily individuals and families with **modest incomes**, with 83% of uninsured people falling below 400% of the federal poverty level.

The state's uninsured population is **disproportionally people of color**, with nearly 22% of Hispanics uninsured versus 9% of white Nevadans.

The Underinsured:

- Even for those with insurance, some individuals may still find premiums and cost-sharing unaffordable and therefore struggle to access healthcare. Some living in rural areas may also find care inaccessible.
- On Nevada Health Link, premiums are below the national average while deductibles are high relative to neighboring states.

Sources: "Nevada's Uninsured Population." Guinn Center 2019 . "Senate Concurrent Resolution No. 10 Study." Manatt Health 2021., Kaiser Family Foundation: "Uninsured Rates" & "Uninsured Rates by Race/Ethnicity"

Public Option Background, Structure, and Requirements

Passed during the 2021 legislative session and signed into law shortly thereafter, Nevada Senate Bill 420 requires the Director of the Department of Health and Human Services (DHHS), in consultation with the Commissioner of Insurance and the Executive Director of the Exchange, to design, establish, and operate a public option health benefit plan in its nongroup markets.

- **All public option products are to satisfy state and federal standards** required by insurance products sold in the Nevada Health Link (i.e., a qualified health plan under the ACA).
  - This means low- and middle-income consumers qualifying for federal premium subsidies under the ACA **could apply their subsidies to the new product** if purchased through the Exchange.
- The new law allows Nevada to **require all health insurers that want to continue to participate in the State's Medicaid managed care program to submit a good faith bid** to also contract with the state to offer and administer products for the public option. The state may also invite non-Medicaid insurers to submit bids.
- The Director of DHHS will oversee the bidding process, using a statewide competitive process in conjunction with the State's next procurement process for Medicaid managed care, in order to **align purchasing incentives and leverage existing provider networks**. The product is intended to be statewide.
- State-contracted health insurers for the public option will be required to pay providers in-network **reimbursement rates at least comparable to, or better than, Medicare rates** for covered services.

NV Public Option Target Launch Date: **January 1, 2026.**

FQHCs, rural hospitals, and certified community behavioral health centers (CCBHCs) will receive special floors for their rates that are tied to cost based payment structures.

Source: SB420 Text (state.nv.us)

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Required Actuarial Analysis

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Required Actuarial Analysis

The federal government requires states applying for a 1332 waiver to submit actuarial analyses and actuarial certifications.[1]

The actuarial assessment must:

- Be completed before the waiver application is submitted
- Include an analysis of the likely effect on premiums for health insurance
- SB 420 requires the analysis to give special attention to the effects of the provider participation requirement in SB 420 on premiums in the market in addition to the other elements that must be considered when preparing a 1332 waiver application[2]

Legislative Text from SB420:	"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."

Source: 1. 45 CFR Part 155. SB420 Text (state.nv.us)

Required Actuarial Analysis

The actuarial analysis will:

- Provide an "estimate" of the premiums for the Nevada public option and the resulting pass-through funding
- Consider history of health care use by consumers and actual costs in the individual market in Nevada with available data
- Make assumptions about provider reimbursement in the aggregate based on state law requirements (rate floor), and other factors impacting product design including cost sharing, state contract requirements, and purchasing initiatives
- Considers the likely effect of SB 420's "provider participation requirement" on market premiums for the public option as compared to having no provider participation requirement for the public option
- Consider impact on health care use and cost of uninsured to health care system (if available)

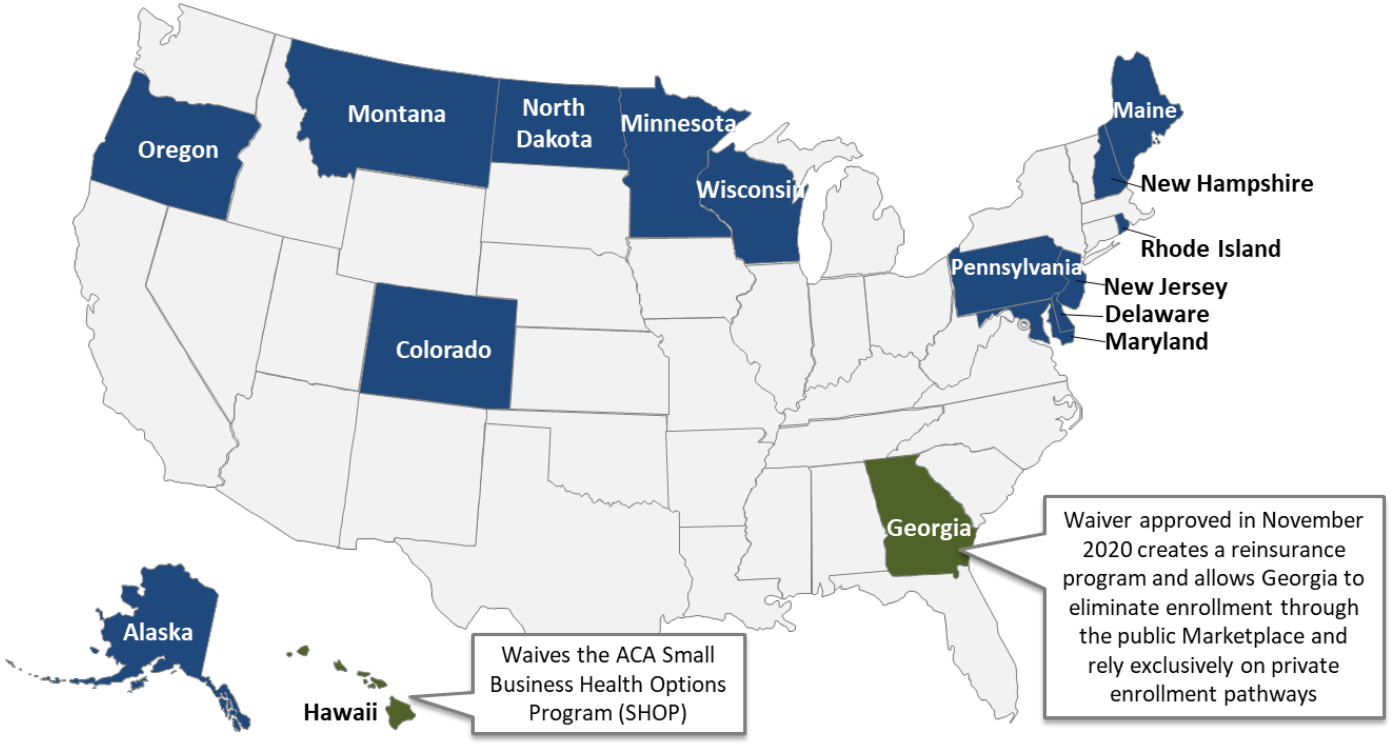
The actuarial analysis will not:

- Provide the actual premiums to be paid by consumers in 2026 for the purchase of a public option product
- Provide a market analysis of the financial viability of providers with the public option products as new entrants in the individual market in 2026
- Provide specific information about provider reimbursement rates by provide type or region
- Assume any future changes to the market that have not been enacted by state legislature or Congress (whichever has the appropriate jurisdiction) or are unknown at this time, or too difficult to estimate at this time (inadequate data)

Background on 1332 Waivers

1332 Background: Overview of Approved Waivers To-Date

To-date, 15 of 17 Section 1332 waiver approvals have been for reinsurance programs. Build Back Better has provisions that may impact States' appetite to pursue additional reinsurance initiatives.



- Hawaii received approval for the first 1332 waiver to preserve its state employer mandate.
- Georgia became the second state to receive approval of a non-reinsurance waiver in 2020. CMS recently announced a new, 60-day public comment period on Georgia's waiver.
- Colorado's 1332 application is in-process and is an example of a more comprehensive waiver
- Multiple states have proposed other 1332 waivers that have been rejected or withdrawn.

For the latest list of states, please see the CMS website.

1332 Background: Why Use a Section 1332 Waiver?

Using a 1332 waiver to implement the public option allows the State to recapture savings that would otherwise accrue to the federal government. This is known as pass-through federal funding.

Much of the cost of commercial coverage purchased on the federal or state-based Marketplaces is federally-funded through advanced premium tax credits available on a "sliding scale" basis to eligible individuals earning up to 400% of the federal poverty level (FPL).

These premium tax credits are calculated based on the price of the "benchmark plan," which is the second-lowest-cost silver-level plan available in the Marketplace.

If introduction of a public option plan on the Marketplace lowers the price of the benchmark plan, the value of the premium tax credits would decrease, yielding savings for the federal government.

Through a 1332 waiver, these savings can be refunded to the State.

SB420 requires these funds be used for future health care affordability issues.

Source: The Landscape of Federal and State Healthcare Buy-In Models (Manatt)

1332 Background: What Can be Waived?

Section 1332 of the Affordable Care Act (ACA) permits states to request waivers of key components of the ACA from the U.S. Department of Health and Human Services and the Treasury Department.

1 *Employer Mandate*

States can modify or eliminate the penalties that the ACA imposes on large employers who fail to offer affordable coverage to their full-time employees

2 *Benefits and Subsidies*

States may modify the rules governing covered benefits and subsidies. States that reallocate premium tax credits and cost-sharing reductions may receive the aggregate value of those subsidies for alternative approaches

3 *Marketplaces and QHPs*

States can modify or eliminate QHP certification and the Marketplaces as the vehicle for determining eligibility for subsidies and enrolling consumers in coverage

"Fair Play Rules"

States may not waive non-discrimination provisions prohibiting carriers from denying coverage or increasing premiums based on medical history

States are precluded from waiving rules that guarantee equal access at fair prices for all enrollees, including age rating.

1332 waivers can be coordinated with 1115 waivers, which is an opportunity for states to address differences among QHP and Medicaid programs that impede efforts to pursue multi-payer delivery system reform

See Appendix for additional background.

1332 Background: Meeting the Guardrails

Guardrails

Scope of Coverage

The waiver must provide coverage to at least as many people as the ACA would provide without the waiver

Comprehensive Coverage

The waiver must provide coverage that is at least as "comprehensive" as coverage offered through the Marketplace

Affordability

The waiver must provide "coverage and cost-sharing protections against excessive out-of-pocket" spending that is at least as "affordable" as Marketplace coverage

4 Federal Deficit

The waiver must not increase the federal deficit including all changes in income, payroll, or excise tax revenue, as well as any other forms of revenue

May be an area of particular concern for reforms that increase enrollment

Other Requirements

CMS and the Treasury Department will require contingency language indicating that state will not implement policy in absence of a waiver

The state must indicate a waivable policy provision of the ACA to receive pass-through funding

1332 Background: Navigating the Deficit Neutrality Guardrail

The fourth guardrail presents the biggest obstacle for encouraging state innovation since it is an impediment to the single most important ACA goal: expanding coverage.

Enrollment Impacts:

- State policies that attract **new enrollees** to the Marketplace (e.g., public option) result in more federal premium tax credits and impact deficit neutrality
- Implementing **reforms *before* a waiver** will impact the baseline calculation for deficit neutrality

Recent Case Study:

Colorado

Background: Signed into law in 2021, CO's public option legislation requires carriers to offer a standardized health care plan and to achieve annual premium reductions. The law authorizes state officials to seek a 1332 waiver.

As highlighted in CO's 1332 application, the increase in federal spending in the form of additional premium tax credits would be offset by premium reductions from the implementation of a reinsurance pool that are prescribed in statute. The net premium reductions and the subsequent pass-through savings as calculated are anticipated to be large enough to offset any additional costs from new enrollment in order to meet the deficit neutrality guardrail.

Source: CO General Assembly, https://drive.google.com/file/d/1mi54sMTLJySOblMm1JmMGEWLJwG5M8rQ/view

Public Option Designs in Other States

A Comparison of Enacted State Public Option Plans

	Nevada The state will contract with MCOs and/or commercial health insurers to provide a Marketplace public option plan.	Washington The state was the first to implement public option QHPs available on the Marketplace and recently enacted new legislation strengthening the law.	Colorado Signed into law in 2021, CO will require carriers to offer a standardized health care plan and to achieve annual premium reductions.
Premium Reduction Targets	**Premium Reduction and Growth Limits.** Requires premiums that are at least 5 percent lower than a benchmark Marketplace plan in the previous year and target a 15% reduction over the first 5 years; premiums must not grow at rates that are greater than the Medicare Economic Index in future years.	**Did not include a premium reduction target.** WA's Cascade Care plan saw premium's slightly higher than the Marketplace average, potentially due to lower deductible limits. Cascade Select plans saw small premium decreases, potentially due to provider reimbursement caps.	**Increasing Premium Reductions.** The state is proposing to implement the Colorado Option, which includes premium reduction requirements of 5, 10 and 15% from 2023-2025; standardized plan designs; and state subsidies, under a single 1332 waiver.
Provider Payments	**Rate floor.** Must be, in aggregate, comparable to or better than Medicare reimbursement rates.	**Rate caps and floors.** Aggregate provider reimbursement cap of 160% of Medicare rates with reimbursement floors for primary care providers and critical access hospitals.	**No initial rate caps, but authority to direct rates.** Rates are set through provider/carrier negotiations, with the insurance commissioner authorized to set certain provider reimbursement rates if targets unmet.
Network Adequacy	Providers participating in other publicly-funded plans must enroll in at least one network of providers established for the public option.	Beginning in 2022, all hospitals that accept Medicaid or public employee health benefits will be required to enter a network agreement with at least one Cascade Select plan if there is not a public option plan in each county by 2022.	The state may fine, suspend, or impose conditions on a hospital refusing to participate.

Sources: NV Legislature, WA State Legislature, CO General Assembly, The State of Play: A Mid-Year Update on the Public Option at the Federal and State Level

Next Steps

- Visit the Public Option webpage for regular updates: https://dhhs.nv.gov/PublicOption/
  - **To submit questions or comments**, write to NVpublicoption@dhhs.nv.gov

- **Attend Design Session #2 on December 22nd 2-3 pm PT**. The purpose of Session #2 is to receive stakeholder feedback on product design and priorities for a public option in the individual market and possibly small group market.

The law also contemplates inclusion of small group market and welcomes stakeholder feedback.

- Design topics include:
  - Affordability: Cost-sharing and premiums
  - Rate-setting
  - Provider contracting
  - Value-based payment/cost containment
  - Benefits
  - Strengthening the marketplace
  - Licensure and oversight

Appendix

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1332 Background: Updates and Considerations

In June 2021, the U.S. Departments of Health and Human Services (HHS) and the Treasury proposed new regulations to strengthen coverage-related guardrails for Section 1332 waivers, consistent with 2015 guidance; they do not propose any new interpretations around the deficit neutrality guardrail.

THE ACA

The ACA outlined the ability of states to apply for a State Innovation Waiver to implement innovative ways to provide health care access.

2015 Guidance

The Obama Administration issued guidance interpreting the statutory guardrails.

2018 Guidance

The Trump Administration loosened the guardrails and directed states toward "Market oriented" reforms. This guidance was partly codified in the first 2022 Notice of Benefit and Payment Parameters.

2021 Proposed Rule

The proposed rule generally reverts the Section 1332 guardrail standards to the 2015 guidance. It removes preference for "Market oriented" reforms. There are no changes to deficit neutrality guardrail.

The June 2021 rule proposes to repeal portions of the 2018 guidance that had been codified into regulations and clarifies and updates waiver application procedures and standards, including those related to emergency 1332 waivers and coordinated 1332 waivers and Medicaid demonstrations, the addition of racial equity in waiver evaluation, and processes for extensions and amendments.

Washington is Strengthening its Public Option

Washington residents were offered the nation's first public option plans during the 2021 OEP; the state has since passed legislation that continues to bolster the state's Cascade Care offerings.

- In 2021, the public option was delivered by carriers with a **target aggregate provider reimbursement rate of 160% of Medicare**
  - **Standard plans** were also offered in 2021 with richer plan design, which contributed to increased premiums and reduced impact of public option rollout
- In May 2021, Washington enacted legislation to **strengthen the public option** by:
  - **Requiring provider participation;** beginning in 2022, all hospitals that accept Medicaid or public employee health benefits will be required to enter a network agreement with at least one Cascade Select plan if there is not a public option plan in each county by 2022
  - **Appropriating $50 million to fund state subsidies** beginning in 2023.
  - Authorizing state officials to seek a **Section 1332 waiver.**
  - Requiring plans to offer a standardized silver and gold plan **in every county they offer Marketplace products by 2023.**
  - **Promoting standardized plans** by limiting non-standardized plan offerings.

Sources: WA State Legislature

Oregon Passes a Second Public Option Study

In June 2021, the Oregon legislature approved HB 2010 directing OHA and DCBS to develop a public option implementation plan.

- **HB 2010** directs the Oregon Health Authority (OHA) and Dept. of Consumer Business Services (DCBS) to:
  - **Conduct analyses and provide recommendations** on the governance and structure for the public option.
  - **Consider three potential models for implementation**:
    - **A CCO-led model,** in which the State would leverage the existing coordinated care organization (CCO) platform that currently provides Medicaid benefits for a public option product.
    - **A carrier-based model,** in which the State would utilize commercial carriers to deliver a public option product.
    - **A state-run model** in partnership with a third-party administrator (TPA), in which the State would hold the plan risk and use a TPA to support claims processing and plan administration.
  - **Advance state goals for health equity and cost containment** through cost growth cap and use of VBP.
  - **Create an implementation plan for a public health plan** for the individual and small employer Markets.
- **The implementation plan, analyses, and recommendations are due to Legislative Assembly on Jan. 1, 2022.**

Sources: https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/HB2010/Enrolled

Nevada Passes a Public Option for 2026

In June 2021, Nevada enacted Senate Bill 420, establishing a public option slated to launch in 2026.

Under Nevada's legislation:

- **Medicaid managed care organizations (MCOs) and/or commercial health insurers** will be contracted to offer a Marketplace public option in 2026.
  - The public option must meet requirements for classification as a qualified health plan and meet silver and gold actuarial values (70 and 80 percent, respectively).
- **Until 2030, premiums for public option in each zip code must be at least 5 percent lower than the reference premiums** for that zip code.
  - Premiums cannot increase faster than the increase in the Medicare Economic Index for that year.
  - This requirement may be revised if average public option premiums are at least 15 percent lower than the average reference premium in the state over the first 4 years in which the public option is live.
- **Providers participating in other public programs will be required to enroll in at least one public option provider network.**
- State officials are authorized to seek a **Section 1332 waiver.**

Sources: NV Legislature