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Nevada Public Option Implementation
Design Session #3

Target Population | Affordability

January 5, 2022

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.
- Individuals will be recognized for up to three 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
- The State will publish a public option FAQ and will continue to use this resource to inform the public and address design questions

Today's Agenda

- Meeting Overview
- Public Option Target Population Discussion
- Affordability Discussion
- Next Steps and Public Comment

Meeting Overview

Design Session Schedule

	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, networks, access, provider reimbursement, etc.)
Today	3	January 5th 2-3 pm PT	• Target population • Affordability: Cost-sharing and premiums
	4	January 13th 1-2 pm PT	• Value-based payment / cost containment • Rate setting and rate review, provider contracting, and networks
	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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Key Public Option Coverage & Design Decisions Laid Out in SB 420

Topic	Legislative Provision
Type of Product	• Must offer a policy of individual health insurance that meets all federal and state standards for qualified health plans and for insurance sold in the state's individual health insurance market. • Must be offered through the Nevada Health Link and outside the Nevada Health Link to consumers in the individual market.
Product Cost Coverage	• Carriers must offer one Silver and one Gold Plan which means that these products cover at least 70 and 80 percent of consumer health care costs, annually, respectively.
Premium Reduction Targets Requirement	• DHHS is responsible for ensuring public option plans meet premium targets (-5% premiums each year); must not increase greater than inflation • DHHS Director may change target as needed but must ensure that public option plans achieve 15 percent premium reduction in total over the first four years of operation • Targets for premiums apply for first four years of operation (expire on January 1, 2030)

Key Operational & Administrative Design Decisions Laid Out in SB 420

Topic	Legislative Provision
Plan Participation / Statewide Procurement Requirement	• Medicaid Managed Care Organizations (MCOs) are required to submit a 'good-faith' bid to participate in state's managed care program • Currently, most Medicaid MCOs participate in the Nevada Health Link. In the future, MCOs will all participate in Nevada Health Link as a requirement in their state managed care contract. • Director must seek proposals from health carriers in a statewide procurement for the public option plans that coincides with next MCO procurement with product launch date of Jan. 1, 2026
Provider Participation Requirements	• Providers in the Public Employee's Benefits Program (PEBP) or Medicaid are required to enroll in at least one network for the Public Option • The Director may waive provider participation requirements when necessary to ensure that PEBP and Medicaid beneficiaries have sufficient access to services
Provider Reimbursement Requirements	• Rates, in aggregate, must be comparable to or better than Medicare rate • SB 420 provides exceptions for certain safety-net providers that allow for higher rate floors for certain provider types (e.g., FQHCs and RHCs cannot be paid below cost-based rates in Medicare; and certified community behavioral health centers must receive the APM rate in Medicaid) • This is not a cap on provider reimbursement rates; instead, it is a floor to prevent rates from being lower than average Medicare rates in the public option networks • Providers will still negotiate with health carriers for reimbursement rates in public option like they do today

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Other Public Option Design Elements within State's Discretion

Topic	Questions to Consider
Small Group Market (Optional)	• Should the state consider in future years offering the public option to small employers in the small group market? • What considerations should the state give to this market and plans before pursuing this option? • Should DHHS recommend a separate stakeholder process and study of impact in small group market of new Public Option (with the expectation that this would require new authority and funding from legislature)?
Public Option Procurement Factors (set forth in SB 420 as factors for scoring bids from carriers)	• Should there be new network adequacy requirements (beyond state standards that apply to health insurance plans) for public option plans? • How much alignment should the state seek between MCO plan networks and public option networks (to improve consumer access to providers and continuity of care)? • Should the state consider preference for plans that include additional benefits (beyond minimum required by state for qualified health plans) in their bids for the public option?
Use of Any New Federal Pass-through Funding* (dependent on how much state receives in a 1332 waiver approval)	• Where should the state target this funding to improve consumer affordability and access to care (e.g., additional consumer subsidies, provider rate increases, etc.)? • If funds are limited, should state consider additional state funds to help build up the trust fund?

*Note: Some design decisions (not laid out in SB 420) may require new state authority, appropriations and legislation to be passed in 2023; actuarial analysis will help inform these requests and decisions (e.g., family glitch, reinsurance, risk corridors, additional state subsidies, etc.).

Today's Goals

Overarching Objective	Develop proposals for the public's consideration related to the public option's target population and affordability considerations.

Key questions for the public include:

Target Population

- What specific population should the public option target in the individual market? (e.g., Marketplace eligible but uninsured, undocumented residents, or by residents by geography or age)?
- Are there things the State should consider in marketing the new plans that may help with coverage access broadly?
- Should the state consider making the plans available in the small group market?

Affordability

- How will the State use its current authority (and discretion regarding the public option) to generate pass-through savings that can be used to reinvest in affordability policies?
- What should the state consider as policy goals for affordability?
- Which affordability policy(s) might have a more significant impact on equity?

Public Option Target Population Discussion

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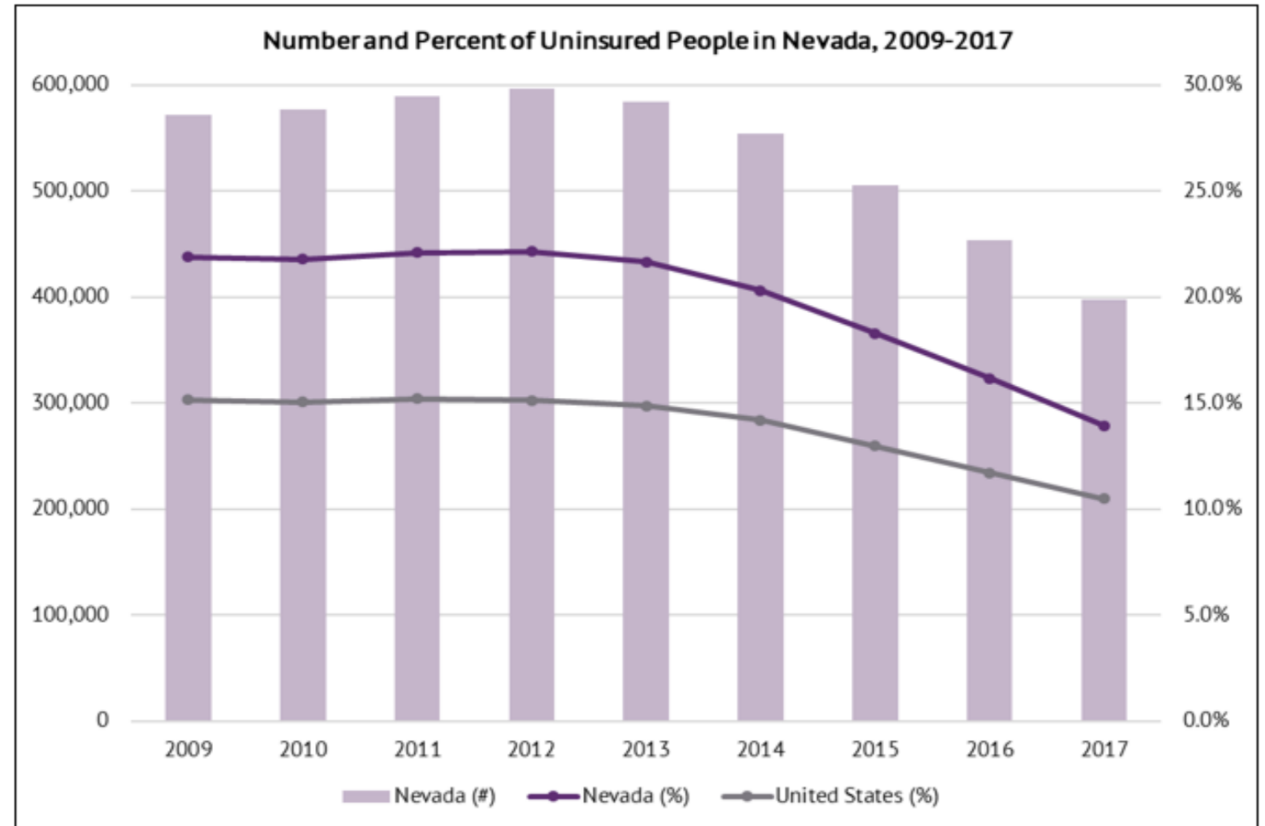
Uninsurance in Nevada: A Historical Look

The enactment of the Affordable Care Act significantly expanded access to health insurance. NV expanded Medicaid in 2014 and moved to a fully state-based Marketplace in 2018.

- From 2009 to 2017, the uninsured population in Nevada fell by 30.4 percent; in 2017 approximately 400,000 residents were uninsured.[1]
- Despite progress, Nevada has the sixth highest uninsured rate in the nation.[2]
- Underinsurance and overall affordability remain concerns; some individuals may still find premiums and cost-sharing unaffordable and therefore struggle to access health care.



Sources: 1. "Nevada's Uninsured Population." Guinn Center 2019. 2. "Senate Concurrent Resolution No. 10 Study." Manatt Health 2021

Other Demographic Characteristics of Nevada's Uninsured Population

Ethnicity

There are disparities in the state's uninsured rates by ethnicity.

Latino Nevadans represent just over one-third of Nevada's population but 59.1 percent of its uninsured population.

Geography

There is a comparable proportion of uninsured in urban and rural counties.

The uninsurance rate in rural/frontier counties is 12.0 percent, while that in the urban counties is 14.2 percent. In absolute terms, most uninsured Nevadans live in Clark County.

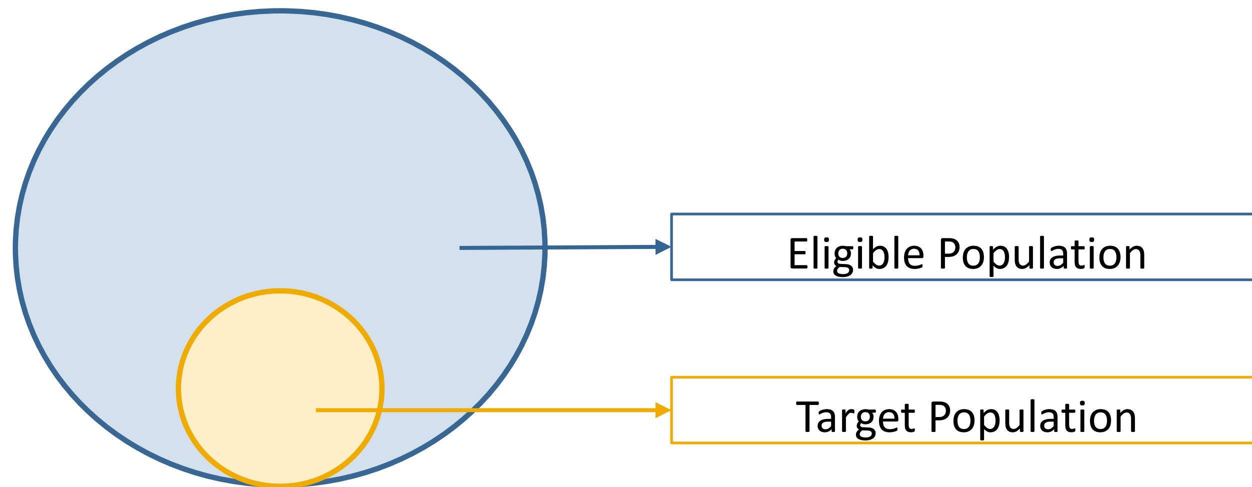
In addition to coverage challenges, all areas in Nevada suffer from workforce challenges. The public option procurement could be used to score potential plans on their approach to address shortages.

How might the State 'market' or promote the public option to potential enrollees? How might current MCO experience inform potential enrollee outreach?

Sources: 1. "Nevada's Uninsured Population." Guinn Center 2019

What is the Target Population *within* the Eligible Population?

The focus of this discussion is to narrow **the eligible population to a target population in the individual market**. The target population will be top of mind when designing the public option.

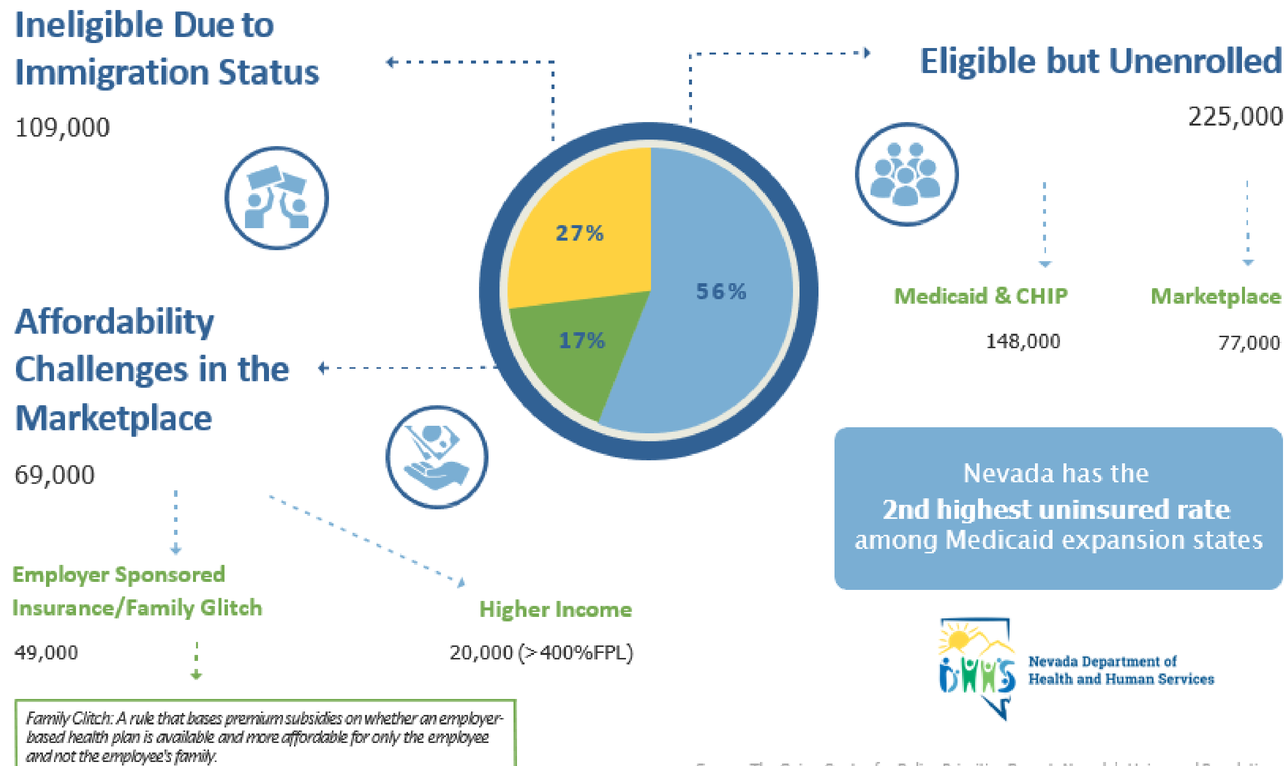


Design Decision Linked to Target Population

- Cost-sharing design
- Benefits
- Network Adequacy Requirements
- Value-Based Purchasing Requirements

The target population the State focuses on will shape the menu of affordability policies to pursue.

Who are the Uninsured for the Public Option to Target?



Which of these segments of the uninsured could be helped by Public Option and what factors impact coverage for these populations?

- **Eligible but Unenrolled**
  - Opportunities through marketing to increase enrollment in both Marketplace and Medicaid
- **Ineligible due to immigration status**
  - Affordability outside Nevada Health Link
  - No federal premium tax credits
  - Amount of pass-through funds available
- **Affordability challenges in Marketplace**
  - Higher income folks (premiums)
  - Others (cost-sharing)
  - Family glitch (waiver?)

Target Populations Are Impacted by Different Affordability Policies

Uninsured Nonelderly People in Nevada by Eligibility Type (Guinn Center Study)

Program Eligibility	Number of Uninsured People, 2019	Percent of Total Uninsured
Medicaid/CHIP Eligible	148,000	37%
Ineligible Because of Immigration Status	109,000	27%
Marketplace Tax Credit Eligible	77,000	19%
Family Income at or Below 200% FPL	*26,000*	6%
Family Income Above 200% FPL	*51,000*	13%
Ineligible for Tax Credit Because of Affordable ESI Offer	49,000	12%
Ineligible Because of Higher Income	20,000	5%
Total	403,000	100%

Potential State Actions

- Improve outreach to members Medicaid/CHIP eligible but not enrolled
- Design affordability policies (e.g., premium subsidies) that can be used off-Exchange
- Improve affordability by supplementing federal premium subsidies and cost sharing reductions (CSRs)
- Develop policies to address the 'family glitch'

Source: The Urban Institute's Health Insurance Policy Simulation Model (HIPSM) from "Nevada's Uninsured Population." Guinn Center 2019. *Based on 2019 pre-American Rescue Plan Act eligibility.

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Affordability Discussion

NV Public Option: Key Affordability Questions

- How can the State generate additional pass-through savings that can be used to reinvest in affordability policies beyond the premium target outlined in SB 420?
- What are the State's policy goals for affordability? Which might have the largest impact on equity?
  - Lower premiums for consumers
  - Reduced consumer cost-sharing (e.g., deductibles)
  - Other affordability policies like addressing the plan standardization, addressing the 'family glitch', or improving affordability for members purchasing plans off-Exchange (some of which may require future legislative action)
  - Should the state find ways to address costs outside the Nevada Health Link where we know a significant number of uninsured are? (e.g., state subsidies for the public option plans that are partially funded by pass-through funds received under waiver)

Untangling Impacts to Pass-Through Savings

If state policy reduces the federal government's cost of premium subsidies, states can capture those "pass-through" savings under a 1332 waiver.

Pass-Through Savings Impact

A public option is likely to impact federal premium subsidies in two ways:

Increases
Pass-Through Savings

- Required premium reductions leading to a lower 'benchmark plan' premium

Decreases
Pass-Through Savings

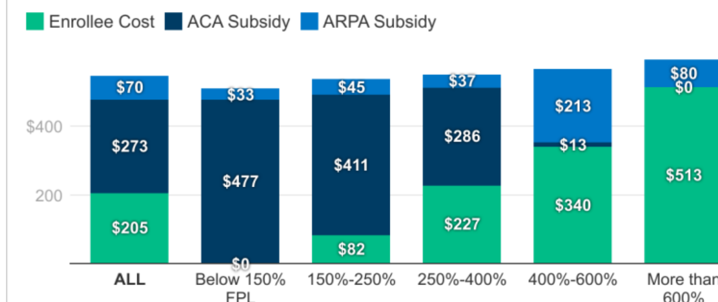
- Expanded enrollment due to State affordability policies (e.g., enhanced subsidies or CSRs)

Pass-Through Savings can be thought as the "piggy bank" for the affordability policies we will discuss in this section. The actuarial analysis as part of 1332 application will estimate size of pass-through funding.

Federal Affordability Policies May Reduce Importance of Premium Levels for Most

Federal policies have boosted premium affordability, but these changes could be temporary.

- The **American Rescue Plan Act (ARPA)** increased the amount of premium tax credits available for those who are eligible and made individuals with incomes above 400% FPL available for the first time.
  - Currently, 13M enrollees on the Exchanges with an estimated 56 percent of enrollees eligible for a $0 plan for 2022 and 78 percent of enrollees eligible for a plan costing $50/month or less.
  - The expansion is temporary, lasting only through the 2022 plan year.
- If enacted, the **Build Back Better Act (BBB)** would extend the ARPA expansions of Marketplace premium tax credit (PTC) support through 2025. As of Dec 23, 2021 BBB progress in the Senate appears stalled.



Sources: H.R. 5376, BUILD BACK BETTER ACT, Kaiser Family Foundation, Premiums Will Drop, ARPA Savings Continue As 2022 Open Enrollment Period Draws Near (HealthAffairs)

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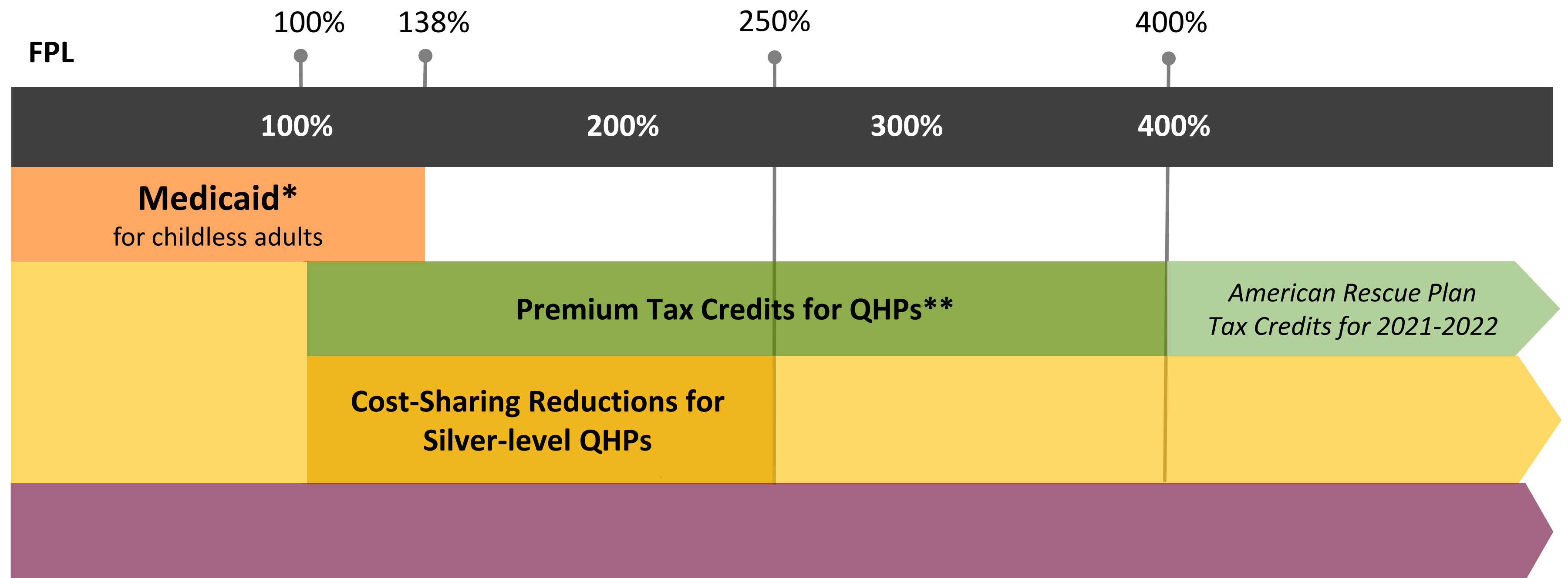
Landscape of Current Affordability Support on the Marketplaces

Premium subsidies have been temporarily enhanced and extended beyond the 'cliff' of 400% FPL.

Marketplace eligible and between 100 – 400% FPL

(~19% of uninsured)



*Visual is only showing Medicaid childless adults. Other populations, including children and non-qualified citizens are not shown.

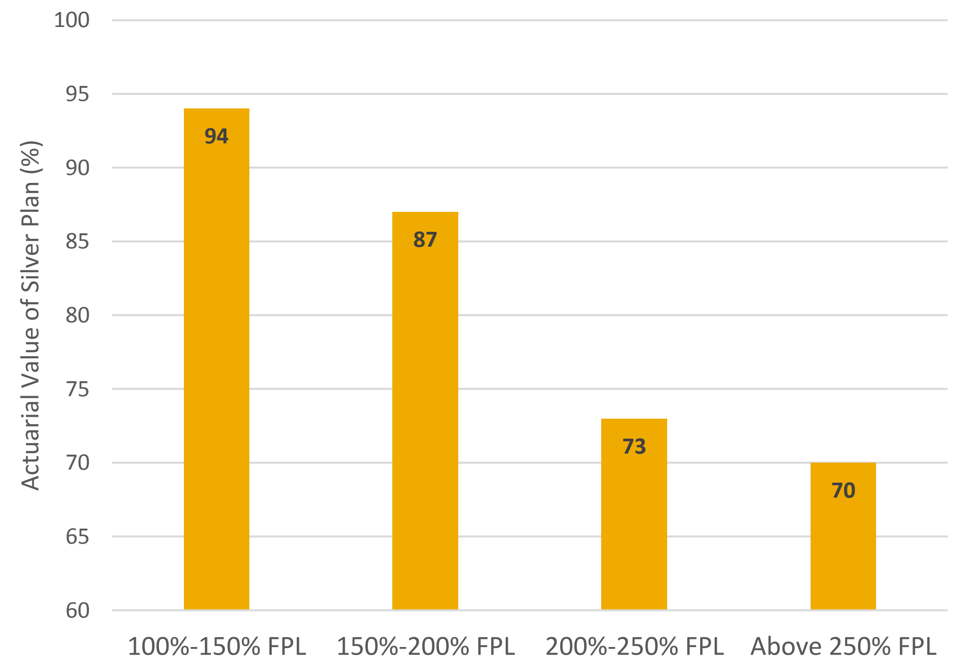
** Beneficiaries eligible for Medicare are not eligible for advance premium tax credits (APTCs)

Implications of Cost-Sharing Reductions on Affordability

On Nevada Health Link, premiums have historically been below the national average while deductibles are high relative to neighboring states.[1]

Nevada Health Link's average deductible in 2019 was $4,341, while Marketplaces in neighboring states such as Arizona, Utah, and Oregon offered plans with deductibles between $3,499 and $4,034, on average.

- Cost-sharing reduction (CSR) payments lower the amount qualifying consumers pay for deductibles, copayments, and coinsurance.
- Another way to think of CSRs is increasing a plan's actuarial value (see graphic). Although CSRs extend to people with incomes up to 250% FPL, they are the largest below 200% FPL.
- The State could consider using pass-through funding to extend CSRs to higher income levels



Sources 1. "Senate Concurrent Resolution No. 10 Study." Manatt Health 2021

Other Affordability Considerations

Should the State consider additional opportunities to increase pass-through funding?

- Value-based care and purchasing opportunities that can further reduce premiums?
- Additional mandated premium reductions beyond the 15% over 4 years set out in statute?*
- Tools to strengthen the Marketplace (e.g., reinsurance, risk corridors)?*

Additional Affordability Considerations

- Should the State seek to reduce cost sharing for certain groups? If so, which groups?
- Is it more important to lower cost-sharing or create a benefit design that lets enrollees access more care before hitting a deductible?

*Note: Some design decisions (not laid out in SB 420) may require new state authority, appropriations and legislation to be passed in 2023; actuarial analysis will help inform these requests and decisions (e.g., family glitch, reinsurance, risk corridors, additional state subsidies, etc.).

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 #4 on **January 13th 1-2 pm PT.** This session will focus on:
  - Value-based payment / cost-containment
  - Rate setting and rate review, provider contracting, and networks

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Public Comments