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DIVISION OF HEALTH CARE FINANCING AND POLICY
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GENERAL GUIDANCE LETTER 22-001

Date: October 4, 2022

From: Richard Whitley, DHHS Director
Suzanne Bierman, Administrator

Subject: Requirements for the Public Option Premiums

PURPOSE: This letter is intended to clarify the premium requirements of NRS 695K.200 for the Public Option products. As provided in state law, these requirements will be effective as of January 1, 2026 and expire on December 31, 2029. Pursuant to the Director's express authority in subsection 5 of NRS 695K.200, the Director revises the premium requirements in subsection 4 to mean that premiums for the Public Option:

- Must be lower than the average reference premium in each county by a percentage that increases each year, starting with 4% in year 1 and growing by at least 4% each year until it reaches at least 16% in year 4; and
- Must not increase in any given year by a percentage greater than the increase in the Consumer Price Index for Medical Care plus any adjustments necessary to reflect local changes in utilization and morbidity.

Also, for the purposes of these revisions and as further explained in this guidance, the average reference premium shall mean "the average second-lowest cost silver level plan available through the Exchange during the 2024 plan year by county trended forward for inflation according to the Consumer Price Index for Medical Care and any adjustments to reflect local changes in utilization and morbidity."

AUTHORITIES:

NRS 695K.200: [...]

4. Except as otherwise provided in this section, the premiums for the Public Option:
 - (a) Must be at least 5 percent lower than the reference premium for that zip code; and
 - (b) Must not increase in any year by a percentage greater than the increase in the Medicare Economic Index for that year.
5. The Director, in consultation with the Commissioner and the Executive Director of the Exchange, may revise the requirements of subsection 4, provided that the average premiums for the Public Option must be at least 15 percent lower than the average reference premium in this State over the first 4 years in which the Public Option is in operation.
6. As used in this section: [...]
 - (d) "Reference premium" means, for any zip code, the lower of:
 - (1) The premium for the second-lowest cost silver level plan available through the Exchange in the zip code during the 2024 plan year, adjusted by the percentage change in the Medicare Economic Index between January 1, 2024, and January 1 of the year to which a premium applies; or

(2) The premium for the second-lowest cost silver level plan available through the Exchange in the zip code during the year immediately preceding the year to which a premium applies.

NRS 695K.240: [...]

2. Except as otherwise provided in subsections 3 to 6, inclusive, reimbursement rates under the Public Option must be, in the aggregate, comparable to or better than reimbursement rates available under Medicare. For the purposes of this section, the aggregate reimbursement rate under Medicare:

(a) Includes any add-on payments or other subsidies that a provider receives under Medicare; and

(b) Does not include payments under Medicare for a patient encounter or a cost-based payment rate under Medicare.

3. If a provider of health care currently receives reimbursement under Medicare at rates that are cost-based, the reimbursement rates for that provider of health care under the Public Option must be comparable to or better than the cost-based reimbursement rates provided for that provider of health care by Medicare.

4. The reimbursement rates for a federally qualified health center or a rural health clinic under the Public Option must be comparable to or better than the reimbursement rates established for patient encounters under the applicable Prospective Payment System established for Medicare by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services.

5. The reimbursement rates for a certified community behavioral health clinic under the Public Option must be comparable to or better than the reimbursement rates established for community behavioral health clinics under the State Plan for Medicaid.

6. The requirements of subsections 2 to 5, inclusive, do not apply to a payment model described in paragraph (b) of subsection 1.

7. As used in this section, "Medicare" means the program of health insurance for aged persons and persons with disabilities established pursuant to Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395 et seq.

APPLICATION

As provided in state statute, the premium-reduction requirements for the Public Option products are time-limited and will begin on January 1, 2026 and end on December 31, 2029. The plain language of subsection 5 under NRS 695K.200 provides that the Director may revise these requirements as long as the average premiums for the Public Option are at least 15 percent lower than the average reference premium in the State over the first four years of the program. For the reasons listed below, the Director revises the premium-reduction requirements in subsection 4 as follows:

4. Except as otherwise provided in this section, the premiums for the Public Option:

(a) Must be ~~at least 5 percent~~ lower than the average reference premium in each county by a percentage that increases each year, starting with 4% in year 1 and growing by at least 4% each year until it reaches at least 16% in year 4 for that zip code; and

(b) Must not increase in any year by a percentage greater than the increase in the ~~Medicare Economic Index Consumer Price Index for Medical Care~~ Consumer Price Index for Medical Care for that year plus any adjustments necessary to reflect local changes in utilization and morbidity.

The purpose of these revisions is to ensure that the Public Option premiums will be actuarially sound, meaning that they can reasonably cover the projected cost of health care claims and growth of medical inflation in the state's individual health insurance market. For example, subsection 4 of NRS 695K.200, as originally written, applies the Medicare Economic Index (MEI) as a trend factor for controlling the cost of inflation in the Public Option products. Upon review and in consultation with the Department of Insurance, Exchange, and independent actuarial experts—the Department has determined that MEI does not adequately reflect the high rate of growth in medical inflation in the State's individual

health insurance market, where the Public Option products must be offered. Therefore, pursuant to the Director's authority under subsection 5 of NRS 695K.200, the Director revises subsection 4 of NRS 695K.200 to replace MEI with Consumer Price Index for Medical Care (CPI-M) to better reflect the cost of inflation in this market. The revision also allows the Department to make any adjustments deemed necessary to reflect local changes in utilization and morbidity.

The Director also defines "average reference premium" for purposes of implementing these revisions to subsection 4 and meeting the 15 percent premium-reduction target in the first four years in subsection 5 as follows:

The average reference premium means the second-lowest cost silver level plan available through the Exchange during the 2024 plan year by county trended forward for inflation according to the Consumer Price Index for Medical Care and any adjustments to reflect local changes in utilization and morbidity.

Such an interpretation is consistent with Nevada rules of statutory construction, which provide that "provisions within a common statutory scheme [must be interpreted] harmoniously with one another in accordance with the general purpose of those statutes and to avoid unreasonable or absurd results, thereby giving effect to the Legislature's intent." *Dezzani v. Kern & Assocs., Ltd.*, 134 Nev. 61, 64 (2018) (quoting *Torrealba v. Kesmetis*, 124 Nev. 95, 101 (2008)). Construing the "reference premium" definition in subsection 6 to apply to the revised premium-reduction requirements for subsection 4 and the 15 percent target in subsection 5 would create a direct conflict with the Director's duty to meet the express mandate in NRS 695K.240, which is to ensure provider reimbursement rates in the Public Option are no lower than Medicare rates (i.e., the express provider-reimbursement mandate). This is because the definition of "reference premium" in subsection 6 creates an unintended and unreasonable result with respect to premium reductions in the Public Option, where health carriers would be required to lower premiums to levels that risk actuarial soundness and full compliance with the express provider-reimbursement mandate under NRS 695K.240.

For example, applying the definition of reference premium in subsection 6, as written, would result in a target that relies either on: (1) MEI, which as previously stated is unworkable and therefore has been replaced by CPI-M in accordance with the Director's revision authority; or (2) a target based on the preceding year, each year, which has a compounding effect and would drive down premiums exponentially (i.e., at a rapid, additive rate). This creates an absurd and unintended result, where the Director must use a definition that relies on the elements deemed revisable under subsection 5 and applies a target based on a reference point that can only be reasonably achieved by risking compliance with the express provider-reimbursement mandate under NRS 695K.240. Unlike the premium-reduction requirements in NRS 695K.200 and other key statutory provisions related to the operation of the Public Option, the express provider-reimbursement mandate in NRS 695K.200 can neither be revised nor waived by the Director.

For all these reasons, the Director interprets "average reference premium" in a separate and distinct manner from "reference premium," as permitted by Nevada rules of statutory construction, to balance and give effect to the legislature's intent, which was to allow the Director to revise the premium-reduction requirements and meet a 15 percent reduction target in the first four years, all while ensuring such reductions do not result in provider reimbursement rates in the Public Option that are below those paid by Medicare.

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