PUBLIC OPTION INSTITUTE

Wynne Health Group

Summary of Nevada Public Option Design Session Meetings

Executive Summary

Signed into law by Governor Steve Sisolak, Nevada Senate Bill 420 (SB420) 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, Nevada Health Link, to design, establish, and operate a public option health benefit plan. DHHS convened six sessions to solicit feedback from stakeholders on critical design elements of the public option. DHHS will likely design the public option to maximize alignment with Medicaid managed care. However, DHHS and stakeholders remain undecided on several design elements.

The most pressing unresolved design element is the public option's target population. DHHS staff stated that the target population will influence other design elements, and several stakeholders stated that identifying and understanding the needs of a target population is crucial to answering other design questions. Stakeholders advocated for the target population to include individuals who are in coverage gaps, including individuals 50 to 64 years of age and undocumented individuals.

The public option's benefit structure is also unresolved. Stakeholders are conflicted on what benefits the public option should cover. Insurers advocated for benefits to be limited to essential health benefits (EHBs) to minimize premiums. Some community members also advocated for premiums to be as low as possible. However, patient advocates urged DHHS to provide expansive benefits such as that in behavioral health.

Additionally, DHHS must consider how value-based purchasing (VBP) will be implemented, whether to impose additional network adequacy standards, and whether to offer the public option in the small group market. DHHS will progress into the next phase of implementation, which includes completing an actuarial analysis and developing a 1332 state innovation waiver application. DHHS will continue to solicit stakeholder feedback and update stakeholders on their progress through the Nevada public option website. The state intends to submit a final 1332 waiver application to the Centers for Medicare and Medicaid Services (CMS) by February 28, 2023 and launch the public option on January 1, 2026.

Timeline

Date	Activity
December 8, 2021	Design Session #1: Goals and Guiding Principles, Overview of Legislation and Waivers, and Overview of Designs in Other States
December 22, 2021	Design Session #2: Stakeholder Priorities for the Design of This Public Option
January 5, 2022	Design Session #3: Target Population and Affordability
January 13, 2022	Design Session #4: Benefits and Value-Based Payment / Cost Containment
January 18, 2022	Design Session #5: Health Plan Rate Setting and Review, Provider Contracting and Networks, and Strengthening Individual and Small Group Markets

January 28, 2022	Design Session #6: Licensure and Oversight, Offering the Public Option in the Small Group Market, and Next Steps

Senate Bill (SB) 420

The law requires the Director of the Nevada Department of Health and Human Services (DHHS) to establish a public option, to be offered by carriers in the individual market on and off the Exchange, by January 1, 2026. The Director is permitted, but not required, to make the public option available in the small group market.

The public option will be a qualified health plan (QHP) and, therefore, compliant with the Affordable Care Act (ACA) (i.e., covers essential health benefits, meets other federal and state requirements). At a minimum, the public option will be offered at silver and gold tiers of coverage. Going beyond the ACA's generosity requirements (related to actuarial value), the law includes additional guardrails intended to lower premiums:

- **Reference Premium** – The premiums for the public option will be set at least five percent lower than the reference premium for that zip code, which is defined as the lower of:
  1) The premium for the second-lowest cost silver level plan available in the Exchange for plan year 2024 in the zip code, adjusted by the percentage change in the Medicare Economic Index (i.e., inflation adjusted clinician costs) between January 1, 2024 and January 1 of the applicable plan year; or
  2) The premium for the second-lowest silver plan available through the Exchange in the zip code during the year immediately preceding the applicable plan year.

- **Inflation Cap** – Premiums will also be prohibited from increasing greater than the increase in the Medicare Economic Index.

Additionally, SB 420 allows DHHS to choose to administer the plan or contract with insurers to administer the plan; requires any provider that participates in the Medicaid program or the Public Employees' Benefits Program to participate in at least one network established for the public option; and requires provider reimbursement rates to be comparable to Medicare reimbursement rates.

Key Takeaways from Stakeholder Meetings (schedule and materials available here)

December 8th: Design Session #1 – Goals and Guiding Principles, Overview of Legislation and Waivers, and Overview of Designs in Other States

1. **DHHS staff encouraged stakeholders to provide feedback on the design of the public option health benefit plan through various channels, including public comments at design sessions and email (NVpublicoption@dhhs.nv.gov).** DHHS will also conduct outreach, a public presentation, and two public hearings prior to submitting a Section 1332 waiver. Suzanne Bierman, Administrator of the DHHS Division of Health Care Financing and Policy, also highlighted that DHHS will provide regular and ongoing updates through a designated webpage and will compile a list of Frequently Asked Questions (FAQs).

2. **DHHS plans to submit a final draft of the Section 1332 waiver by February 28, 2023 and launch the public option on January 1, 2026.** Opportunities for stakeholder engagement are concentrated to the time period prior to waiver submission.

3. **SB 420 requires DHHS, the Division of Insurance, and the Silver State Health Insurance Exchange, to design, establish, and operate a public option health benefit plan in its individual markets.** The legislation allows Nevada to require all health insurers that wish to continue to participate in Medicaid managed care to submit a good faith bid for the public option. The legislation also requires insurers to pay providers at reimbursement rates comparable to Medicare rates for public option services.

4. **Nevada has partnered with Manatt Health to complete an actuarial analysis and certification.** NV SB 420 also requires the analysis to give special attention to the effects of the legislation's provider participation requirement on premiums.

5. **DHHS anticipates that the fourth guardrail for Section 1332 waivers, the requirement that the waiver must not increase the federal deficit, will be the biggest obstacle in designing a public option product.** The guardrails are as follows:

    a. **Scope of coverage** – The waiver must provide coverage to at least as many people as would have coverage without the waiver.
    b. **Affordability** – The waiver must provide coverage that is at least as affordable as coverage without the waiver.
    c. **Comprehensive coverage** – The waiver must provide coverage that is at least as comprehensive as coverage without the waiver.
    d. **Deficit neutrality** – The waiver must not increase the federal deficit over the waiver period, including all changes in income, payroll, or excise tax revenue or any other forms of revenue.

    These guardrails reflect the interpretations as modified by the Biden Administration in the Calendar Year (CY) 2022 Notice of Benefit and Payment Parameters (NBPP). The U.S. Department of Health and Human Services (HHS) and the U.S. Department of the Treasury (the Departments) finalized modifications to the first three guardrails. However, the Departments did not propose to modify the fourth guardrail regarding deficit neutrality. Anne Karl from Manatt Health noted that the fourth guardrail impedes coverage expansion as the introduction of new enrollees to the Marketplace will result in increased federal premium tax credits, increasing federal spending.

6. **DHHS is looking to other states, especially Colorado (CO), as the state designs a public option product and waiver.** Karl highlighted that in CO's Section 1332 waiver application, the state proposes to implement a reinsurance pool that would result in premium reductions to offset the increase in federal spending. Karl also provided a comparison of Nevada's legislation to public option plans in Washington (WA) and CO, focusing on premium reduction targets, provider payments, and network adequacy.

December 22nd: Design Session #2 – Stakeholder Priorities for the Design of This Public Option

1. **DHHS staff emphasized the agency's dedication to incorporating stakeholder feedback.** They stated that the primary purpose of this design session was to obtain stakeholder feedback to inform future design sessions and program development.

2. **Anne Karl from Manatt Health walked through the key questions for each future design session.** Karl emphasized that DHHS is seeking feedback on the proposed questions and welcomes input on any additional questions that should be added and any apparent answers to the proposed questions. These questions include the following:

    a. **For Design Session #3 on affordability:**
        i. What specific population should the public option target?
        ii. Are reduced premiums or reduced cost-sharing a greater barrier for that population?
        iii. Are there any other affordability challenges that should be addressed?
        iv. How could the rate review process be used to provide state oversight and assistance in meeting premium reduction targets?
    b. **For Design Session #4 on provider contracting:**
        i. How should the state and health plans balance robust provider participation with premium reduction targets?
        ii. How will the state ensure plans and providers agree to fair rates?
        iii. How do issues related to provider contracting differ across rural and urban areas?
        iv. Are there provider contracting and value-based care opportunities to improve equity, access, and culturally competent care? Are there successful models in Nevada?
        v. How can the state align its purchasing strategies, cost-controls, and value-based care?
    c. **For Design Session #5 on benefits:**
        i. Will the public option provide a more comprehensive set of benefits than do QHPs?
        ii. How will the state balance adding additional benefits with premium reduction targets?
        iii. What policies might strengthen the state's individual and small group markets?
        iv. How will oversight of the public option differ from other QHPs?

3. **Stakeholders provided comments on a variety of aspects of the public option design.** Two stakeholders raised concerns that discussions around public option design are premature and will not accurately represent or address Nevada's needs until an actuarial analysis is completed.

January 5th: Design Session #3 – Target Population and Affordability

1. **Administrator Suzanne Bierman reviewed design elements stipulated by legislation and elements open to stakeholder feedback.** Bierman stated that DHHS solicits feedback on the following broad elements of the public option:

a. **Small group market –** SB 420 gives the state the option to offer the public option in the small group market. DHHS seeks feedback on if the state should consider offering the public option to small employers in future years, as well as if there should be a separate stakeholder process and study on the impact of the public option in the small group market.
b. **Public option procurement –** DHHS asked if new and enhanced network adequacy requirements should apply to public option plans beyond requirements for QHPs in the State Exchange (further described in Design Session #5), how much alignment the state should seek between Medicaid managed care plan networks and public option networks, and if the state should prefer plans that include additional benefits in their public option bids.
c. **Use of pass-through funding –** DHHS asked where the state should target pass-through funding to improve consumer affordability and access by employing methods such as additional consumer subsidies or provider rate increases. Additionally, SB 420 creates a Public Option Trust Fund administered by the State Treasurer. The Trust Fund consists of state appropriated funds, any pass-through funds, and all income and interest earned on the money in the fund. The legislation appropriated $1,639,366 to the Trust Fund for use by June 2023. DHHS asked if the state should consider dedicating additional state funds to supplement the Trust Fund if funds are limited.

2. **DHHS staff also reviewed possible target populations, stating that the target population will shape the state's affordability policies.** DHHS identified several sub-groups of Nevada's uninsured population and possible state actions for each potential target population. For individuals who are eligible for Medicaid or CHIP but unenrolled, the state could improve outreach. For individuals who are ineligible due to immigration status, the state could design affordability policies that can be used off-Exchange. For individuals who are eligible for Marketplace tax credits but still face affordability challenges, the state could supplement federal premium subsidies and cost sharing reductions (CSRs). Finally, for individuals ineligible for tax credits due to the "family glitch" – when family members of an employee who are offered employer-sponsored coverage deemed affordable are ineligible for premium tax credits – the state could develop policies to address family glitch.

3. **Anne Karl discussed affordability considerations, including the use of pass-through funding and CSRs.** Expanded enrollment as a result of public option implementation would decrease savings but would be offset by the legislation's required premium reductions, which would increase savings and meet the deficit neutrality guardrail. These factors would also affect the amount of available pass-through funds. Karl explained that on Nevada Health Link, premiums are historically below the national average while deductibles are high compared to neighboring states. CSRs lower the amount consumers must pay for out-of-pocket costs such as deductibles. Nevadans with incomes up to 250 percent of the federal poverty level (FPL) receive CSRs of decreasing value with increasing income level. Karl stated that pass-through funding can be used to extend CSRs to individuals with higher income levels.

4. **Karl asked if the state should further increase pass-through funding.** Karl pointed to several options to achieve this, including reducing premiums beyond the statutory 15 percent reduction over four years, leveraging value-based care and purchasing opportunities, and

strengthening the Marketplace to increase competition and drive down premiums through methods like implementing reinsurance pools. Another question raised was if it is more important to lower cost sharing or create a benefit design that lets enrollees access more care.

5. **Consumer advocates urged DHHS to focus on uninsured individuals from the 50 to 64-year age group and to develop off-Exchange products for undocumented individuals.** Representatives from AARP Nevada and New Day Nevada noted that Nevadans aged 50 and older are a significant population of concern as they are transitioning away from employer sponsored insurance but are not yet eligible for Medicare. They highlighted that this age group comprises a third of Health Link's consumer population and are more likely to buy coverage than young adults. Consumer advocates also noted that the uninsured population are disproportionately Latino individuals and undocumented individuals who face barriers from accessing health care coverage such as language and lack of cultural competency in outreach. Advocates emphasized that undocumented individuals need access to affordable care off the State Exchange.

January 13th: Design Session #4 – Benefits and Value-Based Payment / Cost Containment

1. **The goal of design session #4 is to discuss the public option plan's benefit structure and integration of value-based payment.** Administrator Suzanne Bierman outlined the following questions that DHHS seeks to answer:

    a. What is most needed to ensure that enrollees have access to the care they need?
    b. How can the state align its purchasing strategies, cost-controls, and value-based care between its Medicaid MCOs and Exchange initiatives?
    c. Are there opportunities to leverage provider contracting and value-based care to improve equity, access, and culturally competent care?

2. **Public option products must cover essential health benefits (EHBs), but DHHS seeks feedback on any additional benefits that should be included, especially in mental health care.** EHBs include preventive services, ambulatory and emergency services, maternity and newborn care, mental health and substance use disorder (SUD) services, hospitalization, prescription drugs and laboratory services, rehabilitative services, and pediatric services. Anne Karl asked if there are any additional benefits that the public option should include, such as care coordination, dental services for adults, or more extensive coverage of behavioral health services.

    Karl expanded on considerations for mental health benefits, explaining that the statute requires plans to cover inpatient SUD services with a minimum benefit of $9,000. She also outlined other covered services, including intensive outpatient treatment for SUD, mental health outpatient clinic, and tobacco cessation. Karl asked for information on challenges to coverage, access, and affordability. Karl also asked how the mental health benefit can be enhanced to be most impactful.

3. **SB 420 requires that the DHHS Director encourage the use of VBP to increase value and improve health outcomes but gives the state flexibility in designing VBP requirements and policies.** Presenters highlighted key considerations for VBP design, including that VBPs

can be used across multiple markets via multi-product VBP contracts between plans and providers and that incentive payments to providers need to be adequately generous to motivate investment in value-based care. Staff also outlined Nevada's history with VBP. In 2021, the state began to require Medicaid managed care organizations (MCOs) to adopt alternative payment models (APMs). The state is using the Health Care Payment Learning and Action Network (HCP-LAN) APM framework to categorize and measure provider payments.

4. **Nevada has several options in how it approaches VBP in the public option.** Nevada may take a state-directed approach such as directing per-member per-month (PMPM) payments for certain services or establishing an incentive-based payment schedule for plans to use. Conversely, Nevada may take a less prescriptive plan-led approach such as allowing plans to design their own approaches to achieve state-specified targets. DHHS seeks feedback on these options or other delivery system and payment reforms. DHHS also seeks feedback on whether Nevada should explore other cost containment strategies and any other information that is needed to guide the state in developing these plans.

5. **Different stakeholders provided contradicting opinions on benefits and VBP.** A health plan representative argued that adding benefits beyond EHBs will increase premiums, contradictory to the goal to offer a premium below marketplace value. A member of the community also urged DHHS to keep premiums low. Other patient advocates asked for coverage of comprehensive behavioral health services and the inclusion of caregiver support and training. The health plan representative also advocated for DHHS to take a plan-led approach to VBP in encouraging insurers to develop their own APM methodologies.

January 18th: Design Session #5 – Health Plan Rate Setting and Review, Provider Contracting and Networks, and Strengthening Individual and Small Group Markets

1. **DHHS seeks feedback from the public on the following questions regarding network adequacy, rate review, and strengthening the Marketplace:**

    a. Does the state have additional network adequacy initiatives the public option should consider beyond the minimum requirements for the marketplace as outlined in SB 420? Are these initiatives needed to help improve access for consumers enrolled in the public option plans?
    b. How should state agencies coordinate the rate review process to provide oversight of the mandated premium reduction requirements while balancing administrative burden?
    c. Should the state pursue policies that could strengthen the Marketplace, and if so, which policies?

2. **The public option plans are subject to Exchange network adequacy requirements, but DHHS is considering additional network adequacy requirements to align with Medicaid network adequacy.** SB 420 requires the Director of DHHS to reward alignment of Medicaid managed care and public option networks; include cost-based reimbursement providers; include proposals to strengthen the workforce in key areas such as primary care, behavioral health, and in rural areas; and reward approaches that reduce disparities, expand access, and expand culturally competent care. **Consultant Stacie Weeks** highlighted

Colorado as an example of including cultural competency in network adequacy. In the Colorado public option, carriers must describe efforts to construct culturally responsive networks and must include the majority of essential community providers in a service area in the network.

Weeks asked if the state has additional network adequacy initiatives, such as those in Medicaid, that should be considered in procurement for the public option. She compared network adequacy standards between Medicaid and QHPs. In Medicaid, the state Medicaid agency monitors network adequacy using time and distance standards and provider to member ratios. For QHPs, the State Exchange relies on the Division of Insurance (DOI) to conduct network adequacy reviews. To meet network adequacy requirements, QHP network plans must:

a. Contain the standards in the Centers for Medicare & Medicaid Services' (CMS') *Letter to Issuers in the Federally-facilitated Marketplaces* (2022 Letter);
b. Provide reasonable access to at least provider in specified specialty areas for at least 90 percent of enrollees and complies with maximum time and distance standards specified in Nevada Administrative Code (NAC) 687B.768;
c. Contract with at least 30 percent of the essential community providers (ECPs) in the service area of the network plan that are available to participate in the network;
d. Offer contracts in good faith to all available Indian health care providers in the service area of the network plan; and
e. Offer contracts in good faith to at least one ECP in each ECP category.

The Network Adequacy Advisory Council (Council) also provides recommendations to DOI. The Council was established to recommend alternative standards for determining whether a carrier's provider network plan is adequate. The Council provides annual recommendations to the Commissioner of Insurance, who decides whether to accept and act on the recommendations. Weeks asked if there should be any network adequacy requirements for public option plans that go beyond those developed by the Council. The Council's most recent recommendation for plan year 2023 can be found here.

3. **As previously stated, the DOI reviews QHP network adequacy. However, for the public option, DHHS will also have a role in network adequacy as it will review and evaluate plans' premiums and network adequacy as part of the public option procurement process.** DHHS seeks feedback on how state agencies can coordinate the rate review process for the public option to minimize administrative burden, recognizing that DHHS will be involved as an additional regulating body.

4. **"Strengthening the Marketplace" can mean different things across stakeholders, and DHHS seeks feedback in what a strong Marketplace looks like, whether it be measured by the amount of carriers in the market, the amount of plans that are offered, lowered premiums, lowered cost-sharing, or a combination of factors.** Another consideration is that the state must balance creating a public option product with a tailored and desirable design with avoiding reducing competition in the Marketplace. Karl suggested that one possible policy could be to implement a reinsurance pool, which can provide subsidies to carriers for high-cost enrollees and reduce enrollee premiums. A 2019 actuarial analysis in

Nevada found that combined with a 1332 waiver, a reinsurance pool could reduce average premiums by 13 percent. However, it also found that external funds are necessary for reinsurance in the state to be successful. This may include pass-through funding, but additional funds are likely to be necessary. The state can also leverage the procurement process to change the cost-sharing design.

5. **Stakeholders generally supported maintaining current network adequacy standards but with different reasons.** A health plan stakeholder stated that Nevada has robust network adequacy for QHPs, including a council with diverse representation. A provider stakeholder stated that while DHHS should avoid "skinny networks" with limited provider availability, network adequacy is difficult given vast workforce shortages. The stakeholder advocated for this issue to be addressed first to improve access to care.

January 28th: Design Session #6 – Licensure and Oversight, Offering the Public Option in the Small Group Market, and Next Steps

1. **Public option plans will be subject to oversight from DOI, Exchange, and DHHS.** DOI will perform annual rate reviews, review requirements for forms and binders including network adequacy, and monitor solvency, as required for other QHPs. The Exchange certifies QHPs and determines eligibility for premium tax credits. DHHS will act as an additional agency performing oversight for the public option as it is directed by SB 420 to oversee procurement and work with DOI and the Exchange to ensure state requirements are met through ongoing engagement in contract oversight activities.

2. **DHHS' specific role in oversight will be largely determined by the state's public option contracts with carriers.** Anne Karl mentioned that DHHS has heard that network adequacy is one challenge in access to care and suggested public option plan contracts can have heightened network adequacy requirements as discussed in the previous design session, in which case DHHS will provide oversight to ensure that these requirements are met. DHHS will also work with DOI and the Exchange to provide oversight in monitoring requirements such as premium reduction and any VBP guidelines. DHHS seeks public feedback on the following questions regarding licensure and oversight:

    a. What are the biggest risks of having DHHS as an additional agency playing a role in oversight?
    b. What areas should DHHS consider for additional oversight?

3. **The policies that DHHS is considering to strengthen oversight point to greater alignment with oversight in Medicaid managed care**. DHHS can leverage contracts to require public option plans to report quality and encounter data, similar to requirements for Medicaid managed care plans. DHHS can also work with DOI to streamline reporting of financial information between Medicaid managed care and the individual market. DHHS can also require carriers to share data with the State Health Information Exchange (HIE) or All-Payer Claims Database (APCD). Karl asked what Medicaid managed care flexibilities or policies can be extended to the Marketplace. She pointed to medical loss ratio (MLR) reporting guidance and in-lieu-of services (ILOS) authorized under 42 CFR §438.3(e)(2) as examples of policies that could be applied to the public option.

4. **SB 420 gives the state the option to make the public option available to small employers through the small group market, but DHHS requires more information and feedback to make this decision.** DHHS seeks feedback on the following considerations for offering the public option in the small group market:

    a. What are the trade-offs to offering the public option on the small group market?
    b. Are there other actions the state can take that would benefit small business and their employees, such as expanding access to employer subsidies in the individual market?
    c. Should the state recommend a specific stakeholder engagement process and separate analysis studying the potential impacts of the public option in the small group market?

5. **DHHS is moving into Phase 2 of the public option implementation timeline, which involves the actuarial analysis and additional stakeholder engagement.** DHHS will release a synopsis of the six design sessions to conclude Phase 1 of the process. The actuarial analysis will be completed for public review in spring or summer 2022, after which DHHS will hold a public presentation on the findings from the analysis and any updates on the waiver. As directed by SB 420, the actuarial analysis will give special focus on the effects of the provider participation requirement on market premiums. DHHS will solicit feedback on the analysis at this presentation. DHHS will also solicit public feedback on a draft 1332 waiver application through a stakeholder outreach plan and two public hearings. The draft application will be posted for public comment for 45 days in fall 2022, then DHHS will incorporate all public feedback to submit a draft application by February 2023. Meanwhile, stakeholders may track progress on the timeline through a dashboard that the state will publish on its public option website.

6. **Stakeholders from a variety of backgrounds emphasized the need for direct consumer feedback for different reasons.** A representative from AARP Nevada commented that the stakeholder input process as designed is not conducive to soliciting feedback from the average consumer. He stated that the idea of a public option has become politically polarized, with some consumers seeing it as an example of government overreach. He recommended that DHHS conduct focus groups to directly connect with consumers. Other stakeholders emphasized the need for consumer feedback to understand why currently eligible individuals are not enrolled in coverage. A health plan representative stated that 37 percent of individuals eligible for Medicaid are not enrolled in coverage and stressed the need for aggressive enrollment outreach. She asked, if individuals are already eligible for coverage through Medicaid or the Exchange, what the impetus would be for them to enroll in a public option plan that is more costly to the consumer. A provider representative added that there should be an independent survey process to understand why eligible people do not participate in coverage. Finally, some stakeholders from insurers and providers asked what population the public option will target, emphasizing that this basic question must be answered to answer other design questions.