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# Senate Concurrent Resolution No. 10 Study: Evaluating Public Health Insurance Plan Options for Nevada Residents

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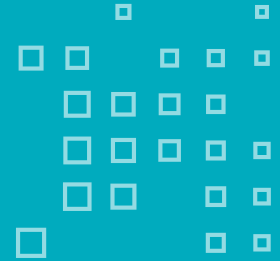
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## Executive Summary

Enacted in 2019, Senate Concurrent Resolution 10 (SCR 10) directed the Legislative Commission to conduct a study exploring the feasibility, potential design and impact of a publicly offered health insurance plan, or public option, to improve the stability of Nevada's health insurance market, decrease the number of uninsured Nevadans and increase access to affordable health insurance coverage.

This report outlines two potential public option models for Nevada based on key design considerations including the specific target population that may enroll, opportunities to achieve cost savings, the plan affordability for potential enrollees, implications for existing health insurance offerings, and the feasibility and projected cost of implementation.

Notably, the premium, enrollment and market impact estimates in this report do not account for the potential impact of the ongoing COVID-19 pandemic on Nevada's healthcare and economic landscape.

### Models for Consideration and Estimated Impact

This report explores in detail two public option models:

- A public option offered through a "buy-in" to Nevada's Public Employees' Benefits Program (PEBP)
- A public option offered through Nevada's Marketplace, Nevada Health Link, as a qualified health plan (QHP)

Either of these plans would be offered statewide and would be designed to meet the needs of the populations in Nevada facing barriers to coverage: the currently uninsured and underinsured, particularly those residing in the state's rural areas. The selection of the two models for evaluation was based on the enacting legislation (SCR 10 directed the study to explore a PEBP-based option) as well as conversations with healthcare stakeholders throughout Nevada.

This report includes an actuarial estimate of the premiums, enrollment and market impact associated with each model.

### PEBP Buy-In Plan

**Overview:** Under this model, Nevadans would have the option of purchasing coverage through a PEBP look-alike plan. The plan would be offered outside the Affordable Care Act (ACA) individual market, either through a new risk pool or as part of an existing PEBP risk pool. As a result of being outside the individual market (and off the Marketplace), PEBP buy-in enrollees would be ineligible for federal tax credits.

A PEBP buy-in plan would be administered by PEBP, and while a PEBP buy-in plan would benefit from the agency's existing infrastructure, expertise and statewide contracting relationships, the state will need to address startup and ongoing implementation costs (e.g., staffing and technology) if Nevada policymakers choose to pursue a PEBP buy-in public option.

Product affordability would derive from reduced overhead relative to other commercial coverage (from administrative efficiencies and no profit margin) and a statewide risk pool to smooth out geographic and health status premium differences. Based on its design, the PEBP buy-in would be most attractive to

Nevadans who are not eligible for tax credits offered on the Marketplace, due to income (over 400% of the federal poverty level (FPL)) or immigration status. Since the PEBP benefit package is comparable to Marketplace Gold coverage, it may also be attractive to individuals seeking a higher-value plan. The state may also encourage small businesses to subsidize PEBP buy-in coverage for their employees through Health Reimbursement Arrangements (HRAs).

**Estimated Impact:** The analysis finds that introducing a PEBP plan as a new risk pool would not be viable without significant state subsidization because the small pool of enrollees and likelihood of attracting a disproportionate number of enrollees from high-cost areas will result in high premiums. However, introducing a PEBP buy-in plan that combines buy-in enrollees with the existing state employee and retiree risk pool is a viable option. Under this model, projected premiums for a 2022 buy-in are estimated at \$440–\$444 per month, depending on the health risk profile of collective enrollees, or 9% cheaper than similar coverage on Nevada Health Link, as projected in 2022. The premium difference would be more significant in rural areas, where Nevada Health Link premiums are higher than the statewide average. The buy-in at this premium level is expected to attract approximately 6,500 enrollees, with the majority of enrollment from the uninsured population in rural counties.

While impact to the individual market would be negligible under this option, the new buy-in is estimated to increase PEBP premiums by 2%–3%, based on the assumption that buy-in enrollees would have a less healthy risk profile than current state employees. This change in premiums could be absorbed by enrollees in the form of higher premiums, could be accrued by PEBP as HRA contributions, or could be separately subsidized through a state appropriation, estimated to total between \$6.5 million and \$9.6 million annually.

## State-Sponsored Marketplace QHP Public Option

**Overview:** Under this option, the state would sponsor QHPs offered at Silver and Gold cost-sharing levels on the Marketplace and in the individual market—either through a contract with an existing insurer or administered directly by a state agency. In either scenario, the Silver State Health Insurance Exchange (the state agency that operates Nevada Health Link) or the Division of Health Care Financing and Policy could oversee the product. If a state agency administers the plan, it can do so in partnership with a third-party administrator (TPA) to administer the provider network and process claims. Similar to a PEBP buy-in plan, this model would benefit from existing state infrastructure, but may incur additional startup and implementation costs that would need to be borne by the state.

The target population for this product would include both subsidized and unsubsidized populations who may benefit from a lower-premium product. Because this plan would be offered on the Marketplace and would be an ACA-compliant QHP, enrollees eligible for federal tax credits could use them to offset premium costs. The state could also offer a mirrored product outside the Marketplace (and in the individual market) to allow people who are ineligible for Marketplace coverage due to immigration status to enroll.

A key consideration for a Marketplace QHP public option is how it will contain costs as compared with existing offerings. The analysis outlined in this report assumes a 10%–20% premium reduction for illustrative purposes, but to achieve such a reduction, the state will need to determine how to contain costs, such as setting a provider reimbursement cap or a premium reduction target for contracting insurers.

**Estimated Impact:** The analysis in this report assumes Silver- and Gold-level state-sponsored public option plans, which gives enrollees a choice of a higher-value product with improved cost-sharing. Under the 10% and 20% premium reduction scenarios, the Silver plan monthly average statewide premium would cost \$297–\$358 and the Gold plan would cost \$385–\$433, either on- or off-Marketplace (with off-Marketplace plans being slightly cheaper within that range). Enrollment is estimated at 9,000–32,000 individuals, of which 1,500–4,900 would be previously uninsured, depending on the premium reduction scenario. Overall, the individual market is estimated to grow in size by 0%–5.6%, depending on the scenario.

## Additional Implementation Considerations

To ensure increased affordability, both models may ultimately require some financial investment from the state to fund new operational functions within the administering agency, or to prevent premium increases in the existing PEBP by subsidizing the expanded buy-in program.

Nevada policymakers may also consider the utility of an ACA Section 1332 State Innovation Waiver to allow the state to offer a Gold-only plan on Nevada Health Link, to capture pass-through tax credit savings due to benchmark plan changes or to use federal tax credits for a PEBP buy-in outside of Nevada Health Link. The following report explores these options in more detail.

## Next Steps

As directed by SCR 10, this report outlines potential models and design features for a feasible and meaningful public option for Nevada. It is meant to memorialize conversations with state stakeholders, to put forth an initial analysis of public option plans, and ultimately to inform ongoing discussions among the public, state lawmakers and other stakeholders regarding the future of coverage programs in Nevada.

# Introduction

## Overview of SCR 10

The Nevada Legislature enacted SCR 10 during the 2019 legislative session, calling for the state to conduct a study of the feasibility, viability and design of a public healthcare insurance plan, or a “public option.” The resolution further requires that the analysis include a public option plan within PEBP, Nevada’s health insurance program for over 70,000 state and local employees and retirees.

The concept of a public option/Medicaid buy-in is evolving but generally encompasses programs through which the state can leverage its government bargaining power to offer a more affordable coverage option compared with existing health plan offerings.

The state identified three key goals for the study considering the design of a public option:

- **Improve insurance market stability.** The first goal is to improve the stability of the health insurance market in Nevada. Against the backdrop of COVID-19, the imperative to ensure that current markets are strengthened and not further disrupted is particularly relevant.
- **Decrease the number of uninsured Nevadans.** The second goal is to reduce the number of Nevadans without health insurance coverage. Among Nevada’s nonelderly population, about 13% (or 331,700 people) lacked health insurance as of 2019, before the COVID-19 pandemic—well above the 10% national average.
- **Increase access to affordable coverage.** Finally, a public option should increase access to affordable coverage for healthcare services to all Nevadans. This report elaborates on some of the specific barriers to access and affordability facing Nevadans, and examines two public option designs as a tool to ameliorate those barriers.

## Current Sources of Coverage in Nevada

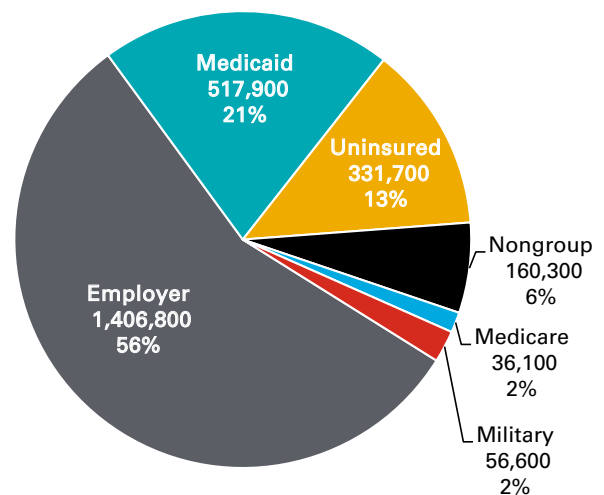
Coverage distribution in Nevada broadly mirrors national trends. As of 2018, a majority (56%) of Nevadans received their health insurance coverage through their employer, about 21% received coverage through Medicaid, and 6% received coverage through nongroup coverage, which includes the state’s Marketplace enrollees.<sup>1,2</sup> Notably, however, these counts do not reflect changes in 2020 due to the COVID-19 pandemic, which is likely shifting more Nevadans toward public coverage sources and uninsured status.

### Marketplace

As of early 2020, approximately 77,410 Nevadans were enrolled in health insurance coverage through Nevada Health Link, operated by the Silver State Health Insurance Exchange.<sup>3</sup> Nevada Health Link is Nevada’s state-based health insurance Marketplace, which offers plans arrayed into metal tiers based on their actuarial value; Bronze, Silver and Gold plans have actuarial values of 60%, 70% and 80%, respectively. Insurer participation in Nevada Health Link is robust and on the rise; from 2019 to 2020, the number of Marketplace insurers rose from two to three, and in 2021, there will be five issuers offering coverage through Nevada’s Marketplace.

Those with incomes between 100% and 400% FPL may receive federal subsidies for their coverage in the form of advanced premium tax credits and/or cost-sharing reductions. These subsidies make coverage more affordable for approximately 80% of Nevada Health Link’s enrollees, who earn too much to qualify for Medicaid and do not have an affordable offer of employer-sponsored coverage.

Figure 1. Nevada Sources of Coverage, Ages 0–64, 2018



Without subsidies, the average Silver premium in Nevada is \$372 per month for an individual—lower than the national average of \$442. Cost-sharing for plans on Nevada Health Link, however, is higher than Marketplace plan cost-sharing in neighboring states.

## **Medicaid**

Nevada's Medicaid program has been a main driver of coverage gains in the state in the past decade; Medicaid covered about 330,000 Nevadans before Nevada opted to adopt the ACA's expansion of Medicaid to adults with incomes below 138% FPL. At the end of 2019, Nevada Medicaid covered twice that number of Nevadans, over 625,000 people, or about 20% of Nevada's population.

While Nevadans in Clark and Washoe counties are enrolled almost exclusively in managed care, Nevada offers fee-for-service Medicaid coverage in rural areas, with approximately 74% of enrollees in managed care and 26% covered under fee-for-service Medicaid statewide.<sup>4</sup>

At the same time, Nevada's Medicaid program has faced significant challenges due to COVID-19. Job losses due to COVID-19 have fueled program growth, with enrollment growing to over 755,000 enrollees as of October 2020, an increase of more than 17% since February 2020.<sup>5</sup> The state is also facing significant budget pressure as a result of the COVID-19-related economic downturn. An August 2020 budget reduction package cut provider reimbursement under Medicaid by 6% due to decreased state revenues.<sup>6</sup>

## **Public Employees' Benefits Program**

PEBP is Nevada's state health insurance plan for state employees and retirees and covers more than 70,000 Nevadans.<sup>7</sup> It maintains two separate, statewide risk pools: one for current state employees and retirees and one for nonstate members (including, for example, employees and retirees of local governments and municipalities).

State subsidization of PEBP coverage is dynamic based on the enrollment mix, as participating agencies and nonstate governmental entities (e.g., local and municipal government entities) contribute a monthly assessment per enrollee. In fiscal year 2020, the state was expected to contribute over \$286 million in subsidies for the program, and the plan was budgeted to receive nearly \$30 million in subsidies from other nonstate employers.

PEBP leases its provider networks from commercial carriers through a procurement process with a TPA for plan administration. The plans PEBP offers include a statewide consumer-driven health plan (CDHP), which is a high-deductible health plan (HDHP) that can be coupled with a Health Savings Account (HSA) or an HRA for some enrollees; an exclusive provider organization (EPO) plan in northern Nevada; and a health maintenance organization (HMO) plan in southern Nevada.

PEBP covers medical, dental, vision and pharmacy services.<sup>8</sup> Similar to Medicaid, PEBP faced budget reductions due to COVID-19. The PEBP board, to achieve a target budget savings of 6% as directed by Governor Steve Sisolak's Finance Office, reduced their catastrophic and HRA reserves and implemented HRA rollover caps for retirees. These measures were selected in order to have a minimal impact on enrollees.<sup>9,10</sup>



## Nevada's Uninsured

Nevada has made significant strides over the past decade in reducing the number of Nevadans without health insurance, though there is still room for progress. The uninsured rate among those under age 65 (who are ineligible for Medicare) dropped from 25% in 2010 to 13% in 2018,<sup>11</sup> in large part due to the health coverage programs enacted by the ACA. While the state's uninsurance rate remains above the 10% national average, Nevada's significant gains in coverage point to a positive trend, with momentum for additional coverage gains.

The uninsured population in Nevada is primarily individuals and families with modest incomes, with 83% of uninsured people falling below 400% FPL.<sup>12</sup> Approximately 33,000 uninsured individuals are ineligible for Medicaid or Marketplace subsidies based on their income, while 35,000 are ineligible for Marketplace subsidies due to an offer of employer-sponsored coverage that is officially deemed affordable.<sup>i</sup> This is often referred to as the "family glitch," a structural issue preventing some family members of employees with access to employer-sponsored insurance from being eligible for tax credits. Individuals impacted by the family glitch are ineligible for tax credits because of a family member's access to employer-sponsored coverage that is deemed "affordable" for both the individual and his or her family based solely on the cost of individual coverage rather than the cost of the family plan. Spouses in particular may consider coverage unaffordable and therefore be uninsured (children may be eligible for Medicaid or the Children's Health Insurance Program, CHIP). These family members fall into the family glitch, and because neither the employer nor the Marketplace coverage is truly affordable, they are at an increased risk of being uninsured. Finally, approximately 84,000 Nevadans are ineligible for Medicaid or Marketplace subsidies due to their immigration status.<sup>13</sup>

Geographically, the remaining uninsured are not evenly distributed. While the majority live in more urban areas of the state—with about 92% of the uninsured in counties classified as urban by the Nevada State Office of Rural Health (Carson City, Clark and Washoe counties)—this aligns with the overall state population distribution; just under 10% of Nevada's population reside in rural areas, and 90% live in urban areas. Several rural counties have the highest rates of uninsurance in the state, including Mineral, Humboldt and Pershing counties, which have uninsurance rates of 15%, 16% and 16.5%, respectively.<sup>14</sup>

## The Underinsured

Even for those with health insurance, some individuals may still find premiums and cost-sharing unaffordable and therefore may have difficulty accessing healthcare. Additionally, some insured individuals may find care inaccessible in rural areas with limited providers. A key feature of having health insurance is being able to access quality care. When benefits or provider networks are too narrow, or cost-sharing is too high, health insurance is not truly providing access to care. Nationally, in the individual market, a single person earning just over 400% FPL (\$50,000/year) with average health needs spends \$4,500 in premiums and

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<sup>i</sup> Coverage is deemed unaffordable if an employee's share of premiums exceeds 9.78% of the employee's household income in 2020. In 2021, the threshold will be 9.83%.

\$2,450 in additional out-of-pocket (OOP) health costs, or 14% of their annual income. For a person in worse-than-average health, total spending increases to 21% of their income. This level of healthcare spending is unsustainable for many families and individuals.

On Nevada Health Link, premiums are below the national average while deductibles are high relative to neighboring states. 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.

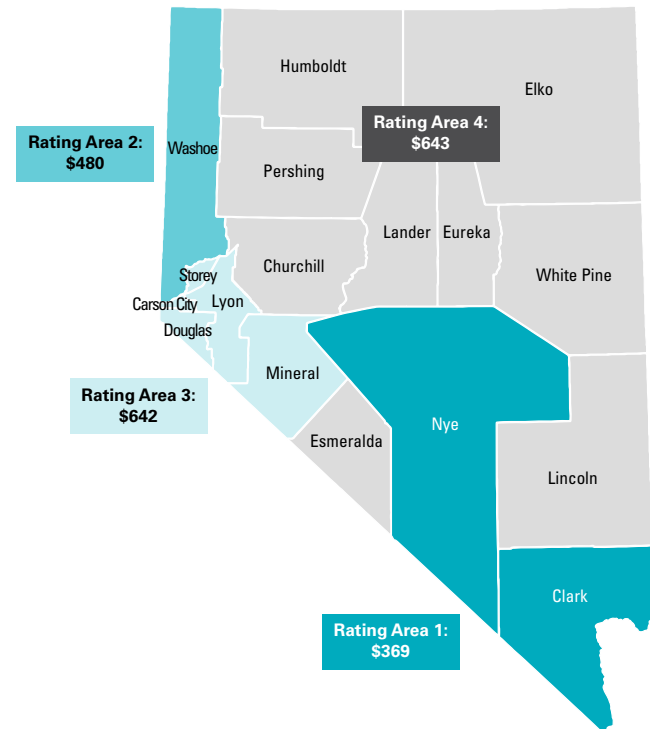
HDHPs have received national attention for their relatively low premiums coupled with high deductibles, which create cost barriers for insured enrollees who require care. Evidence shows that HDHPs generally decrease the amount of care consumers receive, including appropriate care, because enrollees defer treatment due to OOP costs.<sup>15</sup> As a policy matter, Nevada seeks to ensure not only that Nevadans are covered by health insurance, but also that insured individuals are able to use their insurance.

## Rural Affordability and Access

Nevada's rural areas are distributed throughout the state and are inhabited by only about 10% of the state's population (about 268,660 individuals). This poses unique challenges for healthcare affordability and access in these areas. More than four in five rural Nevadans (81.4%) live in a primary medical care professional shortage area, according to 2016 data. Further, rural counties have fewer specialists than do urban areas. In total, rural areas have 72.3 allopathic physicians per 100,000 residents, as compared with over 190 per 100,000 residents in urban counties.<sup>16</sup> The lack of healthcare workers not only impedes access, but it also inflates prices due to lack of provider competition.

Many Nevadans in rural areas work for large employers, such as in the mining industry, providing them with relatively robust health insurance coverage. Others are eligible for and enrolled in Medicaid or subsidized Marketplace coverage, with approximately one in five (50,996 total) rural Nevadans enrolled in Medicaid in 2018.<sup>17</sup> However, Nevadans who work for smaller employers and who are not eligible for government tax credits due to their income or immigration status have limited options, as Marketplace premiums are high relative to their incomes. In comparison with premiums in more urban rating areas, Marketplace premiums are almost double in rural areas (see [Figure 2](#)).

**Figure 2. Nevada Average Marketplace Premiums by Rating Area (2019)**



Based on the benchmark, second-lowest-cost Silver plan for a 40-year-old. Source: Nevada Division of Insurance, Health Insurance Rates, 2020.

Those in rural areas enrolled in PEBP coverage benefit from premiums lower than those available through the Marketplace (without subsidies), in large part because PEBP's premiums are uniform statewide. This means that lower-cost urban areas bring down costs relative to high-cost rural areas, whereas Marketplace premiums are determined by smaller rating areas, concentrating high premiums in high-cost areas.

The high cost for health insurers to provide coverage in rural areas is due to several factors. First, there is a lack of freestanding diagnostic facilities in rural areas, which requires plans to contract with higher-cost hospital-based diagnostic services, often at Critical Access Hospitals. Second, specialists in Nevada are concentrated in urban areas, preventing competition among specialists in rural areas. Due to these cost challenges, many insurers pay for their members to receive care out of state or direct members to providers in Clark or Washoe counties.

### **The Impact of COVID-19**

The COVID-19 pandemic is placing unprecedented strain on Nevada's healthcare system and economy and may create new challenges for Nevada as it considers options for improving healthcare affordability throughout the state. COVID-19 has shed a light on and exacerbated existing economic and health disparities. Nationally, a disproportionate burden of COVID-19 is falling on Black/African American, American Indian/Alaskan Native (AI/AN), Pacific Islander and Latino/Latina/Latinx populations.<sup>18</sup> Additionally, the pandemic will have short- and long-term impacts on consumers, healthcare industry stakeholders and the state. Some of the industries that are integral to Nevada's state revenues and to employing Nevada's residents are hardest hit by the pandemic—including hospitality, culinary services and business travel. The still-unfolding consequences of the pandemic are likely to change the coverage landscape in the state, impair solvency of key providers and plunge some Nevadans further below the poverty line. For more on the potential impacts of COVID-19 on the Nevada healthcare system, see page 32.

## **Potential Public Option Models for Nevada**

Of the three programs under consideration as a potential source of new coverage—Marketplace, Medicaid and PEBP—two were chosen for comparative analysis in this report, based on meetings with state officials and stakeholder interviews.

In this report, Manatt Health, in partnership with Wakely Consulting for actuarial analysis, considers a PEBP buy-in model and a state-sponsored plan made available on Nevada Health Link as a QHP.<sup>ii</sup> Both of these options could potentially lower costs for Nevadans in key ways—including by offering the state greater influence on product design and issuers compared with current offerings and by leveraging the state's

<sup>ii</sup> A QHP is a health insurance plan offered through a Marketplace established by the ACA. QHPs must abide by specific criteria, including coverage of ten essential health benefits and specific cost-sharing limitations, among others.

bargaining power. These affordability levers include changes to provider payment rates, administrative efficiencies, heightened negotiating power, and long-term public health and/or cost-containment investments. These levers are explored in more detail throughout this report.

For the purposes of this analysis, a Medicaid-based model is not included due to concern that a Medicaid buy-in design with Medicaid provider rates (which are typically lower than Medicare and commercial reimbursement rates) would not be feasible in the Nevada context. It should be noted, however, that the Division of Health Care Financing and Policy, the state’s Medicaid agency, could play a role in administering a public option plan based on its experience contracting with vendors in the Medicaid managed care program.

Provider rates in PEBP and in QHPs on Nevada Health Link are understood to be much closer to rates offered by commercial insurers, and therefore are preferred by providers, contributing to their selection as potential models. But despite exclusion of the Medicaid-based model due to rate sufficiency concerns, achieving increased affordability may require a reduction in rates from current levels. The mechanisms for cost savings in all public option models will vary and are to be determined by the state.

A brief overview of each model is provided here, with a comparison of specific design parameters of each option in the chart below. Following this outline, an in-depth discussion of specific implementation considerations and premium and enrollment analysis are included for each model.

**Figure 3. PEBP Buy-In and On-Marketplace Public Option Overview**

Public Employees’ Benefits Program Buy-In	State-Sponsored Public Option
<ul style="list-style-type: none"> <li>• The state makes state employee-like coverage available to consumers who are not eligible for those programs as a buy-in product</li> <li>• Coverage offered as an off-Marketplace, state-administered buy-in plan</li> </ul>	<ul style="list-style-type: none"> <li>• The state offers a state-sponsored QHP on Nevada Health Link</li> <li>• The state may also offer a mirrored off-Marketplace individual market plan to those who do not qualify for Marketplace coverage or subsidies (e.g., due to immigration status)</li> <li>• Potentially a partnership with an existing insurer (e.g., Medicaid managed care plan) or administered by the state with a TPA partner</li> </ul>

**PEBP Buy-In Plan:** Under this model, Nevadans would have the option of purchasing coverage through a PEBP look-alike plan. The plan would be offered outside the ACA individual market as either a new risk pool or as part of one of the existing PEBP risk pools. As a result of being outside the individual market (and off the

Marketplace),<sup>iii</sup> PEBP buy-in enrollees would be ineligible for federal tax credits. Product affordability would derive from reduced overhead, a statewide risk pool to smooth out geographic and health status differences, and negotiated provider rates (see additional discussion below).

Based on its design, the PEBP buy-in would be most attractive to Nevadans who are not eligible for tax credits offered on the Marketplace, due to income (over 400% FPL) or immigration status.

**State-Sponsored QHP Public Option:** Under this option, the state would sponsor QHPs offered at Silver and Gold cost-sharing levels<sup>iv</sup> on the Marketplace and in the individual market—either through a contract with an existing insurer or administered directly by a state agency. In either scenario, the Silver State Health Insurance Exchange (the state agency that operates Nevada Health Link) or the Division of Health Care Financing and Policy could oversee the product. If a state agency administers the plan, it can do so in partnership with a TPA to administer the provider network and process claims. Because this model is an ACA-compliant QHP, enrollees eligible for federal tax credits could use them to offset premium costs.

This plan would be most appealing to the unsubsidized population if it reduces premiums. Subsidized enrollees are shielded from most premium changes in Silver-level plans because of how their subsidies are calculated, therefore the state-sponsored Silver QHP would need an additional differentiator to attract enrollees eligible for subsidies. A lower-premium Gold plan may attract subsidized enrollees shopping for higher-value plans.

Affordability in this option can be achieved in multiple ways. The state can set parameters for participating insurers to lower provider rates and/or increase value-based payments to reach a premium reimbursement target (similar to the Cascade Care approach in Washington). Alternatively, if the state offers a plan with the help of a TPA (instead of contracting with an existing insurer), it can negotiate new rates with providers and will incur lower administrative costs, resulting in reduced premiums.

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<sup>iii</sup> Offering a PEBP buy-in inside the individual market, or on the Marketplace, would require significant changes to the existing PEBP to meet ACA requirements. Therefore, that option was not explored at this time, but could be considered in the future at the state's discretion.

<sup>iv</sup> QHPs are organized by metal tiers with specific actuarial values (AVs), ranging from 60% (Bronze) to 90% (Platinum). The higher the AV, the lower the cost-sharing and the higher the premium. Federal law requires QHPs to follow specific cost-sharing design requirements—including AVs by metal tiers and access to preventive services pre-deductible—reducing flexibility for new cost-sharing design within a public option in the individual market, without a waiver. Having the public option offer coverage at multiple tiers, e.g., Silver and Gold plans, would allow consumers to choose a low cost-share plan with higher premiums to meet their needs.

Design Parameters	PEBP Buy-In Parameters	State-Sponsored QHP Parameters
<p><b>Risk-Bearing/Administering Entity</b></p> <p>The risk-bearing entity is ultimately responsible for the financial risk of the program. The administrative entity is responsible for program operations.</p>	PEBP	Contracted insurer or state with TPA
<p><b>Risk Pool</b></p> <p>Placement in/out of the individual market and on/off the Marketplace will have implications for who enrolls, who has access to tax credits, what regulations are required, how much risk the implementing entity takes on and the potential impact on other markets.</p>	<ul style="list-style-type: none"> <li>Options for a separate risk pool or blending the buy-in population with the existing PEBP state employee risk pool<sup>v</sup> (with legislative changes)</li> <li>Outside of the individual market</li> </ul>	Individual market
<p><b>Eligibility</b></p> <p>Determining the target population and eligibility requirements will influence how the option is designed, the health status of those enrolling and, in turn, the projected premium.</p>	<ul style="list-style-type: none"> <li>Open to all, specifically targeting the uninsured or underinsured</li> <li>May be offered to small businesses with or without an employee contribution</li> </ul>	Marketplace-eligible and populations ineligible for subsidies through a mirrored off-Marketplace product
<p><b>Availability</b></p> <p>Each region or rating area will have a different risk profile and therefore different premiums. For example, rural areas have a small population (and therefore risk pool) and higher provider costs.</p>	Statewide	Statewide
<p><b>Benefits</b></p> <p>These are the medical services covered by the plan; offering more comprehensive coverage is beneficial to consumers but raises cost.</p>	PEBP benefits, excluding dental	Essential health benefits
<p><b>Cost-Containment Mechanisms</b></p> <p>To provide a more affordable product than is currently being offered, some cost-saving measures will be required, which may include changes to provider reimbursement payments.</p>	Using existing PEBP provider rates via a leased network	<p>This analysis uses 10% and 20% premium-reduction scenarios and did not select a provider reimbursement rate. The state can choose to achieve savings via provider reimbursement changes, including:</p> <ul style="list-style-type: none"> <li>Setting a specific target reimbursement rate</li> <li>Requiring plans to achieve premium reductions by a specified amount</li> </ul>

<sup>v</sup> Combining PEBP risk pools will require legislative changes.

Design Parameters	PEBP Buy-In Parameters	State-Sponsored QHP Parameters
<p><b>Premiums</b></p> <p>These are determined by the costs of coverage benefits, service utilization and administering the insurance plan (including taxes and profit margin).</p>	<ul style="list-style-type: none"> <li>• Projected monthly premiums vi of \$440–\$635, depending on the risk pool placement and enrollee health status</li> <li>• PEBP buy-in premiums will use a 3:1 age rating for premiums, mirroring the ACA structure</li> </ul>	<ul style="list-style-type: none"> <li>• Projected monthly premium ranges for on-Marketplace QHP based on 10% and 20% reduction scenarios: <ul style="list-style-type: none"> <li>– Silver: \$318–\$358</li> <li>– Gold: \$393–\$442</li> </ul> </li> <li>• A mirrored off-Marketplace plan will have slightly reduced premiums</li> </ul>
<p><b>Cost-Sharing</b></p> <p>The amount consumers contribute toward the cost of health services, including co-payments, coinsurance and deductibles; cost-sharing design would depend on the delivery model.</p>	Existing PEBP cost-sharing (equivalent to ACA Gold-level)	Silver-level and Gold-level
<p><b>Federal Authority</b></p> <p>Changes to existing ACA requirements would require a waiver; additionally, if the state would like to recoup savings otherwise accrued by the federal government as a result of state policy changes, it can apply for a Section 1332 waiver.</p>	<ul style="list-style-type: none"> <li>• Can be administered without waiver authority</li> <li>• Future iterations may benefit from pass-through funding</li> </ul>	<ul style="list-style-type: none"> <li>• Can be administered without waiver authority</li> <li>• May benefit from pass-through funding or waiving ACA requirements to offer only Gold-level coverage</li> </ul>
<p><b>State Authority</b></p> <p>Some public option designs require changes to state law or exemptions for a state-sponsored plan to operate a lower-cost option.</p>	<ul style="list-style-type: none"> <li>• Depending on design, may require statutory changes to PEBP</li> <li>• May require startup support to meet operational and reserve requirements</li> </ul>	Depending on design, may require legislative or administrative changes to certify a state-sponsored plan with a TPA as insurance coverage
<p><b>Potential Funding</b></p> <p>Both options will be funded by premiums. In addition, the state can provide financial support to help consumers afford premiums and/or cost-sharing payments.</p> <p>State subsidies can be separate from, or build on, existing federal tax credits; subsidies require a sustainable state funding source.</p> <p>Employers may also subsidize coverage costs for their employees.</p>	<ul style="list-style-type: none"> <li>• Premium revenue</li> <li>• Subsidization options: <ul style="list-style-type: none"> <li>– State subsidies</li> <li>– Employer contributions (e.g., HRAs, direct purchase on behalf of employees)</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Premium revenue</li> <li>• Subsidization options: <ul style="list-style-type: none"> <li>– Federal premium tax credits</li> <li>– State subsidies</li> <li>– Employer contributions via HRAs</li> </ul> </li> </ul>

<sup>vi</sup> Throughout this report, premium estimates are based on coverage for a 40-year-old.

## Implementation Considerations for a PEBP Buy-In Model

SCR 10 highlighted PEBP as a key potential vehicle for a public option. In addition to the design parameters discussed above, there are unique opportunities and challenges associated with implementing a PEBP buy-in model in Nevada.

While a PEBP public option would be open for any Nevadan to enroll, it would primarily benefit the currently uninsured or underinsured people, particularly those who earn over 400% FPL in rural areas. This population currently has few or no affordable options for coverage because of both high QHP premiums and lack of access to federal tax credits on the Marketplace.

Since many individuals and families work for smaller employers and because of the high cost of small group coverage, the state may encourage small businesses to participate in a PEBP offering and subsidize coverage for their employees through an HRA.<sup>vii</sup> PEBP already has infrastructure in place to provide an HRA option for local government/municipality employees. In future years, Nevada could consider allowing employers to directly purchase employee PEBP plans, similar to other large group plans. This will create additional operational complexity and should be implemented after the program has been operationalized.

**Risk-Bearing/Administering Entity:** A PEBP buy-in would be administered alongside PEBP's existing plan offerings through the program's TPA and would require additional resources to operationalize and manage.

Today, PEBP is operated by a staff of 34 employees and is governed by a governor-appointed board. Leveraging PEBP's existing operational and governance infrastructure would give the program certain advantages. PEBP already has statewide contracts, covering rural areas and Critical Access Hospitals, which would allow for streamlined buy-in contracting processes. Additionally, using PEBP as the administering entity would allow the buy-in to leverage and enhance PEBP's existing purchasing power, which would result in immediate benefits for the buy-in and potentially overall contract savings in future years. Notably, while an operational framework already exists in PEBP, operationalizing an expanded buy-in plan will require additional capacity and resources within PEBP, including human resources, actuarial services for new premium assessments, technology investments, and funding to meet financial reserve requirements as a result of new enrollees and increases in medical claims.<sup>viii</sup> These administrative costs should be accounted for in implementing legislation.

Based on the PEBP buy-in enrollment estimates listed below (see [Figure 6](#)), Wakely estimates PEBP's reserve requirements will increase by between \$6.8 million and \$8.5 million, or around 20% of current reserves, driven by both the increase in enrollment and the increase in claims. If the reserving methodology changes in the future, the analysis would need to reflect such changes.

<sup>vii</sup> The quantitative analysis in this report does not reflect an HRA option. An HRA is an employer-funded group health plan from which employees are reimbursed tax-free for qualified medical expenses up to a fixed dollar amount per year. These funds can be used to purchase health insurance coverage.

<sup>viii</sup> A previous estimate of the cost of managing a new population ranged from \$500,000 to \$1 million in program enhancements. Projected startup, operational and ancillary costs will depend on the chosen program design and level of integration with the existing program.



**Benefits and Cost-Sharing:** A PEBP buy-in could mirror existing PEBP plans in benefits and cost-sharing design, in part to make it easier to operationalize. PEBP plans span a range of premiums, deductibles and other cost-sharing, but generally include more generous benefits when compared with Marketplace plans. PEBP’s statewide plan, CDHP, compares roughly to a Marketplace Gold-tier plan but includes additional benefits such as vision and adult dental benefits. Figure 4 shows an illustrative comparison between PEBP and Marketplace Silver and Gold plans in 2020. Notably, 2020 CDHP premiums are significantly lower than Marketplace premiums in rural areas (though higher than Marketplace premiums in Clark County), and OOP maximums are lower in PEBP plans compared with QHPs.

The buy-in analysis in this report includes vision services as part of the PEBP buy-in benefit package, but it excludes dental services in order to increase the product’s affordability and comparability to ACA Gold-level coverage. Carving out dental services for the buy-in population will require an operational change to the current PEBP plan. This carve-out is already under consideration by the PEBP board.

Offering a PEBP public option plan with reduced cost-sharing may attract enrollees looking for better value for their premium.

**Figure 4. Nevada PEBP and QHP Cost-Sharing Comparison, 2020**

	PEBP		QHPs (Gold)		Silver*
	CDHP	EPO	Example Plan	Example Plan	Range
Unsubsidized Single Premium	\$639	\$872	Carson: \$656 Clark: \$450 Washoe: \$572 <b>Rurals: \$777</b>	Carson: \$663 Clark: \$508 Washoe: \$576 <b>Rurals: \$798</b>	Clark: \$336–\$450 <b>Rurals: \$653–\$737</b>
Unsubsidized Family Premium	\$1,473	\$2,137	<b>Carson: \$2,097</b> Clark: \$1,439 <b>Washoe: \$1,849</b> <b>Rurals: \$2,485</b>	<b>Carson: \$2,119</b> <b>Clark: \$1,623</b> <b>Washoe: \$1,841</b> <b>Rurals: \$2,554</b>	
Deductible	\$1,500/\$3,000	N/A	\$1,250/\$2,500	\$1,400/\$2,800	\$2,000–\$7,050
OOP Max	\$3,900/\$7,800	\$7,150/\$14,300	\$5,900/\$11,800	\$8,160/\$16,300	\$8,150

\* Based on 40-year old. Source: Nevada Division of Insurance, Health Insurance Rates, 2020.

**Cost-Containment Mechanisms and Provider Participation:** According to various stakeholders, PEBP payment rates are competitive with commercial plan rates and are viewed favorably by providers. This analysis assumes current PEBP provider reimbursement rates; however, increased enrollment in PEBP as a result of the buy-in may result in a better negotiating position and lower costs in future provider network contracts.

An option to include rate setting similar to that of public option programs in other states (e.g., the Washington Cascade Care model of aggregate reimbursement rates at 160% of Medicare) was considered in the PEBP buy-in design. However, PEBP currently leases its provider network, making reimbursement rate setting

less feasible operationally without significantly increasing buying/negotiating power. Provider participation incentives considered in other public option proposals (e.g., tying provider participation in other state programs such as Medicaid to public option participation) may also not be impactful with leased networks.

**Federal Authority:** There is no need for federal approval to provide this coverage option. A buy-in offered outside the ACA individual market and Marketplace gives Nevada relative flexibility in program design and implementation. If the PEBP buy-in is primarily targeted to Nevadans who are ineligible for federal tax credits in the Marketplace, there is limited benefit to a Section 1332 waiver for the initial plan offering. However, Nevada could consider leveraging a Section 1332 waiver if the off-Marketplace PEBP buy-in has significant impact on the existing Marketplace and would benefit from pass-through funding or the state would like to apply to allow enrollees to access federal tax credits outside the Marketplace (see page 28 for more on the potential for a future Section 1332 waiver strategy).

**Risk Pool:** PEBP currently operates two separate risk pools, as required by statute:<sup>ix</sup> one for active state government employees and retirees, and one for nonstate employees (active employees, retirees and their dependents).

A PEBP buy-in could either add enrollees to an existing PEBP risk pool (which would require legislative change) or create a separate risk pool for the buy-in enrollees. The analysis below includes both scenarios: adding the buy-in population as a third PEBP risk pool or including them in the current state employee risk pool. The state employee risk pool was selected as the most viable option for analysis due to its size, data availability and demographic similarities with the buy-in population. The nonstate risk pool consists mostly of retirees with a higher age distribution and is small, with approximately 500 contracts for 2021. The larger risk pool serves to dampen the impact on premiums of new enrollees with unknown health status.

Each of these risk pool scenarios has benefits and drawbacks for the state and public option enrollees. Analytical results for both scenarios are outlined in more detail on page 19.

- **Buy-In as a Separate Risk Pool.** Providing the PEBP buy-in plan as a third risk pool is unlikely to result in affordable premiums for a variety of reasons. First, a stand-alone risk pool must be priced conservatively (i.e., higher premiums) to offset an uncertain health risk mix for the buy-in population. Additionally, because PEBP premiums are statewide, affordable premiums require significant enrollment from urban areas to offset higher costs in rural areas. With a higher premium (and more robust, Gold-like benefits) in a separate risk pool scenario, the plan is likely to be less attractive to urban residents with more low-cost options. Essentially, this could result in a scenario where the premiums end up aligning with current ACA premiums for the highest-cost rating area(s), where only high-need residents in high-cost areas find the PEBP plan (with more robust, Gold-like benefits) attractive, degrading the risk pool health status and further increasing premiums.
- **Buy-In Blended With State Employee Risk Pool.** Offering the public option as part of the PEBP state employee risk pool would increase the size of the risk pool and provide more stable premium rates for buy-in enrollees. Depending on the health status of the buy-in population, this could increase or decrease premiums for the current state employee PEBP population. While the exact health status of prospective

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<sup>ix</sup> Adding or changing existing risk pools within the PEBP program will require revisions to the program's underlying legislation. NRS 287.043, <https://www.leg.state.nv.us/nrs/nrs-287.html>.

buy-in enrollees is unknown, research suggests that individual market enrollees—particularly enrollees who would be attracted to a Gold-equivalent plan—are sicker than enrollees in employer-based insurance plans.<sup>19</sup> Given the state contributions to the state employee plan, significant changes to the health status of the risk pool that impact premiums will also impact the level of state contributions for state employees. If this option is chosen for implementation, blending the risk pool will require changes to existing law.<sup>20</sup>

**Market Impact:** A PEBP buy-in offered outside the individual market will only impact existing market premiums if a significant number of people migrate from individual coverage to the PEBP buy-in. Since the PEBP buy-in offers a richer benefit package (at Gold-level equivalent), it is assumed enrollees seeking robust coverage in the PEBP buy-in would have more health needs than the average individual market enrollee. Therefore, significant movement of this population out of the individual market could reduce premiums for those who remain.

### **Premium and Enrollment Analysis for a PEBP Buy-In Model**

Wakely conducted a preliminary analysis of a potential PEBP buy-in offered in 2022. The goal of the analysis was to estimate the projected premiums, the potential enrollment and the impact of a buy-in on the existing program. The analysis is based on the benefit design of the statewide CDHP plan (excluding dental coverage and existing HRA/HSA contributions) available in 2020. Proposed changes to the 2021 benefit package were not included in this analysis.

As noted above, this analysis includes two scenarios: (1) keeping new PEBP buy-in enrollees in a separate risk pool and (2) blending the buy-in population with the existing state employee risk pool.

**Scenario 1: Separate PEBP Buy-In Risk Pool.** The analysis results imply that a separate risk pool for a statewide PEBP buy-in plan is likely not viable.

The separate risk pool buy-in premium is estimated at \$539–\$635 per month depending on the health status of enrollees, or 15%–35% higher than the projected 2022 PEBP average premium. Since this statewide premium exceeds the premium of similar Marketplace options in urban areas, it is unlikely that residents of those areas will be attracted to the PEBP buy-in. A buy-in at this premium is only expected to attract a low number of enrollees (800–2,600) in the highest-cost rating areas (areas 3 and 4)<sup>x</sup> (see [Figure 5](#)), which represent rural counties with higher-than-average healthcare costs. Without participation for enrollees in lower-cost areas, premiums increase to cover the medical claims from high-cost regions.

Subsidized individuals are unlikely to purchase a buy-in plan that is offered outside the Marketplace and ineligible for federal subsidies. The vast majority of enrollment is projected to come from the uninsured population.

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<sup>x</sup> ACA rating areas were used for the analysis to compare the buy-in against current market premiums and coverage options.

**Figure 5. Separate Risk Pool PEBP Buy-In Plan Enrollment and Premium Scenarios**

Enrollment and Premium Scenarios for PEBP Buy-In Plan Offered in a <u>Separate Risk Pool</u> , by Projected Enrollee Health Status												
	Enrollee Health Status Scenarios											
	High-Morbidity Health Status						Low-Morbidity Health Status					
<b>Projected 2022 per Patient per Month Premium Analysis</b>												
Total Monthly PEBP Buy-In Premium	\$635						\$539					
Comparative Project PEBP Premiums, Minus Dental and HRA/HSA Contribution	\$471						\$471					
<b>Projected 2022 Enrollment Analysis</b>												
	Estimated Enrollment, by ACA Rating Area						Estimated Enrollment, by ACA Rating Area					
	1 Urban Counties	2	3	4 Rural Counties	Total	% of Total	1 Urban Counties	2	3	4 Rural Counties	Total	% of Total
<b>Currently Uninsured</b>					<b>776</b>	<b>94%</b>					<b>2,657</b>	<b>93%</b>
Ineligible for subsidies due to income	0	0	0	335	335	41%	0	4	466	679	1,149	40%
Ineligible for subsidies due to employer offer	0	0	0	278	278	34%	0	3	386	562	951	33%
Ineligible for subsidies due to citizenship	0	0	0	163	163	20%	0	1	226	330	557	20%
<b>Migration From ACA Individual Market</b>					<b>51</b>	<b>6%</b>					<b>186</b>	<b>7%</b>
Currently on-Marketplace	0	3	18	23	44	5%	0	36	57	37	131	5%
Currently off-Marketplace	0	0	0	6	6	0.8%	0	6	39	10	55	2%
<b>Total Expected Enrollment</b>	<b>0</b>	<b>3</b>	<b>18</b>	<b>805</b>	<b>827</b>	<b>100%</b>	<b>0</b>	<b>50</b>	<b>1,174</b>	<b>1,618</b>	<b>2,842</b>	<b>100%</b>
Rating Area Enrollees: % of Total	0%	0.4%	2%	97%	100%		0%	2%	41%	57%	100%	
Take-up by current ACA enrollees, of total market	0%	0%	0.4%	1.6%	0.1%		0%	0.3%	2.2%	2.6%	0.2%	
Take-up by uninsured, of total state uninsured	0%	0%	0%	2.0%	0.4%		0%	0.1%	2.1%	4.0%	1.5%	

Further, even though the enrollment numbers are low in both scenarios, they may be overstated because the PEBP buy-in premium was adjusted to assume the uninsured are more likely to pay a higher premium because the value of the PEBP buy-in is higher than that of the ACA plans. To the extent this is not the case, enrollment in the buy-in could be lower.

**Scenario 2: Blended With PEBP State Employee Risk Pool.** The modeling also includes a blended risk pool scenario with the current state employee PEBP population.<sup>xi</sup>

The analysis implies that a blended risk pool buy-in has a higher take-up as compared with the separate risk pool model. Projected premiums for a 2022 buy-in are estimated at \$440–\$444 per month,<sup>xii</sup> depending on the health status of enrollees. Comparatively, the projected 2022 statewide premium average for ACA Gold-level coverage is \$481–\$491 (see [Figure 7](#) for more information). The PEBP buy-in is approximately 9% cheaper than the average ACA Gold-level plan; however, the premium decrease will be more dramatic in rural counties where ACA plan premiums are higher due to different rating areas. Unlike the state employee premiums, the buy-in premiums use the ACA age rating structure (3:1). Wakely estimates that the buy-in population will be slightly younger than the state employee population, which results in a slightly lower average premium. The buy-in at this premium is expected to attract approximately 6,500 enrollees, with the majority of enrollment from the uninsured population in ACA rating areas 3 and 4. Because the buy-in population is combined with the broader state employee risk pool, geographic differences in enrollees are more diluted than in the separate risk pool model. There is some enrollment from ACA markets in all areas, but the numbers are not large enough to significantly impact existing ACA markets.

However, as described above, this analysis assumes that buy-in enrollees will have a less healthy risk profile than existing state employees. The analysis approximates that changes in the existing risk pool will result in a 2%–3% increase in future PEBP premium costs, or \$6.5 million to \$9.6 million annually. This change in premiums could be absorbed by enrollees in the form of slightly higher premiums, could be accrued by PEBP as part of its dynamic HRA contributions, or could be separately subsidized through a state appropriation. If the increased PEBP contribution or state subsidization is chosen, it should be accounted for as part of the implementing legislation and ongoing cost of the program. Given the current budget shortfall and proposed cuts to PEBP, additional PEBP or state subsidization will likely be challenging to implement.

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<sup>xi</sup> It was determined that the existing nonstate risk pool has a higher age distribution and is too small (approximately 500 contracts in 2021) to serve as a viable blended risk pool scenario. However, given data limitations, some of the assumptions (such as demographics) may incorporate the nonstate data, but the impact on the analysis should be minor.

<sup>xii</sup> This premium under the blended scenario includes medical claims and administrative load only and excludes additional benefits and HRA contributions available to state employees.

**Figure 6. Blended Risk Pool PEBP Buy-In Plan Enrollment and Premium Scenarios**

Enrollment and Premium Scenarios for PEBP Buy-In Plan Offered in a <u>Blended Risk Pool</u> , by Projected Enrollee Health Status														
	Enrollee Health Status Scenarios													
	High-Morbidity Health Status						Low-Morbidity Health Status							
<b>Projected 2022 per Patient per Month Premium Analysis</b>														
Total Monthly PEBP Buy-In Premium	\$444						\$440							
Projected State Employee Premium After Buy-In Introduction (including Dental and HRA/HSA Contributions)	\$544						\$539							
Estimated Premium Impact of Adding PEBP Buy-In Enrollees to the Blended Risk Pool	2.6%						1.8%							
Projected State Contribution to Avoid Premium Increase	\$9.6 million						\$6.5 million							
<b>Projected 2022 Enrollment Analysis</b>														
	By ACA Rating Area						Total	% of Total	By ACA Rating Area					
	1 Urban Counties	2	3	4 Rural Counties	1 Urban Counties	2			3	4 Rural Counties	Total	% of Total		
<b>Currently Uninsured</b>					<b>5,111</b>	<b>79%</b>					<b>5,205</b>	<b>78%</b>		
Ineligible for subsidies due to income	0	148	1,019	1,047	2,213	34%	0	153	1,040	1,061	2,254	34%		
Ineligible for subsidies due to employer offer	0	129	843	866	1,838	28%	0	133	861	878	1,872	28%		
Ineligible for subsidies due to citizenship	0	57	495	508	1,060	16%	0	59	505	515	1,079	16%		
<b>Migration From ACA Individual Market</b>					<b>1,357</b>	<b>21%</b>					<b>1,439</b>	<b>22%</b>		
Currently on-Marketplace	151	161	103	52	468	7%	167	167	105	53	492	7%		
Currently off-Marketplace	388	382	106	14	889	14%	425	400	108	14	948	14%		
<b>Total Expected Enrollment</b>	<b>539</b>	<b>876</b>	<b>2,566</b>	<b>2,487</b>	<b>6,468</b>	<b>100%</b>	<b>592</b>	<b>912</b>	<b>2,619</b>	<b>2,520</b>	<b>6,644</b>	<b>100%</b>		
Rating Area Enrollees: % of Total	8%	14%	40%	38%	100%		9%	14%	39%	38%	100%			
Take-up by current ACA enrollees, of total market	0.8%	3.8%	4.8%	3.6%	1.6%		0.9%	4.0%	4.9%	3.7%	1.6%			
Take-up by uninsured, of total state uninsured	0.0%	3.2%	4.6%	6.2%	2.9%		0.0%	3.4%	4.7%	6.2%	3.0%			

The current estimates in both scenarios do not account for the potential impact on enrollment and coverage costs related to the ongoing COVID-19 pandemic. Additional information on analysis assumptions and methodology can be found on page 33.

These findings suggest that a statewide PEBP buy-in blended with the current state employee risk pool is a viable option for providing a new higher-value coverage option for Nevadans, particularly in rural counties. However, the state will need to carefully consider how to counteract the potential for higher premiums for existing state employees and/or increased costs to provide coverage that is more attractive to new entrants.

## Implementation Considerations for a State-Sponsored Qualified Health Plan Model

Under the parameters laid out on page 14, the state could administer the state-sponsored public option as a QHP offered on Nevada Health Link and eligible for federal tax credits.

Since this plan would be offered on the Marketplace, the target population would include both subsidized and unsubsidized populations who may benefit from a lower-premium product. The state could also offer a mirrored product outside the Marketplace (and in the individual market) to allow people who are ineligible for Marketplace coverage due to immigration status to enroll.<sup>xiii</sup>

A state-sponsored QHP on the Marketplace will need to differentiate itself from current offerings in order to attract enrollees in the Marketplace. In Nevada in 2018, 76,000 people were eligible for tax credits on the Marketplace but remained uninsured. A new state-sponsored public option on the Marketplace with lower premiums and state backing could be attractive to Nevadans who remain uninsured.

The plan would be offered statewide to increase choices in rural areas.

**Risk-Bearing/Administering Entity:** As outlined above, the state-sponsored QHP can be administered in two ways—via contracting with an existing insurance carrier(s) as a vendor or administered by the state with the help of a TPA. Both options have benefits and considerations.

Under a carrier implementation model, the state is shielded from financial risk due to unanticipated changes in the enrollee risk pool. Using a vendor requires significantly fewer administrative state resources, since it only requires contracting and oversight and not full implementation and operational support. However, this model has more limited premium impact, since carriers maintain profit margins, overhead costs and tax obligations.

Under a TPA partnership model, the state holds the risk of premiums covering all medical and administrative expenses, but uses a TPA to operationalize the program. Partnering with a TPA reduces the need for new agency resources, including hiring new expertise and investing in technology to review and pay claims. A state model may lower costs because the state, as a nonprivate entity, is not adding a profit margin to premium costs. The strongest consideration for this model is whether the state is prepared or willing to take on program risk and administrative oversight.

The plan could be administered by the state Marketplace or Medicaid agency. The Marketplace has significant experience working with issuers and establishing and implementing state and federal requirements. The Marketplace therefore could implement the public option by playing more of an active purchasing role and adding stronger QHP requirements. Providers and plans alike may respond more favorably to a public

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<sup>xiii</sup> With a state-based Marketplace, these individuals would still be permitted to shop on the Marketplace, but would be directed to the mirrored plan after an eligibility screening.

option administered by the Marketplace rather than by Medicaid. Either agency would require licensure, accreditation and certifications in line with Department of Insurance and Nevada Health Link requirements to operate a health plan(s). Additionally, the plan would be required to hold reserves and meet all relevant solvency requirements.

**Benefits and Cost-Sharing:** The state-sponsored plan could be offered at any metal level. This analysis assumes offering Silver and Gold plans as required for participation on the Marketplace without a waiver. Offering a Gold-level plan also gives enrollees a choice of a higher-value product with improved cost-sharing.

**Cost-Containment Mechanisms and Provider Participation:** In order for the state-sponsored public option to have a lower premium, it must reduce and contain costs. The analysis below (see [Figure 7](#)) assumes premium reductions of 10% and 20% for illustrative purposes, but does not include specific assumptions about provider reimbursement rates or other cost-saving mechanisms. If the state-sponsored public option is selected, the state will need to determine the best course to achieve cost savings. Potential options include:

- **Setting a reimbursement cap.** Under this option, the state would set a benchmark provider reimbursement rate to be used by the contracted carrier, or in direct state negotiations with providers. In order to reduce premiums, this reimbursement rate would need to be set below the current Marketplace rates, but would have to be balanced against the need to attract providers and pay a reasonable amount for clinical services, particularly in rural areas with provider shortages. The state may consider incenting provider participation in order to maintain lower-than-Marketplace rates, such as tying participation in the public option to participation in other state-procured health coverage programs (e.g., Medicaid).
- **Setting a premium reduction target.** If contracting with an existing insurance carrier, the state could include a requirement for bidders to reach a premium reduction target (e.g., 10%) and leave the mechanisms of the reduction to the carrier. Existing carriers may have more flexibility to negotiate rates for a state-sponsored product than for a traditional commercial offering with the backing of the state.
- **Relying solely on administrative savings.** A state-sponsored public option with a TPA could have significant savings from administrative efficiencies and no profit margin, which would result in a lower-cost product; however, these savings alone may not result in significant premium reductions.

The state has unique tools to encourage or compel provider participation in the public option. The strongest potential tool is tying participation in the plan to other state programs, for example, Medicaid. In other words, the state could make participation in the public option a condition of participating in the Medicaid program. Under tying, ensuring a competitive provider reimbursement rate in the public option—one that is above Medicaid rates—will be essential for preventing a potential erosion of Medicaid participation.

**Federal Authority:** In order to operate on the Marketplace, a state-sponsored public option must meet the requirements of a QHP, including offering the ten essential health benefits, community rating and participating in risk mitigation programs (i.e., risk adjustment and reinsurance).

**Risk Pool:** As a Marketplace plan, the state-sponsored public option will participate in the ACA individual risk pool and in risk adjustment programs. Operating in the individual market mitigates some risk to the state of attracting new entrants with variable health status.



**Market Impact:** Offering a state-sponsored plan on the Marketplace will influence competition with other insurers on the Marketplace and individual market.

A benefit of the state-sponsored plan is that it seeks to grow the existing individual market risk pool by attracting new members. The risk profile of potential enrollees was not modeled for this report, however. Traditionally, people who have chosen to forgo health insurance in the past due to affordability concerns are often healthier than the general population, as they are more price sensitive than people who are sicker and who highly value health insurance. Therefore, bringing the previously uninsured into the market could improve the average overall health risk and thus decrease premiums across the market.

Providing a low-premium state-sponsored plan on the Marketplace will impact the second-lowest-cost Silver plan, the “benchmark” for which enrollee federal tax credits are calculated. While most enrollees who receive tax credits are insulated from fluctuations in premiums because their cost contributions are based on percentage of income, many Marketplace enrollees use their federal tax credits to buy plans in other metal tiers. For example, an enrollee can use tax credits based on the price of a Silver plan to purchase a \$0 premium Bronze plan. Or an enrollee can use tax credits to help pay down the premium of a higher-value Gold or Platinum plan. If the benchmark, and therefore available tax credits, is reduced, it impacts consumer choice across metal tiers. If the impact of the public option is significant enough, it could prompt enrollees to drop coverage and leave the market.

Notably, a lower benchmark premium also lowers federal costs due to reduced federal tax credits. The state could seek a Section 1332 waiver to recoup the difference in costs in the form of pass-through funding (as described on page 28) if the state-sponsored plan is the new benchmark or becomes the lowest-cost plan, therefore putting downward pressure on the second-lowest-cost benchmark plan.

### **Premium and Enrollment Analysis for a State-Sponsored QHP Model**

Wakely conducted a preliminary analysis of a potential PEBP buy-in offered in 2022. The goal of the analysis was to estimate the projected premiums and potential enrollment of a state-sponsored QHP. This analysis includes both on-Marketplace and off-Marketplace Silver and Gold products. It assumes the plan would be offered by a nonprofit issuer or TPA to increase the opportunity for cost savings.

The analysis uses assumptions of 2022 baseline enrollment in the Nevada individual market for on- and off-Marketplace plans, broken down by metal level and subsidy eligibility.

Potential enrollment in the state-sponsored public option is forecasted using a combination of baseline enrollment estimates and the anticipated demand and migration decisions based on estimated premiums if the public option plan is either 10% or 20% less expensive than the lowest Silver and Gold status quo plans.<sup>xiv</sup>

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<sup>xiv</sup> Price elasticity estimates for eligible groups were established as -0.59 for the current uninsured, -1.18 for Nevadans currently enrolled in on- and off-Marketplace Silver and Gold plans, and -0.86 for Nevadans currently enrolled in on- and off-Marketplace Bronze plans. For example, an elasticity of -0.59 implies that if premiums decrease by 10%, the number of people with coverage will increase by 5.9%. In this analysis, no additional variation of these elasticity estimates is attributed by member demographics, morbidity or other characteristics, such as income.

The analysis assumes the following populations are most likely to enroll in the public option plan:

- Current uninsured individuals who are not eligible for subsidies on the Marketplace because of income or immigration/citizenship status
- Current insured individuals who are ineligible for subsidies due to an offer of employer coverage
- Current unsubsidized on-Marketplace enrollees in Silver, Gold and potentially Bronze plans who may be willing to switch to a lower-cost plan<sup>xv</sup>
- Current subsidized on-Marketplace enrollees in Bronze and Silver plans who may be willing to switch to a public option plan due to either richer coverage or lower net premium after subsidies<sup>xvi</sup>
- Current off-Marketplace enrollees in Silver, Gold and potentially Bronze plans who may be willing to switch to a lower-cost plan

This analysis also assumes that individuals currently enrolled in on- or off-Marketplace products would stay in their current market rather than transfer to an off-Marketplace product. Therefore, the majority of enrollees are expected to migrate from other on-Marketplace and off-Marketplace plans in the individual market.

**Figure 7. State-Sponsored QHP Public Option Enrollment and Premium Scenarios**

Projected Status Quo 2022 Market Dynamics and Plan Premiums	
Starting Market Size in 2022	87,410
On-Marketplace enrollment	64,591
Off-Marketplace enrollment	22,820
Starting Lowest-Cost Premium in 2022, Age 40	
On-Marketplace Offering	
Silver	\$398
Gold	\$491
Off-Marketplace, Individual Market Offering	
Silver	\$371
Gold	\$481

<sup>xv</sup> In the case of Bronze, we assumed that a member would choose the public option plan only if its premium is lower than the lowest Bronze premium available on the Marketplace, adjusted for generosity.

<sup>xvi</sup> Notably, as discussed above, introducing the public option will impact the benchmark plan that is used to establish federal tax credits, impacting how subsidized consumers use their tax credits to purchase more or less robust plans.

State-Led On-Marketplace Public Option Scenarios				
Public Option Premium in 2022, Age 40	10% Premium Reduction		20% Premium Reduction	
<b>On-Marketplace Offering</b>				
Silver	\$358		\$318	
Gold	\$442		\$393	
<b>Off-Marketplace, Individual Market Offering</b>				
Silver	\$334		\$297	
Gold	\$433		\$385	
	Low End	High End	Low End	High End
<b>Estimated Average Enrollment in Public Option</b>	<b>9,309</b>	<b>12,346</b>	<b>23,086</b>	<b>31,923</b>
Enrolling into public option plan on-Marketplace	8,357	9,733	20,530	24,414
Enrolling into public option plan off-Marketplace	952	2,612	2,555	7,508
From uninsured take-up (ineligible for subsidies)	0	1,502	307	4,885
From on-Marketplace migration	8,357	9,733	20,530	24,414
From off-Marketplace migration	952	1,111	2,248	2,623
<b>Market Size With Public Option Enrollment</b>	<b>87,410</b>	<b>88,912</b>	<b>87,717</b>	<b>92,296</b>
On-Marketplace enrollment	64,591	64,591	64,591	64,591
Off-Marketplace enrollment	22,820	24,321	23,127	27,705

Under the 10% and 20% premium reduction scenarios, the on-Marketplace Silver plan monthly average statewide premium would cost \$318–\$358, and the Gold plan premium would cost \$393–\$422. The off-Marketplace offerings are slightly cheaper because they do not include Marketplace fees or Silver-loading<sup>xvii</sup> and are estimated at \$297–\$334 monthly for Silver plans and \$385–\$433 monthly for Gold plans.

For the 10% reduction scenario, Wakely estimates that in the first year (2022), uninsured take-up of the state-sponsored option would be 0–1,500 individuals, on-Marketplace migration to the state-sponsored option would be 8,300–9,700 enrollees, and off-Marketplace migration would be 950-1,100 enrollees.

For the 20% scenario, Wakely estimates that uninsured take-up would be 300–4,800 individuals, on-Marketplace migration would be 20,500–24,400 enrollees, and off-Marketplace migration would be 2,200–2,600 enrollees.

<sup>xvii</sup> Silver-loading is a practice where health insurers load the cost of losing cost-sharing reduction payments into the premium of Silver-level Marketplace plans. Loading premium surcharges onto Silver plans increases premium tax credits for eligible enrollees; however, the increased premium must be paid in full by unsubsidized enrollees.

Consequently, Wakely estimates the individual market would grow in size by 0%–5.6%, depending on the scenario.

These enrollment figures highlight that a 10% or 20% reduction in premiums may not be enough to substantially encourage the currently uninsured to enroll in coverage for the first time. This further highlights the need for additional financial assistance to make premiums affordable for these populations, which may be accomplished by state subsidies or reinvestment as result of a federal waiver.

For additional consideration, while the analysis did not dictate a new provider reimbursement rate, the 10% and 20% premium reduction scenarios resulted in some assumptions about the reimbursement reductions needed to support these premium decreases.

- A 10% premium reduction could be achieved with a 12.2%–12.6% decrease in provider rates.
- A 20% premium reduction could be achieved with a 28.8%–30.4% decrease in provider rates.

These estimates include hospital facility cost (inpatient and outpatient) and professional services cost.

These estimates do not account for the potential impact on enrollment and coverage costs from COVID-19. Additional information on analysis assumptions and methodology can be found on page 37.

## Additional Implementation Considerations

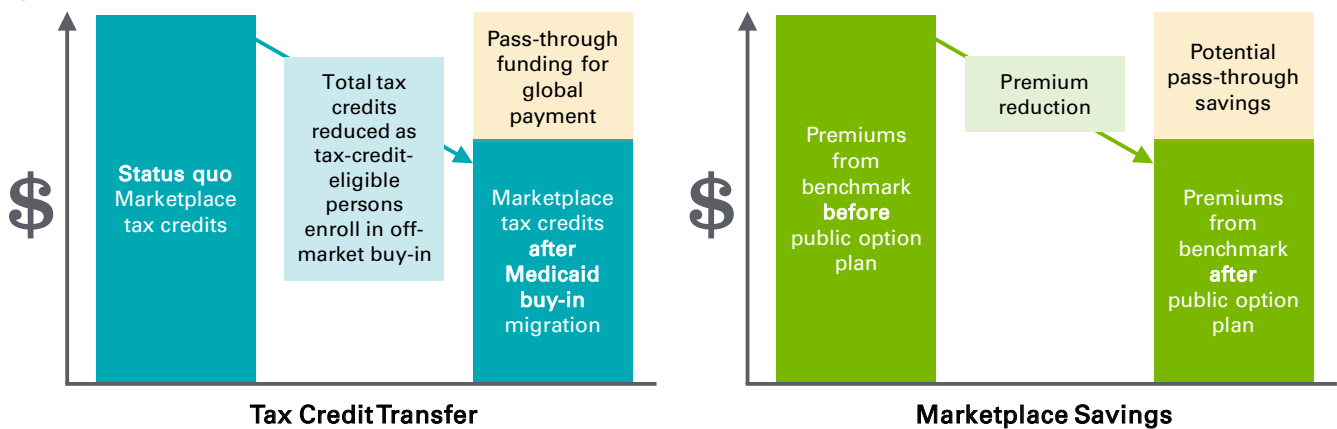
### Potential for a Section 1332 Waiver

Section 1332 of the ACA permits a state to apply for a State Innovation Waiver for innovative strategies that improve affordability and access in the individual insurance market while retaining consumer protections. Under statutory rules, referred to as “guardrails,” a proposed waiver must provide coverage at least as comprehensive and affordable as would be provided absent the waiver, must provide coverage to a comparable number of residents of the state as would be provided coverage absent a waiver, and must not increase the federal deficit. These guardrails are open to interpretation by the Centers for Medicare & Medicaid Services (CMS), and federal administrations may release specific guidance for states on how these guardrails will be interpreted.

To date, Section 1332 waivers have almost exclusively been approved for state-based reinsurance programs; however, multiple states have considered how to use a waiver to recoup savings accrued by the federal government as a result of state-based policies—such as the introduction of a public option—as a means of financing reforms. A Section 1332 waiver could benefit a Nevada public option in three ways:

- **Offering a Gold-only plan on the Marketplace.** A waiver could permit a Nevada public option plan to be offered only as a Gold-level plan on the Marketplace. Offering only a Gold-level plan can mitigate concerns about impacting the benchmark plan and consumer choice while still providing a lower-cost Gold plan compared with current offerings. Currently, carriers are required to offer a Silver plan in order to participate on the Marketplace.
- **Federal pass-through due to changes in the benchmark.** If the state-sponsored QHP is offered on the Marketplace at the Silver level and lowers the benchmark plan for calculation of federal tax credits, a Section 1332 waiver can be used to capture pass-through funding for the savings accrued by the federal government. These can be used to fund subsidies, increase benefits or pay down other parts of the program.
- **Allowing the use of federal tax credits outside the Marketplace.** Nevada could apply to allow federal tax credits be used outside the Marketplace to purchase the PEBP buy-in product. While this would not help individuals currently ineligible for tax credits, it could encourage the subsidized population to seek other coverage if the PEBP plan is more likely to meet their needs (e.g., better provider networks in certain regions).

**Figure 8. Section 1332 Waiver Considerations**



## Offering State Subsidies

Policymakers may consider providing state subsidies to lower the cost of either model. Many, including undocumented immigrants or families that fall within the family glitch, may still find reduced PEBP buy-in and state-sponsored public option premiums unaffordable without additional support. The state could tailor these subsidies to selected populations or regions, or could provide subsidies based on the ACA framework by capping premium contributions at a percentage of income. The design and level of subsidies would be dependent on available state resources. While state subsidies were not included in this analysis, they may be considered in the future.

## Allowing Employers to Contribute to Public Option Coverage

Understanding the challenge of offering affordable coverage for employees, the state can consider opportunities to offer the chosen public option model to employers. Small employers, in particular, struggle to provide their employees with affordable coverage options. The public option models described in this report could provide a new coverage option for small businesses. In either proposed public option model, small employers could be encouraged to contribute to employee enrollment through direct contributions or HRAs.

Under federal HRA guidance, a small employer is permitted to contribute to employees' PEBP buy-in or state-sponsored QHP premiums and cost-sharing via a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA).

Today, PEBP offers tax-free HRAs to state employees in the CDHP. The same could be true for the buy-in in order to encourage small-business contributions to facilitate coverage for employees. As mentioned previously, in future iterations, PEBP could also make direct purchase of coverage available for small businesses after a program for individuals is established. Directly purchasing employee coverage through PEBP could also be offered to larger employers interested in new coverage arrangements for their employees. Under these arrangements, PEBP could see increases in overall enrollment and improvements to the risk pool that may benefit all PEBP enrollees.

## Conclusion

Each public option model explored in this report offers benefits and limitations for advancing the goals of SCR 10: to improve insurance market stability, decrease the number of uninsured Nevadans and increase access to affordable coverage. In particular, this report considers the barriers to affordable coverage faced by rural Nevadans, and the following public option models were designed with the health insurance dynamics in rural Nevada in mind.

In pursuing a public option model, Nevada policymakers must consider the extent to which the model will have the larger impact on affordability for Nevadans, weighed against implementation feasibility, costs to the state and impacts on existing markets.

**PEBP Buy-In Model:** Nevada's strong PEBP plan may be leveraged for public option implementation and confers unique advantages to a potential PEBP buy-in plan, including existing statewide contracting and plan administration infrastructure as well as a strong reputation among Nevada's provider community.

Based on the analysis outlined in this report, offering a PEBP buy-in plan in a new, separate risk pool is likely not feasible for achieving affordability, but a PEBP buy-in that blends new enrollees with the current state employee risk pool is a viable option for providing a new higher-value coverage option for Nevadans, particularly in rural counties.

If Nevada policymakers choose to pursue a PEBP buy-in public option, the state will need to address startup and ongoing implementation costs (e.g., staffing and technology) and should consider how to counteract subsequent higher premiums for existing state employees (an estimated 2% increase over current rates) by offering additional program subsidization. The analysis in this report estimates that this subsidization would require between \$6.5 million and \$9.6 million.

**State-Sponsored QHP Model:** Offering a public option plan as a QHP on Nevada Health Link would grow the individual market by attracting new enrollees and could be offered through an existing health insurance carrier or by the state in partnership with a TPA. In either case, the state-sponsored option would benefit from existing Nevada Health Link contracting functions and expertise in QHP requirements. This analysis assumes Silver- and Gold-level state-sponsored public option plans, which give enrollees a choice of a higher-value product with improved cost-sharing. The key consideration to truly achieve affordability is how to reduce and contain costs in this model. The analysis assumes premium reductions of 10% and 20%, but Nevada policymakers would need to decide on cost-saving mechanisms to achieve these reductions, which could include setting a provider reimbursement cap, setting a premium reduction target or relying solely on administrative savings.

Based on the analysis in this report, the state-sponsored QHP option would enroll more Nevadans overall and have a greater impact in reducing Nevada's uninsured population than the PEBP buy-in option. Depending on the premium reduction in the state-sponsored QHP public option model, enrollment in this option may be 9,000–32,000 individuals, of which 1,500–4,900 would be previously uninsured, whereas the PEBP buy-in plan would enroll approximately 6,500 individuals, including 800–2,700 existing uninsured. While the state-sponsored QHP public option would potentially have higher enrollment than a PEBP buy-in, to achieve these estimated enrollment figures, the state-sponsored public option would likely need to be paired with more significant cost reduction measures that may or may not be feasible in Nevada. The PEBP buy-in also would require either increased premiums for existing PEBP enrollees or additional state or employer subsidization, though these options may be more feasible for the state.

With either model, Nevada could also apply for a Section 1332 waiver to capture and leverage public option savings from the federal government to further improve affordability and support public option design and implementation. The state could also decide to encourage small-employer participation in either model with an HRA option. Each of these options could ameliorate some of the challenges related to state funding and/or affordable premiums outlined in this report.

This report is intended to outline potential designs for a feasible and meaningful public option for Nevada, memorializing conversations with state stakeholders. Further consideration and discussion about future implementation of these models will take place among the public, state lawmakers and other stakeholders.

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# Appendix

## Potential System Impacts of the COVID-19 Pandemic

Potential impacts of COVID-19 on the Nevada healthcare system:

- **Short-term state budget pressure:** Central to understanding the changing coverage landscape in Nevada is revenue losses in the immediate term. Two special legislative sessions were convened in 2020 that aimed to address the public health and related state budget crisis, resulting in significant healthcare cuts including a 6% reduction in Medicaid's provider payments.<sup>21</sup> Agencies were instructed to cut their budgets by 14% for 2020<sup>22</sup> and 12% annually for the 2021–2023 biennium as well.<sup>23</sup> These budget shortfalls are therefore immediately impacting healthcare providers through reduced reimbursement and state agencies through decreased capacity.
- **Coverage losses:** As employers are forced to increasingly lay off workers due to the pandemic, Nevadans are losing their employer-sponsored health insurance coverage. According to a recent survey, about one in five workers who lost their job due to COVID-19 became uninsured.<sup>24</sup> As consumers turn to other coverage sources or become uninsured, employment and health insurance are increasingly de-linked from one another.
- **Increased Medicaid enrollment:** Nevada's Medicaid program has already seen a surge in enrollment since the start of the pandemic, increasing by over 112,000 individuals from February to October 2020, representing a 17% increase in enrollment.<sup>25</sup>
- **Provider financial instability:** Increased Medicaid enrollment coupled with reimbursement cuts puts financial strain on providers, who are seeing an increasing proportion of patients covered by Medicaid and a lower proportion of commercially insured patients. As Nevada considers a public option plan, ensuring that providers receive adequate reimbursement is necessary given the current landscape.

The strain the COVID-19 pandemic has put on consumers and on Nevada's healthcare system underscores the imperative to find new and innovative ways to offer affordable coverage for Nevadans that ultimately strengthens the healthcare system as a whole. Additional priorities for the public option plan that have been re-emphasized by the pandemic include:

- **Advancing health equity and reducing health disparities:** Across the country, age-adjusted COVID-19 mortality is 2.5 to 3.4 times higher in Black/African American, AI/AN, Pacific Islander and Latino/Latina/Latinx populations than in white communities, meaning that both infections and deaths are disproportionately impacting communities of color.<sup>26</sup> Early data is showing this unsettling trend exists in Nevada. For example, while approximately 28% of Nevada's population is Hispanic/Latino/a/x, almost half of the cases in Nevada (45%) are among the Hispanic/Latino/a/x population.<sup>27</sup>

Medicaid policy in particular has an outsized impact on certain communities of color. While the Black/African American population represents 9% of Nevada's overall population,<sup>28</sup> over 20% of Nevada's Medicaid enrollees are Black/African American.<sup>29</sup> The strain COVID-19 has placed on the state's Medicaid program as outlined above will therefore further disproportionately impact communities of color.



The underlying inequities that COVID-19 has highlighted, particularly in healthcare, require policymakers and healthcare industry stakeholders to re-examine their roles in advancing health equity and employ new strategies to make meaningful progress. A public option's impact on health disparities will need to be central to the decision making and design process for a public option plan.

- **Coverage of telehealth as a key component of ensuring access:** Telehealth has been a key issue for policymakers as a way to increase access to care, particularly in rural areas, and the pandemic has accelerated its use as Medicare, Medicaid and private coverage have made it temporarily permissible. This not only has allowed patients to receive healthcare at a safe distance, but also has improved access for many patients, particularly in rural areas, who otherwise would need to travel to see a provider. Increased coverage of telehealth will likely continue after the pandemic, and coverage of telemedicine could potentially be incorporated into a public option plan.

## Analysis Assumptions, Methodology and Caveats

### PEBP Buy-In Model

Wakely has conducted preliminary analysis of the range of potential enrollment in a public option plan structured as a buy-in into PEBP if offered in 2022.<sup>30</sup> This analysis assumed that the public option plan offering would be available outside of the Marketplace. The plan would be offered by PEBP's TPA.

The goal of the analysis was to estimate the potential enrollment and impact on the PEBP program of offering public option buy-in into the PEBP preferred provider plan (PPO) plan (without HRA/HSA contributions). We analyzed the impact of keeping public option buy-in enrollment in a separate risk pool and also combining with the existing PEBP risk pool. PEBP currently has two risk pools in place—one for state employees (actives, retirees and their dependents) and another one for nonstate employees (actives, retirees and their dependents). The nonstate risk pool consists mostly of retirees and is small, with approximately 500 contracts in plan year 2021.

One of PEBP's requests was to consider the impact of combining a public option with each of the two risk pools. However, given the demographics (over retirement age) and the size of the nonstate pool, it would not be a viable option for blending with the public option enrollment. Hence, we are modeling the blended risk pool using only the state PEBP population. Given data limitations, some of the assumptions (such as demographics) may incorporate the nonstate data, but the impact on the analysis should be minor.

### Analysis Results

1. **Separate risk pool:** The current analysis implies that a separate risk pool for the public option plan is likely not viable, as a statewide public option premium attracts a low number of enrollees in the highest-cost rating areas (3 and 4). The public option as its own risk pool may potentially be viable if public option rates are geographically adjusted (this analysis was not performed at this time).

The resulting public option premium is around 15%–35% higher than the PEBP average premium, with resulting enrollment of 800–2,600 enrollees and the majority of enrollment in ACA rating area 4. The vast majority of enrollment is coming from the uninsured population. While the percentage taking up coverage for the uninsured looks higher than that of the ACA take-up, given that subsidized enrollees are unlikely

to buy a public option plan, the take-up rate for unsubsidized ACA enrollees is higher than the uninsured take-up rate. Even though the enrollment numbers are low, they may be overstated as the public option premium was AV adjusted, which assumes the uninsured are more likely to pay a higher premium since the value of the public option is higher than that of the ACA plans. To the extent this is not the case, enrollment in the public option would be even lower.

2. Blended risk pool: The current analysis implies that a blended risk pool results in higher take-up of the public option plan but requires subsidization by PEBP or the state of approximately 2%–3% of existing PEBP premium revenue (\$7 million to \$10 million). The resulting public option claims and administrative load is 11%–21% higher than PEBP average premium, with resulting enrollment of 6,500–6,600 enrollees and the majority of enrollment from the uninsured in ACA rating areas 3 and 4. There is some enrollment from ACA markets in all areas and uninsured enrollment in rating area 2. Similar to the separate risk pool, the uninsured take-up rate may be overstated given the public option premium is value adjusted.

## Methodology

To estimate 2022 baseline enrollment, we have relied on reported or estimated enrollment in 2019 and 2020 in the Nevada individual market on- and off-Marketplace, metal level, and subsidy eligibility, as well as the estimated number of uninsured who would not be eligible for subsidies on the Marketplace because of income or citizenship requirements. To estimate the 2022 enrollment with a PO, we combined these estimates with estimated elasticities of demand in order to model the number of individuals who would be selecting to enroll in the PEBP public option buy-in offering. Further, we assumed that the enrollment in the public option plan will likely comprise the following segments of the population:

1. Current uninsured individuals who are not eligible for subsidies that are available to low-income individuals on the Marketplace as a result of income, employer insurance offer or citizenship status
2. Current unsubsidized on-Marketplace enrollees in Gold, Silver and Bronze plans who may be willing to switch to a lower-cost and higher-richness public option plan with a broader network
3. Current off-Marketplace enrollees in Gold, Silver and potentially Bronze plans who may be willing to switch to a lower-cost and higher-richness public option plan with a broader network

In general, we observe that not many uninsured will take up the public option under any scenario. It is our understanding that the premium has to be lower than the current lowest Bronze premium, since the uninsured are price sensitive. Hence, these individuals are not likely to buy a Gold plan if it is more expensive than the current available Bronze plan, despite the lower cost-sharing offered by the Gold plan. Again, current modeling does adjust for the increased cost-sharing in the PO, but Wakely will run a scenario that compares only the premiums for the uninsured.

Finally, we estimated the impact on the PEBP PPO catastrophic (PPOC) reserve, which is currently set by Aon and is equivalent to 17%–20% of incurred claims. For the blended risk pool scenarios, we estimate the presence of a public option plan will increase the PPOC reserve by \$6.8 million to \$8.5 million, or around 20%, driven by both the increase in enrollment and the increase in claims. If the reserving methodology changes in the future, the analysis would need to reflect such changes.

The current estimates do not account for the potential impact on enrollment and coverage cost from COVID-19.

**Key Assumptions**

Key Assumptions	Low End	High End	Notes
Benefits and Cost-Sharing			PO benefits would be equivalent to PPO-level benefits, without dental and HRA contributions. The PPO cost-sharing is roughly equivalent to an ACA Gold plan.
Allowable Rating Factors			Assumed public option premiums are 3:1 age-rated, but not geographically rated.
Premium Change (2021–2022)	3.0%		Assumed increase in average premiums from 2021 to 2022 in ACA market (on- and off-Marketplace and in PEBP rates.
PO Broker Fees (per member per month, or PMPM)	\$0.00		Assumed no broker fees applicable to public option plan.
PO Risk Load (% premium)	0.0%		Assumed no profit/risk load in public option premiums. Per PEBP, there is concern that the PEBP actuaries would be conservative in pricing for the impact of the public option on the PEBP premiums. This conservatism has not been incorporated into the analysis.
PO Administrative Expense PMPM	\$20.78		Based on PEBP administrative load, translated to PMPM. Assumed the same level of administrative load as in PEBP, without adding any additional broker/marketing expenses, while incremental expenses may be involved.
PO Morbidity Relative to PEBP Morbidity	1.1	1.2	Based on the published research, “compared with large employer market enrollees, health risk was <..> 20% higher among PPACA individual market enrollees.” Source: <a href="https://pubmed.ncbi.nlm.nih.gov/31688571">https://pubmed.ncbi.nlm.nih.gov/31688571</a> .
Morbidity of ACA Enrollees Migrating to PO, Relative to ACA Morbidity	0%	0%	Assumed migrants’ morbidity is similar to overall ACA morbidity.
Medical Claim Trend (2021–2022)	4.0%		Based on PEBP historical average trend in medical claims PY2019–21 and trending 1.5 years to CY2022.
Rx Claim Trend (2021–2022)	3.2%		Based on PEBP historical average trend in Rx claims PY2019–21 and trending 1.5 years to CY2022.
CY2020 PEBP Enrollment			Assumed the same CY2022 PEBP enrollment as reported in October 2020 enrollment reports.

**Senate Concurrent Resolution No. 10 Study: Evaluating Public Health Insurance Plan Options for Nevada Residents**

Key Assumptions	Low End	High End	Notes
<b>Public Option Take-Up Assumptions, Price Elasticity of Demand*</b>			
From Uninsured Take-Up (ineligible for subsidies)	-0.59	-0.59	Assumed purchase elasticity for coverage among people who are currently uninsured (Congressional Budget Office and Joint Commission on Taxation estimated). Uninsured take-up is based on AV-adjusted premium differential relative to lowest off-Marketplace Bronze premium.
Among On- and Off-Marketplace, With Gold Plans	-1.18	-1.18	Assumed purchase elasticity for coverage among people who are currently insured in the nongroup market, currently purchasing either Silver or Gold plan (CBO and JCT estimated).
Among On- and Off-Marketplace, With Bronze and Silver Plans	-0.86	-0.86	Assumed purchase elasticity for coverage among people who are currently insured in the nongroup market, currently purchasing Bronze plan (CBO and JCT estimated).
On-Marketplace migration take-up is based on premium differential relative to lowest on-Marketplace Gold/Silver/Bronze premium (AV-adjusted for Silver and Bronze). Off-Marketplace migration take-up is based on premium differential relative to lowest off-Marketplace Gold/Silver/Bronze premium (AV-adjusted for Silver and Bronze).			
No migration from employer-sponsored insurance market is modeled.			
<b>Public Option Dampening Factor</b>			
From Uninsured:			Same dampening factors are applied to all rating areas.
Ineligible for financial assistance due to income	50%	50%	Elasticity depends on many factors, including perception of the product, education/marketing, provider network, etc. Since the details of the product are still unknown, for the low estimate, dampening of the factors was included to account for a scenario where the elasticity, as a function of premium alone, may be overstated (e.g., if an uninsured person is aware the product is available). These factors are applied to the number of public option enrollees (by cohort), estimated using purchase elasticities above. For example, a factor of 60% reduces the number of enrollees by 40%.
Ineligible for financial assistance due to offer of employer coverage	40%	40%	
Ineligible for financial assistance due to citizenship status	10%	10%	
From On-Marketplace Migration (ineligible for subsidies)	50%	50%	
From Off-Marketplace Migration	60%	60%	
We are assuming lower take-up from on-Marketplace vs. off-Marketplace, as it would require shifting to a different platform to enroll. Those that are already buying off-Marketplace would be more willing to shop around.			

\* An elasticity of -0.59 implies that if premiums decrease by 10%, the number of people with coverage will increase by 5.9%. In this analysis, no additional variation of these elasticity estimates is attributed by member demographics, morbidity or other characteristics, such as income.

## State-Sponsored QHP Model

Wakely has conducted a preliminary analysis of the range of potential enrollment in a public option plan, if offered in Nevada in 2022.<sup>31</sup> This analysis assumed that the public option plan offering would be available on- and off-Marketplace. The plan would be offered by a nonprofit issuer or TPA.

To estimate 2022 baseline enrollment, we have relied on reported or estimated enrollment in 2019 and 2020 in the Nevada individual market on- and off-Marketplace, metal level, and subsidy eligibility, as well as the estimated number of uninsured who would not be eligible for subsidies on the Marketplace because of income or citizenship requirements. To estimate the 2022 enrollment with a PO, we combined these estimates with estimated elasticities of demand in order to model the number of individuals who would be selecting to enroll in the public option plan offering if the public option plan is either 10% or 20% less expensive than the lowest Silver/Gold plan currently available on- or off-Marketplace. Further, we assumed that the enrollment in the public option plan will likely comprise the following segments of the population:

1. Current uninsured individuals who are not eligible for subsidies that are available to low-income individuals on the Marketplace
2. Current uninsured noncitizen individuals who are not eligible for subsidies on the Marketplace
3. Current unsubsidized on-Marketplace enrollees in Silver, Gold and potentially Bronze plans who may be willing to switch to a lower-cost plan (in case of Bronze, we assumed that a member would choose the public option plan only if the public option premium is lower than the lowest Bronze premium available on-Marketplace, adjusted for generosity)
4. Current subsidized on-Marketplace enrollees in Bronze and Silver plans who may be willing to switch to a public option plan due to either richer coverage or lower net premium after subsidies
5. Current off-Marketplace enrollees in Silver, Gold and potentially Bronze plans who may be willing to switch to a lower-cost plan (for Bronze enrollees, we assumed that a member would choose the public option plan only if the public option premium is lower than lowest Bronze premium available off-Marketplace, adjusted for generosity); note that the migration from Bronze to Silver might be understated, as potentially more current Bronze purchasers may be likely to buy up to the public option Silver if they are in a higher-premium Bronze (since the analysis uses the lowest-cost Bronze) than what is implied by the analysis

For Silver and Gold, the on-Marketplace migration is based on the premium reduction of either 10% or 20%, even if a member is currently enrolled in a richer (higher-cost) plan. For Silver and Gold, the off-Marketplace migration is based on the premium reduction relative to the lowest off-Marketplace plan in the same metal tier. For Bronze, the migration on- and off-Marketplace is based on the premium difference (adjusted for the difference in AV) compared with the public option Silver plan.

Since the public option will also be offered on the Marketplace, a reduction in the cost of a second-lowest-cost Silver plan decreases the advance premium tax credit (APTC) subsidies available to the subsidized members currently enrolled on the Marketplace. Since the public option plan will become the lowest-cost Silver, the second-lowest-cost premium will decrease as well, thereby decreasing the subsidy amounts. As

a result, some of the subsidized members will experience a change in the net premium and will likely switch to a plan that offers a lower net premium or richer coverage (i.e., the PO). Hence, we modeled the migration from subsidized Bronze and Silver purchasers to a public option on-Marketplace plan.

To estimate the required reductions in provider reimbursement needed to support a 10% or 20% premium reduction, we have made non-benefit expense assumptions in line with the 2020 market-wide reported data. We have estimated the proportion of medical cost that is composed of non-facility (inpatient and outpatient) and nonprofessional services, and excluded these costs when estimating the required reduction in provider fees. Hence, the provider reimbursement subject to reduction includes hospital facility cost (inpatient and outpatient) and professional services cost.

The current estimates do not account for the potential impact on enrollment and coverage costs from COVID-19.

### **Key Assumptions**

- One of the key assumptions underlying the analysis is the impact of the state-sponsored option on potential premium costs for the uninsured. Wakely measured this change as the difference between the lowest-cost state-sponsored option and the lowest-cost Bronze plan available. Generally, it has been found that premiums, not cost-sharing, are the overwhelming driver of an individual's decision to take up coverage. Consequently, while there are significant decreases in Silver and Gold plan costs, the difference in premiums relative to a Bronze plan is significantly less. Further, the take-up by the uninsured is muted relative to what may be expected.
- Wakely expects that there will be some muting of take-up of the state-sponsored product in the initial year relative to a pure elastic calculation. Since the product is unknown and nonpremium factors may influence decisions, we included a dampening factor. Wakely would expect that, over time and all things being equal, dampening factor effects will decrease.
- Wakely relied on publicly available data for this exercise. While the results were deemed reasonable, additional microlevel data could impact the results. For example, Wakely estimated the current net premiums of those with APTCs and enrolled in Bronze plans. To the extent that administrative data has different results from what is estimated, the impact to Bronze APTC enrollees could differ.

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Key Assumptions	Low End	High End	Notes
Premium Change (2021–2022)	3.0%		Assumed increase in average premiums from 2021 to 2022 in ACA market (on- and off-Marketplace).
PO Exchange Fees (% premium)	2.8%		Assumed Nevada (NV) state fees applicable to public option plan.
NV Exchange Fees	3.15%		Assumed NV state fees applicable to ACA issuers.
PO Broker Fees (PMPM)	\$0.00		Assumed no broker fees applicable to public option plan.
PO Taxes (% premium)	4.3%		Assumed NV state fees applicable to public option plan.
PO Risk Load (% premium)	2.0%		Assumed amount of profit/risk load in ACA premiums. Lower than market average due to nonprofit status of PO.
PO Administrative Expense PMPM:			Portion of premium allocated for nonmedical expenses.
Silver Plan	\$35.01		
Gold Plan	\$45.40		
% Claim Cost Not Subject to Reimbursement Reduction (Rx, DME, other benefits)	30.5%	35.5%	Portion of medical expense representing prescription drug services, injectable medications, durable medical equipment (DME) and other ancillary services not affected by reduced provider reimbursement.
<b>Public Option Take-Up Assumptions, Price Elasticity of Demand*</b>			
From Uninsured Take-Up (ineligible for subsidies)	-0.59	-0.59	Assumed purchase elasticity for coverage among people who are currently uninsured (CBO and JCT estimated).
Among On- and Off-Marketplace, With Silver and Gold Plans	-1.18	-1.18	Assumed purchase elasticity for coverage among people who are currently insured in the nongroup market, currently purchasing either Silver or Gold plan (CBO and JCT estimated).
Among On- and Off-Marketplace, With Bronze Plans	-0.86	-0.86	Assumed purchase elasticity for coverage among people who are currently insured in the nongroup market, currently purchasing Bronze plan (CBO and JCT estimated).

Key Assumptions	Low End	High End	Notes
<b>Public Option Dampening Factor</b>			
From Uninsured:			Elasticity depends on many factors, including perception of the product, education/marketing and provider network. Since the details of the product are still unknown, for the low estimate, dampening of the factors was included to account for a scenario where the elasticity, as a function of premium alone, may be overstated (e.g., if an uninsured person is aware the product is available). These factors are applied to the estimated number of public option enrollees (by cohort) using purchase elasticities above. For example, a factor of 60% reduces the number of enrollees by 40%.
Ineligible for financial assistance due to income	50%	60%	
Ineligible for financial assistance due to offer of employer coverage	40%	50%	
Ineligible for financial assistance due to citizenship status	10%	12%	
From On-Marketplace Migration (ineligible for subsidies)	70%	80%	
From On-Marketplace Migration:			
Subsidized Bronze	20%	30%	
Subsidized Second-Lowest Silver	40%	50%	
Subsidized Lowest Silver	80%	90%	
From Off-Marketplace Migration	70%	80%	

\* An elasticity of -0.59 implies that if premiums decrease by 10%, the number of people with coverage will increase by 5.9%. In this analysis, no additional variation of these elasticity estimates is attributed by member demographics, morbidity or other characteristics, such as income.

## Disclosures and Caveats

**Responsible Actuaries.** Julie Peper and Ksenia Whittal are the actuaries responsible for this communication. They are members of the American Academy of Actuaries and fellows of the Society of Actuaries. They meet the Qualification Standards of the American Academy of Actuaries to issue this report.

**Intended Users.** This information has been prepared for the sole use of the management of the state of Nevada and cannot be distributed to or relied on by any third party without the prior written permission of Wakely. This information is confidential and proprietary. Wakely does not intend to create a reliance to these outside parties, and these materials may not be released to third parties without Wakely’s prior written consent; when consent is granted, the materials should be provided in their entirety. The parties receiving this report should retain their own actuarial experts in interpreting results.



**Risks and Uncertainties.** Please note that these results are preliminary and are subject to change as we gather input and potentially refine the modeling methodology and assumptions. Users of the results should be qualified to use and understand the results and the inherent uncertainty. Actual results may vary, potentially materially, from our estimates. It is the responsibility of the state of Nevada to review the assumptions carefully and notify Wakely of any potential concerns.

**Conflict of Interest.** The responsible actuaries are financially independent and free from conflict concerning all matters related to performing the actuarial services underlying these analyses. In addition, Wakely is organizationally and financially independent of the state of Nevada.

**Data and Reliance.** We have relied on information and data provided by the state of Nevada, Manatt and other public data sources in the analysis. We have reviewed the data for reasonableness but have not performed any independent audit or otherwise verified the accuracy of the data/information. If the underlying information is incomplete or inaccurate, our estimates may be impacted, potentially significantly.

**Subsequent Events.** These analyses are based on the implicit assumption that the ACA will continue to be in effect in future years with no material change. Material changes in state or federal laws regarding health benefit plans may have a material impact on the results included in this analysis. Furthermore, changes in state or federal law (e.g., HRA regulation) were not included in the analysis. The potential impact of COVID-19 was not included in the analysis. There are no other known relevant events subsequent to the date information was received that would impact the results of this report.

**Contents of Actuarial Report.** This document constitutes the entirety of the actuarial report and supersedes any previous communications on the project.

**Deviations From ASOPs.** Wakely completed the analyses using sound actuarial practice. To the best of our knowledge, the report and methods used in the analyses are in compliance with the appropriate Actuarial Standards of Practice (ASOPs), with no known deviations. A summary of ASOP compliance is listed below:

- ASOP No. 23, Data Quality
- ASOP No. 41, Actuarial Communication
- ASOP No. 56, Modeling

- <sup>1</sup> Kaiser Family Foundation, State Health Facts: Health Insurance Coverage & Uninsured, Health Insurance Coverage of Nonelderly 0-64. Accessed at <https://www.kff.org/other/state-indicator/nonelderly-0-64/>.
- <sup>2</sup> Kaiser Family Foundation, State Health Facts: Distribution of the Nonelderly Uninsured by Federal Poverty Level (FPL). Accessed at <https://www.kff.org/uninsured/state-indicator/distribution-uninsured-nonelderly-federal-poverty-level-fpl/>.
- <sup>3</sup> Kaiser Family Foundation, State Health Facts: Health Reform, Marketplace Enrollment, 2014–2020. Accessed at <https://www.kff.org/health-reform/state-indicator/marketplace-enrollment/>.
- <sup>4</sup> Kaiser Family Foundation, State Health Facts: Medicaid & CHIP, Share of Medicaid Population Covered under Different Delivery Systems. Accessed at: <https://www.kff.org/medicaid/state-indicator/share-of-medicaid-population-covered-under-different-delivery-systems/>.
- <sup>5</sup> State of Nevada Department of Health and Human Services Office of Analytics, Nevada Medicaid Chart Pack, Total Medicaid Recipients. Accessed at <http://dhcftp.nv.gov/Resources/AdminSupport/Reports/CaseloadData/>.
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- <sup>13</sup> Ibid.
- <sup>14</sup> Kenny C. Guinn Center for Policy Priorities, Nevada’s Uninsured Population, 2019. Accessed at <https://guinncenter.org/wp-content/uploads/2019/09/Guinn-Center-NV-Uninsured-Population-abridged.pdf>.
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- <sup>20</sup> NRS 287.043, <https://www.leg.state.nv.us/nrs/nrs-287.html>.

<sup>21</sup> AB3, passed in the 31st special session (2020). Accessed at <https://www.leg.state.nv.us/App/NELIS/REL/31st2020Special/Bill/7127/Text>.

<sup>22</sup> Nevada Governor Steve Sisolak, Nevada COVID-19 Fiscal Report, FY2020–21 Budget Summary. July, 6, 2020. Accessed at <https://nvhealthresponse.nv.gov/wp-content/uploads/2020/07/Nevada-COVID-19-Fiscal-Report.pdf>.

<sup>23</sup> Nevada Governor Steve Sisolak, November 6 Press Release: Governor Sisolak asks agencies to review budgets, create reserve proposals for FY21-23. Accessed at <http://dhcfp.nv.gov/Resources/AdminSupport/Reports/CaseloadData/>.

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<sup>25</sup> State of Nevada Department of Health and Human Services Office of Analytics, Nevada Medicaid Chart Pack, Total Medicaid Recipients. Accessed at <http://dhcfp.nv.gov/Resources/AdminSupport/Reports/CaseloadData/>.

<sup>26</sup> 2019 Open Enrollment Public Use Files. Accessed at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2020-Marketplace-Open-Enrollment-Period-Public-Use-Files>.

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<sup>28</sup> World Population Review, Population of Nevada. Accessed at <https://worldpopulationreview.com/states/nevada-population>.

<sup>29</sup> Kenny C. Guinn Center for Policy Priorities, Nevada’s Medicaid Population, 2019. Accessed at <https://guinncenter.org/wp-content/uploads/2019/09/Guinn-Center-NV-Medicaid-Population-Characteristics-2019.pdf>.

<sup>30</sup> See the following references for more information on the analysis assumptions:

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- *Relying on PY21 PEBP premiums and base rate data provided by PEBP.*
- *Relying on ACS, 2019 OEP and CPS census data to model by ACA rating area.*

<sup>31</sup> See the following references for more information on the analysis assumptions:

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