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AGENDA ITEM

- For Possible Action
- Information Only

Date: September 13, 2012

Item Number: IV

Title: Status of work completed related to the Plan Certification and Management Advisory Committee

SUMMARY

This report provides information regarding the following matters of the Silver State Health Insurance Exchange Plan Certification and Management Advisory Committee:

- a. Committee calendar
- b. Information provided at previous Committee meetings
- c. Committee recommendations approved by the Board
- d. Committee recommendation pending Board approval

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COMMITTEE CALENDAR

The following is a schedule for the key deliverables to be provided to the Board. Board meeting dates are subject to change.

Key Deliverables and Timeline

Task	Board Meeting	Status
Review Essential Health Benefits for Nevada’s individual and small group markets, and develop recommended approach	N/A	Complete
Develop key principles for the Exchange’s operating model with regard to qualified health plans’ certification	April 12, 2012	Recommendation 1 Approved
Develop recommendations on criteria used to select qualified health plans, role of the Exchange in the market, and plan design options	April 12, 2012	Recommendation 1 Approved
Review rate review and approval process administered by the Nevada Division of Insurance (DOI), and develop recommendation on how the Exchange may leverage DOI’s rate review and approval	April 12, 2012	Recommendation 2 Approved
Review types of plans purchased in the individual and small group markets	N/A	Complete
Review plan design options under different levels of actuarial value	N/A	Complete
Develop recommendations on whether qualified health plans in the individual and SHOP Exchange should be identical	September 13, 2012	Recommendation 3 Pending Board Approval
Evaluate the extent to which benefits (i.e., cost sharing) may be standardized within each plan level	September 13, 2012	Recommendation 4 Pending Board Approval
Develop recommendations on number of health plans that each insurer will be allowed to offer on the Exchange	September 13, 2012	Recommendation 5 Pending Board Approval
Review 10 potential benchmark plans and make recommendations regarding Nevada’s Essential Health Benefits package	September 18, 2012	Under Review
Review certification criteria required by the ACA and determine whether additional criteria should be used by the Exchange	November 8, 2012	Future Meeting

INFORMATION PROVIDED AT PREVIOUS COMMITTEE MEETINGS

REGULATIONS

The final rule (CMS-9989-F) regarding the establishment of exchanges was published on March 27, 2012. The final rule as well as several other proposed rules and guidance can be found at: <http://cciio.cms.gov/resources/regulations/index.html#hie>

OVERVIEW OF THE COMMERCIAL HEALTH INSURANCE MARKETS IN NEVADA

On August 8, 2011, Public Consulting Group finalized [An Overview of the Commercial Health Insurance Markets in Nevada](#). Key findings included:

- Nevada's commercial insurance markets are competitive, although a limited number of carriers cover the majority of individuals and small employers. These dominant carriers will play an integral role in the implementation of health reform, and their active participation in the Exchange will be critical to the Exchange's success.
- Commercial health insurance is the dominant form of coverage in Nevada, with 59% of residents privately insured. The small group and individual markets are relatively minor components, comprising approximately 7% and 6% of the entire commercial market, and covering 4% and 3% of the overall Nevada population, respectively.
- As is true across the country, the rate at which health insurance is offered to employees is highly dependent on the size of the employer (i.e., the number of employees). Larger employers are far more likely to offer health insurance to their employees than smaller employers.
- Overall, health insurance costs in Nevada are slightly lower – on average – than they are in the rest of the country. However, for single coverage in the individual market, the average premiums in Nevada are 10% higher than the US average.
- The commercial market will be significantly affected by the regulatory changes required per the Patient Protection and Affordable Care Act (ACA). In particular, the elimination of medical underwriting (setting premiums based on an applicant's health status), requiring guaranteed issue of health plans in the individual market, and implementing minimum medical loss ratios will impact the health insurance marketplace.

COVERAGE OF ESSENTIAL HEALTH BENEFITS IN NEVADA

On February 7, 2012, Public Consulting Group finalized [Coverage of Essential Health Benefits in Nevada](#). The report includes a list of minimum required services pursuant to the Affordable Care Act and a list of services mandated by state law. Additionally, side by side comparisons of the 10 possible benchmark plans were provided. It should be noted that two of the ten plans listed in the report have since been replaced by other plans based on updated enrollment data for the quarter ending March 31, 2012.

NEVADA HEALTH INSURANCE MARKET STUDY

On March 28, 2012, Public Consulting Group, in cooperation with Gorman Actuarial, LLC, completed the [Nevada Health Insurance Market Study](#). The report provides the current market landscape, carrier rating practices, private market benefit analysis, Affordable Care Act rating environment reforms, merged market analysis and federal risk mitigation programs.

COMMITTEE RECOMMENDATIONS APPROVED BY THE BOARD

RECOMMENDATION 1: KEY PRINCIPLES

The following key principles were approved to assist the Plan Certification and Management Advisory Committee in the development of its recommendations.

1. **Encourage Participation** – The Exchange and the QHPs offered on the Exchange should be designed in a way that maximizes participation by individuals, employers, employees and carriers. It should be perceived to add value through reduced costs, simplicity in enrollment and better choices. Encouraging participation will also depend on the investment in and effectiveness of outreach and education.
2. **Minimize Adverse Impacts on the Exchange Market and State-Sponsored Health Care Programs** – The policies surrounding plan certification and management should be designed in a way that minimizes adverse market impacts. For example, the Exchange needs to be cautious when making its policy decisions so that it avoids adverse selection and the accompanying higher costs to enrollees. The Exchange plan certification process could also affect whether health care providers or other entities choose to conduct business with the Exchange, due either to high costs or low reimbursement rates.
3. **Minimize Unintended Market Disruptions** – It is recognized that the Affordable Care Act was designed to disrupt the current market. However, there is a lot of unknown surrounding QHPs and the affect the new market will have on enrollees. Carriers build that unknown into a risk margin in the rates, increasing premiums and decreasing affordability. The more the Exchange market is modeled after the current market, the fewer disruptions that will occur and the lower the premium charged.
4. **Protect Special Populations** – The Exchange should ensure access to affordable health care for vulnerable and underserved populations and protect them from excessive user fees and other harmful barriers to coverage.
5. **Monitor, Evaluate and Report Routinely** – The Exchange policies should be subject to routine evaluation and annual adjustment. Such evaluations should consider their impact they have on individuals, employers, employees, carriers, etc. These evaluations should include an assessment of the impact the Exchange is having on employer premiums. Reports of these assessments should be widely available and used to inform the continuous improvement of the Exchange.

6. **Market Facilitator** – A Free Market Facilitator model provides a general structure capable of facilitating market competition, establishes basic rules for buyers and sellers and serves as a source of reliable, impartial, transparent information about the available plans. It is expected that the Free Market Facilitator model will ensure the maximum participation by insurers and the widest choice for consumers.
7. **Maximize Continuity of Care** – As individuals move between the Exchange and state-sponsored health care programs, enrollees could experience a change in the availability of providers, a loss of a preauthorization for a procedure and other discontinuities in their care. The Exchange should be designed in a manner that minimizes disruptions of care.
8. **Improve Patient Outcomes** – The certification standards for QHPs should be set in a manner that encourages or requires carriers to set measures that will improve the health of enrollees.

Recommendation: Adopt the key principles to guide the decision making process regarding plan certification and management.

Approved: April 12, 2012

RECOMMENDATION 2: DIVISION OF INSURANCE CONDUCT RATE REVIEW

The Affordable Care Act requires Qualified Health Plans' rates be reviewed and approved. Additionally, plans must meet actuarial levels (cost sharing levels) of 60% (Bronze), 70% (Silver), 80% (Gold) and 90% (Platinum) and Medical Loss Ratio minimums.

The Division of Insurance (DOI), through its certified health actuaries and/or outside actuarial consulting firms, review rate change applications submitted by carriers to ensure that any proposed rate change is warranted. The accuracy of data included in the application is fully reviewed for historical and mathematical accuracy. During the review, the DOI may request more information from the insurer. An application is not considered complete until all information required has been submitted. Public comments are considered while reviewing the necessity of the proposed rate increase.

The DOI can leverage its current process to complete the additional requirements of the Affordable Care Act (ACA). Additionally, the ACA rate review requirements are for QHPs offered both inside and outside the Exchange (market wide). Reviewing rates for QHPs outside the Exchange may pose problems.

Recommendation: The DOI should conduct the rate review process as required by the ACA in a manner prescribed by the DOI.

Approved: April 12, 2012

COMMITTEE RECOMMENDATION PENDING BOARD APPROVAL

RECOMMENDATION 3: QHP STANDARDIZATION BETWEEN INDIVIDUAL AND SHOP EXCHANGE

The Exchange could require that there be no difference between the QHPs offered in the Individual and SHOP Exchanges. The Exchange could require that if a QHP is offered in the Individual Exchange, it must be offered in the SHOP Exchange and vice versa. This would reduce transition of care issues when a person moves from the SHOP Exchange to Individual Exchange as the plan the person is on while employed will be offered on the Individual Exchange. An individual may or may not be able to continue on a plan if they move from the Individual Exchange to the SHOP, depending on the choice model selected by the SHOP Committee and the plans selected by the employer. Regardless of whether a person can continue on a specific QHP, there will likely be a change in premium to the individual depending on the contribution level of the employer and the income level of the employee.

However, certain carriers prefer to offer individual policies while other carriers prefer to offer group coverage. If the Exchange requires carriers to offer the same plans both inside and outside the Exchange, certain carriers that offer coverage to only one group may be unwilling to participate or will have to change their business models. There is concern that this reduced competition could increase premiums from what they would otherwise be.

It should be noted this item appears on the recommendations for both the SHOP Exchange Advisory Committee as well as the Plan Certification and Management Advisory Committee.

Recommendation: Allow carriers to offer QHPs in either or both Exchanges at their discretion; that QHPs not be required to be identical in the Individual and SHOP Exchanges

RECOMMENDATION 4: COST SHARING STANDARDIZATION

The Exchange could choose to: 1) require all QHPs be offered at “standard” cost sharing amounts (deductibles, coinsurance, copays, etc.); 2) require each carrier that offers a standard QHP in a given tier could also offer a plan of their choosing in that same tier; or 3) include no additional cost sharing standards for QHPs other than those provided by the Affordable Care Act.

The following information from RLCarey Consulting provides greater detail regarding a potential standard QHP:

One option for Nevada to consider is the development of standardized cost sharing for a qualified health plan (QHPs) offered at each actuarial value (AV) level (i.e., platinum, gold, silver and bronze). By making available a “standard” plan at each AV level -- in addition to plan designs developed by the carriers -- consumers will be provided an opportunity to evaluate a plan at each AV level based on premiums, provider networks, ancillary benefits, quality and carrier performance. With potentially tens of thousands of new consumers, many of whom will be

purchasing coverage for the first time, allowing for an apples-to-apples comparison of health plans may be beneficial to some consumers.

The design of the standardized plans could be set at the same time that carriers will be developing their QHPs. Carriers will be developing plan designs that fit into each of the AV levels, based on the state's essential health benefits package, roughly 12-15 months prior to the effective date of coverage. The Nevada Exchange, as part of the QHP solicitation process, could set plan design features for each AV level utilizing the data set being developed by the Centers for Medicare and Medicaid Services (CMS).

The CMS bulletin issued in February 2012 indicated that a standardized data set and AV calculator will be made publicly available to be used by health plans (and others) in determining the AV of QHPs. Nevada could use the AV calculator in developing standardized plan designs at each AV level. The pricing of these plans, like the pricing of all plans offered by the carriers through the Exchange, could follow the same schedule. While QHP premiums should be set as close to open enrollment as feasible, the administrative requirements associated with the enrollment process, the posting of plan design information, and the calculation of rates will require some lead time between the finalization of rates and the effective date of coverage.

Like all other QHPs offered through the Exchange, cost sharing may need to be adjusted annually (or biennially) to account for inflation. Adjustments to cost sharing that may be needed to account for updates in the data set used to determine actuarial value will affect all QHPs, whether or not the Exchange establishes "standard" plan designs.

Recommendations on the types of standardization

The development of a standardized plan design should focus primarily on key services/benefits, and should be limited to major plan design features. These may include the following categories:

- Deductible
- Office visits
 - Primary care physicians
 - Specialists
 - Behavioral health
- Outpatient surgery
 - Office
 - Facility
- Lab/X-Ray
- High tech imaging (CT, PET, MRI, etc.)
- Emergency room
- Inpatient admission
 - Acute care
 - Behavioral health
 - Skilled nursing facility/rehab facility
- Outpatient rehabilitation (physical, occupational and speech therapies)
- Durable medical equipment
- Prescription drugs
 - Tier 1
 - Tier 2
 - Tier 3

Procedures to review/analyze changes in subsequent years should follow the same process as the Exchange will follow for all qualified health plans. As material updates are made to the data set used to calculate actuarial value, the Exchange will need to assess whether the QHPs will need to adjust cost sharing to align with the updated data set.

Carriers have indicated they are opposed to the above methodology as it infringes on their ability to adjust plan design as necessary to meet their price points and marketing goals and would introduce unnecessary regulation that could increase costs. This could cause certain carriers to leave the market, reducing competition and further increasing cost.

The standardization being considered by states such as Massachusetts is based on consumers' reactions to their products. However, the Affordable Care Act creates some standardization by requiring each product meet certain actuarial values (metal tiers). The actuarial value requirements may create relative standards without additional regulation. Massachusetts has a relatively mature exchange that has been in operations for several years and it does not yet have to implement the actuarial value requirements. Setting standards on an exchange that is not yet operational adds variables that will be difficult to quantify.

Furthermore, the Massachusetts Connector uses an active purchaser model in which the Connector limits the number of plans by contracting directly with insurance providers, standardizing plan design parameters and directly negotiating rates with contracted plans. However, the Board approved the Committee's recommendation to use a free market facilitator model to provide a general structure capable of facilitating market competition and establish basic rules for buyers and sellers. It is expected that the Free Market Facilitator model will ensure the maximum participation by insurers and the widest choice for consumers.

The Exchange could revisit this item and implement additional cost sharing standards in 2015 or 2016 after the Exchange has some experience with enrollment and feedback from consumers. Further, it is the intent of the Exchange to offer a customer service experience through the web portal that allows for easy comparison of cost sharing plan components as well as a cost sharing calculator to allow the consumer to estimate potential costs.

Recommendation: Allow carriers to create QHPs that meet the requirements of the Affordable Care; that the Exchange not impose any additional cost sharing requirements on QHPs

RECOMMENDATION 5: NUMBER OF QHPs OFFERED BY CARRIERS

The Exchange could choose to limit the number of QHPs a carrier offers on the Exchange. Limits could be based on the number of QHPs offered in the Exchange as a whole or based on the number of QHPs offered in a specific metal tier in the Exchange. If no limit is created, a carrier could flood the Exchange with many plans so that they get more of the Exchange business. However, it is expected that carriers will limit the number of plans they offer because of the additional expenses associated with licensing and administration. Furthermore, the web portal can be designed so that a random plan is displayed first on the list so that no single plan

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has an advantage based on its position on the list the consumer sees. The system could randomly select a carrier so that all carriers have an equal opportunity to sell products on the Exchange.

Recommendation: The Exchange set no limit on the number of QHPs offered in the Exchange.

RECOMMENDATION(S)

None.