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AGENDA ITEM

[X] **For Possible Action**

[ ] **Information Only**

Date: February 11, 2016

Item Number: V

Title: Adopting 2017 Per Member Per Month Fees

PURPOSE

The purpose of this report is to provide the Board with information regarding adopting the 2017 Per Member Per Month Exchange fees at today's publicly noticed hearing.

CONTENTS

ADOPTION OF 2017 PMPM FEES

PREVIOUS FEE:

On February 12, 2015, the Exchange board voted to set the PMPM fees charged to insurance carriers participating on the Exchange for calendar year 2016 at 3% for QHP's, and 3% for Standalone Dental plans.

PROPOSED FEE:

Staff proposes to set the PMPM fee for calendar year 2016 at 3.15% of the pre-subsidized premium generated by QHPs and standalone dental plans sold through the Exchange.

BASIS FOR SETTING PROPOSED FEE:

The Exchange is required to develop an annual fee which, in the opinion of the Board, allows our agency to perform all duties imposed by state or federal statute without unnecessarily increasing the premiums paid by Nevadans for health plans.

For the past two years, the Exchange has relied upon federal technology and infrastructure to assist in the enrollment of our consumers. In December, CMS issued a proposed Notice of Benefit and Payment Parameters for 2017 which sets user fees for state-based marketplaces which utilize the federal eligibility and enrollment infrastructure at 3% of the pre-subsidized premium generated by QHPs and standalone dental plans sold through the Exchange.

Determining an appropriate access fee for those states utilizing the federal platform is no simple task; it requires a balancing of interests and must fairly reflect the value of the services provided by CMS while recognizing the strictures imposed by each particular state's enrollment level and revenue constraints. In a smaller state like Nevada, the proposed 3% represents not only the entirety of the Exchange's revenues but an arbitrary assessment that does not accurately reflect the resources required to service our population.

While CMS has indicated that it is considering reducing the proposed 3% rate for the 2017 benefit year, we have not been able to either confirm that a lower rate will be available or what that rate might be. This uncertainty creates issues not only for the Exchange but for our issuers as well. Our carrier partners need guidance – and time - to be able to factor the fee into 2017 rates, and despite the unwillingness of CMS to timely provide necessary information it does not seem prudent for the Board to await their ultimate decision before setting our fee.

Staff has reviewed our legislatively approved budget, existing and projected cash reserves, the most recent enrollment figures, historical year-to-year premium adjustments, and anticipated expenses to develop the recommended fee of 3.15% of the pre-subsidized premium generated by QHPs and standalone dental plans sold through the Exchange. We believe this fee allows the Exchange to not simply survive but to continue its important work. Moreover, our fee structure will remain significantly lower than that of the federally facilitated marketplace and would be projected to save Nevada's consumers nearly $1,000,000 annually, assuming that CMS is somehow able to maintain the federal assessment at 3.5% over the coming year despite its documented $621,000,000 shortfall.

CALCULATION OF ADEQUACY OF PROPOSED FEE:

The proposed fee is based upon a combination of actual and projected numbers. Actual premiums reported to the Exchange for Plan Year 2015 are the foundation for our proposed rate.

In order to conservatively forecast future revenues, a 5% increase in premiums for Plan Year 2017 was applied. The 5% projection accounts for anticipated fluctuations in both enrollment and paid premiums over the course of the calendar year. Similar projections have been developed for Calendar Years 18 and 19 to assure data and calculation consistency with prior year results.

Future expenses were modeled using standard state methodologies. Technology and call center costs were developed based on researched vendor pricing models and an anticipated transition year fee for access to federal infrastructure at 1.5% of the pre-subsidized premium generated by QHPs and standalone dental plans sold through the Exchange. We recognize that this figure is subject to change upon release of the Final 2017 Notice of Benefit and Payment Parameters but feel confident that 2016 enrollment levels will provide sufficient revenue to offset any additional cost assessed by CMS.

2017 REVENUE PROJECTIONS AND FFM COMPARISON

Staff believes the 3.15% recommendation provides the Exchange with the ability to meet budgetary requirements, ensures the sustainability of the agency, and keeps costs down for carriers and Nevadans respectively. Additionally, a fee of 3.15% of premium is well below the FFM fee of 3.5% (a reduction of 10%).

Plan Type	Total Premium 2015	5% increase in Premium in 2016	Percent of Premium	Percent as a Dollar PMPM	FFM (3.5% of Premium)
Qualified Health Plan	$247,268,072	$259,631,476	3.15%	$8,178,391	$9,087,102
Standalone Dental Plan	$2,034,053	$2,135,756	3.15%	$67,276	$74,751

The following table further summarizes the Exchanges budgetary needs for 2016 and the anticipated effect of the proposed 3.15% fee.

Legislatively Approved Budget	2017
Cash	$1,237,387
Approved PMPM Fee	$6,549,646
Total Revenue	$7,787,033
Total Approved Expenditures	$7,787,033
Proposed 3.15% Fee on Premiums Collected	$8,245,667
Total Approved Expenditures	$7,787,033
Projected Reserve	$458,634
Projected Reserve	$458,634
Cash Savings	$1,237,387
****Projected increase to Reserves	$1,696,021
****The increase to reserves would help offset cost of a transition from the FFM to a private market place if necessary.	