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AGENDA ITEM

☐ **For Possible Action**

☒ **Information Only**

Date: July 12, 2018

Item Number: IV

Title: Executive Director's Report

PURPOSE

The purpose of this report is to provide information to the Board and public regarding the status of the Exchange's implementation of a state based health insurance exchange and other operational matters of the Exchange.

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GENERAL COMMENTS

The Silver State Health Insurance Exchange (Exchange) has spent the past several months advancing the board's mission to transition to a fully operational State Based Marketplace, refining a comprehensive communications and marketing strategy for a successful open enrollment period, developing the next biennium's budget framework, solicited and awarded in-person assister and broker storefront grants, and collaborated with carriers for plan year 2019 plan certification.

State Based Marketplace Transition

The Exchange, in partnership with Nevada State Purchasing Division closed the Request for Proposal (RFP) for a state based exchange technology and consumer assistance center on April 13, 2018. The RFP committee scored the submitted proposals and invited the highest scoring vendors to provide demonstrations. The Exchange sent a letter of intent to our top scoring vendor, Get Insured, in late May and has spent the month of June negotiating and finalizing the

contract which has been provided to the Board for consideration and approval at today's meeting. The Exchange is confident that the previously announced anticipated savings will be achieved if the contract is awarded at the Board of Examiners' Meeting on August 14, 2018.

Get Insured, an exchange-based technology company, is currently operational in six states including Idaho where the state successfully transitioned its Exchange from HealthCare.gov to a private enrollment platform in 2015. The Nevada Exchange is certain that a relationship with Get Insured will be a collaborative partnership wherein Nevadan consumers will benefit from cutting edge technology and functionality.

On June 20, 2018, Exchange staff received budgetary authority from the Interim Finance Committee to develop a Project Management Office (PMO) to manage the Exchange's transition to a fully operational State Based Marketplace (SBM). While the Exchange is confident in our ability to oversee a successful transition, we made the determination to seek formal project management assistance from qualified personnel with direct experience with establishing a SBM under the Affordable Care Act (ACA). Our conversations and visits with other SBMs, along with the detailed project road map the Exchange received from the Centers for Medicare & Medicaid Services (CMS) convinced us that maximum success in Nevada's transition will require a level of specialized expertise and experience that existing staff cannot provide. Exchange executive staff began the interview and hiring process for the PMO team on June 25, 2018 and are poised to develop an experienced and capable team in time to begin immediately following the Board of Examiners contract approval.

In recognition of the complex and substantial effort necessary to effectively communicate the transition from a State Based Marketplace utilizing the Federal Platform (SBM-FP) to an SBM, the Exchange has begun to develop a comprehensive phased stakeholder communication strategy. Through a partnership with State Health and Values Strategies (SHVS), the Exchange and contracted marketing vendor, Penna Powers have begun work with an advertising and marketing company called GMMB to develop a comprehensive communication strategy surrounding the technology transition which will include consumer, carrier, state agency, CMS, the Exchange's Board, lawmakers, and stakeholder engagement.

The Exchange staff fully recognize the complexity and significance of this project and have worked carefully to develop risk mitigation and contingency plans. There will be bumps in the road, but Exchange employees are determined to address each challenge as it arises and move deliberately toward the end goal—a fully functional exchange as an SBM. Through thoughtful strategizing, strong stakeholder collaboration, and addressing previous lessons learned, staff will minimize disruption and associated risks.

Open Enrollment 2019

While the Exchange works diligently and enthusiastically on the transition project, we remain laser-focused on our sixth Open Enrollment period for plan year 2019. Several federal rule changes create another open enrollment period where consumer education is critical. The final rule on Associated Health Plans (AHP) was released in June 2018 and the Short Term Limited

Duration (STLD) rule will be finalized in the very near future. The Exchange must focus on an education and outreach campaign designed to demonstrate the differences between a qualified health plan (QHP), AHP, and STLDs. Nevadans need to make unbiased and informed health insurance decisions based on their unique health care needs. The STLDs and AHPs do not provide the same comprehensive benefits that can be found in a QHP; it is the Exchange's job to ensure Nevadans have the information, resources and tools necessary to make knowledgeable purchases.

The Exchange has completed our annual Request for Applications (RFA) for Navigator and In-Person Assister and Broker Store Front grants. Administering and managing our Navigator and In-Person Assister entities is often promoted as a strength of the Exchange because of their direct contact with consumers and an instrumental reason for our SBM-FP year-over-year success. The Navigator and In-Person Assister grants topped out at 11 this year and include returning organizations such as:

- Asian Community Resource Center (ACRC)
- State of Nevada Office of Consumer Health Assistance – Las Vegas & Elko
- Dignity Health - St. Rose Dominican Hospitals
- Consumer Assistance and Resource Enterprise (CARE)
- Three Square
- Community Health Alliance (CHA)
- Hope Christian Health Center
- Nevada Health Centers

The Exchange is excited to award new In-Person Assister grants to:

- Community Strong 702
- Nevada Outreach Training Organization/No to Abuse/Pahrump Family Resource Center
- Asian Community Development Council (ACDC)

On the Broker front, the Exchange is enthusiastic about entering its second year of Broker Storefront grants. In the second year of providing funds to encourage brokers to establish storefronts in which to assist consumers about the nuances of enrolling in qualified health plans, the Exchange is looking forward to working again this year with:

- Christopher Carothers of Carothers Insurance Agency, Inc.
- Alberto Ochoa of Smart Buy Insurance, Inc.
- Nathan Kamo of Kamo Insurance Agency

Based on last year's success, the Exchange expanded the storefront program, and is delighted to welcome the following new brokers into the program:

- Brian Douglas of ProtectHealth Ins.
- Brent Leavitt of Battle Born Financial Advisor

Marketing, Advertising and Education strategies have been developed and production for new education focused content is underway. The Exchange Communication Officer and Penna Powers will provide a more comprehensive open enrollment communication plan overview later in the board meeting.

Budget Development for State Fiscal Years 2020-2021

All Nevada state agencies, the Exchange included, must submit our budget for the 2020-2021 biennium to the Governor's Finance Office Budget Division by 5:00 P.M. on August 31, 2018. This budget will carry the Exchange through the transition project and will cover the first year of operations as a fully operational SBM. The Exchange intends to request additional full time employees to support SBM functionality in the areas of consumer support, carrier reconciliation, and compliance. Additional staff will increase operational costs in the personnel budget category, however the combined savings realized on technology and consumer assistance and additional staff will still demonstrate a savings of nearly half of that which would have been spent on HealthCare.gov. The Exchange believes the cost savings, state based control, and stakeholder and consumer improved experience will net a long term positive return on investment.

On February 21, 2018, the Exchange sent a letter to the Secretary of the U.S. Department of Health and Human Services (DHHS), Alex Azar, to request that CMS allow the Exchange to maintain a HealthCare.gov user fee of two percent for plan year 2019. CMS formally denied the Exchange's request in May of this year. While the Exchange is grateful for the support that CMS has provided as it relates to Nevada's transition back to a full SBM, maintenance of the user fee would have been reasonable considering the reduced volume in November when Nevadans will likely enroll on a private platform for plan year 2020. The Exchange is confident in a successful launch of its new technology platform and consumer assistance services; however, being both fiscally realistic and prudent to costs during this parallel period of paying both the federal user fee and the costs associated with a transition, the preference is to control and maximize available funding by holding the fee at a lower rate.

Despite CMS' denial, the Exchange continues to discuss opportunities for negotiation based on the anticipated reduction of demand on the HealthCare.gov platform. The Exchange intends to continue discussion of a reduced fee for at least the portion of calendar year 2019 where demand will be reduced. Further, the Exchange has requested that CMS provide details as to what HealthCare.gov functions the Nevada user fee supports to allow for more substantive conversation to determine an equitable 2019 assessment fee.

Plan Certification 2019

Based on initial plan year 2019 carrier plan submissions each rating area will have at least one carrier offering plans. Both Health Plan of Nevada and SilverSummit have submitted a total of 15 QHP plans as follows; 1 Catastrophic; 4 Bronze; 8 Silver; and 2 Gold plans. Stand Alone Dental Plans have been submitted by Alpha, Best, Delta, EMI, Liberty, and Rocky Mountain with a total of 22 plans.

Carriers have submitted their initial rates to the Nevada Division of Insurance (DOI). The DOI intends to publish the proposed rates for public comment on July 17, 2018 on the agency website. Consumers will have an opportunity to comment on the rates for 30 days. The DOI will publish final rates on October 2, 2018.

Federal Update

The U.S. Department of Justice (DOJ) told a federal court in Texas that it will no longer defend crucial provisions under the ACA in a Texas lawsuit: the guarantee of coverage for pre-existing conditions and the community rating provisions. While it is unusual for the DOJ not to defend federal laws, the legal arguments of the case are largely thought to be without merit. Many industry and advocacy groups filed amicus briefs on June 14, 2018. The list of organizations in opposition includes doctor groups, hospitals, disease groups, consumer advocates, AARP, public health scholars, health economists, the Association of Health Insurance Plans, small businesses, unions, and legal scholars.

If the lawsuit is successful between 50 and 130 million Americans with pre-existing conditions could face exclusions, premium increases, and coverage denials. Individuals with employer sponsored coverage and Medicaid would be locked into their existing coverage. If the lawsuit is successful and carriers can rate plans based on consumers health status it would be impossible to determine premium tax credits. Should consumers lose coverage as a result of a pre-existing conditions it is highly likely that hospitals and providers would see increases in uncompensated care.

Also impacting pre-existing conditions, on June 19, 2018 the Heritage Foundation released a new conservative health reform plan which would turn the ACA into a fixed block grant to states. The plan is similar to the Graham-Cassidy-Heller bill, although with less federal funding, wherein funding would eventually be equalized across states based on the number of low-income residents. It would explicitly remove ACA benefit requirements, limits on age ratings, limits on insurer overhead and profit, and the requirement that insurers maintain a single risk pool. The proposal would effectively remove pre-existing coverage protections by removing benefit requirements and risk pooling. There's also language that states would be required to allow anyone for Medicaid or CHIP to convert their assistance into a voucher for private health insurance. It would allow insurance discounts for people who are continuously covered, implying penalties for people who are not. Health policy experts do not foresee the bill gaining any meaningful traction during the campaign season, however it is important to note that the plan is aligned with the Trump Administration's budget and is aligned with the DOJ's decision not to defend pre-existing conditions.

Pivoting to AHPs, the U.S. Department of Labor finalized the AHP rule on June 19, 2020. The rule allows for associations, such as business chambers to form in order to create a group health plan. The finalized rule leaves regulatory authority in the hands of states, and while AHPs are allowed to set rates based on gender, age, and industry, the rule maintains that AHPs may not rate based on health status.

Continuing with alternatives to QHPs, CMS is expected to finalize the rule on STLDs in the very near future. The Exchange submitted comments to the rule expressing deep concern about the impact the proposed rule may have on the stability of the individual market. Enacting the rule will not increase access to comprehensive quality coverage, rather it will likely result in increased premiums for Exchange consumers while siphoning individuals into plans that do not offer minimum essential coverage.

The Departments of Labor and Health and Human Services propose to reverse the 2016 standards for STLD plans, which currently allow such products to a term of less than three months, by allowing these plans to a term of up to 364 days. STLD plans are exempt from consumer protections guaranteed under the ACA; allowing exclusion from coverage based on pre-existing condition, caps on benefits, annual lifetime limits, and the exclusion of essential health benefits. Consequently, STLD plans do not provide consumers with comprehensive coverage and discriminate against individuals with pre-existing health conditions.

If the rule is to be promulgated as proposed the STLD plans will likely attract healthy people and leave others in the individual market. By using medical underwriting, STLD plans screen and reject individuals with medical needs. STLD plans do not cover pre-existing conditions, exclude prescription drugs, maternity care, and mental health benefits, and have annual lifetime limits. Individuals with pre-existing conditions and those who anticipate needing medical care will choose comprehensive coverage not STLD coverage, leaving behind a more sick risk pool which will result in premium increases for all who remain on the Exchange.

As the AHPs and STLDs rollout, Nevada Health Link must remain the trusted resource for Nevadans to find quality health plans with comprehensive coverage. With more than 91K consumers enrolled in health plans this past year alone, we're committed to continuing to help Nevada residents who want and need access to quality, affordable health coverage find it. And Nevada Health Link remains the only place consumers can get financial help to lower the cost of a plan.

All plans sold through Nevada Health Link provide essential health benefits, including preventive care and screenings, hospitalizations, prescription medicines, check-ups and more. The rules finalized today loosen restrictions on plans offered outside the marketplace to individuals through associations. So, it's more important than ever for consumers to take a close look at a plan's benefits and coverage before they buy it.

Plans that charge a lower premium often cover far fewer benefits and services, and might not provide the same protections as a marketplace plan. Consumers need to read the fine print to ensure they won't be denied coverage for services they need or end up with unexpected medical bills. We will work throughout the year, in close partnership with Nevada Division of Insurance, to help educate consumers on how to pick the plan that's right for them.

Summary

As the Exchange looks through the dynamic ACA landscape toward the future, it becomes more and more evident that state based control will be key to providing trustworthy services to Nevadans. Although the federal landscape remains divided in partisanship the Exchange is confident that our self-funded direction will continue to provide quality resources and services at the lowest cost point available. Through focused, mission- driven planning and implementation the Nevada Exchange is set to lead the country in developing an Exchange technology and consumer assistance package that can be adopted and afforded by other states wishing to control their markets.