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# Silver State Health Insurance Exchange

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**FISCAL AND OPERATIONAL REPORT**  
**PROVIDED TO THE GOVERNOR AND LEGISLATURE**  
**PURSUANT TO NRS 695I.370 (1) (B) & (C)**  
**DECEMBER 31, 2018**

The Silver State Health Insurance Exchange (Exchange) is pleased to offer this Fiscal and Operational Report, required pursuant to [NRS 695I.370 \(1\) \(b\) & \(c\)](#), to the Governor, the Legislature and the public. It provides information regarding the activities of the Exchange since June 30, 2018.

## CONTENTS

CONTENTS .....	1
EXECUTIVE SUMMARY .....	2
MARKETING AND OUTREACH .....	7
SUMMARY .....	11
THE BOARD .....	11
STAFF .....	12
MARKETING & OUTREACH CAMPAIGN HIGHLIGHTS .....	12
STATE BASED EXCHANGE TRANSITION .....	16
BROKERS .....	16
NAVIGATORS, IN-PERSON ASSISTERS, AND CERTIFIED APPLICATION COUNSELORS.....	17
FINANCE .....	19

Silver State Health Insurance Exchange  
Fiscal and Operational Report  
December 31, 2018

## **EXECUTIVE SUMMARY**

During the time period of July through December 2018, the Silver State Health Insurance Exchange (Exchange) continued to advance the Board of Director's mission to transition to a fully operational State Based Exchange (SBE), refined a comprehensive communications and marketing strategy for the 2019 open enrollment period, solicited and awarded in-person assister and broker storefront grants, collaborated with carriers for plan year 2019 plan certification, and developed the next biennium's budget.

## **STATE BASED MARKETPLACE TRANSITION**

The Exchange, Nevada's marketplace for Affordable Care Act (ACA) qualified health and dental plans, currently relies on HealthCare.gov and its associated call center to provide enrollment and customer support functions for Nevada's Exchange consumers. This arrangement has served Nevada well in past years, but increasing user fees for the federal platform threatened to exhaust the Exchange's reserves. The contract for a technology platform and consumer assistance center, signed by the Nevada Board of Examiners on August 14, 2018, will ensure the continued fiscal solvency of the Exchange by significantly lowering the cost of ACA administration for Nevadans, saving the state a projected total of \$18,901,992 through State Fiscal Year 2023 (FY 23), while also providing stakeholders such as insurance carriers, brokers, and policy makers with superior tools for serving Nevada's consumers.

## **BACKGROUND**

The Exchange is a fee-funded agency deriving its revenue entirely from a 3.15% assessment of the gross monthly premiums collected by Nevada's on-exchange insurance carriers. Currently the Exchange operates as a State Based Exchange using the Federal Platform (SBE-FP), a hybrid model under which ACA health insurance exchange functions are shared between Nevada and the federal Centers for Medicare and Medicaid Services (CMS). Marketing, outreach, plan certification, carrier relations, stakeholder management, and broker/navigator functions are provided by the Exchange, while eligibility, enrollment, and customer service functions are provided by HealthCare.gov.

During Plan Year (PY) 2015 and PY 2016 CMS' exchange functions were provided to hybrid states such as Nevada at no cost. However, for PY 2017, CMS implemented a user fee of 1.5% of carrier premiums. This fee increased to 2% for PY 2018 and will further increase to 3% for PY 2019 and beyond. The impact of these increasing user fees would have been significant, reducing the Exchange's operating budget to just 0.15% of carrier premium fees for FY 2020, or a projected total of \$662,760. The Exchange's projected operating expenses for PY 2020 (excluding user fees for the federal platform) is \$6,798,650, resulting in a net projected loss of \$6,135,890. At that rate, and without immediate action to mitigate the impact of the increasing user fees, the Exchange projected that its reserve funding would have been depleted before the close of FY 2021.

Silver State Health Insurance Exchange  
Fiscal and Operational Report  
December 31, 2018

## **TRANSITION STRATEGY**

In November of 2016 the Exchange began a series of meetings with IT personnel from the Division of Welfare and Supportive Services (DWSS), Nevada's Medicaid administering entity. The goal of the meetings was to develop a model for integration between the Medicaid platform and a SBE platform, capitalizing on the successes of the 2014 integration with DWSS, while avoiding the problems which led to the Xerox system's failure. The Exchange continued to develop the integration model throughout 2017, ultimately receiving approval from CMS in September.

In December of 2017 the Exchange issued a Request for Information to assess the feasibility of a transition away from the federal platform and towards autonomous operation as a SBE. The responses received convinced the Exchange that the vendor climate had changed significantly since Nevada's previous attempt to establish a SBE; whereas the first generation of ACA exchanges required complex, custom-built platforms based on unproven technology; multiple vendors now offer proven, turnkey solutions that have been successfully deployed in a number of states. The Exchange followed up with site visits to other SBEs, including Idaho, which has the distinction of being the only state to successfully transition away from the federal platform and establish operations as an SBE. After a detailed analysis of Idaho's transition strategy the Exchange concluded that a similar transition would not only be in the best interest of Nevada's ACA consumers, but would also provide the Exchange with a beneficial level of flexibility and self-sufficiency within the volatile ACA marketplace.

In February of 2018, the Exchange conducted a series of workshops to solicit commentary and feedback on a possible transition from various stakeholders, including insurance carriers, impacted state agencies, Nevada's broker/navigator community, and the general public. The information gathered during these workshops was used to develop a Request for Proposal (RFP) for a SBE platform, with the goal of going live in the Fall of 2019 and offering ACA health plans with coverage beginning January 1, 2020. Chief amongst the RFP's requirements was that the proposed solution must have been successfully deployed in at least one other state and have demonstrated successful operations for at least one complete plan year. The RFP was issued in March under the guidance of the State Purchasing Division, and the Exchange evaluated the responses during April and May. In addition to Exchange staff members, the evaluation committee included representation from Nevada's Division of Insurance, as well as Oregon's Health Insurance Marketplace. The highest scoring respondent was GetInsured, an exchange-based technology company who is currently operational in six states and the same vendor who successfully transitioned the state of Idaho away from the federal platform in 2015.

During June and July 2018 the Exchange worked with GetInsured to negotiate a favorable and innovative contract, minimizing the risks associated with complex, multi-vendor implementations and capitalizing on opportunities for shared cost savings between the many states utilizing the GetInsured platform. The contract was finalized after the Board of Examiner's approval on August 14, 2018. During this same time period the Exchange also received Interim Finance Committee approval to conduct a solicitation for qualified contractors to establish an independent Project Management Office (PMO) who began work on August 15, 2018. Through this solicitation process the Exchange was able to secure the services of exceptionally qualified individuals with extensive

Silver State Health Insurance Exchange  
Fiscal and Operational Report  
December 31, 2018

experience in the establishment of State Based Exchanges. The PMO is not only able to provide centralized leadership and coordination for the multiple agencies involved in the transition, but also allows for a transparent, independent level of verification and validation of the project's progress which could not be provided by the vendor or Exchange internal staff.

Furthermore, the Exchange continues to conduct regular meetings with DWSS personnel to ensure that the requirements for integration between the Medicaid system and the forthcoming SBE platform are well defined and attainable within the proposed project schedule. The Exchange believes that these combined efforts have resulted in the best possible outlook for Nevada as the Exchange works through this crucial transition. As of December 2018, the transition project is fully on schedule, each milestone has been met and deliverables have been submitted on time and satisfactorily. The comprehensive project plan has been fully developed and approved, and work has begun to connect technology systems and establish testing environments in time for a November 1, 2019 go-live date.

In recognition of the complex and substantial effort necessary to effectively communicate the transition from a SBE-FP to an SBE, the Exchange has developed 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 created the framework for an exhaustive communication strategy surrounding the technology transition which will include consumers, carriers, state agencies, CMS, the Exchange's Board, lawmakers, and stakeholder engagement.

The Exchange staff fully recognize the complexity and significance of the transition project and have worked carefully to develop risk mitigation and contingency plans. Every project has challenges, both expected and unexpected, and Exchange employees are determined to address each issue as they arise in order to move deliberately toward the end goal—a fully functional exchange as an SBE. Through thoughtful strategizing, strong stakeholder collaboration, and addressing previous lessons learned, staff will continue to minimize disruption and associated risks.

### **OPEN ENROLLMENT 2019**

Health care was one of the top issues for voters who went to the polls just five days after Open Enrollment 2019 began. With very affordable options, rate decreases, and a stabilizing market, the 2019 plan year offered Nevadans a lot to be encouraged about. Open Enrollment ran from November 1<sup>st</sup> – December 15<sup>th</sup> allowing just 45 days to enroll new consumers and reenroll returning consumers. The Exchange will not have final open enrollment figures until January 2019.

### **PLANS**

Both Health Plan of Nevada (HPN) and SilverSummit returned to the Exchange for PY 2019 to offer a combined total of 14 qualified health plans; two (2) gold plans, seven (7) silver plans, four (4) bronze plans, and one (1) catastrophic plan. The Exchange will have six (6) dental carriers with 22 stand-alone dental plans available to Exchange consumers. Consumers residing in Clark, Nye,

Silver State Health Insurance Exchange  
Fiscal and Operational Report  
December 31, 2018

and Washoe counties were able to select qualified health plans from both insurance carriers while the other counties were able to select from the five SilverSummit plans.

## **RATES**

The Nevada Division of Insurance approved 2019 health insurance rates for all plans in the Individual Health Insurance Marketplace. The approved average rate change in the individual market, both off and on Exchange was 0.3%. The average rate change on Exchange was a decrease of 0.4%, which represented very good news for Exchange consumers. On average, consumers who are eligible for subsidies (82 percent) were able to continue to find low-cost and even no-cost plans, and consumers who are not subsidized (13 percent) saw slight decreases in their monthly premiums.

## **INDIVIDUAL MANDATE**

The United States Congress voted to zero out the penalty associated with the individual mandate effective January 2019. This presented the Exchange with a challenge as it relates to consumer retention and recruitment. Health policy analysts had a difficult time determining the impact of the repeal, however most analysts agreed that the individuals most likely to forgo health insurance as a result of a repeal will be healthy individuals between the age of 26 and 40. The Exchange tailored our marketing and outreach campaign accordingly, with additional emphasis on this segment of the population specifically highlighting the prohibitively high prices associated with medical care should one opt out of health insurance. The Exchange's message was clear—unexpected and routine medical care comes at a significantly high cost that could potentially bankrupt an individual and/or their family—insurance protects against this devastating outcome.

## **COMPETING PLANS**

There are three types of plans that are in direct competition with qualified health plans for PY 2019: Associated Health Plans (AHP), Short Term Limited Duration Plans (STLD), and Health Sharing Ministries (HSM). While Nevada AHPs offer some of the protections afforded by the ACA, STLDs and HSMs offer limited benefits and are not subject to ACA rules. The Exchange's outreach around competing plans aimed to educate consumers while providing assistance and resources to connect them with comprehensive affordable health plans that are right for their individual and family specific needs.

Associated Health Plans allow small businesses and employers to band together by geography or industry to obtain health coverage as if they were a single large employer. Several Chambers of Commerce in Nevada have formed AHPs. The Nevada Division of Insurance regulates the benefit design for these plans, however they do not regulate the rates nor the networks. These plans may offer consumers who are ineligible for subsidies a more affordable option, however the Exchange encourages consumers to work with an enrollment professional to determine if these plans are right for their individual needs and reminds consumers that there are affordable plans available on the Exchange with subsidized premium payment assistance.

Silver State Health Insurance Exchange  
Fiscal and Operational Report  
December 31, 2018

The U.S. Department of Health and Human Services issued a rule expanding the length of STLD plans from 90 days to 364 days with the option for 36 months of renewability. Current Nevada Administrative Code (NAC) limits the sale of these plans to 185 days and bans renewability.

STLDs are useful in some circumstances, for instance when an individual has missed the open enrollment period and needs emergency coverage for a short period of time until they're eligible to purchase a qualified health plan or obtain insurance through another means. However, these plans do not provide comprehensive coverage nor do they provide minimum essential coverage (MEC). Most STLD plans have high deductibles and do not cover prescriptions, behavioral health, maternity care, etc.

Aside from the skimpy benefit package, many STLD carriers engage in post-claim underwriting which can leave consumers on the hook for medical care and the associated costs. When a consumer applies for one of these plans they fill out a health assessment/application and indicate whether they have any medical issues. If they do, the carrier can refuse to cover them, or charge them more based on that medical issue.

Upon receiving an insurance claim a STLD carrier may research the consumer's medical history to determine if the consumer had any indicators of illness prior to the application. If the carrier finds that the consumer had health issues that were not disclosed on their application, they can retroactively terminate their coverage and/or deny the claim leaving the consumer fully responsible for the costs. Even more concerning is that once a consumer is retroactively terminated from their STLD policy they are not eligible for a special enrollment period to enroll in a qualified health plan on the Exchange because the SLTD plan did not provide MEC. This leaves the consumer who has medical needs, without insurance.

There are a dozen insurance carriers currently selling STLD plans in Nevada, with large broker commissions; high commission structures incentivize some brokers to push consumers into STLDs when it may not be in their best long term interest. STLD plans also have a history of misleading marketing tactics convincing consumers they are purchasing comprehensive health benefits. The Nevada Exchange launched an educational outreach campaign warning consumers to read the fine print while highlighting the differences between STLDs and qualified health plans.

Health Sharing Ministries are not actually insurance, despite aggressive marketing asserting otherwise. HSMs are a form of health coverage in which members – who typically share a religious belief – make monthly payments to cover the expenses of other members. HSMs are not insurance and do not guarantee the payment of claims, but because their products closely mimic insurance products they can be confusing at first glance. They are largely unregulated and provide limited benefits and may prove to be disproportionately attractive to healthy individuals. The Exchange worked on educating partners and stakeholders on the limitations of HSMs while identifying fraudulent actors and reporting them to the Division of Insurance as appropriate. Consumers were encouraged to work with licensed enrollment professionals to connect them to comprehensive benefits that best meet their medical and budgetary needs.

Silver State Health Insurance Exchange  
Fiscal and Operational Report  
December 31, 2018

## **MARKETING AND OUTREACH**

While CMS made deep cuts to funding for marketing and outreach for federally facilitated states, the Nevada Exchange continued to invest significant portions of the agency's budget toward these critical functions with year-over-year increases in enrollment as a return on investment. For the 2019 open enrollment period (OEP), the Exchange granted funds to five brokers and twelve navigator entities in order to outreach and enroll consumers on the Exchange. The Exchange provides training, program monitoring, and technical assistance for broker and navigator partners who submit comprehensive reporting on their activities.

Penna Powers and the Exchange's Communications team enhanced our previous year campaign message: "You Can't Afford Not To Be Insured" with new advertisements and scenarios, a robust marketing strategy and an aggressive public relations campaign. In addition to our affordability message, the Exchange focused on educating consumers about working with licensed enrollment professionals to navigate the confusion of competing health insurance products.

The Exchange hosted two "Prep" rallies in the North and the South with Exchange grantees, broker partners and community stakeholders in attendance. The Exchange provided attendees with in-depth insight into plan year 2019 with details around plan offerings, rates, and messaging. Attendees were fortunate to hear from Roy Tuscany, a millennial, with an inspiring story about how insurance helped him afford to triumph over tragedy. Attendees in Las Vegas were fortunate to also hear from Desiree Reed Francois, the UNLV Athletic Director who shared her inspirational story surrounding her successful career and hit on the importance of working with an enrollment professional when purchasing health insurance. Exchange partners were provided with marketing tools to promote and educate consumers about the upcoming open enrollment period.

## **BUDGET DEVELOPMENT FOR STATE FISCAL YEARS 2020-2021**

The Exchange submitted the agency budget for the 2020-2021 biennium to the Governor's Finance Office Budget Division 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 SBE. The Exchange requested an additional eleven (11) full time employees to support SBE 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, 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 2018. The Exchange worked with the entire Nevada federal delegation who sent another letter to CMS on April 26<sup>th</sup> bolstering the request for an adjusted 2019 fee; this was denied on June 7, 2018. Congressman Amodei met with CMS staff in September of 2018, questioning the

Silver State Health Insurance Exchange  
Fiscal and Operational Report  
December 31, 2018

need for Nevada to pay the full three percent for plan year 2019 and was met with the same denial. Finally, Governor Sandoval sent a letter supporting the Nevada Exchange's request in September 2018—this request also did not yield any response.

While the Exchange is grateful for the support that CMS has provided as it relates to Nevada's transition back to a full SBE, maintenance of the user fee would have been reasonable considering the reduced volume in November of 2019 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.

### **FEDERAL UPDATES**

The Democratic win in the House of Representatives in the 2018 midterm elections, ensures the immediate end to legislative actions around repealing and replacing the ACA. While it is unlikely that any substantive legislation will be enacted to support the ACA, the law remains politically divisive, and the Executive branch of the federal government continues to introduce rule changes that will impact the marketplace both locally and nationally. Several lawsuits are also pending court decisions and could have broad and dramatic implications for the Exchange.

### **PROPOSED RULES**

Throughout October and November of 2018 federal agencies issued four proposed rule changes that could have ramifications on the Exchange's mission to reduce the number of uninsured Nevadans.

On October 10, 2018 the Department of Homeland Security announced a proposed rule change that could deny immigrants seeking citizenship in the United States eligibility for visas or green cards if they are deemed likely to receive certain public benefits once they come to the country. Immigrants could be denied a change in legal status once if in the United States they received—or are likely to receive public benefits such as public housing and food stamps—equivalent to a certain monetary threshold. The rule broadens the assumption on what is considered a “public charge,” or someone dependent or likely to become dependent on government benefit programs. If the rule is promulgated as written, immigrants could be rejected from citizenship if they do not forgo benefits that they or their family members would otherwise be eligible to receive. The subsidies Exchange consumers receive are not included in the proposed rule change, meaning immigrant consumers will be able to receive Exchange subsidies without impact to their immigration status; however, the change could serve as a deterrent with consumers being fearful of backlash resulting from the acceptance of any public benefits.

The Exchange launched an aggressive public education campaign in November 2018 after navigators and call center staff noticed an increase in consumers wishing to purchase plans off the exchange or without subsidies due to fear of retribution related to their legal status. Despite the



Silver State Health Insurance Exchange  
Fiscal and Operational Report  
December 31, 2018

fact that the Exchange subsidies are not included in the proposed rule, many consumers experienced a “chilling effect” resulting in their fear of accepting *any* federal assistance.

On October 22, 2018, the Departments of Health and Human Services and Treasury released new guidance on Section 1332 waivers that supersedes and replaces Obama-era guidance while making dramatic changes to the Departments’ approach to review and approval of waivers and to the ACA’s guardrails. Section 1332 waivers allow states to waive certain requirements of the ACA to pursue innovative approaches in line with the goals of the ACA. Among many substantive changes, the proposed rule will look favorably on waiver requests that provide increased access to private market coverage (including AHPs and STLDs) over public programs.

The guidance changes the definition of “access” by allowing the administration to no longer look at the actual coverage purchased under the waiver, rather waivers will be approved based on whether consumers have access to comprehensive and affordable coverage under the waiver, even if they do not enroll. The rule also shifts the previous focus from vulnerable populations by examining the aggregated effects. States will also no longer be required to submit waivers for coverage that meets minimum essential coverage, opening the opportunity for states to apply subsidy to AHPs and STLDs. The guidance changes previous ACA guardrails by redefining comprehensiveness and affordability. The Departments essentially take the position that coverage that is *both* comprehensive and affordable must be *available* to a comparable number of people as it would have been under the ACA. However, the guidance also allows states to provide options that are less comprehensive or less affordable. This means that states can develop a waiver that provides comprehensive or affordable coverage to fewer people relative to the ACA, so long as it provides some access to comprehensive and affordable coverage.

Health policy professionals agree that states that make changes through Section 1332 waivers under the new guidance will likely see an increase in the number of consumers in less comprehensive coverage, increases to consumers exposed to more cost-sharing responsibility, coverage losses and higher out of pocket costs for more vulnerable populations, and an expansion of STLDs and AHPs.

On October 23, 2018 the Departments of Treasury, Health and Human Services, and Labor issued notice of a proposed rule change that would expand the usability of Health Reimbursement Accounts (HRA) to fund access to health insurance and health care. The proposed rule would reverse prior Departmental guidance by allowing HRAs to be used to fund both premiums and out-of-pocket costs associated with individual health insurance coverage (including, QHPs, AHPs and STLDs). Among other significant provisions in the proposed rule, individuals who gain access to an employer sponsored HRA would be eligible for a special enrollment period. The potential expansion of coverage in the individual market could result in positive impacts on the risk pool, assuming migrated consumers are healthy, however there are potential pitfalls for employees who may find themselves responsible for more cost sharing than they were obligated to under their employer sponsored plans. Employees may also be subject to discrimination based on health status from their employers who may push sicker employees to accept the HRA and enter into the individual market. The Exchange will develop comments on the proposed rule in time for the December 28, 2018 deadline.

Silver State Health Insurance Exchange  
Fiscal and Operational Report  
December 31, 2018

On November 7, 2018 the Department of Health and Human Services issued a proposed rule change on exchange program integrity. This rule, if promulgated, could have significant technical ramifications for state based exchanges requiring changes to eligibility and enrollment rules. The rule also propose dramatic changes to the way that insurers and consumers pay for abortion services in QHPs, requiring insurers to send – and consumers to pay – two separate bills, one of which being the amount attributable to the portion of the premium covering abortion services. The rule requires exchanges to periodically data match with Medicare, Medicaid and CHIP at least twice per year. The rule would require exchanges to discontinue subsidies for consumers who become eligible for, or are enrolled in another qualifying program. The Department believes that delaying implementation until 2020 gives exchanges enough time to implement technical changes which it believes will cost each exchange \$1.74 million to implement. The rule proposes changes to Medicare dual eligible terminations and streamlines reporting requirements for state based exchanges. The Exchange will analyze and comment on the proposed rule by the January 8, 2019 deadline.

### **PENDING COURT DECISIONS**

Several ACA court cases remain pending; the Texas vs. United States case having the most immediate and profound implications for the Exchange. On September 5, 2018 a Texas Federal District Court heard arguments in a case led by the Texas Attorney General and 18 Republican state attorney generals. The plaintiffs are urging the court to overturn the ACA now that the individual mandate is no longer being enforced. In a rare move, the Trump Administration is not defending the law, instead they are arguing that pieces of the law associated with protections for individuals with pre-existing conditions should be struck down as these protections were directly tied to the tax penalty.

California’s attorney general, along with 17 democratic attorney generals, have intervened to defend the law. Health advocacy groups, patient organizations, health care providers, scholars, and consumers have filed amicus briefs outlining their opposition and the significant impact the court’s decision could have on health care systems and millions of consumers. The plaintiffs are urging the court to strike down the ACA immediately, but if the judge rules in their favor, the case will likely head to the Supreme Court for consideration. The provisions of the ACA that protect people with pre-existing conditions are the most popular part of the ACA and if overturned, could have the potential to create chaos throughout the entire health care system including Medicaid and the employer insurance market.

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 all but 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.

An estimated 25 percent of Nevadans under the age of 65 have pre-existing conditions. Some states have enacted their own laws to protect consumers with pre-existing conditions including rules with

Silver State Health Insurance Exchange  
Fiscal and Operational Report  
December 31, 2018

guaranteed issue, adjusted community rating and prohibition on pre-existing condition exclusions. The Exchange is monitoring this case and working with stakeholders to analyze the impact on Nevada.

As the judicial branch makes rulings and newly proposed rules threaten to create further volatility the Nevada Health Link must remain the trusted resource for Nevadans to find quality health plans with comprehensive coverage. With tens of thousands of consumers enrolled in health plans the Exchange is committed to continuing to help Nevada residents who want and need access to quality, affordable health coverage find it. Nevada Health Link remains the only place consumers can get financial help to lower the cost of a qualified health plan.

## **SUMMARY**

As the Exchange examines the dynamic future of the ACA landscape, 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 its 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 individual insurance markets.

The Exchange entered into its sixth OEP energized to connect eligible Nevadans to affordable, comprehensive qualified health plans. Exchange grantees, community partners, stakeholders, and staff were at the ready, engaging, educating, and enrolling consumers during the brief 45 day OEP. The OEP landscape was not without challenges which may have impacted enrollment numbers; specifically – the elimination of the ACA individual mandate penalty, competing off-Exchange plans, proposed executive rule changes, and a compressed enrollment timeframe.

Open enrollment success is made up of big and small wins; whether it's connecting someone to their first affordable health insurance plan or setting enrollment records in the face of adversity, the Exchange and our partners receive recognition for our critical work. What doesn't get publicized is the year of intense labor that goes into developing and implementing messaging, engaging stakeholders and grant partners, providing outreach and education to consumers, working with partner agencies, certifying plans, analyzing policy, engaging lawmakers, and operating a state agency. The success of the Exchange is only achievable if built on top of this fundamental work. For the reasons outlined in this report, the Exchange may not see an increase in enrollment for plan year 2019, however the dedicated work of Exchange staff and partners over 2018 is a definitive success

## **THE BOARD**

In accordance with 45 CFR § 155.110(c), the State must insure that the Exchange has in place a clearly defined Governing Board.

Silver State Health Insurance Exchange  
Fiscal and Operational Report  
December 31, 2018

The Board consists of seven voting members and three non-voting members. Of the seven voting Board members, five appointments to the Board were made by the Governor, one by the Speaker of the Nevada Assembly, and one by the Nevada Senate Majority leader.

- Current Voting Board Members:
  - Florence Jameson, MD, Chair
  - Valerie Clark, Vice-Chair
  - Jonathan Johnson
  - E. Lavonne Lewis
  - Quincy Branch
  - Jose Melendrez
  - Dr. Daniel Cook
  
- Ex-Officio Members (non-voting):
  - Bessie Wooldridge – Governor’s Office of Finance for Paul Nicks, Director
  - Barbara Richardson– Commissioner, Division of Insurance
  - Cody Phinney – Department of Health & Human Services, for Richard Whitley, Director

Since the Exchange’s last Fiscal & Operational report, there have been three board meetings. The Board, required to meet at least once every calendar year, has changed the frequency of its meetings from monthly to quarterly, with additional meetings as needed immediately leading up to and during open enrollment, or as directed by the Chair or majority of members (NRS 695I.340). Board meetings are held in Carson City and Henderson as well as streamed over the internet.

## **STAFF**

The Exchange staff currently consists of thirteen full-time employees. Nevada has the lowest Exchange employee count in the nation. Pursuant to NRS 695I.380, all employees of the Exchange are in the unclassified service of the state, with three non-exempt employees.

## **MARKETING & OUTREACH CAMPAIGN HIGHLIGHTS**

The Silver State Health Insurance Exchange (Exchange) concluded its sixth open enrollment period, and although previously, the Exchange reported year over year growth in enrollment—this year there were challenges in reaching above the 91,000 mark. However the Exchange and its stakeholders worked diligently to make sure Nevadans heard the message that affordable health plans exist and to get help from a licensed enrollment professional to enroll in a comprehensive benefit package. The Exchange and marketing partner, Penna Powers, launched their comprehensive open enrollment advertising campaign starting with pre-open enrollment messaging in late September of 2018. The campaign continued to utilize the established messaging of “*You Can’t Afford Not to Be Insured.*” New additional creative spots were developed including: “Dunk,” “Fountain,” and “Dancer,” while reusing the “Pool” and “Twins”

Silver State Health Insurance Exchange  
Fiscal and Operational Report  
December 31, 2018

ad spots. Each spot illustrates a cost analysis of how much the highlighted accident or injury scenario would cost without having health insurance.

For example, in the “Fountain” advertisement, a young woman is walking and texting while holding her coffee and she trips into a fountain, causing her to need ACL surgery on her knee and highlighting the cost without insurance. Each spot demonstrated very real potential scenarios and were designed to convey the dire consequences of what can happen to anyone at any time. The written copy/messaging incorporated affordability, or the availability of subsidies and the inclusion of the 10 essential health plans in every qualified health plan offered through Nevada Health Link. Nevada Health Link is the state’s online marketplace overseen by the Exchange.

The pre-open enrollment launch, whose call to action was: “Learn More at NevadaHealthLink.com,” focused primarily on cable television, out of home, print, radio, and a full suite of digital content. Beginning November 1, 2018, the campaign segued into “It’s Time to Enroll” call to action and both the traditional and digital mediums increased significantly in frequency to ensure target audiences (Hispanic/Latino, Asian/Pacific Islander, the self-employed, multiethnic populations, 50+ generation, young invincibles, ages 26-45, Tribes, individuals/families, underinsured or uninsured individuals) were seeing the campaign in multiple outlets and at very frequent intervals.

The full scope of the TV broadcast media plan was purposely implemented after the Nevada election race on November 7th to ensure messages were not lost prior amongst the myriad of political advertising. Like all other media, TV ran statewide in both general and Spanish language markets. The marketing strategy also included over the top (Internet) TV to reach Nevadans who stream their watching through sources like Netflix and Hulu, and incorporated campaign spots into movie trailers at movie theaters in Reno and Las Vegas.

Strategic marketing efforts resulted in the development of new concepts for continued messaging and brand awareness after open enrollment and into the New Year, incorporating the exploration of health literacy and health insurance plan usage concepts. The Exchange and Penna Powers created marketing support materials designed to educate consumers about what is in a plan before they purchase it. A side-by side educational infographic handout was developed to show consumers a comparison of short term limited duration plans (STLD) vs. qualified health plans (QHP) offered through Nevada Health Link. The Exchange has been committed year-round to engaging and communicating with our stakeholders, statewide community partners, and consumers that a QHP is a comprehensive health coverage option and includes the 10 essential health benefits. A similar comparison for health sharing ministries (HSMs) was also developed and promoted via Nevada Health Link’s blog, website, social channels, and email communications to the stakeholder listserv to educate partners and their consumers.

Since the Exchange will be transitioning to a state based exchange (SBE) for plan year 2020, it is mission-critical for the Exchange to educate Nevadans on how to make informed decisions when it comes to choosing a health insurance option that is right for themselves and their families.

Silver State Health Insurance Exchange  
Fiscal and Operational Report  
December 31, 2018

Social media marketing, often referred to as content marketing, runs throughout the year and is an important component of Nevada Health Link’s ongoing online presence and communication strategy. This year, Penna Powers implemented a search engine optimization (SEO) campaign which has proven to be an efficient online tactic to learn what consumer audiences are searching for when it comes to health insurance topics. Online video posted to social media platforms was a successful component of both off season and open enrollment campaigns; the Exchange has leveraged videos in multiple channels to target the millennials and 40+ audiences to keep Nevada Health Link top of mind. Moreover, Nevada Health Link continues to produce content for email marketing and an online blog focused on health literacy and consumer education, which has seen increasing engagement.

### **MESSAGING & PUBLIC RELATIONS**

The Exchange’s Executive Director and Communications Officer were very busy with open enrollment media relation activities including statewide media interviews, press conferences and partner/stakeholder engagements engaging in messages about open enrollment and the availability of free in-person assistance with an enrollment professional. The Exchange focused public relations on the following messages for plan year 2019:

- Being covered protects you from the unexpected.
- Availability of low cost plans and financial assistance is available.  
NevadaHealthLink.com has an updated table to estimate your costs here:  
<https://www.nevadahealthlink.com/costs/>.
- Plans have changed—shop the marketplace to find a plan that is best suited for your medical needs and budgetary needs for you and your family.
- Nevada Health Link is available to connect consumers to free assistance by calling our consumer assistance center or by visiting NevadaHealthLink.com

### **NEVADA HEALTH LINK OUTREACH**

Outreach continues to be a critical component in the Exchange’s communications strategy. The Exchange remained in close contact with stakeholder groups statewide, and continued to expand and sharpen mechanisms to identify key influencers and community partnerships all throughout the state in order to pursue cross promotional opportunities. This includes collaborations with various non-profit organizations throughout the state and brainstorming cross-promotional opportunities with those groups or agencies.

The generated interest in Nevada Health Link and the response from community partners has been overwhelmingly positive. From the inception of the stakeholder initiative, Nevada Health Link’s community partner list has grown to well over 200 confirmed partners, all whom now have marketing materials and connections as a resource for their related consumer audiences. The Exchange staff and Navigator grantees have seen increased partnership from Chambers of Commerce’s across the state as well as the school districts, particularly in Northern Nevada. Exchange staff has had the opportunity to provide presentations to numerous community partner

Silver State Health Insurance Exchange  
Fiscal and Operational Report  
December 31, 2018

groups, including: The Carson Valley Chamber, TMCC Flames, UNR Student Outreach Clinics, the Boys & Girls Club family groups, the Washoe County School District Counselors, and more.

Nevada Health Link carefully considers and strategizes outreach and event attendance opportunities to maximize exposure to potentially eligible consumers while developing marketing content and educational literature, aligned with open enrollment messaging. Nevada Health Link is fortunate to have had various opportunities to provide email communications to various Chambers of Commerce members as well as school district listservs. The Exchange works with The Las Vegas Metro Chamber, the Latin Chamber, Carson Valley Chamber, and Reno Sparks Chamber, to name a few. Throughout 2018, the Exchange developed relationships with Carson City School District, Washoe County School District, and areas of Clark County School District, as well as the State's university system and private colleges, opening the door for Nevada Health Link to provide education and resources to institutions who have not been previously engaged.

#### **COMMUNITY PARTNER/STAKEHOLDER RELATIONSHIPS**

Outreach and community relations anchor Nevada Health Link's marketing efforts. In addition to attending over 200 targeted, culturally diverse community events statewide, the staff at the Exchange continue to mine into and conduct multiple presentations at various higher education campuses and is a sponsor at several well-known community events throughout the State to help brand and bring open enrollment awareness. In 2018, the Exchange formed new partnerships with Clark County School District Family and Community Engagement, Roseman University, Touro University, Teach for America, UNLV Wellness Center, Northern Nevada Medical Center, UNR School of Medicine, just to name a few.

In an ongoing attempt to maintain awareness year-round, Nevada Health Link also pinpoints sponsorship opportunities where we can work with sponsor partners to develop mutually beneficial marketing opportunities within the community. This year, the Exchange targeted millennials by collaborating with community soccer, baseball and football leagues to reach parents through access to email databases and field signage. In the South, the Exchange partnered with the Las Vegas Lights Soccer Club which offered multiple opportunities to interact with the primarily Hispanic game audience directly through outreach and community activities as well as email marketing to the Lights' audience database. In the North, the University of Nevada, Reno, was able to include Nevada Health Link literature in over 3,000 season ticket holder packets that were mailed in October, a perfect segue to open enrollment. Statewide sponsor partners such as Immunize Nevada, provide the Exchange with multiple opportunities to connect with audiences in both the North and South.

The Exchange also engaged in a robust literature distribution program involving over 225 partners statewide. In 2018, the Exchange developed and distributed a new English and Spanish resource guide, localized each for Northern Nevada and Southern Nevada, including listings of enrollment assistance locations for consumer convenience.

Silver State Health Insurance Exchange  
Fiscal and Operational Report  
December 31, 2018

The Exchange is keenly aware that outreach and community relations are a critical component to not only reaching Nevadans, but to understanding and addressing their concerns. The Exchange engages in these efforts year-round and remains committed to efforts in connecting Nevadans to qualified health plans.

The Exchange hosted two “Prep” rallies prior to the Nov. 1 kickoff of open enrollment. The rallies provided an opportunity to gather stakeholders (carriers, brokers, navigators, community partners, etc.) to reveal Nevada Health Link’s marketing messages and strategies, and arm each attendee with those marketing tools for their consumer audiences to help us ensure that plan year 2019 was a great success. The Prep Rallies were held in Reno and Las Vegas and were well attended.

As a result of last year’s successful pilot program, the Exchange issued another Request for Application for statewide brokers to participate in a broker storefront program. Nevada Health Link partnered with awarded broker agencies to provide even more marketing tools for consumers looking for in person and general assistance about enrollment. The Exchange developed specific techniques and material to cross promote and highlight in person assistance to the awarded brokers and their respective locations throughout the open enrollment period.

#### **STATE BASED EXCHANGE TRANSITION**

The Nevada Exchange is transitioning to a private technology platform, away from HealthCare.gov to be a full functioning SBE by November 1, 2019. Although this project did not directly affect marketing and advertising during the 2018 open enrollment period, the Exchange developed and solidified a comprehensive transition communication plan and determined tasks that need to be concluded for the SBE Transition project. Within the communication plan are campaign phases, audiences, and strategic goals. The timing of specific communication to specific stakeholders has continued to be a focus for the Exchange. The Exchange continues to meet milestones within the SBE transition project.

Nevada Health Link strives to remain a trusted resource, not only by Nevada consumers and stakeholders, but also with the media. Long-term relationship building and fostering of the media to maintain transparency will help ensure Nevada Health Link remains viewed as a positive, trusted resource by Nevadans both during the transition and well after.

#### **BROKERS**

During the last six months of calendar year 2018, the Exchange has continued to make concerted efforts in promoting broker participation in selling qualified health plans on the Nevada marketplace. The Exchange’s broker liaison continues to travel to various areas of the state meeting with licensed brokers and agents individually to promote the benefits of selling plans on the marketplace, discussing how changes to Short Term Limited Duration (STLD) plans and Association Health Plans (AHP) will impact the marketplace, and taking time to educate and review important ACA requirements. Additionally, the broker liaison has been actively engaging and promoting marketplace participation in both northern and southern Nevada broker groups such as the Northern Nevada Association of Health Underwriters (NNAHU), the Clark County



Silver State Health Insurance Exchange  
Fiscal and Operational Report  
December 31, 2018

Association of Health Underwrites (CAHU), chambers of commerce events, and broker-specific task force meetings.

Following up on a successful Request for Application (RFA) released in May of 2017 which solicited applications for a maximum of three Pilot Broker/Agent Storefront programs for plan year 2018 (and where each grantee from 2017 received the healthcare.gov Circle of Champions award presented by CMS) the Exchange decided to grow the program to a maximum of six grantees for plan year 2019. The Exchange released a RFA on May 4, 2018, and five grants of \$10,000 each were awarded on July 1, 2018 to insurance professionals to assist with marketing, outreach and operational costs related to enrolling consumers in qualified health plans (QHPs). The goal of the RFA is to increase the number of enrollees in QHPs by brokers servicing Nevadans in-person at storefront locations. The Exchange recognizes the value of brokers having a public facing physical location to service consumers' questions and concerns, comparatively shop plans, as well as directly assist with the enrollment process during the November 1 through December 15 open enrollment period.

Brokers who were awarded a grant for plan year 2019 expressed a slow start, but enrollments have picked up immensely in the past 2 weeks. Their grants have allowed them to hire additional employees to service consumers, have a more robust outreach and marketing program, and improve office efficiencies.

#### **NAVIGATORS, IN-PERSON ASSISTERS, AND CERTIFIED APPLICATION COUNSELORS**

To be compliant with federal regulations, the Exchange must have consumer assistance resources and functions, including a Navigator program; and must refer consumers to appropriate state resources when available. The Exchange continues to operate with two awarded entities to serve as statewide Navigators and nine IPA entities. Navigator and IPA organizations are responsible for outreach, education, and enrollment for Nevada's uninsured and underinsured populations. Certified enrollment assisters are comprised of private entities that have been trained by Nevada Health Link and work closely with Nevada Health Link to educate consumers on the resources available in the health insurance marketplace. Navigators and IPAs remain the primary event staff when attending statewide community outreach events which continue to be an important and vital part of our marketing campaign. Navigators and IPAs attend community outreach events to promote the upcoming open enrollment while providing consumers with education of the health insurance marketplace. Navigators and IPAs have also continued to educate consumers on Special Enrollment Periods (SEPs) for any consumer who may experience a qualifying life event along with promoting the next open enrollment cycle which began November 1, 2018.

#### **NAVIGATOR ENTITIES**

- Dignity Health - St. Rose Dominican (Southern Nevada)
- State of Nevada - Office for Consumer Health Assistance (Statewide)

Silver State Health Insurance Exchange  
Fiscal and Operational Report  
December 31, 2018

**IN-PERSON ASSISTER ENTITIES**

- Asian Community Development Council (Southern Nevada)
- Asian Community Resource Center (Southern Nevada)
- Consumer Assistance Resource Center (Southern Nevada)
- Community Strong (Southern Nevada)
- Hope Christian Health Center (Southern Nevada)
- Nevada Outreach Training Organization (Southern Nevada)
- Three Square (Southern Nevada)
- Community Health Alliance (Northern Nevada)
- Nevada Health Centers, Inc. (Statewide)
- Nevada Primary Care Association (Statewide Consumer Assistance Center)

In order for the Exchange to ensure that there are adequate resources for consumers wishing to have assistance with their enrollment applications, Navigators, IPAs, and Certified Application Counselors (CACs) across the state will augment the enrollment force. The Exchange has provided additional training and support to Navigators, IPAs, and CACs to prepare them to enroll consumers.

Silver State Health Insurance Exchange  
Fiscal and Operational Report  
December 31, 2018

**FINANCE**

The current State Fiscal Year 2019 budget is as follows:

<b>B/A 1400</b>	<b>Silver State Health Insurance Exchange</b>		
<b>Legislatively Approved SFY 2019 Budget</b>			
<b>Total FTE Count</b>	<b>13</b>		
		<b>RGL 3601</b>	
<b>Revenue</b>		<b>QHP Fees</b>	<b>TOTAL</b>
2511	Balance Forward From Prior Year	\$ 15,140,014	\$ 15,140,014
3601	QHP Fees	\$ 11,706,319	\$ 11,706,319
		<b>\$ 26,846,333</b>	<b>\$ 26,846,333</b>
<b>Expenditures</b>			
Cat 01	Personnel	\$ 1,304,484	\$ 1,304,484
Cat 02	Out-of-State Travel	\$ 22,221	\$ 22,221
Cat 03	In-State Travel	\$ 28,798	\$ 28,798
Cat 04	Operating (supplies and other, less IT)	\$ 3,616,900	\$ 3,616,900
Cat 11	Transfer to CMS	\$ 9,344,850	\$ 9,344,850
Cat 12	Exchange Platform	\$ 1,510,800	\$ 1,510,800
Cat 26	Information Services	\$ 22,414	\$ 22,414
Cat 30	Training	\$ 4,453	\$ 4,453
Cat 71	Navigators	\$ 1,715,457	\$ 1,715,457
Cat 82	DHRM Cost Allocation	\$ 5,555	\$ 5,555
Cat 85	Cash Reserve	\$ 9,231,314	\$ 9,231,314
Cat 87	Purchasing Assessment	\$ 19,638	\$ 19,638
Cat 88	SWCAP	\$ 19,449	\$ 19,449
Cat 89	AG Cost Allocation Plan	\$ -	\$ -
	Total Expenditures	<b>\$ 26,846,333</b>	<b>\$ 26,846,333</b>

**Note:**

In June 2018, the Interim Finance Committee (IFC) approved funding from reserves in the amount of \$510,800 to be used to establish a Project Management Office (PMO) to oversee the State-Based Marketplace transition. Authority was transferred from Category 85 (Reserves) to Category 12 (Exchange Platform) to fund this request. Additionally, funding was approved by IFC in June to transfer \$370,576 from Category 85 (Reserves) to Category 71 (Navigators) to

Silver State Health Insurance Exchange  
Fiscal and Operational Report  
December 31, 2018

maintain a sufficient number of navigators and in-person assisters to continue consumer outreach and education, as well as enrollment, to uninsured and hard-to-reach populations.

**BALANCE FORWARD**

State Fiscal Year (SFY) 2018 closed with the Exchange carrying forward \$15,140,014 in cash reserves into SFY 2019. This is a slight increase from a projected carry forward balance of \$15,006,538 in the Legislatively (L01) Approved Budget. The adjustment to L01 was made via Work Program C45049 at budget closing.

**BUDGET BUILDING FOR SFY 2020 & 2021**

The Agency Request Budget is currently under review by the Governor's Fiscal staff. It consists of 19 enhancement decision units, almost all of which relate to the transition from healthcare.gov to a State-Based Exchange (SBE), and totals \$21,425,341 for SFY 20 and \$13,115,897 for SFY 21. The budget requests includes 24 positions (13 existing and 11 new positions to support operations as an SBE).

**CARRIER PREMIUM FEES (CPF)**

As of November 2018, the Exchange has collected \$12,717,757 in CPF. With one month to go in PY 18, the projected year-end total for CPF will be approximately \$13,884,830. This projected amount is \$2,519,472 over our projected total of \$11,365,358 used for the L01 budget. This overage will not result in a significant increase in reserve levels because CMS user fees are directly related to the amount of revenue collected.

PY 19 revenues are budgeted at \$13,190,589. This represents a 5% decrease from the projected PY 18 revenue. PY19 collections will start in January. The anticipated decrease is due to several factors including elimination of the individual mandate, competing plans (short term limited duration, Associated Health Plans, and Health Sharing Ministries), the proposed public charge rule, and the improving job market in Nevada.

The Carrier Premium Fee for PY20 will be submitted to the Exchange's Board for approval in February 2019. The Exchange does not anticipate increasing or decreasing this fee at this time, which is currently set at 3.15% of premiums. However, once actual enrollment and premiums collected for January are received, the Exchange will have a better understanding of enrollment numbers and will submit a rate accordingly.

**CMS USER FEE**

As of November 2018, the Exchange has paid \$8,095,282 in CMS user fees to utilize healthcare.gov for PY 18. The projected year-end total will be approximately \$8,815,765. This projected amount is \$1,620,181 over the budgeted total of \$7,216,100. This overage will not affect the operations of the Exchange because the revenue collected will be used to offset this expenditure.

Silver State Health Insurance Exchange  
Fiscal and Operational Report  
December 31, 2018

PY 19 fees are budgeted at \$12,562,465. This represents an increase in the user fee from 2% to 3% effective January 1, 2019. Reserve levels are sufficient to cover this increase.

**TRANSITION FROM HEALTHCARE.GOV TO A STATE-BASED EXCHANGE**

In August 2018, the State Board of Examiners approved the contract with Get Insured to begin the Exchange’s transition away from the federal platform. The total not to exceed amount of the contract is \$24,404,401.93 and runs through January 31, 2024. The breakdown of the contract by fiscal year is illustrated below:

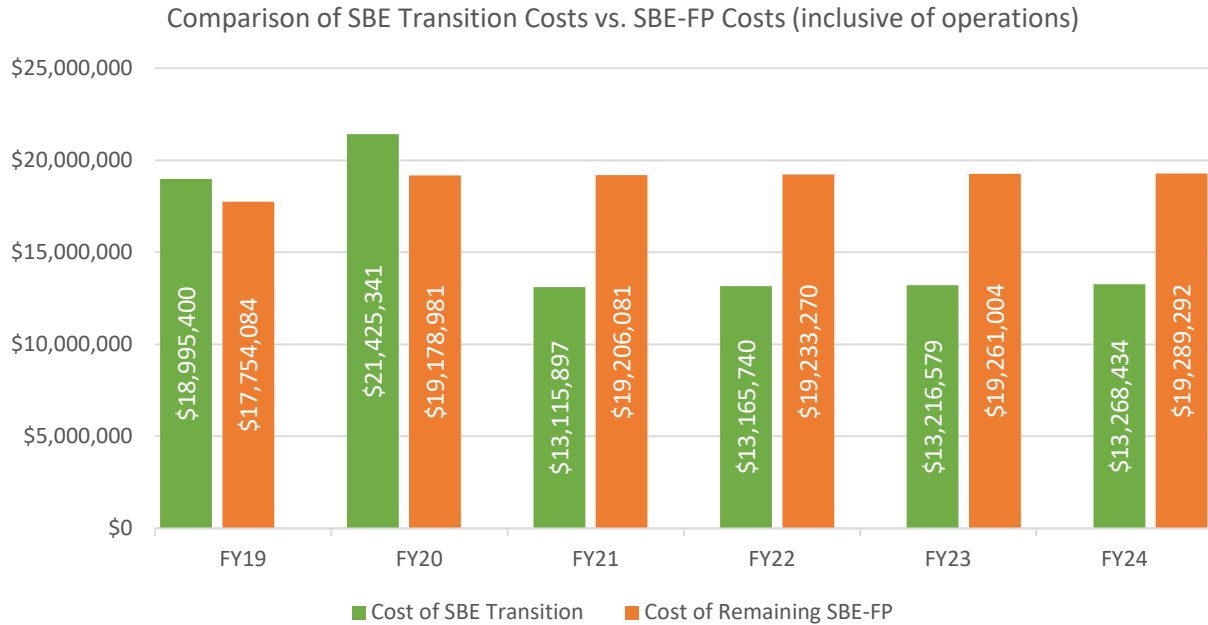
Technology Platform	SFY 19	SFY 20	SFY 21	SFY 22	SFY 23	SFY 24	Total
Tech Phase One	453,394.27	93,805.73					547,200.00
Tech Phase Two		974,517.00					974,517.00
M&O		1,549,209.67	3,098,419.34	3,098,419.34	3,098,419.34	1,549,209.67	12,393,677.36
Optional Programmer Hrs		700,000.00	-	-	-		700,000.00
<b>Total Tech</b>	<b>453,394.27</b>	<b>3,317,532.40</b>	<b>3,098,419.34</b>	<b>3,098,419.34</b>	<b>3,098,419.34</b>	<b>1,549,209.67</b>	<b>14,615,394.36</b>
<b>Consumer Assistance</b>							
Center (CAC)	SFY 19	SFY 20	SFY 21	SFY 22	SFY 23	SFY 24	Total
CAC Phase One	160,035.00	112,365.00					272,400.00
CAC Phase Two		1,288,063.00					1,288,063.00
M&O		1,028,568.08	2,057,136.16	2,057,136.15	2,057,136.12	1,028,568.06	8,228,544.57
<b>Total CAC</b>	<b>160,035.00</b>	<b>2,428,996.08</b>	<b>2,057,136.16</b>	<b>2,057,136.15</b>	<b>2,057,136.12</b>	<b>1,028,568.06</b>	<b>9,789,007.57</b>
<b>Total per FY</b>	<b>613,429.27</b>	<b>5,746,528.48</b>	<b>5,155,555.50</b>	<b>5,155,555.49</b>	<b>5,155,555.46</b>	<b>2,577,777.73</b>	<b>24,404,401.93</b>

Phase One represents costs associated with design, development and implementation (DD&I) totalling \$819,600, compared to the \$1,000,000 originally estimated. Phase Two represents costs associated with the four month transition from healthcare.gov to the private platform and associated consumer assistance center beginning in September 2019 and ending in December 2019, totalling \$2,262,580. Additionally, optional programmer hours in the amount of \$700,000 have been included and will be used on an as needed basis. Finally, ongoing costs for maintenance and operations (M&O) will begin in January 2020 and total \$5,155,555 per year.

The Exchange’s RFP included a funding breakdown which specified that a sustainable fee for the combined operations of the technology platform and consumer assistance center must fall within 1.5% of carrier premiums, or half the cost of the federal platform’s 3% fee for Plan Years 2019 and beyond. Respondents were encouraged to provide cost proposals that offered a choice between a flat annual fee and an annual percentage of carrier premiums. Based upon our latest projections the Exchange estimates that Get Insured’s flat annual fee would result in the lower total cost for the contract while also simplifying and stabilizing the Exchange’s budgeting process. Beginning in State Fiscal Year 2021 (FY21), and inclusive of the administrative costs for the additional functions that the Exchange will be absorbing from the federal platform, we expect to achieve a recurring annual cost savings of approximately 31% versus the federal fees

Silver State Health Insurance Exchange  
Fiscal and Operational Report  
December 31, 2018

associated with continued operation as a hybrid SBE-FP. Total cost savings through FY24 are projected to exceed \$20.7m, even when factoring in the one-time implementation and transition costs during FY19-FY20.

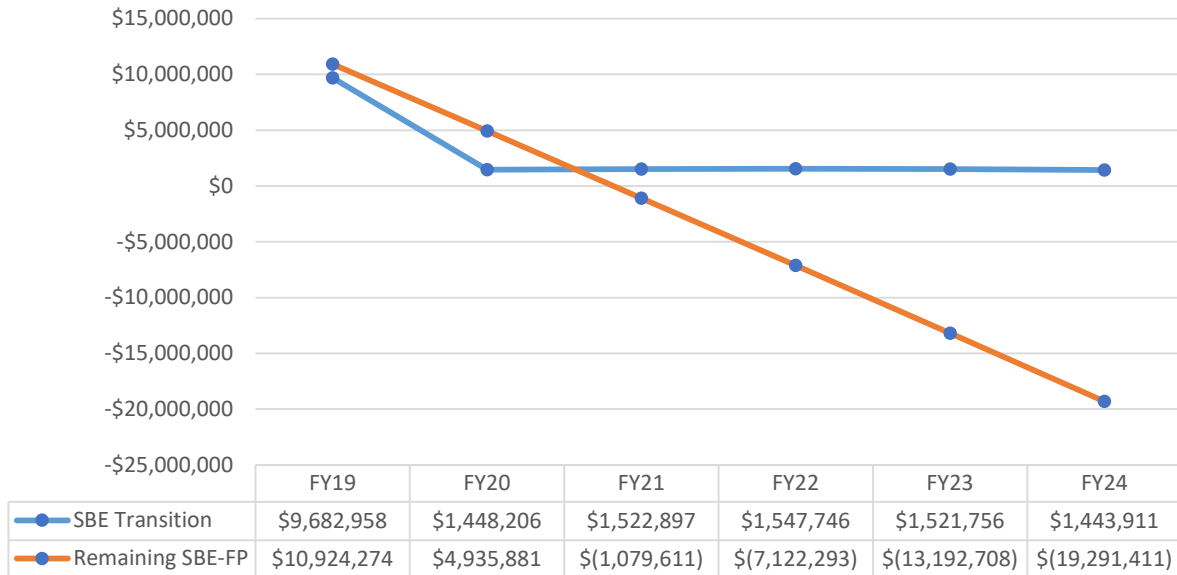


	FY19	FY20	FY21	FY22	FY23	FY24	Total Through FY24
Annual Cost of Remaining SBE-FP	17,754,084.36	19,178,981.15	19,206,080.73	19,233,270.43	19,261,003.93	19,289,292.10	<b>113,922,712.69</b>
Annual Cost of SBE Transition	18,995,400.24	21,425,340.68	13,115,897.00	13,165,739.63	13,216,578.58	13,268,434.35	<b>93,187,390.48</b>
<b>Cost Savings of SBE vs. SBE-FP</b>	<b>(1,241,315.88)</b>	<b>(2,246,359.53)</b>	<b>6,090,183.73</b>	<b>6,067,530.80</b>	<b>6,044,425.35</b>	<b>6,020,857.75</b>	<b>20,735,322.21</b>
<b>Percentage</b>	<b>-6.99%</b>	<b>-11.71%</b>	<b>31.71%</b>	<b>31.55%</b>	<b>31.38%</b>	<b>31.21%</b>	<b>18.20%</b>

The impact of the transition on the Exchange’s reserve levels will be similarly favorable. While continued reliance on the federal platform would fully deplete the Exchange’s reserves before the close of FY21, the SBE transition would allow the Exchange to maintain at least 30 days of operational expenses in its reserves (or \$1.1m) throughout the duration of the contract.

Silver State Health Insurance Exchange  
Fiscal and Operational Report  
December 31, 2018

Comparison of Closing Reserve Levels



The projections illustrated above include implementation and transition costs which overlap with the payment of federal user fees during FY19-FY20. This overlap is a necessary limitation of the Exchange’s transition strategy, as the SBE platform must be online and capable of supporting Open Enrollment in the fall of 2019. The Exchange continues to press CMS to consider lowering their user fees during Nevada’s transition, recognizing that Nevada’s SBE platform will result in decreased Open Enrollment costs for healthcare.gov in 2019. However, even if CMS’ fees are not reduced during the transition the Exchange anticipates a significant net decrease in Nevada’s ACA administration costs over the life of the contract. Contingent upon the stability of the ACA marketplace the Exchange may eventually be able to sustain its operations from a lower assessment of carrier premiums than the current 3.15%.