SILVER STATE HEALTH INSURANCE EXCHANGE

BOARD MEETING

WEDNESDAY, DECEMBER 14, 2022

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CHARLESON: Dr. Jameson is on. Um, we're just working on moving her over. Oh, there she is.

DR. JAMESON: Greetings.

HIGH: Hello, Dr. Jameson. How are you?

Dr. JAMESON: Excellent. Happy holidays.

HIGH: Happy holidays. Well, it looks like it's 12:34, and if you're ready to get going, we can get this started.

DR. JAMESON: Yeah. Do we have a -- a quorum? Let's go ahead and take roll call. It looks like we do. Greetings to everyone. Valerie, Quincy, yes, Jose and, uh, everyone. My goodness. I say -- I think we've got a quorum, but let's go ahead and take a roll call.

HIGH: Sure. I'll take roll call, and then a few housekeeping items to get started, and then I'll turn it back over to you, Dr. Jameson.

JAMESON: I'm impressed. As a man -- I shouldn't say, it sounds sexist -- that you're going to take care of housekeeping. Thank you.

HIGH: That's alright. Um, uh, Dr. Jameson, present.

JAMESON: Present.

HIGH: Great. Uh, Valerie Clark?

CLARK: Present.

HIGH: Lavonne Lewis, I think is absent. Uh, Dr. Sarah Friedman?

DR. FRIEDMAN: Present.

HIGH: Jonathan Johnson? Well, I see your name there, Jonathan. I don't know if you're -- there we go. Oops. Did we just lose you? I'll ask one more time. Jonathan, are you on?

JOHNSON: I'm -- I'm here.

HIGH: Sounds good. Great. Thank you.

JOHNSON: It keeps mute -- it keeps automatically, uh, muting me, so.

HIGH: Uh, we would -- Katie, is there a way we can help fix that?

CHARLESON: I'm not sure. Ryan. because I'm not the host. Um, Kaitlyn, can we just make sure? I still show -- it's, like, a double one as an -- attendees, so make sure Jonathan's completely moved over.

HIGH: That's great. Thank you. Thanks, team. Um, Jose Melendrez?

MELENDREZ: Here.

HIGH: Great. And Quincy Branch?

BRANCH: And I'm here.

HIGH: Great. Uh, we'll go to our ex-officios, uh, Suzanne? Or on -- someone on Suzanne's behalf -- Bierman? Okay. Uh, Commissioner Richardson? Mark as absent. And then, Kelli Anderson?

ANDERSON: Here. Thank you.

HIGH: Sure. Thank you. All right, Madam Chair, we do have

a quorum. And I'll just do a few meeting reminders here. Uh, our next meeting is on Thursday, February 16th, 2023, at 1:30 PM, uh, unless it's determined, there should be, uh, another one before this, but that's the next scheduled one. Uh, we have Kaitlyn, uh, Blagen, who's going to -- who is hosting our webinar. And as a reminder, please keep yourself muted if you are not the one presenting or making a comment. If you would like to make a comment, please raise your electronic hand and indicate in the chat box that you would like to make a comment and Kaitlyn will unmute you. For those on the phone, please remember to mute yourselves or else we will hear your private conversations. And Madam Chair, there may be people on the telephone that would like to make a public comment, so we just want to remember to ask if there are any public comments on the phone. We also have our Carson City conference location open to the public, so public comment may be made there, as well. We took a roll call and I'll turn it back over to you for, uh, I think public comment now, Madam Chair.

DR. JAMESON: Excellent. Thank you, Ryan. I would like to go ahead and ask if we have any public comment, first in the north? Anyone on the phone, there? Since it's virtual and on the phone, I guess we won't specify location. Is there anyone, uh, south or anywhere in the state that, uh, is on the phone who desires to make a public comment today?

DAVIS: Dr. Jameson, Tiffany Davis, for the record. I'd just like to state that there is nobody here in our Carson City office for public comment. Thank you.

DR. JAMESON: Thank you so much. Okay. That having been

the case, we will move on to our next item, the approval of the minutes from the October 13th, 2022, board meeting. Um, I -- do I hear a motion to approve those minutes?

MELENDREZ: So moved, Jose Melendres.

DR. JAMESON: Thank you. And is there a second?

BRANCH: I'll second, Quincy Branch.

DR. JAMESON: Uh-huh. And, um, was there any, uh, concerns before we vote, uh, a discussion? Was there any concerns for there -- was, uh, anything inaccurate, omitted, uh, or errors? Hearing nothing -- and I'll give it a second, because it takes a minute to hit that unmute button. Okay, then, um, everyone in favor of, uh, approving the minutes from October 13th, 2022, board meeting?

MEMBERS: Aye.

DR. JAMESON: Anybody abs -- uh, opposed? Any abstaining? No one abstaining? Okay. The October 13th, 2022, board meeting is approved. And, uh, it seems like, uh, it was just yesterday, we all met for the, uh, kickoff of the, uh, enrollment. And I just want to take a moment and tell, uh, not everyone that's on the phone was there, but I have to take a moment and thank our amazing, uh, team, our staff at the Silver State Exchange, for those of you that were there, uh, I think you can, uh, appreciate or chime in that -- that it's -- just was an amazing, uh, kickoff and that all, uh, I just have to tell you all, you all just did an amazing job. What can I say? Just, uh, a -- a act applause to all of you. Thank you. I can't imagine that we could have been presented in a better light. It was positively -- you all were just go glowing and I thank you. Okay. So, uh, if

anyone else wanted to comment about that, you may. Otherwise we'll move on and, uh, to the business at hand, the usual approval of the semi-annual fiscal and operational report, pursuant NRS 695I.370(1)(b), for the governor and the legislature. And, uh, I hope you all had an opportunity to review the, I think it was 39 pages, I'm not sure, but all those pages. And as always, um, it was wonderful. I don't think you left anything out. It was a very excellent report. Um, does anybody have, uh, before -- did someone want to make a motion to approve and second, and then any discussion will be entertained?

MELENDREZ: Jose Melendrez, motion to approve.

DR. JAMESON: Do we hear a second?

FRIEDMAN: Sarah Friedman, and I can second.

DR. JAMESON: Thank you. All right. Uh, do we have any discussion on the, um, semi-annual fiscal operation report?

MELENDREZ: Just good job to Ryan and staff.

DR. JAMESON: Thank you, Jose. I concur, totally. Okay. No other comments being heard, then. Uh, everybody in favor please say, um, aye or --

MEMBERS: Aye.

DR. JAMESON: Anybody opposed? And anyone abstaining? Okay. We have approved, uh, the motion for the -- to, uh, approve the semi-annual fiscal and operation report. Um, and our next item of business, uh, which I really wasn't even expecting until our next meeting. So wow, Ryan and team, you really rock. I'm very -- very curious to hear what you have to say after some of the comments I've heard in the media.

Public option update presented by DHCFP.

WEEKS: Good afternoon. I don't know if, Ryan, if you want me start with an introduction. I'm Stacie Weeks. I'm the Deputy Administrator at Nevada Medicaid. Um, I'm over the managed care program, as well as the public option. I do have some slides, if that's okay. Ryan, do you want me to pull those up or do you guys have those?

HIGH: Let me see. Do we have these, um, Kaitlyn or Katie?

CHARLESON: Stacie, yeah, if you can go ahead and share your screen, Stacie. I have them, um, on the website, as a backup, in case you run into any --

WEEKS: Ok, cool. Oh, no worries. Okay, good. I just didn't want to jump -- jump there and you were going to do it. I know everyone has a process for this. Um, okay, so I'm going to share my screen. Can everyone see that okay?

DR. JAMESON: Yes. Thank you, Stacie.

WEEKS: Great. So, um, feel free to jump in with questions or we can wait until the end, whatever, um, chair, you would like to do. I'm good with whatever. I'm happy to discuss as we move along, too. So just feel free to, um, whatever works for you guys, I'm open.

DR. JAMESON: Well, usually we'll do re -- questions at the end, but it depends how long this is, Stacie. And if anybody has a burning question, they always should feel free to inter -- to interrupt. Thank you.

WEEKS: I promise it won't be so long that you will all be tired. I promise it will be robust, but not too long. So we'll go ahead and get this started.

DR. JAMESON: Well, we (inaudible).

WEEKS: Yeah -- yeah, no problem. I'm happy you guys wanted to have me come and at least talk about where we're at, because Ryan and his team have been super helpful to us, which, um, at the -- at the Medicaid agency. So we really appreciate the partnership on this. Um, so I'll just start a little bit with the agenda. Obviously I want to walk through a little bit on the background, on the public option. Um, and that -- that really, truly is kind of showing about, like, how we are different than what other states are doing, kind of what the model is. I think there are a lot of different ideas about what public options are, nationally, um, and just want to make sure we're kind of grounded in what Nevada's model is. Um, I think there's just been a lot of confusion, which is fair. There's always different discussions, especially in the media, about what a public option is. And I think just making sure we're all clear on what the approach here is, um, under the statute and how we are implementing it, at the state level. And then I want to bring up the 1332 waiver request, because I think this is really an important piece for the exchange. And this is where Ryan and Janel (phonetic) have been working. We've been working closely together because there's a lot of pass-through funding, federal dollars, that I think will be very useful to, um, to the -- to the Exchange, for example. Um, and then next steps, where we are in the process. It's a several-year timeline. Obviously a session is ahead of us, so changes could happen. We're hoping for the best, but you never know. So, um, we'll move forward with whatever the legislature and the governor wants to do. Um, but right now we are implementing the law, as is. And so that's what I'm

going to walk through today. So the background, I think you guys all know this, it was about, goodness, this feels like a long time ago, I bet, but it's in 2021. Um, Nevada was actually the second state to pass the public option legislation. I think a lot of people think Colorado was the second, but, uh, I think, uh, Nevada beat Colorado by a couple months. So they get to wear the second, you know, label, nationally. Um, and this bill, it -- it really talks -- it really put in place, um, what we consider the Nevada Public Option Program, um, which, uh, will launch on January 1, 2026. We have several years, um, and a ramp-up period. And I'll explain why, um, because our model and how we're doing it requires this timeframe. But it -- the requirement in the statute says that these products must be offered to consumers as a qualified health plan. And we'll talk a little bit about that in a minute, which as you guys know a lot about, um, which operates on the exchange and it can be offered, as well, off the exchange, directly from the insurer. Just like today, if someone doesn't want to shop on the exchange and they're purchasing their own health insurance in the individual market, they too, can go and look on a -- a health plan website and purchase directly. But we all know, often, that's not affordable -- right? -- without subsidies that the exchange offers. So I think a lot of people, hopefully, shop through the exchange so they can get that reduced, um, cost coverage. So just a little bit about the strategy that's behind Nevada's model, and then we'll walk through other state models, so you can kind of see the difference. Um, really what I -- I would say it's kind really using, and you may have heard this in other context around the exchange, was this idea of active purchasing, um, strategy. And really what

it is, is it allows the state to -- to say to health carriers who participate in our Medicaid managed care program, which for some of you who may not know it, man -- our Medicaid managed care program is worth, uh, over $2 billion to insurers, which is a lot more, actually, than premium, or subsidies that are available in exchange. So it's a significant revenue for -- for health carriers that, you know, in to -- currently, we have four, three of which are operating in the exchange. We have Health Plan Nevada, which is United; we have, uh, Molina, which is not operating yet in the exchange; as well as Anthem; and, uh, Centene, which is called Silver Summit. And you know, the others are operating in the exchange today. And that's, a lot of that is because of some of their contract requirements we currently have. Um, but the goal here is to really say, if you continue -- you want to continue to do business in our Medicaid program -- right? -- and receive the profit and the money that's there and that's available to you, you also have to offer a good-faith bid and a procurement for the public option to offer a product that is a QHP that is lower, um, than what we -- you probably would've offered otherwise, and meet certain strategies that we think are important to the state. For example, one of the things in the statute talks about, you know, cultural competency. And so one of the ideas we're thinking about is, should we do some sort of -- some of what we do in Medicaid managed care contracts, is requiring some sort of strategy around improving our workforce and cultural competency in healthcare, for example. The other one that's in statute that we would be adding kind of through the contracting process to the QHP world and the public option would be value-based payment design with providers, trying

to drive better quality outcomes and not just paying on the widgets. Right? So we want to really get past that fee-for-service and really be driving value for the dollar. So that's sort of the strategy. Right? That -- that's the goal. Um, now obviously, there's a lot that goes behind that and implementation. Right? We have to do a procurement, a contract, all those pieces and that -- we'll talk a little bit about that in a minute. But essen -- essentially, um, we are asking these carriers to enter into a contract to -- to do this with us. So that contract becomes our tool for enforcement. So, um, you know, we're not -- and we'll -- and so, I'll go to the next slide, because that's where I'm going. So, unlike Colorado, um, Colorado is really relying on a regulatory approach, which would be our department of insurance -- right? -- in Nev -- in Nevada. Um, we are not relying on that approach. They're really -- because in Nevada, what they're saying is, we're going to standardize all plans by regulation. And so they're applying it to every product, where we're saying, no, it doesn't have to be every product, you know, we are definitely applying it to our Medicaid managed care program plans and any plan that wants to participate, but it's not across the board regulatory and it's not enforced by our department -- department of insurance. It's really the contractual tool and the penalties that we put in that contract. But Colorado has set up a really, I would say, a really robust regulatory process for really standardized their -- their plans hitting bench, you know, rate targets for providers, um, I will -- and premiums that really have created a lot more work for them, which I -- I know some of the folks over there really well and they're -- they're having to do all these rate hearings and it's a lot of work. Right? And so we're

saying, nope, we're not doing that. We're not setting rates. We have -- we'd have -- we don't want anything to do with that. We really want to continue to have some of that flexibility and creativity in the carrier market and let them come up with how they meet the targets. And we'll talk about that in a minute. So the other strategy that you may have heard about -- Washington was the first state, um, to propose a public option. They really just said, hey, we want to do this. And it's really more of a passive purchasing strategy. They put out a procurement, but there was no carrot for anyone really to play. And so no one did, initially. So it took them a lot of -- a lot of different back and forth to get carriers and providers to participate. And I think there's still some struggle there. I think they've got more carrots that they work -- are working on and -- and tying participation. But initially it was very passive and it, you know, so some of the reasons we did the tie to the procurement and try to, you know, dangle the carrot of the Medicaid program is because we know the carriers do want to participate in that program and do find that valuable, nationally to, um, especially a lot of these national carriers. I'll stop there. Are there any quick questions before I move on? Is this all making sense? I apologize if I'm moving fast. I talk fast. Okay. Um, so just to give you a sense of what's in the statute today, uh, I call them statutory safeguards for the program. They're really about making sure it's successful, but it's also ways for us to address concerns and issues that come up. Um, you could also think of them as sort of the floor and sort of the minimums -- right? -- of the program. Um, the -- the first one that -- one of the reasons the premium reduction target is in the statute is because when we -- when

Washington came out with their public option, their public option was more expensive than the other qualified health plans that were offered in their exchange. And it's, like, why are we doing this if it's not more affordable -- right? -- was the big question. So something that was nationally going around at the time, you know, people that were working on this decided we need premium reduction targets. But always the big question is, what is reasonable, right? Everyone wants a 30% decrease, but is that really possible, right? Is that really reasonable? So Colorado did a similar approach, but they have a, I think a -- a much higher target in -- in terms of the amounts, but also the amount of time they allow that target to -- to be met. So the one in our statute, the bare minimum, is about -- is at least that the -- that the public option plans themselves, the carriers, come in at least 15% lower. Basically it's a 15% reduction over the first four years. And those first four years will be under a contract with the state. Right? So if they do not meet that reduction, we will -- we're still working through penalties and what those will look like to make sure that we enforce it. Um, but that is how this -- this piece will operate. Now, right now we -- the director does have, my director at DHHS, Richard Whitley, has the authority to waive, or sort of like, or revise, I would say. Oh, I see, Sarah. Do you have a question?

FRIEDMAN: A quick question. Um, you said 15% reduction over, I missed what that was over --

WEEKS: Four years.

FRIEDMAN: -- (inaudible) of plans on exchange -- over what other plans -- oh, reduction over time, among themselves.

WEEKS: Yeah, so --

FRIEDMAN: Okay.

WEEKS: -- well there is a benchmark. So the benchmark would be 2024, what the cost of the second lowest silver is, in 2024. And we trend that forward by consumer medical, you know, consumer CPI and medical. So we trend that forward and that's our benchmark. I mean, we do have room to move that up and down, based on inflation. We did add that into our revision, but yeah, it's over four years, based on what that benchmark was in the exchange, so looking at that second lowest silver. And the plans themselves just have to show that they're coming in at least -- in the first year it's about 4% lower, and then it builds over time. Right now, the way the revisions have been set forth by the -- the director, it's about 16%. It gives us room to waive 1%, if a plan can't meet it. Um, but it -- it, I think that is, originally it was in the statute, before we revised it under his authority, it was totally 20%. Um, you know, and if we revised it, the state law says, if you do revise this, you still have to meet 15. So we felt like 20%, based on our actuaries, was too much -- I'll be frank with you -- and our actuaries recommended, you really need to lower this and you need to trend with consumer price medical, because -- but that index. At the time, it was Medicare that's in the statute. I think, when the statute was probably being written, there was probably not a real understanding of medical inflation and the growth that we see today, um, and the cost. So those adjustments have been made and we feel pretty good about the 16% over four years, with the ability to adjust that benchmark if we need to, to allow room in the market, um, a cost. So that's where that's at. I know that

sounds pretty complicated, but, um, trying to keep it as -- sorry my voice. I've been having this cold -- miss trying to keep it as simple as possible. Our actuaries, um, make it really technical. So trying to keep it high level. Hopefully that answered your question. Okay. Um, so again, we are hoping to enforce this in -- in -- in the contract. I will say, early on, our conversations with the federal government, they've signaled that they want strong enforcement, because they want to make sure plans actually come in and meet their targets. Um, that's part of the way of, our conversations have been having. So we're trying to think about what is a meaningful penalty that is not going to hurt the market? Right? Like we don't want a penalty to be a high financial penalty and it to be taken out on providers. Right? So we want to make sure whatever tool we use is reasonable, but also going to be meaningful enough for them to -- to meet the target. Excuse me, I'm sorry, my throat. Um, so the other piece here, the other safeguard is the access to care standards in the market. And this one you might have heard about already, um, people talk about it as the provider tying requirement in the statute. It really -- this is really there because, nationally, we always see, um, often providers, depending on how they feel about a program like Medicaid or, um, other, you know, especially Medicaid, you see providers saying, I don't want to participate. Right? And so one of the concerns from Washington, because one of the things that they were challenged with, is that hospitals were not wanting to participate in the network. So the public option plans couldn't build their networks. Right? So we kind of -- one of the things this statute does is really creates a new requirement and it says if -- if a provider is in a

contract to be a Medicaid provider or a public employee benefit plan -- right? -- our state plan -- plan, as well as workers' comp, in the state workers' comp program, they -- to stay -- to make sure they don't -- to stay in their contracts to give -- to allow them to continue those contracts, they also have to at least participate in one public option network. Right? So you can't just say no, you know, we're not participating as a way to sort of like stall the pro -- pro -- process, going forward. And that, you know, based on sort of the participation in Medicaid, um, that felt pretty reasonable, because no matter what the public option, we'll be paying more than Medicaid, um, you know, we generally know that for, you know, based on Medicaid rates. Um, and also the requirement is that if, uh, a person who is enrolled in the public option, um, goes to see a provider, that provider has to treat them just like they treat any other new patient. So if they're denying other, you know, access because they can't take new patients, that's fine. They can deny the public option, too. But if they are taking patients from other, you know, types of insurance, they have to treat the public option, um, folks the same. So that's just sort of the piece around the access. The third protection is this provider reimbursement floor, which I know a lot of folks, when they saw it, they think, oh, we're all getting Medicare rates. But the goal was not to do that. The goal is actually protect them from Medicaid. Right? So often what we -- we worry about when we -- we get involved in these types of things, is that the plans will just negotiate providers down so far that it's not sustainable. So, um, the --- the goal here was to put in a floor in the statute, and the statute says, um, provider rates can be no lower than Medicare rates, um, in the

public option. So that is the floor. They can be higher, uh, and after we did our -- the actuaries have done their analysis, which we will be releasing hopefully, um, fingers crossed, by the end of this month, um, have found that even to get to the 16% reduction, they don't -- they do not believe that all providers will be down to Medicare. There's enough room in the market to go down, without getting all -- everyone at Medicare or below. So there's room there, which is what we were wanting to make sure. Um, the other thing I would note here, is there is also an additional floor that's a little different for rural, um, and community providers. And that should say Medicaid -- Medicare and inter -- encounter rates not Medicaid. Um, Medicare has cost-base rates for a -- a lot of our, um, FQHCs, for example, federally qualified health centers, other community health clinics in the rural areas, they often have cost base rates, which are higher. And so we tagged the floor to that rate and not the service rate. We wanted to make sure that they were kind of held harmless in that and not being driven down too low. Um, market competition and consumer choice. I'm almost done -- through this slide. This is probably the most -- the meatiest slide of all. So I promise (phonetic). Um, the other piece here we've already kind of talk about -- talked about, is that we're really tying, uh, to get participation from carriers and tying it to our Medicaid program. So if they want to play and do business in our Medicaid program, they also have to be a good partner in our exchange and help us control costs -- right? -- and offer this public option product. They can offer other products -- right? -- in -- in the exchange, but they at least have to offer at least a silver and a gold, um, in each of the rating areas. We are -- also are incentivizing a

bronze ban, and we'll talk a little bit about that in a minute. Um, and federal law does require -- someone was asking the other day, oh, does this mean you might end up with one carrier? The good news is Medicaid can never just have one carrier. It has to offer choice, unless we have a waiver. So we know for sure we at least we'll have two or more. Today we have four. And I will tell you, we've also had interest, nationally, from folks saying -- asking about the public option, if they're interested in coming into the market. So I do think it'll be an interesting dynamic to see how it plays out, but I -- I do not expect us to have less than two. But if -- if at the -- at the bare minimum it will be two, at least, products, um, or carriers, offering the products. Um, next slide, please. Next slide. Sorry. Am I frozen?

CHARLESON: You have control. Sorry. You have control of the slides.

WEEKS: Oh, I do. I'm sorry. Oh my, God. I'm having a moment. It's been a week and it feels like a Friday and it's only Wednesday, so I (inaudible). I'm like, next slide, Stacie. All right. So anyways, this is -- I promise there's more visual coming. This is my attempt to try to show people what is the public option, how it's not -- it's not an exchange -- right? -- because a lot of people think it's a separate marketplace. It's not. It's really just taking what my -- my visual, my very simple visual, Ryan, I apologize. I know there's way more to a QHP, but this -- this -- this -- these blue bubbles -- right? -- the light blue bubble is what I think of when I think of the standard QHP, and then, all of our state market rules that go around it. Right? So that's what I think of in my head

when I think of a QHP. It's just a simple visual. Okay? So we have our state market rules, which is, you know, rate review, rate approval, that still happens, network adequacy. And then we have our standard a ACA requirements for every QHP, which is our ACA standards and certification -- right? -- that the exchange has to do and the assessment, the exchange, um, places on all QHPs. So when we think about the public option, we're not saying it's different than this, we're just saying it looks like that. It has a se -- an -- an additional layer that goes around it. And that additional layer has both statutory mandates that we have to, you know, implement through the contract, in addition to whatever contract requirements we, or you guys as the exchange together, we think are important. And we want to in incentivize in this market, right? Or really promote through the public option. So the statutory mandates we've kind of talked about, which is they have to meet these targets that unlike other QHPs -- right? -- the other two bubbles, will not be facing. Um, they will have minimum plan offerings, at least a silver and a gold. And it has to be statewide. So I think -- I think that's an important piece of this that I know often, you know, is challenged in the exchange. So that's a piece. The provider network, um, one of the requirements is us to promote the alignment with Medicaid. And the goal there is that when people leave Medicaid and go to the exchange and move up that income ladder, that they have the opportunity to keep their important critical providers, especially some of these safety net providers that are really important to this population. So we're trying our best to start to align these networks so people and consumers have more, um, continuity of care, essentially, across providers. Um, value-based

payment design -- we are doing that finally in Medicaid. I'm super excited about it. Um, our plans just, we've just started new targets on really seeing new types of arrangements that really reward providers who meet certain outcomes, that are doing really well with patients or achieving certain efficiencies in the market. So it's a similar strategy here. It would be trying to align some of those Medicaid really great strategies for value and payment, uh, in -- into, slowly into our individual market, which hopefully, the goal is to get better outcomes into lower costs, right? I think the jury is always out on these things. I don't think any reform is perfect, but value-based payment honestly is probably the best we got. So we're trying our best. And the last one here, I mean there's a couple others, but the other one I wanted to note here is this cultural workforce plans. And also it's tied to this requirement around addressing workforce shortages in the provider market, which I know we struggle with in Medicaid. I know you guys struggle in the exchange, is -- is networks and access to providers. It's a constant struggle. So something I'm really hopeful for is that in this procurement, we can probably, maybe leverage our carriers to start to invest and help address some of these provider, um, issues and a -- inadequacy. So that's a piece that I -- is dear to my heart, I'm still thinking through and -- and looking for some feedback on that. And then contract requirements -- these are things that we are thinking about, obviously, that we could add things. And we've been talking to Ryan, if there are things that they want to see, um, in these contracts that these plans start to promote. Because often what happens if a plan comes in and does something unique and different and it gets consumers

interested, then you see other plans participating, right? It's kind of, you know, promoting something and hoping the rest of the market takes it up. So one of the things, though, that we're doing, um, to try to help with the reduction target, because we know where the costs are, are mostly in provider reimbursement, right? Um, how do we shift that burden, you know, the 16% over the first four years, how do we shift that burden to not solely be 100% on the providers? The only way we can think about doing this, our actuaries have been working with us, is to look at doing an administrative spend cap. So, you know, part of the premium that, you know, the health plans, part of their premium cost, is an administratives cost, right? Their profits, their salaries, their -- their -- all the HR stuff, all the other things that they lump as administrative. Our goal would either be to cap that, lower it a little bit, so that the burden, some of the reduction can come from there. Now the question is how much is reasonable? And then the other option is to -- to increase bare MLRs -- right? -- um, in the marketplace and actually set a standard that they have to meet that's higher. So those are two things we're thinking about, obviously, trying to be sensitive to where's -- where is there room and what is reasonable, um, to make sure providers aren't taking 100% of the cut, or the reduction, I should say. Um, we're also looking at quality metrics. Um, our Medicaid managed care contracts, I would say, have a lot of quality metrics that we track and I think we're really hoping we can maybe push some of these things. You might have heard some of them, their HEDIS measures, like they track prenatal access, postpartum care, you know, different priorities. Um, preventative screening. So, you know, thinking about, do we want to

set a couple quality metrics that we think are important to this -- this market and this population? And that's something Ryan and our team, I think eventually will get to talk about. Um, but feels like a long ways away. Um, and then the other thing here that again, like I mentioned, we're still trying to figure out, what is a good reasonable penalty in the contract for not meeting their statutory mandates, but also being mindful that we want market stability and we don't want providers to take any hits, you know, addition -- in addition to the reduction. So I'll stop there. Any questions on this slide? I know it's kind of a lot, um, to consume it once.

MELENDREZ: Yeah. Thank you. Uh, Jose Melendrez here. Just for, uh, thank you for your report. Uh, what -- what are they --I -- I guess just more clarification on the cultural workforce plans?

WEEKS: Yeah. So in Medicaid, um, and also in our dental benefit, we have something where we ask all the pro -- uh, plans to really work on increasing, um, the makeup, for example, of their workforce to match more of the population. So really working on disparities and trying to make sure some of the workforce is diverse. So that's an example of what we think of as w -- cultural w -- workforce plans. Other things would be education and training for providers that plans would have to provide. They do that in Medicaid. Why couldn't they do that in, um, the individual market -- right? -- and really trying to make sure that the providers are serving the population and meeting the needs of the diverse, um, members that they -- in their -- that are enrolled in their plan? Does that answer your question?

MELENDREZ: Yeah. And so then the providers actually have

to submit an actual plan? That --

WEEKS: The plan -- the health carriers do and how they're going --

MELENDREZ: Right.

WEEKS: -- to work with their provider networks, and we get to approve that. And I would hope Ryan and his team would be p -- be open to reviewing those with me. Um, because, you know, we can't do it alone. It's really your -- your population. But I-- the goal would be to help take some of the -- I'm not going to say med -- managed care, Medicaid is always amazing, but there are some really good tools that we've been able to create that I think would be valuable to this market, that we can use. And that's one of them.

MELENDREZ: Okay. No, I -- I -- I appreciate that part because I'm on a bunch of different boards right now that I sh -- probably should have said no to, but, uh, but, uh, but you know, the -- the whole issue of, uh, of workforce diversity, uh, cultural competency training or what does that need to look like? I mean all those are top of mind right now, with the -- a lot of different areas across the state of Nevada. So I'm -- I'm glad that's included in there.

WEEKS: Well if you want to be part of the review committee of those plans, I would really welcome that. So, you know, if you're interested in that, because we would need people that really want to help drive things. Obviously we have some of the ideas, but we don't -- I'm not an expert in this area and just definitely want to make sure that people reviewing and improving, um, have been able -- that have that expertise

that can weigh in.

MELENDREZ: I know I should say no, but I'll say yes.

WEEKS: Okay. Well I'll try not to hold you too hard to that, but I will check in with you when we get there. Um, it'll be a couple years. So you've got a little breathing time.

MELENDREZ: Really, a couple years before these things get implemented?

WEEKS: Yeah, so they -- they go online January 1, 2026. Now the procurement will start January 1, the end of January 1, probably the end of 2024, because we're doing Medicaid and this product at the same time, which is two procurements, which is a lot for our team.

MELENDREZ: Right.

WEEKS: But I would hope, if you guys are open to having at least one or two board members on the review with Ryan, as well as sort of -- because we need to create a -- a sc -- a review committee of the -- of the bids. And I would love to have folks from, obviously, the exchange, DOI, board member here would be great, or two, um, just to make sure we've got the right people reviewing these bids and these plans are -- these are the ones that we want, right? Obviously, um, we'll be doing, we'll be doing the Medicaid side, so you don't have to worry about that. But it'd be more on the public option side.

MELENDREZ: Okay. Count me in for 2026.

WEEKS: All right. All right, thank you. Um, so this slide is a lot simpler and this is something, um, we put together just to kind of even keep ourselves clear on what lanes we're in. And I also wanted just to

note, you know, where some of these responsibilities fall. Because I will say, in other states, with the public option, there's -- it's not like this. So a lot of the -- a lot of the work falls on either the exchange, like in Washington or DOI, like in Colorado. Um, here we're taking on a lot of the oversight and sort of any of the requirements that we add right in the contract. We're DHCFP, Nevada Medicaid, that's the -- our piece. Um, and again, you know, we do that today in the Medicaid managed care program. So we're -- I feel like we're well equipped to do it. Um, not to say it's got going to be more work, but I will say that's sort of in our wheelhouse today. So I don't feel as concerned about it being new. It's really a similar process for us. It's just providing that contract oversight, monitoring, and making sure that if there isn't compliance, we are following up with the corrective action plan, for example. And then if that doesn't work, we -- we impose a penalty. So that would be it. And that would be for both the pre -- premium reduction target and anything else we add into those contracts around state law. The exchange still does the same old thing, right? The -- these plans will come to the exchange to submit a certification to be certified, just like they'd submit all their other product -- products. That's going to be part of their contract. They don't meet that, then that's a penalty. You know, they -- that -- they are going to sign to say they will submit this and meet the filing deadlines and have to meet all ACA standards. Right? The other thing I wanted to make sure was clear, because I think there's been some confusion, is that based on the statute, the way it's written, it talks about meeting, you know, being eligible to be in the exchange as -- as a QHP, which means that it has to also pay the

assessment fee, because it operates just like any other product in the exchange. So that's something else to think through for the budget. Like any product -- any enrollment in this product will improve -- I would hope, right? -- revenue. Um, the other piece here for DOI, which is like it is today and the plans, again, will have to agree in their contracts that they will meet these requirements, is they have to submit their rates. Even though we will procure and say here's the target, they still have to go argue that they can meet that rate and be solvent. And if they can't, then they are -- then they've violated their contract and probably will be let go as a public option product, right? Um, and there'll probably be a penalty for that, as well. And network filing, too -- so adequacy, network adequacy and individual market is overseen by DOI. Those -- those filings and that process is the same. So just kind of clarifying, that's -- these are our roles -- right? -- we all work really closely together, um, I think on this project, but this would be more of the roles that we'd be playing. Um, so the waiver -- so this is the -- I think the more excit -- I'm kind of -- is, I guess for right now, because we are working on this right now. I'm kind of excited about it. So we're almost done, at least getting it posted. Ryan, you should be getting it Monday, um, the 1332 waiver and actuarial study. So right now we are just finishing that and we're getting ready to post online, um, to start a 45-day public comment period. And essentially what we're saying is that any money, um, that we save, the federal government -- right? -- in Nevada, with lowering the premiums -- right? -- with this premium target, through the public options, that we get -- we get to capture that savings and that's called pass-through funding. And so that

savings comes to the state. And so that's part of what our actuaries have been trying to work on, because to submit the waiver, we have to do a ten-year analysis and look at ten, oh, for the ten years, from 2026 on, for ten years. How much money does that mean for the federal government that they may owe us? And how -- and are we meeting all the various requirements? There's -- there's certain ones, like it has to be as affordable today, has to cover, you know, same number of people are better, or more need to be covered with the new reform. Um, you know, there're a variety of different requirements that we have to meet. And so that's what we've been working on. Um, we hired Milliman. They actually worked on Colorado's. They didn't announce with Colorado. They're not currently their actuary for the program, but they did look at that, and I will say, um, they have a lot of good expertise and experience that's been really helpful to us. Um, so we're hopeful to be posting that before or by December 30th, is the goal. Um, this is just a kind of a visual to show you. So again, so it's in -- on the pass through funds and what -- what we're thinking about based on what the state law allows us, right? Also, the federal government has restrictions on what they will allow us to use these funds for. Typically, exchanges where these, you know, other waivers like in other states, like for reinsurance for example, any of the pass-through funds that have been received have been, you know, reused and reused in their exchange, right? And so that's similar to what we're proposing here. Um, and same with Colorado. They have a -- a similar approach, but they also are using their funds in different ways. But we're proposing, based on what the statute will allow us is, after we pay for state operations, which

includes our -- some of our staffing that we need for contract oversight, in addition to any staffing Ryan and his team need, we're going to include in the budget. That will be automatic, always taken out of the top, right? And so what's ever left over will be used to -- supposed to be used to improve affordability. When we were thinking about affordability, we were thinking about the ARPA subsidies, which I got -- I know you guys are very familiar with in the exchange. If those go away, which they're set to expire, we could use some of this money to replace those -- those subsidies to sustain enrollment in the exchange, right? That's a big concern, right? In 2025, if they expire at the end, you know, at the end of that year, what happens? How do we sustain people enrolled if the premiums go way up? So one of the goals would be to use some of this funding to try to -- to bridge that and to maintain enrollment if not improve, right? And then the other piece that we're hopeful for is to use the funds to support navigators, right? So helping to not only maybe replace current funding that's being used for that, but also make it more robust than it is today, and to sort of support that piece. So those are the two pieces that we're proposing. Now, CMS, or SACIO (phonetic), sorry, not CMS. If SACIO approves the waiver, you know, it's all projections. I just want to say that. Things can change, and if things change, we actually do submit real data for that year and we actually split, you know, so that the actual money that we receive and -- and -- and everything that we use it on will also be reapproved, right? We have to go through a process to really make sure what we are paid is actually what happened. So this is just projections and it's really SACIO signing off on, we agree that we would pay you these -- these funds, you know? We agree

on your methodology for determining it, really. And they're also agreeing to how we're going to use the funds. Now if we want to change that or the state legislature says we want to use this money on, I don't know, hospital rates, right? Um, first of all, I don't think SACIO would approve that. Second of all, we would have to go to the federal government and ask, or they won't cut the check, really, right? Like they need to know how we're spending the money. So I just want to throw that out there. Right now, we're focused putting this money back into the exchange to really improve affordability. Um, I'm kind of going to skim through this. I feel like this is more of a messagy (phonetic) slide, but I wanted to put it in here because it talks a little bit about the savings and then just some of the early numbers that we're seeing. Again, you know, actuaries, it's like, uh, they move their numbers, like, almost every week on me. So the -- the numbers have changed a little bit, but these are the general numbers to think about when -- when -- and what we presented, um, in our webinar not too long ago, um, with the, um, with the governor and Senator Cannizzaro. So the significant healthcare savings -- right now it's anticipated to generate about $341 to $464 million in healthcare savings to the federal government. Um, and that's over the first five years. Now whether or not we get all of that money, there's some math and some interesting, like, penalties if we get new enrollment -- right? -- they actually reduce the amount of money we get, um, back. But for the most part we will -- we are hopeful to get most of this money back to the state. Um, and it -- we think, you know, based on those early estimates, it's about nearly $1 billion dollars by year ten. So, it’s a lot of money and it's really great, because

Nevada doesn't have much state revenue -- right? -- to spend on healthcare. Um, the other impact that we've been looking at, that was brought up during the legislation and people were worried about the impact on providers. So we asked our actuaries to do a provider analysis. And then, when they looked at this market, um, because it's specific to individual market, it's a very small portion of our revenue mix, or sorry, small portion of a provider's revenue mix. So for example, Medicare, employer-sponsored coverage, Medicaid are a lot larger and make up a lot more of the funding. And this is a much smaller piece. So based on their analysis -- and they also didn't see all providers going down to Medicare. They thought they said there was enough room in -- in the rate in the money today, the reimbursement, to avoid people being at the floor or below, which is good news. Because if it was below we couldn't meet our requirements. Um, and so there's a -- there's an appendix, so I would just recommend if you're interested in this to read that. It's at the end of the report. Um, but really their -- their argument was that, because of the small size of this market and that it's not a huge piece of the money, especially with the amount of people we expect to enroll, that the -- any reductions in revenue should be offset by higher volume of service and also just a reduction on compensated care.

DR. JAMESON: We lost that. There was a blank out on that last sentence. Could you repeat it?

WEEKS: Yeah, yeah. I don't know what I said but I'll -- I'll re -- I'll think about it. Um, oh, um, so they were saying that any revenue reductions to providers -- right? -- are -- because it's such a small piece of

the market and because we don't expect a huge enrollment -- right? -- or in the public option, especially in the first few years, that any reductions will be offset by higher volume of service utilization by people, right? And more people can come to the doctor because they have care. They're not just going to the ER, and also reductions in uncompensated care costs --- that will help offset. There will be some reduction, but overall, it's marginal, is what they said. Now if we were, like, changing premiums in employer-sponsor insurance, which we couldn't do, but if we were, that would be a whole another story, right? Like, when we do a Medicaid cut -- right? -- it's a big piece of the pie. That is felt large and clear, right? We -- and that's why we hear a lot of crying around that, which is fair, because it's a big piece of the revenue mix, especially for our hospitals. This piece, the individual market, is very small in Nevada. So there's a lot of data in the -- in the actual analysis that I don't have in this slide. Any questions on that?

DR. JAMESON: Yeah. We keep hearing you say that it's a small piece and providers, so you're talking physicians, physician assi -- um, nurse practitioners, et cetera.

WEEKS: Uh-huh.

DR. JAMESON: You're not referring to the companies themselves?

WEEKS: No, I'm talking about the number of people enrolled in individual markets. So when you think of how many patients that providers, all types of providers see -- of all their patients and their annual revenue, those individual market patients that are enrolled in individual

coverage, like the public option, is a small portion of all of their mix. So any changes in this small piece of the pie is not going to be a huge offset. It's not going to be a huge impact to those providers. Does that make sense, better?

DR. JAMESON: Well, it makes sense. So I just wondered, because you keep saying so assuredly you believe it's going to be a small piece. Small piece -- we probably heard that almost half a dozen times in the last few minutes. So what is a small piece, if you've got it so calculated that you believe it's a small piece, you must have a number?

WEEKS: I do, but I don't have it in front of me. And I -- I'm sorry, the actuaries have been kind of playing (phonetic), making sure --

DR. JAMESON: Yeah, but --

WEEKS: -- everything's fine and stuff (phonetic).

DR. JAMESON: -- but in other words, we've heard that from the beginning of the public option, that it would --

WEEKS: I can follow up the numbers.

JAMESON: -- (phonetic) well. Yeah, I mean you're -- so you're talking, like, 1% versus 5%?

WEEKS: Yeah, I'm talking, like, in that range.

DR. JAMESON: Really, really small. And that's how, when we first heard about public option and some of the -- some of the con -- you know, questions about even participating, was that it would be such small numbers. But yet, on the other hand, it's surprising, if it's such small numbers that there would be such great federal pass-through funds, such huge savings. (Inaudible) --

WEEKS: Well, that's how much money is in our healthcare system and premiums right now, to buy down premiums.

DR. JAMESON: Yeah. Yeah. So that is quite -- and then I would only --

WEEKS: It is shocking.

DR. JAMESON: -- caution to say that, um, you know, especially even prior to COVID, with the low number of providers in our state specialties and just general prac -- practitioners and, um, the number of patients they're seeing, I caution in saying that, um, you know, they could also make it up by volume. I don't think there's any doctors here that can see more than they're seeing to make anything up on volume.

WEEKS: Yeah, no, I hear you there.

DR. JAMESON: Yeah. I just --

WEEKS: I do think that uncompensated care.

DR. JAMESON: Uh-huh, yeah, yeah. And so is -- as just a caution. But it is exciting to see that even a small number of, uh --

WEEKS: Yeah.

DR. JAMESON: -- patients that -- that this plan would have such federal pass-through funds and such a positive impact. And the question is, you're benefiting not just healthcare in the state, but also the exchange, how that would be apportioned all not de -- all to be determined, but is one of the thoughts, then, that the exchange might not charge a fee --

WEEKS: No.

DR. JAMESON: -- or plan?

WEEKS: Uh-uh. No, like earlier, I was saying it would be subject to any of the fees and assessments.

DR. JAMESON: Uh-huh.

WEEKS: At QHPs, so it has to be.

DR. JAMESON: Okay.

WEEKS: It has to go through the whole process or it's not, uh, going to be able to be offered in the exchange, and then they violate their contract. So they pay the fee, um, they go through the same -- they're just like any other QHP, they just have a contract with the state.

DR. JAMESON: Oh, no, but I mean, uh, the exchange itself.

WEEKS: Uh-huh.

DR. JAMESON: Um, we, you know, uh, we have, uh, 3%. Correct, Ryan?

WEEKS: That's what I'm talking about.

DR. JAMESON: Yeah. You are talking about that.

WEEKS: Uh-huh.

DR. JAMESON: And it wouldn't allow us, with federal pass-through funds, to reduce that fee?

WEEKS: Oh, you're wanting to reduce the fee?

DR. JAMESON: Well, I'm just saying you said it could help the exchange, um --

WEEKS: Yeah, with premium subsidy wraps (phonetic), to help reduce costs further, for more people. And you could add -- we were thinking state subsidies, additional state subsidies to help lower costs. Also, right now, the exchange is like most exch -- uh, all exchanges are

receiving ARPA funding to even reduce those costs more.

DR. JAMESON: Right, right, right.

WEEKS: They expire. So the goal would be, I think, to replace those subsidies with this money.

DR. JAMESON: So more with state, uh, offsetting state and ARPA. Okay.

WEEKS: Yeah. Does that help? I want to make sure I was answering the question. Sorry.

DR. JAMESON: Yes. No, it's good.

WEEKS: Okay. Yeah. No, and I think it's also, um, back to the provider. I should have added here, because the -- since I've made this slide, we did add the admin spend cap. And the point of that was to say, you can't take all the burden on the provider. So the plans have to take some losses, too, on the administrative costs, like profits, salaries, any of those types of things. So that's the other way that the actuary is looking at this, is that -- that we are offsetting the full 4%. So it's -- it's also trying to not hit the providers as hard, if that makes sense.

DR. JAMESON: Yes, it does.

WEEKS: (Inaudible).

DR. JAMESON: (Inaudible). Go ahead, please.

JOHNSON: This, this is Jonathan Johnson. Uh, thanks for sharing this information and, uh, super insightful. We're hearing, um, I want to make sure that I'm understanding it correctly, that, uh, you know, reimbursements, uh, come down, uh, operating margin for insurance companies comes down, and that's where the savings of 16% is -- is

derived.

WEEKS: Uh-huh.

JOHNSON: Uh, but one of the things I didn't hear, is there a way, like, health insurance premiums are expensive because healthcare is expensive.

WEEKS: Yes.

JOHNSON: And we look at whether it's an aging population or, um, an at-risk population for, you know, diabetes or -- or things like that, in terms of population health management. What -- what levers can be pulled there to actually achieve real savings, as opposed to a -- a zero-sum game, where one of the stakeholders benefits at the expense of other stakeholders in the process? It just seems like that gets us nowhere.

WEEKS: I agree, totally agree. That's why we want to do the value-based payment design, to rethink how we do things, and the cost of care. One example that I think is a good way of thinking about controlling cost is to share in the risk and the -- and the savings with the providers. For example, you often can do, like, the one I think of most often is, simple as episode of care, right? So you say to some providers, for this type of diagnosis, you get this lump sum payment for these folks. That's kind of a value-based payment design. If you're able to manage their care and lower the cost of care, um, to do this, then you get to save in that money. If you don't, then you actually -- it costs you money. So it's sort of trying it's best to -- that's one way of value-based payment. There are other ways of like saying to them, like, we think the total cost of care for your population is X, and working with them to work within that, which means trying to lower

those costs. But I agree. I think the big question here always, in any healthcare reform, is how do you dr -- how do you control the cost of care, um, recognizing that that comes in different forms, right? There are different ways that the cost comes. So, like, administrative costs are part of the cost of care, um, and other ways to control costs too -- so, one of the strategies using value-based payment design. Another strategy is just hoping that providers and plans change how they're contracting for healthcare and assume, maybe, a different way of spending and other efficiencies. I will say in Minnesota, where I originally was working on Medicaid, we did a lot of value-based payment design in accountable care organizations. And we did -- with -- and along with some new bidding, like, I would say, like, kind of like this, but with Medicaid in our basic health program, we saved over $1 billion dollars in five years. So, like, based on just really trying to get at sharing the risk with providers differently, but it's not an easy task. And I would say Nevada's newer to this work. So I think you can't boil the ocean overnight. Right? Sorry, that's a long-ended -- long -- long-winded answer to your question. Sorry about that.

JOHNSON: No, but -- but that's the, like, we got to get to the -- to the root cause, and that's just -- not just in the state of Nevada. I think that's, uh, across the board, right? Uh --

WEEKS: Agreed.

JOHNSON: You know, population, health management, and improving outcomes and -- and things like that, that actually lead to, uh, uh, you know, a real reduction in -- in -- in the cost of care, over time.

WEEKS: Right. And that's what a lot of these accountable

care and population health -- you know? -- structured payments are about, is just getting provider participation. And also the hard part is, when it's just Medicaid doing it, it's hard, right? Providers don't want the burden unless it's a burden across -- shared across the markets, in a way where they -- they're -- they're getting the same requirements for participation in a bigger population. Um, so it's just a better win for them.

JOHNSON: Yeah.

WEEKS: So that would be the goal. I would also say, um, I don't see, I mean, I -- this is me personally speaking -- public option is not a -- a win for everything. I can't solve all the problems. I do think the patient protection commission that Nevada currently has, is looking at the cost growth benchmark -- right? -- and a lot of their work that they're doing. I think there are a lot of other tools that states are using, like price caps and other -- other strategies that, you know, I think it isn't -- there's not a one -- one strategy that solves the whole problem. I think it's multifaceted and requires lots of different strategies. Um, but I definitely think we're thinking about some of that, because I hear you. If we're just reducing down the cost, like with the spending, but the costs are still high, that's not a stable market and it's not really addressing the problem. Any other questions?

JOHNSON: Thank you.

WEEKS: Yeah, thank you. Okay, I'm going to move on, because I know we're -- you guys have business to do and not just talk about public option. Um, but I would say, just on -- in general, the -- we are thinking about 50,000 people will enroll in the first year. That includes

people who already currently enrolled. I'll -- I'm speaking frankly. We don't expect this to like, again, solve all the problems of the uninsured. Um, what it does -- does nicely do is bring in the new funding that can maybe help drive premiums even lower to drive more people to the exchange or do other things with. But it is definitely not the -- the full solution, because I think, as you guys know, a lot of undocumented folks, um, in our state, um, are a lot of the uninsured population, in addition to Medicaid. We need to do a better job getting people enrolled in Medicaid, too. So, um, I'm going to move to the next slide. And this is our timeline. It's a doozy. Um, we are in, almost 2023, um, when we will submit the, you know, if all -- depending on how things go, submit the waiver to federal government in March, maybe May, depending on how long it takes us to incorporate public feedback. I would love it if you guys want to submit feedback, Ryan, and your folks want to review. Um, obviously I know you're going to review before we -- we post. But you know, if folks from the board want to send comments, please do. Um, we will be doing negotiations with the federal government, probably all year. That's my cats (phonetic). Um, we also want to, next summer or early spring, offer an RFI, where we start to propose some of our ideas. Like, we're talking about the culturally -- cultural work workforce plan, right? What are our -- what kind of things can plans do? What quality metrics do we want to see? What other things, strategies should we include in our contracting process, um, with plans, that we think are -- is valuable to our, to the individual market. And then, 2024, is when we'd start a lot of our procurement process. Building the -- building the model contract, building the procurement, doing the

procurement, and hopefully, um, getting both Medicaid and pay-out (phonetic), public-option procurements finalized in 2025, in time for them to submit for certification -- right? -- at the exchange, and in time for them to submit for their rate filings at DOI. So I know it sounds -- it looks long, but it feels really tight -- it -- it when you think about it. But I think that's all I have, Ryan. Oh, I have this, just to give you -- you guys have these slides, so I won't walk through this in detail, but this is some of the money and the savings that we're predicting, through the exchange. So as you can see, it's -- it's a lot of money, in five years, depending on what happens with the wrap and what you do with the funding, um, you know, it's a little bit more. Now, if ARPA doesn't remain and does go away, it -- it is about 27% to 45% lower. So there is some cut there, if -- if ARPA can, you know, is -- it actually finally expires. If it continues on a little bit longer, it does increase pass-through, obviously, because that is some of the money you get to capture. And that's it, yeah.

DR. JAMESON: A few questions, uh, from our board? Does our board have any other questions? Uh, Stacie, that was an outstanding presentation. Of course there's so much detail to be filled in. So just clarifying, it'll be posted for comments, uh, on December 30th or public comments are -- yeah.

WEEKS: Yes. In 45 days.

DR. JAMESON: And how long --

WEEKS: In 45 days.

DR. JAMESON: -- how long will the -- it'll be open for 45 days, and it'll close, then, February 15th, or so?

WEEKS: Somewhere around there, uh-huh.

DR. JAMESON: Somewhere around there -- public comments. And people, to make the public comments, would just go where?

WEEKS: Um, on our website you can submit them. We'll have a link. So I'll send it all to Ryan, if he wants to send it out to the board.

DR. JAMESON: Oh, thank you (inaudible) --

WEEKS: (Inaudible).

DR. JAMESON: -- Ryan. Yeah, I'll send it to the board. That would be great.

WEEKS: Yeah. And I would definitely, just, if you guys want, I can send over some high points, once we get it posted, if that's helpful, because I will tell you it's over 100 pages and I don't want anyone to feel overwhelmed. I felt overwhelmed when I got it, I'll be honest.

DR. JAMESON: Oh, totally. And to overwhelm you, who've been immersed in this for your career --

WEEKS: Exactly.

DR. JAMESON: -- it's got to say, it had to be overwhelming. So --

WEEKS: Yes.

DR. JAMESON: -- I mean, we were looking at the, I think is the second to the last slide, and you were also mentioning about first year, maybe 50,000, but as you could see one to five, and then five to ten, the increased revenue.

WEEKS: Uh-huh.

DR. JAMESON: So by the 10th year, in order to increase that revenue, you were projecting a whole lot more than 50,000 people participating. So how many people, by year ten, are you thinking to re -- to rev -- to generate that revenue, are going to be participating?

WEEKS: A little over 100,000.

DR. JAMESON: So -- so you would only go from 50,000 the first year to 100,000 by the 10th year?

WEEKS: Yes.

DR. JAMESON: And it would change the amount of revenue brought in over that period of time, that much? Just -- so that 100,000 is what I heard in early projections. I'm amazed, because of that extra revenue. And that's because a lot of it is extra, because it's being given by the federal government.

WEEKS: Yeah. We don't see that. Like, I know, I don't even as a consumer -- right? -- we -- when we shop for healthcare, of course, I am not doing that now, but when I used to shop for my own healthcare coverage, we don't see that premium in the exchange, because it's bought down. Right? So I think -- and also you have to remember, it's not -- because someone was trying, like Pat Kelly from Nevada Hospital Association was trying to do the math with me one day. He's like, I don't get it. And I'm like, because costs are growing, too. So each year, the costs are higher. So as they go higher we get even more premium subsidy. Right? Um, it -- it, and also if -- so if folks enrolled in a bronze, there is also a mix here that the actuaries are assuming certain percentage enrolls in bronze that changes that scenario. Some enroll differently in silver, based on this

and some may enroll in a gold differently. And some -- and those subsidy amounts are different, too -- right? -- to the state. Bronze is a lot more -- bit of a pass through than silver and gold is less. Right. So there's all these weird nuances. I'll be honest, every time I talk to the actuaries, I have to, like, take a moment, repeat it all back. Yeah. Yeah.

DR. JAMESON: Now, so this is, then, uh, good to, know because, uh, with the way I saw those numbers escalating, I was worried that the numbers -- not worried, but thinking that the numbers would be from 50, not to 100, but from 50 to 200 or 500, looking at those numbers. But that's interesting that they project that on 100,000. So where are those 100,000 coming from, since Ryan told us not too long ago, there's about 200,000 uninsured in Nevada and probably half of them are undocumented? And so there's 100,000. I'm -- surely you're not thinking that it's that 100,000 will equal these 100,000.

WEEKS: No.

DR. JAMESON: And so where are those people coming from, do you think? Where -- are going to steal from Peter to pay Paul? Are they coming from, or other plans? Are they coming from Medicaid? Where are they coming from, do you think?

WEEKS: They are -- they're --

DR. JAMESON: Benefiting most from the new public option.

WEEKS: People (phonetic). I think people will switch in their current QHP products and find the public option more affordable. Um, I think some will stay and some will not. I don't -- sometimes the premium differences are enough in certain areas. Am I frozen? I hope not.

(Inaudible) --

DR. JAMESON: No, no, you're --

WEEKS: Okay. I thought I froze for a moment. I was, like, oh no. Um, yeah, but no, it --

DR. JAMESON: So they'll be coming -- they'll be coming from the exchange.

WEEKS: They'll just be switching QHP plans -- right? -- into a public option, because in their rating area, it'll be more affordable. In some rating areas, it may not be enough to have a switch, so that some of those assumptions are in the analysis. Um, but based on some of the premium differences, depending on where people are and --and -- and where they are today in their products, some will find the public option more affordable. So -- but I will tell you, of the percentage of the uninsured who today are not enrolled in the exchange still, even though they're eligible for a subsidy, we think we're getting at 10 to 12% of that population. So that's the uninsured population --

DR. JAMESON: Okay.

WEEKS: -- we're tackling.

DR. JAMESON: Ten to -- so not only about 10,000 of those people.

WEEKS: Yeah.

DR. JAMESON: So the other 90,000, or so, over time, will probably, likely --

WEEKS: A shift (phonetic).

DR. JAMESON: -- come from our other part of our exchange.

So it's good we'll benefit from some of the pass-through funds, as we lose other clients.

WEEKS: Yeah. Well, again, they're still your clients. They're still (inaudible) --

DR. JAMESON: Yes, yes, yes. They're public option.

WEEKS: It's like, it's finding a way to capture that money and say, you know, I think when I was talking --

DR. JAMESON: We'll likely capture more money, yes.

WEEKS: Uh-huh. Yeah.

DR. JAMESON: From the hoods (phonetic).

WEEKS: Yeah, and still keep people as -- as many people as enrolled today are -- and more, but also keeping people in a more affordable coverage. Right? And also not taking over, like, the whole market. I think it's a delicate dance and I think, right now, it looks positive. But, you know, it's always --

DR. JAMESON: And, I guess that's what I don't understand about the delicate dance is, um, how is it -- what is it exactly that makes it more attractive and function of practical and doable for them, than what the main differences, than what's being offered on the exchange in the amazing number of 170 plus whatever it is, different type of plans we offer?

WEEKS: Yeah.

DR. JAMESON: Um --

WEEKS: More affordable.

DR. JAMESON: -- what is the key -- what is the key thing that

makes it more affordable? What is it, actually --

WEEKS: Premium reduction target.

DR. JAMESON: -- than -- more premium reduction target.

DR. JAMESON: It's the target, uh-huh.

DR. JAMESON: And -- and it's that target that's going to go, hopefully, over time, four perc -- uh, maybe 4% a year, or so --

WEEKS: Uh-huh.

DR. JAMESON: -- over the next several years, that's going to. But then, what puts the break on it, that it doesn't keep shifting people from the exchange? Why, I mean, if I'm getting --

WEEKS: The target goes away, it expires in 2030, um, but we expect the trend, based on our procurement authority -- because we would want it, probably in our procurement, say that people can't increase their rates back up to, like, 14, 15%. Right? Um, so we'd want to say, you can't continue if you do that. Um, but that trend would continue, is the -- is the goal.

DR. JAMESON: I have to apologize. I didn't really understand. So what's going to prevent everyone from going down -- down that road for -- for a --

WEEKS: It's (inaudible) --

DR. JAMESON: -- (inaudible) 15% --

WEEKS: -- yeah.

DR. JAMESON: -- target reduction?

WEEKS: Because not -- the premium difference isn't always that far apart, in certain areas of the state. In some states it -- in some

areas it is. And -- and it looks like, based on what the actuaries are looking at that, you know, some of it will be preference. Like I, like -- I like my product, you know? And there's some -- there's some differences there.

DR. JAMESON: It's so complicated. I hope you can forgive me for finding this very difficult to comprehend. If I look at it simplistically, I would say, you know, there might be some differences in plans, but if in general, there's a, um --

WEEKS: We do expect some plans to compete with it, honestly.

DR. JAMESON: Oh. (Inaudible) --

WEEKS: And I think, you know, that's the other -- that's -- that's why we don't assume 100% take up. We assume six -- about 60%, based on what we know. It's hard, because there's really no --

DR. JAMESON: Ahhh --

WEEKS: -- perfect scenario.

DR. JAMESON: -- Okay. (Inaudible) --

WEEKS: Yeah. Sorry, I missed that part, yeah.

DR. JAMESON: Yeah, there now. Okay. I kind of am understanding our survival of the other plans and programs, then.

WEEKS: Uh-huh.

DR. JAMESON: Okay. So, overall, it'll still be a benefit, huge benefit to the consumer, if as many as 60% compete. And I don't know if it's fair to ask this question, but how are the insurance companies, uh, starting to feel about this, as it's rolling out? What's our feedback?

WEEKS: Um, well I can't speak for them personally, you

know, off hand. But we've had a -- a lot of weekly office hours with them. We've been meeting -- I've met with their actuaries. I'm going to have an actuarial call. So far the pu -- the conversations, I feel like, have been, um, much easier now. And we have, like, frank conversations and I think we've taken a lot of their comments and feedback. Um, but we continue to work with them. I think it's going to be a process throughout the whole rollout. Um, I don't think we're done thinking through how we do the procurement. How do we make sure that a reduction target is reasonable? How do we make sure that penalties are reasonable? All the things that we need to work through, just like we work through with them today, in Medicaid managed care. To me it's no different, because I'm used to that world. I think, for me, it's -- contracting with health plans is very much the way we do business. So I don't see that being different. But I will tell you, we've had interest from out-of-state plans that ha -- are not in our market.

DR. JAMESON: And I would tell you that I think you're doing an amazing job and you must be a totally brilliant woman. And it's a pleasure to speak with you, because I admire much, your, um, perseverance and fortitude, uh, and -- and being willing to, uh, work on this project. Uh, I will tell you, we, at our recent last month, AMA meeting, it was one of the most controversial topics, again, about public option. But in the end, everybody at the AMA, uh, understood that it's all about access to healthcare. And, uh, for providers, it is very difficult to, as you say, walk that delicate balance and -- and make everyone happy and win-win and not have a win-lose. And providers have felt, as you know, they're losing a lot --

WEEKS: Uh-huh.

DR. JAMESON: -- with Medicare and Medicaid, et cetera. And we don't want to have another -- providers don't want to have another loss here. They can't take many more hits. But, overall, the AMA, just so you know, and you can look it up, passed a resolution --

WEEKS: Wow.

DR. JAMESON: -- that they are supportive of the public option. And they really -- it took them a long time to get there.

WEEKS: I'm sure.

DR. JAMESON: In fact, just a few -- just a couple years ago, they finally passed an, uh, that said that healthcare is a human right. So they have progressed immensely.

WEEKS: That's huge, yeah.

DR. JAMESON: And -- and they did have a resolution recently, uh, last month that said, this -- after long controversy, that they were going to be very supportive of public options and they would write that in their policy. And we have, just so you know.

WEEKS: Well that's huge. Thank you for sharing that and did not know that. Um, so thank you. That's really good.

DR. JAMESON: Because I know you were fighting a lot upstream battles, and I just want you to know you have your AMA policy behind you.

WEEKS: That's really nice. Thank you. Um, well, just so you know, it is an upstream battle, but you know, I -- doing it because I think it matters, but obviously, it's going to be a part -- it has to be a partnership

with the exchange and we need it to work and it needs to be valuable, or we shouldn't be doing the work. Right? So happy to implement it and make sure we do it the best we can. But, you know, if it doesn't work, then the question is, why do you do it, right? So, just have to --

DR. JAMESON: Right. Yeah, well we -- we do it for patient access to excellent, quality, affordable healthcare. So I really appreciate that. And -- and in the end, hopefully, the insurers, uh, and the providers and all of us will feel. with the patients, it's a win-win-win. So thank you for this uphill battle.

WEEKS: Yeah. Well, thank you.

DR. JAMESON: And just, uh, I can see you're going to go for it and we thank you for doing that.

WEEKS: Thank you.

DR. JAMESON: Any other questions? Excellent. Excellent. Well, good work. Thank you.

WEEKS: I appreciated meeting everyone. Thanks, Ryan. And let me know if there are follow-ups, and we'll be in touch, for sure. I'll -- I'll drop now, so that's okay.

DR. JAMESON: Yes, you're doing a great job. Keep it up.

WEEKS: Thank you. Thank you.

DR. JAMESON: Thank you, so much.

WEEKS: Thanks. Have a good day. Bye.

DR. JAMESON: Okay. So -- boy, that's an amazing job and challenge. So, um, any other, uh, questions on what we just -- or just comments on what we discussed? Otherwise, we will -- I want to thank

Ryan for arranging that, because we know that, here in our state, it's attached to the exchange and, uh, wa -- want it to be a very positive, not any kind of stepchild, but a eq -- very positive member, new, as in -- in, uh, OB, we say, uh, uh, each child loved equally. And so, um, it was very wonderful of you to get that together for us, Ryan. So I don't hear any other comments.

FRIEDMAN: Uh, Chair -- Chairwoman, Jameson, can I ask a question? Uh, this is Sarah Friedman, for the record. Um, my question is about how -- I -- I understand this is a partnership between the exchange and -- and Medicaid. And I'm trying to understand, I guess -- and this is way down the road, um, when the public option becomes available, will these meetings include updates, as -- as any other exchange, you know, be included in summaries of exchange plan availability? Or is that -- will that not be included?

HIGH: No, it will be. And I see this as, you know, currently we have on our exchange and on our geor -- gei -- uh, enrollment and eligibility platform, we have bronze plans and silver plans and gold plans. I see this as being another -- just a fourth option, right? And we're starting to have initial conversations with -- getting short about, you know, what will that user experience look like? Will you see, instead of three squares, you know, bronze, silver, gold, will you see a fourth one that's maybe a public option plan from a carrier that's selling on the exchange? Or will it be a different, you know, portion of the website? Uh, that's still the, uh, to be determined at this point, but yes, it will be, uh, you know, the metrics will be given about the public option plans sold on the get -- on our

platform, on nevadahealthlink.com. And as, um, Stacie had mentioned earlier, we will also be able to apply that 3.05% assessment fee to public option plans, as well. So it's not going to be competing, per se, it's going to be just like a fourth option, is the way I'm seeing it, and we will still be able to collect that carrier premiums -- there's carrier premium fees, there's CPFs on public option plans that are sold. So we won't -- so for instance, it -- it's not like, um, our consumers may be leaving a traditional exchange plan and going over to the public option, where we're losing numbers, you know, we're losing enrollments, we're losing revenue, it's just going to be an addition and, like, a fourth option.

FRIEDMAN: I see. Thank you for that clarification.

DR. JAMESON: Okay. Is there anything that can -- I meant to ask her this question, and Ryan, you may know better than I -- sometimes we've heard in the news media that, um, that there may be some, um, lack of acceptance of forward movement. But since it is law, is it really possible that anyone can put a break on this or put it in, uh, um, stall?

HIGH: Well, we'll -- we'll see what happens this session, coming up. As you know, uh, our next, uh, legislative session starts in February and I think anything's possible there. Now, I'm not trying to speculate, but you know, um, uh, um, new bill draft requests can come up that may affect this. So it'll be interesting to see what happens this session, coming up.

DR. JAMESON: So it would, pretty much require a bill draft. It couldn't be just an executive order.

HIGH: I don't believe so, because it was passed by the

legislature last year and signed by the governor. So I think it would have to take legislative action and not just executive action.

DR. JAMESON: And that's what my understanding was. And so I just wanted to ask that. Well, there's been a lot of energy into it so far, and I certainly hope I see it. And I will look forward to a further discussion with you offline, not to, uh, belabor this for the rest of the team, in understanding a little better what her finishing words were when she mentioned about a potential 60% of, uh, some of the plans could reduce to be more competitive, uh, of the ones that end up, um, participating in option. And so, uh, and -- and how that doesn't in -- actually, perhaps, affect our exchange. And so I will -- it's all a little TMI for me at this point, and I look forward to further clarifications. But it is -- it is wonderful to see, uh, the -- that the opportunity is there for everyone to work together in a, hopeful, win-win-win, and hear your last words on this subject for now, but you do not feel so much it's going to be in any direct, significant competition, just another option. So I appreciate those reassuring words.

HIGH: Okay.

DR. JAMESON: Okay. So, um, possible actions regarding the dates, times, and agenda items for future meetings. Anybody have, uh -- yes.

HIGH: Excuse me, Dr. Jameson, real quick. We are making some headway in a tribal sponsorship program. So I would just like to read a quick thing, uh, a quick, uh, a few words here about possible, uh, about how tribal sponsorship and that program may affect our February board meeting. If you'd just indulge me for one minute, please.

DR. JAMESON: Oh, excellent. Thank you.

HIGH: Sure. So the exchange would like to propose the board take into consideration an agenda action item for the February board meeting that addresses the tribal sponsorship program. Some background on this -- the ACA provides an opportunity for any tribe to establish a tribally sponsored program to purchase health insurance coverage for their uninsured, tribal members through the health insurance marketplace, also known as the tribal sponsorship. 45 CFR 156.1250 governs requirements related to QHP and QDP issuers, acceptance of third party payments of premiums, and cost sharing, on behalf of the QHP enrollees. As of 2022, the exchange has one tribe, the Fort McDermitt tribe, uh, tribal Wellness Center, uh, enter into the tribal sponsorship program with Nevada HealthLink. The Fort McDermitt tribe is paying the member's premiums on behalf of elible -- eligible tribal members. The Reno-Sparks Tribal Health Clinic is getting very close to engaging in this program, and there are a handful of other tribes looking into it, as well, such as Fallon, Yerington, Pyramid Lake, Duckwater, and others. In order for the tribal health clinics to manage and oversee all the tribal members they are sponsoring, the exchange considers them as navigators and are given access as a certified enrollment counselor through the online portal. Prior to accessing Nevada HealthLink's online portal for enrollment, clinic staff are required to go through the ul -- and ultimately pass the Division of Insurance, the DOI's, and the exchange's CEC/EEF certification process. The exchange recently conducted a tribal sponsorship training that quickly turned into a conversation about the exchange addressing barriers that the

tribal health directors brought to our attention with the program. One of those barriers is concerning the CEC certification process. The current certification process is a barrier for tribes, given their high turnover and staff, monetarily, and their staff already goes through a rigorous background, uh, check. The exchange spoke with both our Deputy Attorney Generals about these concerns, and the Deputy Attorney General mentioned that the exchange board of directors have the authority, uh, or it IS well within the board's authority to create an exemption, uh, specific to tribes, that would allow the tribal health clinics to better serve this under, uh, underserved population. At the February board meeting, the exchange is asking the board to consider allowing Nevada Tribal Nations to not be required to complete the DOI training portion of the certification, but the tribes would be required to take the exchange's training for certification to become a CAC and enroll tribal members into ACA certified plans. So basically what we're asking is, the board to consider, uh, just having the tribal -- the, uh, the tribes take our internal certification that all brokers take, that all navigators take, but not have to, uh, abide by the DOI's rules. So that was just a -- a comment there that we would, uh, like to put that on the -- the board meeting for February.

DR. JAMESON: Excellent. And, uh, so we'll go ahead and, uh, let everybody think about that. And I think it's a wonderful thing to put on there. Again, uh, this is, um, a very cumbersome, uh, for -- to be met, um, I'm sure by some individuals. Just, uh, even the one that the exchange requires is -- is, uh, is, uh, challenging and, um, I think if you can pass that one, you're probably very qualified. But we'll save the comments for later.

But, um, I think that I'm excited, uh, to -- I know that I'm excited to hear how much progress has been made in, um, a different, uh, not just one, but many Indian tribes in different, um, places in the process, but coming along with their engagement with our exchange. And this is so exciting to hear how, also, the tribal, um, uh, funding for the members is -- is being brought, uh, paid for, for their members. And so, you know, we hear, too often, how the healthcare, uh, for the, uh, uh, members of these tribes and these reservations, I mean, it could bring me a tear to my eye, has been lacking. And, uh, they're mo -- most of them rural, literally a tear to my eye. This is so exciting to hear. This is a small population, but they're -- right? -- each individual, every individual is so precious, and that we are reaching out to these people who have been marginalized and forgotten and not had the access they need. This is just -- just thrilling to see that our exchange is making that connection. And we certainly are excited to see if we can help these navigators pass.

HIGH: Great. Thank you.

JAMESON: Okay. That was a great, uh, addition. So other, um, items on the agenda or any other thing about the future date, which he said was February, was it 18th? What was the date?

HIGH: 16th, uh, Thursday, February 16th at 1:30 PM.

JAMESON: Absolutely perfect. Hearing nothing else, I would like to thank everybody and go into public comment. then, if there are any -- no other comments? Okay. And then, uh, any public comments, um, um, online? I -- I -- I thought, perhaps, there could be several who wanted to make a comment on the public option, but they're probably like the rest of

us, we feel a little, uh, blind si -- you know, a little, just TMI and have to think about it. But it was a great presentation. So no other public comments being, um, uh, entertained out there, then I would say, we can make a motion to adjourn. And I want to thank our board members for participating and, uh, the great questions that were asked. Um, thank you so much and happy holidays to everybody. How blessed are we to have such amazing, uh, access to healthcare, which -- right? -- you have your health, you have your wealth? Well, uh, a healthy person has 1,000 wishes, a sick person has but one, to have their health, and -- and -- and we all know to have access to healthcare. So thank you all and know that you are improving holidays throughout our state by your action on participating in this board, both the staff and the board, to make sure that every Nevadan, because every life is of infinite value, has that access to healthcare and a happier, healthy future. So thank you for your participation, everybody. And pretty soon, everyone in Nevada will have healthcare. Thank you.

HIGH: Bye-bye. Thank you.

JOHNSON: Happy holidays.

(end of recording)