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Partnership For America's Health Care Future Action, Inc.

Nevada Public Option Actuarial Analysis

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Developed by:

Wakely Consulting Group

Karan Rustagi, FSA, MAAA
(720) 531-6134 | Karan.Rustagi@Wakely.com

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Introduction

Wakely Consulting Group, LLC (Wakely), a Health Management Associates (HMA) Company, was retained by Partnership for America's Health Care Future Action, Inc. ("Partnership") to provide actuarial support in an analysis of Nevada Senate Bill 420 (SB420), which establishes a public option. We also reviewed the state-sponsored Milliman report titled "1332 Waiver Actuarial / Economic Analysis and Certification for Nevada's Public Option". This memorandum was prepared to summarize our analysis and some of the potential effects of SB420.

We understand that this report may be shared with outside parties. When it is shared, it should be shared in its entirety. Wakely does not intend to create a reliance by outside parties receiving this report. Outside parties receiving this report should retain their own qualified experts in interpreting the results. It is the responsibility of the organizations receiving this report to review the assumptions carefully and notify Wakely of any potential concerns.

Key Findings

In December 2022, the State of Nevada released an actuarial and economic analysis to estimate potential federal pass-through funding related to the establishment of a public option under an Affordable Care Act (ACA) Section 1332 waiver. This analysis assumed that all premium reduction requirements in SB420 could and would be fully realized throughout the state.[1]

Our analysis reviews several factors that the prior State actuarial and economic analysis did not consider. We believe that the projections in the State December 2022 study would have been different if consideration had been given to which assumptions were realistic to achieve.

We find that:

- Physician rates, on average, are likely already at or near 100% of Medicare Fee-for-Service. Because the Nevada Public Option statute has a floor for average physician reimbursement at 100% Medicare FFS, little to no Nevada Public Option premium savings can be expected via physician reimbursement cuts. Further, Nevada is facing a significant provider shortage, which could be further exacerbated by reduced reimbursement rates.
- A 3% increase in loss ratio could reduce a low-cost insurer's risk margins to 0%. We note that a 0% risk margin does not allow for an actuarially appropriate margin of error in estimating claims and risk adjustment expenses and could have negative implications for competition, deter new entrants, and potentially cause some insurers to exit the market.
- To reduce premiums by 16%, the hospitals reimbursement rates may need to be reduced by 25-30%. We note that reductions of this magnitude may put financial hardship on hospitals whose overall margins are sensitive to reimbursement rates in the commercial market.
- We also note that there are limitations in hospital reimbursement cuts as a source of premium savings. First, to the extent that hospital reimbursements approach 100% Medicare FFS, the statutory limit may be a factor. Second, hospitals are only mandated to contract with one public option plan. If each hospital does the minimum required by the Public Option statute, any potential hospital savings will be distributed across insurers further limiting each insurer's ability to achieve a 16% premium reduction.

[1] Nevada Department of Health and Human Services. Milliman Report, "1332 Waiver Actuarial/ Economic Analysis and Certification for Nevada's Public Option." December 16, 2022.

Executive Summary

Wakely was retained by the Partnership to independently determine if a 16% premium reduction is realistic given existing provider reimbursement rates, insurer administrative costs, and necessary insurer risk margins for actuarially sound premiums. We used a combination of Wakely proprietary data and publicly available data to estimate prevailing provider reimbursement rates.

We analyzed three scenarios as described below to understand the impact on insurer margins and hospital reimbursements. We also performed literature review to understand second-order effects on providers and Nevada enrollees in the individual Affordable Care Act members. The key impacts are summarized below followed by a summary of scenario testing.

Impact on providers

- The hospital reimbursement reductions needed to achieve a 16% premium reduction are approximately 25-30%. Such levels of reimbursement reductions are likely to put financial hardship on hospitals given that typical hospital operating margins are significantly lower than this revenue reduction [2,3]. While hospital revenues from the Individual ACA market may be small relative to their overall revenue stream, hospitals rely on reimbursements from commercially insured patients to offset negative margins on Medicare and Medicaid patients. The reduction in reimbursement rates on the individual market may create an outsized strain on hospital finances, particularly in rural and underserved communities, due to payments in government programs set well below the actual cost of providing care.

- As noted in the 'Provider Access and Network Adequacy Considerations' section of this report, Nevada is facing a critical shortage of primary care providers, doctors, and nurses. Provider reimbursement reductions could exacerbate these existing shortages.

- Providers are only mandated to contract with one public option plan. If each provider does the minimum required by the statute, then there is a potential for a situation to emerge where several insurers are unable to achieve the provider reimbursement reductions necessary to meet the premium targets.

Impact on insurers

- The premium targets are calculated based on the second lowest cost silver plan. Insurers who have higher priced plans will need a greater reduction in premiums to achieve the targets. If business cases existed to lower premiums to such competitive levels, we believe market forces would have already driven the premium reductions and the public option does not create any new economic forces to drive these premium reductions. This

[2] https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf

[3] https://www.kaufmanhall.com/sites/default/files/2023-01/KH_NHFR_2023-01.pdf

statement is especially true of rating area 1 where seven insurers compete.

- The premium reduction targets do not consider other headwinds and forward-looking trend projections that could impact the ability to achieve the statutory threshold. The premium targets are calculated using Medicare Economic Index (MEI) (in the Section 10.4(b) of SB420 as originally written) and CPI-M with an adjustment for Nevada utilization and morbidity (which replaces MEI in the general guidance letter 22-001 dated October 4, 2022). Both MEI and CPI-M can be inadequate and inappropriate choice for trending premiums as described further in the Background section.

- Actuarially sound premiums must be sufficient to cover claims, administrative costs, and risk margins. If provider reimbursement reductions are insufficient for a 16% premium reduction, insurers may not have sufficient margin to absorb the additional claims liability and may find themselves in financial difficulty. This may result in insurers exiting the individual ACA market and lower insurer competition in the market.

- When premiums are reduced, the dollars available to insurers to fund administrative costs and risk margins is also reduced without a commensurate reduction in expenses because this is limited to 20% of premiums per Affordable Care Act Medical Loss Ratio (MLR) requirements. Given the competitive nature of the Las Vegas market, to the extent that administrative expenses could have been reduced to drive premium competitiveness, insurers would already have reduced those expenses.

We also note that since the fees assessed to operate the marketplace is calculated as a percent of premiums, there will also be less funding available to the state as premiums are reduced.

We studied three scenarios that differ in how the premium reduction was achieved (provider reimbursement reduction with or without increase to insurer medical loss ratio) and the choice of data (market average data or data from the insurer with second lowest cost silver plan). The choice of data provides insight into whether insurers with differing medical insurance risk profiles would be impacted differently. For example, a hypothetical carrier with perfectly healthy members who had no claims would theoretically not be able to reduce premiums simply by reducing provider reimbursement rates. We used Medical Loss Ratio (MLR) to measure insurer administrative expense and risk margin ratios.

Scenario 1: Reimbursement reduction needed after a 3% increase to MLR using data for the plan with the second lowest cost silver plan.

Scenario 2: Reimbursement reduction needed (without any changes to MLR) using data for the plan with the second lowest cost silver plan.

Scenario 3: Reimbursement reduction needed (without any changes to MLR) using data from all insurers.

Since approximately 80% of the potential members who would enroll in the public option reside in Las Vegas area (referred to as rating area 1 by Nevada), our analysis is based on premiums in rating area 1.

The results of our analysis are summarized in the table below.

Table 1: Reductions in Provider Reimbursement Rates in Rating Area 1

Scenario	Reimbursement Reduction in Las Vegas		
	Inpatient	Outpatient	Professional
Scenario 1	-24.5%	-24.5%	0.0%
Scenario 2	-30.4%	-30.4%	0.0%
Scenario 3	-30.4%	-30.4%	0.0%

In scenario 1, we based our analysis on Silver Summit's most recent publicly available data as Silver Summit had the second lowest Silver premiums in 2023[4]. To increase the loss ratio by 3 percentage points, we needed to reduce the risk load by 100% and per member per month (PMPM) administrative expenses by 8%. We note that a 0% risk margin does not allow for an actuarially appropriate margin of error in estimating claims and risk adjustment expenses.

To achieve the full 16% premium reduction, the non-pharmacy medical costs needed to be reduced by 18.9%. This cost reduction would require a 24.5% reduction in hospital reimbursement rates in Las Vegas / Rating area 1. We estimated that the professional reimbursement rates were already approximately at 100% of Medicare so we assumed no further reduction. The hospital reimbursement reduction of 24.5% is higher than total medical cost reduction of 18.9% because professional fees could not be reduced by 18.9% without reducing reimbursement below 100% of Medicare.

In scenario 2, to achieve the same outcome of 16% premium reduction, we needed to reduce the hospital reimbursements by 30.4% and maintain the professional fees at approximately 100% of Medicare. The issuer risk margin is fixed at 3% and PMPM administrative expenses were reduced by 8%.

In scenario 3, we reduced the hospital reimbursement by 30.4% and maintain the professional fees at 100% of Medicare (same as scenario 2). The scenarios 2 and 3 claims cost reduction levels are expected to be similar because the two carriers had similar claims expense on a risk-neutral basis, and we assumed that risk transfers would also be reduced by 16% as market average premiums

[4] Note that while we used Silver Summit's data to prepare various estimates, these estimates were not reviewed by Silver Summit. Should Silver Summit conduct similar analyses, Silver Summit may come to different conclusions. Estimates in this report are Wakely's estimates using Silver Summit's data without Silver Summit's participation.

are theoretically reduced by 16%. The PMPM administrative expenses were reduced by 8%. The hospital reimbursement result was identical between two scenarios coincidentally.

We raise the question whether Medicare reimbursement levels for hospital services are adequate. In 2021, IPPS hospitals' Medicare margin was -8.3% (–6.2% when including a share of federal relief funds)[5]. MedPAC projects that margin will decline in 2023. Low reimbursement levels may result in access and solvency issues for providers.

The above points collectively raise the question whether a 16% premium reduction is realistic/feasible without significant disruption to access to care, choice of plan, and competition.

[5] https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf

Background

The Nevada Public Option statute (SB420) seeks to establish a public option. One of the key goals of the public option is to lower the premiums in the ACA individual market by 16% relative to a reference premium over 5 years. There are three primary sources of premium savings:

- Lower hospitals reimbursements
- Lower physician reimbursements
- Lower insurer administrative costs and/or risk margins

The expectation from insurers is to negotiate lower reimbursements from their providers (hospitals and physicians). The reimbursement rates for medical services cannot be lower than what Medicare pays for the same services in aggregate. The insurers are also expected to lower their administrative costs and/or risk margins. The requirement for providers is that if they accept Medicaid and state plans (among other requirements), then they must participate in at least one Nevada Public Option plan.

We consider insurer and provider negotiation dynamics. The Nevada Public Option does not dictate how provider rates are negotiated or set. Instead, state law establishes a provider reimbursement floor requiring that health insurers offering Public Option plans pay providers at rates that are no lower than Medicare rates in aggregate. This creates two challenges:

1. There is no mechanism to force provider reimbursements lower. Providers retain negotiating leverage with insurers. Providers must contract with only one public option plan and lack significant incentive to further reduce prices more than what the private market already achieved. Furthermore, network adequacy requirements and requirements to align with the Medicaid network further strengthen provider leverage.
2. Tensions exist between networks adequacy standards and "alignment with Medicaid network." It is possible that no insurer would have an adequate network if Nevada "public option provider contracts" are sufficiently distributed across insurers.

The resulting reduced reimbursement rate environment would put significant pressure on the insurers when attempting to form provider networks for their members, as providers and hospitals would be very unlikely to accept such severe cuts to payments for their services. As discussed in more detail in another section, this would also likely exacerbate provider shortages in Nevada. The primary recipients of these negative effects could ultimately be Nevadans seeking care in the state.

The statutory premium targets are calculated in a way that is inconsistent with actuarial rate setting process. Section 10.4(a) of SB420 defines reference premium as the lower of the 2024 second lowest silver plan premium (SLCS) on the Nevada exchange in 2024 trended to the premium year

at the Medicare Economic Index (MEI), and the SLCS premium in the prior year. We note that actuaries do not use MEI to set premiums for several reasons including but not limited to:

- MEI was intended for use in Medicare and not the individual market.
- MEI measures practice cost inflation[6] for Medicare physicians and is not intended to measure premium changes which are impacted by more factors than just physician payment rates. For example, MEI will not capture the impact of new drugs releases such as the expensive gene therapies expected to be approved in the coming years.
- MEI uses historical data not forward-looking expectations. Actuaries use both historical data and projected changes in costs and utilization to set trends in premium development.

In the general guidance letter 22-001 dated October 4, 2022, MEI is replaced by CPI-M with an adjustment for Nevada utilization and morbidity but neither the choice of CPI-M nor the adjustments are defined. Like the MEI, CPI-M uses historical data only and does not factor in forward-looking expectations of medical costs or premiums.

This disconnect between actuarial trend and MEI/CPI-M can result in unrealistic expectations of the achievability of the stated premium reductions to the extent that the actuaries' expectations of trends diverge materially from published MEI/CPI-M.

[6] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4191233/

Results

We estimated the impact on insurer risk margin (and loss ratio) and on provider reimbursement rates of the efforts to reduce premiums by 16%.

We studied three scenarios:

1. Scenario 1 reviews the medical claims cost reduction needed to produce a 16% premium reduction for an insurer that had the second lowest silver premiums in 2023 based on publicly available data submitted by the insurer for 2021. We assume that part of the 16% reduction would be achieved by such an insurer being able to reduce their risk margins to 0% and reduce their administrative per member per month (PMPM) expenses by 8%.

2. Scenario 2 is like scenario 1 except insurers may not have the ability to reduce risk margins. Under this scenario, the entire 16% premium reduction must be achieved through provider reimbursement reductions and the administrative expense reductions like in scenario 1 but without a change to risk margin.

3. Scenario 3 is like scenario 1 except that we perform the study based on market average data instead of a specific insurer's data. The rationale behind this scenario was to understand the impact on a risk-neutral basis, that is, the medical cost reduction needed for an insurer with market average morbidity. Insurers with significantly different morbidity than the market average risk can have significant portion of their premiums being used to fund risk transfer payments as opposed to medical claims and that could have an impact on the reductions needed to the portion of the premiums that is medical cost.

We also comment on the impact on provider shortages and access to care based on literature review.

Scenario 1: Reimbursement reductions needed for an insurer with the second lowest cost silver plan with increase to MLR

In this scenario, we used the 2021 publicly reported data for Silver Summit because it was the insurer with the second lowest cost silver plan in 2023. We first increased the MLR by 3% (i.e., reduced risk margin to 0%) and then estimated the medical cost reduction needed to achieve the full 16% premium reduction. Components of premiums that are based on a percent of premiums were adjusted so they reflect the same percent of premiums as before. Administrative expenses (on a PMPM basis) were reduced by 8% to reflect reduced broker commissions and potential aggressive efforts by insurers to reduce operating expenses. Note that reducing administrative expenses by 8% is an aggressive assumption. To the extent that these expenses could have reduced, the insurers would have already reduced them especially in highly competitive market such as rating area 1 (Las Vegas).

Impact on Risk Margin / Loss Ratio

Consistent with the Nevada Department of Health and Human Services (DHHS) guidance noted in Milliman's report 'Nevada Public Option 1332 Actuarial and Economic Analysis' dated December 16, 2022, we assumed that a part of the premium reduction would be achieved through a 3% increase in medical loss ratio. To increase MLR, either administrative expenses (as a percentage of premiums) or risk margin or both must be reduced. For this scenario, we assumed risk margin would be reduced from 3% to 0% of premiums. We also assumed that the administrative dollars available to the insurer would be reduced. However, despite the reduction, the administrative expenses represent a higher percent of the reduced premiums and therefore, not a contributor in increasing the MLR.

Note that as premiums are reduced, the administrative dollars available to insurers to operate an insurance company are also reduced because insurers typically set aside a percentage of the premiums for administrative expenses. These administrative dollars are used to fund the expenses including but not limited to the following:

- Agent and broker fees and commissions
- Prevention of fraud, waste, and abuse
- Efforts to improve health quality and increase the likelihood of desired health outcomes such as preventing hospital readmissions, improving patient safety, wellness and health promotion, and health information technology
- Customer service, product design, network contracting, provider accreditation

Insurer administrative expenses are limited to 20% of premiums[7]. A reduction in premiums funded primarily by reducing provider reimbursements and insurer margins does not reduce any of the above expenses but reduces the funding available to cover these expenses. Depending on each insurer's individual circumstances, such services may have to be reduced in response to lower available funding. We assumed that administrative expenses would be reduced by 8%. A portion of this reduction would be achieved by broker commissions scaling down with premiums but most of it may need to be achieved by reducing operating expenses and the corresponding services being funded through those operating expenses.

Impact on Provider Reimbursement

We achieved the remaining reduction in premium (beyond what was achieved by the MLR increase above) by reducing other components of premium such as risk adjustment transfers and medical costs.

Silver Summit expects to pay 26.6% of its premiums as risk transfers. Risk adjustment transfers are calculated as the difference in the insurer's risk relative and the market average risk multiplied by market average premiums. We estimated that the risk adjustment payables would also scale down by 16% because we assume that the market average premium would likely be reduced by 16%.

We also adjusted the components of premiums that are typically calculated on a percent of premium basis such as exchange fees and taxes. These components still represent the same percentage of premium as reported in the rate filing but on a per member per month (PMPM) basis, they scale down 16.0% with premiums.

We then estimated the medical (non-pharmacy) paid claims reduction needed to achieve the full 16% premium reduction. We assumed pharmacy costs would remain unchanged because the main statutory levers to achieve premium reduction are limited to hospital, physician, and insurer cost structures with no mention of pharmacy costs.

Lastly, we translated the medical cost reduction to provider reimbursement rates reduction.

We based this analysis on rating area 1, which includes Las Vegas because it has 80% of the state's ACA enrollment.

A summary of our findings is presented in the table below:

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[7] This statement is a simplification that is adequate for the discussion purposes.

Table 2: Summary of MLR Effects on the SLCSP for Rating Area 1 (Scenario 1)

Components of Premium	Total Variance from 2023 Actuals
Paid Claims - Medical	-18.9%
Paid Claims - Pharmacy	0.0%
Risk Adjustment Payables/Receivables	-16.0%
Administrative Expenses	-8.0%
Risk Margin	-100.0%
Tax	-16.0%
Premium	-16.0%
MLR	3.0%

As shown above, the medical costs need to be reduced by 18.9% in addition to reducing the risk margin to 0% to achieve a 16% reduction in premiums.

The reimbursement rates as a percent of Medicare (% of MCR) vary between inpatient, outpatient, and professional. SB420 section 14 requires that “reimbursement rates under the Public Option must be, in the aggregate, comparable to or better than reimbursement rates available under Medicare.” If all provider reimbursements are reduced equally by 18.9%, then depending on the starting reimbursement levels, it is possible that some providers reimbursement levels are reduced below the floor of Medicare reimbursement levels even if the average reimbursement level exceed Medicare levels. For example, hospitals may have payment levels above Medicare after reductions, but physician pay may be cut to levels below Medicare (not allowable by SB420) if the starting physician payment rates were closer to Medicare levels than hospital payment rates. To test whether payment rates for some providers go below Medicare levels, we estimated the payment rates before and after reductions separately for inpatient, outpatient, and professional. To the extent that payment rates for any service category must be reduced below 100% of Medicare to achieve the target reduction, we floored the payment rate at 100% of Medicare and further reduced the payment rates on other service category until the aggregate payment rate across all services was 18.8% lower. We note that payment rates at 100% of Medicare are considered inadequate by many providers.

The table below shows the rating area 1 average reimbursement rates by service category before and after the reduction to bring medical costs down by 18.9%.

Table 3: Estimated Reimbursement as % of FFS Medicare (Scenario 1)

Category of Service	% MCR Implied in Rating Area 1	Reduction Required	% MCR for Target Premium
Inpatient	159%	24.5%	120%
Outpatient	207%	24.5%	156%
Professional	100%	0.0%	100%
Total Medical (non-pharmacy)	**153%**	**18.9%**	

We estimated that to drive an 18.9% reduction in average medical claims costs, we would need a 24.5% reduction to reimbursement to inpatient and outpatient services because reimbursement levels for professional services in rating area 1 are already at 100% of Medicare. Therefore, the reduction in inpatient and outpatient reimbursement must be increased to account for the inability to further decrease professional reimbursement.

Scenario 2: Reimbursement reductions needed for an insurer with second lowest cost silver plan without an increase to MLR

This scenario is like scenario 1 except that we assume that insurers do not reduce risk margins. The premium reduction of 16% is achieved by reducing medical claims cost and administrative expenses similar to scenario 1.

Impact on Risk Margin / Loss Ratio

There is no impact to the risk margin in this scenario. In this scenario we assumed that carriers would not be able to increase their medical loss ratios by 3.

Impact on Provider Reimbursement

Like scenario 1, we adjusted administrative expenses and risk adjustment transfers first. We then estimated the reduction needed to medical claims cost (keeping pharmacy costs constant) to achieve premiums that are 16% lower than 2023 premiums. This analysis was also based on rating area 1.

A summary of our findings is presented in the table below:

Table 4: Summary of MLR Effects on the SLCSP for Rating Area 1 (Scenario 2)

Components of Premium	Total Variance from 2023 Actuals
Paid Claims - Medical	-23.4%
Paid Claims - Pharmacy	0.0%
Risk Adjustment Payables/Receivables	-16.0%
Administrative Expenses	-8.0%
Risk Margin	-16.0%
Tax	-16.0%
Premium	-16.0%
MLR	-1.3%

As shown in the table above, the reduction needed to medical costs is 23.4%. The claims reduction is higher than scenario 1 because the risk margin as a percent of premium is held constant. The MLR is reduced by 1.3% because the administrative costs are reduced by a lower amount than the premiums.

The table below shows the rating area 1 average reimbursement rates by service category before and after the reduction to bring medical costs down by 23.4%.

Table 5: Estimated Reimbursement as % of FFS Medicare (Scenario 2)

Category of Service	% MCR Implied in Rating Area 1	Reduction Required	% MCR for Target Premium
Inpatient	159%	30.4%	111%
Outpatient	207%	30.4%	144%
Professional	100%	0.0%	100%
Total Medical (non-pharmacy)	**153%**	**23.4%**	

We estimated that to drive a 23.4% reduction in average medical claims costs, we would need a 30.4% reduction to reimbursement to inpatient and outpatient services because reimbursement levels for professional services in rating area 1 are already at 100% of Medicare. Therefore, the reduction in inpatient and outpatient reimbursement must be increased to account for the inability to further decrease professional reimbursement.

Scenario 3: Reimbursement reductions needed for an insurer with market average risk

This scenario is like scenario 2 except that we used statewide market information from all insurers combined instead of the information for the insurer with the second lowest cost silver premium in 2023 (Silver Summit).

Impact on Risk Margin / Loss Ratio

There is no impact to risk margin in this scenario.

Impact on Provider Reimbursement

Like scenario 2, we adjusted administrative expenses and risk adjustment transfers first in the same way as scenario 2. We then estimated the reduction needed to medical claims cost (keeping pharmacy costs constant) to achieve premiums that are 16% lower than 2023 premiums. This analysis was also based on rating area 1.

A summary of our findings is presented in the table below:

Table 6: Summary of MLR Effects on the SLCS plan for Rating Area 1 (Scenario 2)

Components of Premium	Total Variance from 2023 Actuals
Paid Claims - Medical	-23.4%
Paid Claims - Pharmacy	0.0%
Risk Adjustment Payables/Receivables	0.0%
Administrative Expenses	-8.0%
Risk Margin	-16.0%
Tax	-16.0%
Premium	-16.0%
MLR	-1.0%

As shown in the table above, the reduction needed to medical costs is 23.4%. The claims reduction is identical to scenario 2 because the two carriers had similar risk-adjusted claims. The risk adjustment transfers across all insurers sum to 0 and therefore there is no change in risk transfers for an insurer with market average risk. The MLR is reduced by 1.0% because the administrative costs are reduced by a lower amount than the premiums .

The table below shows the rating area 1 average reimbursement rates by service category before and after the reduction to bring medical costs down by 23.4%.

Table 7: Estimated Reimbursement as % of FFS Medicare (Scenario 2)

Category of Service	% MCR Implied in Rating Area 1	Reduction Required	% MCR for Target Premium
Inpatient	159%	30.4%	111%
Outpatient	207%	30.4%	144%
Professional	100%	0.0%	100%
Total Medical (non-pharmacy)	**153%**	**23.4%**	

We estimated that to drive an 23.4% reduction in average medical claims costs, we would need a 30.4% reduction to reimbursement to inpatient and outpatient services because reimbursement levels for professional services in rating area 1 are already at 100% of Medicare. Therefore, the reduction in inpatient and outpatient reimbursement must be increased to account for the inability to further decrease professional reimbursement.

In addition to the three scenarios above, we qualitatively discuss the impact on providers, provider access, and network adequacy in the next section below.

Provider Access and Network Adequacy Considerations

In 2021, IPPS hospitals' Medicare margin was -8.3% (–6.2% when including a share of federal relief funds)[8]. MedPAC projects that margin will decline in 2023. The proposed waiver and its effects on reimbursement may extend to the provider network available to potential public option members in Nevada. Insurers will likely have difficulty establishing contracting networks for their public option members, as many providers will unlikely accept lower reimbursement levels for services for these members as compared to their other membership pools.

In addition, insurers and providers will be constrained by the network and coverage requirements established by the waiver. These requirements add further difficulty in establishing provider networks for public option members. They may be especially difficult in rural areas where the mandated level of coverage is already unsustainable even before considering the required reimbursement levels[9].

Nevada is already suffering from a physician shortage, ranking 48th[10] in the nation in physicians per capita. A recent study on primary care in the United States published by the Milbank Memorial Fund noted that there exist significant pressures on the primary care market in the US, including underinvestment and a shrinking workforce.[11] The Kaiser Family Foundation estimates that only about 43% of the need for primary care in the state is met, and that Nevada needs over 200 more primary care providers to fulfill this gap.[12] Additionally, the CEO of Nevada Hospital Association noted that hospitals are facing shortages of nurses[13]. These pressures are directly related to downward pressure on provider reimbursement for primary care services, and these effects are exacerbated in more rural areas, which comprises a material amount of the Nevada market. Indeed, the report recommends that investment and reimbursement for primary care *increase* to improve the attractiveness of the market and gain and retain practicing care providers. While our analysis

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[8] https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf

[9] According to ruralhealthinfo.org, rural Nevada is served by 13 critical access hospitals and 19 rural health clinics both of which are paid on a cost + 1% basis before considering sequestration which reduced reimbursement by 2%.

[10] https://www.8newsnow.com/news/local-news/nevada-doctor-shortage-the-state-ranks-48-when-it-comes-to-number-of-physicians-per-capita/

[11] https://www.milbank.org/wp-content/uploads/2023/02/Milbank-Baseline-Scorecard_final_V2.pdf

[12] https://www.kff.org/other/state-indicator/primary-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[13] https://thenevadaindependent.com/article/nevada-needs-more-nurses-and-more-physicians-but-what-will-it-take-to-make-it-happen

floors professional payment rates in rating area 1 at 100% of Medicare, we note that even the threat of having payment rates reduced may exacerbate provider shortage.

The proposed waiver's required reductions in reimbursement will create an even more unfavorable market dynamic for primary care in Nevada. If insurers are unable to establish networks in the state for their public option members, the benefits of the lower premiums will be largely lost in reduced access or quality of care as providers decline to accept lower reimbursement for services that they already provide. In addition, potential new providers may view Nevada as a less attractive location than other states to establish a practice due to lower potential revenue.

We did not assume that reduced reimbursement for providers would be offset by increased utilization and increased reimbursement rates driven by the uninsured purchasing coverage in response to lower premiums. To the extent that currently uninsured members are eligible for fully subsidized plans, the reduction in premiums does not necessarily benefit them. A Guinn Center study found that in 2019, 37% of the uninsured were eligible for Medicaid, 19% were eligible for ACA subsidies, and 12% were eligible for an affordable employer-sponsored insurance plan. Another 27% of the uninsured were ineligible for Medicaid or ACA subsidies because of immigration status. These members are unlikely to purchase coverage in response to reductions in Individual Exchange premiums.

In theory, all else equal, lower premiums may result in more uninsured members taking up insurance coverage. However, a significant majority of the uninsured were eligible for significantly subsidized coverage already or ineligible for ACA subsidies or Medicaid because of immigration status. Consequently, it is very unlikely that the Nevada Public Option will change the health insurance enrollment behavior for these segments of the uninsured.

Other Key Considerations

The Medicare Economic Index (MEI) may be an inadequate reflection of trends in the commercial market and is not reflective of prospective trends. As such, using MEI may produce actuarially unsound rates. Section 10.4(b) of SB420 states that the public option premiums cannot increase in any year by more than MEI. Milliman used the Consumer Price Index – Medical (CPI-M) estimate of 3.7% to model general medical inflation, plus an adjustment for utilization and morbidity to model public option premium growth. The report assumes the overall reference premium trend to be 4%. We note that the average allowed PMPM trend across all individual ACA insurers in NV between 2021 and 2023 was 6.1%.

The effective elimination of risk margin presents a material concern on insurer's ability to remain in the market and provide Nevadans with access to insurance. Risk margin is a key factor in a health plan's ability to conduct business in a market, as risk margin often funds required surplus that is needed to ensure the claims-paying ability of the plan, as well as satisfy regulatory and statutory requirements.[14] Including a reasonable surplus in the setting of rates is included in the American Academy of Actuaries (AAA) practice standards for this reason.[15] If insurers are unable to generate a reasonable risk margin, their business becomes unstainable over the long term, and they may exit the Nevada market. Insurer exits reduce competitiveness in the market which can have adverse effects on members and providers, and could also adversely impact the state's ability to meet requirements and guardrails laid out in the 1332 waiver application.

Other considerations include:

- Any state or federal benefit mandates after the 2024 benefit year (reference premium) will make the premium reductions even harder to achieve unless adjustments are allowed for differences in benefits and the pricing actuarial value.
- Future changes to the risk adjustment program can materially change the economics of insuring certain populations. To the extent that risk adjustment program changes materially alter how morbidity is compensated, some plans may need to adjust pricing accordingly.
- Some plans, especially the lowest and second lowest cost silver plans, may be underpriced in the reference year and the statute does not account for correcting the mispricing.

[14] https://www.actuary.org/sites/default/files/files/publications/premiums_settings_mar2010.pdf

[15] https://www.actuary.org/sites/default/files/files/RRPN_100512_final.pdf

Key Caveats

A key assumption implicit in this analysis is that Silver Summit's rates are actuarially-sound in 2023. If the rates are inadequate, an additional reduction will be needed from providers to achieve the 16%. If the rates are excessive, then a lower provider reimbursement may be needed to achieve the 16% premium reduction than what is estimated in our analysis.

We caution that these estimates by service category are still averages and that within these service categories, some providers may be assumed to have reimbursement levels below Medicare levels. To floor the reimbursement levels at 100% at the provider level, it would require that other providers accept an even larger reduction than what is estimated here.

We did not assume reimbursement reductions would be offset by higher demand for services at a higher reimbursement rate by uninsured members purchasing coverage in response to premium reduction. Lower rates of uninsured do not necessarily result in reduced cost shifting[16]. 2017 Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) Annual Report showed that the hospital prices continued to increase despite significant reductions in uncompensated care.

Insurers ability to reduce administrative expenses as premiums are reduced can vary greatly from insurer to insurer. We did not study insurer individual circumstances and whether their ability to reduce administrative expensive by 8% is realistic. To the extent that an insurer prices using a high MLR, such an insurer may be able to keep administrative expenses the same on a PMPM basis and still stay above the 80% MLR requirement. Other carriers that price at 80% MLR may need to reduce administrative expenses by more than 8% to stay above the minimum 80% MLR.

[16] https://hcpf.colorado.gov/colorado-cost-shift-analysis

Data & Methodology

We used a stepwise process to estimate the reduction needed in the medical claims costs to produce a 16% reduction in Silver Summit's premiums for the SLCS plan. We then used Wakely proprietary data to estimate the average reimbursements rates in Nevada statewide, Las Vegas, and the reduced reimbursement rates needed to achieve the premium targets.

Estimating Medical Cost Reduction

For scenarios 1 and 2, we used the 2023 Rate Public Use Files (PUFs) to identify the second lowest silver plan in Nevada rating area 1 in 2023 to be Silver Summit.

We then used the 2023 Uniform Rate Review Template (URRT) data[17] that insurers offering health plans must include with annual rate filings in each state. Plan year 2023 URRTs include claims experience information for plan year 2021 and projected claims, risk adjustment, non-benefit expenses (such as administrative expense, taxes, and exchange fees), and premiums for the 2023 benefit year. We used the data for Nevada individual ACA market for Silver Summit in scenarios 1 and 2 and aggregated the individual ACA information across all insurers in Nevada for scenario 3. This information enabled us to re-create Silver Summit's 2023 premium development and the premium development for all insurers combined.

Section 10.4(a) of SB420 defines reference premium as the lower of the 2024 second lowest silver plan premium (SLCS) on the Nevada exchange in 2024 trended to the premium year at the Medicare Economic Index (MEI), and the SLCS premium in the prior year. As of the timing of analysis, 2024 premiums or the MEI that would be used were not available, and therefore, we used SLCS 2023 premium as the reference premium.

We assumed that the insurers would be able to reduce administrative expenses by 8% to reflect lower broker commissions and reduction in services offered to members. We then estimated the reduction needed to risk margin to produce a 3% increase in MLR in scenario 1.

We adjusted the components of premiums that are generally estimated on a percent-of-premium basis to reflect that premiums will be reduced by 16%. That is, we assumed that the risk margin, taxes, exchange fees, and premiums would all be calculated using the same percent of premiums as reported in the rate filings but on a PMPM basis, they would be reduced by 16%.

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[17] https://www.cms.gov/cciio/resources/data-resources/marketplace-puf

We re-constructed the premiums using these modified components of premiums. We then estimated the reduction needed for medical claims to achieve the remainder of the full 16% reduction in premiums.

The stepwise process is shown in the figure below for scenario 1.

Table 9: Estimating Impact on Risk Margin and Medical Cost of 16% Premium Reduction

Public Option Rate Reduction	2023, Pre-PO	Change	Step 1: Target 3% increase in MR by adjusting Risk Margin	Change	Step 2: 16% reduction in premium and % of premium components	Change	Step 3: Medical claim reduction required	Total Variance from 2023 Actuals
Paid Claims - Medical (IP, OP, Prof, Other)	$416.81		$416.81			18.9%	$338.03	-18.9%
Paid Claims - Pharmacy	$156.29		$156.29				$156.29	0.0%
Risk Adjustment (payable is positive)	-$150.40		-$150.40	16.0%	-$126.34		-$126.34	-16.0%
Administrative Expenses	$73.11		$73.11	-8.0%			$67.26	-8.0%
Risk Margin	$22.40	100.0%	$0.00	16.0%	$18.81		$0.00	-100.0%
Taxes & Exchange Fees	$47.29		$47.29	16.0%	$39.72		$39.72	-16.0%
Premium	$565.48		$543.09	16.0%	$475.01		$474.96	-16.0%
Loss Ratio	81.6%	3.0%	84.6%		n/a		84.6%	3.0%

Reimbursement Level Estimation

We used the estimate of reduction in medical claims to estimate the provider reimbursement that would be required to meet the market premium reduction target.

We first estimated the aggregate provider reimbursement levels as a ratio of Medicare reimbursement for the Nevada statewide individual market. We repriced the 2021 Wakely ACA (WACA) data adjusted to reflect Nevada morbidity using 2021 Medicare payment rates trended to 2023. The table below shows the estimated payment rates in Nevada statewide individual ACA market as a percent of Medicare.

Table 10: Nevada ACA Statewide Average Reimbursement Rates before Reduction

Category of Service	2023 ACA % of Medicare - Nevada
Inpatient	182%
Outpatient	236%
Professional	105%
Total	**172%**

We used Silver Summit's 2023 rating area factors which are intended to reflect unit cost differences by rating area to estimate the rating area 1 provider reimbursement rates[18]. These estimates are shown below. We assumed that the reimbursement levels would not go below 100% of Medicare and therefore, we floored the professional services reimbursement rates at 100% and reduced inpatient and outpatient to cover the difference.

Table 11: Nevada ACA Rating Area 1 Reimbursement Rates before Reduction

Category of Service	2023 ACA % of Medicare - Nevada
Inpatient	159%
Outpatient	207%
Professional	100%
Total	**153%**

We then applied the medical cost reductions calculated previously to estimate the reimbursement rates after reductions. We floored the reimbursement rate for any service category at 100% of Medicare and reduced the remaining service category reimbursement levels such that the average reimbursement was 18.9% lower for scenario 1. The resulting reimbursement rates are shown below.

[18] Note that for scenario 3 where we used Nevada statewide average costs to estimate reimbursement rates, we considered using 2021 Geographic Cost Factors published in the 2021 CMS Risk Adjustment Report. While this methodology produced different estimates of percent of Medicare, the reduction needed to provider reimbursement was different than stated in this report in an immaterial way (less than 1%).

Table 12: Nevada ACA Rating Area 1 Reimbursement Rates after Reduction

2023 ACA % of Medicare - Nevada			
Category of Service	**Scenario 1**	**Scenario 2**	**Scenario 3**
Inpatient	120%	111%	111%
Outpatient	156%	144%	144%
Professional	100%	100%	100%
Total	**124%**	**117%**	**117%**

Disclosures and Limitations

Responsible Actuary

I, Karan Rustagi, am the actuary responsible for this communication. I am a Fellow of the Society of Actuaries (FSA) and member of the American Academy of Actuaries (MAAA). I meet the Qualification Standards of the American Academy of Actuaries to issue this report.

Intended Users

This memorandum was prepared to summarize our analysis of Nevada's proposed 1332 waiver that would introduce a public option to the individual ACA market in the state. In addition, we reviewed Milliman's supporting analysis of Nevada's 1332 application and the conclusions therein. We relied on publicly available information and on discussions with and data provided by the Partnership in developing this memorandum. This information has been prepared for the sole use of the Partnership. Distributions to third parties should be made in its entirety and should only be evaluated by qualified users. Any third parties receiving this report should retain their own actuarial experts in interpreting results.

Risks and Uncertainties

The assumptions and resulting estimates included in this report are inherently uncertain. Users of the results should be qualified to use them and understand the results and the inherent uncertainty. Actual results may vary, potentially materially, from our estimates. Wakely does not warrant or guarantee that the estimated values for premiums or provider reimbursement rates included in the report will be attained. It is the responsibility of those receiving this output to review the assumptions carefully and notify Wakely of any potential concerns.

Conflict of Interest

Wakely provides actuarial services to a variety of clients throughout the health industry. Our clients include commercial, Medicare, and Medicaid health plans, the federal government and state governments, medical providers, and other entities that operate in the domestic and international health insurance markets. Wakely has implemented various internal practices to reduce or eliminate conflict of interest risk in serving our various clients. I, Karan Rustagi, am financially independent and free from conflict concerning all matters related to performing the actuarial services underlying this analysis. In addition, Wakely is organizationally and financially independent to the Partnership.

Subsequent Events

The release of updated rate filing data for 2024, the 2022 CMS risk adjustment report, changes in participation of insurers and their premiums, and any changes in the design of the public option plan may impact estimates included in this report. Changes in state and federal law and/or economic environment may also impact our estimates.

Contents of Actuarial Report

This document and the supporting exhibits/files constitute the entirety of actuarial report and supersede any previous communications on the project.

Deviations from ASOPs

Wakely completed the analysis using sound actuarial practice. To the best of my knowledge, the report and methods used in the analysis comply with the appropriate Actuarial Standards of Practice (ASOP) with no known deviations. A summary of ASOP compliance is listed below:

ASOP No. 23, Data Quality

ASOP No. 28, Statements of Actuarial Opinion Regarding Health Insurance Liabilities and Assets

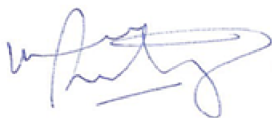
ASOP No. 41, Actuarial Communication

ASOP No. 42, Health and Disability Actuarial Assets and Liabilities Other than Liabilities for Incurred Claims

ASOP No. 45, The Use of Health Status Based Risk Adjustment Methodologies

Please do not hesitate to call if you have any questions or if we may be of additional assistance. Thank you for the opportunity to work on this important project.

Sincerely,



Karan Rustagi, FSA, MAAA
Director and Senior Consulting Actuary
720.531.6134 | karan.rustagi@wakely.com