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Senator Fabian Doñate
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Joint Interim Standing Committee on Health and Human Services

August 8, 2024

Chair Doñate and members of the Joint Interim Standing Committee on Health and Human Services ("Committee"), please accept this public comment relating to Agenda V, items 2 and 7, the work session for discussion and possible action on recommendations relating to "Silver State Health Insurance Exchange" and "Health Insurance Coverage for the Screening and Assessment of Certain Disorders and Disabilities."

After reviewing the work session document, the Division of Insurance ("Division") would like to mention and explain certain mechanics relating to the aforementioned items. To be clear, the Division is neither endorsing nor opposing either potential recommendation and is providing this comment solely as an educational opportunity for the members of the Committee to make the most informed decision possible.

Background

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, hereafter referred to collectively as the Affordable Care Act or "ACA", were passed in March 2010 with most major provisions coming online January 1, 2014. The ACA presented many health insurance reforms including, but not limited to, guaranteed issuance of policies, guaranteed renewability of policies, coverage of 10 categories of Essential Health Benefits ("EHB"), the elimination of certain lifetime and annual limitations of coverage, and the creation of the Exchanges. One of the most well-known of these new provisions was an adjustment to the Internal Revenue Code to provide Advanced Payment Premium Tax Credits ("APTC"), a tax policy mechanism to allow certain individuals with incomes at or below 400% of the federal poverty line to receive assistance with their health insurance premiums.[1]

The APTC provisions of the ACA generally work by limiting the amount an eligible individual might pay monthly for eligible insurance coverage. For example, an individual with an income of $27,180, 200% of the federal poverty line for an individual, would be limited to an annual insurance premium on an eligible insurance plan of not more than $543.60.

[1] 26 U.S. Code § 36B

To the extent that annual premiums exceed that amount, the federal government will make payments to the insurer on the consumer's behalf.

The ACA recognizes that this calculation leaves potentially unlimited exposure for APTC expenses if insurance premiums rise faster than incomes and enacted two provisions to keep inflation of APTC amounts in check: metal tiering and EHB.

Health benefit plans issued pursuant to the ACA are grouped into tiers, represented by metals, based on the actuarial value of the generosity of benefits the plans contain. Plans with an actuarial value of 60% are considered "bronze," 70% are considered "silver," 80% are considered "gold," and 90% are considered "platinum."[2] To prevent excessive APTC exposure for the federal government, the actual APTC amounts an individual receives are indexed to the second-lowest cost silver plan.[3] The APTC received by an individual is the cost of the second-lowest cost silver plan less their individual contribution amount. In other words, if the second-lowest cost silver plan is $8,000 annually our example individual from above would not pay more than $543.60 in premium for that plan and their APTC amount would be $7,456.40, the difference. The consumer is free to take that APTC of $7,456.40 and shop around, eventually paying less than $543.60 out of pocket in premiums if they buy a less expensive plan or paying more than $543.60 out of pocket in premiums if they buy a more expensive plan.

EHB are a set of 10 benefits all individual and small group plans in a state must cover, and consist of things like outpatient care, emergency care, laboratory services, and prescription drug coverage.[4] Each state has its own EHB "benchmark," a listing of benefits based on an existing plan which details the specifications of the 10 EHB.[5] While insurers may cover benefits in addition to the EHB, the federal government limits the APTC calculation to the premium amount attributable to EHB.[6] This means that adding benefits above EHB to health benefit plans will not increase the amount of APTC an individual is eligible to receive as the cost of the benefits above EHB will be ignored in the APTC calculation.

Defrayal

The ACA seeks to dissuade states from implementing benefit mandates above EHB by putting the cost of those mandates on the states. Through a process called "defrayal" or "defrayment" states are required to evaluate the benefits they mandate and determine if they exceed EHB. To the extent that they do, they will be excluded from the APTC calculation and states are required to reimburse consumers directly, or insurers on consumers' behalf, for the extra premium cost.[7] [8] The choice of reimbursing consumers or insurers on consumers' behalf is up to the state.

The state exposure to defrayal is eliminated for benefits mandated before December 31, 2011, and for benefits that are EHB.[9]

This defrayal mechanism is designed to prevent states from passing benefit mandates on health benefit plans and driving up the cost of insurance coverage under the assumption that consumers' premiums are capped by the APTC calculation, and the excess costs will be paid by the federal government.

As an example of a defrayal scenario, consider:

An individual making $27,180 per year is at 200% of the federal poverty line and has their annual premium capped at $543.60. If the second-lowest cost silver plan is $8,000 per year, the individual's APTC amount is $7,456.40. That individual's state passes a new benefit mandate, effective January 1, 2025, which increases all annual premiums by $100. That individual's annual premium contribution is still capped at $543.60 as their income did not change, their

[2] 42 U.S. Code § 18022(d)
[3] 26 U.S. Code § 36B(b)(2)
[4] 42 U.S. Code § 18022(b)
[5] 45 C.F.R § 156.111
[6] 26 U.S. Code § 26B(b)(3)(D)
[7] 42 U.S. Code § 18031(d)(3)(B)
[8] 45 C.F.R. § 155.170(c)
[9] 45 C.F.R. § 155.170(a)(2)

APTC amount is still $7,456.40 as the APTC is based on premiums only covering EHB and excluding new mandates, and the state is liable to pay $100, either to the individual directly or to their insurer on behalf of the individual.

To be explicitly clear, in any scenario in which defrayal is triggered, the state is financially liable for the increased cost to consumers resulting from the state mandate who are enrolled in qualified health plans subject to the mandate.

Item 7 – HEALTH INSURANCE COVERAGE FOR THE SCREENING AND ASSESSMENT OF CERTAIN DISORDERS AND DISABILITIES

The work session document for Item 7 describes the proposal to "Require private and public health insurers to provide coverage for individuals under 18 years of age or, if enrolled in high school, until the person reaches 22 years of age for the screening and assessment of attention deficit and hyperactivity disorder, fetal alcohol spectrum disorder, intellectual disabilities, and specific learning disorders."

This item appears to be a benefit mandate as the proposal requires "insurers to provide coverage" for a health-related screening item. This mandate would be effective on or after January 1, 2012, and is not currently part of Nevada's EHB package. To the extent that the mandate influences premiums, Nevada will be required to pay for this mandated coverage from the State General Fund or other mechanism.

Item 2 – SILVER STATE HEALTH INSURANCE EXCHANGE

The work session document for Item 2, part a, describes the proposal to "Require the Silver State Health Insurance Exchange – in consultation with the Commissioner of Insurance, Division of Insurance, Department of Business and Industry, and the Director of the Department of Health and Human Services (DHHS) – to apply for a State Innovation Waiver under Section 1332 of the Patient Protection and Affordable Care Act (ACA) (H.R. 3590, 111th Congress) through the Centers for Medicaid and Medicare Services (CMS). Specifically, the Exchange shall seek a waiver to Section 1312 (f)(3) of the ACA to the extent it would otherwise require excluding certain Nevada residents from enrolling in qualified dental and health plans of the State's Exchange Section."

Section 1312(f)(3) of the ACA, codified as 42 U.S. Code § 18032(f)(3), states:

"If an individual is not, or is not reasonably expected to be for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States, the individual shall not be treated as a qualified individual and may not be covered under a qualified health plan in the individual market that is offered through an Exchange."

It is the Division's inference that the intent of this item is to amend the applicability of Section 1312(f)(3) to Nevadans, resulting in certain otherwise ineligible individuals becoming eligible for coverage under a qualified health plan offered through the Silver State Health Insurance Exchange. If this inference is correct, it would have the effect of magnifying the impact of any current or future defrayal situation.

The ACA requires that states defray the cost of benefits in addition to the EHB if those benefits are required to be covered by a "qualified health plan."[10] For purposes of the ACA, for a plan to be offered through an exchange it must be a qualified health plan.[11] The result is a waiver to Section 1312(f)(3) increasing the number of individuals eligible to purchase through the Silver State Health Insurance Exchange also increases the number of individuals for whom the state is liable to defray costs in any current of future defrayal scenario. Please note that while a straightforward Section 1312(f)(3) waiver might not make individuals eligible for APTC, this is irrelevant to the issue of defrayal as the potential cost of defrayal is contingent only on an individual's enrollment in a qualified health plan and not receipt of APTC.

Conclusion

[10] 42 U.S. Code § 18031(d)(3)(A)
[11] 42 U.S. Code § 18021(a)(1)(A)

The Division would like to reiterate again that the agency is not advocating for or against either proposal on policy grounds, we are only bringing this discussion forward so that the Committee may make the most informed decision possible. We cannot, at this time, evaluate any proposal for estimated impact as exact language is not available.

We are available to answer any questions that the Committee may have on this matter.

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On behalf of

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