Steve Sisolak
Governor

Richard Whitley
Director

State of Nevada

Department of Health and Human Services

11-16-22 Meeting

Patient Protection Commission

Helping people. It's who we are and what we do.

Agenda

1. PPC Bill Draft Request Update
2. PPH Health Equity Plan
3. Nevada's Health Insurer Rate Review Process
4. Prioritization of Cost Growth Mitigation Strategies
5. Implications of Inflation for Assessing Cost Growth Benchmark Performance and Potential Options
6. Prioritizing Goals, Objectives, Activities of the PPC in 2023

PPC Bill Draft Request Update

PPC Health Equity Plan Requested for Feedback from the Commission for Posting on PPC Website

PPC Health Equity Plan

Slide 2 recommended edits:

- **Health equity** is achieved when every person has the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances. Health inequities are reflected in differences in length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to treatment. (Source https://www.cdc.gov/chronicdisease/healthequity/index.htm)

- **Health** is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. (Source https://www.who.int/about/governance/constitution)

Slide 3 recommended edits:

Initial feedback included recommendation to remove slide 3, as this is addressed in the suggested edits to slide 2.

PPC Health Equity Plan
(continued)

Slide 5 recommended edits:

- Include information from the 2021 Nevada Minority Health Report, such as:
  - Nevada's health disparities can be seen in the number and populations that acquire certain chronic diseases. Chronic disease such as heart disease, stroke, some cancers, respiratory disease, diabetes and liver disease represent five of the top 10 leading causes of death within our state. In Nevada, these health problems are most often found among American Indians, Asian Pacific Islanders and Blacks of non-Hispanic descent.

Slide 8 recommended edits:

- Would like to know **more specific steps** to take to ensure the cost growth benchmark does not lead to inequities.
- Outside of the cost growth benchmark **what other strategies** is the Commission taking to advance health equity?

Nevada's Health Insurer Rate Review Process

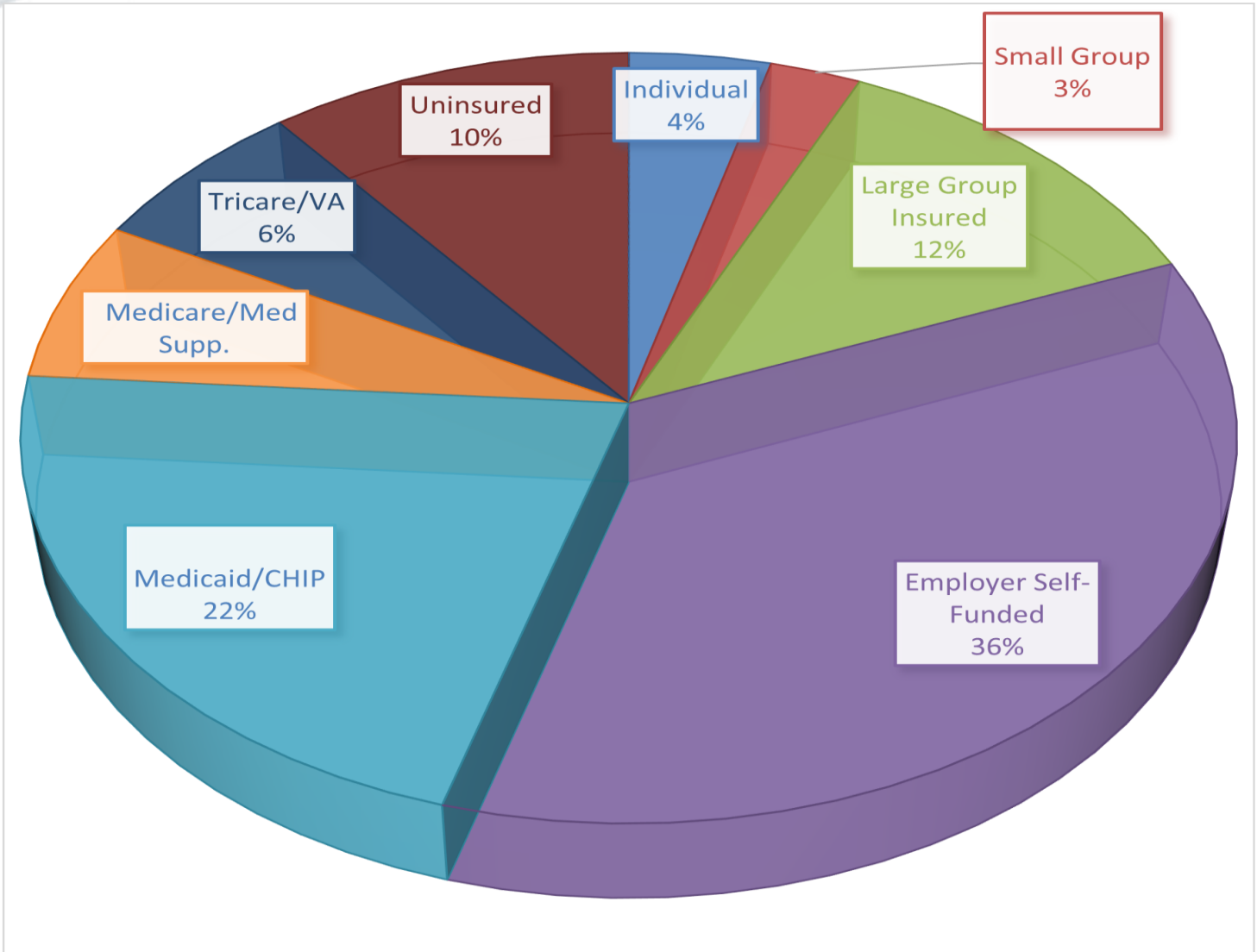
Sources of Health Coverage in Nevada

***NEVADA* DIVISION OF INSURANCE**

HIGH-LEVEL OVERVIEW OF HEALTH INSURANCE COVERAGE BY SOURCE OF COVERAGE IN NEVADA

Population / Coverage Category	Estimated Member Count	Member Count as a Percentage of Total State Population	Data Description	Data Source
Population of Nevada	3,145,184	100%	Certified 07/01/2020 Population Estimates	Nevada Dept. of Taxation
Individual Market	129,350	4.1%	Membership Effective 12/31/2021	NAIC I-Site
Small Group Market	83,340	2.6%	Membership Effective 12/31/2021	NAIC I-Site
Large Group Market (Fully Insured)	379,981	12.1%	Membership Effective 12/31/2021	NAIC I-Site
Group Market (Self-Funded)	1,122,684	35.7%	Estimate based on 2021 Kaiser Foundation Report	Kaiser Foundation
Medicaid / CHIP	679,846	21.6%	Medicaid /CHIP Enrollment 12/2020	Medicaid.gov
Medicare/Medicare Advantage*	210,063	6.7%	2020 Medicare and Medicare Advantage Enrollment	CMS.gov/ 2021 NV Med Sup Guide
Tricare/ VA Health Care (other public)	206,530	6.6%	Tricare Members 2020 + Table HI-05_ACS	Military Health System
Uninsured Estimate	333,390	10.6%	Estimate based on accessible data above	
Total Covered Population	2,682,988	89.4%	Estimate based on accessible data above	

Healthcare Results by Coverage Category



Division of Insurance Health Benefit Plan Rate Review Processes

Required Rate Filing Documentation

1. Rate Checklist
2. Actuarial Memorandum
3. Federal Premium Development Template
4. Nevada Data Template

Rate Approval Considerations

- Carrier Initial Rate Request
- Carrier Rate Modification – if applicable
- Actuarial recommended range of reasonable rate changes
- Contract Actuary Recommended Rate
- Division Staff Recommended Rate
- Summary of rate review assumptions

Nevada Medical Loss Ratio Rebates

	2014	2015	2016	2017	2018	2019	2020	2021
All Markets	**$4,049,168**	**$3,797,839**	**$6,243,165**	**$4,689,070**	**$6,451,083**	**$8,680,429**	**$14,383,246**	**$10,443,945**
Individual	$730,712	$304,236	$67,583	$0	$0	$9,819	$5,338,467	$3,506,856
Small Group	$2,900,801	$3,444,511	$4,055,811	$4,032,525	$6,432,012	$7,494,112	$6,342,430	$3,875,238
Large Group	$417,655	$49,092	$2,119,771	$656,545	$19,071	$1,176,499	$2,702,349	$3,061,851

Source: https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr

Patient Protection Commission Questions

1. Positive and failing aspects of our current rate review.

2. How many rate requests have they felt that they couldn't deny and what [rate review] criteria are missing?

3. How do we feel about implementing and strengthening rate review powers?

4. Do we have the capacity to take on large group rate review.

R.I. Large Group Rate Review

- OHIC reviews the average expected percentage change in premiums from one year to the next, holding benefits constant, across all employers that are up for renewal within a given market. This average expected premium increase is comprised of rate factors that are applied to the employer's existing experience. The resulting weighted average increase across an insurer's large group market represents a maximum average increase that the insurers are committed not to exceed.

NV and R.I. Large Group Experience

Average Premiums per Covered Life	2014	2015	2016	2017	2018	2019	2020	2021
Nevada Large Group	3,796	3,939	4,193	4,375	4,492	4,623	5,040	4,983
Rhode Island Large Group	5,174	5,302	5,292	5,532	5,684	5,874	5,966	6,402

Year over Year Premium Changes	2014	2015	2016	2017	2018	2019	2020	2021
Nevada Large Group	4.3%	3.8%	6.4%	4.3%	2.7%	2.9%	9.0%	-1.1%
Rhode Island Large Group	8.2%	2.5%	-0.2%	4.5%	2.8%	3.3%	1.6%	7.3%

Questions?

Prioritization of Cost Growth Mitigation Strategies

Recap of Cost Growth Mitigation Strategy Presentations

- Over the last two PPC meetings, Bailit Health has presented overviews of the following four cost growth mitigation strategies:
  1) Provider price cap and/or price growth cap
  2) Prescription drug affordability strategies
  3) Strengthening and expanding health insurance rate review
  4) Promoting multi-payer value-based payment
- These strategies are informed by the Phase 1 cost growth driver analyses using Medicaid and PEBP data, which showed prices as driving high spending growth. They are intended to help Nevada keep health care spending growth below the cost growth benchmark.
- The following slides provide a brief recap of each cost growth mitigation strategy, plus:
  - a summary of Commissioner feedback and questions
  - an assessment of the feasibility of implementation

Provider Price Cap and Price Growth Cap (1 of 4)

- Summary:
  - Provider price cap is a limit on provider payment rates in the commercial market. It can be set to market rates, Medicare prices or another reference. This strategy can be applied
    - broadly to include in-network and out-of-network care;
    - more narrowly, e.g., only for out-of-network payments;
    - for specific types of services, or
    - for payments only within specific programs (such as state employee benefit programs, as in MT and OR).
  - Provider price growth cap is a limit on the amount insurer prices paid to providers can grow annually. A price growth cap can be applied broadly across all contracted providers, or to only certain classes of providers, for example, to hospitals (e.g., in DE and RI).

Provider Price Cap and Price Growth Cap (2 of 4)

- Feedback from Commissioners:
  - Some support for the policy of establishing a price cap as a percentage of Medicare, and request to hear from the states that use that approach (Montana and Oregon) on what's working/not working.
  - Some support for price growth caps over price caps.
  - Concern that both proposals would impede access.
  - Request for further information on the potential for unintended consequences of these strategies, and any strategies employed to mitigate against such consequences.
  - Request for further information on Rhode Island's price growth cap and how rate review is used as an enforcement mechanism.
- Potential next steps:
  - The PPC could request presentations from Rhode Island, Montana and/or Oregon to learn from their experience implementing these strategies.

Provider Price Cap and Price Growth Cap (3 of 4)

Price cap: Feasibility of implementation and potential impact	
Political feasibility	Challenging due to the likelihood of strong opposition from whichever provider type(s) might be targeted
Financial feasibility	Low implementation costs for both the state and provider entities
Administrative complexity	Low complexity; can be enforced through purchasing authority and/or existing insurance regulation

Potential impact on slowing health care cost growth	Significant impact; variation based on whether caps are applied broadly (e.g., across the commercial market) or more narrowly (e.g., for out-of-network payments, within PEBP or within a public option), whether to target certain categories of services (e.g., hospital inpatient and/or outpatient, professional services), and where the cap is set

Provider Price Cap and Price Growth Cap (4 of 4)

Price growth cap: Feasibility of implementation and potential impact	
Political feasibility	Challenging due to the likelihood of strong opposition from whichever provider type(s) might be targeted
Financial feasibility	Low implementation costs for both the state and provider entities
Administrative complexity	Low complexity; enforced through existing insurance regulation

Potential impact on slowing health care cost growth	High impact; variation based on how broadly caps are applied (e.g., all hospitals vs. certain classes of providers with highest price growth), and where the cap is set

Prescription Drug Affordability Strategies (1 of 3)

- Summary:
  - Strategies to addressing prescription drug costs in the commercial market include:
    1) Regulation of prescription drug payments
       - Creating a Prescription Drug Affordability Board to establish “upper payment limits,” i.e., the maximum amount all purchasers and payers in the state would pay for a certain prescription drug.
       - Using international reference pricing to establish “upper payment limits”
    2) Penalties on excess drug prices
       - Penalizing pharmaceutical manufacturers if drug price increases are unsupported by new clinical evidence
       - Penalizing pharmaceutical manufacturers if drug price increases exceed a target growth rate, such as inflation plus a specified amount.

Prescription Drug Affordability Strategies (2 of 3)

- Feedback from Commissioners:
  - General interest in these strategies given the role prescription spending is playing as a cost driver.
  - Interest from multiple Commissioners in learning more about international reference pricing, including other comparators aside from Canada.
  - Some concern and lack of support for the proposals to impose financial penalties.
  - Request for information on potential legal challenges that would be anticipated for any of these proposals.
- Potential next steps:
  - The PPC could receive a presentation from the National Academy for State Health Policy (NASHP) regarding international reference pricing and anticipated legal challenges.

Prescription Drug Affordability Strategies (3 of 3)

Feasibility of implementation and potential impact	
Political feasibility	Challenging due to the likelihood of strong opposition from the pharmaceutical industry
Financial feasibility	• *Drug Affordability Board*: High implementation costs for state • *International reference pricing*: Medium/low costs for state • *Penalizing excess drug prices*: Medium/low costs for state
Administrative complexity	• *Drug Affordability Board*: High complexity • *International reference pricing*: Low complexity • *Penalizing excess drug prices*: Medium/low complexity
Potential impact on slowing health care cost growth	• *Drug Affordability Board*: Low impact if the number of impacted drugs is small • *International reference pricing*: Medium to high impact based on the number of drugs subject to the upper payment limit • *Penalizing excess drug prices*: Low to medium impact based on number of drugs that trigger penalties and the amount of the penalties

Health Insurance Rate Review (1 of 3)

- Summary:
  - Rate review authorizes the Division of Insurance to approve, disapprove or modify proposed health insurance rate increases for individual and small group plans, which form the basis for premiums.
  - While the Affordable Care Act mandates minimum requirements for rate review, states can take further steps to strengthen the rate review process.
  - Potential mechanisms for Nevada include incorporating affordability/public interest criteria, expanding review authority to the large group insurance market, further enhancing transparency and public engagement through holding public informational hearings, and/or using rate review as tool to enforce other cost growth mitigation strategies, if pursued.

Health Insurance Rate Review (2 of 3)

- Feedback and questions from Commissioners:
  - Interested in hearing from the Nevada Commissioner of Insurance regarding:
    - How the current rate review process works and how/whether it can be improved
    - How many rate increase requests has DOI felt that they couldn't deny due to current limitations and what criteria is missing
    - Whether DOI has the capacity to expand rate review authority to the large group market
  - The PPC is encouraged to consider how the Insurance Commissioner's feedback presented during today's PPC meeting impacts whether to further explore this strategy.

Health Insurance Rate Review (3 of 3)

Feasibility of implementation and potential impact	
Financial feasibility	
Administrative complexity	Low to medium complexity based on mechanisms pursued
Potential impact on slowing health care cost growth	

Multi-Payer Value-Based Payment (1 of 3)

- Summary:
  - Value-based payment (VBP) is a strategy by which health care purchasers and payers use payment to hold provider organizations accountable for quality and cost of care. Advanced VBP models involve risk transfer and may include prospective payment.
  - VBP models can potentially slow the rate of health care cost growth by applying a budgeting mechanism to payment.
  - Moving towards VBP models is most effective when multiple payers (commercial, Medicaid, Medicare) align around common VBP model elements, such as quality measures and payment structure.

Multi-Payer Value-Based Payment (2 of 3)

- Feedback and questions from Commissioners:
  - Interest in further understanding the impact on vulnerable/chronically ill patients; would want to ensure that any strategy is designed to mitigate against any financial incentives to limit care.
  - Interest in learning about any VBP models currently in use in Nevada to understand from the provider and payer perspective what has worked well and what hasn't.
- Potential next steps:
  - PPC could receive a presentation from Medicaid and/or other entities in Nevada with experience implementing VBPs.

Multi-Payer Value-Based Payment (3 of 3)

Feasibility of implementation and potential impact	
Political feasibility	Level of support or opposition from payers and providers will depend on the scope of VBPs and extent to which providers are expected to take on financial risk
Financial feasibility	Medium implementation costs for the state to facilitate multi-stakeholder planning
Administrative complexity	Medium complexity, although will vary based on the model selected

Potential impact on slowing health care cost growth	Varies based on model selected and the type of budgeting mechanism applied to payments

Discussion

- Which of these strategies, if any, is the PPC interested in further exploring for potential prioritization in 2023?
- Which alternative cost growth mitigation strategies, if any, is the PPC interesting in exploring for potential prioritization in 2023?

Implications of Inflation for Assessing Cost Growth Benchmark Performance and Potential Options

What is Inflation?

- Inflation measures how prices of goods and services increased from a prior time period. There are several indices that measure inflation and the choice of which one to use should reflect the questions at hand.
- The methodology of the current cost growth benchmarks includes a weight of potential gross state product (PGSP), which uses Personal Consumption Expenditures (PCE) as the measure of inflation. PCE is defined as "a measure of the prices that people living in the U.S. pay for goods and services." It is derived from a survey of businesses and what they sell. It is the Federal Reserve's preferred measure when setting monetary policy.

Inflation in the Cost Growth Benchmark (1 of 2)

- Governor's Executive Order
  - Established the following cost growth benchmarks:

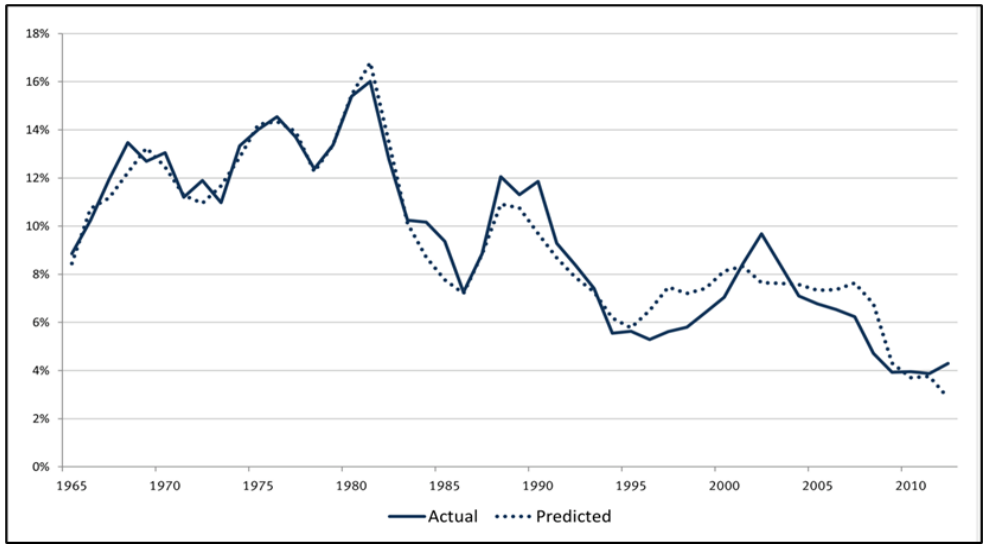
Year	Median Wage Weight	Gross State Product Weight	Benchmark Value
2022	20%	80%	3.19%
2023	35%	65%	2.98%
2024	50%	50%	2.78%
2025	65%	35%	2.58%
2026	80%	20%	2.37%

  - PPC may recommend changes to the cost growth benchmarks, or recommend changes to the manner in which benchmark performance is assessed, "*should the PPC find that there have been significant changes to the economy.*"

Statistical Relationship Between Inflation and Health Care Spending

- Inflation and growth in real GDP are highly predictive of growth in health care spending.

Growth in Health Care Spending, Actual and Predicted



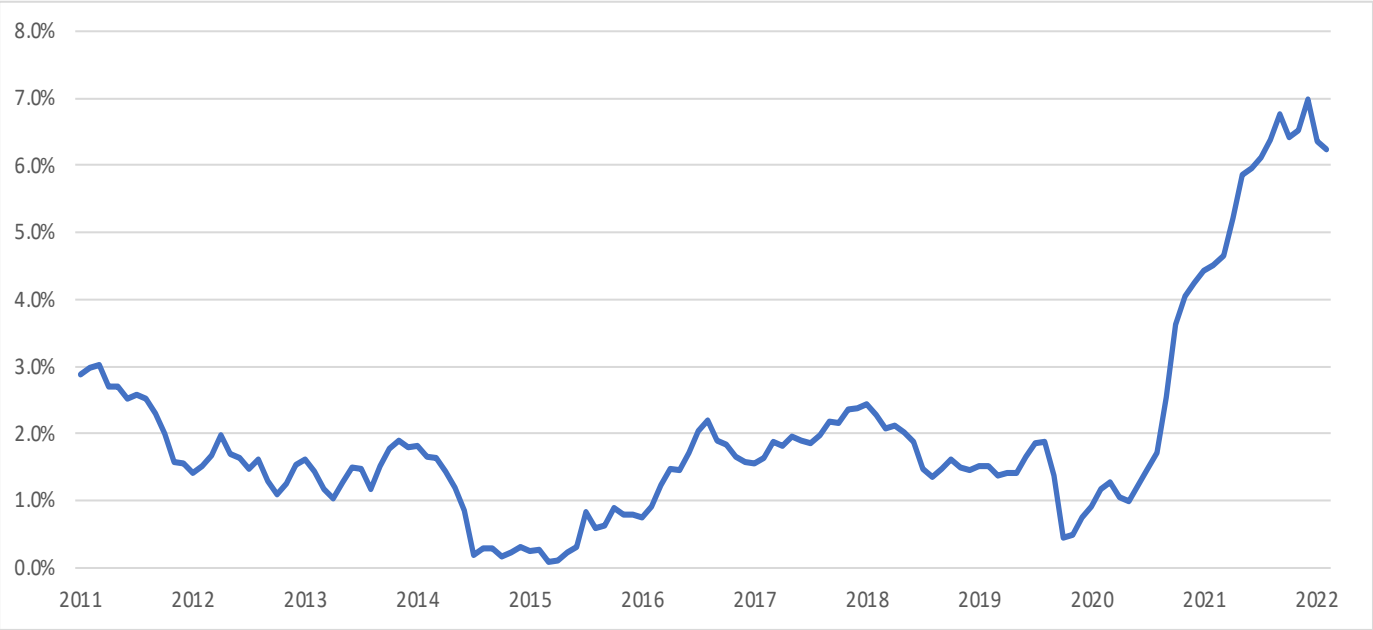
Source: Analysis by the Kaiser Family Foundation and the Altarum Center for Sustainable Health Spending, 2013.

Statistical Relationship Between Inflation and Health Care Spending (continued)

- While there is a close relationship, the effects of inflation and real GDP aren't seen in health care spending immediately.
- The effect of inflation on health care spending lags over two years. This is due to the prospective nature by which prices are set for health care services.
  - Commercial payer prices are often established in multi-year contracts.
  - Public payers set prices prospectively and don't always change them frequently.

Inflation in the U.S., 2011-2022

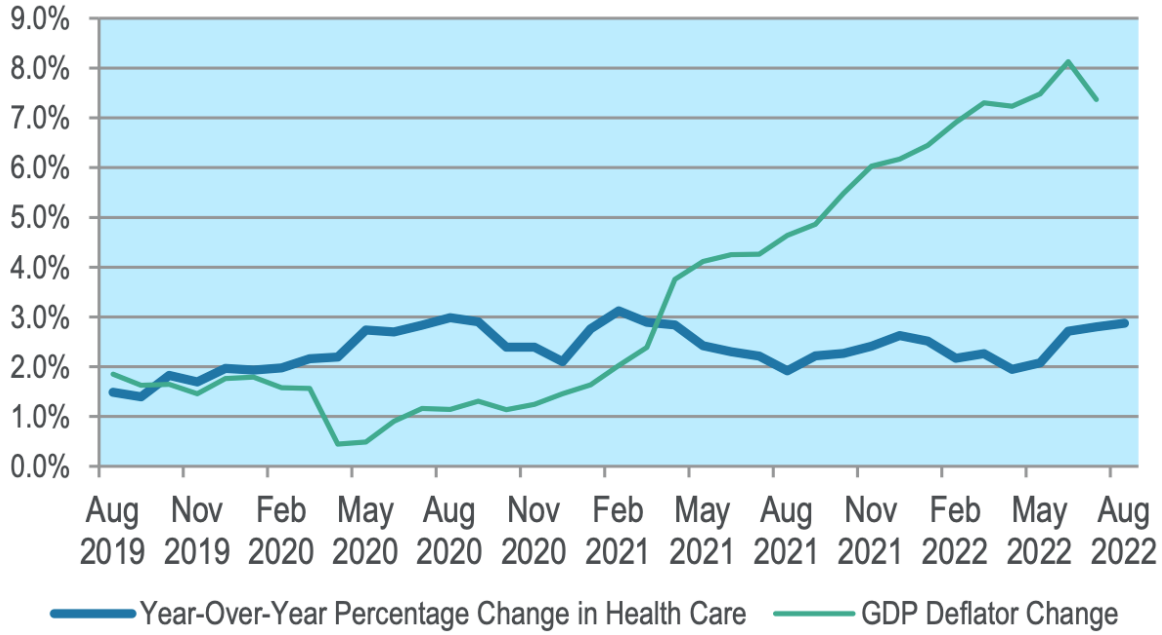
- Inflation (PCE) has climbed dramatically since late 2021.



Source: Bureau of Economic Analysis

Healthcare Prices in the U.S., August 2019 - August 2022

- Health care prices began to rise slightly in the summer of 2022.



Source: Altarum analysis of monthly BLS price data and monthly GDPD data published by Macroeconomic Advisors.

In Summary

1. Inflation impacts health care spending growth.
2. The impact is not immediate, but is delayed or "lagged."
3. General inflation in the U.S., as measured using PCE, is dramatically higher than it has been for the past two decades.
4. Health care prices in the U.S. have grown at slightly elevated rates the last few months. We can anticipate elevated growth into 2023.

Finally, we note that general inflation is forecast to significantly drop in 2023, largely in response to rising interest rates.

Potential Options for Responding to Inflation and Workforce Cost Pressures

Option 1: Make no adjustments. Commit to acknowledge the impact of inflation and labor shortages when interpreting results.	
Pros	**Cons**
1. Consistent with the original intent for the benchmark values to be established for long-term use. 2. Maintains some degree of accountability for affordability during a period when wages are not growing as fast as inflation.	1. Removes the certainty and thus the influence of the benchmark value in constraining spending growth. 2. Sanctions increased rates of spending growth without any prospectively defined restraint.

Potential Options for Responding to Inflation and Workforce Cost Pressures

(2 of 3)

Option 2: Create a specific allowance for exceeding the benchmark on a time-limited basis for those years with very high inflation.

Pros	Cons
1. Maintains benchmark values, but creates a temporary adjustment to inform interpretation of performance, thereby acknowledging the impact of inflation and labor shortages. 2. Maintains accountability for affordability, albeit at temporarily increased levels.	1. Sanctions increased rates of spending growth. 2. Could be viewed as equivalent to changing benchmark values, and thus sets a precedent for doing so.

Potential Options for Responding to Inflation and Workforce Cost Pressures

(3 of 3)

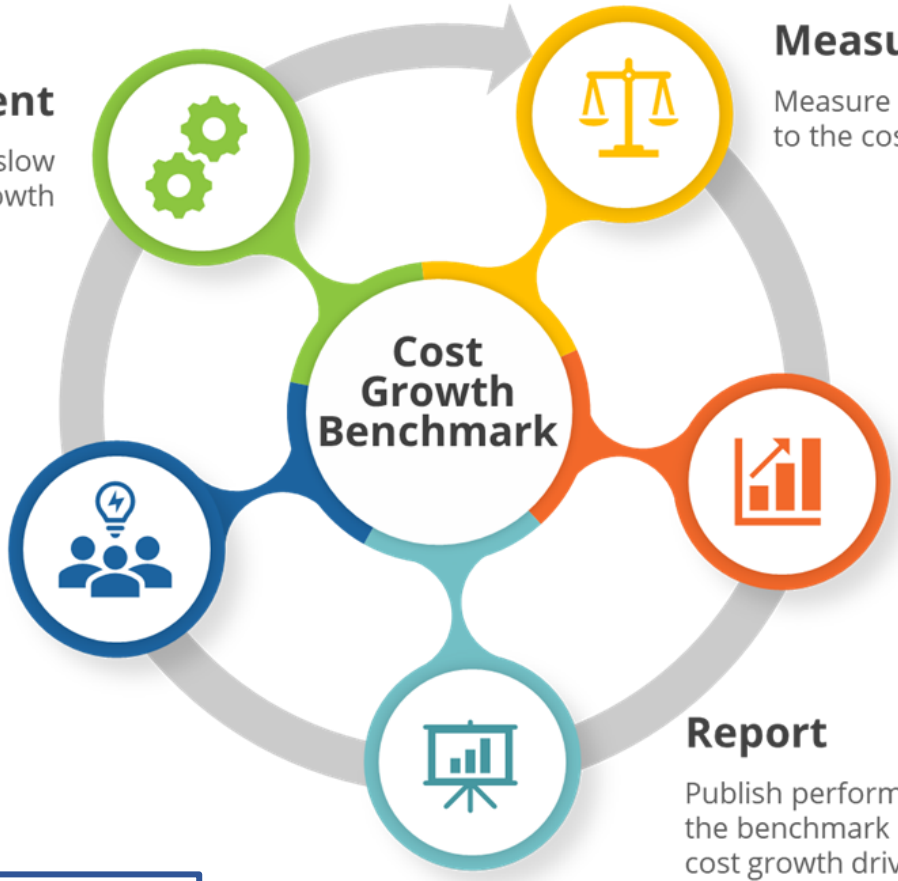
Option 3: Redefine the benchmark values on a time-limited basis for those years with very high inflation.

Pros	Cons
1. Acknowledges the impact of inflation and labor shortages. 2. Maintains accountability for affordability, albeit at temporarily increased levels.	1. Sanctions increased rates of spending growth. 2. Sets a precedent for modifying benchmark values.

Questions & Discussion

Prioritizing Goals, Objectives, Activities of the Commission in 2023

Nevada's Health Care Cost Growth Benchmark Project



Measure

Measure performance relative to the cost growth benchmark

Focus: **Phases 1&2; Aggregate Baseline Spending**

Analyze

Analyze spending to understand cost trends and cost growth drivers

Report

Publish performance against the benchmark and analysis of cost growth drivers

April 2023: **baseline benchmark findings reported!**

Implement

Implement strategies to slow cost growth

Focus: **Cost Growth Mitigation Strategies**

Identify

Identify opportunities and strategies to slow cost growth

Focus: Health Care Affordability

Planning for 2023

Suggested added priorities thus far:

- Goal: Improve health care **accessibility**
  - Objective 1: Increase the percentage of medical school residents and nurses who remain in NV following their residency.
    - Activity 1: Survey medical and nursing residents *statewide* to determine what motivates them to either stay in or leave Nevada after completion.
  - Other objectives?
- Goal: Meet Annual Statutory Requirements:
  - Objective 1: On or before January 1 and July 1, compile a **report** describing the meetings of the Commission and the activities of the Commission during the immediately preceding 6 months.
  - Objective 2: Annually update a **plan** to increase access by patients to their medical records and provide for the interoperability of medical records between providers of health care and submit to the DHHS Director.
    - *Note: this Plan is currently being developed and a final draft will be shared with the Commission in advance of the December 2022 meeting.*

Additions to suggested focus on health care **affordability** and **accessibility** in 2023?

Meeting Cadence in 2023

Options include:

1. Meet 100% virtual
2. Meet in-person 2x/year, otherwise virtual
3. Meet in-person 4x/year, otherwise virtual

9:00am, 3rd Wednesday of the month still work for everyone?