State of Nevada

DEPARTMENT OF BUSINESS AND INDUSTRY

Division of Insurance

Scope of Authority and State-Mandated Benefits

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Nevada Division of Insurance (DOI)

Mission and Functions

- **To protect Nevada consumers and to ensure insurance carriers are solvent**
- Regulation of **Nevada's $25 billion** insurance industry, Title 57 in NRS – Largest in Nevada Statutes
- Areas regulated include: Property, Casualty, Life, Health, Long Term Care, Title, Service Contracts, Workers Compensation, Funeral/Burial Pre-Need, and Bail Bonds Surety
- Currently **1,485 authorized insurers** in Nevada and **140 domestic carriers**
- **249,178 active individual** licensed producers, including **24,159 resident producers**. 16,639 other licenses for a total of **265,817 active licenses** including traditional carriers, reinsurance companies, risk retention groups, captive insurance companies, third party administrators (including PBMs), and service contract providers
- Approval of rates and forms, financial and market examinations of insurers, consumer support
- **Over $600 million annually** in insurance premium tax generated for the General Fund

DIVISION OF INSURANCE

Protect Consumers, Ensure Solvency

Overview of Healthcare Market in Nevada

Overview of Healthcare Market

Nevada's Health Insurance Industry:

Nevada's health insurance market continues to represent the largest segment of direct written premiums, making up approximately 40% of the State's total.

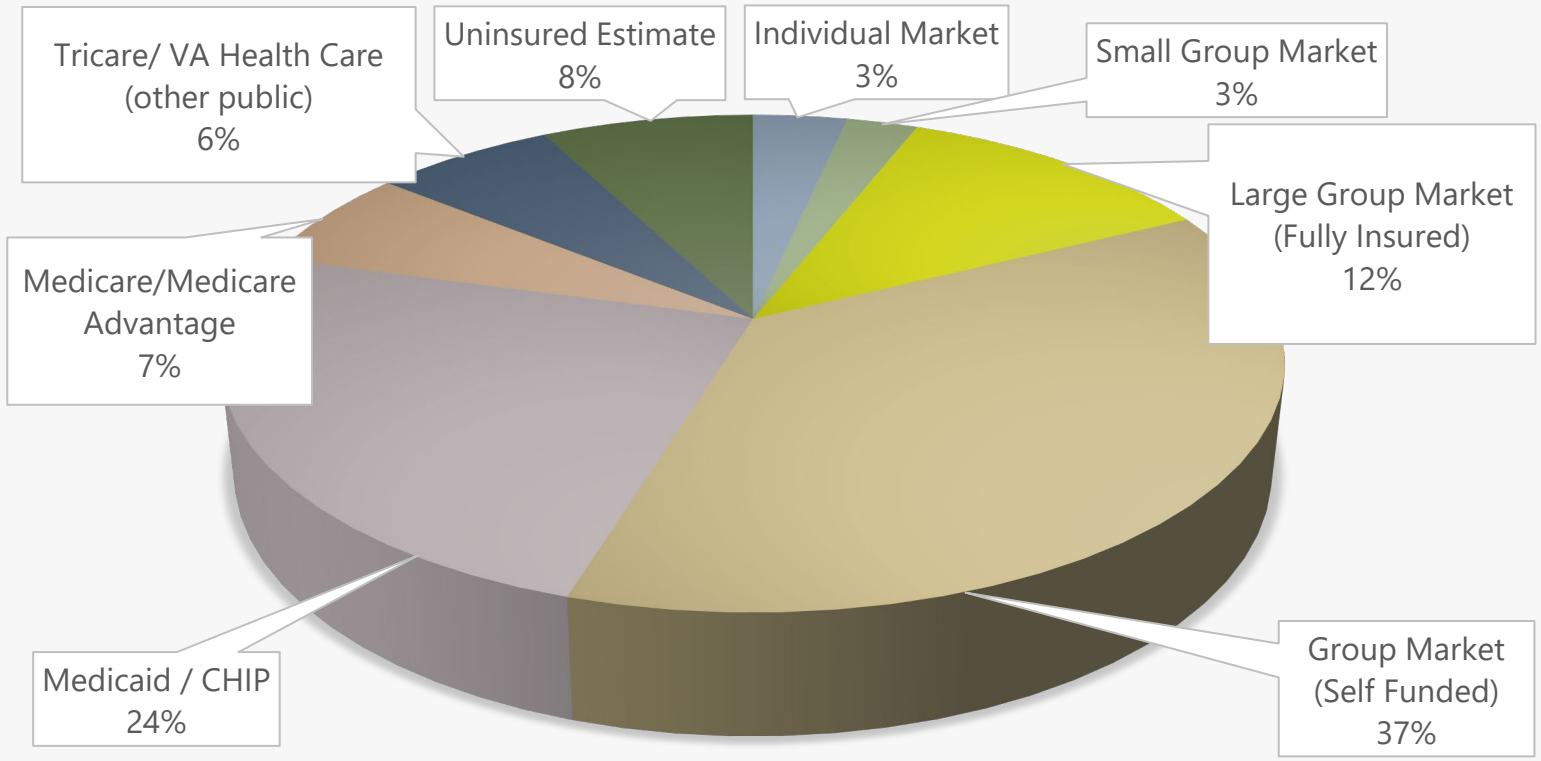
The Division's Key Functions:

- The Division is responsible for the analysis, review and approval (or disapproval) of rates and forms.
- The Division reviews Nevada insurers' rate and form filings to ensure a competitive and stable market for consumers.
- The insurance products regulated by the Division are separately controlled by twenty-five different chapters of the NRS. Notably, life and health insurance products are subject to standards defined in NRS 686B.050, which means that rates cannot be inadequate, excessive, or unfairly discriminatory.

2023 Healthcare Results By Coverage Category

The graph provides an overview of the healthcare coverage by payor source in Nevada.

- The Division regulates the individual and small group markets, which represent products held by approximately 5.6% of the state's population.
- The Division reviews and approves policy forms used in the fully insured large group market (employers with 51 or more employees).
- The Division has no authority to review large group plan rates, provider networks, or drug formularies.



DIVISION OF INSURANCE

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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	

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~19%

Essential Health Benefit (EHB) Benchmark and Defrayal

EHB Benchmark

- Federal law requires states to select a "benchmark" plan defining benefits (essential health benefits, or EHB) in 10 categories that all applicable plans must cover (42 U.S.C. § 18022)
- EHB may not be subject to annual or lifetime limits on benefits (42 U.S.C. § 300gg-11)
- States may elect to change the benchmark plan selection, and the resulting EHB, subject to certain limitations (45 CFR § 156.111)
- Beginning in Plan Year 2026 States may elect to add or remove EHB benefits on a piecemeal basis, though strict numerical standards apply to the generosity and typicality of benefits added
- Beginning in Plan Year 2027 the generosity standard no longer applies to EHB benefits added on a piecemeal basis

APTC – Advanced Payments of the Premium Tax Credit

- To promote affordability of insurance the ACA authorizes tax credits for individuals purchasing Qualified Health Plans through an Exchange. These credits can be claimed on the individual's IRS tax return filed after the year ends or as APTC, calculated and paid by the US Treasury to the insurer during the plan year

- Calculation of APTC is based on your projected income and the cost of the second-lowest priced silver plan in your geographic rating area

- Key: Because the cost of the second-lowest priced silver plan is a factor in the APTC calculation, rising premium costs, for whatever reason, increase the value of the APTC to consumers and costs to the federal government

Federal Defrayal

- Envisioning that States might take advantage of the APTC formula to pass new state-mandated benefits, the ACA locks the benefits that the federal government will pay for to those that are (1) in existence before December 31, 2011 and (2) part of the State's EHB package
- Any state-mandated benefits which do not meet the two requirements as considered "additional required benefits" under federal law (42 USC § 18031(d)(3))
- Under that same federal law, "a State may require that a qualified health plan… offer benefits in addition to the essential health benefits" and "a State shall make payments… to defray the cost of any additional benefits" so required (42 USC § 18031(d)(3)(B))

Federal Defrayal

45 CFR § 155.170 Additional required benefits

(a) ***Additional required benefits.***

(1) A State may require a QHP to offer benefits in addition to the essential health benefits.

(2) A benefit required by State action taking place on or before December 31, 2011, a benefit required by State action for purposes of compliance with Federal requirements, or a benefit covered in the State's EHB-benchmark plan is considered an EHB. A benefit required by State action taking place on or after January 1, 2012, other than for purposes of compliance with Federal requirements, that is not a benefit covered in the State's EHB-benchmark plan, is considered in addition to the essential health benefits.

(3) The State will identify which State-required benefits are in addition to the EHB.

(b) ***Payments.*** The State must make payments to defray the cost of additional required benefits specified in paragraph (a) of this section to one of the following:

(1) To an enrollee, as defined in § 155.20 of this subchapter; or

(2) Directly to the QHP issuer on behalf of the individual described in paragraph (b)(1) of this section.

(c) ***Cost of additional required benefits.***

(1) Each QHP issuer in the State shall quantify cost attributable to each additional required benefit specified in paragraph (a) of this section.

(2) A QHP issuer's calculation shall be:

(i) Based on an analysis performed in accordance with generally accepted actuarial principles and methodologies;

(ii) Conducted by a member of the American Academy of Actuaries; and

(iii) Reported to the State.

Federal Defrayal - Calculation

- The State's primary responsibility under defrayal is to identify which benefits are (1) State-required and (2) in addition to the EHB (45 CFR § 155.170(a)(3))
- Once a State has identified mandates subject to defrayal, the *QHP issuers* have the duty to calculate the financial impact (45 CFR § 155.170(c)(1))
- State is defraying "the cost of additional required benefits" and payments can be made to (1) an enrollee or (2) a QHP issuer on behalf of an enrollee
  - Implication is premium-side calculation
  - CMS has been permitting States to use a claims-incurred calculation
- Regulation uses terms "QHP," "QHP issuer," and "an enrollee, as defined in § 155.20 of this subchapter"
  - Enrollee "means a qualified individual… enrolled in a QHP."
- Federal rules necessitate that someone not receiving APTC but enrolled in a QHP may still trigger defrayal!

Federal Defrayal - Payment

- Federal agencies have given little guidance on how the payment mechanism should work

- Premium rate basis
  - Implied by the regulation
  - Offers States PMPM certainty
  - Varies only by QHP enrollment
  - No States currently use this method

- Claims-incurred basis
  - Clear audit and fiscal accountability trail
  - Less susceptible to unjust enrichment
  - Removes incentive for insurers to control costs
    - "Open checkbook"
  - All States currently use this method

  - "The State must make payments…" (45 CFR § 155.170(b))
    - Which State agency?
    - General Fund?
      - How is it appropriated?

QUESTIONS?