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ResearchReport

Nevada Care Plan

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Issue

This report summarizes Assembly Bill 374 (AB 374), Nevada's "Medicaid-for-All" bill. Nevada governor Brian Sandoval vetoed the bill in 2017.

Summary

The Nevada legislature considered and passed AB 374 during its 2017 regular session. The governor vetoed the act, which would have required the Nevada Department of Health and Human Services director to establish a plan allowing people who are not eligible for Medicaid to buy in to the state's Medicaid program. The plan (the Nevada Care Plan) would cover the same services as the state's fee-for-service Medicaid program except for nonemergency medical transportation.

The act authorized the department to apply for federal waivers in order to (1) contract with one or more insurers to provide coverage for those enrolled in the Nevada Care Plan and (2) allow someone eligible for federal health insurance subsidies to use them to purchase the Nevada Care Plan. The department may also need a waiver to enable the sale of the plan on the state's exchange.

The governor vetoed the act, stating that it relied on a number of assumptions without a sufficient factual record and that he feared unintended consequences. The governor mentioned other ways to examine concepts raised in the act, including SB 394, which requires a legislative committee to study how the state might establish a program for purchase that is similar to its managed care Medicaid program.

AB 374

Summary

AB 374, as amended by Amendment No. 745, requires the Nevada Department of Health and Human Services (DHHS) director to establish "the Nevada Care Plan" within the state's Medicaid program and allow individuals who are not eligible for Medicaid to purchase coverage through the plan. Under the act, the Nevada Care Plan must provide the same coverage as that provided to Medicaid recipients who do not participate in a managed care program (i.e., fee-for-service enrollees), except for nonemergency medical transportation. (Federal law requires state Medicaid programs to include coverage for transportation to and from necessary medical appointments (42 C.F.R. § 431.53).)

The act requires the director to apply to the federal Department of Health and Human Services for a Medicaid demonstration waiver or state innovation waiver to allow:

1. the DHHS director to enter into a contract with one or more insurers to provide coverage to those who enroll in the Nevada Care Plan, and

2. a person who is eligible for advance payments of the federal premium tax credit and cost-sharing reductions (see below) to use the credits and deductions to purchase coverage through the Nevada Care Plan.

If the federal agency approves any necessary waivers, the act authorizes the director to enter into a contract with one or more insurance providers to provide coverage for the Nevada Care Plan and make the plan available on the state's health insurance exchange. The act requires the director, in consultation with the insurance commissioner and the health exchange executive director, to adopt any necessary regulations to carry out the act's provisions.

The act expands the definition of "qualified health plan" to include the Nevada Care Plan, allowing it to be sold in the same manner as other health plans through the state's insurance exchange. It also appropriates $89,540 each year for FYs 18 and 19 to the DHHS's Division of Health Care Financing and Policy for administrative expenses to establish and administer the Nevada Care Plan.

Waivers

The act requires the DHHS director to apply for Medicaid demonstration waivers or state innovation waivers as necessary to implement certain provisions.

Medicaid demonstration waivers (also known as § 1115 waivers) allow states to apply to the federal Centers for Medicare and Medicaid Services (CMS) within Department of Health and Human Services for approval of experimental, pilot, or demonstration projects (42 U.S.C. § 1315). CMS reviews each proposal to determine whether its stated objectives are aligned with Medicaid. According to CMS, demonstrations must be "budget neutral" to the federal government and they are generally approved for an initial five-year period and can be extended for up to an additional three to five years.

State innovation waivers (also known as § 1332 waivers) allow states to waive certain Affordable Care Act requirements and implement their own plans to provide health coverage to state residents, as long as the plans meet certain minimum requirements (42 U.S.C. § 18052). The secretary of the Department of Health and Human Services and the treasury secretary review state innovation waiver applications. More information can be found at CMS's website and this Congressional Research Service report.

According to testimony by the executive director of Nevada's health exchange, the state would need a state innovation waiver to implement several of the act's provisions, including one granting permission to move from a HealthCare.gov platform to a private eligibility platform, which would allow them to design rules that would allow sales of the Nevada Care Plan through the platform.

Medicaid Managed Care

While the majority of Nevada's Medicaid population is served through a managed care delivery model, the act requires the Nevada Care Plan to mirror coverage provided through a fee-for-service model. DHHS staff testified that managed care programs include "carve outs" or exceptions for various populations, geographic regions, and services, and so they believed fee-for-service was a better model to use.

Premium Tax Credits and Cost Sharing Reductions

Under the Affordable Care Act, premium tax credits and cost sharing reductions subsidize the cost of health insurance for those individuals who meet income requirements and purchase insurance through a state or federal health insurance exchange. Plans on exchanges are standardized into four levels: bronze (low premium, high out-of-pocket cost), silver, gold, and platinum (high premium, low out-of-pocket cost).

Individuals with incomes under 400% of the federal poverty level (FPL) who are not eligible for Medicaid are eligible for premium tax credits to reduce their monthly payments for insurance plans purchased through insurance exchanges. The credits effectively set a cap on the amount an individual or family must spend for health insurance based on a "benchmark" plan (i.e., the second-lowest cost silver plan available in the state's exchange). Like Connecticut, Nevada has expanded Medicaid to those earning up to 138% FPL, and so tax credits are effectively available to those making 138 to 400% FPL.

Cost sharing subsidies reduce the out-of-pocket costs of using health insurance (e.g., deductibles, copayments, and coinsurance). These subsidies can only be applied toward a silver plan. Although the federal government has recently announced that it will no longer reimburse insurers for these subsidies, insurers are still required to provide them.

The act requires the DHHS director to apply for federal waivers to allow those who are eligible for premium tax credits or cost sharing subsidies to use them to purchase Nevada Care Plans through the state's exchange. Waivers may be needed to address several issues, including processing eligibility for subsidies for those purchasing Nevada Care Plans and allowing use of subsidies for the plan when it does not fit into a standardized level (e.g., bronze, silver).

Governor's Veto

In his veto message, the governor supported the concept, but stated that it needed more study and that the act "raises more questions than it answers, while adding more uncertainty to an industry that needs less." He argued that the act's provisions could have unintended negative consequences and raised as an example the possibility that those moving to the Medicaid plan could be switching from other insurance rather than moving from the pool of uninsured. He argued that because health care providers have to maintain a mix of patients on Medicaid, Medicare, and commercial insurance, patients switching from commercial insurance to a Medicaid-like insurance could destabilize that provider mix and result in fewer doctors seeing Medicaid patients or fewer doctors generally.

The governor noted that the state may continue to examine the act's concepts through:

1. Senate Bill 394, which requires the Legislative Committee on Health Care to study how Nevada might establish a program similar to Medicaid managed care for purchase,

2. a potential future executive order to establish a committee to study surprise billing for emergency health care that could include study of the act's provisions, and

3. existing state law that allows the state's insurance commissioner to work with commercial insurance companies to fill coverage gaps (NRS 686B.180).

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