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Scott J. Kipper  
Commissioner of Insurance  
Via email to Adam Plain at [aplain@doi.nv.gov](mailto:aplain@doi.nv.gov)

Dear Commissioner Kipper:

My name is Jon Sasser. I am the Statewide Advocacy Coordinator for six civil nonprofit legal services programs and lobby in the Nevada Legislature for Washoe Legal Services and the Legal Aid Center of Southern Nevada. Both programs serve individuals with incomes up to 200% of the federal poverty level. I also serve as a member of the Commission on Services for People with Disabilities.

My interests are those of low income consumers in the Exchange and on Medicaid. I have advocated on their behalf in the Nevada Legislature since 1983.

I followed the Silver State Health Insurance Exchange's (SSHIX) Plan Certification Advisory Committee meetings. I gave written testimony on 8/20 and testified in person on 9/13. As I'm sure you are aware, the Advisory Committee recommended that the full SSHIX Board limit the choice for the benchmark to three plans: HPN POS C-XV-500 HCR (labeled Plan A by the SSHIX staff), NV PEBP (Plan D) and HHP 25 HMO PEBP (Plan F).

Based on my analysis I asked SSHIX Board at its meeting on 9/18 to choose NV PEBP (Plan D) as the Essential Health Benefits package for Nevada. My rationale was that Plan D was by far the top rated package for comprehensiveness. The SSHIX Board, as you know, recommended that you limit your choice of one of these three plans.

I agree with the Board's recommended limitation. The three federal plans, while receiving a comprehensiveness score of 4, would apparently require the state to pay for the cost of the autism state mandate with General Fund dollars of up to \$4 - \$5 million annually. The remaining four plans which were eliminated all receive low scores for comprehensiveness.

I again request that you choose Plan D. The SSHIX staff gave it a score of 5 (the highest possible) on comprehensiveness. Plans A and F received only a 3. The relatively small differences to Plans A and F in the other two factors seem to me to be far less significant than this large "comprehensiveness gap".

- First is the gap in covered services. All three plans fail to cover eye wear (although Plan D does cover it following cataract surgery). Plan D covers all of the other enumerated services while Plan A does not cover optometry exams or speech/hearing exams and Plan F eliminates hearing aides and optometry exams. Plan A does seem to be best in covering needed services following cosmetic implants which go wrong (Plan D is a bit vague while Plan F eliminates coverage altogether).
- Second is the gap in service limits. In most all of the categories plan D is the most generous with no limits on physical, occupational and speech therapy, rehabilitation hospitalizations and durable medical equipment. The only limits which are more restrictive in Plan D. than in the other plans are the 60 day skilled nursing facility limit (Plan A has 100 days while Plan F has 30) and home health care with 60 visits compared to no limits in Plan F and 30 days for Plan A.

Choosing a benchmark that has as few visit limits as possible ensures adequate coverage for the new populations entering the insurance market. Visit limits are confusing and difficult for consumers to understand. While the federal government may allow insurers to add in visit limits (as long as they increase benefits in other areas and show their plan benefits are substantially equivalent to the benchmark) starting with a comprehensive base is important. If services are missing or limited, Nevada cannot get that missing value back later.

Plan D was penalized in the scoring system because it got one point less than the other two plans in the category called "minimally disruptive". The staff explained that *"Higher scores were given to the small group plans and HMOs as they are more typical of the small employer and individual markets"*. The committee to my knowledge received very little in the way of testimony/information on this category. I, for one, am not convinced that this is important.

Finally, Plan D is rated the least affordable but would cost only 3.5% more than Plan C (the cheapest which the SSHIX board dropped from its consideration). Plan F is 1.9% more than Plan C but has the most restrictive limits on rehabilitation services, skilled nursing facilities and rehab hospitals. While Plan A is 1.5% more than Plan C it does not have a pediatric dental benefit and would require a dental rider which would increase its cost. Plan D therefore costs 1.6% -2% (minus cost of pediatric dental benefit) more. That rather minor cost difference translated in the formula to a score of 1 for Plan D compared to a 3.4 for Plan A and 2.9 for Plan F. I still don't quite understand the value judgment

reflected in the math involved there.

The cost estimates in this context are a relative measurement. They don't necessarily translate to higher premiums for consumers/payers nor get passed through dollar for dollar. Insurers have multiple ways of "paying for" the marginal additional costs associated with a benchmark that is (slightly) more comprehensive than the alternatives. Many additional factors go into determining premiums (cost-sharing charges, health care provider network, utilization management practices, administrative costs of the particular insurer, etc). In other words, choosing a benchmark that is estimated to cost 1.6% to 2% more than the alternatives does not mean that this is a cost increase that will filter through to consumers and small businesses.

Even if the costs were fully passed through I believe it is worth 1.6% -2% (minus cost of pediatric dental benefit) more in premiums to get the richer package. For the most vulnerable of the consumers (those between 100%-400% of the federal poverty level) the additional costs will largely be covered by subsidies. It is therefore unlikely that this small increase in costs will impact their decision to participate in the market.

While the remainder of the small group/individual market will obviously care about affordability they are used to much greater rate increases over the last several years and also care about comprehensiveness. On the other hand, for those who actually need the omitted services (medical equipment, rehab hospital care, etc.) the results can be catastrophic to themselves, their families and community. The costs will be borne in other parts of the health care system.

Thank you for your consideration of my ideas.

Jon Sasser  
Statewide Advocacy Coordinator