

Joe Lombardo
Governor



**DEPARTMENT OF
HEALTH AND HUMAN SERVICES**
DIRECTOR'S OFFICE
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Richard Whitley, MS
Director

January 1, 2024

The Honorable Janet Yellen
Secretary of the Treasury
Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, D.C. 20220

The Honorable Xavier Becerra
Secretary of Health and Human Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

RE: Nevada Section 1332 Innovation Waiver Request – Battle Born State Plans (BBSPs) and Market Stabilization Program (MSP)

Dear Secretary Yellen and Secretary Becerra:

The State of Nevada submits this application for a Section 1332 State Innovation Waiver as required by state law as part of the Nevada Department of Health and Human Service's implementation of a Public Option and the establishment and financing of a Market Stabilization Program. Both the Public Option health plans, called "Battle Born State Plans" (BBSPs), and the Market Stabilization Program will be implemented upon the approval of this waiver application, and represent new initiatives aimed at improving access to and affordability of health care while ensuring a healthy and stable marketplace for those who purchase insurance through the individual health insurance market.

Nevada seeks to waive Section 1312(c)(1) of the Affordable Care Act and its implementing regulations for a five-year period to establish the BBSP and Market Stabilization Programs detailed in this application. The BBSP and Market Stabilization Programs are intrinsically tied together by design; therefore, the State seeks federal waiver authority for these initiatives in one waiver request. Presently, Section 1312(c)(1) and its implementing regulations limit issuers' ability to vary premium rates for particular health plans from the index rate. Nevada wishes to waive this requirement for the BBSPs, which will ultimately control health care costs by reducing premiums in the health insurance marketplace and generating federal savings on premium tax credits. A waiver of Section 1312(c)(1) will also allow implementation of the State's new reinsurance program in year two of this waiver (CY 2027) and, with remaining funds, support two other programs designed to improve quality, increase the number of health providers, and lower health care costs in Nevada.

This request lies within the authority of the Director of the Nevada Department of Health and Human

Services (the Director), as stated in NRS 695K.210, to request a Section 1332 waiver and “to subsidize the cost of health insurance” and “improve affordability” for Nevadans. It is also consistent with the broad authority of the Nevada Division of Insurance Commissioner to seek a Section 1332 waiver.

Thank you for considering our application and supporting Nevada’s health care affordability and market stabilization goals.

Sincerely,



Richard Whitley, MS
Director
Nevada Department of Health and Human Services

**SECTION 1332 WAIVER
APPLICATION:
NEVADA COVERAGE AND MARKET
STABILIZATION PROGRAM**



**DEPARTMENT OF
HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE FINANCING & POLICY**



WAIVER APPLICATION

Federal Submission Date: January 1, 2024

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Section 1: Nevada Program Overview and Waiver Request

A. Overview

The State of Nevada seeks a State Innovation Waiver under Section 1332 of the Affordable Care Act (ACA) (Section 1332 Waiver), in accordance with State law, to obtain all necessary federal authorities and available pass-through funding to implement and operate a Public Option and establish and finance a Market Stabilization Program.¹ Together, these new initiatives aim to improve access to health care for Nevadans, while ensuring a healthy and stable marketplace for those who purchase their own health insurance in the nongroup health insurance market (hereinafter “individual market”).

These new State-based initiatives reflect efforts designed by Nevada policymakers and the Governor to address the challenges facing the State’s health care system and insurance market. Although Nevada expanded its Medicaid program under the ACA in 2014, the State continues to rank among the top ten states with the highest uninsured rates in the nation.² Nevada also struggles to provide access to care for its residents, with all counties being designated as one or more types of a Health Professional Shortage Area (HPSA) by the Health Resources and Services Administration (HRSA) due to the low number of health professionals relative to the county population.³ Most of the State’s population lacks a dedicated health care provider and many Nevadans report avoiding care due to cost.⁴ Furthermore, Nevada was recently scored 41st, nationally, and last among Western states, in how well its health care system is working to improve health.⁵

The first initiative for addressing these issues is a new Public Option program. As established under State law, this program must be designed and established by the Nevada Director of Health and Human Services (the Director).⁶ To fulfill this new duty, the Director must contract with carriers to offer new health insurance options to consumers through Nevada’s State-based health insurance exchange—the Silver State Health Insurance Exchange (SSHIX). These new options must be available to Nevadans and certified as Qualified Health Plans (QHPs). This means these new options must provide the same minimum benefits and cost sharing and meet all the same State and federal requirements as standard QHPs. These new coverage options will be referred to as the “Battle Born State Plans” (BBSPs).

The major difference between BBSPs and other QHPs offered on the SSHIX is that carriers offering BBSPs must contract with the State to meet certain State priorities and requirements, including an annual premium reduction target. To initiate these new contracts with carriers, the Director must conduct a State procurement process that coincides with the statewide procurement for Nevada’s Medicaid Managed Care plans. State law requires carriers bidding to participate in Nevada’s Medicaid Managed Care program as a Managed Care Organization (MCO) to also submit a “good faith bid” to offer BBSPs in the SSHIX. A good faith bid must, at a

¹ Nev. Rev. Stat., Chap. 695K, available at: <https://www.leg.state.nv.us/nrs/NRS-695K.html>

² ASPE, National Uninsured Rate Reaches an All-Time Low in Early 2023 After the Close of the ACA Open Enrollment Period, August 2023, available at: <https://aspe.hhs.gov/sites/default/files/documents/e06a66dfc6f62afc8bb809038dfaeb4/Uninsured-Record-Low-Q12023.pdf>.

³ Nevada Div. of Behavioral and Public Health, Health Professional Shortage Areas, available at: https://dph.nv.gov/Programs/HPSA/Health_Professional_Shortage_Area_Designations_-_Home/

⁴ America’s Health Rankings, Nevada Summary, 2022, available at: <https://assets.americashealthrankings.org/app/uploads/allstatesummaries-ahr22.pdf>

⁵ Commonwealth Fund 2023 Scorecard on State Health System, Nevada: Ranking Highlights, available at: <https://www.commonwealthfund.org/publications/scorecard/2023/jun/2023-scorecard-state-health-system-performance>.

⁶ Nev. Rev. Stat. § 695K.200.

minimum, meet the annual premium reduction target for the BBSPs and include a formal certification from the carrier's actuary that the proposed premium rates will meet actuarial soundness principles, as further outlined in this waiver request. The carrier must also commit to submitting their rate filings for BBSPs to the Division of Insurance (DOI) for review and approval. This customary State process will verify actuarial soundness and confirm that solvency standards and all other requirements of standard QHPs have been met. As with every other carrier offering a QHP on the SSHIX, carriers must also commit to filing network adequacy information with the DOI for review and approval and must seek formal QHP certification of their BBSPs each year from SSHIX. However, carriers that offer BBSPs in the SSHIX must meet the annual premium reduction target. The DOI will evaluate the rate filings for the BBSPs in the same manner as other rate filings to determine whether rates are excessive or inadequate and whether carrier solvency and all other requirements of QHPs have been met.

While the introduction of the BBSPs and achieving the premium reduction targets are not expected to disrupt the insurance market, the second initiative—the Market Stabilization Program—is intended to mitigate any unexpected financial risk to carriers and limit the impact on provider networks, while strengthening the long-term sustainability of this market. The Market Stabilization Program accomplishes these goals through three new measures:

- **State-Based Reinsurance Program:** This program is aimed at alleviating any unexpected financial risk to participating carriers and their provider networks with the introduction of the BBSPs that meet premium reduction targets. Under reinsurance, the State will subsidize (or “reinsure”) certain high-cost claims for all carriers in the individual market. The State intends to adjust the size of the reinsurance parameters as needed to ensure that it can be fully funded by the pass-through funding generated in the prior year.
- **Quality Incentive Payment Program:** If there is remaining pass-through funding in any year of the waiver period after financing reinsurance, the State intends to use this funding to establish a Quality Incentive Payment Program for carriers offering BBSPs. This program would be designed to reward carriers and their providers for utilizing value-based efforts to improve health outcomes and quality of care. Through this new program, the State will be able to, for the first-time ever, drive changes in how health care is delivered and paid for in the individual market. Over time, these efforts should lead to a healthier population and therefore reduced risk to carriers. It should also lead to shared savings and financial rewards for network providers that are successful in these efforts with carriers.
- **“Practice in Nevada” Incentive Program for Health Care Providers:** If there is sufficient pass-through funding to finance reinsurance and the Quality Incentive Payment Program, the State intends to use such funding to finance a new “Practice in Nevada” program. Nevada faces critical challenges in attracting many types of health care providers, including primary care physicians, obstetricians, behavioral health practitioners, and other allied health professionals, to practice in the State. For example, Nevada ranks last in the number of primary care providers per 100,000 individuals.⁷ Increasing the number of providers is essential to addressing poor health outcomes and health disparities. It is also important for controlling the rise in the cost of health care and ensuring the stability of the State’s insurance market. Because of the steep demand and supply gap for health care professionals in Nevada, having more medical professionals could help insurers avoid facing unreasonable price hikes from network providers that are in low supply in the State. For example, carriers with smaller market shares (i.e., covered lives) are likely to struggle to negotiate reasonable rates for certain services where only one provider entity is available in a region to provide such services to its members. Most recently, this challenge was notable in the State’s Medicaid Managed Care program, where a carrier with a smaller portion of enrollment in the program faced

⁷ Commonwealth Fund 2023 Scorecard on State Health System, Nevada: Ranking Highlights, available at: <https://www.commonwealthfund.org/publications/scorecard/2023/jun/2023-scorecard-state-health-system-performance>.

unreasonable prices as compared to other carriers from a certain specialty provider type that is in low supply in the State.

Nevada seeks to waive Section 1312(c)(1) of the ACA and its implementing regulations for the purpose of establishing the reforms described herein. If approved, the Section 1332 waiver is targeted to be effective January 1, 2026, for five years. The reforms will not affect any other provision of the ACA but are expected to result in a lower-than-projected second-lowest cost Silver plan (SLCSP) and a reduced market-wide index rate, thereby lowering premiums and reducing the federal cost of premium tax credits (PTCs).

This waiver request is in accordance with the explicit requirement under NRS 695K.210 for the Director to request a Section 1332 waiver and the express authority for the Director to request any additional federal waiver authorities necessary “to subsidize the cost of health insurance” and “to improve affordability” for Nevadans. It is also consistent with the broad authority of the Commissioner of DOI to seek a Section 1332 waiver.

For the reforms to meet the federal requirements for a Section 1332 waiver, the program must satisfy four federal guardrails: affordability, scope of coverage, comprehensiveness, and deficit neutrality for the federal government. The independent actuarial analysis conducted by the firm Milliman, Inc. shows that implementing a new premium reduction target and a State-based reinsurance program would meet the federal requirements for a Section 1332 waiver under each scenario modeled. Milliman estimates federal savings of \$279 to \$310 million in the first five years and \$760 to \$844 million at the end of the first ten years.

B. Federal Provisions to Be Waived

Pursuant to NRS 695K, the State seeks to waive Section 1312(c)(1) of the ACA for the five-year waiver period to support the State’s premium reduction target and State-based reinsurance program. Both initiatives are intrinsically tied together by design as further described herein. The State seeks federal waiver authority for these initiatives in one waiver request.

Section 1312(c)(1) and its implementing regulations limit the factors by which issuers can vary premium rates for a particular plan from the index rate. The goal of the premium reduction targets for the BBSPs in SSHIX is to control health care costs and support coverage by reducing insurance premiums. Through NRS 695K and this waiver, the Director would condition eligibility to bid as an MCO carrier on submitting a good faith bid to offer a Silver plan and a Gold plan on the SSHIX that meets certain premium reduction targets each year, among other QHP requirements. These premium reductions are expected to be achieved through a combination of lower provider rates, administrative efficiencies, and the implementation of reinsurance. To allow these reductions, Nevada is requesting a waiver of the Single Risk Pool provision of the ACA, Section 1312(c)(1). Under the implementing regulations at 45 CFR 156.80(d)(2), an “issuer may vary premium rates for a particular plan from its market-wide index rate for a relevant state market based only on the following actuarially justified plan-specific factors.” These regulations enumerate specific factors, including: (1) actuarial value and cost-sharing; (2) provider network; (3) delivery system; (4) utilization management practices; (5) benefits provided in addition to the EHB; (6) administrative costs; and (7) any expected impact of eligibility for catastrophic plans. A federal waiver of Section 1312(c)(1) will ensure carriers can make plan-level adjustments to the market-wide adjusted index rate for BBSP offerings that correspond to the new premium reduction targets.

A waiver of Section 1312(c)(1) will also allow implementation of the State’s new reinsurance program in year two of this waiver (CY 2027). The waiver of this provision is necessary for Nevada to include pass-through funding from the State reinsurance program when determining the market-wide index rate in 2027.

The State intends, at this time, to establish a reinsurance program that will have a geographic tiered structure that is designed to reduce premiums more in the highest-cost geographic areas (i.e., Rating Areas 3 and 4). The reinsurance program is expected to reduce premiums market-wide by 7.2% by 2030, contributing to plans' ability to meet the premium reduction targets in the years 2027 through 2030 and generating further federal savings.

Section 2: Nevada Section 1332 Waiver Proposal

A. Enabling Statutory Authority

Enabling legislation requires the Director to apply for a Section 1332 waiver no later than January 1, 2024, to implement the reforms and requirements of NRS 695K to establish a new Public Option program and to capture all pass-through funds made available to the State with such reforms.⁸

NRS 695K.210(1)(b)(2) further bestows broad express authority on the Director to seek additional federal waivers, "without limitation," to "subsidize the cost of health insurance" in the State as part of the Director's efforts to implement this chapter. The grant of power "without limitation" permits the Director to implement a reinsurance program.

NRS 695K.300(5) also provides the Director with broad express authority to spend federal pass-through funding made available to pay for the costs associated with administering the reforms of Chapter 695K and any associated waivers. It provides the Director with the authority to spend the remaining federal pass-through funding to improve the affordability of the new coverage options established under the Public Option program. The State has determined that this includes the initiatives within the Nevada Market Stabilization Program, including a State-based reinsurance program, a Quality Incentive Payment Program for participating BBSP carriers, and the Practice in Nevada Incentive Program. Each of these initiatives under the Market Stabilization Program can help the State control the rise in the cost of health care in the individual insurance market and increase long-term affordability by improving the quality of health care among enrollees and bolstering the provider base in the State.

In addition to the Director's authority, the Commissioner of Insurance has specific authority in SB 482 (2019), Section 45, to apply for a Section 1332 waiver and implement a State plan that meets the waiver requirements as approved by the Departments.⁹ Further, the Commissioner has broad authority in NRS 679B.400 to "develop measures to stabilize prices" and to "establish a mechanism to ensure the provision of adequate insurance at reasonable rates to the residents of this state."¹⁰ This highlights an additional source of State authority to establish a reinsurance program, the Quality Incentive Payment Program, and the Practice in Nevada Incentive Program under the State's Market Stabilization Program.

B. The New Battle Born State Plans

Nevada Senate Bill (SB) 420 (2021) was signed into law on June 9, 2021, and later codified in NRS Chapter 695K. Under this new law, the Director is required to design and establish a Public Option program in the individual market.¹¹ The statutory design of this new program relies heavily on a State purchasing and

⁸ NRS 695K.210, available at: <https://www.leg.state.nv.us/nrs/NRS-695K.html#NRS695KSec210>

⁹ Senate Bill 482 (2019), available at: <https://www.leg.state.nv.us/App/NELIS/REL/80th2019/Bill/6923/Text>.

¹⁰ Nev. Rev. Stat., Chap. 679B, available at: <https://www.leg.state.nv.us/nrs/NRS-679B.html#NRS679BSec400>.

¹¹ The authorizing state legislation also permits the state to offer the plans in the small group market, but currently the state is not taking up this option.

contracting strategy of the State’s Medicaid Managed Care program. The State will undertake a statewide Medicaid Managed Care procurement for a five-year contract that begins on January 1, 2026.

The State must require that carriers submitting a bid through the Medicaid Managed Care procurement also produce a good faith bid to offer at least a Silver and Gold BBSP annually in each rating area on the SSHIX. (Through its contracting mechanism and the Quality Incentive Program, the State will also incentivize these carriers to offer Bronze plan products.¹²) Currently, under existing MCO contracts, the MCO carriers must offer an SSHIX product.¹³ The difference between current contracting practices with MCO carriers and the new BBSP program is that the State will be asking MCO carriers to offer a Silver and Gold QHP that meets the new BBSP requirements. Carriers will not be prohibited from offering other SSHIX products and are expected to continue their current offerings.

The State intends to define a good faith bid as any bid by a carrier that is deemed complete under State purchasing guidelines and complies with all State requirements for the Public Option Program (the BBSPs). This includes submitting a bid that, at a minimum, satisfies the premium reduction targets and provides a formal attestation and rate certification by the actuary that derived the premium rates, attesting that the rates for the BBSPs are actuarially sound, meaning they are adequate and reasonable in relationship to the benefits covered. The bid must also include sufficient detail documented in the rate certification to understand the specific data, assumptions, and methodologies behind the rate development and projections, like the requirements for the and projections rates proposed by carriers seeking to offer an MCO plan.

If a carrier bids on Medicaid and does not offer a good faith bid for a BBSP contract, the carrier would be ineligible to receive an award for participation in the State’s Medicaid Managed Care program for that upcoming contract period. Currently, the Director contracts with four carriers for the State’s Medicaid Managed Care program—Anthem, Health Plan of Nevada (United Health Group), Molina, and Silver Summit Health Plan (Centene). The State anticipates that all four will apply to seek to continue participating in Medicaid Managed Care program in the upcoming procurement in 2025, when the State will require statewide bids for the first time. Therefore, the State expects at least four carriers, at a minimum, to submit bids to offer the new BBSPs for coverage year 2026. The upcoming MCO contracts will be for a five-year period, beginning on January 1, 2026, and terminating on December 31, 2030. This timeline for the contract period aligns with this waiver request.

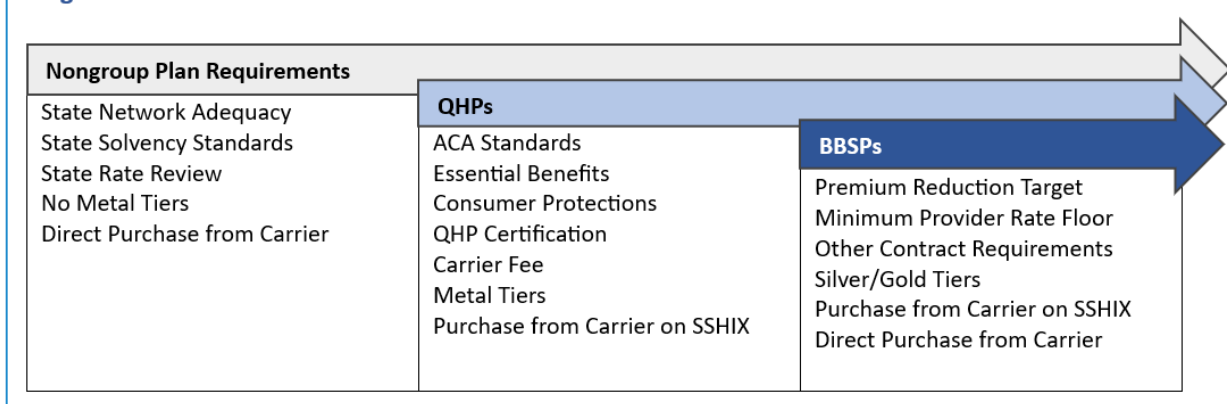
1. Product Design Overview

As illustrated in Figure 1, State law provides that a BBSP must meet all the requirements of a standard QHP, satisfy State network adequacy standards, successfully complete the State’s rate review process, be certified by the SSHIX, and provide benefits and levels of coverage consistent with the actuarial value of at least one Silver plan and one Gold plan in each Rating Region.

¹² All four current Medicaid Managed Care plans participate in SSHIX and offer Bronze plans, and we anticipate that their existing products would continue.

¹³ See Section 7.1.5.1 in the State’s Medicaid Managed Care contract, available at: <https://nevadaepro.com/bsa/external/purchaseorder/poSummary.sdo?docId=40DHHS-NV21-9279&releaseNbr=0&external=true&parentUrl=close>

Figure 1: Individual Market Products v. Battle Born State Plan



The BBSP will include the same benefits as other QHPs.¹⁴ In addition, BBSPs must meet certain statutory requirements for premium reductions and a reimbursement floor for network providers, ensuring rates, in the aggregate, are no lower than those paid by Medicare.

The two major differences between BBSPs and standard QHPs include:

- New Premium Reduction Targets:** Under NRS 695K, carriers offering the new BBSPs must satisfy a new premium reduction target on their Silver plan rates that is at least 15 percent lower than the average reference premium by the fourth plan year. The average reference premium will be based on the SLCSP QHP available in the SSHIX during the 2024 plan year by county, trended forward for inflation according to the Consumer Price Index for Medical Care (CPI-M) and any adjustments necessary to reflect local changes in utilization and morbidity. See Nevada DHCFP Guidance and Bulletin Update 23-003.¹⁵

To ensure annual premium rates for the BBSPs will be actuarially sound and meet provider reimbursement floor requirements, the Director has determined the premium reduction target should be no more than 15 percent by the end of the first four years as permitted by State law.¹⁶ In the event that carriers cannot meet premium targets in any given year while meeting actuarial soundness or solvency requirements, the Director may revise the premium reduction targets to ensure BBSPs are offered at a rate that is actuarially sound. As further described in the milestones section, the Director will also require carriers to attest to the actuarial soundness of their proposed rates in their bids for the BBSP contracts similar to how the State verifies bids for the State’s Medicaid Managed Care program.

In the fifth and final year of the five-year MCO and BBSP contracts with carriers and the 1332 waiver period, the Director intends to include a continuation of the premium reduction targets for BBSP

¹⁴ Through multiple public design sessions in 2021, stakeholders expressed concerns primarily with accessing their current, covered services and had fewer concerns about covering additional benefits. Across all markets, Nevadans face health care access challenges, particularly in rural counties that experience the lowest provider-to-population ratios. Stakeholders also expressed concerns that expanding benefits would place a tension on achieving premium reduction targets due to limited provider capacity.

¹⁵ General Guidance Letter 23-003 Notice of Revised Carrier Premium Reduction Targets for Plans Established in NRS 695K, available at: https://www.medicaid.nv.gov/Downloads/provider/web_announcement_3220_20231120.pdf

¹⁶ Pursuant to the Director’s revision authority under Subsection 5 of NRS 695K.200, the Director issued updated guidance on November 20, 2023 revising the premium reduction requirements to require that carriers establish plans that are “lower than the average reference premium in each county by a percentage that increases each year.” See https://www.medicaid.nv.gov/Downloads/provider/web_announcement_3220_20231120.pdf.

premium rates to ensure the projected reduced trend achieved in the first four years is sustained over time. The Director will use the State’s contract authority with carriers offering the BBSPs to enforce these new targets with associated penalties and sanctions as outlined further in Subsection 3.

- **Provider Reimbursement Floor:** State law requires carriers offering the new BBSPs to ensure that their negotiated rates with network providers are the same or better, in the aggregate, than the rates paid by Medicare.¹⁷ The Director intends to establish reasonable rates for services not covered in Medicare (e.g., pregnancy-related coverage). These rates will be calculated annually as a percentage of Public Employees’ Benefits Program (PEBP) or Medicaid rates for the same or similar service, where a Medicare rate is unavailable. Carriers must attest in their bids on the BBSP contract that they are in compliance with this requirement with respect to the rates they negotiate with their provider networks.

To protect providers, the Director will develop an appeal process for network providers who believe a carrier offering a BBSP has not complied with the requirement of Medicare rates or better. These design features will be outlined in the State’s BBSP contracts. The contract will also include a corrective action process and associated penalties for noncompliance with the reimbursement floor for providers.

2. New Protections for Consumers and Providers

In addition to the provider reimbursement floor described above, State law provides for certain protections to ensure that the premium reduction targets for the BBSPs do not undermine provider networks or access to care for consumers. These include:

- **Provider Participation Requirement** – Any provider who participates in the PEBP, Medicaid, or the State’s workers’ compensation program must agree to participate in at least one provider network for a BBSP or risk participation as a network provider in these other public programs. This requirement will be enforced through the State’s contractual or enrollment agreements with providers to participate in-network in these programs.¹⁸
- **Consumer Access Requirement** – Participating providers or facilities must accept new patients enrolled in a BBSP to the same extent as the provider or facility accepts new patients enrolled in a standard QHP. The Director intends to require carriers in the BBSP contract to monitor providers for compliance and to notify consumers of this protection and a way to report any violations. Noncompliant providers may risk their provider enrollment in Medicaid if they are not compliant with state law which would include this requirement.

The Nevada Division of Health Care Financing and Policy (Nevada Medicaid), which sits under the Director, oversees the State’s contracts with these carriers today and will provide the same oversight of compliance with respect to these new requirements for the BBSP contracts. The Director may waive the provider

¹⁷ State law includes separate floors for certain safety net providers for whom specific cost-based encounter payment methodologies apply in Medicare, including for federally qualified health centers (FQHCs), rural health centers (RHCs), and the Medicaid State Plan rate for certified community behavioral health clinics (CCBHCs). The above-stated rate requirements do not apply to reimbursement arrangements that involve the use of alternative payment models, meaning that plans and providers may agree to alternative payment models. See NRS 695K.240.

¹⁸ Because this is a state law requirement, Nevada Medicaid will amend its provider enrollment agreements to ensure compliance with this new provision. Nevada Medicaid will also implement internal audit mechanisms to enforce this requirement on its providers in fee-for-service and managed care, similar to other provider enrollment eligibility requirements for Medicaid enrollment (payment). As for the State’s PEBP and workers compensation program, the State will amend its contract with carriers to ensure provider networks are bound by this requirement with the option to terminate the agreement with such providers per state law if providers are deemed out of compliance.

participation and consumer access requirements if needed to ensure individuals who receive benefits through the State's PEBP, Medicaid, or the workers' compensation program have sufficient access to covered services from network providers. Although the actuarial analysis by Milliman found that the introduction of the BBSPs will not meaningfully impact provider revenue on an aggregate level, the Director intends to develop a process for providers to seek a waiver of the network participation requirements for the BBSP offerings. Providers seeking such a waiver from participation as a BBSP-network provider must show a significant monetary loss in their total patient revenues from serving patients who enroll in a BBSP. Such a loss must also pose a substantial risk to their financial stability due to the new BBSP revenue displacing a sizable portion of their payor mix and associated commercial revenue.

3. New State-Carrier Contracts

To enforce the statutory requirements for the BBSPs (including the premium reduction targets), the Director will utilize the legal tools under its new BBSP contracts with carriers, similar to the ways in which Nevada Medicaid enforces its existing contracts with carriers for its Medicaid Managed Care program, including the existing contract requirement that MCOs offer a QHP in the SSHIX. For example, MCO contracts include corrective action plans, financial penalties, and/or sanctions that can be imposed by the Director when carriers do not meet their contractual obligations.¹⁹

Like the MCO contracts, the new contractual arrangements with carriers for the BBSPs enable the State to impose additional requirements that go beyond those set forth in State law to meet State health care goals and priorities for the population served. This may include, for example, aligned quality metrics and value-based payment design requirements across MCO and BBSP programs and heightened network adequacy standards, if certain geographic areas are underserved, including requiring carriers to leverage their existing provider networks in Medicaid Managed Care to ensure adequate access for those enrolled in a BBSP.

The State will also require carriers to meet an administrative cost constraint through the new contracts with carriers offering BBSPs that are stricter than prevailing individual market and QHP administrative expense loads (based on most recent publicly available rate filing data). Under the administrative cost constraint, carriers offering BBSPs would be required to reduce a portion of their administrative expenses (such as salary, profits, and other administrative expenses or overhead) for the BBSP offerings, which will help reduce prices relative to non-BBSP offerings, all else being equal. The State is considering excluding from what qualifies as administrative expenses, for purposes of this new requirement, any activities or efforts that relate to quality improvement, recipient outreach, care management, call centers or nurse lines, etc.

These new required administrative expense targets will be set by the Director in the new BBSP contracts and may ramp up each year, over the first four years of the program. These administrative efficiencies at the carrier level would count toward the required premium reduction target, reducing the share of premium reductions that must be achieved through provider reimbursement reductions in BBSPs. This will also help mitigate the risk of carriers cost shifting the entire burden of meeting an annual premium reduction target onto their provider networks. For BBSP carriers that do comply with this new requirement (i.e., shift more than half of the cost of the premium reduction target onto their provider networks), the Director may use all financial penalties and sanctions set forth in the contract to enforce compliance.

Additionally, State law requires the Director to prioritize bids from carriers in the scoring process that will:

¹⁹ See Section 7.15.2 of the state's current MCO contract. MCOs determined to be out of compliance with the state MCO contract must, upon request by the state, develop a corrective action plan.

- Advance quality and value-based payment design with providers,
- Improve continuity of care through better alignment of provider networks in the individual market and Medicaid Managed Care program, and
- Help address the State’s growing health care workforce shortages and health disparities.²⁰

C. Use of Federal Pass-Through Funds

The State understands that, if this waiver application is approved, an initial estimate of the federal pass-through funding amount will be made available to the State in the fall of each year (before the beginning of the plan or coverage year). The final federal pass-through funding amount or final administrative determination by the Centers for Medicare & Medicaid Services (CMS) will be shared in a letter prior to the payment of the federal pass-through funding amount as provided in the specific terms and conditions of the approval letter (typically before the end of April of the corresponding plan or coverage year).

State law requires that any federal pass-through funds received by the State as a result of the approval of this waiver must be reserved to first cover the State administrative costs to implement and operate the program and waiver.²¹ These funds would replace the State’s initial investment of State general funds to cover the “start-up” costs associated with implementation. As shown in the proposed budget (see Section 4.F.) these costs include staffing and vendor-related costs for both the Nevada Department of Health and Human Services (DHHS) and the DOI.

Once the State administrative costs have been paid for with the new federal pass-through funds, State law permits the Director to use a portion of the funding as determined by the State Treasurer to increase consumer affordability. For this waiver’s purposes, the State has determined that the remaining funds should be used by the Director to support a Market Stabilization Program in order to improve affordability in the BBSPs, along with other nongroup plans, as further described in Section 2.E. below.

D. DHHS Consideration of Initial Public Feedback

During the months of December 2021 and January 2022, the State of Nevada hosted six public design sessions to gather initial stakeholder feedback on the design of the 1332 waiver application. These initial public sessions, which included topic areas such as value-based payment reforms and provider contracting, informed the design of the BBSPs and Market Stabilization Program and will continue to inform design as the State plans for the procurement of the BBSPs.

The following points raised by stakeholders during these sessions stood out to the State as key considerations to address via the Section 1332 waiver application:

- Commenters underscored the importance of improving affordability, including through reduced premiums, for Nevadans enrolled in health plans in the individual insurance market.
- Commenters urged the State to invest in the provider workforce to improve Nevadans’ access to timely preventative care and reduce longer-term health care costs.
- Commenters raised concerns about the impact of the premium reduction target on carriers, providers, and market.
- Commenters suggested the State invest in strategies to improve longer-term population health,

²⁰ See NRS 695K.220, available at: <https://www.leg.state.nv.us/nrs/NRS-695K.html#NRS695KSec210>

²¹ See NRS 695K.300.

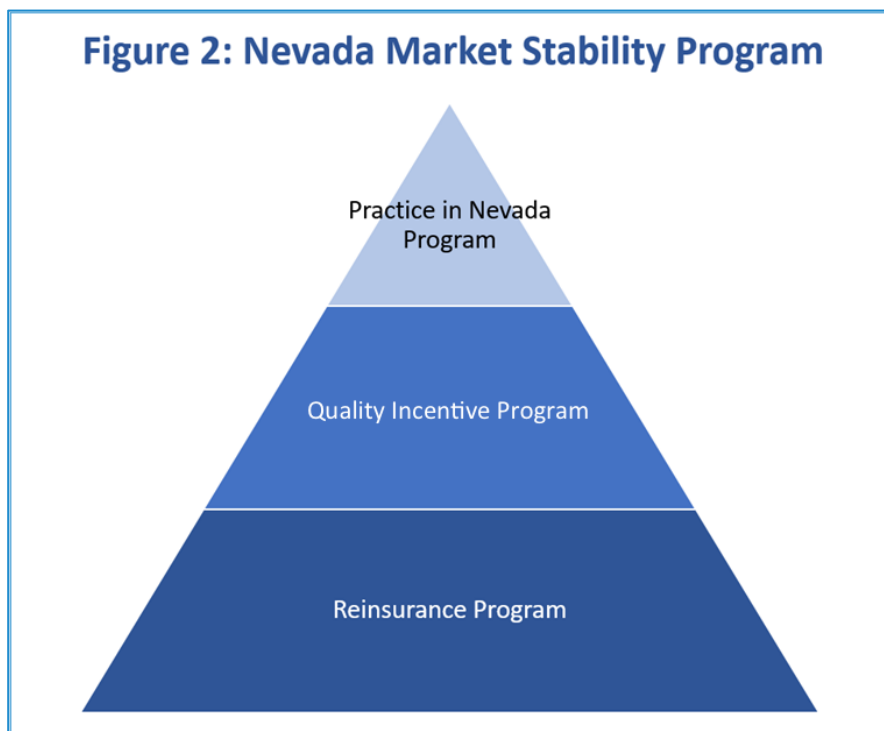
including alternative payment methodologies focused on high-value services to improve health.

Each of these points of feedback is addressed via the Nevada Market Stabilization program.

E. Nevada Market Stabilization Program

In response to carrier and provider feedback on the risk that providers will solely bear the burden of the premium reduction target, the State intends to reinvest the federal pass-through funds into a Market Stabilization Program. Through this new program, the State seeks to improve affordability of coverage and care by reinvesting new federal waiver dollars in efforts that will help to: (1) moderate the risk to carriers of bearing the full burden of high-cost claims in the State’s individual market (reinsurance); (2) increase the use of value-based provider payment and care delivery models to improve efficiencies and outcomes across Medicaid and the individual market; and (3) address the significant gaps in the State’s health care workforce that drive up prices and limit access to care, impacting health outcomes for Nevadans. The program’s design also helps limit the potential risk of carriers cost shifting losses from the premium reduction target onto their provider networks, as further described below.

As summarized in Figure 2, the new Market Stabilization Program includes three core State market-focused investments. The first investment consists of the establishment of a new State-based reinsurance program for all carriers operating in the State’s individual market (i.e., offering nongroup plans). The second, if there is sufficient funding each year after fully financing a reinsurance program, includes a new Quality Incentive Payment Program to reward high-performing insurers that offer BBSPs and meet certain quality metrics or indicators tied to state priorities for the market. And third, if there is sufficient funding to fully finance a reinsurance and Quality Incentive Payment Program, the State intends to finance the Practice in Nevada Incentive Program, which provides for loan repayment to certain health care providers willing to live and work for at least four years in a region of Nevada that qualifies as a federal Health Professional Shortage Area.



The operation and scale of these new programs would be reliant on the amount of federal pass-through funds available to the State each year under an approved Section 1332 waiver, starting in year two. After funding all State operational costs for the Section 1332 waiver program, the State intends to prioritize the remaining funds to first finance in full a State-based reinsurance program. Any remaining funds would be used next to pay for a Quality Incentive Payment Program with the rest being used to support a new workforce development initiative as described below.

1. Invest in Market Stability with a State-Based Reinsurance Program

The State proposes to finance a new State reinsurance program for carriers operating in the State's individual market with the federal pass-through funds made available under this section 1332 waiver. Through this new reinsurance program, the State seeks to share some of the financial risk with carriers for the cost of covering the individual market in a manner that would help lower costs for consumers ineligible for premium assistance. This, in turn, helps limit the potential risk and losses for carriers operating in the individual market.

Based on an actuarial analysis by Milliman, it is anticipated that, as a result of the entry of the BBSPs into the market, the federal savings generated in CY 2026 would fully finance the State-based reinsurance program in CY 2027 with over \$2 million remaining to spend on the other two programs. Each year that the State receives pass-through funding, the State intends to prioritize the financing of the reinsurance program. This means, after covering state administrative costs for the waiver, the Director would first cover the costs of the reinsurance program before using any of the funds to finance the additional efforts outlined below for the Market Stabilization Program.

If in any given year the federal savings is insufficient for fully financing the reinsurance program for the upcoming waiver/plan year, the State intends to reduce the amount it projects to spend on the two other programs that make up the Market Stabilization Program. If such a reduction is still not enough to cover the cost of a reinsurance program, the State would adjust the attachment point and coinsurance to equal the exact amount of pass-through funding available from the previous calendar year. In turn, this also shifts more of the burden back on carriers in meeting the statutorily required premium reduction target of 15 percent over the first four years of the waiver period. In effect, the financing model of this reinsurance program is intended to have the effect of incentivizing carriers to meet the BBSP premium reduction targets so that sufficient funding is available each year to finance a robust reinsurance program. The State's contracts with carriers for the BBSPs would therefore include two sets of agreed-upon certified rates for achieving the premium reduction target—with and without reinsurance—to ensure the mandatory four-year statutory target can be achieved.

Based on an actuarial analysis by Milliman, it is anticipated that, as a result of the entry of the BBSPs into the market, the federal savings generated in CY 2026 would cover the cost of financing a reinsurance program across the individual market, including premium reductions for BBSP carriers that would help offset the impact of the premium reduction target.

Table 1: Projected Pass-Through Funding (PTF) and Cost of Reinsurance			
Year	Pass-Through Funding (thousands)	Cost of Reinsurance (thousands)	Net Funding Remaining (thousands)
2026	\$15,000	\$0	\$15,000
2027	\$58,000	(\$56,000)	\$2,000
2028	\$69,000	(\$60,000)	\$9,000
2029	\$81,000	(\$64,000)	\$17,000
2030	\$87,000	(\$70,000)	\$17,000
2031	\$93,000	(\$76,000)	\$17,000
2032	\$99,000	(\$83,000)	\$16,000
2033	\$106,000	(\$90,000)	\$16,000
2034	\$114,000	(\$98,000)	\$16,000
2035	\$122,000	(\$106,000)	\$16,000
Five-Year Waiver Window	\$311,000	(\$250,000)	NA*
Ten-Year Deficit Neutrality Window	\$846,000	(\$703,000)	NA*
Five-Year Waiver Window – 10% Margin on PTF	\$279,000	(\$250,000)	NA*
Ten-Year Deficit Neutrality Window – with 10% Margin on PTF	\$760,000	(\$703,000)	NA*

*Remaining funds at year-end are expected to be used for various provider-related initiatives; no accumulation is expected.

2. Reward Carriers for Improving Outcomes with a Quality Incentive Payment Program

Currently, the State uses a quality incentive or “bonus” payment program in its Medicaid Managed Care program to reward carriers for achieving certain quality targets or goals. For example, for Plan Year 2023, the State tied a bonus payment (equivalent to a three percent rate increase) for MCOs to a primary care spending target to incentivize MCOs to increase investment in the State’s primary care provider system. The State is still analyzing MCO performance for this bonus payment, but early results show each of the four MCOs made significant progress in achieving this important goal for the State’s Medicaid program. Additionally, for Plan Year 2023, the State tied a second bonus payment (equivalent to a one percent rate increase) for MCOs that achieved certain enhancements with provider networks to accelerate the use of value-based payment design across the recommended LAN Framework for alternative payment models. Early results of MCO performance indicate each MCO made significant progress in meeting the goals outlined for this bonus payment.

Similarly, for the BBSP program, carriers will be required, at a minimum, under their contracts to partner with providers around value-based initiatives focused on improving care delivery, promoting better quality, increasing efficiencies, and improving health outcomes. Through the Quality Incentive Payment Program for BBSPs, the State intends to require or incentivize carriers to align these value-based initiatives across the Medicaid and individual markets and, if feasible and practical, with the value-based initiatives used in the Medicare market to achieve a best practice, “all-payor model” for these efforts in the State. An all-payor model is consistent with the best practices and models promoted by CMS’ Center for Medicare and Medicaid Innovation. See its recently released AHEAD model initiative. With this new initiative, the State can directly influence and improve how care is delivered and financed, aiming to stabilize Nevada’s individual market by improving population health, which in turn reduces costs and risks to carriers.

Examples of Quality Incentive Payment Program the State is considering during the 1332 waiver period include:

- **Value-Based Payment Design Quality Bonus:** Carriers could be rewarded for establishing new value-based payment programs with certain network providers, including shared risk models, for their BBSP products and to align these arrangements with their Medicaid MCO products and provider networks;
- **Primary Care Spending Target:** The State could reward carriers that increase their annual medical expenditures on primary care services to boost revenues for this scarce segment of the health care system in Nevada. Expenditures could also include new value-based payment programs, including payments for infrastructure in support of primary care provider participation;
- **Public Health Crises:** The State could reward carriers for efforts tied to addressing the opioid crisis or improving maternal and child health outcomes in Nevada, as called for in the HEDIS quality measures used by the State's Medicaid Managed Care program; and
- **Provider Workforce Capacity:** The State could reward carriers that establish successful efforts to increase the capacity of the provider workforce in certain health care workforce shortage areas in Nevada.

The State will work with stakeholders and policymakers to finalize the details of program design for the Quality Incentive Payment Program as the BBSP contracts are developed and finalized throughout 2024 and 2025. The State will condition participation in the Quality Incentive Payment Program on serving as a BBSP carrier. The State intends to utilize a Request For Information (RFI) process to seek further feedback on how best to implement and operate these new programs during 2024.

3. Practice in Nevada Incentive Program for Providers

One of the significant drivers of high health care costs and poor health outcomes in Nevada is the alarming provider workforce shortage in the State. The State proposes to utilize federal pass-through funds to finance a new workforce initiative—a loan repayment program that ties payment to a four-year commitment to live and work in Nevada. Anyone violating the loan repayment agreement would be required under the contract to pay back the financial assistance received from the State. As with the Quality Incentive Payment Program, the design features of the Practice in Nevada Incentive Program will be finalized via the development and finalization of the BBSP contracts, which will enforce such relevant provisions.

At a minimum the State will require that providers live in the community in which they practice for at least four years and be willing to enter into a contract with the State to meet specific program requirements. The Practice in Nevada Incentive Program will serve as another lever to control the rising costs of health care in Nevada. Increasing the number of medical professionals in Nevada could help insurers avoid facing unreasonable price hikes from network providers that are in low supply in the State relative to demand.

F. Implementation Milestones

State law outlines three key milestones for implementation of the new BBSPs. The first is the submission of a Section 1332 waiver application no later than January 1, 2024. In this Section 1332 waiver, the Director must seek federal approval to waive all federal authorities necessary for implementation of the Public Option program and to capture all available federal pass-through funds made available to the State as a result of implementation.

The second step is for the Director to conduct a statewide procurement for the new BBSPs alongside its next statewide Medicaid Managed Care procurement, which is anticipated to begin no later than January 1,

2025. The alignment of this procurement process with the Medicaid Managed Care procurement is intended to leverage the State’s purchasing authority and its multi-billion-dollar contracts with carriers.²² Specifically, State law requires any carrier seeking to be eligible to do business with Nevada Medicaid as an MCO to also submit a good faith bid to offer at least two BBSPs per rating region (i.e., one Silver-level plan and one Gold-level plan). Other carriers not seeking an award as an MCO in the State’s Medicaid Managed Care program may also submit a bid to offer a BBSP. The State does not anticipate any carriers opting to offer a bid for a BBSP contract unless they are also offering a bid for the MCO contract with the State. While the actuarial analysis’ findings are not predicated on the BBSP being the Second Lowest Cost Silver Plan, the State anticipates this will be the case.

The third, and final, major milestone for implementation is that the Director must ensure that carriers under contract to offer the new BBSPs meet all the requirements in order to offer these new products to consumers starting on January 1, 2026, through the SSHIX. The Director intends to reprocur these products every five years, alongside its Medicaid Managed Care program. Carriers must commit in accordance with their contracts with DHHS to ensuring that they will take all necessary steps (i.e., submit timely rate filings and seek QHP certification) each year to offer the BBSPs to consumers. DHHS will review the rate filings approved each year in coordination with DOI to ensure carriers are on track to meet their contractual obligations for the annual premium reduction targets.

Although the statutory mandate for the premium reduction target expires on January 1, 2030, nothing prohibits the Director from continuing a similar target and contracts with carriers for the BBSP in future years to ensure the success of the program. In fact, the Director has broad authority to establish contract requirements for the BBSP that are within the intent of the law for the Public Option program. Therefore, the Director intends to maintain a similar target for the BBSPs in year five (2030) and in future contract periods to the extent necessary to maintain controls on cost growth for consumers and adequate funding for the State-based reinsurance program. For example, in year five of the waiver, the Director intends to include a provision in the BBSP contract to ensure the premium reduction trend is maintained at roughly 15% below the benchmark premium (with the ability to adjust for costs associated with changes in morbidity and utilization).

Besides the milestones set forth in State law for the BBSPs, implementation of the Market Stability Program will also take place in 2026, with a rollout date of 2027 upon receipt of federal pass-through funds, pending federal approval.

Table 2 below lists these milestones and key dates for the State’s implementation of NRS 695K and the Market Stabilization Program, pursuant to this 1332 waiver approval.

Table 2: Nevada Battle Born State Plan Implementation Timeline and Milestones	
Quarter 4, 2021	<ul style="list-style-type: none"> Public workshops on product design held by the State.
Quarters 1-3, 2022	<ul style="list-style-type: none"> Actuarial analysis and waiver development.
Quarter 4, 2022	<ul style="list-style-type: none"> Nevada Medicaid hosts weekly “office hours” for the Public Option.

²² MCO contracts are estimated to be worth \$20-\$25 billion in total (or \$4-\$5 billion annually) for carriers participating in the next MCO contract period (5 years).

Quarter 3, 2023	<ul style="list-style-type: none"> • Development of a new Market Stabilization Program for waiver.
Quarter 4, 2023	<ul style="list-style-type: none"> • Finalize actuarial analysis and waiver draft. • Draft waiver application released November 20, 2023. • DHHS hosts two hybrid (in-person and virtual) public workshops/hearings on draft waiver (November 27 and December 5). • DHHS hosts two tribal consultations (November 29 and December 7). • DHHS issues new bulletin to carriers on BBSP revised target and reinsurance program (November 20). • DHHS submits waiver application (by January 1, 2024).
Quarter 1-2, 2024	<ul style="list-style-type: none"> • CMS/Treasury determine completeness within 45 days and hold 30-day federal public comment period. • DHHS begins development of procurement materials and contracts for BBSPs. • DHHS hosts stakeholder meetings to gather input on procurement for BBSPs.
Quarter 2, 2024	<ul style="list-style-type: none"> • CMS/Treasury continues a 180-day review/determination period. • DHHS develops Request for Information to gather stakeholder feedback on design elements for the BBSP contracts. • DHHS releases Request for Information to gather stakeholder feedback on BBSP contracts. • DHHS continues development of procurement materials and contracts for BBSPs.
Quarter 3, 2024	<ul style="list-style-type: none"> • CMS/Treasury make final determination on waiver application. • DHHS finalizes procurement materials and contract for BBSPs
Quarter 4, 2024	<ul style="list-style-type: none"> • MCO/BBSP statewide procurement begins.
Quarter 1, 2025	<ul style="list-style-type: none"> • State evaluators for procurement review bids for MCOs and BBSPs.
Quarter 2, 2025	<ul style="list-style-type: none"> • Continued procurement process.
Quarter 3, 2025	<ul style="list-style-type: none"> • DHHS sends Letter of Intent to Award MCO and BBSP contracts. • Negotiation and awards final for BBSP contracts. • BBSP carriers submit rate filings to DOI for review/approval. • DOI completes rate analyses and approval processes. • DOI submits final rate filings to the Center for Consumer Information and Insurance Oversight (CCIIO). • BBSP carriers submit for SSHIX certification.
Quarter 4, 2025	<ul style="list-style-type: none"> • BBSPs are offered for enrollment during Open Enrollment.

Quarter 1, 2026	<ul style="list-style-type: none"> • BBSPs available on SSHIX for Plan Year 2026.
Quarter 2, 2026	<ul style="list-style-type: none"> • DHHS/DOI guidance to carriers on reinsurance and Quality Incentive Payment Program. • BBSP carriers submit rate filings to DOI for Plan Year 2027 for review/approval.
Quarter 3, 2026	<ul style="list-style-type: none"> • DOI completes rate analyses and approval processes. • DOI submits final rate filings to CCIIO. • BBSP carriers submit for SSHIX certification.
Quarter 4, 2026	<ul style="list-style-type: none"> • BBSP are offered for enrollment during Open Enrollment
Quarter 1, 2027	<ul style="list-style-type: none"> • BBSP available on SSHIX for Plan Year 2027. • Reinsurance program begins for Plan Year 2027.

G. Inter-agency Coordination

The Director, the Commissioner of Insurance, and the Executive Director of SSHIX will be responsible for certain activities necessary for offering the BBSPs to consumers and for maintaining their current operational roles in the health insurance market. These administrative roles are further described below:

1. Nevada DOI

The Commissioner of Insurance will continue to lead the rate review process for plans offered in the individual health insurance market, which includes the new BBSPs. Like other rate filings submitted by carriers, the DOI will review the rate filings submitted by Nevada carriers and oversee compliance with rate and form requirements, network adequacy, and solvency and reserve standards.

2. SSHIX

The SSHIX will continue to annually certify QHPs for participation in its online platform with premium subsidies for consumer shopping as it does today. For Coverage Year 2026 and beyond, QHP offerings will include BBSPs.

3. Nevada DHHS

DHHS will play a new role in overseeing the procurement and contracting process for the BBSP and provide contract monitoring and oversight of compliance with requirements set forth in the contract between the State and the carriers selected to provide BBSPs. This contract is a new agreement with the State, separate from its SSHIX certification, that allows BBSPs to be offered on the SSHIX. The contract with DHHS will outline how the carrier will meet the unique requirements of State law as a BBSP.

DHHS will also determine whether a good faith bid has been submitted by a carrier as required by State law as part of the State MCO purchasing review process and coordinate with DOI during the rate review process to ensure carriers offering the BBSPs remain on track to meet annual premium reduction targets as agreed to under their contracts with the State. If a carrier cannot meet the target set forth in its contractual

agreement with DHHS, the Director may utilize a corrective action plan (if deemed a viable option for the carrier, in order to allow the carrier to make up some of the reduction in future years) and any other penalties set forth in such agreement, including a financial penalty that is worth all or some of the value of the federal pass-through funding that the State would have otherwise received if the carrier had met its agreed-upon premium reduction target. In an extreme scenario, a carrier found out of compliance or in breach of contract could have their existing BBSP and MCO contracts with DHHS terminated and/or the carrier could be deemed ineligible to participate in a future MCO procurement.

Regarding the reinsurance program, DHHS and DOI will be responsible for collaborating and coordinating resources and staff to implement and operate the new program. For the Quality Incentive Payment Program, DHHS will be responsible for establishing criteria and issuing payments to qualifying carriers. DHHS will work with the appropriate entity or entities as necessary to implement the Practice in Nevada Program for health care providers.

H. Expected Federal Savings and Enrollment Changes

The actuarial analysis conducted by Milliman, Inc. estimates that the introduction of new BBSPs into the SSHIX with the support of a reinsurance program for the State’s individual market could achieve nearly \$279 –\$310 million in federal savings in the first five years and \$760–\$844 million at the end of the first ten years.²³

For purposes of the actuarial review conducted by Milliman, it is assumed that the Inflation Reduction Act’s enhanced federal marketplace subsidies will expire on January 1, 2026, at the time the new BBSPs enter the Nevada market and SSHIX.²⁴ Table 3 below shows the projected federal pass-through funding from the BBSPs (i.e., specifically from the new premium reduction target for waiver years 2026–2030) and the new reinsurance program (for waiver years 2027–2030).

Table 3: Summary of Projected Pass-Through Funding by Scenario			
Total Pass-Through Funding (PTF), (in Thousands)			
Time Period	BBSPs Only	Reinsurance	Total
Five-Year Waiver Window	\$ 168,000	\$142,000	\$310,000
Five-Year Waiver Window (With 10% Margin)*	\$151,000	\$128,000	\$279,000
Ten-Year Deficit Neutrality Window	\$445,000	\$399,000	\$844,000
Ten-Year Deficit Neutrality Window (With 10% Margin)*	\$401,000	\$359,000	\$760,000

**Milliman, Inc. reduced each scenario by 10% margin of error.*

Table 4 shows the projected federal savings as a result of the approval of this waiver and the implementation of the BBSPs and, subsequently, a reinsurance program. This table assumes the BBSP carriers meet the premium reduction targets for all five years of the waiver (at least 15 percent in the first four years), and that starting in plan year two, the State implements a State-based reinsurance program using federal pass-through

²³ See Nevada 1332 Waiver Actuarial Report by Milliman, Inc., 2023.

²⁴ The American Rescue Plan (ARP) and the Inflation Reduction Act (IRA) created and extended enhanced financial assistance to purchase health insurance coverage on the marketplaces originally established by the ACA during the public health emergency related to COVID-19. These enhanced subsidies are set to expire December 31, 2025.

from waiver year one to fully finance the program. The premium reduction targets are inclusive of the impact of reinsurance. This analysis also assumes that, with their premium reduction target and the introduction of reinsurance, the BBSPs will be the SLCSP in the SSHIX each year of the waiver period.

Table 4: Impact of Waiver Compared to Baseline				
Year	Premiums	Total Change		Federal Savings (Thousands)
		Individual Market Enrollment		
2026	(3.2%)	600		\$15,000
2027	(12.0%)	1,800		\$58,000
2028	(13.5%)	2,000		\$69,000
2029	(15.0%)	2,100		\$81,000
2030	(15.2%)	1,900		\$87,000

As a result of the new BBSPs in SSHIX and the State-based reinsurance program, Milliman, Inc. also estimates the following changes in enrollment in the SSHIX as described in Table 5, with a BBSP being the SLCSP.

Table 5: Projected SSHIX Enrollment Change from Baseline			
Year	BBSPs Only	Reinsurance	Total
2026	600	0	600
2027	700	1,100	1,800
2028	900	1,100	2,000
2029	1,000	1,100	2,100
2030	800	1,100	1,900
2031	900	1,100	2,000
2032	900	1,100	2,000
2033	900	1,200	2,100
2034	900	1,200	2,100
2035	800	1,200	2,000

It should be noted that, given Colorado’s recent experience with a premium reduction target, it is possible that BBSPs may not be the SLCSP in all waiver/plan years. If this is the case, Nevada intends to review the rate filings and survey all carriers at the time of their rate filings to determine whether carriers offering lower rates in a given year were influenced by the introduction of the BBSPs and their lower premium targets, along with reinsurance in that waiver/plan year (if available).

This survey will inquire, at a minimum, as to whether the new BBSP program impacted their rate filings for that plan year, including whether the new program affected their underlying contractual arrangements with providers about reimbursement rates for services, or whether it resulted in a reduction in the portion of the premium that accounts for their administrative costs and what types of savings or efficiencies they accounted for due to these reforms. In such a scenario, the State (DHHS and DOI) would work with Milliman, Inc. and CMS/Treasury to determine how much of this influence could be attributed to the BBSPs and reinsurance. Using this analysis, the State would be able to update its calculation of federal savings analysis.

If the amount of federal savings, and therefore pass-through funds, is lower than estimated, the State intends to adjust its reinsurance attachment point and coinsurance to ensure that there are adequate funds to support the program for the upcoming calendar year. If the amount of federal savings is greater than needed to fully

fund the reinsurance program, the State intends to utilize the passthrough to fund the State's new Quality Incentive Payment Program and its Practice in Nevada Program.

The analysis of federal savings shows the impact of the new premium reduction targets and reinsurance in the individual health insurance market in Nevada. It does not assume an impact on federal pass-through funding for the other two programs that make up the Market Stabilization Program (e.g., Quality Incentive Payment Program and Practice in Nevada Program). Although both are expected to reduce costs to carriers over time with improvements in quality of care and population health, the potential short-term effects of these efforts on premiums are not quantifiable.

Section 3: Actuarial Analysis of Proposed Waiver

A: Impact on Section 1332 Guardrails

This section discusses the impact of the waiver's individual market elements on the four Section 1332 waiver statutory guardrails. Nevada's actuarial analysis conducted by Milliman, Inc., indicates that Nevada's waiver meets the federal requirements for a Section 1332 waiver under the scenarios modeled.

1. Affordability (1332(b)(1)(B))

The Section 1332 waiver must provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable as would be projected without the waiver.

The waiver satisfies the affordability requirement as follows:

- Table 6 shows the percentage by which BBSPs are expected to lower the cost of the benchmark plan in each year of the five- and ten-year windows.
- Average net premiums (after subsidies) for subsidized Silver enrollees are expected to be no higher than Baseline scenarios. Enrollees who switch to the SLCS, which is assumed to be a BBSP in waiver scenarios, will realize no (zero) change in net premium relative to the Baseline scenario.

Subsidized enrollees who currently receive no-cost Bronze plans could continue to pay no net premium (after subsidies), if they remain in or switch to a Bronze plan with a premium lower than the value of their premium tax credit. Further, Bronze plan enrollees who receive smaller subsidies (e.g., lower-cost areas, younger ages, higher incomes) may see premium decreases (similar to Silver plans described above). The introduction of reinsurance will further lower out-of-pocket premium costs for enrollees. Cost sharing for BBSPs and standard QHPs are not expected to change under the waiver. Therefore, non-premium cost sharing will be at least as affordable under waiver as without the waiver.

As shown below in Table 6, the reinsurance program in 2027 helps to offset the burden on carriers and their provider networks of the premium reduction target by subsidizing the reduction in rates by about half. For example, in waiver year two (2027), carrier rate filings with reinsurance account for 6.8% of that year's reduction, and, by 2030, reinsurance accounts for a cumulative total of 7.2% of the premium reduction target as compared to the average benchmark year. These premium reductions will make coverage more affordable for unsubsidized people.

Table 6: Projected Second-Lowest-Cost Silver Premium Change from Baseline			
Year	BBSPs Only	Reinsurance	Total
2026	-3.2%	0.0%	-3.2%
2027	-5.2%	-6.8%	-12.0%
2028	-6.6%	-6.9%	-13.5%
2029	-8.0%	-7.0%	-15.0%
2030	-8.0%	-7.2%	-15.2%
2031	-8.0%	-7.4%	-15.4%
2032	-8.0%	-7.6%	-15.7%
2033	-8.0%	-7.9%	-15.9%
2034	-8.0%	-8.1%	-16.1%
2035	-8.0%	-8.3%	-16.3%

2. Coverage (1332(b)(1)(C))

The waiver plan must provide coverage to at least a comparable number of its residents as would otherwise be covered without the waiver. Table 7 shows how the waiver plan satisfies the scope of coverage standard for all waiver and deficit neutrality window years. The actuarial report expects modest increases in enrollment due to the introduction of the BBSPs and slightly larger incremental increases in enrollment in the SSHIX due to the implementation of reinsurance, as shown in Table 7. These increases mainly result from individuals who were uninsured but find unsubsidized premiums under the waiver more affordable due to the gross premium reductions related to the reinsurance program.

Table 7: Projected Individual Market Enrollment Change from Baseline			
Year	BBSPs Only	Reinsurance	Total
2026	600	0	600
2027	700	1,100	1,800
2028	900	1,100	2,000
2029	1,000	1,100	2,100
2030	800	1,100	1,900
2031	900	1,100	2,000
2032	900	1,100	2,000
2033	900	1,200	2,100
2034	900	1,200	2,100
2035	800	1,200	2,000

3. Comprehensiveness (1332(b)(1)(A))

The Section 1332 waiver must provide coverage at least as comprehensive as it would be without the waiver. The Nevada Section 1332 waiver complies with this standard because SB420 requires the new BBSPs to meet all QHP standards under the ACA, which includes providing the full set of essential health benefits. It does not make any changes to these benefits, nor does it alter any other coverage requirements for QHPs, for either BBSPs or standard QHPs. Reinsurance does not have any impact on the comprehensiveness of coverage.

4. Deficit Neutrality (1332(b)(1)(D))

The Section 1332 waiver must be deficit neutral to the federal government compared to projections without the waiver. Table 8 shows the total projected pass-through funding by scenario, demonstrating that the reinsurance program and premium reduction target satisfy the deficit neutrality standard.

These reforms reduce federal outlays for premium subsidies relative to the Baseline scenario and these savings are paid to the State in the form of pass-through funding such that total outlays under a waiver (subsidies paid to enrollees plus pass-through funding to the State) are no greater than subsidies paid to enrollees without the waiver. The Milliman report reduces the projected pass-through funding over the five-year waiver and ten-year deficit neutrality windows by a 10% margin to account for unknown contingencies.

Table 8: Projected Pass-Through Funding by Scenario			
Total Pass-Through Funding (Thousands)			
Year	BBSPs Only	Reinsurance	Total
2026	\$15,000	\$0	\$15,000
2027	\$26,000	\$32,000	\$58,000
2028	\$35,000	\$34,000	\$69,000
2029	\$45,000	\$36,000	\$81,000
2030	\$47,000	\$40,000	\$87,000
2031	\$50,000	\$43,000	\$93,000
2032	\$52,000	\$47,000	\$99,000
2033	\$56,000	\$50,000	\$106,000
2034	\$58,000	\$56,000	\$114,000
2035	\$61,000	\$61,000	\$122,000
Five-Year Waiver Window	\$168,000	\$142,000	\$310,000
Ten-Year Deficit Neutrality Window	\$445,000	\$399,000	\$844,000
Five-Year Waiver Window – 10% Margin	\$151,000	\$128,000	\$279,000
Ten-Year Deficit Neutrality Window – with 10% Margin	\$401,000	\$359,000	\$760,000

B. Impact on Health Equity

The authorizing legislation for the waiver and BBSP include, among its stated purposes, the aim to “reduce disparities in access to health care and health outcomes and increase access to health care for historically marginalized communities.” The BBSPs will be specifically designed to increase access and improve outcomes for historically marginalized communities. The State law directs the Director to prioritize awards to carriers that respond to the procurement with provider arrangements and strategies that will help decrease disparities in access and outcomes and support culturally competent care.

The Director must also prioritize bids for the BBSP that demonstrate alignment of provider networks between BBSP and MCO programs, where applicable, to help ensure continuity of care as people move up the income ladder and purchase health insurance in the individual market. In prioritizing alignment of provider networks, the State is minimizing the incidence of disruptions in care that disproportionately impact low-income

Americans and lead to worse health outcomes and increased financial risk.²⁵

Additionally, by leveraging a unified state purchasing strategy, Nevada can improve outcomes for historically marginalized communities. DHHS intends to release a Request for Information before June 2024 to gather stakeholder feedback on opportunities to reduce health disparities and improve health equity through the new BBSPs and other items for procurement and new contracts. The State is exploring the following contract provisions for BBSPs focused on health equity:

- Requirements for BBSP carriers to collect and report on race, ethnicity, and language data.
- Requirements for BBSP carriers to submit health care workforce development plans that align with strategies for the carriers' MCO products that increase access to health care providers where gaps exist and improve cultural competency among Nevada's provider workforce.
- Requirements for BBSP carriers to report on enrollees' out-of-pocket spending annually.
- Quality metrics that align with Medicaid Managed Care metrics that are stratified by race and ethnicity to measure progress toward closing health disparities.
- Financial rewards for BBSP carriers that achieve State goals related to addressing health disparities.

These rewards would be financed through the Quality Incentive Payment Program. Further, the above contractual requirements will empower the State to measure, track, and act on health care disparities, furthering the authorizing legislation's goal of improved access to health care and better health outcomes for historically marginalized communities.

Finally, DHHS plans to use the State-based reinsurance program as a lever to address geographic disparities in market stability and affordability in the individual market. Those living in Rating Areas 3 and 4 – comprised of more rural counties – have historically been exposed to higher gross premiums.²⁶ The State plans to implement a tiered reinsurance program that will have a more pronounced impact on lowering premiums in Rating Areas 3 and 4. In doing so, the State is investing more resources to bring market stability to more rural regions in the State where there have been longstanding affordability challenges.

Section 4: Additional Information

A. Administrative Burden

The waiver will cause minimal administrative burden for the State of Nevada and the federal government. The waiver will cause no additional administrative burden to employers or individual consumers because Section 1312(c)(1) does not relate to administrative functions or requirements typically undertaken by employers or individual consumers.

Individual health insurers will experience additional administrative burden as it relates to the waiver, as carriers will be required to offer an additional plan that conforms to the premium reduction targets defined in Nevada statute and authorized by this waiver. The additional plan offering will require development and submission of rate and form approval.

²⁵ Ben Sommers and others. Insurance Churning Rates for Low-Income Adults Under Health Reform available at: <https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0455>.

²⁶ 2023 Nevada Division of Insurance Market Report, available at: https://doi.nv.gov/uploadedFiles/doi.nv.gov/Content/News_and_Notices/2023_InsuranceMarketReport_FINAL_ADA.pdf

With the new federal pass-through funds available from this waiver, Nevada will be able to sustain the necessary resources and staff to carry out the following administrative tasks for the new BBSPs and reinsurance program under a Section 1332 waiver:

- Collect and apply for federal pass-through funds.
- Distribute pass-through funds.
- Monitor and enforce the provisions of the premium reduction requirement by leveraging aligned BBSP and Medicaid MCO procurement processes.
- Administer the reinsurance program and other market stabilization programs funded with pass-through funding as approved under this waiver.
- Monitor compliance with federal and State law.
- Collect and analyze data related to the waiver.
- Perform reviews of the implementation of the waiver.
- Submit all required reports to the federal government.

The waiver will require the federal government to perform the following administrative tasks:

- Review documented complaints, if any, related to the waiver.
- Review State reports.
- Periodically evaluate the Section 1332 waiver program.
- Calculate and facilitate the transfer of federal pass-through funds to the State.
- Allow the State to use EDGE server to calculate reinsurance payments. If allowed, DHHS and DOI will provide the federal government with the applicable reinsurance parameters for each plan year through written communication, to be used for calculating carrier reimbursements under the reinsurance program.

Nevada believes that the above administrative tasks are similar to other administrative functions currently performed by the federal government so that their impact is minimal. The waiver of Section 1312(c)(1) does not necessitate any changes to the Federally Facilitated Exchange or to IRS operations and will not impact how advanced premium tax credits and premium tax credit payments are calculated or paid.

B. Implementation of Non-waived ACA Provisions

The implementation of this waiver application does not have any impact on the implementation of those provisions of the ACA that are not being waived.

C. Impact on Residents Who Need to Obtain Health Care Services Out of State

Because Nevada shares borders with California, Oregon, Idaho, Utah, and Arizona, insurer service areas and networks that cover border counties contain providers in those states, especially in areas where the closest large hospital system is in the border state. It is expected that provider networks in service areas where out-of-state providers are commonly used will include those out-of-state providers.

D. Compliance, Waste, Fraud, and Abuse

The Director of DHHS, in consultation with the Commissioner of DOI and the Executive Director of the SSHIX, shall implement and oversee the administration of the BBSPs from their respective administrative roles. Under State law, the BBSPs shall operate as individual health insurance products that comply with State and

federal requirements for QHPs and all State health insurance laws and regulations.

DHHS will oversee the procurement of the BBSPs and oversee compliance with the requirements set forth in the contract between the State and the carriers selected to provide these plans, such as the premium reduction targets. DHHS intends to hire an actuarial consultant to determine the average reference premium, including defining the morbidity index and a historical utilization trend; to review proposed rates during the procurement process for reasonableness and actuarial soundness, like the process DHHS uses for the MCO procurement; and to provide ongoing modeling support of additional premium subsidies.

The SSHIX will serve in the role it has today with carriers seeking to offer QHPs. Any carrier awarded a contract by DHHS to offer BBSPs must agree to seek certification of these plans as QHPs from the SSHIX. The SSHIX will determine whether these plans meet the certification requirements and whether they are eligible for premium tax credits like other plans being offered as QHPs in the SSHIX. This includes applying the premium assessment fee, which is used as revenue to fund the operations of the SSHIX.

DOI will continue to lead its rate review and network adequacy processes for private health insurance plans in the individual market, which as of 2026 will include the BBSP products. DOI is responsible for regulating, ensuring compliance of, and monitoring the solvency of all carriers; performing market conduct analysis, examinations, and investigations; and providing consumer outreach and protection. The DOI investigates all complaints that fall within the agency's regulatory authority.

DOI will review the rate filings submitted by the BBSP carriers and oversee compliance with rate and form requirements, network adequacy, and solvency and reserve standards as set forth in State law. DHHS will coordinate with DOI during the rate review process to ensure BBSP carriers are on track to meet premium reduction targets that are set forth in contract with the State and will work with DOI to make any permissible adjustments to ensure actuarial soundness and market stability. Auditing and reporting obligations of participating insurers will be established by rule.

DHHS and DOI are audited as part of the Annual Comprehensive Financial Report (ACFR) and are included in the State Audit. The Legislature's Audit Subcommittee contracts with an external firm to conduct the audits, and the audits are presented to the Legislature. The Nevada BBSP program and federal pass-through funding will be subject to audit under the State's ACFR and Single Audit. The reinsurance program will also be subject to those audits and will be part of the annual report. The federal government is responsible for calculating the federal savings resulting from this waiver and for ensuring that this waiver does not increase federal spending.

E. State Reporting Requirements and Targets

Pursuant to 45 CFR 155.1320(b) and 45 CFR 155.1324(a), DHHS will conduct periodic reviews related to the implementation of the waiver. A report on the operation of the BBSP premium reduction implementation progress will be submitted by March 31, 2026. A similar report on the reinsurance program's operation will be submitted on March 31, 2027.

DHHS will report on the operation of the waiver quarterly, including, but not limited to, providing reports of any ongoing operational challenges, as well as plans and results of associated corrective actions no later than 60 days following the end of each calendar quarter. DHHS will submit its annual report in lieu of its fourth-quarter report. DHHS will submit and publish annual reports by the deadlines established in 45 CFR 155.1324(c) or the deadlines established by the terms of the waiver.

Each quarterly report will include the following:

- The progress of the Section 1332 waiver;
- Data, similar to that contained in this waiver application, necessary to demonstrate compliance with Section 1332(b)(1)(B) through (D) of the ACA;
- A summary of the annual post-award public forum, held in accordance with 45 CFR 155.1320 (c), including all public comments received at the forum regarding the progress of the waiver and any actions taken in response to comments received;
- Other information DHHS determines necessary to evaluate the waiver and accurately calculate the pass-through payments to be made by federal government; and
- Reports of ongoing operational challenges, if any, and plans for and results of corrective actions that have been taken.

DHHS will submit a draft annual report within 90 days after the end of the first waiver year and each subsequent year that the waiver is in effect. DHHS will publish the draft annual report on its website within 30 days of submission of the draft report to CMS. Within 60 days of receipt of comments from CMS on the draft annual report, DHHS will submit the final annual report for the waiver year. That submission will include a summary of the comments received and a copy of the comments submitted to DHHS on the draft annual report. Once the final annual report is approved by CMS, DHHS will publish the final annual report on its website within 30 days of approval.

The annual report prepared by DHHS will include the following metrics to assist evaluation of the waiver's compliance with the requirements found in Section 1332(b)(1):

- Actual individual market enrollment in the State.
- Actual average individual market premium rate (i.e., total individual market premiums divided by total member months of all enrollees).
- The actual SLCSPP premium under the waiver and an estimate of the SLCSPP premium as it would have been without the waiver for a representative consumer (e.g., a 21-year-old nonsmoker) in each rating area.
- The actual amount of Advance Premium Tax Credit (APTC) paid, by rating area, for the plan year.
- The actual number of APTC recipients for the plan year. The number should be the number summed over all 12 months and divided by 12 to provide an annualized measure.
- Changes to the waiver programs, including the funding level the program will be operating at for the next plan year, or other program changes.
- Notification of changes to state law that may impact the waiver.
- Reporting of:
 - Federal pass-through funding spent on subsidy programs adopted by DHHS. The unspent balance of federal pass-through funding for the reporting year, if applicable.

F. Proposed State Operations Budget for Waiver Program

NRS 695K.300 provides that federal pass-through funds shall be used to pay for the costs associated with carrying out the statutes pertaining to the administration of the public option at the state level. Below are estimated State administrative costs associated with operating the BBSPs as outlined under state law in NRS 695K.

Table 9: Estimated Annual SFY Budget Costs for State Operations, Starting SFY 2026	
Nevada Division of Insurance Operation Costs for Public Option	
Data Process Setup Assistance	One-Time Set-Up Cost of \$60,000.00
Software License	\$10,000.00 per SFY
Reinsurance Program Manager	\$80,000.00 per SFY
Increased Rate Review Costs	\$20,000.00 per SFY
Outside Auditing Services	\$20,000.00 per SFY
Estimated subtotal	\$60,000.00 One Time Cost
	\$130,000.00 per SFY
Nevada Medicaid Operation Costs for Public Option	
New Staffing Costs for Contracts Oversight /Waiver Management	\$400,000.00 per SFY
New Actuary and Transaction Fees ²⁷	\$1,600,000.00 per SFY
Estimated subtotal	\$2,000,000.00 per SFY
Estimated Total Operational Costs per SFY	\$2,130,000.00 per SFY

Furthermore, NRS 695K.200 also provides that any additional federal dollars received as pass-through funds pursuant to a Section 1332 waiver may be used by the Director to increase consumer affordability. At this time, the State is requesting use of remaining funds to be used to finance the new Market Stability Program as described in this waiver request to improve affordability and ensure the sustainability of the market with the new BBSPs.

G. Evidence of Public Notice and Tribal Consultation Requirements

The State of Nevada held a public comment period beginning on November 20, 2023 and ending on December 20, 2023. The public comment period was announced through a posting on the Nevada Department of Health and Human Services Division of Health Care Financing and Policy (DHCFP/the Division)'s [website](#). The State also sent a press release to local media outlets and a similar notice through the Nevada Market Stabilization Program ListServ, announcing the beginning of the 30-day public comment period (see Appendix for this press release). The public hearings were also announced on DHCFP's website as public notices (see Appendix materials). During the public comment period, the Division of Health Care Financing and Policy held two tribal consultations (November 29 and December 7), and two public hearings (November 27 and December 5). The presentations for the consultations and hearings are available in the Appendix.

The Division used several mechanisms to notify the public of the comment period and 1332 Waiver Application, offering significant opportunity to provide feedback to the State through both hybrid (in-person and virtual) meetings and written comments. The public notice for this Waiver complies with 31 CFR 33.112 and 45 CFR 155.1312. The Waiver Application was posted on the Division of Health Care Financing and Policy's [website](#) on November 20, 2023.

The tribal consultations for the 1332 Waiver Application were held on November 29 and December 7, 2023, from 9:00 – 10:00am PST and 1:30 – 2:30pm PST, respectively, both in-person and via Teams. The meetings were hosted by the Division and all Tribal Chairs and Tribal Health Clinic Directors from the Nevada Tribes were

²⁷ The State requires dedicated funding for actuarial support focused on procurement and contract development as well as rate review technical assistance to ensure premium reduction targets are on track for being met.

invited to the consultations.²⁸ During the consultations, staff members from the Division presented an overview of the 1332 Waiver Application and the anticipated impact of the Waiver on tribal communities. After the presentation, Division staff addressed questions from the meeting attendees. Commenters raised questions about the BBSPs, including network provider requirements, whether tribes would be able to sponsor premiums for BBSPs offered on the Exchange with federal funding, and if BBSPs would include an Indian Addendum to coordinate health coverage for tribes with providers in multiple states. The State confirmed that all requirements that apply to Qualified Health Plans also apply to the BBSPs.

The public hearings for the 1332 Waiver Application were held on November 27 and December 5, 2023, 1:00 – 3:00pm PST, both in-person and via Teams. A total of 99 persons attended the November 27 hearing and 88 persons attended the December 5 hearing. At the hearings, staff members from the Division presented the details of the Waiver Application, including the BBSPs and Market Stabilization Program. Staff members then opened the floor for questions and comments from meeting attendees. Commenters provided positive feedback on the BBSPs as a mechanism to strengthen health equity in Nevada through improving health care affordability. Attendees also positively supported features of the State’s Market Stabilization Program, including provisions to strengthen the health care workforce and implement a reinsurance program. Some commenters expressed concerns related to the required BBSP premium reduction targets, anticipated provider reimbursement reductions, and provider participation requirements. In the Appendix, the Division has identified public hearing comments pertinent to the Waiver Application and provided a response to themes from those comments. The Division also posted recordings of the two public hearings on the Coverage & Market Stabilization Program [website](#).

The Division also accepted written comments during the 30-day comment period. 37 written comments were submitted during this time period. Those submitting written comments expressed similar themes as outlined above during the public hearings. The State received several comments in support of the 1332 Waiver Application, highlighting the potential for the BBSPs to improve affordability and narrow health care disparities. Other commenters expressed concerns related to mandated premium reductions, anticipated provider reimbursement reductions, and certain provider participation requirements. The Appendix also includes responses to themes raised from written comments.

²⁸ Tribes invited to tribal consultations include: Battle Mountain Band Council, Carson Colony Community Council, Confederated Tribes of Goshute, Dresslerville Community Council, Duck Valley Shoshone-Paiute Tribe, Duckwater Shoshone Tribe, Elko Band Council, Ely Shoshone Tribe, Fallon Paiute Shoshone Tribe, Ft McDermitt Paiute-Shoshone Tribe, Fort Mojave Indian Tribe, Las Vegas Paiute Tribe, Lovelock Paiute Tribe, Moapa Band of Paiutes, Pyramid Lake Paiute Tribe, Reno-Sparks Indian Colony, South Fork Band Council, Stewart Community Council, Summit Lake Paiute Tribe, Te-Moak Tribe of Western Shoshone, Timbisha Shoshone Tribe, Walker River Paiute Tribe, Washoe Tribe of Nevada & California, Wells Band Council, Winnemucca Indian Colony, Woodfords Community Council, Yerington Paiute Tribe, Yomba Shoshone Tribe, Te-Moak Shoshone Tribe Bands, and Washoe Tribe of Nevada & California Councils.

Attached Materials

MILLIMAN REPORT

1332 Waiver Actuarial / Economic Analysis and Certification for Nevada's Market Stabilization Program

Prepared for Nevada Department of Health and Human Services

December 22, 2023

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I. EXECUTIVE SUMMARY

Milliman, Inc. (Milliman) has been contracted by the State of Nevada to perform actuarial and economic analyses of the impact of a Section 1332 waiver and provide an actuarial certification that the waiver complies with federal guardrail requirements. The State of Nevada is seeking a 1332 waiver to obtain pass-through funding (PTF) related to the establishment of the Nevada Market Stabilization Program (NMSP) that includes the operation of a Public Option (PO) program on the Silver State Health Insurance Exchange (the Exchange) beginning in 2026 and a reinsurance program for the individual market beginning in 2027. The legislation that establishes a PO and grants authority for establishment of a reinsurance program was introduced through Nevada Senate Bill 420 as passed during the 2021 State Legislative Session (SB420) and is described in more detail in Section II of this report. The State of Nevada's Division of Health Care Financing and Policy (DHCFP) and Department of Health and Human Services (DHHS) issued guidance that clarifies the methodologies and assumptions the state intends to use when implementing the legislated premium reduction targets.

Based on Section 2 of SB420, which can be found in Appendix B, the stated purpose of the PO is to lower individual market health insurance premiums and consumer out-of-pocket premium costs, improve access to health care, reduce disparities in health care access and outcomes, and improve the availability of coverage for residents of rural areas. Furthermore, the PO plan offerings, hereafter referred to as Battle Born State Plans (BBSPs), are expected to provide the opportunity for some Nevadans to obtain a lower-priced product through reduced provider reimbursement, reduced issuer administrative expenses, and value-based purchasing initiatives designed to drive efficiency in utilization. With lower gross premiums, it is likely that a BBSP will become the benchmark plan in all rating areas in Nevada, thereby lowering federal outlays for premium subsidies, which then become available to the State of Nevada as PTF under the Section 1332 waiver. Where a BBSP does not become the SLCS,¹ it is expected that the introduction of these lower cost plans will increase competition such that standard QHPs, or individual market plans that are not BBSPs, are lower than they otherwise would be, thereby reducing federal subsidies and generating PTF. Therefore, the PTF under the Section 1332 waiver is not expected to rely on having at least two BBSPs in each rating area or on a BBSP being the SLCS.

In addition to the introduction of BBSPs, the State of Nevada intends to implement a reinsurance program in the individual market beginning in 2027. The stated intent of the reinsurance program is to transform the PO into a market stabilization program by reinvesting 1332 waiver pass-through funding back into Nevada's individual health insurance market.² The reinsurance program implementation will occur after the implementation of BBSPs to allow for the accumulation of sufficient PTF to cover the State of Nevada's portion of the reinsurance program costs.

It is our understanding, based on conversations with DHCFP and DHHS, that the revisions and clarifications in the DHHS guidance are intended to align the NMSP implementation with the intent of SB420. The agency's memorandum of guidance is provided in Appendix C. Any changes to this approach or guidance subsequent to the date of this analysis may affect the applicability of the findings in this report.

This report provides the required actuarial and economic analyses and an actuarial certification to support the State of Nevada's determination that the NMSP meets the requirements of a Section 1332 waiver. Consistent with current law, we provide the actuarial and economic analyses assuming premium subsidy amounts for on-exchange coverage under the Patient Protection and Affordable Care Act (ACA), which were increased by the American Rescue Plan Act (ARP) for 2021 and 2022 and extended through 2025 by the Inflation Reduction Act (IRA), revert in calendar year (CY) 2026 to levels similar to those in place prior to the temporary increase in premium subsidy amounts authorized by ARP. We refer to these increased subsidies due to ARP and the IRA as "enhanced subsidies" throughout this report.

The parameters modeled in our analyses are consistent with our understanding of the statutory language of SB420 and the State of Nevada's guidance in Appendix C. Our analyses model the impact of the implementation of the NMSP. In addition, the analyses in this report assume Medicaid redeterminations following the expiration of the COVID-19 public health emergency (PHE) will be completed prior to the implementation of the NMSP.

The initial scenario assumes the state does not have a 1332 waiver, and thereby does not have BBSPs or a reinsurance program. We refer to this scenario as the "Baseline" scenario.

¹ For modeling purposes, whether a BBSP or a standard QHP becomes the second lowest cost silver is not material and we assume the same effect on subsidies.

² State of Nevada. "Governor Joe Lombardo Announces Plan to Transform the Nevada Public Option into NMSP." State of Nevada press release, October 11, 2023. https://gov.nv.gov/uploadedFiles/gov2022nvqov/content/Newsroom/PRs/2023/2023-10-11_DHHS_NVPublicOption-Memo.pdf. Accessed October 31, 2023.

The “Market Stabilization” scenario is compared to the Baseline scenario to measure the projected PTF available to the State of Nevada after the introduction of the NMSP. This scenario, including the calculation of premium tax credits (PTCs), is also required to demonstrate compliance of the NMSP with federal 1332 waiver deficit neutrality requirements. As noted above, reinsurance will be implemented after the BBSPs. The Market Stabilization scenario assumes BBSPs are available beginning in 2026 and reinsurance begins in 2027.

We model the incremental PTF available to the State of Nevada from the introduction of the BBSPs and then the reinsurance program separately. The PTF attributable to the introduction of BBSPs will be used, in conjunction with federal PTF generated by the reinsurance pool, to fully fund the reinsurance pool. Based on input from the State of Nevada, we assume any remaining PTF generated under the Market Stabilization scenario, after fully funding the reinsurance program and paying DHHS and Department of Insurance (DOI) administrative costs to run the NMSP, will be used to fund provider quality incentives and workforce initiatives.

For simplicity and no loss of accuracy, we assume the second lowest cost silver (SLCS) plan in the Market Stabilization scenario will be a BBSP.³ We assume minimal change in total individual market enrollment, as PTC-eligible individuals’ net premiums will be largely the same⁴ as in the Baseline scenarios assuming they are enrolled in the SLCS BBSP.

There is increased uncertainty regarding future individual health insurance market enrollment, premium rates, and premium subsidies due to the ongoing impact of Medicaid redeterminations following the expiration of the COVID-19 PHE on health insurance coverage and economic activity, as well as the unknown status of the enhanced subsidies beyond CY 2025. Moreover, the recent environment of higher general inflation will affect the health insurance markets with uncertain timing and impact. The projection period in this analysis does not begin for a full two years beyond the date of this report and extends out 10 years. Furthermore, it is a certainty that there will be material changes in the health care environment during that time that cannot be known or captured in an analysis of this type. Therefore, actual health care premiums, claims costs, membership, and PTF will differ from the estimates shown here. Moreover, the values presented in this report are estimates based on assumptions that incorporate our best estimates given the latest information available. It is a certainty that, given the passage of time and the emergence of additional information, these assumptions would change and will change in any future analysis. Changes in these assumptions will produce different estimates than those presented here.

A. SUMMARY OF RESULTS

Table 1 shows the estimated PTF, reinsurance cost, and net funding available after paying the state’s share of reinsurance during each year during the 5-year waiver window and the 10-year deficit neutrality window. The State of Nevada plans to use the net funding available from 2026 to pay for the state’s share of reinsurance in 2027. The net funds remaining in 2027 and beyond is the estimated amount of funding available to the State of Nevada to fund other initiatives, such as provider quality incentives and workforce initiatives.

The results presented in Table 1 and throughout this report assume the reinsurance program, beginning with 2027 and for the remainder of the 10-year deficit neutrality window, will reflect a \$60,000 attachment point and a \$1,000,000 cap, as described in further detail in Section II.B of this report. We assume coinsurance will vary by rating area, as noted in Table 10. Actual reinsurance parameters in each of those years will be adjusted, as directed by the Director of DHHS, to align with actual experience, available funding, and NMSP objectives.

³ For modeling purposes, whether a BBSP or standard QHP becomes the second lowest cost silver is not material and we assume the same effect on subsidies.

⁴ There are limited circumstances where a PTC-eligible consumer’s net premium will decrease after choosing the SLCS BBSP offering. This may occur with either higher-income or younger (or both) individuals who receive smaller subsidies.

Table 1
State of Nevada
NMSP Actuarial and Economic Analysis
Projected Pass-Through Funding and Cost of Reinsurance

Year	Pass-Through Funding (thousands)	Cost of Reinsurance (thousands)	Net Funding Remaining (thousands)
2026	\$15,000	\$0	\$15,000
2027	\$58,000	(\$56,000)	\$2,000
2028	\$69,000	(\$60,000)	\$9,000
2029	\$81,000	(\$64,000)	\$17,000
2030	\$87,000	(\$70,000)	\$17,000
2031	\$93,000	(\$76,000)	\$17,000
2032	\$99,000	(\$83,000)	\$16,000
2033	\$106,000	(\$90,000)	\$16,000
2034	\$114,000	(\$98,000)	\$16,000
2035	\$122,000	(\$106,000)	\$16,000
5-Year Waiver Window	\$310,000	(\$250,000)	NA*
10-Year Deficit Neutrality Window	\$844,000	(\$703,000)	NA*
5-Year Waiver Window – With 10% Margin on PTF	\$279,000	(\$250,000)	NA*
10-Year Deficit Neutrality Window – With 10% Margin on PTF	\$760,000	(\$703,000)	NA*

**Remaining funds at year-end are expected to be used for various provider-related initiatives; no accumulation is expected.*

For the NMSP to meet the federal requirements for a 1332 waiver, the program must meet four guardrails: affordability, scope of coverage, comprehensiveness, and deficit neutrality. Our analysis indicates that Nevada's waiver for the NMSP meets these federal requirements for a 1332 waiver.

The full scope of provider quality incentives and workforce initiatives is dependent on future PTF and reinsurance costs. Furthermore, these uses of PTF are longer-term investments in the health care sector, so it may take years to fully realize their benefits. Due to their interactions with the broader health care market, it is also difficult to isolate how much of the impact is attributable to the waiver. For these reasons, we did not explicitly evaluate the impact of provider quality incentives and workforce initiatives on the guardrails, but we provide general observations regarding their directional impact on each guardrail below.

We summarize the key results of our analysis of each of these standards below, with additional detail provided in Sections IV and V of this report.

Affordability: The 1332 waiver must provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable as would be projected without the waiver. The Nevada NMSP satisfies the affordability requirement as follows:

- Table 2 illustrates that the NMSP is expected to offer gross premium rates in all years of the five-year waiver window and the 10-year deficit neutrality window that are lower than premiums under the Baseline scenario. As described in Appendix C, the BBSPs are expected to be at least 3% lower than the average reference premium (see Appendix C) in 2026 and 15% lower by 2029. Table 2 shows how the BBSPs independently satisfy this guardrail prior to reinsurance, and reinsurance further improves affordability under the NMSP.
- *Available* net premiums (after federal subsidies) for subsidized silver plan enrollees are expected to be no higher than in the Baseline scenario. Enrollees who *actually* switch to the SLCS option, which is assumed to be a BBSP in the Market Stabilization scenario, will realize no (zero) change in net premium relative to the Baseline scenario. Moreover, for younger or higher-income silver plan enrollees who typically have smaller subsidies, BBSP premiums may be below their current net premiums, providing an opportunity for lightly subsidized individuals to realize premium savings if they switch to a BBSP.

Subsidized enrollees who currently receive no-cost bronze plans could continue to have zero net premium (after subsidies) if they switch to a bronze plan (whether a BBSP or not) that is priced below their subsidy in the NMSP. Further, bronze plan enrollees who receive smaller subsidies (e.g., lower-cost areas, younger ages, higher incomes) may see premium decreases (similar to silver plans described above) if they switch to a bronze BBSP.

- The reinsurance program will further reduce gross premiums. Fully subsidized enrollees are not expected to be impacted by reinsurance. Rather, the gross premium reductions stemming from the reinsurance program will result in savings to the federal government by reducing PTCs. However, the additional premium reductions due to reinsurance for lightly or non-subsidized enrollees will be realized, in part or in whole, by enrollees.
- Cost-sharing is not expected to be different under the waiver, for either BBSPs or standard qualified health plans (QHPs), than it is without the waiver. SB420 requires BBSPs to include both silver and gold plans, and DHS intends to incentivize plans to include bronze BBSP offerings. Since cost sharing is based on an actuarial value (i.e., a percentage of plan costs) which is tied to the metal level, aggregate out-of-pocket costs for enrollees will decrease if they enroll in a plan with the same or higher metal level. Our modeling assumes all individuals enroll in a plan with the same or higher metal due to the lower premiums available for the same (or better) coverage under the waiver. Therefore, non-premium cost-sharing will be at least as affordable under the waiver as it is without the waiver.
- Due to the ACA's permissible 3:1 age rating factor, some older adults are eligible for a \$0 bronze plan at income levels above 250% FPL. As the NMSP is estimated to reduce premiums, it is likely the number of marketplace enrollees qualifying for a \$0 bronze plan will decrease by a very small degree relative to without the waiver.
- Unsubsidized enrollees with large health care spending burdens relative to their incomes may be able to purchase plans with better coverage under the waiver due to the lower premiums under the NMSP.
- The use of PTF for provider quality initiatives may improve affordability further than what is shown in the results below to the extent they improve patient outcomes and reduce overall costs long term. Workforce initiatives may also eventually improve affordability due to increased availability of providers. However, we conservatively do not make any assumptions to reflect the potential impact of these programs during the 10-year deficit neutrality window (i.e., PTF could be understated).

Year	BBSPs Only	Reinsurance	Total*
2026	-3.2%	0.0%	-3.2%
2027	-5.2%	-6.8%	-12.0%
2028	-6.6%	-6.9%	-13.5%
2029	-8.0%	-7.0%	-15.0%
2030	-8.0%	-7.2%	-15.2%
2031	-8.0%	-7.4%	-15.4%
2032	-8.0%	-7.6%	-15.7%
2033	-8.0%	-7.9%	-15.9%
2034	-8.0%	-8.1%	-16.1%
2035	-8.0%	-8.3%	-16.3%

**Percentages by year are additive to illustrate the impact from Baseline. The percentage reduction in premiums driven by reinsurance noted in other sections of the analysis is slightly higher because it is applied to the lower BBSP premiums.*

Scope of coverage: Coverage must be provided under the waiver to at least as many people as would be projected to be covered without the waiver. Table 3 shows how the NMSP satisfies the scope of coverage standard for all waiver and deficit neutrality window years.

We expect modest increases in enrollment due to the introduction of the BBSPs and slightly larger incremental increases in enrollment due to the implementation of reinsurance, as shown in Table 3. These increases mainly result from individuals who were uninsured (including those with higher health care cost burdens) but who would find unsubsidized premiums under the waiver more affordable due to the gross premium reductions related to the NMSP, noted in Table 2 above. We assume the use of PTF for provider quality incentives and workforce initiatives do not impact the scope of coverage.

Table 3 State of Nevada NMSP Actuarial and Economic Analysis Projected Individual Market Enrollment Change From Baseline				
Year	No Waiver		Enrollment Increase Due to Waiver	
	Baseline	BBSPs Only	Reinsurance	Total
2026	101,400	600	0	102,000
2027	102,700	700	1,100	104,500
2028	104,000	900	1,100	106,000
2029	105,300	1,000	1,100	107,400
2030	106,800	800	1,100	108,700
2031	108,200	900	1,100	110,200
2032	109,600	900	1,100	111,600
2033	111,000	900	1,200	113,100
2034	112,400	900	1,200	114,500
2035	113,900	800	1,200	115,900

* Values are rounded to the nearest hundred

Comprehensiveness: The 1332 waiver must provide coverage at least as comprehensive, as defined by the ACA's essential health benefits (EHBs), as would be projected without the waiver. The Nevada 1332 waiver complies with this standard because SB420 requires the new BBSPs to meet all QHP standards under the Affordable Care Act, which includes providing the full set of essential health benefits. It does not make any changes to these benefits, nor does it alter any other coverage requirements for QHPs, for either BBSPs or standard QHPs. Reinsurance does not have any impact on the comprehensiveness of coverage. Since the waiver is not expected to impact comprehensiveness of coverage; therefore, by extension, there are no impacts to any specific populations of individuals or households, including those with higher health care cost burdens. Similarly, the use of PTF for provider quality incentives and workforce initiatives do not impact the comprehensiveness of coverage.

Deficit neutrality: The 1332 waiver must be deficit neutral to the federal government compared to projections without the waiver. Table 4 shows the Market Stabilization scenario, demonstrating that the NMSP satisfies the deficit neutrality standard. The Market Stabilization scenario reduces federal outlays for premium subsidies relative to the Baseline scenario and these savings are paid to the state in the form of PTF such that total outlays under a waiver (subsidies paid to enrollees plus pass-through funding to the state) are no greater than subsidies paid to enrollees without the waiver. The annual projected PTF amounts represent our best estimates of the savings in each year. Additionally, we provide the projected PTF over the five-year waiver and 10-year deficit neutrality windows, and we apply a 10% margin to account for unknown contingencies.

The use of PTF for provider quality initiatives could reduce premiums in the waiver scenario further, including the SLCS, to the extent they improve patient outcomes and reduce overall costs. Likewise, workforce initiatives may also eventually reduce premiums due to increased availability of providers and resulting improved patient outcomes. We conservatively do not make any assumptions to reflect the potential impact of these programs during the 10-year deficit neutrality window (i.e., PTF could be understated).

Table 4
State of Nevada
NMSP Actuarial and Economic Analysis
Projected Pass-Through Funding (in Thousands)*

Year	Advanced PTCs		Total Pass-Through Funding		
	No Waiver	With Waiver	BBSPs Only	Reinsurance	Total
2026	\$396,000	\$379,000	\$15,000	\$0	\$15,000
2027	\$418,000	\$354,000	\$26,000	\$32,000	\$58,000
2028	\$442,000	\$365,000	\$35,000	\$34,000	\$69,000
2029	\$466,000	\$376,000	\$45,000	\$36,000	\$81,000
2030	\$493,000	\$396,000	\$47,000	\$40,000	\$87,000
2031	\$520,000	\$417,000	\$50,000	\$43,000	\$93,000
2032	\$550,000	\$440,000	\$52,000	\$47,000	\$99,000
2033	\$581,000	\$463,000	\$56,000	\$50,000	\$106,000
2034	\$614,000	\$487,000	\$58,000	\$56,000	\$114,000
2035	\$648,000	\$513,000	\$61,000	\$61,000	\$122,000
5-Year Waiver Window			\$168,000	\$142,000	\$310,000
10-Year Deficit Neutrality Window			\$445,000	\$399,000	\$844,000
5-Year Waiver Window – With 10% Margin			\$151,000	\$128,000	\$279,000
10-Year Deficit Neutrality Window – With 10% Margin			\$401,000	\$359,000	\$760,000

* Values are rounded to the nearest million

The remainder of this report provides the requested information in the Centers for Medicare and Medicaid Services (CMS) 1332 Waiver Checklist for the Nevada waiver's actuarial certification and economic analyses.

- In Section II of this report, we describe the federal requirements in more detail and provide additional information to demonstrate how the Nevada waiver satisfies these federal requirements. We provide information related to the requirements of Nevada's SB240, give background into how the bill creates savings in the individual market versus a non-waiver scenario, and explain how PTF is ultimately generated under a 1332 waiver.
- Section III describes the Market Stabilization (with waiver) and Baseline (without the waiver) scenarios and provides detailed discussions on important dynamics within the scenarios that impact PTF. These dynamics are somewhat unique to a PO offering versus a standalone reinsurance-type waiver.
- Section IV provides the actuarial analysis required by CMS, as well as detailed descriptions and data to demonstrate compliance with the affordability, comparable coverage, and comprehensive coverage requirement.
- Section V provides the required economic analysis for waiver approval. We model the expected PTF (premium tax credit savings to the federal government) under the waiver scenario and describe the assumptions and results.
- In Section VI, we detail the data, assumptions, and methodology used in our modeling.
- The Exhibits section provides detailed exhibits to support the actuarial analysis in Section IV.
- Appendices provide our certification of waiver analysis and various other documentation items, including the CCIIO checklist.

B. DATA RELIANCE AND IMPORTANT CAVEATS

Milliman developed certain models to estimate the values included in this report. The intent of the models was to estimate the impact of the Nevada NMSP and provide actuarial analysis required for the State of Nevada's application for a Section 1332 waiver. We reviewed the models, including their inputs, calculations, and outputs, for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

The models rely on data and information as input to the models. We relied upon certain data and information provided by the Nevada Department of Health and Human Services (DHHS), the Silver State Health Insurance Exchange, the Department of Insurance (DOI), Nevada individual market issuers and publicly available data published by the State of Nevada and federal agencies to develop the analyses shown in this report. We did not audit this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. We performed a limited review of the data used directly in our analysis for reasonableness and consistency, and we did not find material defects in the data. If there are material defects in the data, it is possible they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable, or for relationships that are materially inconsistent. Such a review was beyond the scope of our engagement. Please see Section VI below for a list of the data relied upon to produce the analyses in this report.

This report represents our best estimate of future experience given the assumptions described in this report and information that is currently available.

Differences between the projected amounts in this report and actual NMSP experience will depend on the extent to which future experience conforms to the assumptions made in the calculations. It is certain that actual experience will not conform exactly to the assumptions used in the calculations due to differences in health care trend, economic changes, provider reimbursement levels, regulatory or legislative changes, consumer behavior, issuer pricing assumptions, population changes, and many other factors.

There is heightened uncertainty concerning future insurance market enrollment due to the Medicaid eligibility redeterminations occurring following the expiration COVID-19 public health emergency and its associated policies.

Milliman prepared this report for the specific purpose of evaluating the enrollment changes and financial impacts to premiums and federal subsidies in the Nevada Individual Market due to the introduction of the NMSP. This report should not be used for any other purpose. This report has been prepared for the internal business use of, and is only to be relied upon by, the management of DHHS. We understand this report may be shared with other interested parties, including CMS, as a part of the State of Nevada's 1332 waiver application. Milliman does not intend to benefit or create a legal duty to any third-party recipient of its work. This report should only be reviewed in its entirety. The results of this analysis may not be appropriate for every stakeholder.

The results of this report are technical in nature and are dependent upon specific assumptions and methods. No party should rely on these results without a thorough understanding of those assumptions and methods. Such an understanding may require consultation with qualified professionals.

The authors of this report are health actuaries. Milliman's advice is not intended to be a substitute for qualified tax, legal, or accounting counsel.

The authors of this report are actuaries for Milliman, members of the American Academy of Actuaries, and meet the Qualification Standards of the Academy to render the actuarial opinion contained herein. To the best of their knowledge and belief, this report is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

II. BACKGROUND: NEVADA SB420, FEDERAL 1332 WAIVER REQUIREMENTS, AND THE CURRENT HEALTH COVERAGE LANDSCAPE

A. NEVADA SB420, NEVADA MARKET STABILIZATION PROGRAM, AND STATE REQUIREMENTS

Nevada Senate Bill 420 (SB420) was signed into law on June 9, 2021.⁵ This law establishes a health benefit plan, the public option (PO) which is hereafter referred to as the Battle Born State Plan or BBSP, that will be administered by the State of Nevada through contracts with issuers. The BBSP must be made available as qualified health plans through the Silver State Health Insurance Exchange beginning in 2026. Some provisions of SB420 specifically related to the BBSP premium targets will expire on December 31, 2029. Therefore, some analyses in this report related to the premium targets focus on the first four years of the NMSP and assume the same level of savings thereafter, through the remaining duration of both the 5-year waiver window and the 10-year deficit neutrality window. A reference to the full text of SB420 is provided in Appendix B.

The stated objectives of SB420 are to lower health insurance premiums and costs, improve access to health care, reduce disparities in health care access and outcomes, and improve the availability of coverage for residents of rural areas. The legislation intends to achieve these objectives through the PO by lowering enrollee costs, improving access to health care, and improving health care coverage in rural areas.

In an October 11, 2023 press release,⁶ the State of Nevada announced plans to transform the Nevada Public Option into a Market Stabilization Program (NMSP) by including a reinsurance program in the individual market. This reinsurance program is intended to increase stability in Nevada's individual market, and the program will be financed through pass-through funding (PTF) generated by the 1332 waiver. Section 11.1(b) of SB420 grants the Nevada Department of Health and Human Services (DHHS) the authority to apply for additional federal waivers or approvals, such as a reinsurance program.

The key aspects of SB420 that influence the actuarial analysis provided in this report are summarized below.

Levels of Coverage

Section 10.3(b) of SB420 requires that the PO provide "at least levels of coverage consistent with the actuarial value of one silver plan and one gold plan." This section of the legislation ensures a minimum threshold of coverage and plan choices for BBSPs. The key impact of this requirement on the actuarial and economic analyses is that it increases the probability that the second lowest cost silver (SLCS) premium will decrease by guaranteeing the PO will include at least one silver BBSP. Because other state requirements discussed below place upper limits on the BBSP premium amounts, the BBSP premiums are expected to be lower than premiums for standard qualified health plan (QHP) silver plans that would be otherwise available on the Silver State Health Insurance Exchange.⁷

Reinsurance does not have any direct impact on levels of coverage, although some beneficiaries may switch to a higher level of coverage if a higher metal-level plan becomes more affordable due to reinsurance-driven premium decreases.

Although not required by SB420, the State of Nevada will incentivize bronze BBSPs to be offered through the statutorily required procurement and contracting process with issuers. Generally, a bronze offering will have the following effects, by income level:

- Lower-income enrollees with larger subsidies who currently have zero net premium bronze plans could maintain zero net premium either by keeping their plan or by switching to a bronze BBSP, depending on market pricing of bronze plans and changes in subsidies.
- Lightly subsidized enrollees (generally higher-income and / or younger ages) are more likely to see increases in net premiums while maintaining bronze coverage, particularly if they do not switch to a bronze BBSP, because there may be fewer zero premium bronze plans available, depending on how subsidies and market pricing of bronze plans are affected by the NMSP.

⁵ See <https://www.leg.state.nv.us/App/NELIS/REL/81st2021/Bill/8151/Overview>.

⁶ State of Nevada. "Governor Joe Lombardo Announces Plan to Transform the Nevada Public Option into NMSP." State of Nevada press release, October 11, 2023. https://gov.nv.gov/uploadedFiles/gov2022nv.gov/content/Newsroom/PRs/2023/2023-10-11_DHHS_NVPublicOption-Memo.pdf. Accessed October 31, 2023.

⁷ Standard QHPs could, in response to the BBSPs, reduce prices or curtail rate increases to remain competitive against Silver State Star Plans. We do not attempt to model various issuers' reactions or behaviors in our analysis.

- Higher-income enrollees who are unsubsidized will likely see decreases in premium by switching to a bronze BBSP.

A bronze BBSP offering increases pass-through funding (see Section III.B for additional discussion), all else equal.

Therefore, the analyses in this report assume the BBSPs will include silver, gold, and bronze plan offerings.

Access

Section 13.1 of SB420 includes a provision requiring health care providers who currently participate in certain state coverage programs to enroll in at least one provider network for a BBSP. This provider participation requirement, also called the provider tying requirement, is intended to ensure enough providers participate in a BBSP such that the NMSP can fulfill any anticipated growth in the demand for health care services arising from the NMSP. SB420 gives the State of Nevada authority to waive this requirement as necessary to ensure access for enrollees in other state programs is sufficient.

Based on the State of Nevada's guidance outlined in Appendix C, we do not expect the tying provision to have a significant impact on BBSP premiums, total provider reimbursement across all health insurance markets, or access to care for consumers. Therefore, we do not make adjustments in our analysis of the NMSP related to the tying provision.

Section 12.2 of SB420 requires issuers that participate in the Medicaid managed care program to submit good faith proposals to participate in the PO. We do not expect this requirement to have a significant impact on BBSP premiums. Therefore, we do not make any explicit adjustments in our analysis of the NMSP to account for the requirement that Medicaid managed care issuers submit bids for a BBSP. We do expect this requirement will play a role in driving plan participation.

Reinsurance does not have a direct impact on access. However, since a portion of the premium target will be achieved through reinsurance, the reinsurance program decreases the amount of the premium reductions that need to be achieved through a combination of provider contracting and carrier administrative expense efficiencies. For every one percent of the premium reduction achieved through reinsurance or administrative expense efficiency, the provider reimbursement decrease required to meet the premium reduction target is reduced by approximately 1.67%.⁸

Therefore, the reinsurance program further contributes to market stability and access to health care services in Nevada by reducing the portion of the premium reductions that needs to be achieved through provider contracting.

Premium amounts

SB420 seeks to lower enrollee premium costs by establishing constraints on the PO plan premiums. The first constraint is the *reference premium*. Section 10.4(a) of SB420 states that PO premiums must be at least 5% lower than the reference premium. The reference premium is defined in Section 10.6(d) of SB420 as the lower of the following two clauses:

1. The 2024 premium for the SLCS available through the Silver State Health Insurance Exchange, trended to the premium year at the Medicare Economic Index (MEI).
2. The SLCS premium in the prior year.

As outlined in Appendix C, the Director can revise the inflation index in the first clause as long as the premium reduction is at least 15% over the first four years. Our modeling assumes an inflation index based on the Consumer Price Index – Medical (CPI-M) plus an adjustment for utilization and morbidity changes in the local Nevada individual market, as described in Appendix C. Furthermore, based on the State of Nevada's methodology outlined in Appendix C, the reference premium defined in Section 10.6(d) is replaced by an "average reference premium" as defined in the guidance. The "average reference premium" is not tied to the second clause. Our modeling assumes that the standard QHP premiums will trend at the medical inflation index, based on CPI-M plus an adjustment for utilization and morbidity changes in the local Nevada individual market, each year. The adjustments for utilization and morbidity are intended to capture broader influences on health care costs in the individual market that are either beyond the control of BBSP or QHP issuers or otherwise not captured in the CPI-M.

⁸ This is because provider reimbursement, on average, is approximately 60% of premium. The remaining 40% covers prescription drug and insurer administrative expenses. Thus, it takes $1\%/6 = 1.67\%$ decrease in provider reimbursement to effect a 1% change in total premium.

Further, SB420 allows the Director to change the requirement that PO plans (i.e., BBSPs) generate 5% savings in the first year relative to the reference premium. At the direction of the State of Nevada, our modeling assumes that the requirement will be 3% in the first year of the NMSP.

DHS will evaluate the premium requirements in SB420 on an ongoing basis to ensure the outcomes of the PO remain consistent with the intent of SB420. As appropriate, the Director will collaborate with key stakeholders, including issuers and providers, to develop reasonable assumptions and adjustments to the premium reduction targets and reinsurance parameters.

The analyses in this report disregard the second clause of the reference premium definition and assume the average reference premium is based on 2024 SLCS premium trended at CPI-M plus an adjustment for utilization and morbidity.

The second constraint included in Section 10.4(b) of SB420 states that PO premium growth cannot increase in any year by more than MEI. Appendix C outlines that the Director has similar discretion to revise the inflation index applied to restrict the annual BBSP premium growth as is allowed for the reference premium, as described above. Consistent with the reference premium assumptions, our modeling assumes the Director will select an inflation index based on CPI-M plus an adjustment for utilization and morbidity changes appropriate for the local market.

The analyses in this report assume annual BBSP premium growth cannot exceed expected general medical inflation based on CPI-M plus an adjustment for utilization and morbidity.

The third constraint in Section 10.5 of SB420 targets at least a 15% reduction in the PO premiums versus the average reference premium in year 4. We modeled this target premium reduction consistent with the State of Nevada's methodology outlined in Appendix C, which targets annual reductions in BBSP premiums up to a 15% reduction in BBSP premiums versus the average reference premium in year 4.

The analyses in this report assume the SLCS BBSP premium in 2029 will be at least 15% lower than the 2024 SLCS premium trended to 2029 with expected general medical inflation.

Based on discussions with DHHS, the requirements of SB420, and the introduction of the reinsurance program, we expect the BBSP premium reductions to be driven from four sources: provider reimbursement decreases, lower issuer premium expense loads required for BBSPs, value-based purchasing initiatives, and the reinsurance program.

Provider reimbursement

SB420 requires that provider reimbursement rates for the PO be, in the aggregate, comparable to or better than Medicare rates. The law includes exceptions for certain safety net providers for whom specific payment methodologies apply, including for federally qualified health centers (FQHCs), rural health centers (RHCs), and the Medicaid State Plan rate for certified community behavioral health clinics (CCBHCs). Per Sections 14.1(b) and 14.6 of SB420, the above-stated rate requirements do not apply to "payment models that increase value for persons enrolled in the Public Option," meaning that plans and providers may agree to alternative payment models.

B. GENERATING PASS-THROUGH FUNDING UNDER A 1332 WAIVER

A PO program and a reinsurance program generate PTF through different mechanisms. The assumption that the PO generates PTF is based on two key modeling assumptions related to individual market dynamics as well as assumptions regarding how BBSPs might achieve lower premiums. On the other hand, the reinsurance program generates PTF based on the structure of the reinsurance program and is less dependent on assumptions. We describe each of these drivers of PTF in the following four subsections.

Competitive landscape driven by BBSPs decreases the benchmark silver plan

Our modeling assumes more than one BBSP will be offered in each rating area. Therefore, a BBSP is expected to become the SLCS plan in all rating areas⁹ in Nevada in 2026. While a BBSP is highly likely to be the SLCS plan in all years of the program, it becomes even more likely in the second through fourth years of the NMSP, as the discounts relative to the reference premium and standard QHP premiums increase. It is possible that a benchmark (i.e., SLCS) plan would not be a BBSP under the following circumstances:

⁹ Benchmark silver plans are determined at the county level under the ACA. However, in Nevada in 2023, the benchmark plan is the same across all counties in any one of the four rating areas. For simplicity and brevity, we refer to the SLCS or benchmark plan in a rating area.

- If a county had only a single issuer prior to the NMSP implementation in 2026, it is possible that a single BBSP in such a county in 2026 would not become the SLCS plan. In this case, if only one BBSP is offered in the county, the BBSP would become the lowest-cost silver plan and the benchmark plan would be unchanged (i.e., the single standard QHP offered prior to 2026) and drive no savings in federal subsidies. This circumstance is highly unlikely to occur in the two largest rating areas, which include roughly 90% of the State of Nevada's population and individual market enrollees. If this circumstance occurs in the smaller counties, the overall impact would be small because there are few QHP enrollees in these counties. We expect the overall impact on the results related to the risk of a standard QHP being the SLCS plan to be minimal.
- In the first year of the NMSP, when required discounts to the reference premium are only 3% per the State of Nevada's guidance in Appendix C, issuers could choose to price standard QHPs very competitively or recontract provider agreements underlying the standard QHPs to reduce underlying cost structure, or both. If this happens, the premiums for one or more standard QHPs could be lower than the premiums for some BBSPs, and a standard QHP could become the SLCS. However, in such a situation, the impact to PTF would be the same as if a BBSP were the SLCS since this behavior would not appear in the Baseline (no waiver) scenario, assuming the waiver is given credit by CMS for the change in standard QHP pricing and provider contracting.¹⁰

The competitive situation as of 2023, shown in Table 5 below, shows that there are at least two issuers offering plans with premiums within 5% of the lowest-cost silver (LCS) plan in all rating areas in Nevada. Assuming these issuers also offer BBSP plans that are compliant with the required premium reductions in SB420 and Appendix C, it is highly likely and a reasonable modeling assumption that the benchmark plan will be a BBSP plan and at least 3% lower than in a Baseline (no waiver) scenario. Although SB420 requires issuers of Medicaid managed care plans to offer BBSPs, it does not preclude non-managed care plans from offering BBSPs.

Table 5
State of Nevada
NMSP Actuarial and Economic Analysis
Nevada 2023 Individual Exchange Market
Top 10 Lowest-Cost Silver Plans by Rating Area

Rating Area 1		Rating Area 2		Rating Area 3		Rating Area 4	
Issuer Name	% Difference to LCS	Issuer Name	% Difference to LCS	Issuer Name	% Difference to LCS	Issuer Name	% Difference to LCS
SilverSummit	0.0%	SilverSummit	0.0%	Colorado DBA HMO Nevada	0.0%	SilverSummit	0.0%
SilverSummit	0.2%	SilverSummit	0.2%	Colorado DBA HMO Nevada	0.5%	SilverSummit	0.2%
SilverSummit	1.2%	SilverSummit	1.2%	Colorado DBA HMO Nevada	0.9%	SilverSummit	1.2%
SelectHealth	3.3%	SilverSummit	11.6%	Colorado DBA HMO Nevada	1.1%	SilverSummit	2.6%
Health Plan of Nevada	3.9%	SilverSummit	11.8%	Colorado DBA HMO Nevada	2.8%	SilverSummit	5.4%
SelectHealth	4.3%	SilverSummit	13.0%	Colorado DBA HMO Nevada	2.8%	SilverSummit	5.5%
Health Plan of Nevada	5.1%	Aetna	13.7%	Hometown Health	6.2%	SilverSummit	6.7%
SilverSummit	6.2%	SilverSummit	14.5%	SilverSummit	6.9%	SilverSummit	8.1%
SilverSummit	6.4%	Health Plan of Nevada	14.6%	SilverSummit	7.0%	Friday Health	21.8%
SelectHealth	7.1%	Health Plan of Nevada	15.9%	SilverSummit	8.2%	Friday Health	22.0%

¹⁰ CMS' interpretation of market responses to the BBSPs is not known. If CMS does not credit the BBSPs with market responses in standard QHP plan pricing, PTF may be impacted.

Reference premium tracks closely to individual market before reinsurance

Our modeling also assumes that the reference premium inflation index (CPI-M plus utilization / morbidity adjustment) tracks closely with overall increases in gross premiums for the individual market and standard QHPs before reinsurance. This is the intent of SB420 and the DHHS guidance outlined in Appendix C.

Table 6 shows a simple illustration of the mechanics behind how the NMSP generates PTF under a 1332 waiver, given the requirements of SB420 and the State of Nevada's methodology outlined in Appendix C.

Table 6
State of Nevada
NMSP Actuarial and Economic Analysis
Illustration of Reference Premium Trended at Market Rate

	2024	2026	2027	2028	2029
(1) Second Lowest Cost Silver Plan* (Baseline)	\$ 541.47	\$598.26	\$622.19	\$647.07	\$672.96
(2) <i>Assumed Annualized Trend</i>		5.1%	4.0%	4.0%	4.0%
(3) Reference Premium	\$ 541.47	\$598.26	\$622.19	\$647.07	\$672.96
(4) <i>Assumed Annualized Trend</i>		5.1%	4.0%	4.0%	4.0%
(5) BBSP Premium		\$579.23	\$547.61	\$559.45	\$571.99
(6) <i>Cumulative Difference From Reference Premium</i>		(3.2%)	(12.0%)	(13.5%)	(15.0%)
(7) <i>Cumulative Difference From Baseline</i>		(3.2%)	(12.0%)	(13.5%)	(15.0%)

* This is a composite across all ages based on Nevada demographics; does not represent a specific age.

We note the following in Table 6:

- Line 1 shows the projection for the SLCS in 2024, trended at 5.1% annually through 2026 and 4% annually thereafter.¹¹ The 4% trend is based on projections of per capita spending in the private insurance markets from CMH National Health Care Expenditure data, reduced by approximately 1% for value-based care initiatives in the Nevada market. We assume the expiration of ARP subsidies to increase morbidity by approximately 2.5% in 2026; however, we simplified this adjustment in Table 6 by increasing the annualized trend from 2024 to 2026 by 1.2%. Additional references and information on this can be found in Section VI of this report. This represents a forecast of the individual market premiums in absence of the NMSP.
- Line 3 is the calculated reference premium as defined by SB420 and reflecting the State of Nevada's methodology and guidance outlined in Appendix C. It is assumed that medical unit costs will trend at the CPI-M index, which we estimate in this modeling at 3.7%.¹² We also assume that an appropriate utilization and morbidity adjustment will be chosen that will be consistent with overall individual market dynamics in Nevada. In this illustration, that adjustment is assumed to be approximately 1.4% annually between 2024 and 2026 and 0.3% thereafter *such that the reference premium trend equals the overall market change in premiums in the absence of the NMSP*. Additional information and references on this can be found in Section VI of this report.
- Line 6 shows that the BBSP premium, in accordance with the requirements of SB420 and the State of Nevada's methodology and guidance outlined in Appendix C, is at least 3% less than the calculated reference premium in year 1 of the program and 15% less by year 4.
- Line 7 illustrates that the difference between BBSPs and the estimated individual market premium without the waiver is also approximately 3% in year 1 and approximately 15% by year 4. This difference is identical to the BBSPs' difference from the reference premium (Line 6) because the reference premium is assumed to be indexed at a rate that is reflective of the overall individual market in Nevada without the waiver, as shown in Lines 2 and 4.

¹¹ The modeled 2024 premium is based on actual 2023 premiums, trended forward one year at 7% based on expected average 2024 rate increases and a 0.4% decrease for anticipated market morbidity due to the redeterminations of Medicaid eligibility following the end of the PHE. After 2024, premium is trended at the 4% projected trend assumption. Premium amounts in 2025 do not have a direct bearing on our modeling. Therefore, we intentionally do not include a column for 2025 in Tables 6 and 7.

¹² BLS Data accessed November 19, 2023. [Archived Consumer Price Index Supplemental Files: U.S. Bureau of Labor Statistics \(bls.gov\)](https://www.bls.gov). CPI-M index starting in March of 2023 shows decreases in both professional and hospitals costs year over year. We do not believe this reflective of overall changes in underlying costs or premium increase into the future. The choice of CPI-M of 3.7% is more consistent with longer term averages and therefore a more reasonable assumption.

Table 6 illustrates how BBSPs can achieve the required 15% savings relative to the reference premium. Because the reference premium tracks to the market, the BBSP premiums will also be 15% below the Baseline SLCS (i.e., the SLCS absent the waiver).

It is *not* the intent of SB420 and the DHHS guidance outlined in Appendix C for the BBSPs to be any lower than 15% below the Baseline premium by year 4. BBSP savings relative to the Baseline premium of greater than 15% could occur if an inflation index applied to the reference premium does not appropriately reflect local individual market dynamics.

For example, if the reference premium were to be trended at a rate lower than the overall individual market, BBSP premiums would be less than 15% below the Baseline SLCS premium by 2029. In Table 7 below, we assume a reference premium trend of 3%, which is below the overall individual market trend and is not adjusted for changes in morbidity, for illustrative purposes.

	2024	2026	2027	2028	2029
(1) Second Lowest Cost Silver* (Baseline)	\$ 541.47	\$ 598.26	\$ 622.19	\$ 647.07	\$ 672.96
(2) <i>Assumed Annualized Trend</i>		5.1%	4.0%	4.0%	4.0%
(3) Reference Premium	\$541.47	\$574.44	\$591.67	\$609.42	\$627.71
(4) <i>Assumed Annualized Trend</i>		3.0%	3.0%	3.0%	3.0%
(5) BBSP Premium		\$556.17	\$520.75	\$526.90	\$533.53
(6) <i>Cumulative Difference From Reference Premium</i>		(3.2%)	(12.0%)	(13.5%)	(15.0%)
(7) <i>Cumulative Difference From Baseline</i>		(7.0%)	(16.3%)	(18.6%)	(20.7%)

* This is a composite across all ages based on Nevada demographics; does not represent a specific age.

In the example in Table 7, the reference premium is only trending at 3% (Line 4) while the overall individual market is trending at 5.1% through 2026 and 4% thereafter (Line 2). This implies that the BBSP premiums could be as much as approximately 21% less (Line 7) than the overall market absent the waiver rather than the 15% described in SB420.

It is not realistic nor required by SB420 to assume NMSP savings beyond the 15% by year 4 or to assume increasing annual savings in perpetuity, and making this type of assumption would overstate PTF. Such an assumption implies that BBSPs would or could find additional cumulative savings above and beyond the required 15%. This could be challenging as it puts undue burden on providers, issuers, or both. If cost savings above 15% were not found, BBSPs would have to be underpriced, which could destabilize the market and provide disincentives for issuers to offer a BBSP in the first place.

In summary, SB420 generates PTF primarily through a) the requirement that BBSP premiums are a certain percentage below the reference premium over the course of the first four years of the NMSP, and b) the likelihood that this requirement results in the SLCS or benchmark premium in all areas being no greater than the BBSP target premium. We assume no additional savings from the BBSPs related to annually indexing the reference premium to an artificially low measure of health care inflation (illustrated in Table 7) that is not reflective of the overall individual market absent the waiver. Nor do we assume that BBSPs will contain materially greater advantages in provider reimbursement cost structure, medical management, or value-based purchasing (VBP) to support lower premiums beyond the required 15% reduction versus the reference premium. Under the assumption that the reference premium is properly indexed to the overall individual market without the waiver, as is the intent of the DHHS Guidance in Appendix C, the NMSP will continue to generate PTF under the waiver beyond the first four years of the program due to the availability of BBSPs.

Sources of BBSP premium savings

We assume the procurement process used by DHHS and the requirement of good faith BBSP bids by Medicaid managed care organizations (MCOs) participating in Nevada's Medicaid program will produce BBSP offerings that comply with the premium reduction targets outlined in the DHHS guidance in Appendix C. Reductions in costs underlying BBSP premiums relative to standard QHPs are assumed to come from three sources listed in order of importance:

- *Reductions in provider reimbursement unit costs:* It is expected that unit costs paid to facilities and professional providers in Nevada will be reduced to support the lower BBSP premium targets.
- *Reductions in administrative costs:* Issuers will be required to price BBSPs with a smaller expense load relative to standard QHPs to reduce the portion of BBSP premium reductions placed on providers. The required administrative expense targets will be set by the Director and will grade in over the first four years of the program.
- *Improved cost structures and efficiencies due to value-based purchasing initiatives:* Based on discussions with DHHS and the provisions in SB420 related to value-based purchasing, it is expected that the state will see an increased use of these initiatives with providers across both Medicaid MCOs and BBSPs. When these initiatives are aligned across markets in this manner, it increases the likelihood that providers will experience success with respect to their patient populations and outcomes, in addition to reduced administrative burden. The actual scope and impact of these initiatives will likely vary by issuers offering BBSPs, and specific estimates of the impact of these initiatives are outside the scope of this analysis.

Reinsurance program structure

The reinsurance program generates PTF by reducing premiums for all plans on the individual market, including BBSPs and standard QHPs, by design. The program reimburses carriers for a portion of the annual claims per enrollee that fall within a specified range from a reinsurance pool. The specified range is defined by a minimum annual claim amount (“attachment point”) and a maximum annual claim amount (“maximum” or “cap”). A percentage of each beneficiary’s claims (“coinsurance”) between the attachment point and maximum is reimbursed to the carrier by the reinsurance pool. Because this reimbursement lowers carriers’ post-reinsurance liability, carriers can reduce premiums, including for the benchmark plan. These lower benchmark premiums reduce federal outlays for premium subsidies, and this federal savings is, in turn, passed to the state in the form of PTF.

The cost of the reinsurance program is funded by the 1332 federal PTF and typically some state funding. The state share of the funding for the reinsurance program will be funded by the PTF attributable to the introduction of the BBSP plans.

The premium reduction driven by the reinsurance program will be combined with premium savings specific to BBSPs noted above to evaluate whether the premium reduction targets have been satisfied.

This analysis assumes that premium reduction targets under the NMSP will be achieved by some combination of the above initiatives. It should be noted that if any one of the sources of savings does not materialize or materializes less than expected, the remaining savings from other sources must increase for the BBSPs to achieve their premium reduction goals.

These cost reductions and the resulting premium savings that comply with the premium reduction targets outlined in DHHS Guidance in Appendix C are assumed to phase in over the course of the first four years of the NMSP.

C. FEDERAL 1332 WAIVER REQUIREMENTS

The federal requirements applicable to Section 1332 State Innovation Waivers are summarized below.

Waivable Provision

The NMSP is seeking a waiver of Section 1312(c)(1) related to the single risk pool in the individual market.

Section 1332 waiver guardrails

CMS requires 1332 waivers to satisfy four guardrails. As explained in more detail below, the proposed Nevada 1332 waiver meets the first three guardrails by design. The fourth guardrail (deficit neutrality) will be impacted by several factors that cannot be known with certainty prior to implementation; however, our analysis shows that the NMSP is expected to satisfy this guardrail.

1. Affordability of premiums and cost-sharing

Section 31 CFR 33.108(f)(3)(iv)(B) requires that premiums and cost-sharing under the waiver must be at least as affordable overall as premiums and cost-sharing absent the waiver. The NMSP satisfies this requirement by requiring that the BBSP premiums be lower than the reference premium by a specified percentage. By statute, the

reference premium cannot be greater than the 2024 SLCS, trended to the benefit year based on a medical inflation index plus an adjustment for local market utilization and morbidity changes (see Appendix C), for the first four years of the NMSP program. Because we assume the standard QHP premiums in the individual market trend at this index (assumed to be 4%, as noted above), these constraints on the reference premium and BBSP premiums ensure that the BBSP premium does not exceed projected premium amounts without the waiver.

The State of Nevada will not force enrollees to select a BBSP; however, **the premiums and cost-sharing available under the waiver will be at least as affordable as premiums and cost-sharing absent the waiver for all enrollees.** In short, the affordability guardrail is fulfilled because all enrollees will have access to a BBSP offering in 2026. The addition of reinsurance in 2027 ensures all premiums on the individual market will be more affordable with the waiver than without the waiver in the second year of the NMSP.

Although the affordability guardrail is met, the actual premium savings *realized* by individuals may vary based on the enrollee's level of subsidy and plan selection.

- **Unsubsidized:** Current enrollees who are not eligible for any subsidies will realize the entire premium savings driven by the NMSP if they switch to the SLCS, which is assumed to be a BBSP. If they elect a standard QHP (assuming it is not the SLCS), they will only realize the direct impact due to the reinsurance portion of the NMSP, unless market dynamics cause the BBSPs to influence premium rates for standard QHPs. Unsubsidized enrollees will realize the full savings attributable to reinsurance, regardless of plan selection.
- **Lightly subsidized:** Current enrollees who receive smaller subsidies may realize some net premium savings (after subsidy) if the BBSP gross premium falls below the enrollee's current net premium and they elect a BBSP. Any savings driven by the NMSP for these enrollees will be shared with the federal government, which is then passed through to the State of Nevada under the waiver. If they elect a standard QHP, these enrollees may pay higher net premiums because they will be paying the difference between the pre-NMSP subsidies (based on a higher benchmark silver plan) and the lower post-NMSP subsidies (based on a lower BBSP benchmark plan).
- **Heavily or fully subsidized:** The impact of the NMSP on net premiums for current enrollees who receive substantial subsidies will depend on whether they elect a BBSP or a standard QHP. If they switch to a BBSP, which is assumed to be the SLCS, their net premium will remain the same as without the NMSP. If they do not elect a BBSP, their net premium will likely increase to offset the decrease in federal subsidies.

The federal premium subsidy structure will remain unchanged with the introduction of the BBSPs. The out-of-pocket premium cost for the SLCS for a member will continue to be limited to a percentage of household income prescribed under the ACA. *Therefore, the consumer premiums or cost-sharing requirements under the waiver will be no greater than, and possibly lower than, the cost-sharing required absent the waiver.*

The mechanics of a PO offering and corresponding 1332 waiver are different from a standalone reinsurance waiver in at least one important way. Under the latter, premiums for *all plans* offered in the market will be reduced by the effects of the reinsurance program, as the index rate¹³ is lowered by the expected reinsurance program receipts. Therefore, all premiums are reduced, regardless of QHP issuer, although in practice issuers can and often do price somewhat different impacts into their premiums to account for their anticipated issuer-specific receipts under the program. The savings from these lower gross premiums accrue to either the consumer (in the case of an unsubsidized enrollee) or the federal government (in the case of a subsidized enrollee) or a mix of both.¹⁴

This contrasts with a PO program where BBSPs are brought into the market and one of these offerings is assumed to become the second lowest-cost silver plan in the county. All other standard QHPs are assumed to be largely unaffected in terms of price.¹⁵ In this case, both the unsubsidized and the subsidized enrollee may not see any reductions in their premiums *unless they switch to a BBSP that has become the lowest-cost or second lowest cost silver plan.*

The NMSP combines these mechanics to lower the SLCS plan, reduce federal subsidy outlays, and generate PTF under a 1332 waiver. Section V of this report illustrates the projected premium reductions under the Market Stabilization scenario in Section III below, based on the SLCS plan, which is the benchmark plan used to determine premium subsidies.

¹³ Under the ACA, the index rate is the allowed claims cost experience for the entire market and serves as the starting point for rate development. If the index rate is lowered for the effect of reinsurance, all rates in the market will be lower, all else equal.

¹⁴ An additional difference between reinsurance waivers and a public option waiver is that the PTF under reinsurance is used to pay for the program costs. The state will also have to contribute to cover program costs. Under a PO waiver, the costs of the program are entirely covered by the PTF.

¹⁵ As noted earlier, the entrance and / or presence of BBSPs could affect pricing of standard QHPs depending on issuer responses.

2. Comparable number of state residents covered

Section 31 CFR 33.108(f)(3)(iv)(C) requires that coverage must be provided to a comparable number of state residents under the waiver as would be covered without the waiver. The Nevada legislation does not contain any provisions that would be expected to decrease the number of state residents covered. To the contrary, the NMSP may increase the number of state residents covered because it will result in lower premiums.

Section IV.B of this report illustrates the projected coverage for State of Nevada residents under the Market Stabilization scenario in Section III below.

3. Comparable coverage

Section 31 CFR 33.108(f)(3)(iv)(A) requires that coverage provided under the waiver must be at least as comprehensive overall as coverage available without the waiver. The waiver does not make any changes to the requirements for QHPs, network adequacy, metallic level requirements (including de minimis amounts), essential health benefits, or other coverage requirements; therefore, the Nevada 1332 waiver complies with this guardrail.

4. No increase to federal deficit

Section 31 CFR 33.108(f)(3)(iv)(D) states that the waiver will not increase the federal deficit, either over the five-year waiver period or the 10-year federal deficit neutrality window. CMS requires the total of various costs to be considered when determining the impact on the federal deficit. Section V of this report details those costs and the treatment of them in this waiver modeling. It also shows the projected federal subsidies during the 10-year federal deficit neutrality window under both the Market Stabilization scenario and the Baseline scenario. The Market Stabilization scenario presented in this report illustrates that the Nevada 1332 waiver is not expected to increase the federal deficit when compared to the Baseline scenario without the waiver. The analysis shows that federal costs are expected to decline due to the lowering of the SLCS benchmark premium, which lowers the aggregate federal subsidies.

Other federal requirements

A 1332 waiver must meet several other federal requirements related to modeling parameters, program operations, and reporting. The following requirements are considered in the actuarial analysis and described in this report, as applicable:

1. Current law requirement

Guidance from CMS, including 86 FR 53459, states that the analysis must only reflect law and legislation that has currently been enacted. The analysis must also ignore the effects of any accompanying 1115 waiver, if applicable. As of the date of this document, the enhanced subsidies are intended to sunset at the end of 2025. We cannot predict whether the enhanced subsidies will be further extended beyond 2025. Therefore, the actuarial and economic analysis is prepared based on current law under which enhanced subsidies expire after 2025. As previously mentioned, the waiver must assume current law (state and federal). This includes applying the State of Nevada's interpretation of statute regarding the premium reduction target; see Appendix C for state-specific guidance regarding the methodology to be utilized by the State of Nevada. And thus, this modification to the requirements of a 1332 waiver has been discussed with the Center for Consumer Information and Insurance Oversight (CCIO).

2. Health coverage analysis

Section 31 CFR 33.108(f)(4)(ii)(B) requires that the 1332 waiver include a detailed analysis of the impact of the waiver on health insurance coverage in the State of Nevada. Based on the provisions of the SB 420 legislation, we reasonably assume the Nevada NMSP will not have a material impact on enrollment in other markets. Specifically, the populations eligible to enroll in BBSPs are the individual market and the uninsured. Employer groups, including small employers, are not eligible to enroll in the BBSPs.¹⁶ The enrollment changes in the markets other than the individual and uninsured that are modeled in the actuarial analysis are attributable to forces unrelated to the NMSP, including population growth and shifts, the expiration of ARP subsidies, and the end of the PHE.

¹⁶ Small group employers cannot enroll in the PO. However, small employers do have the option to offer an Individual Coverage health reimbursement arrangement (ICHRA) to their employees to enroll in individual market coverage. We assume that this phenomenon occurs to the same degree in the Baseline scenarios as it does in waiver scenarios.

3. Demographic information

Section 31 CFR 33.108(f)(4)(iii)(A) requires that the 1332 waiver include the following:

- Information on the age, income, health expenses, and current health insurance status of the relevant state population.
- The number of employers by number of employees and whether the employer offers insurance.
- Cross-tabulations of these variables.
- An explanation of data sources and quality.

Our actuarial analysis later in this report includes these elements except for the number of employers by number of employees and whether the employer offers insurance, as that information is not used in the model.

4. Explanation of assumptions

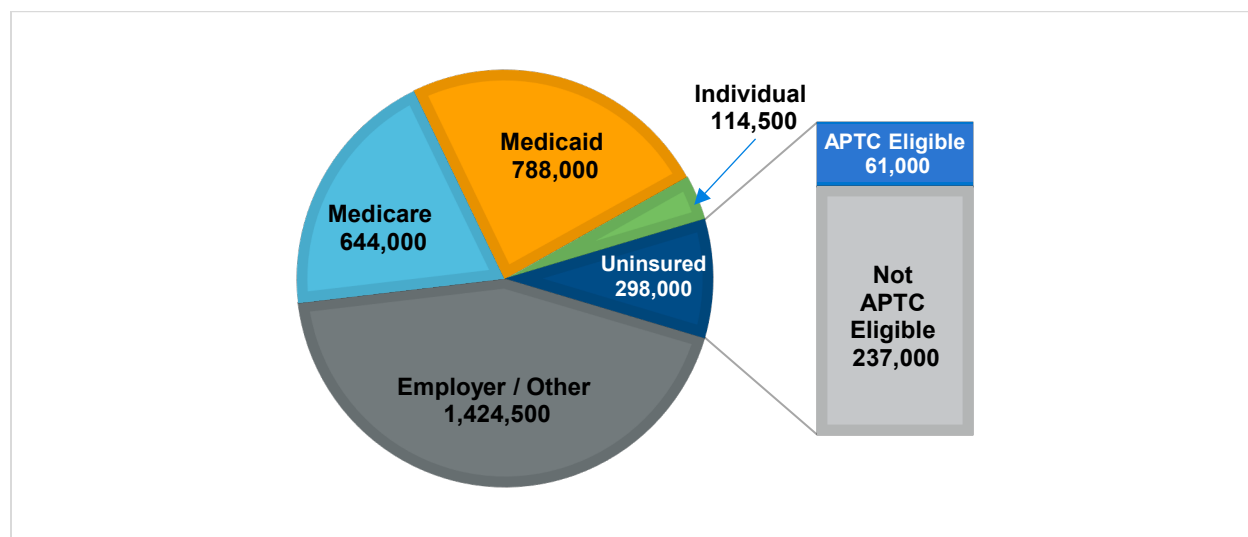
Section 31 CFR 33.108(f)(4)(iii)(B) requires that the 1332 waiver include an explanation of the key assumptions used to develop the estimates of the effect of the waiver on coverage and the federal budget, such as individual and employer participation rates, behavioral changes, premium and price effects, and other relevant factors. These key assumptions are described within this report.

5. Additional federal requirements that the State of Nevada will need to consider, but that do not impact the actuarial analysis, are shown in Appendix D for reference.

D. CURRENT NEVADA COVERAGE LANDSCAPE

We estimate the number of Nevadans with coverage in the various available public and private health insurance markets in 2022 as context and a baseline for further modeling. Please note, these enrollment totals are provided as general estimates. Eligibility for coverage in each of these markets is primarily a function of employment status, employer health insurance offerings and affordability, household income relative to the federal poverty level (FPL), age, disability status, family circumstances, and other potential factors.

Figure 1: Sources of Coverage for Nevada Residents in 2022



Sources: **Medicaid:** Milliman PHE research, State of Nevada DHHS Medicaid Chart Pack; **Individual:** Silver State Health Insurance Exchange, American Community Survey, CMS 2022 Open Enrollment Files; **Medicare:** Kaiser Health Foundation; **Employer:** American Community Survey; **Uninsured Split:** Guinn Center "Nevada's Uninsured Population," page 26.

In 2022, approximately 90.9% of Nevadans had health insurance coverage through one of the public or private markets shown above, leaving approximately 9.1% of Nevadans uninsured. The stated intent of SB420 is to increase coverage for currently uninsured residents, particularly those who are currently eligible for PTCs, but are not enrolled.

Since March 2020, all coverage markets have been affected by the public health emergency (PHE), which has several implications for the NMSP and the waiver modeling herein. In addition to the overall impact of the PHE on health care utilization and costs in all markets, PHE-related policy changes may also affect how the BBSPs will interact with other markets. For each of the existing markets, we discuss the relative importance of the market in terms of its relationship with the individual market, the impact of the end of the PHE, enhanced subsidies under ARP, and the interaction of those effects.

Medicare

The primary source of coverage for older Americans and those with qualifying disabilities is Medicare. Based on the program design of the NMSP, we do not assume any enrollment will transition between Medicare and the individual market due to the introduction of BBSPs or a state reinsurance program in the individual market. Although some individual market enrollees will become eligible for Medicare based on age between 2022 and 2026, we assume the overall enrollment distribution among insurance markets in Nevada, excluding the uninsured population and individual market, will remain consistent over time under the non-waiver Baseline scenario and the Market Stabilization waiver scenario.¹⁷

Employer-sponsored

Based on the NMSP design, we do not assume any enrollment will transition between employer-sponsored coverage and the individual market, other than what would normally happen absent the waiver. Normal movement between these markets often occurs due to the affordability of employer-sponsored coverage. We assume these dynamics will remain consistent with past patterns and that these dynamics will be similar under the waiver and non-waiver scenarios because BBSP premiums are not expected to be sufficiently advantageous relative to the employer group market to incentivize movement to the BBSPs.

¹⁷ Medicare enrollment does not impact the determination that Nevada's 1332 waiver meets the required guardrails discussed in this report.

Medicaid

The Nevada Medicaid program provides health care coverage for beneficiaries who qualify on the basis of income, disability, or other factors, such as being in foster care or receiving adoption assistance. In general, beneficiaries who qualify for Medicaid are not eligible to acquire health care coverage or receive premium tax credits on the Silver State Health Insurance Exchange. However, enrollment application increases on the exchange have sometimes led to increased Medicaid enrollment because some of the uninsured who apply for coverage on the exchange are redirected to the Medicaid program.

As a result of the Families First Coronavirus Response Act (FFCRA), state Medicaid programs were subject to Maintenance of Eligibility (MOE) requirements beginning in 2020 to qualify for a temporary 6.2-percentage-point Federal Medical Assistance Percentage (FMAP) increase.¹⁸ States were not permitted to disenroll anyone from Medicaid until the PHE expired unless the member was deceased, moved out of state, or asked the state to be disenrolled. Enrollment in Medicaid populations where eligibility is tied to income has grown significantly since the beginning of the PHE, particularly among adults. The PHE ended May 11, 2023. Beginning in June 2023, states were allowed to begin redetermining Medicaid eligibility and disenrolling those who no longer qualify. We expect some of these disenrolled members to be eligible for individual insurance and premium tax credits through the Silver State Health Insurance Exchange. Medicaid eligibility redeterminations and associated disenrollments are required to be completed by May 2024, which is prior to the NMSP effective date. This waiver analysis assumes a portion of 2022 Medicaid enrollees will enroll in the Silver State Health Insurance Exchange prior to the implementation of the NMSP. We do not expect the exact timing of the Medicaid redetermination and disenrollment process to have a material impact on the results of the waiver analysis. This transition from Medicaid to the Silver State Health Insurance Exchange is reflected in the Baseline and Market Stabilization scenarios.

Individual coverage

Since the inception of the ACA, health care coverage on the Silver State Health Insurance Exchange has been available on a guaranteed issue basis to Nevadans who are not eligible for other coverage (employer, Medicare, Medicaid) and have qualifying immigration status. This includes people with household incomes greater than 138% of the FPL and some specific populations with incomes less than 138% of the FPL, such as legal immigrants, who are not eligible for Medicaid.

Prior to the PHE, qualifying enrollees with household incomes up to 400% FPL were eligible for federal subsidies to offset part or all of their premium payments. The ARP legislation passed in response to the PHE extended federal subsidies to exchange enrollees with incomes greater than 400% FPL and enhanced subsidies for those below 400% FPL. These enhanced subsidies were renewed through 2025 with the Inflation Reduction Act.

The expiration of the PHE and potential end to enhanced subsidies under ARP will both have significant impacts on the individual market in Nevada. In particular, material changes in enrollment and morbidity could occur that will affect PTF estimates modeled in this report. As with Medicaid, we do not expect the exact timing of these events to have a material impact on the results of the waiver analysis, and we assume these changes will occur between 2022 and the beginning of the NMSP in 2026.

In 2021, the Biden administration announced administrative changes that affected certain individuals previously unable to enroll in exchange coverage due to the so called “family glitch.” Proposed rules for these changes were released in October 2022. These changes made it easier for these individuals and their families to enroll, in many cases. This may result in a potential increase in enrollment in Nevada’s individual market, coming primarily from the uninsured.¹⁹ However, the increase would be small and would appear in both the Baseline and Market Stabilization scenarios, with an immaterial impact overall on pass-through funding. Therefore, we do not make any specific assumptions for the impact of this change in our modeling, with the estimated effect being similar with or without the waiver.

¹⁸ Dolan, R. et al. (December 17, 2020). Medicaid Maintenance of Eligibility (MOE) Requirements: Issues to Watch. Kaiser Family Foundation. Retrieved November 8, 2022, from <https://www.kff.org/medicaid/issue-brief/medicaid-maintenance-of-eligibility-moe-requirements-issues-to-watch/>

¹⁹ CMS has estimated an increase of 1 million individual market enrollees nationwide due to this change. <https://www.federalregister.gov/documents/2022/10/13/2022-22184/affordability-of-employer-coverage-for-family-members-of-employees#p-215>

Uninsured

The number of uninsured in Nevada will fluctuate for various reasons over time, but for purposes of this analysis material fluctuations can be expected due to the expiration of the PHE and the end of enhanced subsidies under ARP. Specifically, we assume a portion of those disenrolled from Medicaid due to the expiration of the PHE will become uninsured. Likewise, if ARP subsidies are not extended beyond 2025, some people on the individual market may disenroll and become uninsured.

The number of uninsured in Nevada becomes important in the modeling of PTF as the uninsured are the exclusive pool from which we assume new individual enrollment will enter when BBSPs are offered and reinsurance is introduced under the Market Stabilization scenario.

E. PROJECTED 2026 NEVADA COVERAGE LANDSCAPE

The NMSP will begin in 2026; however, as described above, we anticipate changes in the Nevada coverage landscape between 2022 and 2026 due to the expiration of the PHE and the impending expiration of ARP subsidies. To advance the enrollment and population estimates from 2022 to 2026 for purposes of establishing a baseline scenario for modeling pass-through funding, the impacts from the PHE, ARP, and general population growth are shown in Table 8. These values are rounded to emphasize that they are estimates of enrollment four years out with material known changes to the coverage landscape taking place by then, as well as potential unknown changes. There is a high degree of uncertainty related to these projections, but they represent reasonable expectations given current information and for purposes of this modeling.

Table 8
State of Nevada
NMSP Actuarial and Economic Analysis
Estimated Nevada Market Enrollment Shifts 2022-2026

	Individual	Uninsured PTC-Eligible*	Uninsured Non-PTC- Eligible**	Medicaid / CHIP	Employer- Sponsored / Medicare / Other	Total
2022 Enrollment	114,500	61,000	237,000	788,000	2,068,500	3,269,000
PHE Ends	15,700	33,000	0	(191,000)	142,300	0
ARP Ends	(29,800)	18,800	11,000	0	0	0
Population Growth	1,000	3,200	12,600	41,800	109,700	168,300
2026 Enrollment	101,400	116,000	260,600	638,800	2,320,500	3,437,300

*Includes members who may not qualify for subsidies based on income and gross SLCS premium.

**Includes members eligible for employer-sponsored insurance or Medicaid, or who do not qualify for the individual market due to immigration status.

We note the following regarding Table 8:

- We estimate Medicaid disenrollment by looking at historical Medicaid data over the past several years to estimate the enrollment increase due to the PHE. We assume some of the enrollment growth during the PHE remains, but enrollment will revert closer to pre-PHE levels. Further, we assume that beneficiaries disenrolled from Medicaid who transition to the individual market will all be PTC-eligible.
- We assume beneficiaries disenrolled from Medicaid will enroll in employer-sponsored and individual coverage or become uninsured approximately in proportion to current market sizes (i.e., proportional allocation).
- We assume the expiration of ARP subsidies at the end of 2025 will result in some current individual market enrollees transitioning to uninsured PTC-eligible status because required out-of-pocket premiums will increase for many enrollees.
- Moreover, given the structure of ARP subsidies, specifically that those with incomes over 400% FPL are eligible for subsidies, the ending of ARP subsidies will make these enrollees ineligible for subsidies. Hence, a material portion of the uninsured over 400% FPL move into the uninsured non-PTC-eligible segment.

- We estimate the total number of enrollees transitioning out of individual coverage due to the expiration of ARP subsidies (29,800) by reviewing the change in historical enrollment from 2019 to the open enrollment of 2022 in the State of Nevada. The detailed assumptions used to develop these projected enrollment impacts are described in more detail in Section VI below.
- We assume population growth at 1.3% annually,²⁰ except that we adjust population growth in the individual market to reflect an observed enrollment decline of approximately 3,800 from 2022 to 2023.

²⁰ The sources used to inform the population growth assumption are described in Section 6 below.

III. DESCRIPTION OF SCENARIOS

Under current law as of this writing, ARP subsidies are set to expire at the end of 2025. Therefore, the scenarios modeled in our analysis assume ARP subsidies expire after 2025. We modeled a Baseline scenario to illustrate the projected enrollment, premiums, and federal costs without the NMSP. From there, we modeled a Market Stabilization scenario to illustrate the potential impact of the NMSP on enrollment, premiums, and PTF. We identify the incremental impact of the two primary sources of pass-through funding, specifically the BBSPs and reinsurance.

A. DESCRIPTION OF SCENARIOS

The Market Stabilization scenario assumes the NMSP will achieve the gross premium savings targets, namely 3% in the first program year (required) and growing to at least 15% by year 4, consistent with direction from the State of Nevada, SB420, and the State of Nevada's methodology outlined in Appendix C. This scenario also assumes at least one bronze BBSP will be available in each rating area. Also, BBSPs will be available to off-exchange enrollees at full-cost (unsubsidized).

PTF is the difference between the net federal spending (outlays minus revenues) that would have been generated without the waiver (the Baseline scenario) and the net federal spending after the waiver. To the extent the Section 1332 waiver reduces net²¹ federal outlays for premium tax credits, these savings can be passed through to the State of Nevada (i.e., PTF) to be used for various purposes, such as reducing enrollee out-of-pocket premium costs (either subsidized or unsubsidized) or providing further incentives to either enroll in coverage (if uninsured) or stay enrolled (if currently enrolled). Under any 1332 waiver scenario, PTF could also be used for outreach or other initiatives that do not solely or directly impact the individual market. SB420 does require that the state's PTF first be used to fund administrative costs to operate the BBSPs before it is used to fund other initiatives.

Table 9 lists the key assumptions that impact each scenario. A brief description of each is provided below. Detailed methodology and sourcing can be found in Section VI of this report.

Table 9 State of Nevada NMSP Actuarial and Economic Analysis Scenario Assumptions		
	Baseline	Market Stabilization
Enrollment		
General population growth	X	X
Expiration of the PHE	X	X
Expiration of ARP subsidies	X	X
BBSP appeal		X
BBSP bronze offering		X
Reinsurance		X
Premiums		
Standard QHP premium trend	X	X
Expiration of the PHE (morbidity)	X	X
Expiration of ARP (morbidity)	X	X
Increased enrollment due to BBSP appeal (morbidity)		X
Premium reduction target		X
Reinsurance		X
Subsidies		
Indexed FPL	X	X
Indexed ACA affordability limits	X	X
BBSP adoption rate		X

²¹ Net here means after deductions for any other increases federal spending or reductions in federal revenues. We assume these deductions to be immaterially small.

**Table 10
State of Nevada
NMSP Actuarial and Economic Analysis
Scenario Assumption Descriptions**

	Assumption	Brief Description
Enrollment	General population growth	Individual market enrollment after 2023 is assumed to grow at the statewide population growth rate, or 1.3%, at a minimum. This growth is assumed to apply uniformly (e.g., across income levels, age groups, metallic levels).
	Expiration of the PHE	We assume the Medicaid disenrollment process due to the expiration of the PHE is completed prior to the effective date of the NMSP in 2026, most likely during 2024. Individual market enrollment is assumed to increase due to the expiration of the PHE as Medicaid disenrollment occurs. The impact varies by income level to account for Medicaid eligibility categories.
	Expiration of ARP subsidies	If ARP subsidies expire in 2025, as currently scheduled, a portion of current Silver State Individual Health Exchange enrollees are assumed to disenroll from individual coverage at the beginning of 2026, driven by increases in net (post-subsidy) premiums. This decreases enrollment in the individual market and increases the uninsured pool.
	BBSP appeal	Some previously uninsured Nevadans who are not subsidy-eligible (mainly near or above 400% FPL) are assumed to enroll in the ACA coverage, either on or off the exchange, due to the lower premiums available through the BBSPs and heightened awareness of the exchange due to NMSP marketing and communications.
	BBSP bronze offering	The BBSPs, by legislation, are only required to have silver and gold level offerings. We assume the BBSPs also offer bronze plans. See Section III.B for a detailed discussion.
	Reinsurance	We assume some previously uninsured Nevadans who are not subsidy-eligible will enroll in ACA coverage due to lower premiums available after the implementation of reinsurance. We assume a higher enrollment growth percentage due to reinsurance in Rating Areas 3 and 4 than in Rating Areas 1 and 2 because the higher coinsurance in Rating Areas 3 and 4 results in a larger premium decrease.
Premiums	Standard QHP premium trend	Gross premiums (before reinsurance) for standard QHPs and off-exchange offerings are assumed to increase 4% ²² per year both with and without the waiver. This assumption is based on CMS projections of per capita national health expenditures and the impact of additional value-based purchasing initiatives that will be part of Nevada's broader efforts to move a larger share of Medicaid and BBSP payments to a value-based purchasing framework.
	Individual market morbidity	<p>Morbidity is the overall illness burden of a population, independent of the population's average age. Higher morbidity increases prices in a risk pool such as Nevada's Individual market, all else equal.</p> <p><u>End of PHE:</u> We assume premiums for existing standard QHPs on the Silver State Individual Health Exchange decrease by 0.4% in 2023 due to improved morbidity from the additional enrollment transitioning from Medicaid after the expiration of the PHE.</p> <p><u>End of ARP:</u> The exit of enrollees who leave the individual market due to the expiration of ARP subsidies is assumed to increase morbidity by 2.5%.</p> <p><u>Increased enrollment due to BBSP appeal:</u> Morbidity is projected to improve 0.2% in 2026 and 0.1% in 2027 relative to the baseline due to additional enrollment from the lower-priced BBSPs. No additional morbidity changes are assumed to happen beyond 2027.</p>
	Premium reduction target	We assume the NMSP will achieve the premium reduction targets described in the agency's memorandum of guidance in Appendix C.

²² CMS. Download: NHE Projections - Tables (ZIP), Table 1, Line 42, Private Health Insurance Expenditures. National Health Expenditure Data: Projected. Retrieved November 19, 2023, from <https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/projected>

	Assumption	Brief Description
	Reinsurance	<p>We assume reinsurance will reflect the following parameters:</p> <ul style="list-style-type: none"> ▪ Attachment point: \$60,000 ▪ Cap: \$1,000,000 ▪ Coinsurance: 20% in Rating Area 1, 35% in Rating Area 2, and 70% in Rating Areas 3 and 4 <p>Based on these reinsurance parameters, we estimate reinsurance will decrease premiums by approximately the following percentages:</p> <ul style="list-style-type: none"> ▪ Rating Area 1: 5% ▪ Rating Area 2: 9% ▪ Rating Area 3: 15% ▪ Rating Area 4: 28%
Subsidies	Indexed FPL	The federal poverty level (FPL) is assumed to increase by 2.5% every year after 2023. ²³
	ACA affordability limits	The maximum amount of premium for which an ACA enrollee is responsible as a percentage of their income is indexed based on National Health Expenditure data and projections published by CMS. We analyzed the changes in these values year over year prior to ARP subsidies becoming available in 2021. Based on the historical change, we projected income limits through the duration of the 10-year deficit neutrality window.
	BBSP adoption rate	Fully subsidized enrollees are assumed to enroll in a BBSP at a higher rate than lower or nonsubsidized enrollees.

Each of the assumptions in Table 10 is developed independently based on our best estimates; however, actual experience relative to each assumption will most likely differ to varying degrees. Furthermore, the amount of time between this analysis and the beginning of the NMSP introduces additional potential for variability to the projected impact of the NMSP on enrollment and costs because it extends the duration of the projection and the opportunity for unforeseen events. We apply an additional 10% discount to the five-year waiver and 10-year deficit estimates to reflect cumulative conservatism across all assumptions. The potential variances include, but are not limited to, enrollment volume and distribution, plan selection, regulatory changes, utilization and cost trend, and member agency.

Additional details about the data sources, methodology, and assumptions used to model each of these scenarios are provided in Section VI of this report below.

B. DISCUSSION OF BBSP TAKE-UP RATE ASSUMPTIONS

The impact of a bronze BBSP offering

As noted earlier, a BBSP is assumed to become the SLCS plan across all rating areas in Nevada in all of the NMSP's first four years of operation and throughout the five-year waiver and 10-year deficit neutrality windows. The two driving factors in the calculation of premium tax credit (PTC) savings in this analysis are (1) the percentage by which a BBSP, as the SLCS, is below what would otherwise be the SLCS plan in the Baseline scenario, and (2) the total enrollment of PTC-eligible individuals. However, there is an additional factor that impacts the pass-through funding, which is whether BBSPs are available to consumers at the bronze plan level.

Under a non-waiver scenario, subsidy-eligible individuals will sometimes purchase a bronze plan. This happens most often when consumers have incomes greater than 250% FPL. This income level makes many enrollees eligible for premium subsidies, but not eligible for cost-sharing reduction (CSR) subsidies, which are only available (to most consumers) on silver-level plans at or below 250% FPL. Thus, some individuals in this situation may obtain a no-cost bronze plan with their subsidy rather than a silver plan where they still might have some monthly premium amount. If the bronze plan is chosen, the full subsidy available to the consumer is most likely not entirely used up and the unused portion of the subsidy decreases the federal government expenditures.

Under a waiver scenario where a BBSP becomes the SLCS plan, many existing silver plan consumers under a Baseline scenario may switch to the benchmark plan or something close in price to that plan. Likewise, many bronze purchasers under the Baseline scenario will be expected to purchase a bronze-level BBSP under the Market Stabilization scenario.

²³ CMS. Download: NHE Projections - Tables (ZIP), Table 1, Line 30, Private Health Insurance Expenditures. National Health Expenditure Data: Projected. Retrieved November 19, 2023, <https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/projected>

If BBSP issuers do not have a bronze offering available, some amount of previous bronze purchasers will be assumed to take coverage under a silver BBSP, thereby using up the entire available subsidy.

The primary downstream implication of including bronze BBSPs for this waiver analysis is that the take-up assumption in the BBSPs does impact the overall PTF calculation. A higher assumed take-up rate in the BBSPs increases PTF, as it is assumed more bronze purchasers will also take up BBSP coverage and use only a portion (as opposed to all) of their available subsidy.²⁴ Said differently, if the BBSPs only offered silver and gold plans, take-up in the BBSPs would have no impact at all on PTF. The actual take-up of the BBSPs will only be impactful on PTF if we assume bronze-level BBSPs are offered.

In our analysis, we assume a price advantage for BBSPs due to the requirements of SB420. This implies that consumers will see additional value in the BBSPs and will take up BBSP coverage at some unknown rate. It is difficult to predict consumer behavior in the presence of the BBSPs' price advantage, and this difficulty stems from several sources:

- Although price is an important factor, consumers do not always choose a plan based on price.
- Provider networks will be required to align with Medicaid's broad networks to a certain extent; however, other product features of BBSPs by the various individual exchange insurers are not known at this time.

Notwithstanding, we assume that some material share of the market will respond to the lower prices of BBSPs in the individual market, both on and off the exchange. However, a separate material share of the market may not take up BBSP coverage for various reasons, based on exchange experience across the country. Our analysis of public data shows that a carrier that offers both the SLCS and LCS typically has between 30% and 60% of market share. Please see additional commentary in the Methodology section for more detail in the development of these estimates. We use an estimate within this range but slightly higher than the midpoint for the following reasons:

- There will be more publicity around the PO offerings relative to simply being the SLCS in any given year,
- BBSP plans are likely to have certain notation on the exchange enrollment page that further draws attention to them, and
- The BBSPs are offered by known carriers in the market, not a new entrant to the market in the typical sense.

Therefore, under the Market Stabilization scenario, we assume an ultimate take-up rate for enrollees on-exchange of 50% realized by the fourth year of the NMSP.

To understand the relative impact of BBSP take-up on the 10-year PTF, the estimated impact of a 50% versus a 60% take-up assumption is shown in Table 11.

Table 11
State of Nevada
NMSP Actuarial and Economic Analysis
BBSP Take-Up Sensitivity on Pass-Through Funding Through 10-Year Deficit Neutrality Window

Scenario	BBSP Take-Up 50%	BBSP Take-Up 60%	Change in PTF (thousands)	Change in PTF %	Change in BBSP Take-Up (50% to 60%)	PTF Impact of 1% Increase in Take-Up
Market Stabilization	\$844,000	\$844,000	(\$897)	-0.11%	20%	-0.01%

Note: All dollar values in thousands.

As can be seen in Table 11, the change from a 50% to a 60% assumed take-up in the BBSPs has only a small impact on PTF. This small impact reflects two offsetting components as take-up increases:

1. Bronze enrollees who enroll in a BBSP, which increases PTF if the BBSP has \$0 net premium when their Standard QHP had a non-zero net premium, as discussed above.
2. More total members enrolling in a BBSP, which decreases premiums and leads to a lower impact of reinsurance and thus lower PTF.

²⁴ Since bronze gross premiums are generally lower than silver and gold plan premiums, subsidies for bronze plans are likewise generally less than subsidies for silver and gold plans. Therefore, if issuers offer a bronze BBSP, we assume a portion of current bronze individual market enrollees and new individual market enrollees will select the bronze BBSP instead of a silver or gold BBSP, thereby reducing subsidies under the waiver and increasing the pass-through funding.

The assumption of a 50% ultimate BBSP take-up rate is based on actuarial judgement given that no PO program exists that is similar to Nevada's program and has enrollment experience. Colorado's program is approved but just began in 2023, and Washington's program does not have key features that will distinguish Nevada's program, such as enforceable premium targets and procurement ties to the Medicaid program. Therefore, the 50% assumption is based on balancing considerations already noted above but, for clarity, we repeat here:

- The BBSPs will offer a material price advantage over standard QHPs
- However, not all consumers shop on price
- Some features of the BBSPs are not known at this time

In short, given the price advantage, it is reasonable to assume some material share of the individual market will shift to BBSPs. However, given the uncertainty in both consumer behavior and product features, it is also reasonable to assume that some material share of the market does NOT switch to a BBSP.

Reinsurance

Reinsurance has the same proportionate impact on premiums for both BBSPs and standard QHPs. We assume the premium reductions driven by reinsurance will not have a significant impact on enrollment in the individual market. This is primarily due to the subsidized nature of the individual market. Most enrollees get subsidies and pay no more (or no less) than a fixed percentage of their income and are largely insulated from gross price changes, whether increases or decreases. As gross prices decline due to reinsurance, many of the uninsured who are eligible for subsidies will see no difference in the net price available to them and will have no additional incentive to purchase coverage. Waivers in other states have not shown large increases in enrollment attributable to the implementation of reinsurance.

However, unsubsidized individuals will receive the full benefit of the price reduction under a reinsurance program. Hence, to the extent premium reductions due to reinsurance may provide additional incentives for some uninsured individuals to enroll in the individual market, we assume enrollment in BBSPs will also increase slightly due to the implementation of reinsurance.

Small employer migration

While the BBSPs are not formally available for purchase by small employers in Nevada, these employers currently have the option to use an Individual Coverage HRA (ICHRA) to allow employees to purchase coverage on the individual market using employer contributions. Under this analysis, this option would be available under both the Baseline scenario and the waiver scenario.

However, under a waiver scenario, gross premium decreases relative to the Baseline starting in Year 2 of the NMSP are projected to be material, (i.e., approximately 12 to 15%). We include additional details on this deviation in Section VI. Our analysis of average premiums in both the small group and individual markets in Nevada indicates that, with the reduction in individual prices stemming from the NMSP, some incremental number of employers could consider offering an ICHRA benefit to some or all of their employees as average prices each market could reach closer to parity.²⁵

However, under an ICHRA, an employee waives the federal subsidies they might otherwise have received. Thus, under the Market Stabilization scenario (waiver scenario), we expect that the largest part of any incremental membership growth coming from small group to the individual market in response to an ICHRA offering will be unsubsidized. Consequently, there would be no increase to federal subsidies for these individuals.

There is a limited circumstance under which ICHRAs (or the offer of an ICHRA) might increase federal subsidies in the waiver scenario. If an employee received an ICHRA benefit that is deemed unaffordable, that individual can refuse the ICHRA benefit and claim any subsidy for which they might be eligible. However, an offering of an unaffordable ICHRA does not make sense relative to simply not offering coverage in any form, traditional or ICHRA. Therefore, this circumstance is very unlikely, and its only effect might be to increase an employee's awareness of their subsidy eligibility.

For these reasons, when evaluating the waiver against the deficit neutrality guardrail, we make no assumption of any enrollment increases under a waiver scenario relative to ICHRA offerings in the small group market. This assumption might somewhat understate federal subsidies in the waiver scenario, thereby increasing the estimate of PTF. This would be offset, however, by possible individual market morbidity improvements in the waiver scenario from any incremental membership migration. All told, we consider the net effect of this dynamic to be a very small impact on the

²⁵ Please see Methodology section for further discussion and development of the small group and individual rate relationships.

calculation of PTF and of little consequence to our overall evaluation of compliance with the deficit neutrality guardrail. Moreover, any upward bias in our calculation of estimated PTF that might occur due to small employer migration would fall well within the 10% margin we apply to the total PTF calculation.

IV. ACTUARIAL ANALYSIS

This section describes the required actuarial analysis for Nevada's Section 1332 Waiver application. Appendix A of this report contains the actuarial certification for the 1332 waiver. A description of the actuarial analysis meeting the requirements under 45 CFR 155.1308(f)(4)(i) and other applicable information as requested in the Checklist for Section 1332 Waiver Applications has been provided in this section.

A. AFFORDABILITY OF PREMIUMS AND COST-SHARING

As required under 45 CFR 155.1308(f)(3)(iv)(B), a state's proposed 1332 waiver must provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable under Title I of the ACA. As described in CMS-9936-N, increasing the number of state residents with large health care spending burdens relative to their incomes would result in a waiver proposal failing to meet the affordability requirement of the 1332 waiver application.²⁶ Additionally, regulations state an evaluation of the affordability requirement will take into account the impact of the waiver proposal to "vulnerable residents, including low-income individuals, elderly individuals, and those with serious health issues or who have a greater risk of developing serious health issues." The exhibits referenced in this section are shown in the Exhibits section at the end of the report.

The Market Stabilization scenario premium projections are shown on the following exhibits:

- Exhibit 1: Statewide 10-year premium projection and change from Baseline scenario
- Exhibit 2: Ten-year SLCS projection and change from Baseline scenario

Exhibit 2 demonstrates the waiver provides coverage that is at least as affordable as the coverage available without the waiver, as required by the guardrail. Exhibits 2.1 through 2.4 further demonstrate that this guardrail is satisfied for each of Nevada's four rating areas. The SLCS in Rating Areas 3 and 4, which are rural areas with underserved populations, decreases by 23% and 35%, respectively, by the end of the five-year waiver period. The SLCS in Rating Areas 1 and 2 decreases by less than 20% during the same time period.

The SLCS premiums shown in all versions of Exhibit 2 are based on a non-smoker for the sample age.

We conservatively assume some enrollees will not choose to enroll in BBSPs. The projected decrease in member premiums under the waiver shown in Exhibit 1 is attributable to the BBSP adoption rate assumption. Table 12 illustrates how these projected member premiums change based on different aggregate BBSP adoption rate assumptions. If all eligible enrollees choose a BBSP, member premiums will decrease by the same amount as the SLCS plan premium decreases in Exhibit 1.

Note, Table 12 assumes the BBSP take-up rate applies in all years, whereas the scenarios modeled in this report assume BBSP take-up rates increase over the first four years of the NMSP. Furthermore, the BBSP take-up percentage off-exchange take up is expected to be lower than on-exchange. We assume 50% take-up on-exchange in our analysis; however, the effective take-up rate across the entire individual market reflected in our analysis is slightly lower than 50%. Therefore, the premiums shown in Table 12 will not match any of the scenario results.

²⁶ See <https://www.gpo.gov/fdsys/pkg/FR-2015-12-16/pdf/2015-31563.pdf> for more information.

Table 12
State of Nevada
NMSP Actuarial and Economic Analysis
Sensitivity Illustration
Individual Market Composite Monthly Premium by BBSP Take-Up Rate

BBSP Take-Up Rate					
Year	30%	40%	50%	60%	70%
2026	\$603.22	\$602.05	\$600.53	\$598.14	\$595.74
2027	\$579.06	\$576.94	\$574.47	\$571.12	\$567.77
2028	\$596.39	\$592.91	\$589.31	\$585.39	\$581.47
2029	\$614.51	\$609.50	\$604.65	\$600.20	\$595.76
2030	\$638.01	\$632.80	\$627.75	\$623.13	\$618.51
2031	\$661.24	\$655.82	\$650.57	\$645.78	\$640.98
2032	\$686.55	\$680.90	\$675.44	\$670.44	\$665.45
2033	\$711.69	\$705.82	\$700.14	\$694.95	\$689.75
2034	\$738.48	\$732.38	\$726.47	\$721.06	\$715.66
2035	\$766.36	\$760.01	\$753.86	\$748.23	\$742.61

B. COMPARABLE NUMBER OF STATE RESIDENTS COVERED

As required under 45 CFR 155.1308(f)(3)(iv)(C), a proposed waiver of the State of Nevada must provide coverage to at least a comparable number of its residents as the provisions of Title I of the ACA. Under Nevada's 1332 waiver, we estimate the number of Nevadans with health insurance coverage will increase relative to without the waiver.

The exhibits referenced in this section are shown in the Exhibits section at the end of the report. Note, we do not show any enrollment projections by health status. The improvement in affordability under the NMSP will be consistent across health statuses, all else equal.

The Market Stabilization scenario enrollment projections compared to the Baseline scenario are shown on the following exhibits:

- Exhibit 3: Ten-year projected enrollment by income level
- Exhibit 4: Ten-year projected enrollment by metallic coverage level
- Exhibit 5: Ten-year projected enrollment by age group
- Exhibit 6: Ten-year projected enrollment by subsidy eligibility
- Exhibit 7: Ten-year projected enrollment by rating area

Exhibit 6 demonstrates the waiver provides coverage to at least as many residents as without the waiver, as required by the guardrail. Exhibit 7 demonstrates how the waiver is expected to have a greater impact on enrollment in underserved rural areas. We project enrollment in Rating Areas 3 and 4 to increase by more than 7% by 2027 due to the waiver, whereas we project enrollment in Rating Areas 1 and 2 to increase by slightly more than 1% and 2%, respectively.

C. COMPARABLE COVERAGE

Section 31 CFR 33.108(f)(3)(iv)(A) requires that coverage provided under the waiver must be at least as comprehensive overall as coverage available without the waiver. The waiver does not make any changes to the requirements for QHPs, network adequacy, metallic level requirements (including de minimis amounts), essential health benefits, or other coverage requirements; therefore, the Nevada 1332 waiver complies with this guardrail under all scenarios.

V. ECONOMIC ANALYSIS

Section 31 CFR 33.108(f)(3)(iv)(D) states that the waiver will not increase the federal deficit, either over the five-year waiver period or the 10-year federal deficit neutrality window. CMS requires various costs to be considered when determining the impact on the federal deficit. We list those costs below and address how the modeling handled each cost and the rationale for inclusion or exclusion.

- a. **Income, payroll, and excise taxes:** The excise tax to fund the Patient-Centered Outcomes Research Initiative (PCORI) for plan years that end on or after October 1, 2023 and before October 1, 2024 is \$3.22 per enrolled member per year. Given that the enrollment increase in the individual market expected from the proposed waiver is between approximately 600 and 2,100 for all 10 years of the deficit neutrality window, we do not expect the increase in federal revenue to be more than \$10,000 in a year, even with inflation. Relative to the premium tax credit (PTC) reductions, which are in the hundreds of millions, the PCORI fee change is immaterial to the economic analysis and was not modeled explicitly.
- b. **User fees:** Nevada's exchange has been a state-based exchange since 2020 and does not utilize the federal platform.²⁷
- c. **Changes in PTCs and other tax credits:** Our modeling includes the changes to the premium tax credits for those exchange enrollees qualifying for subsidies. We estimate premium tax credits by modeling advanced premium tax credits (APTCs)²⁸ and then applying an adjustment to account for the tax reconciliation process. This adjustment is 10%.²⁹
- d. **Changes in CSRs and Medicaid spending:** Cost-sharing reductions (CSRs) are not a federal obligation and, therefore, are not modeled. It is assumed that the NMSP does not impact Medicaid spending in the Market Stabilization scenario relative to the Baseline scenario.
- e. **Changes in employer mandate penalties:** Because the NMSP is not expected to affect the employer group market, the employer mandate revenue impact is zero. If the NMSP were to cause an increase in the migration of employees of small group employers utilizing ICHRAs, the employer mandate does not apply to this market.
- f. **Changes in individual mandate penalties:** The impact to individual mandate penalty revenue is zero because the penalty is set to \$0.
- g. **Tax deductions for employer premiums and medical expenses:** Because the NMSP is not expected to affect the employer group markets, the federal costs from the tax deductibility of employer premiums and other medical expenses are expected to be zero.
- h. **Changes in IRS administrative costs, healthcare.gov administrative costs, and any other federal administrative costs that may be affected by the waiver:** We are not aware of, nor do we anticipate, any impact from Nevada's waiver to IRS administrative costs.

In summary, the economic analysis of deficit neutrality over the 10-year deficit neutrality window presented in this analysis is calculated using estimates of federal savings driven exclusively by changes in premium tax credits and enrollment.

At a high level, changes in PTCs related to SB420 and the implementation of the NMSP will be driven by overall enrollment of PTC-eligible individuals and families, the percentage savings the BBSPs will drive relative to standard QHPs as they become the second lowest cost silver plan in each of the rating areas in Nevada, and the decrease in all individual market premiums due to reinsurance. In addition, as noted in Section III.B of this report, the effect on PTF will be influenced by the actual enrollment in bronze BBSPs. Therefore, we illustrate the development of PTC savings and PTF for each scenario by using a series of four exhibits:

- Projected enrollment of PTC-eligible enrollees in the individual market. In the Market Stabilization scenario, we also show the change in enrollment from the Baseline scenario.

²⁷ Governor Brian Sandoval (May 11, 2018). Letter to CMS CCIIO. Retrieved November 9, 2022, from <https://www.cms.gov/CCIIO/Resources/Technical-Implementation-Letters/Downloads/nv-declaration-letter.pdf>.

²⁸ ATPCs are based on estimated household income and household size, as opposed to PTCs that are determined after the end of the year based on actual income and household size.

²⁹ IRS. Table 2: Individual Income and Tax Data, by State and Size of Adjusted Gross Income, Tax Year 2019. Retrieved November 9, 2022, from <https://www.irs.gov/pub/irs-soi/19in29nv.xlsx> (Excel download).

- Projected gross premiums, split by BBSP and standard QHP enrollment, and then a composite market-wide premium based on the assumed take-up of BBSPs.
- Composite gross premiums split by PTC eligibility, with the APTC and net premium portions of an PTC-eligible enrollee's premium shown separately.
- Calculation of total APTCs and final estimated PTCs after tax reconciliation. Per member per month (PMPM) values are multiplied by membership values for each year to obtain the 10-year deficit neutrality window totals.

Note, the annual projected PTF amounts in our analysis represent our best estimates of the savings in each year. We reduce the projected PTF over the five-year waiver and 10-year deficit neutrality windows by a 10% margin to account for unknown contingencies.

A. PROJECTED CHANGES IN PTCS

The Baseline and Market Stabilization scenarios assume enhanced subsidies provided by ARP expire at the end of 2025.

Baseline Scenario

Enrollment

Table 13 shows the 10-year enrollment projection under the Baseline scenario for enrollees both on- and off-exchange. The enrollment projection for enrollees on-exchange is further split between members with and without PTC.

Table 13 State of Nevada NMSP Actuarial and Economic Analysis Baseline Scenario Individual Market Enrollment by Segment					
Year	On-Exchange			Off-Exchange	(5) Total Individual Market
	(1) PTC-Eligible	(2) Non-PTC-Eligible	(3) Total	(4) Total	
2026	75,400	10,600	86,000	15,400	101,400
2027	76,400	10,700	87,100	15,600	102,700
2028	77,400	10,800	88,200	15,800	104,000
2029	78,400	10,900	89,300	16,000	105,300
2030	79,500	11,100	90,600	16,200	106,800
2031	80,500	11,200	91,700	16,500	108,200
2032	81,600	11,300	92,900	16,700	109,600
2033	82,800	11,300	94,100	16,900	111,000
2034	83,900	11,400	95,300	17,100	112,400
2035	85,000	11,600	96,600	17,300	113,900
Average Annual Change	1.34%	1.01%	1.30%	1.30%	1.30%

- The 2026 Total Individual Market enrollment shown in column (5) for the beginning of the 10-year deficit neutrality window is consistent with Table 8, which illustrates the development of the 2026 number from 2022.
- Column (1) values increase due to population growth and for a small amount of movement from column (2).
- The non-PTC-eligible enrollment in column (2) increases, albeit at a slower rate than other segments. This is because federal poverty levels and the income affordability limits are indexed such that they increase slower than overall individual market premium growth; therefore, more people become eligible for at least some federal subsidy amounts and move to column (1). The income affordability limits are assumed to index at about 0.05% of income per year.

- Column (4) includes the individual market catastrophic plan enrollment.
- Columns (4) and (5) values beyond 2026 increase at the annual population growth estimate of 1.3%.

Premiums

The following assumptions apply to projected premiums under the Baseline scenario:

- *Standard QHP premium trend:* Gross premiums for the individual market are projected with a 4% annual increase. See Section VI below for a detailed description of the development of this factor.

Table 14 shows the statewide 10-year premium projection under the Baseline scenario. The PMPMs are averages based on the current mix of plan selections which is based on FPL, age, and metal level. We assume all enrollees remain in their current plan. There is no BBSP offering in the Baseline scenario, so BBSP enrollment and premiums are shown as zero to keep the format of exhibits consistent across the Baseline and Market Stabilization scenarios.

Table 14 State of Nevada NMSP Actuarial and Economic Analysis Baseline Scenario Summary of Enrollment and Premium by BBSP and Standard QHP Segments – All Rating Areas										
Year	BBSP				Standard QHP			Total		
	BBSP Take-Up %	Enrollment	Premium		Enrollment	Premium		Enrollment	Premium	
			Aggregate (thousands)	PMPM		Aggregate (thousands)	PMPM		Aggregate (thousands)	PMPM
2026	0%	0	0	0	101,400	\$740,000	\$608	101,400	\$740,000	\$608
2027	0%	0	0	0	102,700	\$780,000	\$633	102,700	\$780,000	\$633
2028	0%	0	0	0	104,000	\$822,000	\$658	104,000	\$822,000	\$658
2029	0%	0	0	0	105,300	\$866,000	\$685	105,300	\$866,000	\$685
2030	0%	0	0	0	106,800	\$912,000	\$711	106,800	\$912,000	\$711
2031	0%	0	0	0	108,200	\$961,000	\$740	108,200	\$961,000	\$740
2032	0%	0	0	0	109,600	\$1,013,000	\$770	109,600	\$1,013,000	\$770
2033	0%	0	0	0	111,000	\$1,067,000	\$801	111,000	\$1,067,000	\$801
2034	0%	0	0	0	112,400	\$1,124,000	\$833	112,400	\$1,124,000	\$833
2035	0%	0	0	0	113,900	\$1,184,000	\$866	113,900	\$1,184,000	\$866

Tables 14.1 through 14.4 show the same statewide 10-year premium projection under the Baseline scenario for each of Nevada’s four rating areas. As these tables illustrate, the average premiums in the more rural regions, Rating Areas 3 and 4, are significantly higher than in the more urban regions, Rating Areas 1 and 2. The average premiums in Rating Area 3, which has the highest premiums, are nearly 60% higher than the average premiums in Rating Area 1, which has the lowest premiums.

Table 14.1
State of Nevada
NMSP Actuarial and Economic Analysis
Baseline Scenario
Summary of Enrollment and Premium by BBSP and Standard QHP Segments - Rating Area 1

Year	BBSP				Standard QHP			Total		
	BBSP Take-Up %	Enrollment	Premium		Enrollment	Premium		Enrollment	Premium	
			Aggregate (thousands)	PMPM		Aggregate (thousands)	PMPM		Aggregate (thousands)	PMPM
2026	0%	0	0	0	80,100	\$548,000	\$570	80,100	\$548,000	\$570
2027	0%	0	0	0	81,100	\$578,000	\$594	81,100	\$578,000	\$594
2028	0%	0	0	0	82,100	\$609,000	\$618	82,100	\$609,000	\$618
2029	0%	0	0	0	83,200	\$641,000	\$642	83,200	\$641,000	\$642
2030	0%	0	0	0	84,300	\$675,000	\$668	84,300	\$675,000	\$668
2031	0%	0	0	0	85,400	\$712,000	\$695	85,400	\$712,000	\$695
2032	0%	0	0	0	86,500	\$750,000	\$723	86,500	\$750,000	\$723
2033	0%	0	0	0	87,600	\$790,000	\$752	87,600	\$790,000	\$752
2034	0%	0	0	0	88,800	\$832,000	\$781	88,800	\$832,000	\$781
2035	0%	0	0	0	89,900	\$877,000	\$813	89,900	\$877,000	\$813

Table 14.2
State of Nevada
NMSP Actuarial and Economic Analysis
Baseline Scenario
Summary of Enrollment and Premium by BBSP and Standard QHP Segments - Rating Area 2

Year	BBSP				Standard QHP			Total		
	BBSP Take-Up %	Enrollment	Premium		Enrollment	Premium		Enrollment	Premium	
			Aggregate (thousands)	PMPM		Aggregate (thousands)	PMPM		Aggregate (thousands)	PMPM
2026	0%	0	0	0	13,900	\$114,000	\$683	13,900	\$114,000	\$683
2027	0%	0	0	0	14,100	\$120,000	\$710	14,100	\$120,000	\$710
2028	0%	0	0	0	14,300	\$126,000	\$737	14,300	\$126,000	\$737
2029	0%	0	0	0	14,400	\$133,000	\$771	14,400	\$133,000	\$771
2030	0%	0	0	0	14,700	\$140,000	\$796	14,700	\$140,000	\$796
2031	0%	0	0	0	14,900	\$148,000	\$828	14,900	\$148,000	\$828
2032	0%	0	0	0	15,100	\$156,000	\$860	15,100	\$156,000	\$860
2033	0%	0	0	0	15,300	\$164,000	\$894	15,300	\$164,000	\$894
2034	0%	0	0	0	15,500	\$173,000	\$930	15,500	\$173,000	\$930
2035	0%	0	0	0	15,700	\$182,000	\$967	15,700	\$182,000	\$967

Table 14.3
State of Nevada
NMSP Actuarial and Economic Analysis
Baseline Scenario
Summary of Enrollment and Premium by BBSP and Standard QHP Segments - Rating Area 3

Year	BBSP				Standard QHP			Total		
	BBSP Take-Up %	Enrollment	Premium		Enrollment	Premium		Enrollment	Premium	
			Aggregate (thousands)	PMPM		Aggregate (thousands)	PMPM		Aggregate (thousands)	PMPM
2026	0%	0	0	0	5,200	\$56,000	\$904	5,200	\$56,000	\$904
2027	0%	0	0	0	5,300	\$59,000	\$934	5,300	\$59,000	\$934
2028	0%	0	0	0	5,300	\$63,000	\$984	5,300	\$63,000	\$984
2029	0%	0	0	0	5,400	\$66,000	\$1,018	5,400	\$66,000	\$1,018
2030	0%	0	0	0	5,500	\$69,000	\$1,053	5,500	\$69,000	\$1,053
2031	0%	0	0	0	5,500	\$73,000	\$1,109	5,500	\$73,000	\$1,109
2032	0%	0	0	0	5,600	\$77,000	\$1,148	5,600	\$77,000	\$1,148
2033	0%	0	0	0	5,700	\$81,000	\$1,188	5,700	\$81,000	\$1,188
2034	0%	0	0	0	5,700	\$86,000	\$1,251	5,700	\$86,000	\$1,251
2035	0%	0	0	0	5,800	\$90,000	\$1,296	5,800	\$90,000	\$1,296

Table 14.4
State of Nevada
NMSP Actuarial and Economic Analysis
Baseline Scenario⁴
Summary of Enrollment and Premium by BBSP and Standard QHP Segments - Rating Area 4

Year	BBSP				Standard QHP			Total		
	BBSP Take-Up %	Enrollment	Premium		Enrollment	Premium		Enrollment	Premium	
			Aggregate (thousands)	PMPM		Aggregate (thousands)	PMPM		Aggregate (thousands)	PMPM
2026	0%	0	0	0	2,200	\$22,000	\$816	2,200	\$22,000	\$816
2027	0%	0	0	0	2,200	\$23,000	\$860	2,200	\$23,000	\$860
2028	0%	0	0	0	2,300	\$24,000	\$867	2,300	\$24,000	\$867
2029	0%	0	0	0	2,300	\$25,000	\$913	2,300	\$25,000	\$913
2030	0%	0	0	0	2,300	\$27,000	\$962	2,300	\$27,000	\$962
2031	0%	0	0	0	2,400	\$28,000	\$971	2,400	\$28,000	\$971
2032	0%	0	0	0	2,400	\$29,000	\$1,023	2,400	\$29,000	\$1,023
2033	0%	0	0	0	2,400	\$31,000	\$1,078	2,400	\$31,000	\$1,078
2034	0%	0	0	0	2,400	\$33,000	\$1,136	2,400	\$33,000	\$1,136
2035	0%	0	0	0	2,500	\$34,000	\$1,149	2,500	\$34,000	\$1,149

Subsidies

The following assumptions apply to projected subsidies under the Baseline scenario:

- **FPL increases:** The 100% federal poverty level (FPL), used to calculate a PTC-eligible person's subsidy, is increased by 2.5% annually after 2023.³⁰
- **Income affordability limits:** These limits are indexed over time. We based our indexing on a conservative estimate of past indexing (i.e., generating less pass-through funding) projected into the 10-year deficit neutrality window. We assume the annual increase in the income affordability limits is approximately 0.05% of income per year.

³⁰ We assume a larger increase in 2023 given current levels of inflation. See Consumer prices up 8.5 percent for year ended March 2022: The Economics Daily: U.S. Bureau of Labor Statistics (bls.gov) at <https://www.bls.gov/opub/ted/2022/consumer-prices-up-8-5-percent-for-year-ended-march-2022.htm>.

Table 15 State of Nevada NMSP Actuarial and Economic Analysis Baseline Scenario Average Aggregate Premiums and Member Subsidies Per Member Per Month (PMPM)						
Year	On-Exchange				Off-Exchange	Total Individual Market
	PTC-Eligible		Non-PTC-Eligible			
	(1) Average Aggregate Gross Premium	(2) Average Aggregate APTC	(3) Average Aggregate Enrollee Net Premium	(4) Average Aggregate Enrollee Gross Premium	(5) Average Aggregate Enrollee Gross Premium	(6) Average Aggregate Gross Premium
2026	\$630	\$438	\$193	\$583	\$532	\$608
2027	\$656	\$456	\$200	\$608	\$553	\$633
2028	\$682	\$476	\$206	\$633	\$575	\$658
2029	\$709	\$496	\$213	\$660	\$598	\$685
2030	\$737	\$517	\$220	\$682	\$622	\$711
2031	\$767	\$539	\$228	\$712	\$647	\$740
2032	\$797	\$562	\$236	\$741	\$673	\$770
2033	\$829	\$585	\$244	\$774	\$699	\$801
2034	\$861	\$610	\$252	\$808	\$727	\$833
2035	\$896	\$635	\$260	\$836	\$757	\$866

Note: Total Individual Market Gross Premiums in column (6) are consistent with Table 14 above. Column (4) values are materially lower than gross premiums in the rest of the individual market as the catastrophic plans are included and constitute approximately 25% of the enrollment. Table 16 below illustrates the changes in each of the PMPM values in Table 15.

We note the following regarding Table 15:

- Average aggregate gross premiums, APTCs, and enrollee net premiums are based on the current mix of plan selections which is based on FPL, age, and metal level. We assume all enrollees remain in their current plan.

Table 16 State of Nevada NMSP Actuarial and Economic Analysis Baseline Scenario Annual Change in Average Aggregate Premiums and Member Subsidies PMPM						
Year	On-Exchange				Off-Exchange	Total Individual Market
	PTC-Eligible		Non-PTC-Eligible			
	(1) Average Aggregate Gross Premium	(2) Average Aggregate APTC	(3) Average Aggregate Enrollee Net Premium	(4) Average Aggregate Enrollee Gross Premium	(5) Average Aggregate Enrollee Gross Premium	(6) Average Aggregate Gross Premium
2026	--	--	--	--	--	--
2027	4.00%	4.25%	3.41%	4.15%	4.00%	4.02%
2028	4.01%	4.27%	3.40%	4.22%	4.00%	4.03%
2029	4.02%	4.29%	3.40%	4.26%	4.00%	4.05%
2030	3.90%	4.17%	3.26%	3.37%	4.00%	3.87%
2031	4.05%	4.32%	3.41%	4.33%	4.00%	4.06%
2032	3.97%	4.21%	3.40%	4.10%	4.00%	3.99%
2033	3.93%	4.10%	3.53%	4.47%	4.00%	4.01%
2034	3.97%	4.25%	3.31%	4.38%	4.00%	4.02%
2035	3.99%	4.26%	3.33%	3.48%	4.00%	3.95%

We note the following regarding the annual changes illustrated in Table 16:

- Average aggregate gross premiums, as noted earlier, are increasing at 4% per year (within tolerance for rounding), for both on-exchange enrollees and off-exchange enrollees.
- Average aggregate enrollee net premiums are indexed to federal poverty levels, which are assumed to increase at 2.5% per year, and therefore are increasing less than gross premiums.
- Average aggregate APTCs, being the balancing item, are increasing more than gross premium annually.
- Non-PTC-eligible exchange enrollee average aggregate gross premiums are more volatile due their small size and a changing mix of enrollees from year to year. Various enrollees will move from non-PTC-eligible to PTC-eligible over time as the income limits increase more slowly than premiums.

Market Stabilization Scenario

This scenario reflects expected premiums, enrollment, and federal subsidies under the Nevada 1332 waiver.

Enrollment

The Market Stabilization scenario reflects the same enrollment assumptions as the Baseline scenario plus the following assumptions:

- *“BBSP Appeal” increases unsubsidized enrollment:* Because unsubsidized consumers will absorb the full benefit of the lower premiums of a BBSP, unsubsidized enrollment is projected to increase as more of the uninsured with incomes over 400% FPL take up coverage.

Projected enrollment is based on a simple linear elasticity coefficient³¹ of between -0.003 and -0.005, meaning that a 1% rate decrease will result in an approximately 0.3% to 0.5% increase in coverage take-up in the target enrollment population.³² Table 17 shows the development of the enrollment increases based on the estimated size of the uninsured population in Nevada in 2026 that will have incomes near or above 400% FPL and the resulting elasticity coefficient.

Table 17 State of Nevada NMSP Actuarial and Economic Analysis Market Stabilization Scenario 2026 Enrollment Elasticity – Members Above 400% FPL		Market Stabilization Scenario
(a)	BBSP Appeal Enrollment Increase – Over 400%	450
(b)	Uninsured – Above 400% FPL	26,800
(c) = (a) / (b)	% Increased Assumed	1.7%
(d)	Premium Reduction	(3.2%)
(e) = (c) / (d)	Elasticity	-0.528

- *Decrease in subsidized enrollment:* A small number of subsidized enrollees under the Baseline scenario will lose subsidy eligibility (mainly younger and / or higher-income enrollees) as BBSP premiums drop below their current net premiums in the Baseline scenario and the enrollees no longer qualify for subsidies.

³¹ Elasticity is defined as a consumer’s sensitivity to price changes in making purchasing decisions. An elasticity of -1.00 indicates that a 1% price decrease will result in 1% more eligible consumers purchasing coverage. Elasticity of 0.00 means price changes do not affect purchasing decisions at all. Elasticity between -1.00 and 0.00 means that consumers have at least some sensitivity to price changes. Moreover, elasticity is very likely different at different income levels. However, we use a simple linear mechanism that ignores the income level aspect of consumer behavior as the additional complexity does not add additional precision of results or change our conclusions. We note that the elasticity implied in our enrollment increase estimates is reasonably within range of a published benchmark.

³² See the discussion in “Understanding Recent Developments in the Individual Health Insurance Market” (2017), at https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701_individual_health_insurance_market_cea_issue_brief.pdf, which on page 6 cites a .004 coefficient. Our modeling does not use this figure strictly but assumes a coefficient within a range of this estimate is reasonable.

Table 18 shows the 10-year enrollment projection under the Market Stabilization scenario. Table 19 shows the change in enrollment from the Baseline scenario to the Market Stabilization scenario.

Table 18 State of Nevada NMSP Actuarial and Economic Analysis Market Stabilization Scenario Individual Market Enrollment by Segment					
Year	On-Exchange			Off-Exchange	(5) Total Individual Market
	(1) PTC-Eligible	(2) Non-PTC-Eligible	(3) Total	(4) Total	
2026	75,200	11,100	86,300	15,700	102,000
2027	76,400	11,900	88,300	16,200	104,500
2028	77,400	12,100	89,500	16,500	106,000
2029	78,400	12,300	90,700	16,700	107,400
2030	79,400	12,400	91,800	16,900	108,700
2031	80,500	12,600	93,100	17,100	110,200
2032	81,500	12,700	94,200	17,400	111,600
2033	82,600	12,900	95,500	17,600	113,100
2034	83,700	13,000	96,700	17,800	114,500
2035	84,800	13,100	97,900	18,000	115,900
Average Annual Increase	1.34%	1.86%	1.41%	1.53%	1.43%

- The 2026 Total Individual Market enrollment shown in column (5) for the beginning of the 10-year deficit neutrality window is slightly higher than Table 8 in Section II.D above, which illustrates the development of the 2026 number from 2022, due to the expected additional enrollment from the BBSP appeal.
- Column (1) enrollment increases over time due to population growth and some movement from column (2), as in the Baseline scenario.
- Column (4) increases relative to the Baseline scenario due to the “BBSP Appeal” as well.

The net total enrollment changes from Baseline are shown in Table 19.

Table 19 State of Nevada NMSP Actuarial and Economic Analysis Market Stabilization Scenario Impact of NMSP on Individual Enrollment			
Year	Change in PTC Eligible	Change in Non-PTC Eligible	Total Change
2026	(200)	800	600
2027	0	1800	1800
2028	0	2,000	2000
2029	0	2,100	2,100
2030	(100)	2,000	1,900
2031	0	2,000	2,000
2032	(100)	2,100	2,000
2033	(200)	2,300	2,100
2034	(200)	2,300	2,100
2035	(200)	2,200	2,000

Table 19 shows that the NMSP is expected to increase the nonsubsidized enrollment as gross premiums will be cheaper and nonsubsidized consumers will reap the full savings of a BBSP offering (i.e., the “BBSP Appeal”). Subsidized enrollment is projected to decrease slightly as subsidies decrease under the NMSP and current enrollees with small subsidies no longer qualify for subsidies.

Premiums

The Market Stabilization scenario reflects the same premium assumptions as the Baseline scenario plus the following assumptions:

- **BBSP adoption rate:** New and existing individual market enrollment is assumed to shift into BBSPs due to lower gross prices for unsubsidized consumers and lower net premiums (i.e., after subsidy) for subsidized consumers who switch to a BBSP. Adoption of BBSPs is assumed to increase over the course of the first four program years and level out at 50% of the individual market. The shift to BBSPs causes composite market-wide premiums to be lower, all else equal.

The adoption rate of BBSPs is likely important for various other aspects of program management, provider satisfaction, and overall success of the program. For that reason, we assume adoption will be relatively high but that a material percentage of the market may not choose a BBSP (in this case, 50% for on-exchange enrollees).

- **BBSP premium rate progression:** Table 20 assumes the reference premium increases by 4% annually in the first four years, and the BBSP discount relative to the reference premium before reinsurance is approximately 3.2%, 5.2%, 6.6%, and 8.0% in the first through fourth years of the program, respectively. Note, this has the overall effect of keeping BBSP premium trend lower than overall market trend over this time period (2026 through 2029), and then BBSP premiums increase at the rate of the reference premium increase, which is assumed to be equal to overall individual market premium growth.
- **Morbidity of individual market:** Market morbidity is assumed to decrease (improve) slightly due to the increased enrollment as a result of the NMSP.
- **Reinsurance:** A reinsurance program will be introduced in the second year of the NMSP. The reinsurance parameters will target³³ statewide premium reductions of 7.2%, 7.4%, and 7.6% in the second through fourth years of the program, respectively. Reinsurance has the overall effect of reducing premiums across the entire individual market, although the actual premium reduction will vary by plan based on each carrier’s evaluation of the impact of the reinsurance program on their specific experience.

Table 20 shows the 10-year premium projection under the Market Stabilization scenario. The PMPMs are averages based on the projected mix of plan selections which is based on FPL, age, and metal level. Note, membership mix differences between the BBSPs and standard QHPs mean the actual premium differences will not match the projected discount from the reference premium. The BBSP take-up percentage in 2029 and later in Table 20 is slightly less than 50% because off-exchange take up is expected to be lower than on-exchange.

³³ Actual parameters may change due to CMS pass-through funding determinations and claims experience throughout the course of the NMSP.

Table 20
State of Nevada
NMSP Actuarial and Economic Analysis
Market Stabilization Scenario
Summary of Enrollment and Premium by BBSP and Standard QHP Segments – All Rating Areas

Year	BBSP				Standard QHP			Total		
	BBSP Take-Up %	Enrollment	Premium		Enrollment	Premium		Enrollment	Premium	
			Aggregate (thousands)	PMPM		Aggregate (thousands)	PMPM		Aggregate (thousands)	PMPM
2026	29%	29,100	\$210,000	\$601	72,700	\$526,000	\$603	101,800	\$736,000	\$602
2027	33%	35,000	\$241,000	\$573	69,500	\$481,000	\$576	104,500	\$722,000	\$575
2028	41%	43,800	\$308,000	\$585	62,200	\$443,000	\$594	106,000	\$751,000	\$590
2029	47%	50,700	\$364,000	\$598	56,700	\$417,000	\$613	107,400	\$781,000	\$606
2030	47%	51,300	\$382,000	\$621	57,400	\$438,000	\$636	108,700	\$820,000	\$629
2031	47%	52,000	\$402,000	\$644	58,200	\$460,000	\$659	110,200	\$862,000	\$652
2032	47%	52,700	\$422,000	\$668	58,900	\$484,000	\$685	111,600	\$906,000	\$677
2033	47%	53,400	\$444,000	\$693	59,700	\$508,000	\$710	113,100	\$952,000	\$702
2034	47%	54,100	\$466,000	\$718	60,400	\$534,000	\$737	114,500	\$1,000,000	\$728
2035	47%	54,800	\$490,000	\$745	61,100	\$561,000	\$765	115,900	\$1,051,000	\$755

Tables 20.1 through 20.4 show the same statewide 10-year premium projection under the Market Stabilization scenario for each of Nevada's four rating areas. As these tables illustrate, the average premiums in the more rural regions are still projected to be higher than in the more urban regions under the waiver; however, the magnitude of the difference is smaller because of the variance in the reinsurance coinsurance percentages across rating areas. The average premiums in Rating Area 3 in the Market Stabilization scenario are approximately 40% higher than the average premiums in Rating Area 1 by year 4 of the NMSP versus approximately 60% in the Baseline Scenario.

The differences in BBSP take-up assumptions in Tables 20.1 through 20. are driven by differences in member mix by on and off-change and by FPL and metal. Rating Area 1 has more a higher proportion of members for whom we assume higher take-up (e.g., on-exchange silver under 200% FPL) than the other rating areas.

Table 20.1
State of Nevada
NMSP Actuarial and Economic Analysis
Market Stabilization Scenario
Summary of Enrollment and Premium by BBSP and Standard QHP Segments – Rating Area 1

Year	BBSP				Standard QHP			Total		
	BBSP Take-Up %	Enrollment	Premium		Enrollment	Premium		Enrollment	Premium	
			Aggregate (thousands)	PMPM		Aggregate (thousands)	PMPM		Aggregate (thousands)	PMPM
2026	29%	23,200	\$157,000	\$563	57,200	\$388,000	\$566	80,400	\$545,000	\$565
2027	34%	27,900	\$183,000	\$545	54,100	\$359,000	\$553	82,000	\$542,000	\$550
2028	42%	34,900	\$233,000	\$556	48,300	\$331,000	\$571	83,200	\$564,000	\$565
2029	48%	40,300	\$275,000	\$570	44,000	\$311,000	\$589	84,300	\$586,000	\$580
2030	48%	40,800	\$290,000	\$592	44,600	\$327,000	\$611	85,400	\$617,000	\$602
2031	48%	41,400	\$305,000	\$613	45,100	\$343,000	\$635	86,500	\$648,000	\$624
2032	48%	41,900	\$320,000	\$637	45,700	\$361,000	\$659	87,600	\$681,000	\$649
2033	48%	42,500	\$337,000	\$660	46,300	\$380,000	\$684	88,800	\$717,000	\$673
2034	48%	43,100	\$354,000	\$684	46,800	\$399,000	\$711	89,900	\$753,000	\$698
2035	48%	43,600	\$372,000	\$711	47,400	\$420,000	\$738	91,000	\$792,000	\$725

Table 20.2
State of Nevada
NMSP Actuarial and Economic Analysis
Market Stabilization Scenario
Summary of Enrollment and Premium by BBSP and Standard QHP Segments – Rating Area 2

Year	BBSP				Standard QHP			Total		
	BBSP Take-Up %	Enrollment	Premium		Enrollment	Premium		Enrollment	Premium	
			Aggregate (thousands)	PMPM		Aggregate (thousands)	PMPM		Aggregate (thousands)	PMPM
2026	27%	3,800	\$31,000	\$679	10,200	\$83,000	\$674	14,000	\$114,000	\$675
2027	31%	4,500	\$35,000	\$641	9,900	\$75,000	\$629	14,400	\$110,000	\$633
2028	39%	5,700	\$45,000	\$653	8,900	\$69,000	\$647	14,600	\$114,000	\$650
2029	45%	6,700	\$53,000	\$661	8,100	\$65,000	\$670	14,800	\$118,000	\$666
2030	46%	6,800	\$56,000	\$684	8,100	\$68,000	\$704	14,900	\$124,000	\$695
2031	45%	6,900	\$59,000	\$708	8,300	\$72,000	\$722	15,200	\$131,000	\$715
2032	45%	6,900	\$62,000	\$744	8,500	\$76,000	\$741	15,400	\$138,000	\$742
2033	45%	7,000	\$65,000	\$770	8,600	\$79,000	\$768	15,600	\$144,000	\$769
2034	45%	7,100	\$68,000	\$797	8,700	\$83,000	\$797	15,800	\$151,000	\$797
2035	45%	7,200	\$71,000	\$825	8,800	\$87,000	\$828	16,000	\$158,000	\$826

Table 20.3
State of Nevada
NMSP Actuarial and Economic Analysis
Market Stabilization Scenario
Summary of Enrollment and Premium by BBSP and Standard QHP Segments – Rating Area 3

Year	BBSP				Standard QHP			Total		
	BBSP Take-Up %	Enrollment	Premium		Enrollment	Premium		Enrollment	Premium	
			Aggregate (thousands)	PMPM		Aggregate (thousands)	PMPM		Aggregate (thousands)	PMPM
2026	29%	1,500	\$16,000	\$886	3,700	\$40,000	\$903	5,200	\$56,000	\$898
2027	32%	1,800	\$18,000	\$819	3,800	\$36,000	\$782	5,600	\$54,000	\$794
2028	39%	2,200	\$23,000	\$855	3,500	\$33,000	\$782	5,700	\$56,000	\$810
2029	45%	2,600	\$27,000	\$854	3,200	\$31,000	\$804	5,800	\$58,000	\$826
2030	44%	2,600	\$28,000	\$895	3,300	\$32,000	\$817	5,900	\$60,000	\$851
2031	43%	2,600	\$29,000	\$937	3,400	\$34,000	\$831	6,000	\$63,000	\$877
2032	45%	2,700	\$31,000	\$946	3,300	\$36,000	\$897	6,000	\$67,000	\$919
2033	44%	2,700	\$32,000	\$991	3,400	\$37,000	\$912	6,100	\$69,000	\$947
2034	44%	2,700	\$34,000	\$1,038	3,500	\$39,000	\$928	6,200	\$73,000	\$976
2035	45%	2,800	\$35,000	\$1,048	3,400	\$41,000	\$1,001	6,200	\$76,000	\$1,022

Table 20.4
State of Nevada
NMSP Actuarial and Economic Analysis
Market Stabilization Scenario
Summary of Enrollment and Premium by BBSP and Standard QHP Segments – Rating Area 4

Year	BBSP				Standard QHP			Total		
	BBSP Take-Up %	Enrollment	Premium		Enrollment	Premium		Enrollment	Premium	
			Aggregate (thousands)	PMPM		Aggregate (thousands)	PMPM		Aggregate (thousands)	PMPM
2026	27%	600	\$6,000	\$850	1,600	\$15,000	\$796	2,200	\$21,000	\$811
2027	32%	800	\$6,000	\$608	1,700	\$12,000	\$573	2,500	\$18,000	\$584
2028	40%	1,000	\$7,000	\$618	1,500	\$11,000	\$596	2,500	\$18,000	\$604
2029	44%	1,100	\$9,000	\$660	1,400	\$10,000	\$597	2,500	\$19,000	\$625
2030	44%	1,100	\$9,000	\$689	1,400	\$10,000	\$624	2,500	\$19,000	\$653
2031	44%	1,100	\$9,000	\$719	1,400	\$11,000	\$651	2,500	\$20,000	\$681
2032	46%	1,200	\$10,000	\$688	1,400	\$11,000	\$680	2,600	\$21,000	\$684
2033	46%	1,200	\$10,000	\$719	1,400	\$12,000	\$710	2,600	\$22,000	\$714
2034	46%	1,200	\$11,000	\$751	1,400	\$12,000	\$742	2,600	\$23,000	\$746
2035	44%	1,200	\$11,000	\$784	1,500	\$13,000	\$723	2,700	\$24,000	\$750

Subsidies

Premiums under the Market Stabilization scenario reflect the same key assumptions as the Baseline scenario plus the following assumption:

- *BBSP becomes the SLCS plan:* We assume a BBSP becomes the SLCS plan in each rating area and achieves the targeted savings relative to the reference premium. Similarly, we assume a BBSP also achieves savings relative to the SLCS premium modeled in the Baseline scenario. See additional discussion in Section II.B above related to why we assume the competitive landscape driven by BBSPs decreases the benchmark silver plan, regardless of whether a BBSP becomes the SLCS.

Table 21
State of Nevada
NMSP Actuarial and Economic Analysis
Market Stabilization Scenario
Average Aggregate Premiums and Member Subsidies Per Member Per Month (PMPM)

Year	On-Exchange					Off-Exchange	Total Individual Market
	PTC-Eligible			Non-PTC-Eligible			
	(1) Average Aggregate Gross Premium	(2) Average Aggregate APTC	(3) Average Aggregate Enrollee Net Premium	(4) Average Aggregate Enrollee Gross Premium			
2026	\$624	\$420	\$204	\$552		\$526	\$601
2027	\$599	\$386	\$212	\$525		\$503	\$575
2028	\$614	\$393	\$221	\$540		\$516	\$590
2029	\$630	\$400	\$230	\$555		\$530	\$606
2030	\$654	\$416	\$238	\$577		\$550	\$629
2031	\$678	\$432	\$246	\$597		\$570	\$652
2032	\$704	\$449	\$254	\$623		\$591	\$677
2033	\$729	\$467	\$263	\$644		\$613	\$702
2034	\$757	\$485	\$272	\$669		\$636	\$728
2035	\$785	\$504	\$281	\$697		\$660	\$755

We note the following regarding Table 21:

- Average aggregate gross premiums, APTCs, and enrollee net premiums are based on the projected mix of plan selections under the Market Stabilization scenario which is based on FPL, age, and metal level. We assume 50% of members enroll in a BBSP and the other 50% remain in their current plan (i.e., the same plan as in the Baseline scenario).

Table 22
State of Nevada
NMSP Actuarial and Economic Analysis
Market Stabilization Scenario
Change versus Baseline in Average Aggregate Premiums and Member Subsidies PMPM

Year	On-Exchange				Off-Exchange	Total Individual Market
	PTC-Eligible		Non-PTC-Eligible			
	(1) Average Aggregate Gross Premium	(2) Average Aggregate APTC	(3) Average Aggregate Enrollee Net Premium	(4) Average Aggregate Enrollee Gross Premium	(5) Average Aggregate Enrollee Gross Premium	(6) Average Aggregate Gross Premium
2026	(1.0%)	(3.9%)	5.7%	(5.4%)	(1.1%)	(1.2%)
2027	(8.7%)	(15.3%)	6.5%	(13.6%)	(9.0%)	(9.1%)
2028	(9.9%)	(17.4%)	7.3%	(14.8%)	(10.2%)	(10.3%)
2029	(11.2%)	(19.3%)	7.9%	(15.9%)	(11.4%)	(11.5%)
2030	(11.3%)	(19.5%)	8.1%	(15.4%)	(11.6%)	(11.6%)
2031	(11.6%)	(19.8%)	7.9%	(16.1%)	(11.8%)	(11.9%)
2032	(11.7%)	(20.0%)	7.9%	(16.0%)	(12.1%)	(12.1%)
2033	(12.0%)	(20.1%)	7.7%	(16.9%)	(12.3%)	(12.4%)
2034	(12.2%)	(20.4%)	7.8%	(17.3%)	(12.5%)	(12.6%)
2035	(12.4%)	(20.7%)	7.8%	(16.7%)	(12.8%)	(12.8%)

Commentary on Table 22:

- Average Aggregate Gross Premiums in column (1) decline under the Market Stabilization scenario relative to the Baseline scenario. The difference grows over time as BBSP premium discounts relative to the reference premium and BBSP take-up both increase through year 4 of the program.
- The change in Average Aggregate APTCs in column (2) relative to the Baseline scenario is greater than the BBSP premium discounts relative to both the reference premium by year (as noted in Table 6 in Section II.D above) and to the Baseline SLCS premium, as expected.
- Average Aggregate Enrollee Net Premiums in column (3) reflect projected plan selections. The average aggregate enrollee net premiums are increasing relative to the Baseline scenario because we assume only approximately 50% of the individual market adopts a BBSP in year 4 and after. Based on this assumption, some consumers' net premiums (after subsidy) will increase because they have not switched plans, and the subsidy decrease due to the waiver leaves the enrollee with a higher net premium. The average net premium for subsidized members is sensitive to the BBSP take-up rate. If all consumers enroll in a BBSP, the Average Aggregate Enrollee Net Premiums will be no greater than in the Baseline scenario in each year. To illustrate how a higher BBSP adoption rate impacts the average aggregate enrollee net member premium, Exhibits E-1 and E-2 in Appendix E present the same results as shown in Tables 21 and 22 assuming an 80% BBSP adoption rate.

Finally, we calculate the savings in premium tax credits (PTCs) by multiplying APTC PMPMs by membership for the Baseline and Market Stabilization scenarios, calculating the difference in APTCs between the two scenarios, and adjusting for tax reconciliation.³⁴ The PTC membership under the Market Stabilization scenario reflects the decrease shown in Table 19 above due to some current enrollees with small subsidies who will no longer qualify for subsidies.

³⁴ PTC reconciliation involves truing up APTC (paid on estimated income) versus actual income on income tax forms filed with the IRS. Normally, PTCs are less than APTCs. See <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-Key-Components-Pass-through-Estimate-Feb-2021.xlsx>.

Table 23
State of Nevada
NMSP Actuarial and Economic Analysis
Market Stabilization Scenario
Impact of NMSP on Premium, Subsidies, and Pass-Through Funding

Baseline		Market Stabilization			Change			
Year	PTC Membership	APTC PMPM	Annual APTC (thousands)	PTC Membership	APTC PMPM	Annual APTC (thousands)	Change in APTC	PTC Savings
2026	75,400	\$438	\$396,000	75,200	\$420	\$379,000	(\$17,000)	\$15,000
2027	76,400	\$456	\$418,000	76,400	\$386	\$354,000	(\$64,000)	\$58,000
2028	77,400	\$476	\$442,000	77,400	\$393	\$365,000	(\$77,000)	\$69,000
2029	78,400	\$496	\$466,000	78,400	\$400	\$376,000	(\$90,000)	\$81,000
2030	79,500	\$517	\$493,000	79,400	\$416	\$396,000	(\$97,000)	\$87,000
2031	80,500	\$539	\$520,000	80,500	\$432	\$417,000	(\$103,000)	\$93,000
2032	81,600	\$562	\$550,000	81,500	\$449	\$440,000	(\$110,000)	\$99,000
2033	82,800	\$585	\$581,000	82,600	\$467	\$463,000	(\$118,000)	\$106,000
2034	83,900	\$610	\$614,000	83,700	\$485	\$487,000	(\$127,000)	\$114,000
2035	85,000	\$635	\$648,000	84,800	\$504	\$513,000	(\$135,000)	\$122,000
5-Year Waiver Window								\$310,000
10-Year Deficit Neutrality Window								\$844,000
5-Year Waiver Window – With 10% Margin								\$279,000
10-Year Deficit Neutrality Window – With 10% Margin								\$760,000

We estimate the federal PTC savings under the Market Stabilization scenario to be \$310 million over the five-year waiver period and \$844 million over the 10-year deficit neutrality period.

As required by CMS, the federal subsidies under the Market Stabilization scenario do not exceed the federal subsidies in the Baseline scenario over the 10-year deficit neutrality period.

VI. DATA AND METHODOLOGY

DATA SOURCES AND ADJUSTMENTS

Health care coverage and enrollment

The Silver State Health Insurance Exchange provided enrollment data as of early 2023. The exchange data included the following elements:

- Exchange individual identifier
- Household case identifier
- Federal poverty level (FPL) percentage
- Age
- ZIP Code
- County
- Plan level
- Net premium
- Advance premium tax credit (APTC) amount
- Health Insurance Oversight System (HIOS) issuer identifier
- CMS plan identifier
- Relationship to subscriber
- Enrollee status
- Status start date
- Status end date
- Last update date

We reviewed the exchange data for reasonableness and compared against publicly available sources. We summarized the key fields by various cuts to gauge feasibility of the data.

We mapped in each member's and contract's total SLCS plan premium amount from the publicly available Public Use Files (PUFs) based on their county. We also excluded a minimal amount of membership with invalid or missing entries for key fields such as county, age, and premium.

The exchange data represented a snapshot as of early 2023, and thus will not match the full year 2023 due to new enrollment, terminations, and midyear plan changes, among other reasons. We did account for membership that terminated prior to our snapshot.

Publicly available data

- Individual market Federal Risk Adjustment Reports
- Open enrollment PUFs
- Benefits and cost-sharing PUFs
- American Community Survey (ACS)
- National Health Expenditures (NHE) projections
- Commercial medical loss ratio form data submitted to CMS
- Statutory statement insurer financial data

Nevada Issuer EDGE Server Data

Six Nevada issuers provided 2022 full year High-Cost Risk Pool reports from the EDGE server. These reports contain member-level pharmacy and medical paid claims for the 2022 benefit year. We used this information to model estimated 2027 reinsurance costs.

Other

- State of Nevada Department of Health and Human Services guidance memo

METHODOLOGY

We summarized the 2023 exchange enrollment and premium information to create a baseline, grouped by metallic coverage level, rating area, age band, FPL, and contract size to produce approximately 3,000 model cells. In 2023, we calculated subsidies based on the member's selected premium, premium of SLCS plan available, household FPL, and current premium limits (based on the expanded ARP levels). For 2023 through 2035, we projected enrollment and premium increases for each scenario, and calculated the corresponding subsidies for each model cell. The following sections provide further detail on the assumptions for enrollment and premium changes.

Based on each scenario's ACA premium limits, we calculated revised subsidies for each model cell and year. The total subsidies in the Market Stabilization scenario are compared to the Baseline scenario to calculate the estimated PTF.

To model the estimated cost of reinsurance, we summarized 2022 member-level individual market claims by rating area and metal from the EDGE data and project forward through 2035. We adjusted for anticipated medical and pharmacy trend, Medicaid redeterminations, expiration of ARP subsidies, and the impact of BBSP plans on the market. Reinsurance was calculated based on members' total annual medical and pharmacy claims compared to the program parameters.

Enrollment Assumptions

Population-driven enrollment growth

We assumed the exchange will grow by the population growth rate, at a minimum. The population of the State of Nevada is assumed to grow 1.3% annually after 2022.³⁵

Enrollment growth due to expiration of the PHE

We assumed exchange enrollment will increase in each income level between 2023 and 2026 due to the expiration of the PHE, as shown in Table 24. First, we estimated the total membership at each income level that we expect to lose Medicaid coverage upon expiration of the PHE by reviewing growth in Nevada Medicaid enrollment since the PHE started compared to pre-PHE enrollment. Although Medicaid disenrollment due to the expiration of the PHE will impact all income levels and eligibility groups, we expect the impact to be greater for higher-income members and for the Childless Adults eligibility group. For each cohort, we estimated the percentage that will take up group coverage, individual exchange coverage, or become uninsured upon disenrollment from Medicaid. We expect higher-income individuals will be more likely to have commercial group insurance available, and less likely to enter the individual market.

Income (% FPL)	Member Increase
Under 100%	295
100 to 133%	1,327
133 to 150%	1,994
150 to 200%	3,368
200 to 250%	3,998
250 to 300%	2,386
300 to 400%	1,040
Over 400%	1,291
Total	15,700

³⁵ Nevada Department of Taxation (October 1, 2022). Nevada County Age, Sex, Race, and Hispanic Origin Estimates and Projections 2000 to 2041: Estimates From 2000 to 2021 and Projections From 2022 to 2041. Table: Nevada Statewide ASRHO Summary File Estimated for 2000 to 2021 and Projected 2022 to 2041 W GQ, page 3. Retrieved November 9, 2022, from https://tax.nv.gov/uploadedFiles/taxnv.gov/Content/TaxLibrary/2022_ASRHO_Estimates_and_Projections.pdf.

Enrollment decrease due to the expiration of ARP subsidies

We assumed exchange enrollment will decrease in each income level between 2023 and 2026 due to the expiration of ARP subsidies, as shown in Table 25. To develop these assumptions, we estimated the increase in members due to ARP by measuring the 2021 and 2022 increases in enrollment. We assumed that a relatively comparable number of members will disenroll due to the expiration of ARP subsidies.

Table 25 State of Nevada NMSP Actuarial and Economic Analysis Modeling Assumptions Enrollment Decrease Due to Expiration of ARP Subsidies	
Income (% FPL)	Member Decrease
Under 100%	733
100 to 133%	2,071
133 to 150%	3,682
150 to 200%	3,699
200 to 250%	3,080
250 to 300%	2,589
300 to 400%	3,206
Over 400%	10,768
Total	29,830

Premium assumptions

Consumer Price Index – Medical

We assumed the annual increase in the Consumer Price Index – Medical (CPI-M) is 3.7% in all future years, which is the annualized average change in the CPI-M from April 2002 through April 2022.

Standard QHP gross premium increases (before reinsurance)

From 2018 through 2022, the average annual change in SLCS plan premiums on the individual exchange is -1.58% nationwide (decreasing each year) and -2.0% in Nevada³⁶ (decreasing in three of the four years). The actual annual percentage changes fluctuated widely in many states during this time due to market circumstances that are not expected to recur. Therefore, we did not assume the recent decreases and fluctuations in exchange premiums will continue in the future.

We expect the annual trend on standard QHP exchange gross premiums (before reinsurance) to converge near medical inflation indices. However, medical inflation indices typically do not reflect all prospective drivers of health care costs. For example, the CPI-M does not account for emerging treatments or changes in utilization. Therefore, we assumed the standard QHP exchange gross premiums will increase by 0.3% more than CPI-M, or 4.0% per year.

Morbidity changes due to the expiration of the PHE

We assumed the new enrollees who join the exchange due to the expiration of the PHE reduce total individual market morbidity by 0.4%, and we assumed this improvement will be reflected through comparably lower exchange premiums. We derived the 0.4% estimate using Milliman's population shift model, which uses census data and self-reported health status to estimate population movements among various sectors, incomes, and health statuses across the United States.

³⁶ Kaiser Family Foundation. Percent Change in Average Marketplace Premiums by Metal Tier, 2018-2023. State Health Facts. Retrieved November 9, 2022, from <https://www.kff.org/health-reform/state-indicator/percent-change-in-average-marketplace-premiums-by-metal-tier/?currentTimeframe=0&sortModel=%7B%22collId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

Morbidity changes due to the expiration of ARP subsidies

We assumed the enrollees who leave the Silver State Individual Health Exchange due to the expiration of ARP subsidies increase morbidity by 2.5%, and we assumed this change in morbidity will be reflected through comparably higher exchange premiums. Silver State Individual Health Exchange members who enrolled after ARP subsidies went into effect are estimated to be about 10% healthier, on average, than members enrolled prior to the ARP subsidies.

Demographic and distribution assumptions

BBSP adoption rate

We assumed new and existing Silver State Individual Health Exchange enrollees will enroll in BBSPs. The BBSPs will reduce the SLCS plan premium, which will result in lower federal premium subsidies for all subsidy-eligible enrollees. Any difference between the federal subsidy and the premium must be paid by the enrollee. For a fully subsidized enrollee to maintain the same level of out-of-pocket cost, they will likely need to shift to a BBSP. We assumed low-subsidy or nonsubsidized enrollees are less sensitive to these out-of-pocket cost increases than fully subsidized enrollees. Therefore, we assumed fully subsidized enrollees will enroll in a BBSP at higher rates than low-subsidy or nonsubsidized enrollees. The projected number of enrollees assumed to enroll in BBSP by income and metallic levels during the 10-year deficit neutrality window are shown in Exhibits 3 and 4, respectively.

To estimate our take-up of the PO, we assumed BBSPs as a whole could be treated as an exchange issuer. We then analyzed the historical market share for SLCS issuers at the county level as a proxy for what market share the BBSPs might receive, given they are assumed to be both the SLCS and LCS in this analysis. We used public data from the following sources:

- County-level Plan data from QHP Landscape files (Healthcare.gov Data Services Hub)
<https://data.healthcare.gov/datasets?keyword%5B0%5D=QHP>
- Rate information from CMS's "Rate PUF"
<https://www.cms.gov/marketplace/resources/data/public-use-files>
- Enrollment data from CMS's Issuer-Level Public Use File
<https://www.cms.gov/marketplace/resources/data/issuer-level-enrollment-data>

We analyzed data for 2018 through 2022 and excluded counties with two or fewer issuers to better simulate the Nevada competitive environment. We calculated the market share in counties where the SLCS and the LCS were offered by the same issuer, calculated the weighted average market share across all counties, and calculated ranges of market share estimates.

Subsidized members under 100% FPL

PTC subsidies typically are not available to enrollees below 100% FPL because those residents are expected to enroll in Medicaid. It is our understanding that some legal immigrants are not eligible for Medicaid in Nevada, but they are eligible for PTC subsidies on the exchange.

Income levels

The FPL in 2022 and 2023 is \$13,590 and \$14,580, respectively, for a one-person household. For modeling purposes, we assumed all enrollees in each income level have the same FPL percentage, based on the approximate distribution of 2023 exchange enrollment within each bucket. The modeled FPL percentages for 2023 in each bucket are shown in Table 26.

Table 26
State of Nevada
NMSP Actuarial and Economic Analysis
Modeling Assumptions
Modeled Household Income Levels – One-Person Household

Income (% FPL)	Modeled FPL %	Modeled 2023 Household Income
Under 100%	100%	Less than \$14,580
100 to 133%	120%	\$17,496
133 to 150%	145%	\$21,141
150 to 200%	190%	\$27,702
200 to 250%	245%	\$35,721
250 to 300%	280%	\$40,824
300 to 400%	385%	\$56,133
Over 400%	600%	\$87,480

FPL increases

We assumed the FPL will increase each year with trend. The FPL is assumed to increase by 2.5% every year, based on CMS projections.

ACA affordability limits

The maximum amount of premium for which an ACA enrollee is responsible as a percentage of their income is indexed based on National Health Expenditure data and projections done by CMS. We analyzed the changes in these values year over year prior to ARP subsidies becoming available in 2021. Based on the historical change, we projected income limits through the duration of the 10-year deficit neutrality window. Our estimates are higher than historical changes to be conservative on PTF calculations.

Small Group Rates

In estimating the impact and potential migration from the small group market, we used public premium rate data from carriers in the individual and small group markets in Nevada in 2022 (CMS PUF files for individual and rate files from the SERFF filing system for small group). We reviewed rate increases in each market for 2023 and 2024 and concluded that the overall relationship of rates between markets has not changed materially. Table 27 below shows that small group rates are lower than individual rates across almost all metal levels and geographic areas.

Table 27
State of Nevada
NMSP Actuarial and Economic Analysis
Modeling Assumptions
Small Group to Individual Premium Rate Relationship

	Bronze	Silver	Gold
Rating Area 1	96.1%	96.3%	92.2%
Rating Area 2	89.5%	87.6%	85.3%
Rating Area 3	74.0%	73.0%	68.8%
Rating Area 4	85.1%	86.9%	86.8%

EXHIBITS

Exhibit 1
State of Nevada
Nevada Market Stabilization Actuarial and Economic Analysis
Individual Market Composite Monthly Premium

Year	Baseline	Waiver	Difference
2026	\$608.37	\$601.20	-1.2%
2027	\$632.82	\$575.40	-9.1%
2028	\$658.33	\$590.41	-10.3%
2029	\$684.98	\$605.89	-11.5%
2030	\$711.45	\$629.04	-11.6%
2031	\$740.37	\$651.91	-11.9%
2032	\$769.94	\$676.83	-12.1%
2033	\$800.81	\$701.59	-12.4%
2034	\$833.03	\$727.98	-12.6%
2035	\$865.91	\$755.43	-12.8%

Exhibit 2
State of Nevada
Nevada Market Stabilization Actuarial and Economic Analysis
Individual Market Changes in SLCS Plan Monthly Premium from 1332 Waiver Implementation
All Rating Areas

Year	21-Year Old Monthly Premium				40-Year Old Monthly Premium			
	Baseline	Waiver	Difference	Percent Change	Baseline	Waiver	Difference	Percent Change
2026	\$359.03	\$347.61	(\$11.42)	-3.2%	\$458.84	\$444.24	(\$14.59)	-3.2%
2027	\$373.39	\$328.63	(\$44.76)	-12.0%	\$477.19	\$419.99	(\$57.20)	-12.0%
2028	\$388.32	\$335.74	(\$52.58)	-13.5%	\$496.28	\$429.08	(\$67.20)	-13.5%
2029	\$403.86	\$343.26	(\$60.59)	-15.0%	\$516.13	\$438.69	(\$77.44)	-15.0%
2030	\$420.01	\$356.10	(\$63.91)	-15.2%	\$536.78	\$455.10	(\$81.68)	-15.2%
2031	\$436.81	\$369.39	(\$67.42)	-15.4%	\$558.25	\$472.08	(\$86.17)	-15.4%
2032	\$454.29	\$383.15	(\$71.14)	-15.7%	\$580.58	\$489.66	(\$90.91)	-15.7%
2033	\$472.46	\$397.40	(\$75.05)	-15.9%	\$603.80	\$507.88	(\$95.92)	-15.9%
2034	\$491.35	\$412.17	(\$79.18)	-16.1%	\$627.95	\$526.76	(\$101.20)	-16.1%
2035	\$511.01	\$427.47	(\$83.54)	-16.3%	\$653.07	\$546.31	(\$106.76)	-16.3%

Exhibit 2.1
State of Nevada
Nevada Market Stabilization Actuarial and Economic Analysis
Individual Market Changes in SLCS Plan Monthly Premium from 1332 Waiver Implementation
Rating Area 1

Year	21-Year Old Monthly Premium				40-Year Old Monthly Premium			
	Baseline	Waiver	Difference	Percent Change	Baseline	Waiver	Difference	Percent Change
2026	\$330.90	\$320.34	(\$10.56)	-3.2%	\$422.89	\$409.39	(\$13.50)	-3.2%
2027	\$344.13	\$309.61	(\$34.52)	-10.0%	\$439.80	\$395.69	(\$44.11)	-10.0%
2028	\$357.90	\$316.49	(\$41.41)	-11.6%	\$457.39	\$404.47	(\$52.92)	-11.6%
2029	\$372.21	\$323.78	(\$48.44)	-13.0%	\$475.69	\$413.79	(\$61.90)	-13.0%
2030	\$387.10	\$336.13	(\$50.98)	-13.2%	\$494.72	\$429.57	(\$65.15)	-13.2%
2031	\$402.59	\$348.92	(\$53.67)	-13.3%	\$514.51	\$445.92	(\$68.59)	-13.3%
2032	\$418.69	\$362.18	(\$56.51)	-13.5%	\$535.09	\$462.87	(\$72.22)	-13.5%
2033	\$435.44	\$375.93	(\$59.51)	-13.7%	\$556.49	\$480.44	(\$76.05)	-13.7%
2034	\$452.85	\$390.17	(\$62.68)	-13.8%	\$578.75	\$498.64	(\$80.11)	-13.8%
2035	\$470.97	\$404.94	(\$66.03)	-14.0%	\$601.90	\$517.51	(\$84.39)	-14.0%

Exhibit 2.2
State of Nevada
Nevada Market Stabilization Actuarial and Economic Analysis
Individual Market Changes in SLCS Plan Monthly Premium from 1332 Waiver Implementation
Rating Area 2

Year	21-Year Old Monthly Premium				40-Year Old Monthly Premium			
	Baseline	Waiver	Difference	Percent Change	Baseline	Waiver	Difference	Percent Change
2026	\$400.64	\$387.89	(\$12.74)	-3.2%	\$512.01	\$495.72	(\$16.29)	-3.2%
2027	\$416.66	\$358.71	(\$57.95)	-13.9%	\$532.49	\$458.44	(\$74.06)	-13.9%
2028	\$433.33	\$366.33	(\$67.00)	-15.5%	\$553.79	\$468.17	(\$85.62)	-15.5%
2029	\$450.66	\$374.39	(\$76.27)	-16.9%	\$575.94	\$478.47	(\$97.47)	-16.9%
2030	\$468.69	\$388.15	(\$80.54)	-17.2%	\$598.98	\$496.05	(\$102.93)	-17.2%
2031	\$487.43	\$402.38	(\$85.06)	-17.5%	\$622.94	\$514.24	(\$108.70)	-17.5%
2032	\$506.93	\$417.10	(\$89.83)	-17.7%	\$647.86	\$533.06	(\$114.80)	-17.7%
2033	\$527.21	\$432.35	(\$94.86)	-18.0%	\$673.77	\$552.55	(\$121.23)	-18.0%
2034	\$548.30	\$448.16	(\$100.14)	-18.3%	\$700.72	\$572.74	(\$127.98)	-18.3%
2035	\$570.23	\$464.59	(\$105.64)	-18.5%	\$728.75	\$593.74	(\$135.01)	-18.5%

Exhibit 2.3
State of Nevada
Nevada Market Stabilization Actuarial and Economic Analysis
Individual Market Changes in SLCS Plan Monthly Premium from 1332 Waiver Implementation
Rating Area 3

Year	21-Year Old Monthly Premium				40-Year Old Monthly Premium			
	Baseline	Waiver	Difference	Percent Change	Baseline	Waiver	Difference	Percent Change
2026	\$598.41	\$579.40	(\$19.01)	-3.2%	\$764.77	\$740.48	(\$24.30)	-3.2%
2027	\$622.35	\$501.11	(\$121.24)	-19.5%	\$795.36	\$640.42	(\$154.94)	-19.5%
2028	\$647.24	\$510.75	(\$136.49)	-21.1%	\$827.18	\$652.74	(\$174.43)	-21.1%
2029	\$673.13	\$520.85	(\$152.28)	-22.6%	\$860.26	\$665.65	(\$194.61)	-22.6%
2030	\$700.06	\$538.80	(\$161.26)	-23.0%	\$894.67	\$688.58	(\$206.09)	-23.0%
2031	\$728.06	\$557.28	(\$170.78)	-23.5%	\$930.46	\$712.21	(\$218.25)	-23.5%
2032	\$757.18	\$576.32	(\$180.86)	-23.9%	\$967.68	\$736.54	(\$231.14)	-23.9%
2033	\$787.47	\$595.94	(\$191.53)	-24.3%	\$1,006.39	\$761.62	(\$244.77)	-24.3%
2034	\$818.97	\$616.13	(\$202.83)	-24.8%	\$1,046.64	\$787.42	(\$259.22)	-24.8%
2035	\$851.73	\$636.95	(\$214.78)	-25.2%	\$1,088.51	\$814.02	(\$274.49)	-25.2%

Exhibit 2.4
State of Nevada
Nevada Market Stabilization Actuarial and Economic Analysis
Individual Market Changes in SLCS Plan Monthly Premium from 1332 Waiver Implementation
Rating Area 4

Year	21-Year Old Monthly Premium				40-Year Old Monthly Premium			
	Baseline	Waiver	Difference	Percent Change	Baseline	Waiver	Difference	Percent Change
2026	\$511.67	\$495.43	(\$16.24)	-3.2%	\$653.91	\$633.16	(\$20.75)	-3.2%
2027	\$532.13	\$365.27	(\$166.86)	-31.4%	\$680.07	\$466.82	(\$213.25)	-31.4%
2028	\$553.42	\$371.09	(\$182.32)	-32.9%	\$707.27	\$474.26	(\$233.01)	-32.9%
2029	\$575.55	\$377.13	(\$198.42)	-34.5%	\$735.56	\$481.98	(\$253.58)	-34.5%
2030	\$598.58	\$388.61	(\$209.96)	-35.1%	\$764.98	\$496.65	(\$268.33)	-35.1%
2031	\$622.52	\$400.36	(\$222.16)	-35.7%	\$795.58	\$511.66	(\$283.92)	-35.7%
2032	\$647.42	\$412.35	(\$235.07)	-36.3%	\$827.40	\$526.99	(\$300.42)	-36.3%
2033	\$673.32	\$424.79	(\$248.53)	-36.9%	\$860.50	\$542.88	(\$317.62)	-36.9%
2034	\$700.25	\$438.01	(\$262.24)	-37.4%	\$894.92	\$559.77	(\$335.15)	-37.4%
2035	\$728.26	\$451.42	(\$276.84)	-38.0%	\$930.72	\$576.91	(\$353.81)	-38.0%

Exhibit 3
State of Nevada
Nevada Market Stabilization Actuarial and Economic Analysis
Individual Market Estimated Enrollees: 2026 through 2035 by Federal Poverty Level

Total Enrollment by FPL % - Baseline

Income Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Under 100%	2,030	2,060	2,080	2,110	2,140	2,160	2,190	2,220	2,250	2,280
100 to 133%	7,190	7,280	7,380	7,470	7,570	7,670	7,770	7,870	7,970	8,070
133 to 150%	12,980	13,140	13,310	13,490	13,660	13,840	14,020	14,200	14,390	14,570
150 to 200%	22,370	22,660	22,960	23,260	23,560	23,870	24,180	24,490	24,810	25,130
200 to 250%	18,490	18,730	18,980	19,220	19,470	19,720	19,980	20,240	20,500	20,770
250 to 300%	10,820	10,960	11,100	11,240	11,390	11,540	11,690	11,840	11,990	12,150
300 to 400%	8,070	8,170	8,280	8,380	8,490	8,600	8,720	8,830	8,940	9,060
Over 400%	19,450	19,700	19,960	20,220	20,480	20,740	21,010	21,290	21,560	21,840
Total Individual*	101,380	102,700	104,040	105,390	106,760	108,150	109,550	110,980	112,420	113,880

Total Enrollment by FPL % - With Waiver

Income Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Under 100%	2,040	2,090	2,120	2,140	2,170	2,200	2,230	2,260	2,290	2,320
100 to 133%	7,190	7,330	7,430	7,520	7,620	7,720	7,820	7,920	8,020	8,130
133 to 150%	12,980	13,240	13,420	13,590	13,770	13,950	14,130	14,320	14,500	14,690
150 to 200%	22,410	22,930	23,240	23,540	23,850	24,160	24,470	24,790	25,110	25,440
200 to 250%	18,520	18,970	19,220	19,470	19,720	19,980	20,240	20,500	20,770	21,040
250 to 300%	10,840	11,110	11,260	11,410	11,550	11,700	11,860	12,010	12,170	12,330
300 to 400%	8,150	8,400	8,510	8,620	8,740	8,850	8,960	9,080	9,200	9,320
Over 400%	19,780	20,400	20,760	21,070	21,340	21,620	21,900	22,190	22,480	22,770
Total Individual*	101,920	104,470	105,940	107,370	108,770	110,180	111,610	113,060	114,530	116,020

Change in Enrollment Due to Waiver

Income Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Under 100%	10	30	40	30	30	40	40	40	40	40
100 to 133%	0	50	50	50	50	50	50	50	50	60
133 to 150%	0	100	110	100	110	110	110	120	110	120
150 to 200%	40	270	280	280	290	290	290	300	300	310
200 to 250%	30	240	240	250	250	260	260	260	270	270
250 to 300%	20	150	160	170	160	160	170	170	180	180
300 to 400%	80	230	230	240	250	250	240	250	260	260
Over 400%	330	700	800	850	860	880	890	900	920	930
Total Individual*	540	1,770	1,900	1,980	2,010	2,030	2,060	2,080	2,110	2,140

*Changes at the FPL level may not sum to the total due to rounding.

Exhibit 4
State of Nevada
Nevada Market Stabilization Actuarial and Economic Analysis
Individual Market Estimated Enrollees: 2026 through 2035 by Metal

Total Enrollment by Metal - Baseline

Plan Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Catastrophic	810	820	830	840	850	870	880	890	900	910
Bronze	40,180	40,710	41,240	41,770	42,310	42,860	43,420	43,990	44,560	45,140
Silver	56,560	57,300	58,040	58,800	59,560	60,340	61,120	61,910	62,720	63,530
Gold	3,830	3,880	3,930	3,980	4,030	4,080	4,140	4,190	4,240	4,300
Total Individual*	101,380	102,700	104,040	105,390	106,760	108,150	109,550	110,980	112,420	113,880

Total Enrollment by Metal - With Waiver

Plan Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Catastrophic	830	850	870	880	890	900	910	930	940	950
Bronze	40,490	41,630	42,230	42,810	43,370	43,930	44,500	45,080	45,670	46,260
Silver	56,740	58,040	58,830	59,610	60,390	61,170	61,970	62,770	63,590	64,420
Gold	3,860	3,950	4,010	4,070	4,120	4,170	4,230	4,280	4,340	4,390
Total Individual*	101,920	104,470	105,940	107,370	108,770	110,180	111,610	113,060	114,530	116,020

Change in Enrollment Due to Waiver

Plan Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Catastrophic	20	30	40	40	40	30	30	40	40	40
Bronze	310	920	990	1,040	1,060	1,070	1,080	1,090	1,110	1,120
Silver	180	740	790	810	830	830	850	860	870	890
Gold	30	70	80	90	90	90	90	90	100	90
Total Individual*	540	1,770	1,900	1,980	2,010	2,030	2,060	2,080	2,110	2,140

*Changes at the metal level may not sum to the total due to rounding.

Exhibit 5
State of Nevada
Nevada Market Stabilization Actuarial and Economic Analysis
Individual Market Estimated Enrollees: 2026 through 2035 by Age Group

Total Enrollment by Age Group - Baseline

Age Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
0-14	12,540	12,700	12,870	13,040	13,210	13,380	13,550	13,730	13,910	14,090
14-20	5,520	5,590	5,670	5,740	5,820	5,890	5,970	6,050	6,120	6,200
21-25	4,690	4,750	4,810	4,870	4,930	5,000	5,060	5,130	5,200	5,260
26-30	7,510	7,600	7,700	7,800	7,900	8,010	8,110	8,220	8,320	8,430
31-35	8,420	8,520	8,640	8,750	8,860	8,980	9,090	9,210	9,330	9,450
36-40	8,320	8,430	8,540	8,650	8,760	8,870	8,990	9,110	9,220	9,340
41-45	7,790	7,890	8,000	8,100	8,200	8,310	8,420	8,530	8,640	8,750
46-50	8,370	8,480	8,590	8,700	8,810	8,930	9,040	9,160	9,280	9,400
51-55	10,410	10,550	10,690	10,820	10,970	11,110	11,250	11,400	11,550	11,700
56-60	12,940	13,110	13,280	13,450	13,630	13,810	13,990	14,170	14,350	14,540
60-65	13,180	13,350	13,520	13,700	13,880	14,060	14,240	14,420	14,610	14,800
Over 65	1,700	1,720	1,750	1,770	1,790	1,820	1,840	1,860	1,890	1,910
Total Individual*	101,380	102,700	104,040	105,390	106,760	108,150	109,550	110,980	112,420	113,880

Total Enrollment by Age Group - With Waiver

Age Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
0-14	12,610	12,920	13,100	13,280	13,450	13,630	13,810	13,980	14,170	14,350
14-20	5,550	5,690	5,770	5,850	5,930	6,000	6,080	6,160	6,240	6,320
21-25	4,710	4,830	4,900	4,960	5,030	5,090	5,160	5,220	5,290	5,360
26-30	7,550	7,740	7,840	7,950	8,050	8,160	8,260	8,370	8,480	8,590
31-35	8,460	8,670	8,790	8,910	9,030	9,150	9,260	9,380	9,510	9,630
36-40	8,360	8,570	8,690	8,810	8,920	9,040	9,160	9,280	9,400	9,520
41-45	7,830	8,030	8,140	8,250	8,360	8,470	8,580	8,690	8,800	8,920
46-50	8,410	8,620	8,740	8,860	8,980	9,090	9,210	9,330	9,450	9,580
51-55	10,470	10,730	10,880	11,030	11,170	11,320	11,460	11,610	11,760	11,920
56-60	13,010	13,340	13,520	13,710	13,880	14,070	14,250	14,430	14,620	14,810
60-65	13,250	13,580	13,770	13,960	14,140	14,320	14,510	14,700	14,890	15,080
Over 65	1,710	1,750	1,780	1,800	1,830	1,850	1,870	1,900	1,920	1,950
Total Individual*	101,920	104,470	105,940	107,370	108,770	110,180	111,610	113,060	114,530	116,020

Change in Enrollment Due to Waiver

Age Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
0-14	70	220	230	240	240	250	260	250	260	260
14-20	30	100	100	110	110	110	110	110	120	120
21-25	20	80	90	90	100	90	100	90	90	100
26-30	40	140	140	150	150	150	150	150	160	160
31-35	40	150	150	160	170	170	170	170	180	180
36-40	40	140	150	160	160	170	170	170	180	180
41-45	40	140	140	150	160	160	160	160	160	170
46-50	40	140	150	160	170	160	170	170	170	180
51-55	60	180	190	210	200	210	210	210	210	220
56-60	70	230	240	260	250	260	260	260	270	270
60-65	70	230	250	260	260	260	270	280	280	280
Over 65	10	30	30	30	40	30	30	40	30	40
Total Individual*	540	1,770	1,900	1,980	2,010	2,030	2,060	2,080	2,110	2,140

*Changes at the age group level may not sum to the total due to rounding.

Exhibit 6
State of Nevada
Nevada Market Stabilization Actuarial and Economic Analysis
Individual Market Estimated Enrollees: 2026 through 2035 by APTC Eligibility

Total Enrollment by Subsidy Eligibility - Baseline

Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Subsidized	75,390	76,410	77,420	78,440	79,460	80,500	81,580	82,820	83,900	84,990
Unsubsidized	25,990	26,300	26,620	26,950	27,300	27,650	27,970	28,160	28,530	28,900
Total Individual*	101,380	102,700	104,040	105,390	106,760	108,150	109,550	110,980	112,420	113,880

Total Enrollment by Subsidy Eligibility - With Waiver

Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Subsidized	75,170	76,420	77,410	78,390	79,440	80,470	81,510	82,580	83,730	84,830
Unsubsidized	26,750	28,050	28,520	28,980	29,330	29,710	30,100	30,480	30,800	31,190
Total Individual*	101,920	104,470	105,940	107,370	108,770	110,180	111,610	113,060	114,530	116,020

Change in Enrollment Due to Waiver

Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Subsidized	(220)	10	(10)	(50)	(20)	(30)	(70)	(240)	(170)	(160)
Unsubsidized	760	1,750	1,900	2,030	2,030	2,060	2,130	2,320	2,270	2,290
Total Individual*	540	1,770	1,900	1,980	2,010	2,030	2,060	2,080	2,110	2,140

*Changes at the subsidized level may not sum to the total due to rounding.

Exhibit 7
State of Nevada
Nevada Market Stabilization Actuarial and Economic Analysis
Individual Market Estimated Enrollees: 2026 through 2035 by Rating Area

Total Enrollment by Rating Area - Baseline

Rating Area	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Rating Area 1	80,050	81,090	82,150	83,220	84,300	85,390	86,500	87,630	88,770	89,920
Rating Area 2	13,940	14,120	14,300	14,490	14,680	14,870	15,060	15,260	15,460	15,660
Rating Area 3	5,190	5,260	5,330	5,400	5,470	5,540	5,610	5,690	5,760	5,830
Rating Area 4	2,200	2,230	2,260	2,280	2,310	2,340	2,370	2,410	2,440	2,470
Total Individual*	101,380	102,700	104,040	105,390	106,760	108,150	109,550	110,980	112,420	113,880

Total Enrollment by Rating Area - With Waiver

Rating Area	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Rating Area 1	80,460	82,040	83,180	84,310	85,400	86,510	87,640	88,780	89,930	91,100
Rating Area 2	14,030	14,400	14,610	14,810	15,000	15,200	15,400	15,600	15,800	16,000
Rating Area 3	5,220	5,640	5,720	5,800	5,870	5,950	6,030	6,110	6,190	6,270
Rating Area 4	2,210	2,390	2,420	2,450	2,490	2,520	2,550	2,580	2,620	2,650
Total Individual*	101,920	104,470	105,940	107,370	108,770	110,180	111,610	113,060	114,530	116,020

Change in Enrollment Due to Waiver

Rating Area	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Rating Area 1	410	950	1,030	1,090	1,100	1,120	1,140	1,150	1,160	1,180
Rating Area 2	90	280	310	320	320	330	340	340	340	340
Rating Area 3	30	380	390	400	400	410	420	420	430	440
Rating Area 4	10	160	160	170	180	180	180	170	180	180
Total Individual*	540	1,770	1,900	1,980	2,010	2,030	2,060	2,080	2,110	2,140

*Changes at the rating area level may not sum to the total due to rounding.

APPENDIX A

Actuarial Certification

Appendix A

State of Nevada Section 1332 Waiver Application Actuarial Certification

I, Frederick S. Busch, Principal and Consulting Actuary with the firm of Milliman, Inc., am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the standards of practice established by the Actuarial Standards Board. I have been employed by the State of Nevada through a subcontracting relationship with Manatt to perform an actuarial analysis and certification regarding the State of Nevada's operation of a Public Option (PO) program under a Section 1332 State Relief and Empowerment Waiver. I am generally familiar with the federal requirements for Section 1332 waiver proposals, commercial health insurance rating rules, Medicaid eligibility, insurance exchanges, the Patient Protection and Affordable Care Act's premium assistance structure, and other components of the ACA relevant to this Section 1332 State Relief and Empowerment Waiver proposal.

As required under 45 CFR 155.1308 (f)(4)(i), this certification provides documentation that my actuarial analyses support the State of Nevada's finding that the 1332 waiver complies with the following requirements for Section 1332 waivers as defined under 45 CFR 155.1308 (f)(3)(iv)(a)-(c):

- The proposal will provide coverage to at least a comparable number of the state's residents as would be provided absent the waiver
- The proposal will provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable for the state's residents as would be provided absent the waiver
- The proposal will provide access to coverage that is at least as comprehensive for the state's residents as would be provided absent the waiver

The assumptions and methodology used in the development of the actuarial certification have been documented in my report provided to the State of Nevada. The actuarial certification provided with this report is for the period from January 1, 2026, through December 31, 2030. To the extent state or federal regulations are modified through the end of the waiver period, it may be necessary for this actuarial certification and corresponding analyses to be amended.

The actuarial analyses presented with this certification are based on a projection of future events. Actual experience may be expected to vary from the experience assumed in the analyses.

In developing the actuarial certification, I have relied upon data and information provided by the Silver State Health Insurance Exchange, publicly available federal government data sets and reports, population data coming from the American Community Survey, and statutory financial statement data downloaded through S&P Global Market Intelligence. I have relied upon these third parties for audit of the data. However, I did review the data for reasonableness and consistency.



Frederick S. Busch, FSA
Member, American Academy of Actuaries

December 22, 2023
Date

APPENDIX B

State Legislation

See Full Waiver Application's Appendix B

APPENDIX C

State of Nevada Guidance Memorandum

Joe Lombardo
Governor

Richard Whitley, MS
Director



DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF HEALTH CARE FINANCING AND POLICY

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



Stacie Weeks, JD
MPH
Administrator

GENERAL GUIDANCE LETTER 23-003

Date: November 20, 2023

From: Richard Whitley, DHHS Director
Stacie Weeks, DHCFP Administrator

Subject: Notice of Revised Carrier Premium Reduction Targets for Plans Established in NRS 695K

PURPOSE: This letter serves as updated state guidance on the premium reduction targets as revised by the Director pursuant to NRS 695K.200, which were previously outlined in the Department's General Guidance Letter 22-001, published on October 4, 2022.

AUTHORITIES:

NRS 695K.200: [...]

5. The Director, in consultation with the Commissioner and the Executive Director of the Exchange, may revise the requirements of subsection 4, provided that the average premiums for the Public Option must be at least 15 percent lower than the average reference premium in this State over the first 4 years in which the Public Option is in operation.

APPLICATION:

As provided in state law, the new premium reduction requirements will be effective for the Plan Year that is effective on January 1, 2026. It will apply to all carriers that contract with the Department to offer the new health insurance options, established under Chapter NRS 695K, referred to as Battle Born State Plans (BBSPs). The updates to the premium reduction target, as described in this guidance, is reflective of the updated actuarial analysis and the findings from Milliman, Inc. about the addition of a reinsurance program as part of the State's updated Section 1332 Innovation Waiver proposal.¹ These findings are available in the State's Section 1332 Innovation Waiver and the Milliman Actuarial Analysis, 2023, and available at: <https://dhcfp.nv.gov/marketstabilization/>.

This guidance shall apply, unless otherwise revised by the Director, to the Department's 5-year contract period with carriers for the BBSP program, starting Calendar Year 2026. For future contract periods, the Director will issue additional guidance regarding any premium reduction targets deemed necessary for the success of the waiver programs.

Updated Premium Reduction Target for Plan Years 2026-2030 for Participating Carriers

Pursuant to the Director's broad and express authority in subsection 5 of NRS 695K.200, the Director establishes a premium reduction target for the new BBSPs for Plan Years 2026-2030 as follows:

¹ State law requires the Director to submit a 1332 Waiver

The annual premium cost of a carrier’s BBSP (silver plan) in the Silver State Health Insurance Exchange (SSHIX) must be lower than the average reference premium (“the benchmark”) in each county by a percentage that increases each Plan Year through Plan Year 2030, as outlined below and cannot increase more than the increase in Consumer Price Index for Medical Care plus any adjustments necessary to reflect local changes in utilization and morbidity:

- For Plan Year 2026, this percentage must be at least three percent lower than the benchmark.
- For Plan Year 2027 to Plan Year 2029, BBSP carriers must achieve a cumulative premium reduction of at least 15 percent as compared to the benchmark. For Plan Years 2027 and 2028, the premium reduction amounts will be negotiated by the Director as part of the procurement and contracting process with carriers with the goal of ensuring that the 15 percent overall reduction target is achieved by participating carriers by Plan Year 2029.
- For Plan Year 2030, carriers must maintain a 15 percent premium reduction as compared to the benchmark.

For the purposes of the premium reduction targets for Plan Years 2026-2030, the benchmark (average reference premium) shall mean “the second-lowest cost silver level plan available through the SSHIX during the 2024 plan year by county trended forward for inflation according to the Consumer Price Index for Medical Care and any adjustments to reflect local changes in utilization and morbidity.”

Impact of State-Based Reinsurance Program

For Plan Years 2027, 2028, 2029, and 2030—the percentage of the premium reduction target will be inclusive of the impact of a state reinsurance program on premium costs. The reinsurance program is intended to account for a substantial portion of the required premium reductions beginning Plan Year 2027. For Plan Years 2027 and 2028, the premium reduction amounts will be negotiated by the Director as part of the procurement and contracting process with carriers with the goal of ensuring that the 15 percent overall reduction target is achieved by participating carriers.

APPENDIX D
CCIIO Checklist for Section 1332 State Relief
and Empowerment Waivers

Appendix D

CCIIO Checklist for Section 1332 State Relief and Empowerment Waivers

The table below lists each item in the CCIIO Checklist for Section 1332 State Relief and Empowerment Waivers Applications (Updated July 2019)³⁷ and discusses how Nevada addresses each issue and/or directs the reader to other parts of this report.

	HHS Citation and Description	Actuary Response
1.	45 CFR 155.1308(a), (b), (c), (d) Application format, application timing, preliminary review, notification of preliminary determination.	This report is intended to be an attachment to Nevada’s 1332 waiver application. The actual application submission date is not known as of the date of this report.
2.	45 CFR 155.1308(f)(2) Written evidence of the state’s compliance with the public notice and comment requirements, set forth in 45 CFR 155.1312.	See Section 4 of waiver application
	Written evidence of the state’s compliance with the public hearing’s requirements, set forth in 45 CFR 155.1312.	See Section 4 of waiver application
	Written evidence of state’s compliance with the meaningful Tribal consultation requirements (if the state has one or more Federally-recognized Indian tribes), set forth in 45 CFR 155.1312.	See Section 4 of waiver application
3.	45 CFR 155.1308(f)(3)(i), (ii) Comprehensive description of state’s enacted legislation and program to implement a plan meeting the requirements for a section 1332 waiver and a copy of the state’s enacted legislation	See Appendices B and C
4.	45 CFR 155.1308(f)(3)(iii) List of provision(s) of the law that the state seeks to waive and reason for the specific request(s).	See Section 1B of waiver application

³⁷ CMS (July 2019). Checklist for Section 1332 State Relief and Empowerment Waivers (also called Section 1332 waivers or State Innovation Waivers) Applications. Retrieved November 9, 2022, from <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Checklist-for-Section-1332-State-Relief-and-Empowerment-Waivers.pdf>.

Appendix D

	HHS Citation and Description	Actuary Response
5.	<p>45 CFR 155.1308(f)(4)(i)-(iii) Actuarial analyses and actuarial certifications</p> <p>Economic analyses</p> <p>Data and assumptions</p> <p><i>*Note a state can combine the elements of an actuarial analysis and economic analysis into one report or submit separate actuarial and economic reports</i></p>	<p>1. See Appendix A for the actuarial certification.</p> <p>i. See Section IV.B for a demonstration that the Nevada Section 1332 waiver complies with the coverage requirement.</p> <p>a. See the Exhibits section</p> <p>ii. See Sections IV.A and IV.C for a demonstration that the Nevada Section 1332 waiver complies with the comprehensiveness and affordability requirements.</p> <p>a. See the Exhibits section</p> <p>b. See the Exhibits section</p> <p>2. See Section V</p> <p>3. See Section VI</p> <p>The Nevada 1332 waiver impacts the individual market. The baseline projection and a comparison to the projection under the waiver are included in Sections IV and V.</p> <p>The required analyses are included as noted below:</p> <ul style="list-style-type: none"> ▪ Exhibit 3: Non-group market enrollees by income as a share of FPL. ▪ Exhibit 1: Overall average non-group market premium rate. ▪ Exhibit 2: SLCS plan rate. ▪ The State of Nevada uses the federal default age rating curve. ▪ Section V: Aggregate premiums and PTC. ▪ The State of Nevada uses a state-based platform. Costs are assumed to be the same both with and without the waiver. ▪ Sections IV through VI: Documentation of all assumptions and methodologies used to develop the projections and growth of healthcare spending. <p>Nevada is not considering establishing a Risk Stabilization Waiver Concept as part of this 1332 waiver application.</p>
6.	<p>45 CFR 155.1308(f)(4)(iv) Draft timeline for implementation of the proposed waiver.</p>	See Section 1D of waiver application
7.	<p>45 CFR 155.1308(f)(4)(v)(A)-(E) Additional Information.</p>	See Section 5 of waiver application
8.	<p>45 CFR 155.1308(f)(4)(vi) Reporting targets.</p>	See Section 5E of waiver application
9.	<p>83 FR 53575 Administration's Principles.</p>	Need from Manatt / Nevada

APPENDIX E

Sensitivity Test of 80% BBSP Take-up

Appendix E-1
State of Nevada Market Stabilization Actuarial and Economic Analysis
Market Stabilization Scenario
Premiums and Member Subsidies Assuming 80% BBSP Take-up

Year	On-Exchange			Enrollee Gross Premiums	Enrollee Gross Premiums	Enrollee Gross Premiums	Total Individual Market Gross Premiums
	PTC Eligible		Enrollee Net Premiums				
	Gross Premiums	APTC					
2026	\$618	\$420	\$198	\$546	\$520	\$595	
2027	\$589	\$387	\$203	\$517	\$495	\$566	
2028	\$601	\$393	\$208	\$529	\$505	\$578	
2029	\$614	\$400	\$213	\$541	\$516	\$590	
2030	\$637	\$416	\$221	\$563	\$535	\$613	
2031	\$660	\$432	\$228	\$582	\$555	\$635	
2032	\$685	\$450	\$236	\$606	\$576	\$659	
2033	\$710	\$467	\$243	\$627	\$597	\$683	
2034	\$737	\$485	\$252	\$651	\$620	\$709	
2035	\$764	\$504	\$260	\$679	\$643	\$736	

Appendix E-2
State of Nevada Market Stabilization Actuarial and Economic Analysis
Market Stabilization Scenario
Impact of NMSP on Premium and Subsidies Assuming 80% BBSP Take-up

Year	On-Exchange			Enrollee Gross Premiums	Enrollee Gross Premiums	Enrollee Gross Premiums	Total Individual Market Gross Premiums
	PTC Eligible		Enrollee Net Premiums				
	Gross Premiums	APTC					
2026	(2.0%)	(3.9%)	2.5%	(6.4%)	(2.1%)	(2.2%)	
2027	(10.1%)	(15.3%)	1.6%	(15.0%)	(10.5%)	(10.5%)	
2028	(11.8%)	(17.3%)	0.9%	(16.5%)	(12.1%)	(12.2%)	
2029	(13.4%)	(19.3%)	0.1%	(18.1%)	(13.7%)	(13.8%)	
2030	(13.5%)	(19.4%)	0.2%	(17.6%)	(13.9%)	(13.9%)	
2031	(13.9%)	(19.8%)	0.0%	(18.3%)	(14.1%)	(14.2%)	
2032	(14.0%)	(19.9%)	0.0%	(18.2%)	(14.4%)	(14.4%)	
2033	(14.2%)	(20.1%)	(0.2%)	(19.0%)	(14.6%)	(14.7%)	
2034	(14.4%)	(20.4%)	(0.1%)	(19.4%)	(14.8%)	(14.9%)	
2035	(14.7%)	(20.6%)	(0.2%)	(18.8%)	(15.1%)	(15.0%)	

Appendix B: Nevada Legislation and Statute

Senate Bill No. 420—Senators Cannizzaro, Donate, Lange, Spearman; Brooks, Denis, Dondero Loop, D. Harris, Ohrenschall, Ratti and Scheible

Joint Sponsors: Assemblymen
Benitez-Thompson and Frierson

CHAPTER.....

AN ACT relating to insurance; providing for the establishment of a public health benefit plan; prescribing certain goals and requirements relating to the plan; requiring certain health carriers to participate in a competitive bidding process to administer the plan; requiring certain providers of health care to participate in the plan; exempting rules and policies governing the plan from certain requirements; requiring the Executive Director of the Silver State Health Insurance Exchange to apply for a federal waiver to allow certain policies to be offered on the Exchange; requiring certain persons to report the abuse and neglect of older persons, vulnerable persons and children; requiring the State Plan for Medicaid to include coverage for the services of a community health worker and doula services; revising provisions relating to coverage of services for pregnant women under Medicaid; requiring the establishment of a statewide Medicaid managed care program if money is available; revising requirements relating to health insurance coverage of enteral formulas; making appropriations; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law requires the Department of Health and Human Services to administer the Medicaid program, which is a joint program of the state and federal governments to provide health coverage to indigent persons. (NRS 422.270, 439B.120) Existing law also creates the Silver State Health Insurance Exchange to assist natural persons and small businesses in purchasing health coverage. (Chapter 695I of NRS) **Section 10** of this bill requires the Director of the Department, in consultation with the Executive Director of the Exchange and the Commissioner of Insurance, to design, establish and operate a public health benefit plan known as the Public Option. **Section 2** of this bill sets forth the purposes of the Public Option, and **sections 3.5-9** of this bill define terms relevant to the Public Option. **Section 10** requires the Public Option to be available through the Exchange and for direct purchase and authorizes the Director to make the Public Option available to small employers in this State or their employees. **Section 10** requires the Public Option to meet the requirements established by federal and state law for individual health insurance or health insurance for small employers where applicable. **Section 10** also establishes requirements governing the levels of coverage provided by the Public Option and the premiums for the Public Option. **Sections 38 and 41** of this bill remove the requirements relating to premiums on January 1, 2030. **Section 11**



of this bill requires the Director, the Commissioner and the Executive Director of the Exchange to apply for certain waivers to obtain federal financial support for the Public Option. **Section 39** of this bill requires the Director, the Commissioner and the Executive Director of the Exchange to contract for the performance of an actuarial study before submitting the initial waiver application. **Section 12** of this bill requires the Director to use a statewide competitive bidding process to solicit and enter into contracts with health carriers and other qualified persons to administer the Public Option. **Section 12** requires a health carrier that provides health care services to recipients of Medicaid through managed care to participate in the competitive bidding process. **Section 12** additionally authorizes the Director to directly administer the Public Option if necessary. **Sections 13, 21 and 29** of this bill require providers of health care, including health care facilities, who participate in Medicaid or the Public Employees' Benefits Program or provide care to injured employees under the State's workers' compensation program to enroll in the Public Option as a participating provider of health care. **Section 14** of this bill prescribes requirements governing the establishment of networks and the reimbursement of providers under the Public Option. **Section 15** of this bill establishes the Public Option Trust Fund to hold certain funds for the purpose of implementing the Public Option. **Section 20** of this bill exempts rules and policies governing the Public Option from provisions governing notice-and-comment rulemaking. **Sections 16, 19, 22, 32 and 34-37** of this bill make various changes so that the Public Option is treated similarly to comparable forms of public health insurance.

Section 16.5 of this bill requires the Executive Director of the Exchange to apply to the federal government for a waiver to authorize certain labor, agricultural and horticultural organizations to offer on the Exchange a policy of insurance to meet the unique needs of tradespersons that can serve as an alternative to the continuation of certain group health benefits. **Section 16.5** requires such a policy to be annually certified by the Executive Director in order to be offered on the Exchange. **Sections 16.3 and 16.8** of this bill make conforming changes to reflect the fact that a policy of insurance offered pursuant to **section 16.5** may not meet all requirements: (1) for individual health insurance prescribed by state law; or (2) to be considered a qualified health plan under federal law. **Section 39.5** of this bill requires the Executive Director to apply for the waiver and submit certain recommendations concerning such policies to the Legislature on or before January 1, 2025.

Sections 24-28 of this bill expand coverage under Medicaid in various manners. Specifically, **section 24** of this bill requires the Director of the Department to expand coverage under the State Plan for Medicaid for pregnant women by: (1) providing coverage for pregnant women whose household income is between 165 percent and 200 percent of the federally designated level signifying poverty if money is available; (2) providing that pregnant women who are determined by certain entities to qualify for Medicaid are presumptively eligible for Medicaid for a prescribed period of time, without submitting an application for enrollment in Medicaid which includes additional proof of eligibility; and (3) prohibiting the imposition of a requirement that a pregnant woman who is otherwise eligible for Medicaid and resides in this State must reside in the United States for a prescribed period of time before enrolling in Medicaid. **Section 25** of this bill requires Medicaid to cover the services of a community health worker who provides services under the supervision of a physician, physician assistant or advanced practice registered nurse. **Section 26** of this bill requires Medicaid to cover certain costs for doula services provided to Medicaid recipients by a doula who has enrolled with the Division of Health Care Financing and Policy of the Department. **Sections 17 and 33** of this bill require a registered doula to report the



suspected abuse, neglect, exploitation, isolation or abandonment of older or vulnerable persons or the suspected abuse or neglect of a child. **Section 27** of this bill requires Medicaid to reimburse services provided to recipients of Medicaid who do not receive services through managed care by an advanced practice registered nurse to the same extent as if those services were provided by a physician if money is available to reimburse those services at those rates. If money is available, **section 28** of this bill requires Medicaid to cover breastfeeding supplies, certain prenatal screenings and tests and lactation consultation and support. **Section 18** of this bill makes a conforming change to indicate the proper placement of **sections 24-28** in the Nevada Revised Statutes.

Existing law establishes certain requirements that apply if a Medicaid managed care program is established in this State. (NRS 422.273) To the extent that money is available, **section 30** of this bill requires the Department to: (1) establish such a program to provide health care services to recipients of Medicaid in all geographic areas of this State; and (2) conduct a statewide procurement process to select health maintenance organizations to provide such services. To the extent that money is available, **section 30** requires the Medicaid managed care program to include a state-directed payment arrangement to require Medicaid managed care organizations to reimburse critical access hospitals and any affiliated federally-qualified health centers or rural health clinics for covered services at a rate that is equal to or greater than the rate those facilities receive for services provided to recipients of Medicaid on a fee-for-service basis.

Existing law requires certain health insurers, including local governments that adopt a system of group health insurance for their employees, to cover enteral formulas under certain conditions. (NRS 287.010, 689A.0423, 689B.0353, 695B.1923, 695C.1723) **Sections 16.35-16.47** of this bill specify that enteral formulas include formulas that are ingested orally. **Section 20.5** of this bill requires the Public Employees' Benefits Program to cover enteral formulas, including formulas that are ingested orally, under the same conditions as health insurers that are currently required to cover enteral formulas.

Section 38.3 of this bill appropriates money to the Division of Welfare and Supportive Services of the Department to pay the costs of making enhancements to its information technology system that are necessary to carry out the provisions of **sections 24-28** of this bill. **Sections 38.6 and 38.8** of this bill appropriate money to the Public Option Trust Fund and the Silver State Health Insurance Exchange, respectively, to implement the Public Option.

EXPLANATION – Matter in *bolded italics* is new; matter between brackets ~~omitted material~~ is material to be omitted.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN
SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Title 57 of NRS is hereby amended by adding thereto a new chapter to consist of the provisions set forth as sections 2 to 15, inclusive, of this act.

Sec. 2. *It is hereby declared to be the purpose and policy of the Legislature in enacting this chapter to:*

1. Leverage the combined purchasing power of the State to lower premiums and costs relating to health insurance for residents of this State;



2. *Improve access to high-quality, affordable health care for residents of this State, including residents of this State who are employed by small businesses;*

3. *Reduce disparities in access to health care and health outcomes and increase access to health care for historically marginalized communities; and*

4. *Increase competition in the market for individual health insurance in this State to improve the availability of coverage for residents of rural areas of this State.*

Sec. 3. *As used in this chapter, unless the context otherwise requires, the words and terms defined in sections 3.5 to 9, inclusive, of this act have the meanings ascribed to them in those sections.*

Sec. 3.5. *“Certified community behavioral health clinic” means a community behavioral health clinic certified in accordance with section 223 of the Protecting Access to Medicare Act of 2014, Public Law No. 113-93.*

Sec. 4. *“Commissioner” means the Commissioner of Insurance.*

Sec. 5. *“Director” means the Director of the Department of Health and Human Services.*

Sec. 6. *“Exchange” means the Silver State Health Insurance Exchange.*

Sec. 6.5. *“Federally qualified health center” has the meaning ascribed to it in 42 C.F.R. § 405.2401.*

Sec. 7. *“Provider of health care” has the meaning ascribed to it in NRS 695G.070.*

Sec. 8. *“Public Option” means the Public Option established pursuant to section 10 of this act.*

Sec. 8.5. *“Rural health clinic” has the meaning ascribed to it in 42 C.F.R. § 405.2401.*

Sec. 9. *“Trust Fund” means the Public Option Trust Fund created by section 15 of this act.*

Sec. 10. *1. The Director, in consultation with the Commissioner and the Executive Director of the Exchange, shall design, establish and operate a health benefit plan known as the Public Option.*

2. The Director:

(a) Shall make the Public Option available:

(1) As a qualified health plan through the Exchange to natural persons who reside in this State and are eligible to enroll in such a plan through the Exchange under the provisions of 45 C.F.R. § 155.305; and



(2) For direct purchase as a policy of individual health insurance by any natural person who resides in this State. The provisions of chapter 689A of NRS and other applicable provisions of this title apply to the Public Option when offered as a policy of individual health insurance.

(b) May make the Public Option available to small employers in this State or their employees to the extent authorized by federal law. The provisions of chapter 689C of NRS and other applicable provisions of this title apply to the Public Option when it is offered as a policy of health insurance for small employers.

(c) Shall comply with all state and federal laws and regulations applicable to insurers when carrying out the provisions of sections 2 to 15, inclusive, of this act, to the extent that such laws and regulations are not waived.

3. The Public Option must:

(a) Be a qualified health plan, as defined in 42 U.S.C. § 18021; and

(b) Provide at least levels of coverage consistent with the actuarial value of one silver plan and one gold plan.

4. Except as otherwise provided in this section, the premiums for the Public Option:

(a) Must be at least 5 percent lower than the reference premium for that zip code; and

(b) Must not increase in any year by a percentage greater than the increase in the Medicare Economic Index for that year.

5. The Director, in consultation with the Commissioner and the Executive Director of the Exchange, may revise the requirements of subsection 4, provided that the average premiums for the Public Option must be at least 15 percent lower than the average reference premium in this State over the first 4 years in which the Public Option is in operation.

6. As used in this section:

(a) "Gold plan" means a qualified health plan that meets the requirements established by 42 U.S.C. § 18022 for a gold level plan.

(b) "Health benefit plan" means a policy, contract, certificate or agreement to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

(c) "Medicare Economic Index" means the Medicare Economic Index, as designated by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services pursuant to 42 C.F.R. § 405.504.



(d) *“Reference premium” means, for any zip code, the lower of:*

(1) The premium for the second-lowest cost silver level plan available through the Exchange in the zip code during the 2024 plan year, adjusted by the percentage change in the Medicare Economic Index between January 1, 2024, and January 1 of the year to which a premium applies; or

(2) The premium for the second-lowest cost silver level plan available through the Exchange in the zip code during the year immediately preceding the year to which a premium applies.

(e) *“Silver plan” means a qualified health plan that meets the requirements established by 42 U.S.C. § 18022 for a silver level plan.*

(f) *“Small employer” has the meaning ascribed to it in 42 U.S.C. § 18024(b)(2).*

Sec. 11. 1. The Director, the Commissioner and the Executive Director of the Exchange:

(a) Shall collaborate to the Secretary of Health and Human Services for a waiver pursuant to 42 U.S.C. § 18052 to obtain pass-through federal funding to carry out the provisions of sections 2 to 15, inclusive, of this act; and

(b) Except as otherwise provided in subsection 4, may collaboratively apply to the Secretary of Health and Human Services for any other federal waivers or approval necessary to carry out the provisions of sections 2 to 15, inclusive, of this act, including, without limitation, and to the extent necessary, a waiver pursuant to 42 U.S.C. § 1315 of Title XIX of the Social Security Act. Such waivers or approval may include, without limitation, any waiver or approval necessary to:

(1) Combine risk pools for the Public Option with risk pools established for Medicaid, if the Director can demonstrate that doing so would lower costs, result in savings to the federal and state governments and not increase the costs of private insurance or Medicaid; or

(2) Obtain federal financial participation to subsidize the cost of health insurance for residents of this State with low incomes.

2. In preparing an application for any waiver described in subsection 1, the Director, the Commissioner and the Executive Director of the Exchange may contract with an independent actuary to assess the impact of the Public Option on the markets for health care and health insurance in this State and health coverage for natural persons, families and small businesses. The



actuary must have specialized expertise or experience with state health insurance exchanges, the type of waiver for which the application is being made, measures to contain the costs of providing health coverage, reforming procedures for the purchasing and delivery of government services and Medicaid managed care programs. A contract pursuant to this subsection is exempt from the provisions of chapter 333 of NRS.

3. The Director, the Commissioner and the Executive Director of the Exchange shall:

(a) Cooperate with the Federal Government in obtaining any waiver for which he or she applies pursuant to this section.

(b) Deposit any money received from the Federal Government pursuant to such a waiver in the Trust Fund.

4. The Director, the Commissioner and the Executive Director of the Exchange shall not apply under the provisions of subsection 1 to waive any provision of federal law prescribing conditions of eligibility to purchase a qualified health plan, as defined in 42 U.S.C. § 18021, through the Exchange or receive federal advanced payment of premium tax credits pursuant to 42 U.S.C. § 18082 for such a purchase.

5. The Director may:

(a) Accept gifts, grants and donations to carry out the provisions of sections 2 to 15, inclusive, of this act. The Director shall deposit any such gifts, grants or donations in the Trust Fund.

(b) Employ or enter into contracts with actuaries and other professionals and may enter into contracts with other state agencies, health carriers or other qualified persons and entities as are necessary to carry out the provisions of sections 2 to 15, inclusive, of this act. Such contracts are exempt from the requirements of chapter 333 of NRS.

Sec. 12. *1. The Director, in consultation with the Commissioner and the Executive Director of the Exchange, shall use a statewide competitive bidding process, including, without limitation, a request for proposals, to solicit and enter into contracts with health carriers or other qualified persons or entities to administer the Public Option. If a statewide Medicaid managed care program is established pursuant to subsection 1 of NRS 422.273, the competitive bidding process must coincide with the statewide procurement process for that Medicaid managed care program.*

2. Each health carrier that provides health care services through managed care to recipients of Medicaid under the State



Plan for Medicaid or the Children's Health Insurance Program shall, as a condition of continued participation in any Medicaid managed care program established in this State, submit a good faith proposal in response to a request for proposals issued pursuant to subsection 1.

3. Each proposal submitted pursuant to subsection 2 must demonstrate that the applicant is able to meet the requirements of section 10 of this act.

4. When selecting a health carrier or other qualified person or entity to administer the Public Option, the Director shall prioritize applicants whose proposals:

(a) Demonstrate alignment of networks of providers between the Public Option and Medicaid managed care, where applicable;

(b) Provide for the inclusion of critical access hospitals, rural health clinics, certified community behavioral health clinics and federally-qualified health centers in the networks of providers for the Public Option and Medicaid managed care, where applicable;

(c) Include proposals for strengthening the workforce in this State and particularly in rural areas of this State for providers of primary care, mental health care and treatment for substance use disorders;

(d) Use payment models for providers included in the networks of providers for the Public Option that increase value for persons enrolled in the Public Option and the State; and

(e) Include proposals to contract with providers of health care in a manner that decreases disparities among different populations in this State with regard to access to health care and health outcomes and supports culturally competent care.

5. Notwithstanding the provisions of subsections 1 to 4, inclusive, the Director may directly administer the Public Option if necessary to carry out the provisions of sections 2 to 15, inclusive, of this act.

6. Any health carrier or other person or entity with which the Director contracts to administer the Public Option pursuant to this section or the Director, if the Director directly administers the Public Option pursuant to subsection 5, shall take any measures necessary to make the Public Option available as described in paragraph (a) of subsection 2 of section 10 of this act and, if required by the Director, paragraph (b) of that subsection. Such measures include, without limitation:

(a) Filing rates and supporting information with the Commissioner of Insurance as required by NRS 686B.010 to 686B.1799, inclusive; and



(b) Obtaining certification as a qualified health plan pursuant to 42 U.S.C. § 18031.

7. The Director shall deposit into the Trust Fund any money received from:

(a) A health carrier or other person or entity with which the Director contracts to administer the Public Option pursuant to subsection 1 which relates to duties performed under the contract; or

(b) If the Director directly administers the Public Option pursuant to subsection 5, any money received from any person or entity in the course of administering the Public Option.

8. As used in this section:

(a) "Critical access hospital" means a hospital which has been certified as a critical access hospital by the Secretary of Health and Human Services pursuant to 42 U.S.C. § 1395i-4(e).

(b) "Health carrier" means an entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the Commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including, without limitation, a sickness and accident health insurance company, a health maintenance organization, a nonprofit hospital and health service corporation or any other entity providing a plan of health insurance, health benefits or health care services.

Sec. 13. 1. *Except as otherwise provided in subsection 2, each provider of health care who participates in the Public Employees' Benefits Program established pursuant to subsection 1 of NRS 287.043 or the Medicaid program, or who provides care to an injured employee pursuant to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS, shall:*

(a) Enroll as a participating provider in at least one network of providers established for the Public Option; and

(b) Accept new patients who are enrolled in the Public Option to the same extent as the provider or facility accepts new patients who are not enrolled in the Public Option.

2. *The Director and the Executive Officer of the Public Employees' Benefits Program may waive the requirements of subsection 1 when necessary to ensure that recipients of Medicaid and officers, employees and retirees of this State who receive benefits under the Public Employees' Benefits Program have sufficient access to covered services.*



Sec. 14. 1. *In establishing networks for the Public Option and reimbursing providers of health care that participate in the Public Option, the Director shall, to the extent practicable:*

(a) Ensure that care for persons who were previously covered by Medicaid or the Children's Health Insurance Program and enroll in the Public Option is minimally disrupted;

(b) Encourage the use of payment models that increase value for persons enrolled in the Public Option and the State;

(c) Improve health outcomes for persons enrolled in the Public Option;

(d) Reward providers of health care and medical facilities for delivering high-quality services; and

(e) Lower the cost of care in both urban and rural areas of this State.

2. *Except as otherwise provided in subsections 3 to 6, inclusive, reimbursement rates under the Public Option must be, in the aggregate, comparable to or better than reimbursement rates available under Medicare. For the purposes of this section, the aggregate reimbursement rate under Medicare:*

(a) Includes any add-on payments or other subsidies that a provider receives under Medicare; and

(b) Does not include payments under Medicare for a patient encounter or a cost-based payment rate under Medicare.

3. *If a provider of health care currently receives reimbursement under Medicare at rates that are cost-based, the reimbursement rates for that provider of health care under the Public Option must be comparable to or better than the cost-based reimbursement rates provided for that provider of health care by Medicare.*

4. *The reimbursement rates for a federally-qualified health center or a rural health clinic under the Public Option must be comparable to or better than the reimbursement rates established for patient encounters under the applicable Prospective Payment System established for Medicare by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services.*

5. *The reimbursement rates for a certified community behavioral health clinic under the Public Option must be comparable to or better than the reimbursement rates established for community behavioral health clinics under the State Plan for Medicaid.*



6. *The requirements of subsections 2 to 5, inclusive, do not apply to a payment model described in paragraph (b) of subsection 1.*

7. *As used in this section, “Medicare” means the program of health insurance for aged persons and persons with disabilities established pursuant to Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395 et seq.*

Sec. 15. 1. *There is hereby created in the State Treasury the Public Option Trust Fund as a nonreverting trust fund. The Trust Fund must be administered by the State Treasurer.*

2. *The Trust Fund consists of:*

(a) *Any money deposited in the Trust Fund pursuant to sections 11 and 12 of this act;*

(b) *Any money appropriated by the Legislature for the purpose of carrying out the provisions of sections 2 to 15, inclusive, of this act; and*

(c) *All income and interest earned on the money in the Trust Fund.*

3. *Any interest earned on money in the Trust Fund, after deducting any applicable charges, must be credited to the Trust Fund. Money that remains in the Trust Fund at the end of a fiscal year does not revert to the State General Fund, and the balance in the Trust Fund must be carried forward to the next fiscal year.*

4. *Except as otherwise provided in subsection 5, the money in the Trust Fund must be used to carry out the provisions of sections 2 to 15, inclusive, of this act. Such money must not be used to pay administrative costs that are not directly related to the operations of the Public Option.*

5. *If the State Treasurer determines that there is sufficient money in the Trust Fund to carry out the provisions of sections 2 to 15, inclusive, of this act, for the current fiscal year, the Director may use a portion determined by the State Treasurer of any additional money in the Trust Fund to increase the affordability of the Public Option.*

Sec. 16. NRS 683A.176 is hereby amended to read as follows:
683A.176 “Third party” means:

1. An insurer, as that term is defined in NRS 679B.540;

2. A health benefit plan, as that term is defined in NRS 687B.470, for employees which provides a pharmacy benefits plan;

3. A participating public agency, as that term is defined in NRS 287.04052, and any other local governmental agency of the State of Nevada which provides a system of health insurance for the benefit



of its officers and employees, and the dependents of officers and employees, pursuant to chapter 287 of NRS; ~~or~~

4. *The Public Option established pursuant to section 10 of this act; or*

5. Any other insurer or organization that provides health coverage or benefits or coverage of prescription drugs as part of workers' compensation insurance in accordance with state or federal law.

↳ The term does not include an insurer that provides coverage under a policy of casualty or property insurance.

Sec. 16.3. NRS 689A.020 is hereby amended to read as follows:

689A.020 Nothing in this chapter applies to or affects:

1. Any policy of liability or workers' compensation insurance with or without supplementary expense coverage therein.

2. Any group or blanket policy.

3. Life insurance, endowment or annuity contracts, or contracts supplemental thereto which contain only such provisions relating to health insurance as to:

(a) Provide additional benefits in case of death or dismemberment or loss of sight by accident or accidental means; or

(b) Operate to safeguard such contracts against lapse, or to give a special surrender value or special benefit or an annuity if the insured or annuitant becomes totally and permanently disabled, as defined by the contract or supplemental contract.

4. Reinsurance, except as otherwise provided in NRS 689A.470 to 689A.740, inclusive, and 689C.610 to 689C.940, inclusive, relating to the program of reinsurance.

5. *Any policy of insurance offered on the Silver State Health Insurance Exchange in accordance with section 16.5 of this act.*

Sec. 16.35. NRS 689A.0423 is hereby amended to read as follows:

689A.0423 1. A policy of health insurance must provide coverage for:

(a) Enteral formulas for use at home that are prescribed or ordered by a physician as medically necessary for the treatment of inherited metabolic diseases characterized by deficient metabolism, or malabsorption originating from congenital defects or defects arising shortly after birth, of amino acid, organic acid, carbohydrate or fat; and

(b) At least \$2,500 per year for special food products which are prescribed or ordered by a physician as medically necessary for the treatment of a person described in paragraph (a).



2. The coverage required by subsection 1 must be provided whether or not the condition existed when the policy was purchased.

3. A policy subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after ~~January~~ **July 1, 1998, 2021**, has the legal effect of including the coverage required by this section, and any provision of the policy or the renewal which is in conflict with this section is void.

4. As used in this section:

(a) ***“Enteral formula” includes, without limitation, a formula that is ingested orally.***

(b) “Inherited metabolic disease” means a disease caused by an inherited abnormality of the body chemistry of a person.

~~(b)~~ (c) “Special food product” means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be consumed under the direction of a physician for the dietary treatment of an inherited metabolic disease. The term does not include a food that is naturally low in protein.

Sec. 16.4. NRS 689B.0353 is hereby amended to read as follows:

689B.0353 1. A policy of group health insurance must provide coverage for:

(a) Enteral formulas for use at home that are prescribed or ordered by a physician as medically necessary for the treatment of inherited metabolic diseases characterized by deficient metabolism, or malabsorption originating from congenital defects or defects arising shortly after birth, of amino acid, organic acid, carbohydrate or fat; and

(b) At least \$2,500 per year for special food products which are prescribed or ordered by a physician as medically necessary for the treatment of a person described in paragraph (a).

2. The coverage required by subsection 1 must be provided whether or not the condition existed when the policy was purchased.

3. A policy subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after ~~January~~ **July 1, 1998, 2021**, has the legal effect of including the coverage required by this section, and any provision of the policy or the renewal which is in conflict with this section is void.

4. As used in this section:

(a) ***“Enteral formula” includes, without limitation, a formula that is ingested orally.***

(b) “Inherited metabolic disease” means a disease caused by an inherited abnormality of the body chemistry of a person.



~~(b)~~ (c) “Special food product” means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be consumed under the direction of a physician for the dietary treatment of an inherited metabolic disease. The term does not include a food that is naturally low in protein.

Sec. 16.43. NRS 695B.1923 is hereby amended to read as follows:

695B.1923 1. A contract for hospital or medical service must provide coverage for:

(a) Enteral formulas for use at home that are prescribed or ordered by a physician as medically necessary for the treatment of inherited metabolic diseases characterized by deficient metabolism, or malabsorption originating from congenital defects or defects arising shortly after birth, of amino acid, organic acid, carbohydrate or fat; and

(b) At least \$2,500 per year for special food products which are prescribed or ordered by a physician as medically necessary for the treatment of a person described in paragraph (a).

2. The coverage required by subsection 1 must be provided whether or not the condition existed when the contract was purchased.

3. A contract subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after ~~January~~ **July** 1, ~~1998,~~ **2021**, has the legal effect of including the coverage required by this section, and any provision of the contract or the renewal which is in conflict with this section is void.

4. As used in this section:

(a) ***“Enteral formula” includes, without limitation, a formula that is ingested orally.***

(b) “Inherited metabolic disease” means a disease caused by an inherited abnormality of the body chemistry of a person.

~~(b)~~ (c) “Special food product” means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be consumed under the direction of a physician for the dietary treatment of an inherited metabolic disease. The term does not include a food that is naturally low in protein.

Sec. 16.47. NRS 695C.1723 is hereby amended to read as follows:

695C.1723 1. A health maintenance plan must provide coverage for:

(a) Enteral formulas for use at home that are prescribed or ordered by a physician as medically necessary for the treatment of inherited metabolic diseases characterized by deficient metabolism,



or malabsorption originating from congenital defects or defects arising shortly after birth, of amino acid, organic acid, carbohydrate or fat; and

(b) At least \$2,500 per year for special food products which are prescribed or ordered by a physician as medically necessary for the treatment of a person described in paragraph (a).

2. The coverage required by subsection 1 must be provided whether or not the condition existed when the health maintenance plan was purchased.

3. Any evidence of coverage subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after ~~[January]~~ **July** 1, ~~[1998,]~~ **2021**, has the legal effect of including the coverage required by this section, and any provision of the evidence of coverage or the renewal which is in conflict with this section is void.

4. As used in this section:

(a) ***“Enteral formula” includes, without limitation, a formula that is ingested orally.***

(b) ***“Inherited metabolic disease” means a disease caused by an inherited abnormality of the body chemistry of a person.***

~~[(b)]~~ (c) ***“Special food product” means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be consumed under the direction of a physician for the dietary treatment of an inherited metabolic disease. The term does not include a food that is naturally low in protein.***

Sec. 16.5. Chapter 695I of NRS is hereby amended by adding thereto a new section to read as follows:

1. The Executive Director, in collaboration with the Director of the Department of Health and Human Services, shall apply to the Secretary of Health and Human Services for a waiver pursuant to 42 U.S.C. § 18052 to authorize an organization described in section 501(c)(5) of the Internal Revenue Code that processes health claims in this State to offer on the Exchange a policy of insurance to meet the unique needs of tradespersons, including, without limitation, persons who work temporary or seasonal jobs, that is capable of serving as an alternative to the continuation of group health benefits under the Consolidated Omnibus Budget Reconciliation Act of 1985.

2. The application for a waiver submitted pursuant to subsection 1 must include, without limitation, an application for a waiver of any provisions of federal law or regulations that would otherwise require a policy described in subsection 1 to meet the requirements of chapter 689A of NRS in order to be offered on the



Exchange or for persons who purchase the plan on the Exchange to receive applicable federal subsidies.

3. To be offered on the Exchange, a policy of insurance described in subsection 1 must:

(a) Meet all requirements established by the Federal Act for a qualified health plan, to the extent that those requirements do not prevent an organization described in section 501(c)(5) of the Internal Revenue Code from offering such a policy; and

(b) Be certified by the Executive Director. Such certification must be renewed annually.

4. The Executive Director shall prescribe:

(a) Requirements for certification of a policy of insurance pursuant to paragraph (b) of subsection 3; and

(b) Criteria to determine when a person becomes eligible for a policy of insurance described in subsection 1. Those criteria must address:

(1) Persons who recently began employment but have not yet met the requirements concerning hours of work necessary to receive insurance through their employer; and

(2) Persons who have recently lost their jobs.

5. When performing the duties described in subsections 1 and 4, the Executive Director shall consult with organizations described in section 501(c)(5) of the Internal Revenue Code and other interested persons and entities concerning the requirements for certification of a policy of insurance described in subsection 1 and the criteria described in paragraph (b) of subsection 4.

Sec. 16.8. NRS 695I.210 is hereby amended to read as follows:

695I.210 1. The Exchange shall:

(a) Create and administer a health insurance exchange;

(b) Facilitate the purchase and sale of qualified health plans consistent with established patterns of care within the State;

(c) Provide for the establishment of a program to assist qualified small employers in Nevada in facilitating the enrollment of their employees in qualified health plans offered in the small group market;

(d) ~~Make~~ *Except as otherwise authorized by a waiver obtained pursuant to section 16.5 of this act, make* only qualified health plans available to qualified individuals and qualified small employers ; ~~on or after January 1, 2014;~~ and

(e) Unless the Federal Act is repealed or is held to be unconstitutional or otherwise invalid or unlawful, perform all duties



that are required of the Exchange to implement the requirements of the Federal Act.

2. The Exchange may:

(a) Enter into contracts with any person, including, without limitation, a local government, a political subdivision of a local government and a governmental agency, to assist in carrying out the duties and powers of the Exchange or the Board; and

(b) Apply for and accept any gift, donation, bequest, grant or other source of money to carry out the duties and powers of the Exchange or the Board.

3. The Exchange is subject to the provisions of chapter 333 of NRS.

Sec. 17. NRS 200.5093 is hereby amended to read as follows:

200.5093 1. Any person who is described in subsection 4 and who, in a professional or occupational capacity, knows or has reasonable cause to believe that an older person or vulnerable person has been abused, neglected, exploited, isolated or abandoned shall:

(a) Except as otherwise provided in subsection 2, report the abuse, neglect, exploitation, isolation or abandonment of the older person or vulnerable person to:

(1) The local office of the Aging and Disability Services Division of the Department of Health and Human Services;

(2) A police department or sheriff's office; or

(3) A toll-free telephone service designated by the Aging and Disability Services Division of the Department of Health and Human Services; and

(b) Make such a report as soon as reasonably practicable but not later than 24 hours after the person knows or has reasonable cause to believe that the older person or vulnerable person has been abused, neglected, exploited, isolated or abandoned.

2. If a person who is required to make a report pursuant to subsection 1 knows or has reasonable cause to believe that the abuse, neglect, exploitation, isolation or abandonment of the older person or vulnerable person involves an act or omission of the Aging and Disability Services Division, another division of the Department of Health and Human Services or a law enforcement agency, the person shall make the report to an agency other than the one alleged to have committed the act or omission.

3. Each agency, after reducing a report to writing, shall forward a copy of the report to the Aging and Disability Services Division of the Department of Health and Human Services and the Unit for the Investigation and Prosecution of Crimes.



4. A report must be made pursuant to subsection 1 by the following persons:

(a) Every physician, dentist, dental hygienist, chiropractor, optometrist, podiatric physician, medical examiner, resident, intern, professional or practical nurse, physician assistant licensed pursuant to chapter 630 or 633 of NRS, perfusionist, psychiatrist, psychologist, marriage and family therapist, clinical professional counselor, clinical alcohol and drug counselor, alcohol and drug counselor, music therapist, athletic trainer, driver of an ambulance, paramedic, licensed dietitian, holder of a license or a limited license issued under the provisions of chapter 653 of NRS or other person providing medical services licensed or certified to practice in this State, who examines, attends or treats an older person or vulnerable person who appears to have been abused, neglected, exploited, isolated or abandoned.

(b) Any personnel of a hospital or similar institution engaged in the admission, examination, care or treatment of persons or an administrator, manager or other person in charge of a hospital or similar institution upon notification of the suspected abuse, neglect, exploitation, isolation or abandonment of an older person or vulnerable person by a member of the staff of the hospital.

(c) A coroner.

(d) Every person who maintains or is employed by an agency to provide personal care services in the home.

(e) Every person who maintains or is employed by an agency to provide nursing in the home.

(f) Every person who operates, who is employed by or who contracts to provide services for an intermediary service organization as defined in NRS 449.4304.

(g) Any employee of the Department of Health and Human Services, except the State Long-Term Care Ombudsman appointed pursuant to NRS 427A.125 and any of his or her advocates or volunteers where prohibited from making such a report pursuant to 45 C.F.R. § 1321.11.

(h) Any employee of a law enforcement agency or a county's office for protective services or an adult or juvenile probation officer.

(i) Any person who maintains or is employed by a facility or establishment that provides care for older persons or vulnerable persons.

(j) Any person who maintains, is employed by or serves as a volunteer for an agency or service which advises persons regarding the abuse, neglect, exploitation, isolation or abandonment of an



older person or vulnerable person and refers them to persons and agencies where their requests and needs can be met.

(k) Every social worker.

(l) Any person who owns or is employed by a funeral home or mortuary.

(m) Every person who operates or is employed by a peer support recovery organization, as defined in NRS 449.01563.

(n) Every person who operates or is employed by a community health worker pool, as defined in NRS 449.0028, or with whom a community health worker pool contracts to provide the services of a community health worker, as defined in NRS 449.0027.

(o) Every person who is enrolled with the Division of Health Care Financing and Policy of the Department of Health and Human Services to provide doula services to recipients of Medicaid pursuant to section 26 of this act.

5. A report may be made by any other person.

6. If a person who is required to make a report pursuant to subsection 1 knows or has reasonable cause to believe that an older person or vulnerable person has died as a result of abuse, neglect, isolation or abandonment, the person shall, as soon as reasonably practicable, report this belief to the appropriate medical examiner or coroner, who shall investigate the cause of death of the older person or vulnerable person and submit to the appropriate local law enforcement agencies, the appropriate prosecuting attorney, the Aging and Disability Services Division of the Department of Health and Human Services and the Unit for the Investigation and Prosecution of Crimes his or her written findings. The written findings must include the information required pursuant to the provisions of NRS 200.5094, when possible.

7. A division, office or department which receives a report pursuant to this section shall cause the investigation of the report to commence within 3 working days. A copy of the final report of the investigation conducted by a division, office or department, other than the Aging and Disability Services Division of the Department of Health and Human Services, must be forwarded within 30 days after the completion of the report to the:

(a) Aging and Disability Services Division;

(b) Repository for Information Concerning Crimes Against Older Persons or Vulnerable Persons created by NRS 179A.450; and

(c) Unit for the Investigation and Prosecution of Crimes.

8. If the investigation of a report results in the belief that an older person or vulnerable person is abused, neglected, exploited,



isolated or abandoned, the Aging and Disability Services Division of the Department of Health and Human Services or the county's office for protective services may provide protective services to the older person or vulnerable person if the older person or vulnerable person is able and willing to accept them.

9. A person who knowingly and willfully violates any of the provisions of this section is guilty of a misdemeanor.

10. As used in this section, "Unit for the Investigation and Prosecution of Crimes" means the Unit for the Investigation and Prosecution of Crimes Against Older Persons or Vulnerable Persons in the Office of the Attorney General created pursuant to NRS 228.265.

Sec. 18. NRS 232.320 is hereby amended to read as follows:

232.320 1. The Director:

(a) Shall appoint, with the consent of the Governor, administrators of the divisions of the Department, who are respectively designated as follows:

(1) The Administrator of the Aging and Disability Services Division;

(2) The Administrator of the Division of Welfare and Supportive Services;

(3) The Administrator of the Division of Child and Family Services;

(4) The Administrator of the Division of Health Care Financing and Policy; and

(5) The Administrator of the Division of Public and Behavioral Health.

(b) Shall administer, through the divisions of the Department, the provisions of chapters 63, 424, 425, 427A, 432A to 442, inclusive, 446 to 450, inclusive, 458A and 656A of NRS, NRS 127.220 to 127.310, inclusive, 422.001 to 422.410, inclusive, *and sections 24 to 28, inclusive, of this act*, 422.580, 432.010 to 432.133, inclusive, 432B.6201 to 432B.626, inclusive, 444.002 to 444.430, inclusive, and 445A.010 to 445A.055, inclusive, and all other provisions of law relating to the functions of the divisions of the Department, but is not responsible for the clinical activities of the Division of Public and Behavioral Health or the professional line activities of the other divisions.

(c) Shall administer any state program for persons with developmental disabilities established pursuant to the Developmental Disabilities Assistance and Bill of Rights Act of 2000, 42 U.S.C. §§ 15001 et seq.



(d) Shall, after considering advice from agencies of local governments and nonprofit organizations which provide social services, adopt a master plan for the provision of human services in this State. The Director shall revise the plan biennially and deliver a copy of the plan to the Governor and the Legislature at the beginning of each regular session. The plan must:

(1) Identify and assess the plans and programs of the Department for the provision of human services, and any duplication of those services by federal, state and local agencies;

(2) Set forth priorities for the provision of those services;

(3) Provide for communication and the coordination of those services among nonprofit organizations, agencies of local government, the State and the Federal Government;

(4) Identify the sources of funding for services provided by the Department and the allocation of that funding;

(5) Set forth sufficient information to assist the Department in providing those services and in the planning and budgeting for the future provision of those services; and

(6) Contain any other information necessary for the Department to communicate effectively with the Federal Government concerning demographic trends, formulas for the distribution of federal money and any need for the modification of programs administered by the Department.

(e) May, by regulation, require nonprofit organizations and state and local governmental agencies to provide information regarding the programs of those organizations and agencies, excluding detailed information relating to their budgets and payrolls, which the Director deems necessary for the performance of the duties imposed upon him or her pursuant to this section.


(f) Has such other powers and duties as are provided by law.

2. Notwithstanding any other provision of law, the Director, or the Director's designee, is responsible for appointing and removing subordinate officers and employees of the Department.

Sec. 19. NRS 232.459 is hereby amended to read as follows:

232.459 1. The Advocate shall:

(a) Respond to written and telephonic inquiries received from consumers and injured employees regarding concerns and problems related to health care and workers' compensation;

(b) Assist consumers and injured employees in understanding their rights and responsibilities under health care plans, including, without limitation, the Public Employees' Benefits Program  and *the Public Option*, and policies of industrial insurance;



(c) Identify and investigate complaints of consumers and injured employees regarding their health care plans, including, without limitation, the Public Employees' Benefits Program **§ 3** and the **Public Option**, and policies of industrial insurance and assist those consumers and injured employees to resolve their complaints, including, without limitation:

(1) Referring consumers and injured employees to the appropriate agency, department or other entity that is responsible for addressing the specific complaint of the consumer or injured employee; and

(2) Providing counseling and assistance to consumers and injured employees concerning health care plans, including, without limitation, the Public Employees' Benefits Program **§ 3** and the **Public Option**, and policies of industrial insurance;

(d) Provide information to consumers and injured employees concerning health care plans, including, without limitation, the Public Employees' Benefits Program **§ 3** and the **Public Option**, and policies of industrial insurance in this State;

(e) Establish and maintain a system to collect and maintain information pertaining to the written and telephonic inquiries received by the Office for Consumer Health Assistance;

(f) Take such actions as are necessary to ensure public awareness of the existence and purpose of the services provided by the Advocate pursuant to this section;

(g) In appropriate cases and pursuant to the direction of the Advocate, refer a complaint or the results of an investigation to the Attorney General for further action;

(h) Provide information to and applications for prescription drug programs for consumers without insurance coverage for prescription drugs or pharmaceutical services;

(i) Establish and maintain an Internet website which includes:

(1) Information concerning purchasing prescription drugs from Canadian pharmacies that have been recommended by the State Board of Pharmacy for inclusion on the Internet website pursuant to subsection 4 of NRS 639.2328;

(2) Links to websites of Canadian pharmacies which have been recommended by the State Board of Pharmacy for inclusion on the Internet website pursuant to subsection 4 of NRS 639.2328; and

(3) A link to the website established and maintained pursuant to NRS 439A.270 which provides information to the general public concerning the charges imposed and the quality of the services provided by the hospitals and surgical centers for ambulatory patients in this State;



(j) Assist consumers with accessing a navigator, case manager or facilitator to help the consumer obtain health care services;

(k) Assist consumers with scheduling an appointment with a provider of health care who is in the network of providers under contract to provide services to participants in the health care plan under which the consumer is covered;

(l) Assist consumers with filing complaints against health care facilities and health care professionals;

(m) Assist consumers with filing complaints with the Commissioner of Insurance against issuers of health care plans; and

(n) On or before January 31 of each year, compile a report of aggregated information submitted to the Office for Consumer Health Assistance pursuant to NRS 687B.675, aggregated for each type of provider of health care for which such information is provided and submit the report to the Director of the Legislative Counsel Bureau for transmittal to:

(1) In even-numbered years, the Legislative Committee on Health Care; and

(2) In odd-numbered years, the next regular session of the Legislature.

2. The Advocate may adopt regulations to carry out the provisions of this section and NRS 232.461 and 232.462.

3. As used in this section:

(a) "Health care facility" has the meaning ascribed to it in NRS 162A.740.

(b) "Navigator, case manager or facilitator" has the meaning ascribed to it in NRS 687B.675.

(c) "Public Option" means the Public Option established pursuant to section 10 of this act.

Sec. 20. NRS 233B.039 is hereby amended to read as follows:

233B.039 1. The following agencies are entirely exempted from the requirements of this chapter:

(a) The Governor.

(b) Except as otherwise provided in NRS 209.221, the Department of Corrections.

(c) The Nevada System of Higher Education.

(d) The Office of the Military.

(e) The Nevada Gaming Control Board.

(f) Except as otherwise provided in NRS 368A.140 and 463.765, the Nevada Gaming Commission.

(g) Except as otherwise provided in NRS 425.620, the Division of Welfare and Supportive Services of the Department of Health and Human Services.



(h) Except as otherwise provided in NRS 422.390, the Division of Health Care Financing and Policy of the Department of Health and Human Services.

(i) Except as otherwise provided in NRS 533.365, the Office of the State Engineer.

(j) The Division of Industrial Relations of the Department of Business and Industry acting to enforce the provisions of NRS 618.375.

(k) The Administrator of the Division of Industrial Relations of the Department of Business and Industry in establishing and adjusting the schedule of fees and charges for accident benefits pursuant to subsection 2 of NRS 616C.260.

(l) The Board to Review Claims in adopting resolutions to carry out its duties pursuant to NRS 445C.310.

(m) The Silver State Health Insurance Exchange.

(n) The Cannabis Compliance Board.

2. Except as otherwise provided in subsection 5 and NRS 391.323, the Department of Education, the Board of the Public Employees' Benefits Program and the Commission on Professional Standards in Education are subject to the provisions of this chapter for the purpose of adopting regulations but not with respect to any contested case.

3. The special provisions of:

(a) Chapter 612 of NRS for the adoption of an emergency regulation or the distribution of regulations by and the judicial review of decisions of the Employment Security Division of the Department of Employment, Training and Rehabilitation;

(b) Chapters 616A to 617, inclusive, of NRS for the determination of contested claims;

(c) Chapter 91 of NRS for the judicial review of decisions of the Administrator of the Securities Division of the Office of the Secretary of State; and

(d) NRS 90.800 for the use of summary orders in contested cases,

↳ prevail over the general provisions of this chapter.

4. The provisions of NRS 233B.122, 233B.124, 233B.125 and 233B.126 do not apply to the Department of Health and Human Services in the adjudication of contested cases involving the issuance of letters of approval for health facilities and agencies.

5. The provisions of this chapter do not apply to:

(a) Any order for immediate action, including, but not limited to, quarantine and the treatment or cleansing of infected or infested animals, objects or premises, made under the authority of the State



Board of Agriculture, the State Board of Health, or any other agency of this State in the discharge of a responsibility for the preservation of human or animal health or for insect or pest control;

(b) An extraordinary regulation of the State Board of Pharmacy adopted pursuant to NRS 453.2184;

(c) A regulation adopted by the State Board of Education pursuant to NRS 388.255 or 394.1694;

(d) The judicial review of decisions of the Public Utilities Commission of Nevada;

(e) The adoption, amendment or repeal of policies by the Rehabilitation Division of the Department of Employment, Training and Rehabilitation pursuant to NRS 426.561 or 615.178;

(f) The adoption or amendment of a rule or regulation to be included in the State Plan for Services for Victims of Crime by the Department of Health and Human Services pursuant to NRS 217.130;

(g) The adoption, amendment or repeal of rules governing the conduct of contests and exhibitions of unarmed combat by the Nevada Athletic Commission pursuant to NRS 467.075; ~~for~~

(h) The adoption, amendment or repeal of regulations by the Director of the Department of Health and Human Services pursuant to NRS 447.335 to 447.350, inclusive ~~and~~; *or*

(i) The adoption, amendment or repeal of any rule or policy governing the Public Option established pursuant to the chapter created by sections 2 to 15, inclusive, of this act.

6. The State Board of Parole Commissioners is subject to the provisions of this chapter for the purpose of adopting regulations but not with respect to any contested case.

Sec. 20.5. NRS 287.04335 is hereby amended to read as follows:

287.04335 If the Board provides health insurance through a plan of self-insurance, it shall comply with the provisions of NRS 687B.409, **689B.0353**, 689B.255, **695C.1723**, 695G.150, 695G.155, 695G.160, 695G.162, 695G.164, 695G.1645, 695G.1665, 695G.167, 695G.170 to 695G.174, inclusive, 695G.177, 695G.200 to 695G.230, inclusive, 695G.241 to 695G.310, inclusive, and 695G.405, in the same manner as an insurer that is licensed pursuant to title 57 of NRS is required to comply with those provisions.

Sec. 21. NRS 287.0434 is hereby amended to read as follows:
287.0434 The Board may:

1. Use its assets only to pay the expenses of health care for its members and covered dependents, to pay its employees' salaries and to pay administrative and other expenses.



2. Enter into contracts relating to the administration of the Program, including, without limitation, contracts with licensed administrators and qualified actuaries. Each such contract with a licensed administrator:

(a) Must be submitted to the Commissioner of Insurance not less than 30 days before the date on which the contract is to become effective for approval as to the licensing and fiscal status of the licensed administrator and status of any legal or administrative actions in this State against the licensed administrator that may impair his or her ability to provide the services in the contract.

(b) Does not become effective unless approved by the Commissioner.

(c) Shall be deemed to be approved if not disapproved by the Commissioner within 30 days after its submission.

3. Enter into contracts with physicians, surgeons, hospitals, health maintenance organizations and rehabilitative facilities for medical, surgical and rehabilitative care and the evaluation, treatment and nursing care of members and covered dependents. The Board shall not enter into a contract pursuant to this subsection unless:

(a) Provision is made by the Board to offer all the services specified in the request for proposals, either by a health maintenance organization or through separate action of the Board.

(b) The rates set forth in the contract are based on:

(1) For active and retired state officers and employees and their dependents, the commingled claims experience of such active and retired officers and employees and their dependents for whom the Program provides primary health insurance coverage in a single risk pool; and

(2) For active and retired officers and employees of public agencies enumerated in NRS 287.010 that contract with the Program to obtain group insurance by participation in the Program and their dependents, the commingled claims experience of such active and retired officers and employees and their dependents for whom the Program provides primary health insurance coverage in a single risk pool.

(c) For a contract with a physician, surgeon, hospital or rehabilitative facility, the physician, surgeon, hospital or rehabilitative facility has also complied with the requirements of section 13 of this act.

4. Enter into contracts for the services of other experts and specialists as required by the Program.



5. Charge and collect from an insurer, health maintenance organization, organization for dental care or nonprofit medical service corporation, a fee for the actual expenses incurred by the Board or a participating public agency in administering a plan of insurance offered by that insurer, organization or corporation.

6. Charge and collect the amount due from local governments pursuant to paragraph (b) of subsection 4 of NRS 287.023. If the payment of a local government pursuant to that provision is delinquent by more than 90 days, the Board shall notify the Executive Director of the Department of Taxation pursuant to NRS 354.671.

Sec. 22. NRS 333.705 is hereby amended to read as follows:

333.705 1. Except as otherwise provided in this section, a using agency shall not enter into a contract with a person to provide services for the using agency if:

(a) The person is a current employee of an agency of this State;

(b) The person is a former employee of an agency of this State and less than 2 years have expired since the termination of the person's employment with the State; or

(c) The person is employed by the Department of Transportation for a transportation project that is entirely funded by federal money and the term of the contract is for more than 4 years,

↳ unless the using agency submits a written disclosure to the State Board of Examiners indicating the services to be provided pursuant to the contract and the person who will be providing those services and, after reviewing the disclosure, the State Board of Examiners approves entering into a contract with the person. The requirements of this subsection apply to any person employed by a business or other entity that enters into a contract to provide services for a using agency if the person will be performing or producing the services for which the business or entity is employed.

2. The provisions of paragraph (b) of subsection 1 apply to employment through a temporary employment service. A temporary employment service providing employees for a using agency shall provide the using agency with the names of the employees to be provided to the agency. The State Board of Examiners shall not approve a contract pursuant to paragraph (b) of subsection 1 unless the Board determines that one or more of the following circumstances exist:

(a) The person provides services that are not provided by any other employee of the using agency or for which a critical labor shortage exists; or



(b) A short-term need or unusual economic circumstance exists for the using agency to contract with the person.

3. The approval by the State Board of Examiners to contract with a person pursuant to subsection 1:

(a) May occur at the same time and in the same manner as the approval by the State Board of Examiners of a proposed contract pursuant to subsection 7 of NRS 333.700; and

(b) Must occur before the date on which the contract becomes binding on the using agency.

4. A using agency may contract with a person pursuant to paragraph (a) or (b) of subsection 1 without obtaining the approval of the State Board of Examiners if the term of the contract is for less than 4 months and the head of the using agency determines that an emergency exists which necessitates the contract. If a using agency contracts with a person pursuant to this subsection, the using agency shall submit a copy of the contract and a description of the emergency to the State Board of Examiners, which shall review the contract and the description of the emergency and notify the using agency whether the State Board of Examiners would have approved the contract if it had not been entered into pursuant to this subsection.

5. Except as otherwise provided in subsection 9, a using agency shall, not later than 10 days after the end of each fiscal quarter, report to the Interim Finance Committee concerning all contracts to provide services for the using agency that were entered into by the using agency during the fiscal quarter with a person who is a current or former employee of a department, division or other agency of this State.

6. Except as otherwise provided in subsection 9, a using agency shall not contract with a temporary employment service unless the contracting process is controlled by rules of open competitive bidding.

7. Each board or commission of this State and each institution of the Nevada System of Higher Education that employs a consultant shall, at least once every 6 months, submit to the Interim Finance Committee a report setting forth:

(a) The number of consultants employed by the board, commission or institution;

(b) The purpose for which the board, commission or institution employs each consultant;

(c) The amount of money or other remuneration received by each consultant from the board, commission or institution; and



(d) The length of time each consultant has been employed by the board, commission or institution.

8. A using agency, board or commission of this State and each institution of the Nevada System of Higher Education:

(a) Shall make every effort to limit the number of contracts it enters into with persons to provide services which have a term of more than 2 years and which are in the amount of less than \$1,000,000; and

(b) Shall not enter into a contract with a person to provide services without ensuring that the person is in active and good standing with the Secretary of State.

9. The provisions of subsections 1 to 6, inclusive, do not apply to:

(a) The Nevada System of Higher Education or a board or commission of this State.

(b) The employment of professional engineers by the Department of Transportation if those engineers are employed for a transportation project that is entirely funded by federal money.

(c) Contracts in the amount of \$1,000,000 or more entered into:

(1) Pursuant to the State Plan for Medicaid established pursuant to NRS 422.063.

(2) For financial services.

(3) Pursuant to the Public Employees' Benefits Program.

(4) Pursuant to the Public Option established pursuant to section 10 of this act.

(d) The employment of a person by a business or entity which is a provider of services under the State Plan for Medicaid and which provides such services on a fee-for-service basis or through managed care.

(e) The employment of a former employee of an agency of this State who is not receiving retirement benefits under the Public Employees' Retirement System during the duration of the contract.

Sec. 23. Chapter 422 of NRS is hereby amended by adding thereto the provisions set forth as sections 24 to 28, inclusive, of this act.

Sec. 24. 1. *The Director shall, to the extent authorized by federal law, include in the State Plan for Medicaid authorization for a pregnant woman who is determined by a qualified provider to be presumptively eligible for Medicaid to enroll in Medicaid until the last day of the month immediately following the month of enrollment without submitting an application for enrollment in Medicaid which includes additional proof of eligibility.*



2. *To the extent that money is available, the Director shall, to the extent authorized by federal law, include in the State Plan for Medicaid authorization for a pregnant woman whose household income is at or below 200 percent of the federally designated level signifying poverty to enroll in Medicaid.*

3. *Unless otherwise required by federal law, the Director shall not include in the State Plan for Medicaid a requirement that a pregnant woman who resides in this State and who is otherwise eligible for Medicaid must reside in the United States for a prescribed period of time before enrolling in Medicaid.*

4. *As used in this section, "qualified provider" has the meaning ascribed to it in 42 U.S.C. § 1396r-1(b)(2).*

Sec. 25. 1. *The Director shall include in the State Plan for Medicaid a requirement that the State, to the extent authorized by federal law, pay the nonfederal share of expenditures incurred for the services of a community health worker who provides services under the supervision of a physician, physician assistant or advanced practice registered nurse.*

2. *As used in this section, "community health worker" has the meaning ascribed to it in NRS 449.0027.*

Sec. 26. 1. *The Director shall, to the extent authorized by federal law, include in the State Plan for Medicaid a requirement that the State pay the nonfederal share of expenditures incurred for doula services provided by an enrolled doula.*

2. *The Department shall apply to the Secretary of Health and Human Services for a waiver granted pursuant to 42 U.S.C. § 1315 or apply for an amendment of the State Plan for Medicaid that authorizes the Department to receive federal funding to include in the State Plan for Medicaid coverage of doula services provided by an enrolled doula. The Department shall fully cooperate in good faith with the Federal Government during the application process to satisfy the requirements of the Federal Government for obtaining a waiver or amendment pursuant to this section.*

3. *A person who wishes to receive reimbursement through the Medicaid program for doula services provided to a recipient of Medicaid must submit to the Division:*

(a) *An application for enrollment in the form prescribed by the Division; and*

(b) *Proof that he or she possesses the required training and qualifications prescribed by the Division pursuant to subsection 4.*

4. *The Division, in consultation with community-based organizations that provide services to pregnant women in this*



State, shall prescribe the required training and qualifications for enrollment pursuant to subsection 3 to receive reimbursement through Medicaid for doula services.

5. As used in this section:

(a) "Doula services" means services to provide education and support relating to childbirth, including, without limitation, emotional and physical support provided during pregnancy, labor, birth and the postpartum period.

(b) "Enrolled doula" means a doula who is enrolled with the Division pursuant to this section to receive reimbursement through Medicaid for doula services.

Sec. 27. 1. To the extent that money is available, the Director shall include in the State Plan for Medicaid a requirement that, except as otherwise provided in subsection 2, the State must provide reimbursement for the services of an advanced practice registered nurse, including, without limitation, a certified nurse-midwife, to the same extent as if the services were provided by a physician.

2. The provisions of subsection 1 do not apply to services provided to a recipient of Medicaid who receives health care services through a Medicaid managed care program.

3. As used in this section, "certified nurse-midwife" means a person who is:

(a) Certified as a nurse-midwife by the American Midwifery Certification Board, or its successor organization; and

(b) Licensed as an advanced practice registered nurse pursuant to NRS 632.237.

Sec. 28. 1. To the extent that money is available, the Director shall include in the State Plan for Medicaid a requirement that the State pay the nonfederal share of expenditures incurred for:

(a) Supplies for breastfeeding a child until the child's first birthday. Such supplies include, without limitation, electric or hospital-grade breast pumps that:

(1) Have been prescribed or ordered by a qualified provider of health care; and

(2) Are medically necessary for the mother or the child.

(b) Such prenatal screenings and tests as are recommended by the American College of Obstetricians and Gynecologists, or its successor organization.

2. The Director shall include in the State Plan for Medicaid a requirement that, to the extent that money and federal financial participation are available, the State must pay the nonfederal



share of expenditures incurred for lactation consultation and support.

3. As used in this section:

(a) "Medically necessary" has the meaning ascribed to it in NRS 695G.055.

(b) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 29. NRS 422.2372 is hereby amended to read as follows:

422.2372 The Administrator shall:

1. Supply the Director with material on which to base proposed legislation.

2. Cooperate with the Federal Government and state governments for the more effective attainment of the purposes of this chapter.

3. Coordinate the activities of the Division with other agencies, both public and private, with related or similar activities.

4. Keep a complete and accurate record of all proceedings, record and file all bonds and contracts, and assume responsibility for the custody and preservation of all papers and documents pertaining to the office of the Administrator.

5. Inform the public in regard to the activities and operation of the Division, and provide other information which will acquaint the public with the financing of Medicaid programs.

6. Conduct studies into the causes of the social problems with which the Division is concerned.

7. Invoke any legal, equitable or special procedures for the enforcement of orders issued by the Administrator or the enforcement of the provisions of this chapter.

8. *Exclude from participation in Medicaid any provider of health care that fails to comply with the requirements of section 13 of this act.*

9. Exercise any other powers that are necessary and proper for the standardization of state work, to expedite business and to promote the efficiency of the service provided by the Division.

Sec. 30. NRS 422.273 is hereby amended to read as follows:

422.273 1. *To the extent that money is available, the Department shall:*

(a) Establish a Medicaid managed care program to provide health care services to recipients of Medicaid in all geographic areas of this State. The program is not required to provide services to recipients of Medicaid who are aged, blind or disabled pursuant to Title XVI of the Social Security Act, 42 U.S.C. §§ 1381 et seq.



(b) Conduct a statewide procurement process to select health maintenance organizations to provide the services described in paragraph (a).

2. For any Medicaid managed care program established in the State of Nevada, the Department shall contract only with a health maintenance organization that has:

(a) Negotiated in good faith with a federally-qualified health center to provide health care services for the health maintenance organization;

(b) Negotiated in good faith with the University Medical Center of Southern Nevada to provide inpatient and ambulatory services to recipients of Medicaid; ~~and~~

(c) Negotiated in good faith with the University of Nevada School of Medicine to provide health care services to recipients of Medicaid ~~;~~ ***and***

(d) Complied with the provisions of subsection 2 of section 12 of this act.

↳ Nothing in this section shall be construed as exempting a federally-qualified health center, the University Medical Center of Southern Nevada or the University of Nevada School of Medicine from the requirements for contracting with the health maintenance organization.

~~2.~~ **3.** During the development and implementation of any Medicaid managed care program, the Department shall cooperate with the University of Nevada School of Medicine by assisting in the provision of an adequate and diverse group of patients upon which the school may base its educational programs.

~~3.~~ **4.** The University of Nevada School of Medicine may establish a nonprofit organization to assist in any research necessary for the development of a Medicaid managed care program, receive and accept gifts, grants and donations to support such a program and assist in establishing educational services about the program for recipients of Medicaid.

~~4.~~ **5.** For the purpose of contracting with a Medicaid managed care program pursuant to this section, a health maintenance organization is exempt from the provisions of NRS 695C.123.

~~5.~~ ***6. To the extent that money is available, a Medicaid managed care program must include, without limitation, a state-directed payment arrangement established in accordance with 42 C.F.R. § 438.6(c) to require a Medicaid managed care organization to reimburse a critical access hospital and any federally-qualified health center or rural health clinic affiliated***



with a critical access hospital for covered services at a rate that is equal to or greater than the rate received by the critical access hospital, federally-qualified health center or rural health clinic, as applicable, for services provided to recipients of Medicaid on a fee-for-service basis.

7. The provisions of this section apply to any managed care organization, including a health maintenance organization, that provides health care services to recipients of Medicaid under the State Plan for Medicaid or the Children's Health Insurance Program pursuant to a contract with the Division. Such a managed care organization or health maintenance organization is not required to establish a system for conducting external reviews of adverse determinations in accordance with chapter 695B, 695C or 695G of NRS. This subsection does not exempt such a managed care organization or health maintenance organization for services provided pursuant to any other contract.

~~6.~~ 8. As used in this section, unless the context otherwise requires:

(a) *"Critical access hospital" means a hospital which has been certified as a critical access hospital by the Secretary of Health and Human Services pursuant to 42 U.S.C. § 1395i-4(e).*

(b) "Federally-qualified health center" has the meaning ascribed to it in 42 U.S.C. § 1396d(1)(2)(B).

~~(b)~~ (c) "Health maintenance organization" has the meaning ascribed to it in NRS 695C.030.

~~(e)~~ (d) "Managed care organization" has the meaning ascribed to it in NRS 695G.050.

(e) *"Rural health clinic" has the meaning ascribed to it in 42 C.F.R. § 405.2401.*

Sec. 31. (Deleted by amendment.)

Sec. 32. NRS 427A.605 is hereby amended to read as follows:

427A.605 1. The Director may establish a program to negotiate discounts and rebates for hearing devices and related costs, including, without limitation, ear molds, batteries and FM systems, for children in this State who are deaf or hard of hearing on behalf of entities described in subsection 2 who participate in the program.

2. The following persons and entities may participate in a program established pursuant to subsection 1:

(a) The Public Employees' Benefits Program;

(b) A governing body of a county, school district, municipal corporation, political subdivision, public corporation or other local



governmental agency that provides health coverage to employees through a self-insurance reserve fund pursuant to NRS 287.010;

(c) An insurer that holds a certificate of authority to transact insurance in this State pursuant to chapter 680A of NRS;

(d) An employer or employee organization based in this State that provides health coverage to employees through a self-insurance reserve fund;

(e) A governmental agency or nonprofit organization that purchases hearing devices for children in this State who are deaf or hard of hearing;

(f) A resident of this State who does not have coverage for hearing devices; ~~and~~

(g) *The Public Option established pursuant to section 10 of this act; and*

(h) Any other person or entity that provides health coverage or otherwise purchases hearing devices for children in this State who are deaf or hard of hearing.

3. A person or entity described in subsection 2 may participate in any program established pursuant to subsection 1 by submitting an application to the Department in the form prescribed by the Department.

Sec. 33. NRS 432B.220 is hereby amended to read as follows:

432B.220 1. Any person who is described in subsection 4 and who, in his or her professional or occupational capacity, knows or has reasonable cause to believe that a child has been abused or neglected shall:

(a) Except as otherwise provided in subsection 2, report the abuse or neglect of the child to an agency which provides child welfare services or to a law enforcement agency; and

(b) Make such a report as soon as reasonably practicable but not later than 24 hours after the person knows or has reasonable cause to believe that the child has been abused or neglected.

2. If a person who is required to make a report pursuant to subsection 1 knows or has reasonable cause to believe that the abuse or neglect of the child involves an act or omission of:

(a) A person directly responsible or serving as a volunteer for or an employee of a public or private home, institution or facility where the child is receiving child care outside of the home for a portion of the day, the person shall make the report to a law enforcement agency.

(b) An agency which provides child welfare services or a law enforcement agency, the person shall make the report to an agency other than the one alleged to have committed the act or omission,



and the investigation of the abuse or neglect of the child must be made by an agency other than the one alleged to have committed the act or omission.

3. Any person who is described in paragraph (a) of subsection 4 who delivers or provides medical services to a newborn infant and who, in his or her professional or occupational capacity, knows or has reasonable cause to believe that the newborn infant has been affected by a fetal alcohol spectrum disorder or prenatal substance use disorder or has withdrawal symptoms resulting from prenatal substance exposure shall, as soon as reasonably practicable but not later than 24 hours after the person knows or has reasonable cause to believe that the newborn infant is so affected or has such symptoms, notify an agency which provides child welfare services of the condition of the infant and refer each person who is responsible for the welfare of the infant to an agency which provides child welfare services for appropriate counseling, training or other services. A notification and referral to an agency which provides child welfare services pursuant to this subsection shall not be construed to require prosecution for any illegal action.

4. A report must be made pursuant to subsection 1 by the following persons:

(a) A person providing services licensed or certified in this State pursuant to, without limitation, chapter 450B, 630, 630A, 631, 632, 633, 634, 634A, 635, 636, 637, 637B, 639, 640, 640A, 640B, 640C, 640D, 640E, 641, 641A, 641B, 641C or 653 of NRS.

(b) Any personnel of a medical facility licensed pursuant to chapter 449 of NRS who are engaged in the admission, examination, care or treatment of persons or an administrator, manager or other person in charge of such a medical facility upon notification of suspected abuse or neglect of a child by a member of the staff of the medical facility.

(c) A coroner.

(d) A member of the clergy, practitioner of Christian Science or religious healer, unless the person has acquired the knowledge of the abuse or neglect from the offender during a confession.

(e) A person employed by a public school or private school and any person who serves as a volunteer at such a school.

(f) Any person who maintains or is employed by a facility or establishment that provides care for children, children's camp or other public or private facility, institution or agency furnishing care to a child.

(g) Any person licensed pursuant to chapter 424 of NRS to conduct a foster home.



(h) Any officer or employee of a law enforcement agency or an adult or juvenile probation officer.

(i) Except as otherwise provided in NRS 432B.225, an attorney.

(j) Any person who maintains, is employed by or serves as a volunteer for an agency or service which advises persons regarding abuse or neglect of a child and refers them to persons and agencies where their requests and needs can be met.

(k) Any person who is employed by or serves as a volunteer for a youth shelter. As used in this paragraph, "youth shelter" has the meaning ascribed to it in NRS 244.427.

(l) Any adult person who is employed by an entity that provides organized activities for children, including, without limitation, a person who is employed by a school district or public school.

(m) Any person who is enrolled with the Division of Health Care Financing and Policy of the Department of Health and Human Services to provide doula services to recipients of Medicaid pursuant to section 26 of this act.

5. A report may be made by any other person.

6. If a person who is required to make a report pursuant to subsection 1 knows or has reasonable cause to believe that a child has died as a result of abuse or neglect, the person shall, as soon as reasonably practicable, report this belief to an agency which provides child welfare services or a law enforcement agency. If such a report is made to a law enforcement agency, the law enforcement agency shall notify an agency which provides child welfare services and the appropriate medical examiner or coroner of the report. If such a report is made to an agency which provides child welfare services, the agency which provides child welfare services shall notify the appropriate medical examiner or coroner of the report. The medical examiner or coroner who is notified of a report pursuant to this subsection shall investigate the report and submit his or her written findings to the appropriate agency which provides child welfare services, the appropriate district attorney and a law enforcement agency. The written findings must include, if obtainable, the information required pursuant to the provisions of subsection 2 of NRS 432B.230.

7. The agency, board, bureau, commission, department, division or political subdivision of the State responsible for the licensure, certification or endorsement of a person who is described in subsection 4 and who is required in his or her professional or occupational capacity to be licensed, certified or endorsed in this State shall, at the time of initial licensure, certification or endorsement:



(a) Inform the person, in writing or by electronic communication, of his or her duty as a mandatory reporter pursuant to this section;

(b) Obtain a written acknowledgment or electronic record from the person that he or she has been informed of his or her duty pursuant to this section; and

(c) Maintain a copy of the written acknowledgment or electronic record for as long as the person is licensed, certified or endorsed in this State.

8. The employer of a person who is described in subsection 4 and who is not required in his or her professional or occupational capacity to be licensed, certified or endorsed in this State must, upon initial employment of the person:

(a) Inform the person, in writing or by electronic communication, of his or her duty as a mandatory reporter pursuant to this section;

(b) Obtain a written acknowledgment or electronic record from the person that he or she has been informed of his or her duty pursuant to this section; and

(c) Maintain a copy of the written acknowledgment or electronic record for as long as the person is employed by the employer.

9. Before a person may serve as a volunteer at a public school or private school, the school must:

(a) Inform the person, in writing or by electronic communication, of his or her duty as a mandatory reporter pursuant to this section and NRS 392.303;

(b) Obtain a written acknowledgment or electronic record from the person that he or she has been informed of his or her duty pursuant to this section and NRS 392.303; and

(c) Maintain a copy of the written acknowledgment or electronic record for as long as the person serves as a volunteer at the school.

10. As used in this section:

(a) "Private school" has the meaning ascribed to it in NRS 394.103.

(b) "Public school" has the meaning ascribed to it in NRS 385.007.

Sec. 34. NRS 439B.260 is hereby amended to read as follows:

439B.260 1. A major hospital shall reduce or discount the total billed charge by at least 30 percent for hospital services provided to an inpatient who:

(a) Has no policy of health insurance or other contractual agreement with a third party that provides health coverage for the charge;



(b) Is not eligible for coverage by a state or federal program of public assistance that would provide for the payment of the charge; and

(c) Makes reasonable arrangements within 30 days after the date that notice was sent pursuant to subsection 2 to pay the hospital bill.

2. A major hospital shall include on or with the first statement of the hospital bill provided to the patient after his or her discharge a notice of the reduction or discount available pursuant to this section, including, without limitation, notice of the criteria a patient must satisfy to qualify for a reduction or discount.

3. A major hospital or patient who disputes the reasonableness of arrangements made pursuant to paragraph (c) of subsection 1 may submit the dispute to the Bureau for Hospital Patients for resolution as provided in NRS 232.462.

4. A major hospital shall reduce or discount the total billed charge of its outpatient pharmacy by at least 30 percent to a patient who is eligible for Medicare.

5. As used in this section, "third party" means:

(a) An insurer, as that term is defined in NRS 679B.540;

(b) A health benefit plan, as that term is defined in NRS 687B.470, for employees which provides coverage for services and care at a hospital;

(c) A participating public agency, as that term is defined in NRS 287.04052, and any other local governmental agency of the State of Nevada which provides a system of health insurance for the benefit of its officers and employees, and the dependents of officers and employees, pursuant to chapter 287 of NRS; ~~or~~

(d) *The Public Option established pursuant to section 10 of this act; or*

(e) Any other insurer or organization providing health coverage or benefits in accordance with state or federal law.

↳ The term does not include an insurer that provides coverage under a policy of casualty or property insurance.

Sec. 35. NRS 439B.665 is hereby amended to read as follows:

439B.665 1. On or before February 1 of each year, a nonprofit organization that advocates on behalf of patients or funds medical research in this State and has received a payment, donation, subsidy or anything else of value from a manufacturer, third party or pharmacy benefit manager or a trade or advocacy group for manufacturers, third parties or pharmacy benefit managers during the immediately preceding calendar year shall:

(a) Compile a report which includes:



(1) For each such contribution, the amount of the contribution and the manufacturer, third party or pharmacy benefit manager or group that provided the payment, donation, subsidy or other contribution; and

(2) The percentage of the total gross income of the organization during the immediately preceding calendar year attributable to payments, donations, subsidies or other contributions from each manufacturer, third party, pharmacy benefit manager or group; and

(b) Except as otherwise provided in this paragraph, post the report on an Internet website that is maintained by the nonprofit organization and accessible to the public. If the nonprofit organization does not maintain an Internet website that is accessible to the public, the nonprofit organization shall submit the report compiled pursuant to paragraph (a) to the Department.

2. As used in this section, “third party” means:

(a) An insurer, as that term is defined in NRS 679B.540;

(b) A health benefit plan, as that term is defined in NRS 687B.470, for employees which provides coverage for prescription drugs;

(c) A participating public agency, as that term is defined in NRS 287.04052, and any other local governmental agency of the State of Nevada which provides a system of health insurance for the benefit of its officers and employees, and the dependents of officers and employees, pursuant to chapter 287 of NRS; ~~or~~

(d) *The Public Option established pursuant to section 10 of this act; or*

(e) Any other insurer or organization that provides health coverage or benefits in accordance with state or federal law.

↳ The term does not include an insurer that provides coverage under a policy of casualty or property insurance.

Sec. 36. NRS 439B.736 is hereby amended to read as follows:

439B.736 1. “Third party” includes, without limitation:

(a) The issuer of a health benefit plan, as defined in NRS 695G.019, which provides coverage for medically necessary emergency services;

(b) The Public Employees’ Benefits Program established pursuant to subsection 1 of NRS 287.043; ~~and~~

(c) *The Public Option established pursuant to section 10 of this act; and*

(d) Any other entity or organization that elects pursuant to NRS 439B.757 for the provisions of NRS 439B.700 to 439B.760,



inclusive, to apply to the provision of medically necessary emergency services by out-of-network providers to covered persons.

2. The term does not include the State Plan for Medicaid, the Children's Health Insurance Program or a health maintenance organization, as defined in NRS 695C.030, or managed care organization, as defined in NRS 695G.050, when providing health care services through managed care to recipients of Medicaid under the State Plan for Medicaid or insurance pursuant to the Children's Health Insurance Program pursuant to a contract with the Division of Health Care Financing and Policy of the Department.

Sec. 37. NRS 449A.162 is hereby amended to read as follows:

449A.162 1. Except as otherwise provided in subsection 3, if a hospital provides hospital care to a person who has a policy of health insurance issued by a third party that provides health coverage for care provided at that hospital and the hospital has a contractual agreement with the third party, the hospital:

(a) Shall proceed with any efforts to collect on any amount owed to the hospital for the hospital care in accordance with the provisions of NRS 449A.159.

(b) Shall not collect or attempt to collect from the patient or other responsible party more than the sum of the amounts of any deductible, copayment or coinsurance payable by or on behalf of the patient under the policy of health insurance.

(c) Shall not collect or attempt to collect that amount from:

(1) Any proceeds or potential proceeds of a civil action brought by or on behalf of the patient, including, without limitation, any amount awarded for medical expenses; or

(2) An insurer other than an insurer that provides coverage under a policy of health insurance or an insurer that provides coverage for medical payments under a policy of casualty insurance.

2. If the hospital collects or receives any payments from an insurer that provides coverage for medical payments under a policy of casualty insurance, the hospital shall, not later than 30 days after a determination is made concerning coverage, return to the patient any amount collected or received that is in excess of the deductible, copayment or coinsurance payable by or on behalf of the patient under the policy of health insurance.

3. This section does not apply to:

(a) Amounts owed to the hospital which are not covered under the policy of health insurance; or

(b) Medicaid, Medicare, the Children's Health Insurance Program or any other public program which may pay all or part of the bill.



4. This section does not limit any rights of a patient to contest an attempt to collect an amount owed to a hospital, including, without limitation, contesting a lien obtained by a hospital.

5. As used in this section, "third party" means:

(a) An insurer, as defined in NRS 679B.540;

(b) A health benefit plan, as defined in NRS 687B.470, for employees which provides coverage for services and care at a hospital;

(c) A participating public agency, as defined in NRS 287.04052, and any other local governmental agency of the State of Nevada which provides a system of health insurance for the benefit of its officers and employees, and the dependents of officers and employees, pursuant to chapter 287 of NRS; ~~or~~

(d) *The Public Option established pursuant to section 10 of this act; or*

(e) Any other insurer or organization providing health coverage or benefits in accordance with state or federal law.

Sec. 38. Section 10 of this act is hereby amended to read as follows:

Sec. 10. 1. The Director, in consultation with the Commissioner and the Executive Director of the Exchange, shall design, establish and operate a health benefit plan known as the Public Option.

2. The Director:

(a) Shall make the Public Option available:

(1) As a qualified health plan through the Exchange to natural persons who reside in this State and are eligible to enroll in such a plan through the Exchange under the provisions of 45 C.F.R. § 155.305; and

(2) For direct purchase as a policy of individual health insurance by any natural person who resides in this State. The provisions of chapter 689A of NRS and other applicable provisions of this title apply to the Public Option when offered as a policy of individual health insurance.

(b) May make the Public Option available to small employers in this State or their employees to the extent authorized by federal law. The provisions of chapter 689C of NRS and other applicable provisions of this title apply to the Public Option when it is offered as a policy of health insurance for small employers.

(c) Shall comply with all state and federal laws and regulations applicable to insurers when carrying out the



provisions of sections 2 to 15, inclusive, of this act, to the extent that such laws and regulations are not waived.

3. The Public Option must:

(a) Be a qualified health plan, as defined in 42 U.S.C. § 18021; and

(b) Provide at least levels of coverage consistent with the actuarial value of one silver plan and one gold plan.

4. ~~Except as otherwise provided in this section, the premiums for the Public Option:~~

~~—(a) Must be at least 5 percent lower than the reference premium for that zip code; and~~

~~—(b) Must not increase in any year by a percentage greater than the increase in the Medicare Economic Index for that year.~~

~~—5. The Director, in consultation with the Commissioner and the Executive Director of the Exchange, may revise the requirements of subsection 4, provided that the average premiums for the Public Option must be at least 15 percent lower than the average reference premium in this State over the first 4 years in which the Public Option is in operation.~~

~~—6.]~~ As used in this section:

(a) “Gold plan” means a qualified health plan that meets the requirements established by 42 U.S.C. § 18022 for a gold level plan.

(b) “Health benefit plan” means a policy, contract, certificate or agreement to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

(c) “Medicare Economic Index” means the Medicare Economic Index, as designated by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services pursuant to 42 C.F.R. § 405.504.

(d) “Reference premium” means, for any zip code, the lower of:

(1) The premium for the second-lowest cost silver level plan available through the Exchange in the zip code during the 2024 plan year, adjusted by the percentage change in the Medicare Economic Index between January 1, 2024, and January 1 of the year to which a premium applies; or

(2) The premium for the second-lowest cost silver level plan available through the Exchange in the zip code during the year immediately preceding the year to which a premium applies.



(e) “Silver plan” means a qualified health plan that meets the requirements established by 42 U.S.C. § 18022 for a silver level plan.

(f) “Small employer” has the meaning ascribed to it in 42 U.S.C. § 18024(b)(2).

Sec. 38.3. 1. There is hereby appropriated from the State General Fund to the Division of Welfare and Supportive Services of the Department of Health and Human Services the sum of \$167,850 to pay the costs for enhancements to the information technology system of the Division that are necessary to carry out the provisions of sections 24 to 28, inclusive, of this act.

2. Any remaining balance of the appropriation made by subsection 1 must not be committed for expenditure after June 30, 2023, by the entity to which the appropriation is made or any entity to which money from the appropriation is granted or otherwise transferred in any manner, and any portion of the appropriated money remaining must not be spent for any purpose after September 15, 2023, by either the entity to which the money was appropriated or the entity to which the money was subsequently granted or transferred, and must be reverted to the State General Fund on or before September 15, 2023.

Sec. 38.6. 1. There is hereby appropriated from the State General Fund to the Public Option Trust Fund created by section 15 of this act the sum of \$1,639,366 to pay the costs of carrying out the provisions of sections 2 to 15, inclusive, and 39 of this act.

2. Any remaining balance of the appropriation made by subsection 1 must not be committed for expenditure after June 30, 2023, by the entity to which the appropriation is made or any entity to which money from the appropriation is granted or otherwise transferred in any manner, and any portion of the appropriated money remaining must not be spent for any purpose after September 15, 2023, by either the entity to which the money was appropriated or the entity to which the money was subsequently granted or transferred, and must be reverted to the State General Fund on or before September 15, 2023.

Sec. 38.8. 1. There is hereby appropriated from the State General Fund to the Silver State Health Insurance Exchange the sum of \$600,000 to pay the costs of carrying out the provisions of sections 2 to 15, inclusive, and 39 of this act.

2. Any remaining balance of the appropriation made by subsection 1 must not be committed for expenditure after June 30, 2023, by the entity to which the appropriation is made or any entity to which money from the appropriation is granted or otherwise



transferred in any manner, and any portion of the appropriated money remaining must not be spent for any purpose after September 15, 2023, by either the entity to which the money was appropriated or the entity to which the money was subsequently granted or transferred, and must be reverted to the State General Fund on or before September 15, 2023.

Sec. 39. 1. The Director of the Department of Health and Human Services, the Commissioner of Insurance and the Executive Director of the Silver State Health Insurance Exchange shall apply for the waiver described in paragraph (a) of subsection 1 of section 11 of this act not later than January 1, 2024.

2. In preparing the initial application for the waiver described in paragraph (a) of subsection 1 of section 11 of this act, the Director of the Department of Health and Human Services, the Commissioner of Insurance and the Executive Director of the Silver State Health Insurance Exchange shall contract with an independent actuary to conduct an actuarial assessment pursuant to subsection 2 of section 11 of this act. The actuarial assessment:

(a) Must be completed before the application for the waiver is submitted; and

(b) Must include, without limitation, an analysis of the likely effect on premiums for health insurance in this State of:

(1) The provisions of subsection 1 of section 13 of this act, as those provisions apply to providers of health care, as defined in NRS 695G.070, who participate in the Public Employees' Benefits Program established pursuant to subsection 1 of NRS 287.043 or provide care to an injured employee pursuant to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS, and the amendatory provisions of section 21 of this act; and

(2) Repealing the provisions described in subparagraph (1).

3. The Director of the Department of Health and Human Services shall make the Public Option available to natural persons who reside in this State in accordance with the provisions of section 10 of this act for the coverage year that begins on January 1, 2026.

4. As used in this section, "Public Option" has the meaning ascribed to it in section 8 of this act.

Sec. 39.5. On or before January 1, 2025, the Executive Director of the Silver State Health Insurance Exchange, in collaboration with the Department of Health and Human Services, shall:

1. Apply for the waiver described in subsection 1 of section 16.5 of this act; and



2. Submit to the Director of the Legislative Counsel Bureau for transmittal to the 83rd Session of the Legislature a report of recommendations concerning any revisions to Nevada law necessary to:

(a) Authorize an organization described in section 501(c)(5) of the Internal Revenue Code to offer a policy of insurance described in subsection 1 of section 16.5 of this act for direct purchase outside the Exchange as a policy of individual health insurance;

(b) Align state law concerning individual health insurance with the requirements in the request for the waiver described in subsection 1 of section 16.5 of this act; and

(c) Ensure that any state subsidies available to reduce the cost of premiums for individual health insurance are available for a policy of insurance described in subsection 1 of section 16.5 of this act.

Sec. 40. Notwithstanding the provisions of NRS 218D.430 and 218D.435, a committee, other than the Assembly Standing Committee on Ways and Means and the Senate Standing Committee on Finance, may vote on this act before the expiration of the period prescribed for the return of a fiscal note in NRS 218D.475. This section applies retroactively from and after March 22, 2021.

Sec. 40.5. The provisions of NRS 354.599 do not apply to any additional expenses of a local government that are related to the provisions of this act.

Sec. 41. 1. This section and sections 16.3, 16.5, 16.8 and 39 to 40.5, inclusive, of this act become effective upon passage and approval.

2. Sections 1 to 14, inclusive, 16, 19, 20, 21, 22, 29 to 32, inclusive, and 34 to 37, inclusive, of this act become effective:

(a) Upon passage and approval for the purposes of procurement and any other preparatory administrative tasks necessary to carry out the provisions of those sections; and

(b) On January 1, 2026, for all other purposes.

3. Sections 15, 16.35 to 16.47, inclusive, 20.5, 38.3 and 38.6 of this act become effective on July 1, 2021.

4. Sections 17, 18, 23 to 28, inclusive, 33 and 38.8 of this act become effective on January 1, 2022.

5. Section 38 of this act becomes effective on January 1, 2030.



CHAPTER 695K - PUBLIC OPTION

GENERAL PROVISIONS

NRS 695K.010	Purpose and policy of Legislature in enacting chapter. [Effective January 1, 2026.]
NRS 695K.020	Definitions. [Effective January 1, 2026.]
NRS 695K.030	“Certified community behavioral health clinic” defined. [Effective January 1, 2026.]
NRS 695K.040	“Commissioner” defined. [Effective January 1, 2026.]
NRS 695K.050	“Director” defined. [Effective January 1, 2026.]
NRS 695K.060	“Exchange” defined. [Effective January 1, 2026.]
NRS 695K.070	“Federally qualified health center” defined. [Effective January 1, 2026.]
NRS 695K.080	“Provider of health care” defined. [Effective January 1, 2026.]
NRS 695K.090	“Public Option” defined. [Effective January 1, 2026.]
NRS 695K.100	“Rural health clinic” defined. [Effective January 1, 2026.]
NRS 695K.110	“Trust Fund” defined. [Effective January 1, 2026.]

ADMINISTRATION; OPERATION

NRS 695K.200	Design, establishment and operation; availability; requirements; premiums. [Effective January 1, 2026, through December 31, 2029.]
NRS 695K.200	Design, establishment and operation; availability; requirements. [Effective January 1, 2030.]
NRS 695K.210	Application for federal waivers and approvals; acceptance of gifts, grants and donations; deposit of money; contracts for services. [Effective January 1, 2026.]
NRS 695K.220	Administration: Contract with health carrier or other qualified person or entity or performance by Director; duties of administrator; deposit of money. [Effective January 1, 2026.]
NRS 695K.230	Duties of certain providers of health care; exception. [Effective January 1, 2026.]
NRS 695K.240	Establishment of networks and reimbursement of providers of health care: Requirements. [Effective January 1, 2026.]

PUBLIC OPTION TRUST FUND

NRS 695K.300	Creation; administration; sources of money; interest; nonreversion; uses.
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GENERAL PROVISIONS

NRS 695K.010 Purpose and policy of Legislature in enacting chapter. [Effective January 1, 2026.] It is hereby declared to be the purpose and policy of the Legislature in enacting this chapter to:

1. Leverage the combined purchasing power of the State to lower premiums and costs relating to health insurance for residents of this State;
2. Improve access to high-quality, affordable health care for residents of this State, including residents of this State who are employed by small businesses;
3. Reduce disparities in access to health care and health outcomes and increase access to health care for historically marginalized communities; and
4. Increase competition in the market for individual health insurance in this State to improve the availability of coverage for residents of rural areas of this State.

(Added to NRS by [2021, 3616](#), effective January 1, 2026)

NRS 695K.020 Definitions. [Effective January 1, 2026.] As used in this chapter, unless the context otherwise requires, the words and terms defined in [NRS 695K.030](#) to [695K.110](#), inclusive, have the meanings ascribed to them in those sections.

(Added to NRS by [2021, 3616](#), effective January 1, 2026)

NRS 695K.030 “Certified community behavioral health clinic” defined. [Effective January 1, 2026.] “Certified community behavioral health clinic” means a community behavioral health clinic certified in accordance with section 223 of the Protecting Access to Medicare Act of 2014, Public Law No. 113-93.

(Added to NRS by [2021, 3616](#), effective January 1, 2026)

NRS 695K.040 “Commissioner” defined. [Effective January 1, 2026.] “Commissioner” means the Commissioner of Insurance.

(Added to NRS by [2021, 3616](#), effective January 1, 2026)

NRS 695K.050 “Director” defined. [Effective January 1, 2026.] “Director” means the Director of the Department of Health and Human Services.

(Added to NRS by [2021, 3616](#), effective January 1, 2026)

NRS 695K.060 “Exchange” defined. [Effective January 1, 2026.] “Exchange” means the Silver State Health Insurance Exchange.

(Added to NRS by [2021, 3617](#), effective January 1, 2026)

NRS 695K.070 “Federally qualified health center” defined. [Effective January 1, 2026.] “Federally qualified health center” has the meaning ascribed to it in 42 C.F.R. § 405.2401.

(Added to NRS by [2021, 3617](#), effective January 1, 2026)

NRS 695K.080 “Provider of health care” defined. [Effective January 1, 2026.] “Provider of health care” has the meaning ascribed to it in [NRS 695G.070](#).

(Added to NRS by [2021, 3617](#), effective January 1, 2026)

NRS 695K.090 “Public Option” defined. [Effective January 1, 2026.] “Public Option” means the Public Option established pursuant to [NRS 695K.200](#).

(Added to NRS by [2021, 3617](#), effective January 1, 2026)

NRS 695K.100 “Rural health clinic” defined. [Effective January 1, 2026.] “Rural health clinic” has the meaning ascribed to it in 42 C.F.R. § 405.2401.

(Added to NRS by [2021, 3617](#), effective January 1, 2026)

NRS 695K.110 “Trust Fund” defined. [Effective January 1, 2026.] “Trust Fund” means the Public Option Trust Fund created by [NRS 695K.300](#).

(Added to NRS by [2021, 3617](#), effective January 1, 2026)

ADMINISTRATION; OPERATION

NRS 695K.200 Design, establishment and operation; availability; requirements; premiums. [Effective January 1, 2026, through December 31, 2029.]

1. The Director, in consultation with the Commissioner and the Executive Director of the Exchange, shall design, establish and operate a health benefit plan known as the Public Option.

2. The Director:

(a) Shall make the Public Option available:

(1) As a qualified health plan through the Exchange to natural persons who reside in this State and are eligible to enroll in such a plan through the Exchange under the provisions of 45 C.F.R. § 155.305; and

(2) For direct purchase as a policy of individual health insurance by any natural person who resides in this State. The provisions of [chapter 689A](#) of NRS and other applicable provisions of this title apply to the Public Option when offered as a policy of individual health insurance.

(b) May make the Public Option available to small employers in this State or their employees to the extent authorized by federal law. The provisions of [chapter 689C](#) of NRS and other applicable provisions of this title apply to the Public Option when it is offered as a policy of health insurance for small employers.

(c) Shall comply with all state and federal laws and regulations applicable to insurers when carrying out the provisions of this chapter, to the extent that such laws and regulations are not waived.

3. The Public Option must:

(a) Be a qualified health plan, as defined in 42 U.S.C. § 18021; and

- (b) Provide at least levels of coverage consistent with the actuarial value of one silver plan and one gold plan.
- 4. Except as otherwise provided in this section, the premiums for the Public Option:
 - (a) Must be at least 5 percent lower than the reference premium for that zip code; and
 - (b) Must not increase in any year by a percentage greater than the increase in the Medicare Economic Index for that year.
- 5. The Director, in consultation with the Commissioner and the Executive Director of the Exchange, may revise the requirements of subsection 4, provided that the average premiums for the Public Option must be at least 15 percent lower than the average reference premium in this State over the first 4 years in which the Public Option is in operation.
- 6. As used in this section:
 - (a) “Gold plan” means a qualified health plan that meets the requirements established by 42 U.S.C. § 18022 for a gold level plan.
 - (b) “Health benefit plan” means a policy, contract, certificate or agreement to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.
 - (c) “Medicare Economic Index” means the Medicare Economic Index, as designated by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services pursuant to 42 C.F.R. § 405.504.
 - (d) “Reference premium” means, for any zip code, the lower of:
 - (1) The premium for the second-lowest cost silver level plan available through the Exchange in the zip code during the 2024 plan year, adjusted by the percentage change in the Medicare Economic Index between January 1, 2024, and January 1 of the year to which a premium applies; or
 - (2) The premium for the second-lowest cost silver level plan available through the Exchange in the zip code during the year immediately preceding the year to which a premium applies.
 - (e) “Silver plan” means a qualified health plan that meets the requirements established by 42 U.S.C. § 18022 for a silver level plan.
 - (f) “Small employer” has the meaning ascribed to it in 42 U.S.C. § 18024(b)(2).
(Added to NRS by [2021, 3617](#), effective January 1, 2026)

NRS 695K.200 Design, establishment and operation; availability; requirements. [Effective January 1, 2030.]

- 1. The Director, in consultation with the Commissioner and the Executive Director of the Exchange, shall design, establish and operate a health benefit plan known as the Public Option.
- 2. The Director:
 - (a) Shall make the Public Option available:
 - (1) As a qualified health plan through the Exchange to natural persons who reside in this State and are eligible to enroll in such a plan through the Exchange under the provisions of 45 C.F.R. § 155.305; and
 - (2) For direct purchase as a policy of individual health insurance by any natural person who resides in this State. The provisions of [chapter 689A](#) of NRS and other applicable provisions of this title apply to the Public Option when offered as a policy of individual health insurance.
 - (b) May make the Public Option available to small employers in this State or their employees to the extent authorized by federal law. The provisions of [chapter 689C](#) of NRS and other applicable provisions of this title apply to the Public Option when it is offered as a policy of health insurance for small employers.
 - (c) Shall comply with all state and federal laws and regulations applicable to insurers when carrying out the provisions of this chapter, to the extent that such laws and regulations are not waived.
- 3. The Public Option must:
 - (a) Be a qualified health plan, as defined in 42 U.S.C. § 18021; and
 - (b) Provide at least levels of coverage consistent with the actuarial value of one silver plan and one gold plan.
- 4. As used in this section:
 - (a) “Gold plan” means a qualified health plan that meets the requirements established by 42 U.S.C. § 18022 for a gold level plan.
 - (b) “Health benefit plan” means a policy, contract, certificate or agreement to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.
 - (c) “Silver plan” means a qualified health plan that meets the requirements established by 42 U.S.C. § 18022 for a silver level plan.
 - (d) “Small employer” has the meaning ascribed to it in 42 U.S.C. § 18024(b)(2).
(Added to NRS by [2021, 3617](#); A [2021, 3645](#), effective January 1, 2030)

NRS 695K.210 Application for federal waivers and approvals; acceptance of gifts, grants and donations; deposit of money; contracts for services. [Effective January 1, 2026.]

1. The Director, the Commissioner and the Executive Director of the Exchange:
 - (a) Shall collaborate to apply to the Secretary of Health and Human Services for a waiver pursuant to 42 U.S.C. § 18052 to obtain pass-through federal funding to carry out the provisions of this chapter; and
 - (b) Except as otherwise provided in subsection 4, may collaboratively apply to the Secretary of Health and Human Services for any other federal waivers or approval necessary to carry out the provisions of this chapter, including, without limitation, and to the extent necessary, a waiver pursuant to 42 U.S.C. § 1315 of Title XIX of the Social Security Act. Such waivers or approval may include, without limitation, any waiver or approval necessary to:
 - (1) Combine risk pools for the Public Option with risk pools established for Medicaid, if the Director can demonstrate that doing so would lower costs, result in savings to the federal and state governments and not increase the costs of private insurance or Medicaid; or
 - (2) Obtain federal financial participation to subsidize the cost of health insurance for residents of this State with low incomes.
2. In preparing an application for any waiver described in subsection 1, the Director, the Commissioner and the Executive Director of the Exchange may contract with an independent actuary to assess the impact of the Public Option on the markets for health care and health insurance in this State and health coverage for natural persons, families and small businesses. The actuary must have specialized expertise or experience with state health insurance exchanges, the type of waiver for which the application is being made, measures to contain the costs of providing health coverage, reforming procedures for the purchasing and delivery of governmental services and Medicaid managed care programs. A contract pursuant to this subsection is exempt from the provisions of [chapter 333](#) of NRS.
3. The Director, the Commissioner and the Executive Director of the Exchange shall:
 - (a) Cooperate with the Federal Government in obtaining any waiver for which he or she applies pursuant to this section.
 - (b) Deposit any money received from the Federal Government pursuant to such a waiver in the Trust Fund.
4. The Director, the Commissioner and the Executive Director of the Exchange shall not apply under the provisions of subsection 1 to waive any provision of federal law prescribing conditions of eligibility to purchase a qualified health plan, as defined in 42 U.S.C. § 18021, through the Exchange or receive federal advanced payment of premium tax credits pursuant to 42 U.S.C. § 18082 for such a purchase.
5. The Director may:
 - (a) Accept gifts, grants and donations to carry out the provisions of this chapter. The Director shall deposit any such gifts, grants or donations in the Trust Fund.
 - (b) Employ or enter into contracts with actuaries and other professionals and may enter into contracts with other state agencies, health carriers or other qualified persons and entities as are necessary to carry out the provisions of this chapter. Such contracts are exempt from the requirements of [chapter 333](#) of NRS.

(Added to NRS by [2021, 3618](#), effective January 1, 2026)

NRS 695K.220 Administration: Contract with health carrier or other qualified person or entity or performance by Director; duties of administrator; deposit of money. [Effective January 1, 2026.]

1. The Director, in consultation with the Commissioner and the Executive Director of the Exchange, shall use a statewide competitive bidding process, including, without limitation, a request for proposals, to solicit and enter into contracts with health carriers or other qualified persons or entities to administer the Public Option. If a statewide Medicaid managed care program is established pursuant to subsection 1 of [NRS 422.273](#), the competitive bidding process must coincide with the statewide procurement process for that Medicaid managed care program.
2. Each health carrier that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid or the Children's Health Insurance Program shall, as a condition of continued participation in any Medicaid managed care program established in this State, submit a good faith proposal in response to a request for proposals issued pursuant to subsection 1.
3. Each proposal submitted pursuant to subsection 2 must demonstrate that the applicant is able to meet the requirements of [NRS 695K.200](#).
4. When selecting a health carrier or other qualified person or entity to administer the Public Option, the Director shall prioritize applicants whose proposals:
 - (a) Demonstrate alignment of networks of providers between the Public Option and Medicaid managed care, where applicable;

(b) Provide for the inclusion of critical access hospitals, rural health clinics, certified community behavioral health clinics and federally-qualified health centers in the networks of providers for the Public Option and Medicaid managed care, where applicable;

(c) Include proposals for strengthening the workforce in this State and particularly in rural areas of this State for providers of primary care, mental health care and treatment for substance use disorders;

(d) Use payment models for providers included in the networks of providers for the Public Option that increase value for persons enrolled in the Public Option and the State; and

(e) Include proposals to contract with providers of health care in a manner that decreases disparities among different populations in this State with regard to access to health care and health outcomes and supports culturally competent care.

5. Notwithstanding the provisions of subsections 1 to 4, inclusive, the Director may directly administer the Public Option if necessary to carry out the provisions of this chapter.

6. Any health carrier or other person or entity with which the Director contracts to administer the Public Option pursuant to this section or the Director, if the Director directly administers the Public Option pursuant to subsection 5, shall take any measures necessary to make the Public Option available as described in paragraph (a) of subsection 2 of [NRS 695K.200](#) and, if required by the Director, paragraph (b) of that subsection. Such measures include, without limitation:

(a) Filing rates and supporting information with the Commissioner of Insurance as required by [NRS 686B.010](#) to [686B.1799](#), inclusive; and

(b) Obtaining certification as a qualified health plan pursuant to 42 U.S.C. § 18031.

7. The Director shall deposit into the Trust Fund any money received from:

(a) A health carrier or other person or entity with which the Director contracts to administer the Public Option pursuant to subsection 1 which relates to duties performed under the contract; or

(b) If the Director directly administers the Public Option pursuant to subsection 5, any money received from any person or entity in the course of administering the Public Option.

8. As used in this section:

(a) "Critical access hospital" means a hospital which has been certified as a critical access hospital by the Secretary of Health and Human Services pursuant to 42 U.S.C. § 1395i-4(e).

(b) "Health carrier" means an entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the Commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including, without limitation, a sickness and accident health insurance company, a health maintenance organization, a nonprofit hospital and health service corporation or any other entity providing a plan of health insurance, health benefits or health care services.

(Added to NRS by [2021, 3619](#), effective January 1, 2026)

NRS 695K.230 Duties of certain providers of health care; exception. [Effective January 1, 2026.]

1. Except as otherwise provided in subsection 2, each provider of health care who participates in the Public Employees' Benefits Program established pursuant to subsection 1 of [NRS 287.043](#) or the Medicaid program, or who provides care to an injured employee pursuant to the provisions of [chapters 616A](#) to [616D](#), inclusive, or chapter [617](#) of NRS, shall:

(a) Enroll as a participating provider in at least one network of providers established for the Public Option; and

(b) Accept new patients who are enrolled in the Public Option to the same extent as the provider or facility accepts new patients who are not enrolled in the Public Option.

2. The Director and the Executive Officer of the Public Employees' Benefits Program may waive the requirements of subsection 1 when necessary to ensure that recipients of Medicaid and officers, employees and retirees of this State who receive benefits under the Public Employees' Benefits Program have sufficient access to covered services.

(Added to NRS by [2021, 3620](#), effective January 1, 2026)

NRS 695K.240 Establishment of networks and reimbursement of providers of health care: Requirements. [Effective January 1, 2026.]

1. In establishing networks for the Public Option and reimbursing providers of health care that participate in the Public Option, the Director shall, to the extent practicable:

(a) Ensure that care for persons who were previously covered by Medicaid or the Children's Health Insurance Program and enroll in the Public Option is minimally disrupted;

- (b) Encourage the use of payment models that increase value for persons enrolled in the Public Option and the State;
 - (c) Improve health outcomes for persons enrolled in the Public Option;
 - (d) Reward providers of health care and medical facilities for delivering high-quality services; and
 - (e) Lower the cost of care in both urban and rural areas of this State.
2. Except as otherwise provided in subsections 3 to 6, inclusive, reimbursement rates under the Public Option must be, in the aggregate, comparable to or better than reimbursement rates available under Medicare. For the purposes of this section, the aggregate reimbursement rate under Medicare:
- (a) Includes any add-on payments or other subsidies that a provider receives under Medicare; and
 - (b) Does not include payments under Medicare for a patient encounter or a cost-based payment rate under Medicare.
3. If a provider of health care currently receives reimbursement under Medicare at rates that are cost-based, the reimbursement rates for that provider of health care under the Public Option must be comparable to or better than the cost-based reimbursement rates provided for that provider of health care by Medicare.
4. The reimbursement rates for a federally-qualified health center or a rural health clinic under the Public Option must be comparable to or better than the reimbursement rates established for patient encounters under the applicable Prospective Payment System established for Medicare by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services.
5. The reimbursement rates for a certified community behavioral health clinic under the Public Option must be comparable to or better than the reimbursement rates established for community behavioral health clinics under the State Plan for Medicaid.
6. The requirements of subsections 2 to 5, inclusive, do not apply to a payment model described in paragraph (b) of subsection 1.
7. As used in this section, “Medicare” means the program of health insurance for aged persons and persons with disabilities established pursuant to Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395 et seq.
(Added to NRS by [2021, 3621](#), effective January 1, 2026)

PUBLIC OPTION TRUST FUND

NRS 695K.300 Creation; administration; sources of money; interest; nonreversion; uses.

1. There is hereby created in the State Treasury the Public Option Trust Fund as a nonreverting trust fund. The Trust Fund must be administered by the State Treasurer.
2. The Trust Fund consists of:
- (a) Any money deposited in the Trust Fund pursuant to [NRS 695K.210](#) and [695K.220](#);
 - (b) Any money appropriated by the Legislature for the purpose of carrying out the provisions of this chapter; and
 - (c) All income and interest earned on the money in the Trust Fund.
3. Any interest earned on money in the Trust Fund, after deducting any applicable charges, must be credited to the Trust Fund. Money that remains in the Trust Fund at the end of a fiscal year does not revert to the State General Fund, and the balance in the Trust Fund must be carried forward to the next fiscal year.
4. Except as otherwise provided in subsection 5, the money in the Trust Fund must be used to carry out the provisions of this chapter. Such money must not be used to pay administrative costs that are not directly related to the operations of the Public Option.
5. If the State Treasurer determines that there is sufficient money in the Trust Fund to carry out the provisions of this chapter for the current fiscal year, the Director may use a portion determined by the State Treasurer of any additional money in the Trust Fund to increase the affordability of the Public Option.
(Added to NRS by [2021, 3621](#))

Excerpt: Nevada SB 482 (2019)

Sec. 45.

1. The Commissioner may apply to the Secretary of Health and Human Services pursuant to 42 U.S.C. § 18052 for a waiver for state innovation of applicable provisions of the Patient Protection and Affordable Care Act, Public Law 111-148, with respect to health insurance coverage in this State for a plan year beginning on or after January 1, 2020.
2. The Commissioner may implement a state plan that meets the waiver requirements in a manner consistent with state and federal law and as approved by the Secretary of Health and Human Services.

Excerpt: Nevada Revised Statute Chapter 679B.120

The Commissioner shall:

1. Organize and manage the Division, and direct and supervise all its activities;
2. Execute the duties imposed upon him or her by this Code;
3. Enforce the provisions of this Code;
4. Have the powers and authority expressly conferred upon him or her by or reasonably implied from the provisions of this Code”

Excerpt: Nevada Revised Statute Chapter 679B.400

1. The Legislature finds and declares that:
 - (a) Stabilizing the cost of insurance is of vital concern to the residents of this state; and
 - (b) It is necessary to establish a comprehensive system to collect, analyze and distribute information concerning the cost of insurance in order to stabilize that cost effectively.
2. The purposes of NRS 679B.400 to 679B.460, inclusive, are to:
 - (a) Promote the public welfare by studying the relationship of premiums and related income of insurers to costs and expenses of insurers;
 - (b) Develop measures to stabilize prices for insurance while continuing to provide insurance of high quality to the residents of this state;
 - (c) Permit and encourage competition between insurers on a sound financial basis to the fullest extent possible;
 - (d) Establish a mechanism to ensure the provision of adequate insurance at reasonable rates to the residents of this state; and
 - (e) Protect the rights of customers of insurance in this state.

Appendix C: Public Comment and Tribal Consultation Materials



Medicaid Seeks Public Comment for New State Innovation Waiver

Carson City, NV November 20, 2023

The Nevada Division of Health Care Financing and Policy (Nevada Medicaid) today announced the beginning of a 30-day public comment period for a State Section 1332 State Innovation Waiver application. The public comment period is open from November 20 through December 20, 2023. Stakeholders, the public, patients, insurers, and providers are encouraged to provide feedback. This is the first formal step in submitting a proposal to the Centers for Medicare and Medicaid Services for the implementation of new state health insurance options as required by [Nevada Revised Statutes 695K](#).

As part of the waiver application, Nevada Governor Joe Lombardo is proposing to establish a new Market Stabilization Program to help mitigate the potential risks posed to the state’s health care system by the implementation of the new health insurance options.

The proposal includes seeking federal approval for implementing:

- A state-based reinsurance program at no cost to the state.
- An annual bonus payment program to reward health insurance carriers that make strides in improving health outcomes and quality of care.
- A loan repayment program designed to support health care providers who commit to living and practicing in Nevada for at least four years.

“The new initiatives outlined in this waiver application aim to improve access to health care for Nevadans, while strengthening the marketplace for those who purchase their own health insurance,” Nevada Medicaid Administrator Stacie Weeks said.

Public notices, meetings, public comment methods, 1332 Actuarial Analysis/Economic Analysis, and the draft of the 1332 State Waiver Application are available here: <https://dhcfp.nv.gov/MarketStabilization/>.

Contact

Ky Plaskon
Public Information Officer, Division of Health Care Financing and Policy
KyPlaskon@dhcfp.nv.gov

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Joe Lombardo
Governor

Richard Whitley, MS
Director



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Stacie Weeks,
JD MPH
Administrator

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如果希望获得本文件的翻译版本，请提交申请至 dhcftp@dhcftp.nv.gov; (702) 668-4200 o (775) 687-1900

REVISED NOTICE OF PUBLIC WORKSHOP

1332 Waiver Application Presentation and Public Comment ~~Workshop Meeting~~

Date of Publication: November 9, 2023

Date of Revision: **November 13, 2023**

Date and Time of Meeting: November 27, 2023, at 1:00 PM to 3:00 PM

Name of Organization: The State of Nevada, Department of Health and Human Services (DHHS), Division of Health Care Financing and Policy (DHCFP)

Place of Meeting: Division of Public and Behavioral Health (DPBH)
4150 Technology Way
Third Floor Conference Room #303
Carson City, Nevada 89706

Note: This Public Meeting will be held in person at the DPBH location listed above. Please use the teleconference/Microsoft Teams options provided below for the virtual option. If accommodations are requested, please advise using the information at the end of this agenda.

Note: If at any time during the meeting an individual who has been named on the agenda or has an item specifically regarding them included on the agenda is unable to participate because of technical or other difficulties, please email Michael Gorden at michael.gorden@dhcftp.nv.gov and note at what time the difficulty started so that matters pertaining specifically to their participation may be continued to a future agenda if needed or otherwise addressed.

General Public Comments (No action may be taken upon a matter raised under public comment period unless the matter itself has been specifically included on an agenda as an action item. To provide public comment telephonically, you may join the meeting by dialing (775) 321-6111 and when prompted to provide the Meeting ID, enter 816 527 440#. You may then press *5 to raise your hand during the public comment periods to provide your comment. Comments will be limited to three minutes per person. Persons making comment will be asked to begin by stating their name for the record and to spell their last name. Those who wish to provide a written comment may submit their comment via mail to 1100 E. William Street, Ste. 101, Carson City, Nevada 89701 or via email to documentcontrol@dhcftp.nv.gov 1332WaiverProgram@dhcftp.nv.gov). Written comments will be accepted between November 20, 2023, and December 20, 2023.

Please be cautious and do not click on links in the chat area of the meeting unless you have verified they are safe. If you ever have questions about a link in a document purporting to be from Nevada Medicaid, please do not hesitate to contact michael.gorden@dhcftp.nv.gov for verification.

Webinar: <https://tinyurl.com/PW112723>

Select "Join," enter your name and email and then select "Join."
The meeting should not require a password.

Audio Only: (775) 321-6111
Conference ID: 816 527 440#

PLEASE DO NOT PUT THIS NUMBER ON HOLD (*hang up and rejoin if you must take another call*)

YOU MAY BE UNMUTED BY THE HOST WHEN SEEKING PUBLIC COMMENT, PLEASE HANG UP AND REJOIN IF YOU ARE HAVING SIDE CONVERSATIONS DURING THE MEETING OR THOSE MAY BE HEARD BY OTHERS AND RECORDED

This meeting may be recorded to facilitate note-taking or other uses. By participating you consent to recording of your participation in this meeting.

Agenda

1. Presentation and public comment on the ~~State's Section 1332 Innovation Waiver Nevada Market Stability Program (previously known as Public Option)~~

- a. The purpose of this workshop is to bring awareness that Nevada ~~will~~ is seeking a State Innovation Waiver under Section 1332 of the Affordable Care Act (ACA) (also known as a Section 1332 Waiver) in accordance with State statutory requirements of Chapter 695K of the Nevada Revised Statutes (NRS). State law requires the Director of Health and Human Services to establish a Public Option program, in which the Director contracts with health carriers to offer new health insurance options in the State's health exchange, starting January 1, 2026. The state-contracted health plans (~~i.e., Nevada Qualified Health Plans — NQHPs~~) must meet certain premium reduction targets and pay providers at or above Medicare rates.

As part of this waiver request, the Governor is seeking ~~federal authority~~ to also establish and finance a new Market Stabilization Program (MSP). The key ~~goals~~provisions of this new program would ~~be to~~: (1) implement a reinsurance program to stabilize the individual health insurance market and mitigate ~~the any~~ financial risk of the new premium reduction targets on health carriers and their provider networks; (2) reward health carriers and their provider networks for efforts to improve health outcomes and quality; and (3) ~~ensure greater stability for health carriers in Nevada's individual health insurance market~~ increase the State's health care provider base with a "Practice in Nevada" incentive program.

Consistent with federal requirements, the Section 1332 Waiver program will provide coverage to at least as many Nevadans; be at least as affordable with comparable benefits that are at least as comprehensive as they otherwise would have been without the waiver under federal law – all without increasing the federal deficit.

Waiver application text and actuarial analysis will be posted on November 20, 2023, for public review and comment. All public comments are due by December 20, 2023. Please submit your public comments during this 30-day period to: 1332WaiverProgram@dhcfp.nv.gov.

The waiver text, notice of public comment and Tribal consultation, and public comments

received will be posted at the Division's Market Stabilization Program webpage located here: <https://dhcfp.nv.gov/marketstabilization/>.

- b. Public comment regarding subject matter.
2. Public comment regarding any other issue
3. Adjournment

NOTE: To use the long link to the meeting in the event there are issues with the URL shortener, please use the following complete link:

https://teams.microsoft.com/l/meetup-join/19%3ameeting_ZmM5ODBiOTAtZmFjMC00ZGIyLTllMwltMWVlMjQzMDUwZGY2%40thread.v2/0?context=%7b%22Tid%22%3a%22e4a340e6-b89e-4e68-8eaa-1544d2703980%22%2c%22Oid%22%3a%22cc4c7a00-e2be-4dda-a27b-3405a8271b9c%22%7d

Nevada Medicaid is unaware of any financial impact to other entities or local government due to this public hearing, other than as stated above.

PLEASE NOTE: Items may be taken out of order. Items may be pulled or removed from the agenda at any time. All public comment may be limited to three minutes.

The DHCFP is exempt from Chapter 233B according to NRS 233B.039 and is not required to comply with the Nevada Administrative Procedure Act in this process. This meeting is conducted by and with state agency staff which is not a public body for purposes of NRS 241 related to Nevada Open Meeting Law but every effort is made to be transparent in notice and information provided to encourage public awareness and participation.

This notice and agenda have been posted online at <http://dhcfp.nv.gov> and <http://notice.nv.gov>, as well as Carson City, Las Vegas, Elko, and Reno central offices for DHCFP. E-mail notice has been made to such individuals as have requested notice of meetings (to request notifications please contact michael.gorden@dhcfp.nv.gov , or at 1100 East William Street, Suite 101, Carson City, Nevada 89701.

DHCFP, 1100 E. William St., Suite 101, Carson City, Nevada 89701
DHCFP, 1010 Ruby Vista Drive, Suite 103, Elko, Nevada 89801
DHCFP, 1210 S. Valley View, Suite 104, Las Vegas, Nevada 89102
DHCFP, 745 W. Moana Lane, Suite 200, Reno, Nevada 89509

If you require a physical copy of supporting material for the public meeting, please contact michael.gorden@dhcfp.nv.gov , or at 1100 East William Street, Suite 101, Carson City, Nevada 89701. Supporting material will also be posted online as referenced above.

Note: We are pleased to make reasonable accommodations for members of the public with a disability and wish to participate. If accommodated arrangements are necessary, notify DHCFP as soon as possible in advance of the meeting, by e-mail at michael.gorden@dhcfp.nv.gov in writing, at 1100 East William Street, Suite 101, Carson City, Nevada 89701.

Joe Lombardo
Governor

Richard Whitley, MS
Director



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Stacie Weeks,
JD MPH
Administrator

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NOTICE OF PUBLIC WORKSHOP

1332 Waiver Application Presentation and Public Comment Meeting

Date of Publication: November 15, 2023

Date and Time of Meeting: December 5, 2023, at 1:00 PM to 3:00 PM

Name of Organization: The State of Nevada, Department of Health and Human Services (DHHS), Division of Health Care Financing and Policy (DHCFP)

Place of Meeting: Division of Health Care Financing and Policy (Las Vegas District Office)
1210 S. Valley Blvd, Suite #104
Las Vegas, Nevada 89102

Note: This Public Meeting will be held in person at the DPBH location listed above. Please use the teleconference/Microsoft Teams options provided below for the virtual option. If accommodations are requested, please advise using the information at the end of this agenda.

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Webinar: <https://tinyurl.com/PW12052023>

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 - a. The purpose of this workshop is to bring awareness that Nevada is seeking a State Innovation Waiver under Section 1332 of the Affordable Care Act (ACA) (also known as a Section 1332 Waiver) in accordance with State statutory requirements of Chapter 695K of the Nevada Revised Statutes (NRS). State law requires the Director of Health and Human Services to establish a Public Option program, in which the Director contracts with health carriers to offer new health insurance options in the State's health exchange, starting January 1, 2026. The state-contracted health plans must meet certain premium reduction targets and pay providers at or above Medicare rates.

As part of this waiver request, the Governor is seeking federal authority to also establish and finance a new Market Stabilization Program (MSP). The key provisions of this new program would: (1) implement a reinsurance program to stabilize the individual health insurance market and mitigate any financial risk of the new premium reduction targets on health carriers and their provider networks; (2) reward health carriers and their provider networks for efforts to improve health outcomes and quality; and (3) increase the State's health care provider base with a "Practice in Nevada" incentive program.

Consistent with federal requirements, the Section 1332 Waiver program will provide coverage to at least as many Nevadans; be at least as affordable with comparable benefits that are at least as comprehensive as they otherwise would have been without the waiver under federal law – all without increasing the federal deficit.

Waiver application text and actuarial analysis will be posted on November 20, 2023, for public review and comment. All public comments are due by December 20, 2023. Please submit your public comments during this 30-day period to: 1332WaiverProgram@dhcfp.nv.gov.

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https://teams.microsoft.com/l/meetup-join/19%3ameeting_M2VINzZhZWQtMDFIZC00MzdjLWFIYjYtZmFhZDNmYWlxYWFj%40thread.v2/0?context=%7b%22Tid%22%3a%22e4a340e6-b89e-4e68-8eaa-1544d2703980%22%2c%22Oid%22%3a%22cc4c7a00-e2be-4dda-a27b-3405a8271b9c%22%7d

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Joe Lombardo
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Richard Whitley, MS
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DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF HEALTH CARE FINANCING AND POLICY

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Stacie Weeks, JD
MPH
Administrator

November 6, 2023

Inter-Tribal Council of Nevada
Serrell Smokey, ITCN President
Tribal Chairman of Washoe Tribe
919 Highway 395 South
Gardnerville, Nevada 89410

Dear Tribal Members:

In accordance with established consultation guidelines, the Division of Health Care Financing and Policy (DHCFP) is notifying Nevada tribes of the following:

The 2021 Legislature signed into law the "Public Option" through Senate Bill 420. This bill requires the Nevada Department of Health and Human Services (Department) to contract with health carriers to offer a public health insurance option no later than January 1, 2026. This reform aligns with the state's efforts to control the growth of health care costs, while improving access to coverage for Nevadans. The state-contracted health plans (i.e., Nevada Qualified Health Plans (NQHPs)) will be available for purchase through Nevada Health Link marketplace, starting January 1, 2026. These plans must meet certain premium reduction targets and pay their providers at or more than Medicare rates.

To implement this new option, the Department must seek the state's first-ever Section 1332 Waiver of the Affordable Care Act in coordination with the Nevada Department of Insurance and Nevada Health Link. This letter is intended to provide formal notice of this waiver and the opportunity for tribes to provide feedback and comment prior to the state's submission on January 1, 2024.

As part of this waiver request, the Governor is seeking to establish a new Market Stabilization Program to mitigate some of the concerns raised by stakeholders about the risk of cost shifting onto providers as a result of the premium reduction targets. This program includes a new reinsurance program to help control high costs in the individual, nongroup market, along with a quality bonus payment for high performing plans and a loan repayment program for providers willing to live and work in the state of Nevada for at least four years.

The draft application for the waiver will be posted online on the Division of Health Care Financing and Policy (DHCFP) website for a 30-day public comment period on November 15, 2023. To receive federal approval of this new waiver, the new option or program must satisfy four federal requirements. These include:

- Health coverage will be as affordable as without the waiver;
- Coverage under the waiver will be available to at least as many people as would be expected to be covered without the waiver;
- Coverage under the waiver will be as comprehensive as it would have been without the waiver; and
- The waiver is deficit neutrality for the federal government.

The Department looks forward to hearing from Tribal Leaders about any questions and/or feedback they may have. We would like to offer the following meeting times during this period for DHCFP to present to Tribal Leaders:

Wednesday, November 29, 2023 at 9am (calendar invite to follow)

Thursday, December 7, 2023 at 1:30pm (calendar invite to follow)

DHCFP will enter into a 30-day public comment period upon completion of the Nevada Plan for Market Stability Waiver within the next two weeks and looks forward to meeting with Tribal Leaders during this period of time to present and take back any feedback.

There is no anticipated fiscal impact to Tribal Governments.

Please look for calendar invites from Monica Schiffer to discuss the Nevada Plan for Market Stability. If you would like a consultation regarding this proposed change in policy, please contact Monica at (775) 684-3653 or mschiffer@dhefp.nv.gov who will schedule a meeting. We would appreciate a reply within 30 days from the date of this letter. If we do not hear from you within this time, we will consider this an indication that no individual consultation is requested.

Sincerely,

Casey Angres

Casey Angres (Nov 6, 2023 08:48 PST)

Casey Angres
Division Compliance Chief, DHCFP

cc: Sandie Ruybalid, CPM, Deputy Administrator, DHCFP
Malinda Southard, D.C., CPM, Deputy Administrator, DHCFP
Michael Gorden, Waiver & Stakeholder Director, DHCFP
Monica Schiffer, Tribal & Community Liaison, DHCFP

Joe Lombardo
Governor



Richard Whitley
Director

Nevada Battle Born State Plans and Market Stabilization Program Tribal Consultation

Division of Health Care Financing and Policy

November 29 and December 7, 2023



Department of Health and Human Services

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Purpose and Agenda

In its effort to implement State law, the Division is soliciting feedback and comments from Nevada Tribal communities on the State's 1332 waiver application.

Agenda

- Waiver Overview: Battle Born State Plans & Nevada Market Stabilization Program
- Impact to Tribal Communities
- Questions & Public Comment



Overview: Battle Born State Plans

- State law requires the Nevada Director of Health and Human Services to contract with health carriers to offer new health insurance options – referred to in the waiver as Battle Born State Plans (BBSPs).
- These new options must be available to consumers who shop for health insurance in the State’s health exchange (Nevada Health Link), starting January 1, 2026.
- These new options will, for the most part, mirror other plans in the Nevada Health Link except that they must meet an annual premium reduction target and pay their provider networks rates that at or better than Medicare.

1. See Nevada Revised Statutes (NRS) Chap. 695K.



Overview: Market Stabilization Program

- The second key initiative is a Market Stabilization Program.
- The waiver proposes to use federal savings from the BBSPs to finance this program.
- The key goals of the program are to:
 - **Mitigate the potential risk** of the new premium reduction targets on health carriers and their provider networks;
 - Reward health carriers and their provider networks if they **improve health outcomes and quality of care**; and
 - **Ensure market stability** in Nevada's individual health insurance market with the introduction of the new health insurance options and reforms.



Overview: Market Stabilization Program (cont.)

To achieve these goals, the Governor has outlined three new initiatives:

- 1. A state-based reinsurance program** at no cost to the state that is aimed at alleviating any unexpected financial risk to participating carriers and their provider networks with the introduction of the BBSPs;
- 2. A quality incentive payment program** to reward high-performing health carriers and their provider networks; and
- 3. A “Practice in Nevada” program** to provide incentive more providers to live and practice in Nevada, especially in rural regions of the State.

These programs, if approved, would begin in Plan Year 2027 after the State receives its first year of federal savings under the waiver from Plan Year 2026.



BBSP Statutory Requirements

State law requires the Director to contract with health carriers to offer the new Battle Born State Plans and use the Director's **Medicaid contracting authority** to enforce certain state requirements.

Participating carriers must:

- Offer these new plans through the Nevada Health Link and **meet all federal and state standards for qualified health plans** under the Affordable Care Act.
- Offer at least **one Silver and one Gold** Battle Born State Plan.
- Offer plans that will **meet certain premium reduction targets** which will increase gradually to at least 15% percent over the first four years.
- Pay **providers rates that are no lower than Medicare rates.**



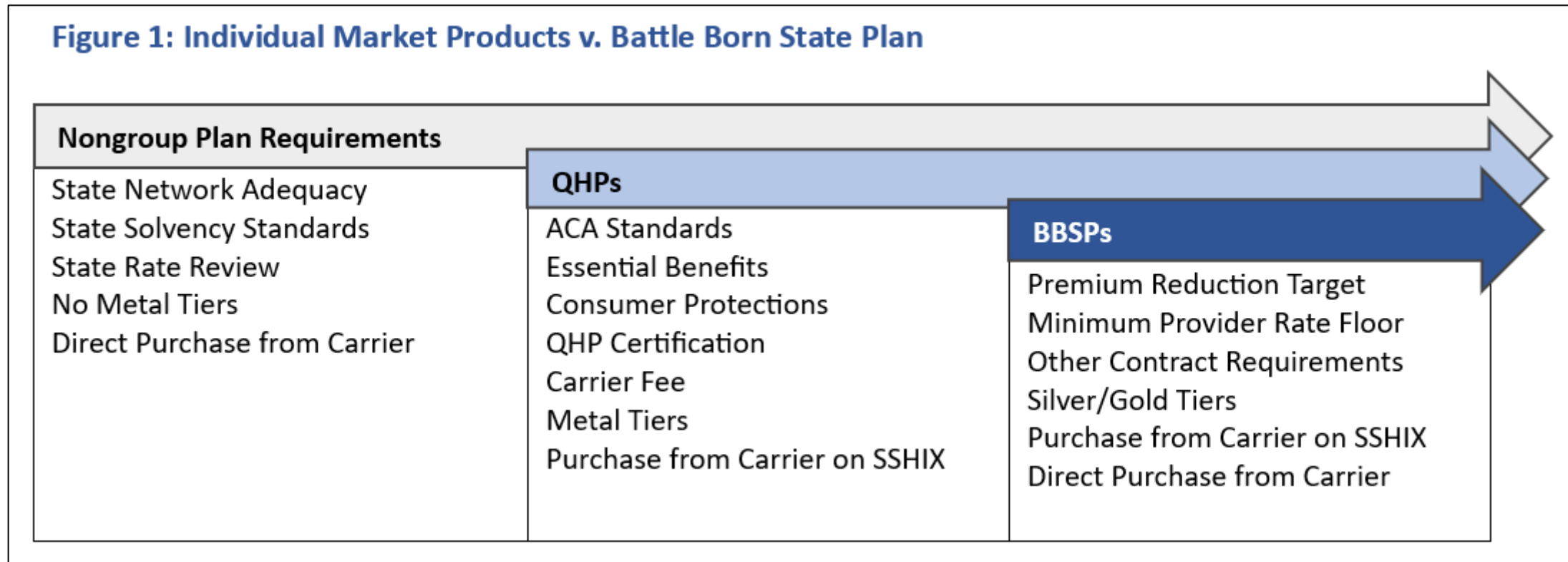
New State Procurement Process

- Under State law, the Director must implement a **new procurement process** to establish the new contracts with health carriers, creating a State-private model for operating the new health plans.
- This procurement must take place at the same time as the State's next **Medicaid managed care procurement** (slated for January 1, 2025 or earlier).
- Any health carriers seeking to participate in the State's Medicaid managed care program must submit a **good faith bid** to also contract with the State to offer and administer the new Battle Born State Plans.
- The Division will use the new **contract as its tool to enforce** the statutory requirements for the Battle Born State Plans, including the premium reduction target.
- Currently, the Division contracts with four health carriers for its Medicaid managed care program (Anthem, Health Plan of Nevada, Silver Summit, Molina).



BBSP Design

- The Battle Born State Plans will need to comply with existing nongroup and qualified health plan rules, as well as an **additional layer** of new requirements set forth in a contract with the State.





Other New BBSP Requirements

- A provider under contract with the State as a network provider in other state-contracted health insurance programs must participate **as an in-network provider in at least one network** with one carriers offering the BBSPs.
- These providers must also apply policies to **accept new patients** enrolled in BBSPs to the same extent as the provider accepts new patients enrolled in other private health insurance plans
- State law requires the Director to **promote in its contracting process** strategies with health carriers that will:
 - Better align networks between Medicaid and the individual market
 - Address health disparities in the individual market
 - Improve cultural competency in the provider workforce
 - Increase the use of value-based payment models with providers
 - Address the gaps in Nevada's health care workforce



1332 Waiver & Actuarial Study

- The 1332 Waiver is expected to lower premiums and generate savings for the federal government due to lower premium tax credits.
- Nevada can bring home these savings to fund other State-based programs that strengthen the health insurance market and access to care.
- The 1332 Waiver is expected to achieve an estimated **\$279 million in federal savings** in the first five years, and **\$760 million** at the end of the first ten years.
- The new reinsurance program is anticipated to relieve pressure on health carriers and their provider networks by nearly half once it's up and running.

The Process

1. Actuarial study & waiver development
2. Post for state public comment period
3. Public workshops / hearings and Tribal consultation
4. Federal submission
5. Completeness review
6. Federal public comment period
7. Negotiations/ Federal Decision



Impact to Tribal Communities



Impact to Tribal Communities

- Mandated premium reductions will reduce premiums for consumers purchasing Battle Born State Plans, which includes consumers who are **American Indian/Alaskan Natives (AI/AN)**.
 - According to the 2023 Open Enrollment Public Use File, there were **516 AI/AN members** enrolled in coverage through the Nevada Health Link in 2023.¹
- The Battle Born State Plan program **does not impact existing protections** available to American Indian/Alaskan Natives through the Nevada Health Link:
 - American Indian/Alaskan Natives who earn less than 300% of the Federal Poverty Level (FPL) remain exempt from cost sharing and qualify for premium tax credits.
 - The Modified Adjusted Gross Income calculation for American Indian/Alaskan Natives will continue to exclude some revenue earned on reservations from Federal Trust payments.
 - American Indian/Alaskan Natives may still change QHPs once a month, without worrying about enrollment dates.²



Impact to Tribal Communities (cont.)

- The Battle Born State Plan will not impact existing financial assistance provided under the Division of Health Care Financing and Policy (Medicaid) in which American Indian/Alaskan Natives eligible for Medicaid do not pay premiums and do not have any other cost sharing.
- The BBSPs will not impact health care services provided through IHS, Tribal or urban Indian health programs.
- The BBSPs do require more robust and aligned networks with Medicaid, including essential community providers.
- As a reminder, Qualified Health Plans, which will include BBSPs, must include at least 35% of available essential community providers in each plan's service area in the provider network, and must offer contracts in "good faith" to all Indian Health Service providers.
- Participating health carriers are also required to pay tribal providers participating in BBSP networks no lower than what they pay in Medicare.



Public Comment



Questions & Comments

The Division will now collect questions and comments from the tribal representatives regarding the waiver application and new Battle Born State Plans.

*Any questions will be answered in writing in the next two weeks. The Division will be accepting written public comment on the State's 1332 waiver application **until December 20, 2023**. The 1332 waiver application will be submitted to the federal government **by January 1, 2024**.*

Waiver Materials can be found online at:

[Nevada Market Stabilization Program \(nv.gov\)](https://www.nv.gov)



Contact Information

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Monica Schiffer - DHCFP Tribal Liaison, Division of Health Care Financing and Policy; mschiffer@dhcfp.nv.gov



Acronyms

ACA – Affordable Care Act

AI/AN – American Indian/Alaskan Natives

BBSP – Battle Born State Plan

DHCFP – Division of Health Care Financing and Policy (NV Medicaid Program)

MSP – Market Stabilization Program

QHP – Qualified Health Plan

Joe Lombardo
Governor



Richard Whitley
Director

Nevada Battle Born State Plans and Market Stabilization Program Public Hearing

Division of Health Care Financing and Policy

November 27, 2023, and December 5, 2023



Department of Health and Human Services

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



Purpose and Agenda

The Division is hosting two public meetings to engage stakeholders on the State's 1332 Waiver application, which must be submitted for federal approval no later January 1, 2024, per state law.

This waiver seeks federal approval for the State to receive the federal savings from its implementation of new state-contracted health insurance options and a reinsurance program to establish and finance a Market Stabilization Program.

Agenda

- Waiver Overview: Battle Born State Plans & Market Stabilization Program
- Questions & Public Comment
- Next Steps



Overview: Battle Born State Plans

- State law requires the Nevada Director of Health and Human Services to contract with health carriers to offer new health insurance options – referred to in the waiver as Battle Born State Plans (BBSPs).
- These new options must be available to consumers who shop for health insurance in the State’s health exchange (Nevada Health Link), starting January 1, 2026.
- These new options will, for the most part, mirror other plans in the Nevada Health Link except that they must meet an annual premium reduction target and pay their provider networks rates that at or better than Medicare.

1. See Nevada Revised Statutes (NRS) Chap. 695K.



Overview: Market Stabilization Program

- The second key initiative is a Market Stabilization Program.
- The waiver proposes to use federal savings from the BBSPs to finance this program.
- The key goals of the program are to:
 - **Mitigate the potential risk** of the new premium reduction targets on health carriers and their provider networks;
 - Reward health carriers and their provider networks if they **improve health outcomes and quality of care**; and
 - **Ensure market stability** in Nevada's individual health insurance market with the introduction of the new health insurance options and reforms.



Overview: Market Stabilization Program (cont.)

To achieve these goals, the Governor has outlined three new initiatives:

- 1. A state-based reinsurance program** at no cost to the state that is aimed at alleviating any unexpected financial risk to participating carriers and their provider networks with the introduction of the BBSPs;
- 2. A quality incentive payment program** to reward high-performing health carriers and their provider networks; and
- 3. A “Practice in Nevada” program** to provide incentive more providers to live and practice in Nevada, especially in rural regions of the State.

These programs, if approved, would begin in Plan Year 2027 after the State receives its first year of federal savings under the waiver from Plan Year 2026.



BBSP Statutory Requirements

State law requires the Director to contract with health carriers to offer the new Battle Born State Plans and use the Director's **Medicaid contracting authority** to enforce certain state requirements.

Participating carriers must:

- Offer these new plans through the Nevada Health Link and **meet all federal and state standards for qualified health plans** under the Affordable Care Act.
- Offer at least **one Silver and one Gold** Battle Born State Plan.
- Offer plans that will **meet certain premium reduction targets** which will increase gradually to at least 15% percent over the first four years.
- Pay **providers rates that are no lower than Medicare rates.**



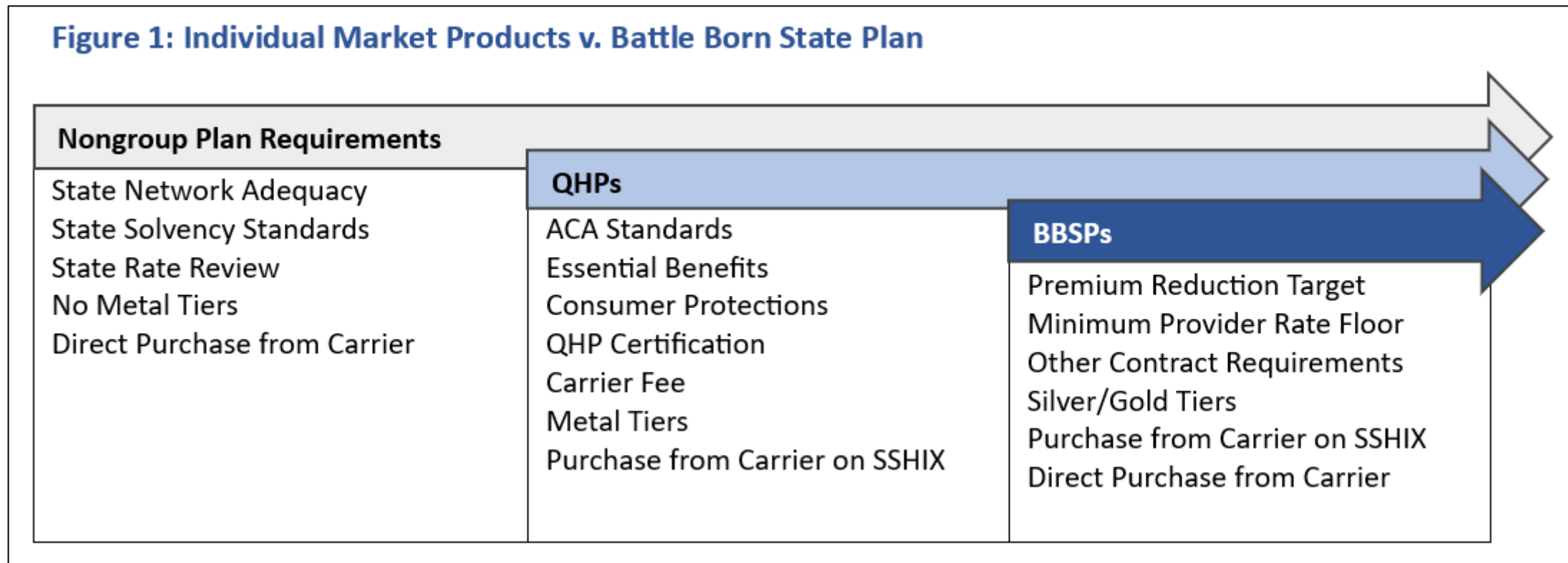
New State Procurement Process

- Under State law, the Director must implement a **new procurement process** to establish the new contracts with health carriers, creating a State-private model for operating the new health plans.
- This procurement must take place at the same time as the State's next **Medicaid managed care procurement** (slated for January 1, 2025 or earlier).
- Any health carriers seeking to participate in the State's Medicaid managed care program must submit a **good faith bid** to also contract with the State to offer and administer the new Battle Born State Plans.
- The Division will use the new **contract as its tool to enforce** the statutory requirements for the Battle Born State Plans, including the premium reduction target.
- Currently, the Division contracts with four health carriers for its Medicaid managed care program (Anthem, Health Plan of Nevada, Silver Summit, Molina).



BBSP Design

- The Battle Born State Plans will need to comply with existing nongroup and qualified health plan rules, as well as an **additional layer** of new requirements set forth in a contract with the State.





Other New BBSP Requirements

- A provider under contract with the State as a network provider in other state-contracted health insurance programs must participate **as an in-network provider in at least one network** with one carriers offering the BBSPs.
- These providers must also apply policies to **accept new patients** enrolled in BBSPs to the same extent as the provider accepts new patients enrolled in other private health insurance plans
- State law requires the Director to **promote in its contracting process** strategies with health carriers that will:
 - Better align networks between Medicaid and the individual market
 - Address health disparities in the individual market
 - Improve cultural competency in the provider workforce
 - Increase the use of value-based payment models with providers
 - Address the gaps in Nevada's health care workforce



1332 Waiver & Actuarial Study

- The 1332 Waiver is expected to lower premiums and generate savings for the federal government due to lower premium tax credits.
- Nevada can bring home these savings to fund other State-based programs that strengthen the health insurance market and access to care.
- The 1332 Waiver is expected to achieve an estimated **\$279 million in federal savings** in the first five years, and **\$760 million** at the end of the first ten years.
- The new reinsurance program is anticipated to relieve pressure on health carriers and their provider networks by nearly half once it's up and running.

The Process

1. Actuarial study & waiver development
2. Post for state public comment period
3. Public workshops / hearings and Tribal consultation
4. Federal submission
5. Completeness review
6. Federal public comment period
7. Negotiations/ Federal Decision



Public Comment



Next Steps



- Public comments will be accepted through December 20, 2023.
- The 1332 waiver application will be submitted to the federal government by January 1, 2024.



Contact Information

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Acronyms

ACA – Affordable Care Act

BBSP – Battle Born State Plan

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MSP – Market Stabilization Program

The Nevada Coverage and Market Stabilization Program Section 1332 Waiver

State Responses to Public Comments

The Nevada Department of Health and Human Services (DHHS) held a public comment period on its draft waiver application beginning on November 20, 2023 and ending on December 20, 2023. During this comment period, two public hearings were held in person and via webinar on November 27 and December 5 and two tribal consultations were held in person and via webinar on November 29 and December 7. The State received a total of 52 comments from consumer advocates, hospitals and providers, carriers, and other stakeholders. The State received 32 comments in strong support of the waiver while multiple comments included concerns that are addressed below. The below represents a summary of comments Nevada received through the public hearings and written comments and the State's responses to those comments. All written comments submitted are available on the Nevada Coverage and Stabilization Program [landing page](#).

1. **Public Comment:** The State received more than 30 comments in support of the Nevada Coverage and Market Stabilization Program under the Section 1332 waiver. Commenters expressed support for provisions of the waiver that could help lower the costs of health care coverage, invest in provider workforce development, and seek value-based payment reforms. Supporters also pointed to the promise of the Public Option (i.e., Battle Born State Plans, or BBSPs) in providing consumers enhanced job mobility, guarding against medical debt, and narrowing health disparities.
 - a. **State Response:** DHHS appreciates commenters' support for the waiver application and the shared goals to expand access to affordable coverage, improve quality, and invest in health practitioners in the State. DHHS also appreciates commenters' urging to improve health coverage affordability in the individual insurance market.
2. **Public Comment:** Several commenters underscored the importance of improving affordability in the individual market. A few commenters urged the State to use pass-through funding for a premium subsidy rather than a state-based reinsurance program, while another commenter expressed opposition to using taxpayer funds (e.g., federal pass-through funding) to subsidize carriers in meeting their required premium reductions.
 - a. **State Response:** DHHS has undertaken careful consideration of this policy design, and earlier drafts of the actuarial report modeled for a state-based premium subsidy using federal pass-through funds. The nature of the deficit neutrality guardrail for Section 1332 waivers limits the impact of any premium subsidies to substantially improve health coverage affordability. The State would receive reduced pass-through funds if it were to implement a state-based premium subsidy, as new enrollment would increase federal spending and that increased federal spending would reduce available pass-through funding. In other words, states are unable to make premium subsidies (or similarly cost-sharing subsidies) "too attractive" since doing so erodes the pass-through funding. The State has determined that investing in reinsurance, quality incentive payments, and the provider workforce are effective tools to ensure a healthy and stable individual marketplace that improves long-term affordability of care for Nevadans, while still maintaining the pass-through funding needed to maintain the program.
3. **Public Comment:** One commenter expressed concern that the Nevada Division of Insurance (DOI) would administer the BBSP, referencing existing auto insurance policies that have increased car insurance premiums in the State.
 - a. **State Response:** DHHS will be responsible for administering the BBSPs, not DOI. DHHS will oversee the procurement and contracting process and will provide ongoing monitoring of compliance of requirements established in the contract between the State and BBSP carriers. While the DOI will not administer the BBSPs, it will continue to lead the rate review process, license the carriers, and

oversee plan solvency for plans offered in the individual health insurance market, which includes BBSPs, like all other nongroup products.

4. Public Comment: One commenter suggested the State create funding benchmarks to ensure sufficient funds are available to invest in the Quality Incentive Payment Program and the Practice in Nevada Program.
 - a. State Response: The State agrees that investments in quality improvement and the provider workforce are vitally important in Nevada. Based on the actuarial analysis by Milliman, it is anticipated that starting in Year 2 of the program, as a result of the entry of the BBSPs into the market, the federal savings generated each year would cover the cost of financing a reinsurance program across the individual market while garnering millions of dollars in additional remaining funds each year for the Quality Incentive Payment Program and Practice in Nevada Program.
5. Public Comment: A few commenters expressed concern that the premium reduction requirements will result in a cost shift from carriers to providers through reduced reimbursement rates. Commenters stated the cost shift could incentivize providers to leave the State or reduce the scope of services provided, exacerbating provider shortage challenges. Other commenters expressed concern that providers would recoup their reduced reimbursement by seeking higher reimbursement rates from other health care purchasers, putting upward pressure on premiums across payers.
 - a. State Response: The BBSPs' provider reimbursement rates will likely have a minimal impact on provider behavior due to the fact that the BBSP is being targeted at the individual market in Nevada, representing a very small proportion of a provider's revenue. In December 2022 the actuarial firm Milliman conducted an assessment (see [Appendix D](#) in 2022 waiver draft) to determine the impact of the BBSPs on providers and concluded that the law's provider participation requirement would likely have little effect on provider participation in BBSP offerings and providers would be likely to contract with the BBSP at the required rates to achieve premium targets. Additionally, the state-based reinsurance program to be implemented under the Section 1332 waiver is anticipated to help subsidize the reduction in premiums under the new BBSPs, which will count towards achieving the required premium reduction targets. The State projects that starting in Year 2, the reinsurance program will account for roughly half of required premium reductions. Furthermore, the State plans to require carriers to meet an administrative cost constraint that is stricter than prevailing individual market Qualified Health Plan (QHP) administrative expense loads to ensure carriers and providers share the weight of achieving premium savings, equally. In other words, BBSP carriers cannot cost shift all of the savings needed to achieve the premium reduction target onto their providers, or they risk a breach of contract and associated penalties.
6. Public Comment: Commenters expressed concern that the law's provider reimbursement design using Medicare rates as a floor (or establishing rates for services not covered in Medicare) does not adequately compensate providers and could in practice become a reimbursement ceiling. One commenter urged the State to permit physicians to negotiate rates not covered within Medicare.
 - a. State Response: The Medicare rates, and comparable rates identified by DHHS for services not covered by Medicare, will serve only as a floor for reimbursement. Providers and BBSPs are expected to negotiate rates for participation, just as they do today for private health insurance. Depending on the provider and BBSP negotiations, provider rates may be higher than Medicare in some instances. The reference to Medicare rates (and comparable rates for non-Medicare services) is intended to protect providers from receiving rates below Medicare. Providers who feel like rates, in the aggregate, are not at least as high as Medicare rates can appeal for DHHS review. If a carrier is deemed out of compliance, they will face certain penalties under their contract and be required to correct the improper reimbursement scheme.

7. Public Comment: One commenter noted that the waiver application’s actuarial analysis does not adequately explore the impact of provider reimbursement rate reductions on provider participation in the BBSPs, which the commenter stated could result in BBSPs having fewer participating providers and in turn the perception of BBSPs as a lower quality insurance product.
 - a. State Response: BBSP provider networks will be robust due to several factors. First, there is a requirement for providers who participate in Medicaid, the Public Employees’ Benefit Plan, or the workers’ compensation program to also be in-network with at least one BBSP. Second, the State has existing network adequacy requirements for QHPs. Also, BBSPs’ provider reimbursement rates will most likely have a marginal impact on provider behavior because the BBSP is being targeted at the individual market in Nevada, representing a small proportion of a provider’s revenue. Further, while the State is implementing a reimbursement floor for provider payments under the BBSPs tied to Medicare rates, it anticipates providers and health carriers offering BBSPs to continue to negotiate their rates for all services as they do today.
8. Public Comment: A few commenters urged the State to encourage carriers offering BBSPs to reimburse providers at rates above Medicare, including by developing incentive payments for instituting commercial reimbursement rates or by conditioning participating in value-based payment arrangements on carriers reimbursing providers at commercial rates.
 - a. State Response: The State appreciates commenters’ feedback and intends to solicit additional input in a future RFI on how it can reward plans for quality and other state priorities. This could include offering rates that are above Medicare rates in the BBSPs, among other design considerations.
9. Public Comment: A few commenters expressed concern with the requirement that providers who participate in the Public Employees’ Benefits Program, Medicaid, or the State’s workers’ compensation program must agree to participate in at least one provider network for a BBSP, stating that this requirement could disrupt providers’ payer mix and drive providers out of the market, in turn reducing the number of participating providers in the Medicaid program.
 - a. State Response: A Milliman analysis conducted in December 2022 (see [Appendix D](#) in 2022 waiver draft) found that the BBSPs’ provider participation requirements will likely have a marginal impact on provider revenue and participation given the small proportion of revenue impacted. Additionally, under current law DHHS retains authority to waive the BBSP provider participation requirements when necessary to ensure that those who receive coverage under Medicaid and the Public Employees’ Benefits Program have sufficient access to covered services. DHHS is considering establishing a process for offering a waiver for those providers who can show that the BBSP will have a substantial negative impact on their provider revenues based on their patient mix.
10. Public Comment: A few commenters highlighted strong support for the Practice in Nevada Program. Commenters requested additional information about eligibility for the program, urged the State to consider expanding eligibility for the Practice in Nevada program to all providers statewide, and requested the State prioritize pass-through funding for the Practice in Nevada program.
 - a. State Response: The State appreciates commenters’ feedback and will work with stakeholders and policymakers to finalize the details of program design – including Practice in Nevada Program eligibility – throughout 2024. At a minimum, the State will require providers to commit to living and practicing in the State for at least four consecutive years and making such commitment through a contract with the State which will require providers to return the funds if such commitment is not met.
11. Public Comment: One commenter suggested DHHS limit who can enroll in the BBSPs to minimize disruption to the commercial insurance market.

- a. State Response: The State does not have authority to limit who can enroll in the BBSPs. The BBSPs must be available as QHPs as required by Nevada Revised Statute 695K. The Affordable Care Act (ACA) requires guaranteed issue for all QHPs, meaning insurance companies are required to issue a health plan to any applicant regardless of health status or other factors. This federal requirement is one of the few that cannot be waived under a Section 1332 waiver. Moreover, it is very unlikely that BBSPs will disrupt the commercial insurance market. Few consumers currently enrolled in the commercial market would have a financial incentive to leave their current coverage and enroll in a BBSP. Any consumer with an offer of affordable minimum essential coverage (MEC) from their employer does not qualify for an advance premium tax credit (APTC) for purchase of a plan within the Nevada Health Link, including a BBSP. In addition, the ACA's employer shared responsibility provision, which requires large employers to offer affordable coverage or pay a fee, keeps large employers engaged in offering health benefits and means that most consumers employed by large businesses do currently have an offer of affordable MEC and therefore will likely not be driven to enroll in the BBSP. Note that this same argument was made with the implementation of the new federal premium tax credits and exchanges after the Affordable Care Act passed and no major disruption occurred to the commercial insurance market at that time.
12. Public Comment: A few commenters expressed concern that insurers will be unable to meet the BBSP premium reduction requirements, noting there is little room to make administrative or in many cases provider cuts, particularly with the providers serving rural regions of the state.
 - a. State Response: If the waiver is approved, the State would subsidize a portion of carriers' premium reductions through the state-based reinsurance program, which is anticipated to reduce premiums and help insurers achieve the required premium reductions. The State estimates that the reinsurance program in 2027 can help to offset the burden of premium reductions on carriers and their provider networks by subsidizing the reduction in rates by about half. The State is also exploring how it will calibrate the trend factor to consider multiple factors influencing premiums and costs in Nevada's market.
13. Public Comment: A few commenters expressed concern with the State's proposal to implement an administrative cost constraint that is stricter than the prevailing QHP administrative expense load in the Medical Loss Ratio (MLR), stating carriers will struggle to reduce administrative expenses and that this could undermine services benefiting consumers.
 - a. State Response: This policy is intended to mitigate the risk of carriers cost-shifting the entire burden of meeting an annual premium reduction target onto their provider networks. Further, the State is already subsidizing a portion of carriers' premium reductions through the State's reinsurance program, which is anticipated to reduce premiums and will count towards the required premium reductions. The State estimates that the reinsurance program in 2027 can help to offset the burden of premium reductions on carriers and their provider networks by subsidizing the reduction in rates by about half.
14. Public Comment: A few commenters urged for transparency in how the State calculates pass-through funding and determines available funds for the reinsurance program. Commenters also expressed concern with the tiered structure of the reinsurance program in which reinsurance will have a lesser impact on reducing premiums in Rating Areas 1 and 2.
 - a. State Response: The Centers for Medicare and Medicaid Services (CMS) and the Department of the Treasury are responsible for calculating the amount of pass-through funding. The federal government then communicates federal pass-through funding amounts to the state prior to the payment of the pass-through funding. While the State acknowledges carriers' concerns with the tiered reinsurance design, it is supportive of this design in order to address longstanding affordability disparities by geographic region in the State. In implementing a geographic tiered

structure, DHHS can reduce premiums more in the highest-cost, more rural geographic areas (i.e., Rating Areas 3 and 4). However, DHHS is open to modeling other scenarios for reinsurance if such models align with goals of improving access to lower premiums for more consumers, statewide.

15. **Public Comment:** One commenter expressed concern that the State is relying on federal pass-through funds rather than a pre-determined set of funding to finance the State's reinsurance program.
 - a. **State Response:** The State does not anticipate seeking additional funding for this program if not obtained through the waiver in the form of federal pass-through funding. Further, the waiver application's actuarial report projects that starting in Year 2, there will be sufficient funding from federal pass-through funds to finance the first year of the reinsurance program. Based on the actuarial analysis by Milliman, it is anticipated that starting in Year 2 of the program, the entry of the BBSPs into the market will generate enough federal savings each year to cover the cost of financing a reinsurance program across the individual market, while garnering millions of dollars in additional remaining funds each year for the Quality Incentive Payment Program and Practice in Nevada Program. Depending on the amount of federal pass-through funds received each year, the State retains the authority to adjust the attachment point and limits on the reinsurance program to ensure the funds available cover the cost of the program.
16. **Public Comment:** A few commenters expressed concern with conditioning eligibility to offer a bid in the Medicaid Managed Care Program on submitting a good faith bid to offer a BBSP, stating that this could result in less competition in the bid process since plans may not have the ability to propose a BBSP which will not enter the Exchange market until 2026. Commenters are also concerned that tying the BBSPs to the Managed Care program could risk destabilizing the Medicaid program as a whole if carriers cannot meet BBSP requirements.
 - a. **State Response:** Nevada's Medicaid Managed Care procurement is competitive, with seven carriers submitting bids to participate in the program during the last procurement in 2021. Further, carriers in Nevada offering Managed Care Plans already participate in the individual insurance market due to an existing contractual requirement that Managed Care Plans also offer an Exchange product. This requirement has not destabilized the Medicaid program. Additionally, the alignment of the BBSP procurement process with the Medicaid Managed Care procurement is intended to leverage the State's purchasing authority in the Medicaid program to ensure that good faith bids for BBSPs are provided and achieved. The State will evaluate bids for the Managed Care plans and BBSPs separately, and each procurement will result in separate contracts with DHHS – one for Medicaid managed care and one for the new BBSP program. If a carrier does not offer a good faith bid for the BBSP, they will be deemed ineligible to participate (through the procurement) in Medicaid Managed Care program.
17. **Public Comment:** A few commenters questioned if the State can effectively reduce costs and improve affordability with the implementation of the BBSPs given the challenges encountered by other states implementing premium reductions under their public option programs.
 - a. **State Response:** Unique to the Market Coverage and Stabilization Program in Nevada, DHHS will enforce statutory requirements for the BBSPs – including the premium reduction targets – by using the legal tools under its new contracts with carriers, similar to the ways in which the State's Medicaid program enforces its existing contracts with Managed Care Plan carriers. These tools include corrective action plans, financial penalties, and/or sanctions that can be imposed by the Director if carriers do not meet contractual obligations. In leveraging its robust contracting oversight authority, the State can more effectively ensure that carriers will meet the premium reduction targets and other requirements of state law for the BBSP program.

November 20, 2023

DHHS
400 West King Street, Suite 300
Carson City, Nevada 89703

RE: Nevada Draft Section 1332 State Innovation Waiver Application Public Notice

Thank you for the opportunity to provide comments on Nevada's section 1332 State Innovation Waiver application.

My name is Pauline Lavoie and me and my daughter have struggled for years to secure affordable insurance. A few years ago, I had to quit my job to find work that gave me the flexibility I needed for my daughter. I am fortunate to be able to work and still have time to take and pick my daughter up from school and her extracurricular activities, help her with homework, and have dinner together. Unfortunately, choosing this flexibility has meant giving up the health coverage available through my previous job. Since then, finding affordable and adequate coverage for her and myself has been challenging. Being a working mom is difficult enough, and I know a lot of moms in this exact situation.

Thankfully, Nevada passed the Public Option and not only will this provide affordable coverage - with the approval of this waiver Nevada can finally invest in the critical healthcare infrastructure like a provider pipeline and stabilization so that Nevada can finally address our decade long provider shortage.

I am particularly supportive of Public Option plans being offered because, unlike the junk plans that I so often see presented as an affordable option, these plans will be qualified health plans that cover basic necessities like preventative care.

And, Nevada's ability to leverage Medicaid insurance contracts means that families like mine will be able to actually see 15% reduction in premiums because we all know those insurance companies will do anything to keep those billion dollar contracts.

For the first time in a very long time, the Public Option and the millions of dollars we can get from this waiver will provide hope to families like mine that have, for so long, struggled with securing healthcare coverage and actually accessing healthcare.

Thank you for the opportunity to provide comments on the section 1332 waiver application in support of Nevada's Public Option.

Please approve this waiver and deliver hope to families like mine.

Sincerely,

Pauline Lavoie
Lunabears@yahoo.com

Support Letter for Nevada's Public Option
Cullen McGinnis

My name is Cullen McGinnis, and I have lived in Nevada my whole life and am from an immigrant family. I have watched my family struggle with high healthcare costs and I have experienced this myself as someone who has lived with asthma since I was a child. In 2018 my grandfather had heart surgery and afterwards he had to live in an assisted living facility. He did not recover from this surgery and he would go on to pass away in that center shortly afterwards. The cost for that surgery and his rehabilitation afterwards was a significant burden to my family and it added to the stress and suffering of my family during that time. A public option would have allowed my family to have access to affordable health insurance. I know that many Asian Pacific Islanders have experienced something similar, as many of us live in multigenerational homes and struggle with the high cost of caring for our aging family.

In my personal experience as someone living with asthma I have had to pay high prices for my inhaler that I need to function. Even with insurance my inhalers cost me hundreds of dollars. In the past this has led me to ration my medication or to even go without until I could afford it, often to the detriment of my health. 32% of API and Native Nevadans have reported rationing medication due to high cost as well, so we can see that high medication costs are a huge burden to our community.

I know that once I turn 26 the high cost of health insurance will become a huge burden to me, especially as someone with a pre existing condition. High costs in Nevada have led me to consider that my future may be brighter in other states where there is more public investment in healthcare and where costs are lower and outcomes are better. Many young Nevadans grapple with this reality as well, and it would be a shame for Nevada to lose talented people to states that have created a more competitive health insurance market.

76% of API and Native Nevadans reported that they worry about health insurance becoming unaffordable. High healthcare costs are becoming untenable for many in my community, and we should not have to go into debt to receive necessary medical attention or preventative care. By creating a public option and introducing a more competitive market, health insurance costs will go down for us.

I hope that the public option will be properly implemented so that healthcare costs can go down and I can continue to afford to live in this state that I have called home for my whole life.

As someone who struggles with chronic illness, I need access to medical care often that I can't afford without health insurance. High health insurance prices are a burden and barrier to accessing the care I need as a recent college graduate. I support the public option to create more reasonably priced health insurance plans so people like me can access the care they need.

Navigating Healthcare as Filipino American Immigrants

I am Lorenzita Santos, the daughter of Filipino immigrants, writing to shed light on the profound impact of healthcare costs on my family. My father, grappling with diabetes for most of his life, bore the weight of healthcare expenses, particularly during the 2008 recession when he juggled three jobs to cover groceries, our home, and insulin.

Affordability Struggles

Healthcare costs have always been a concern, affecting not only my family but also the broader Filipino community. Shockingly, the AAPI community, to which we belong, is twice as likely to be diagnosed with diabetes than other communities. Affordable healthcare is crucial for the well-being of hardworking immigrant families.

The Public Option: A Solution

In the midst of these challenges, the Public Option emerges as a vital step forward. By offering reasonably priced plans with sufficient coverage, it signifies a positive shift toward protecting families and immigrant communities like ours. Keeping insurance costs low becomes a lifeline for those navigating the complexities of healthcare affordability.

Urgent Need for Change

Nevada's high uninsured rate, particularly within the AAPI community, underscores the urgency for solutions like the Public Option. Over 340,000 Nevadans, including a significant AAPI population, grapple with being uninsured. The Public Option is more than a policy shift; it's a promise to safeguard the health and well-being of families like mine.

Sincerely,

Lorenzita Santos

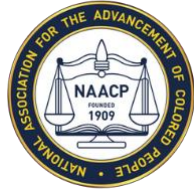
As the Community Engagement Director at One APIA Nevada, my commitment to advocating for a public health option in Nevada stems from the urgent need to enhance healthcare affordability and accessibility.

High healthcare costs have been a significant barrier, preventing Nevadans from seeking necessary medical care or obtaining comprehensive insurance coverage. I have encountered many cases where community members face financial strain due to exorbitant medical bills, forcing them to forgo essential treatments or preventive care.

A public health option is a critical step towards mitigating these challenges, as it promotes affordability by leveraging tax dollars to benefit Nevada consumers. The approval of the waiver and the consequent funding for healthcare workforce development are paramount. The scarcity of healthcare providers in Nevada not only limits access to care but also contributes to escalating costs. By investing in workforce development, we not only address the shortage of healthcare professionals but also pave the way for a more competitive healthcare landscape in Nevada.

We must take steps to make quality healthcare accessible, affordable, and equitable for all Nevadans.

Shelby Parkes
One APIA Nevada



NAACP

Las Vegas Branch

November 25, 2023

State of Nevada
Department of Health & Human Services
Mr. Richard Whitley, Director
400 W. King St., Suite 300
Carson City, Nev. 89703

Director Whitley,

The Las Vegas Branch of the NAACP stands in unwavering support for the implementation of Nevada's state-based health exchange. Implementing a public option will improve access to quality healthcare for all residents and play a crucial role in mitigating the health inequities faced by Black people and communities of color.

Communities of color, specifically Black people face higher rates of chronic illnesses, limited access to care, and poorer health outcomes compared to their white counterparts. A public option will provide affordable and comprehensive coverage, addressing financial constraints and systemic barriers that hinder access to quality healthcare.

Creating a state-based health exchange will reduce health disparities by ensuring that marginalized communities can access the care they need. By focusing on proactive measures like regular check-ups and screenings, we can identify health issues sooner and prevent them from escalating. **This approach improves health outcomes and reduces the financial burden on individuals and the state.**

States with public health exchanges experience significant cost savings. Studies from the Center for American Progress or the National Partnership for Women and Families have shown that states operating their own healthcare exchanges can save millions of dollars annually through administrative efficiencies and reduced costs associated with uncompensated care. These savings are essential in a state like Nevada that lack diverse income streams.

In conclusion, Nevada's public option healthcare system is a vital step towards achieving health equity and justice for all residents. It ensures affordable and comprehensive coverage, empowering Black people and communities of color to access the care they deserve. The cost savings associated with a public state health exchange benefit both the state's economy and the well-being of its residents. It's truly a win-win.

Sincerely yours,

A handwritten signature in black ink, appearing to read "Quentin-Michael Savvoir".

Quentin-Michael Savvoir
President, NAACP Las Vegas



Fax: (702) 369-1342
Phone: (702) 638-1300



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Las Vegas, NV 89130



www.naacplasvegas.org



December 5, 2023

Good afternoon.

I am Adam Zarrin (Z-A-R-R-I-N), the Director of State Government Affairs for the Leukemia & Lymphoma Society (LLS). Our mission is to cure blood cancers and improve the quality of life of patients and their families.

Last week, we shared how Americans nationwide feel trapped by medical debt. Others bravely shared their stories from across Nevada about their struggle to afford their medical bills.

This is not surprising when nearly 7 in 10 adults in the U.S. say they are concerned about affording healthcare.

We also encouraged the Department to focus on individuals and their experiences with the healthcare system. Our comments today are focused on how the state's policy can improve the quality of life for patients.

Affordable, high-quality insurance is necessary to prevent medical debt.

The public option plans will continue efforts to improve health plan options for Nevadans.

We are glad that the proposed waiver is projected to increase marketplace enrollment.

It would also reduce individual premiums, starting at 3 percent in 2026 and almost 14 percent in 2028. And it would do so without jeopardizing provider networks and quality of care for patients.

The Department can further improve these outcomes by funding the subsidies it contemplated in the first draft of the waiver. These subsidies immediately help patients in a meaningful way.

Patients still have out-of-pocket costs besides their premiums. Co-pays, co-insurances, and travel cause patients to consider delaying treatment. Or lead to the medical debt that traps patients.

Using pass-through funds for a premium subsidy will benefit patients more directly than reinsurance. So again, the state should consider including it as they did in their first draft of the waiver.

The public option will bring needed investments to improve Nevada's healthcare system.

Overall, the public option does what it set out to do -- reduce premiums, improve coverage, and save the state money.



Thank you to the Department and the Legislature for their leadership in improving patients' quality of life.

We hope that the waiver will continue through its process toward approval so that patients can enjoy the benefits of the public option.

We appreciate your consideration. Thank you.



We want to thank Sen. Cannizzaro for passing and Governor Lombardo for implementing SB 420.

This innovative policy and implementation plan takes a new approach to delivering affordable, quality healthcare to Nevadans and offers the opportunity to dramatically reduce the cost of healthcare in this state.

By leveraging the state's purchasing power through Medicaid, the state is able to drive down costs for consumers on the individual market and enact critical reforms in the Medicaid market. While all Nevadans will be able to benefit from this policy, one of the biggest beneficiaries will be Nevada families that make too much money for federal premium support but are still priced out of health insurance.

These are not rich families. These are middle-income and in some cases low income families that have not been at the center of the healthcare affordability conversation.

For a family of four with two working parents, they would not qualify for any premium support if each parent makes just \$60,000 a year. That is just slightly higher than the average annual salary in Nevada of about \$59,000 a year or \$28 an hour, according to [Ziprecruiter](#).

These families need help and support and this policy delivers exactly that.

For the first time, these families have a policy, a Public Option, which will allow them to see reduced premiums so they are able to secure more affordable, quality insurance.

For the first time, we have a state policy focused on consumers left in the gap between income levels that allow a family to ***actually*** afford insurance and government coverage and subsidies for low-income families.

In addition to the real benefits, the state's 1332 waiver application also has important provisions dedicated to addressing Nevada's decades-long provider shortage problem.

Nevada was [ranked](#) 48th in the nation with regard to the availability of primary care physicians and a [report](#) by UNR's School of Medicine found that Nevada needs more than 2,500 additional providers just to meet the national average. Some of the main ways that we can address this is funding workforce development initiatives like state based residency training slots, expanding

pay parity and scope for APRNs and tearing down barriers that prevent healthcare providers from moving to and practicing in Nevada.

These are important reforms and we encourage the state and CMS to look at comprehensive reforms and best practices that Nevada can engage in, along with the funding that will be provided through approval of the 1332 waiver, to truly rebuild and expand Nevada's network of healthcare providers. We need a healthcare infrastructure that can actually meet the needs of Nevada families and the 1332 waiver application provisions focused on workforce development are essential - we are strongly in support of them and thankful for their inclusion.

Finally, we wanted to point out and applaud the outcome based payment reforms included in SB420 and the 1332 waiver application. For far too long, Nevadans have been suffering under a healthcare system that is among the most expensive in the country with some of the worst healthcare outcomes. It is indeed the inverse of the type of healthcare system you actually want; instead of low cost, high quality we suffer from high cost, low quality.

By modernizing Nevada's payment system so that we incentivize healthcare providers to focus on patients outcomes, Nevada can drastically and practically address this issue. We can deliver in the individual market some of the same reforms that we are seeing in the Medicare and Medicaid market. Over the long-term, these incentive based payment solutions can finally change our healthcare system that has been focused on maximizing profits for insurers while demonstrating indifference to patient care and patient outcomes.

We want to remind everyone, including current providers that all MCOs offer exchange plans already and have been required to for years. We encourage DHHS and Medicaid to continue to explore additional administrative actions and reforms that can realign Nevada's healthcare system to the benefit of consumers and Nevada families and not simply deliver an additional point or two in profit margins to some of the largest healthcare corporations in the world.

Maite Guerra
Latino Anti-Disinformation Manager for BBP/IPN

Public Option Comment

My name is Maite Guerra and I am the Anti-Disinformation manager at Battle Born Progress/Institute for a Progressive Nevada.

I am here to discuss how for decades wealthy insurance companies have raised health insurance rates and profited at the expense of hard-working Nevadans. We see many hardworking Nevadans unable to afford quality insurance that effectively covers their medical needs. For that reason, I am here on behalf of the organization to show support for the public option because it will increase insurance options for Nevadans who continue to struggle with affordable healthcare despite medical concerns for themselves and their families.

Currently, 11.6 percent of Nevada residents lack coverage from either public or private insurance, placing the state among the bottom ten in terms of health insurance inclusion. Public option aims to offer a cost-effective alternative for individuals ineligible for public insurance such as Medicare or Medicaid, for those without employer-provided insurance, or those who are self-employed.

The effectiveness of Nevada's Public Option Insurance lies in its exemplary governance, as it places the needs of community members at the forefront. By offering a choice for Nevadans to obtain affordable healthcare, it grants them greater autonomy to make decisions that enhance the quality of Nevadans lives.

December 5, 2023

Nevada Department of Health and Human Services
Division of Health Care Financing and Policy
1210 S. Valley View Boulevard
Las Vegas, NV 89102

Dear Sirs,

The Nevada State Education Association has been the voice of Nevada educators for over 120 years.

NSEA supports the creation of Battle Born Health Plans to ensure high-quality, affordable healthcare options for Nevadans.

Like public education and other vital services, Nevada ranks near the bottom of states in investment in healthcare. In addition to underinvestment, health disparities continue to run deep in our healthcare system. Nevada's low-income communities face fewer options and higher prices, and there is a significant health disparity in Nevada's communities of color.

In Nevada's rural communities, there are even fewer health insurance options and higher prices. Outside of Clark and Washoe there is typically just one plan on the health exchange, or none at all. This has left rural Nevadans with less choice and higher costs. In order to access basic healthcare in rural areas, many Nevadans have to travel for hours. In some emergency situations, air transport is required at a very high cost.

Due to WEP/GPO, many retired Nevada teachers may not qualify for Medicare and rely on private insurance plans. Some insurance carriers have been known to push older people into sub-standard insurance programs, with high deductible and high co-pay programs.

This new healthcare option will ensure that Nevadans always have equal access to affordable, quality coverage -- especially if they lose their job and insurance or do not have Medicare eligibility. Moreover, it will cut health care costs for everyone in the state by driving competition into the market and forcing insurance companies to compete with the new option for Nevadans' business.

In Solidarity,



Dawn Etcheverry, President

Thank you for the opportunity to testify on this important subject, for the record my name is Steven J Horner I am the President of Nevada State Education Association-Retired and I live in SD 11 and AD8.

So many public employees have worked 30 years or more but because we are a Windfall Elimination Provision/Government Pension Offset (WEP/GPO) state they have discovered that they are not eligible for Medicare. This public option is a way for our dedicated teachers, support professionals, and administrators to have affordable health insurance.

Drug prices and health costs are skyrocketing. Without affordable health insurance many of the teachers and support professionals I work with cannot afford to retire with dignity. That is a blight on our state. Working until a person is eighty or eighty-five simply because they cannot afford to go onto the open market for health insurance should end with this fully funded affordable public option.

This doesn't affect just public-school employees but all public employees that have dedicated their lives to serving the people of Nevada. Full funding is so important to those that sacrificed to serve. Please make sure this is properly and fully funded.

Support Letter for Nevada's Public Option

Fiorina Chau

My name is Fiorina and I am a first generation Asian American. Last year marked a profound loss in our family as my grandmother experienced a stroke. Hearing the news was devastating, especially since every sporadic movement gave us hope that she would recover from her coma. A decision awaited us – the agonizing choice between clinging to the possibility of her recovery through continued hospitalization, surgeries, and medications, all of which incurred substantial costs, or making the painful decision to let her go. Gratefully, our family, along with our extended relatives, unanimously pooled our resources, allowing my grandmother to persist in her fight. It's a decision that, I believe, resonates with countless families facing similar heart-wrenching choices.

Nevertheless, I can't help but wonder: What if we hadn't had that support? Unfortunately, many are forced to abandon the fight due to the unattainability of affordable health insurance. The prospect that the well-being of our loved ones, and even ourselves, hinges on financial resources is a stark reality. A public option could redefine this narrative, offering families a genuine choice.

Even when it doesn't come down to life or death, lack of affordable healthcare affects many Nevadans in their everyday lives. For instance, due to financial constraints, my friend had to opt for a less effective medication than the one prescribed. They rely on this medication everyday to complete daily tasks. Having access to more affordable high quality healthcare would improve his quality of life. This struggle is shared by 76% of API and Native Nevadans grappling with escalating health insurance concerns.

The implementation of a public option policy in Nevada could be transformative for its residents. It has the potential to instigate a more competitive healthcare market, thereby driving down costs for alternative insurance options. Moreover, affordable healthcare could be a game-changer, granting Nevadans access to necessary medications and procedures without the suffocating weight of financial burdens. For many, it could mean the difference between life and death.

November 30, 2023

DHHS
400 West King Street, Suite 300
Carson City, Nevada 89703

RE: Nevada Draft Section 1332 State Innovation Waiver Application Public Notice

Thank you to the Nevada Department of Health and Human Services (DHHS) and the Nevada Division of Health Care Financing and Policy for the opportunity to provide comments on Nevada's section 1332 State Innovation Waiver application.

My name is Brenda Rodriguez and in 2020 I was pregnant with my first child and uninsured. During this time like most, I was struggling and wasn't sure how I would be paying for doctor appointments and the hospital bill once I delivered my son. Due to the fact that I was on DACA, I was able to only qualify to receive emergency Medicaid which helped only pay for the delivery of my son. Although I would not qualify for the Public Option due to my immigration status many others will have the opportunity to access affordable coverage in Nevada.

Despite being one the most expensive states in the nation for healthcare costs we have some of the worst healthcare outcomes. [Two-thirds of Nevadans](#) have struggled to afford healthcare and "65% of respondents who reported health care affordability burdens in the prior 12 months included people foregoing health insurance because it was too expensive, delaying visits for medical needs including dental care, mental health care or addiction treatment, and struggling to pay medical bills." Despite the high costs, even Nevadans that have coverage struggle to get care - with Nevada [ranked](#) as the worst state to get primary care providers.

Now, with the Public Option, Nevada is leveraging taxpayer dollars to bring affordability and competition into Nevada. Because of the Public Option, 90,000 Nevadans will see more affordable health insurance options, cutting the uninsured rate amongst those eligible for individual health coverage by 12% and saving Nevadans more than \$500 million. For those without access to coverage, this new affordable coverage option will be a lifeline that will save people money and allow them to more easily plan and budget for their family's needs.

On top of this, because of the \$500 million in savings, Nevada will be able to recapture these dollars with this 1332 waiver to invest in marketplace stability, workforce development and payment optimization. Three things Nevada's broken healthcare market desperately needs.

With the approval of this waiver, Nevada will have the resources to deploy to address these problems.

Thank you for the opportunity to provide my insight and experience with Nevada's healthcare market and how the Nevada Public Option and the 1332 waiver will help fix our broken healthcare system.

Please approve this waiver and give Nevadans some hope.

Sincerely,

Brenda Rodriguez
brendarodriguez17@gmail.com

From: [z.har](#)
To: [DHCFP 1332waiverprogram](#)
Subject: Health Insurance Public Option
Date: Tuesday, November 28, 2023 6:48:51 PM

WARNING - This email originated from outside the State of Nevada. Exercise caution when opening attachments or clicking links, especially from unknown senders.

I am in favor of Nevada exploring the option of a public health insurance.

Thank you,
Kelly Larson

From: [Michelle Krieg](#)
To: [DHCFP 1332waiverprogram](#)
Subject: Public Comment
Date: Monday, November 27, 2023 4:43:15 PM

WARNING - This email originated from outside the State of Nevada. Exercise caution when opening attachments or clicking links, especially from unknown senders.

Hello,

My name is Michelle Krieg and I'm a Reno, Nevada resident. In January of this year I was diagnosed with an early stage of cervical cancer, and had to undergo a number of procedures and tests before needing a hysterectomy. At the time I was on a high deductible plan through my husband's work, but a month before the hysterectomy the company he worked for for over 10 years, laid him off and closed their business. We then had to go through cobra for our insurance. On one hand, we are grateful for the cobra option, but on the other, it meant that our premium now doubled in cost at a time when we were already mentally and financially stressed because of the health condition I was dealing with, and my husband being laid off. We managed to get through the next few months, I had the surgery and my husband got a new job, but we are still paying medical bills from my surgery.

My husband's new job hires workers as independent contractors and since I'm already a sole proprietor, we had to go to healthlink for insurance. Yet again we were faced with an array of high deductible plans. Currently, our so-called affordable plan costs us \$9,000 in annual premiums, and is followed by a \$17,000 family deductible, for a total of \$26,000 a year of out of pocket costs before any healthcare services are covered by our insurance. This means, we do not go to the doctor or seek medical care unless absolutely necessary. These high deductible plans do not actually provide healthcare, they provide catastrophic insurance. \$26,000 every year! This is not affordable healthcare, this is not quality and this is not sustainable for working class families. There must be another way.

- Kindly,
Michelle Krieg

From: [Megan Lewis](#)
To: [DHCFP 1332waiverprogram](#)
Subject: Public Option LTE: Carlos Perez Campbell 12/05
Date: Wednesday, December 6, 2023 2:21:53 PM

WARNING - This email originated from outside the State of Nevada. Exercise caution when opening attachments or clicking links, especially from unknown senders.

Nevada Department of Health and Human Services
400 West King Street, Suite 300
Carson City, Nevada 89703

RE: Reno Family Healthcare Costs

Nevadans have long deserved affordable options for healthcare. As a head of household, insuring my family of three cost me \$448 a month. My employer contributes a large portion on top of the amount that I put in. Yet, we typically only have maintenance healthcare and dental work done. While the monthly amount of healthcare is a cost that we are used to being taken out of our paychecks, the question must be asked if there is a better path forward. In Nevada, the democratic controlled legislature has crafted a better path forward through a Public Option.

The public option would allow people to opt into a state operated insurance program that will compete with other health insurance providers in the state. This is significant for a few reasons, mainly that through the public option, prices to insure yourself and your family goes down and it will create an insurance plan that will be vastly more affordable for people to obtain. The public option is not only sound policy, but it is a tool which will insure 90,000 Nevadans within 5 years of its implementation thanks to its more affordable price. In addition, it will give the government the greater ability to negotiate prescription drug prices downward which in our time of major inflation would provide real economic relief for families, especially sectors of our state that are most vulnerable.

Many in our community rightfully may see this and misunderstand it as a government grab into healthcare choice and lament the thought of the government forcing people to get healthcare through their scheme. Our Governor, Joe Lambardo, appears to be on that side of the issue. However, I strongly urge Nevadans to see the facts and the benefits of having a public option.

Firstly, competition has always proven to improve the quality of services in all industries. With the entry of a state backed insurance plan, the traditional insurance companies will be forced to compete for Nevadans. They will have to lower costs and improve their services in order to entice us for our business! A public option to you would above all else give you an OPTION. In addition, uninsured individuals will have a health care plan that is in reach. This opportunity will provide Nevadans with an alternative to our current system which is overwhelming Nevadans. It is important that we strengthen the Public option, expand it and preserve it.

I support Nevada's creation of a Public Option that meets the same standards and offers the same essential benefits as private plans offered in the individual market. For those without access to coverage, this new affordable coverage option will be a lifeline that will save people money and allow them to more easily plan and budget for their family's needs.

Thank you for the opportunity to provide comments on the section 1332 waiver application in support of Nevada's Public Option.

Sincerely,

Carlos Perez Campbell
(775) 750-0232

Megan Lewis
For Our Future Nevada
NNV Organizing Manager
She/Hers
(775) 685-0544

From: [Madisen McGrath](#)
To: [DHCFP 1332waiverprogram](#)
Subject: RE: Nevada Draft Section 1332 State Innovation Waiver Application Public Notice
Date: Wednesday, December 6, 2023 2:22:27 PM

WARNING - This email originated from outside the State of Nevada. Exercise caution when opening attachments or clicking links, especially from unknown senders.

December 5, 2023

Nevada Department of Health and Human Services
400 West King Street, Suite 300
Carson City, Nevada 89703

RE: Nevada Draft Section 1332 State Innovation Waiver Application Public Notice

Thank you to the Nevada Department of Health and Human Services (DHHS) and the Nevada Division of Health Care Financing and Policy for the opportunity to provide comments on Nevada's section 1332 State Innovation Waiver application.

Even with expanded access to public and private health insurance coverage during the pandemic, Nevada suffers the highest uninsured rate of any state that has expanded Medicaid. [Nearly half](#) of uninsured Nevadans report the major reason they are uninsured is due to coverage being "too expensive". For those who are able to access health insurance, individual marketplace premiums have continued to [rise](#). As a result, many Nevadans, like myself, go without care or are forced to make difficult choices between necessities like food, rent and getting the care we need.

I am Ms. McGrath, an educator who has proudly served our school district for over two decades. I've always seen teaching as my calling and my students as my second family. I enjoyed the work, but eventually realized it was time to retire. I had been on the district's health insurance plan for decades, and now I was alone in the individual markets before I qualify for Medicare in 6 months. However, after researching the marketplace I realized that my health insurance would be \$800/month. I was shocked. In order to pay for this new, expensive bill, I had to return to substitute teaching to pay for my health insurance.

My story is not unique, and it speaks to a larger issue: the sky-high cost of healthcare in our country. It's a problem that calls for immediate reform. Educators like me, who have devoted their lives to shaping young minds, shouldn't have to make such painful choices between health and livelihood.

Nevadans, and all Americans, deserve an affordable and accessible healthcare system. It's time for our leaders to consider a public option that provides lower health costs for all. Let's ensure that educators and countless others can retire without the weight of financial stress, and that healthcare becomes a right, not a privilege.

I support Nevada's creation of a Public Option that meets the same standards and offers the same essential benefits as private plans offered in the individual market. For those without access to coverage, this new affordable coverage option will be a lifeline that will save people money and allow them to more easily plan and budget for their family's needs.

Thank you for the opportunity to provide comments on the section 1332 waiver application in support of Nevada's Public Option.

Sincerely,

Julie McGrath

(775) 815-9187

jmcgrath@washoeschools.net



December 8, 2023

Stacie Weeks, JD, MPH, Administrator
Nevada Division of Health Care Financing and Policy
1100 E. William Street, Suite 101
Carson City, NV 89701

Dear Ms. Weeks:

The Nevada Association of Health Plans (NvAHP) appreciates the opportunity to provide comments on the recently released 1332 Waiver Application and Actuarial Analysis of the Nevada Market Stabilization Program (NMSP) that includes the operation of a Public Option (PO) health insurance offering on the Silver State Exchange, as required by statute.

The NvAHP is a statewide trade association representing [ten member companies](#) who provide commercial health insurance and government programs to Nevadans. Our mission is to ensure the growth and development of a high-quality and affordable health care delivery system throughout the state.

The NvAHP has collaborated with the State of Nevada (State) throughout the multi-year process since the passage of SB420 in 2021. We have submitted eight letters beginning with the public design phase through stakeholder engagement and waiver design. We appreciate Governor Lombardo's efforts to collaborate with us and we support him in the effort to focus on market stabilization with the waiver application and understand there are limitations because of the language in SB420. However, our coalition continues to have serious concerns and questions about portions of the program structure. We respectfully provide key suggestions for the state's consideration as it moves forward with the 1332 Waiver Application and implementation of the PO that we believe will improve the market stabilization proposal while not risking instability in the Medicaid procurement process.

1332 Waiver Application

Medicaid Managed Care RFP Process

- Section 12(1) of SB420 outlines that the competitive bidding process for the PO must coincide with the statewide procurement process for the Medicaid managed care program. However, the State's waiver application dictates that it will issue a joint statewide Public Option and Medicaid procurement process, where bidding carriers will be scored based on whether they offer good faith bids for both: (1) a Medicaid Managed Care contract and (2) a Public Option contract.
- We are concerned with tying the scoring process of the MCO Request for Proposal (RFP) submission for Medicaid to the approval of a PO plan. Bidders know the statute requires a good

faith offer of a PO plan by any insurer who may win the contract but beyond that, the statute does not tie the two programs together to the extent proposed in the waiver application. Tying submission of a PO plan to the bidding process for management of Medicaid, in August of 2024 when the RFP is issued, is likely to result in less competition in the bid process since plans may not have the ability to propose a PO plan that will not hit the Exchange market until 2026.

- Since the PO process is new and untested in Nevada, and as we have seen in other states, tying these two elements so closely together creates a serious risk of destabilizing the Medicaid program as a whole if the PO is not successful. If for any myriad of reasons, the PO does not perform as expected and benchmarks are not able to be met, it could put the Medicaid MCO contracts in jeopardy if those benchmarks are part of the RFP.

Our members are concerned with the adverse impact these requirements may have on the Medicaid program and the Nevadans that managed care organizations serve. The concept that Medicaid bid proposals may be rejected based solely on the bid proposals for what is a distinct and entirely separate program that will not serve Medicaid members seems unduly punitive.

We strongly urge the State to reconsider the actuarial certification requirement and the automatic ineligibility for participation in the Medicaid program to ensure that the Medicaid managed care program does not falter - especially as managed care expands statewide for the first time.

Administrative Cost Constraints to Meet Premium Reduction Targets

We do not believe there is a need to implement an administrative cost constraint that is stricter than the prevailing individual market Qualified Health Plan (QHP) administrative expense load Medical Loss Ratio (MLR). And our members do not see any lever in the PO that would reduce administrative expenses for insurers or address the rise in health care costs.

- The Affordable Care Act (ACA) MLR provision already requires commercial health insurance providers to spend a certain percentage of premiums on medical care and limits the portion of premium dollars that can be spent on administration, marketing, and risk margin. As a result, administrative costs are already capped as a percentage of premium with or without the PO. Any additional constraints would be duplicative of the existing ACA requirements.
- As the individual ACA market matured and stabilized over the past nine years, carriers have aggressively priced their offerings to compete, almost eliminating required MLR rebates. Carriers have streamlined their administrative expenses to lower overall pricing and capture more membership, ensuring a sustainable risk pool.
- The framework presumes that issuers have excessive administrative costs that can be cut. Nevada is a competitive insurance market and the costs to administer and offer a PO plan would be no different than a non-public option plan. It is possible that administrative costs for the PO could increase depending on the requirements associated with the plan offering if there are unique network requirements or unique benefit design requirements that are not provided in non-PO plans.
- We are concerned that the PO has no mechanism to reduce administrative costs and that any reductions in insurer's required risk margins pose a significant threat to issuer competition and consumer choice in the Nevada market.

- Insurer administrative costs are spent on programs that benefit consumers vis-à-vis cost containment and quality improvement. This includes:
 - **Cost Containment:** Prevention of fraud, waste, and abuse by doctors and patients. Answering questions from doctors and hospitals, helping providers with best practices, and ensuring proper credentialing for quality care. Programs to better manage chronic conditions and coordinate care between doctors to ensure that the right treatment is provided to the right patient at the right time.
 - **Quality Improvement:** Preventive care programs to keep consumers healthy, like weight management plans or helping people to quit smoking. Patient education and follow-up calls by health plan staff to members discharged from a hospital and services to improve health in communities, like sponsoring local health fairs and providing free disease screenings and other educational events.
 - **Administrative:** General and administrative costs to run the business, including salaries, outsourced services, equipment, accreditation and certification fees, rent, legal fees and expenses, advertising, postage, utilities, to name a few.
 - **Premium Tax:** Nevada's highest premium tax.

We suggest not setting reduction targets of administrative costs beyond what current Silver State Exchange (Exchange) plans have. The intention of the State to require reductions in administrative costs beyond what has been found appropriate by the Division of Insurance (DOI) for Exchange plans is also not directed by the statute and will create yet another factor which could reduce the ability of insurers to meet the goals of the statute.

Premium Reductions

The NvAHP does not see a path for premium reductions, and we would like more details from the State on where cuts can be made in order to reach the premium reductions. We understand that they are dictated by statute, but a premium is still required to be actuarially sound.

Outside of Nevada's two most populous counties, Critical Access Hospitals ensure that Nevadans can receive medical care when needed. These hospitals are reimbursed at much higher rates than the 100% of Medicare hospitals in Clark and Washoe counties receive. CMS has designated these locations to receive higher reimbursement rates so that they may continue to operate on lower patient counts than their counterparts. The public option premium reductions may cause reimbursement reductions that could negatively impact our rural care sites and the members that utilize them for care.

- Premium reductions through lower physician or hospital rates are unrealistic.
 - Physicians on average are already at least 100 percent of Medicare.
 - Prescription drug affordability is not addressed.

Market Stabilization Reinsurance Program

A successful reinsurance program cannot rely on an unproven public option to generate federal pass-through funding for its portion which places significant risks and unknowns on carriers. If the State wants a reinsurance program, we strongly recommend an alternative financing mechanism for the State portion outside of an unproven and unrealistic public option.

- Presents significant risks and unknowns to the market.
 - “If a carrier cannot meet the target set forth in its contractual agreement with DHHS, the Director may utilize a corrective action plan (if deemed a viable option for the carrier, in order to allow the carrier to make up some of the reduction in future years) and any other penalties set forth in such agreement, including a financial penalty that is worth all or some of the value of the federal pass-through funding that the State would have otherwise received if the carrier had met their agreed-upon premium reduction target(s).” (pg. 18 of waiver application)
 - If federal funding is insufficient for the reinsurance program in any given year, the state will adjust the reinsurance program attachment point and coinsurance. “In turn, this also shifts more of the burden back on carriers in meeting the statutorily required premium reduction target of 15 percent over the first four years of the waiver period. The State’s contracts with carriers for the BBSPs would therefore include two sets of agreed-upon certified rates for achieving the premium reduction target– with and without reinsurance—to ensure the mandatory four-year statutory target can be achieved.” (pg. 14 of waiver application). Are we including this as is or is this meant to be a starting point?
- Transparency is vital in how pass-through funding will be calculated.

The tiered structure of the reinsurance program will make the premium reduction targets in rating area 1 that much harder to meet.

- Per the state’s actuarial report, reinsurance will reduce premiums by 7.2% on average across the entire state.
- Individual market state-based reinsurance program parameters. \$60K attachment point with \$1M cap per member. Coinsurance b/w attachment point and cap varies by rating area. Coinsurance:
 - Rating area 1: 20%
 - Rating area 2: 35%
 - Rating areas 3 & 4: 70%
- By the state’s design, reinsurance will have a much lower impact on premiums than 7.2%. in rating areas 1 and 2. Will the state look to the public option to have an even greater impact on premiums than 7.8% in rating areas 1 and 2?
- A recent study indicates providers in rating area 1 are already at 100% of Medicare. Hospitals are very close. There is almost no way to hit the premium reduction target and even less so with the least generous reinsurance parameters in rating area 1.

Implementation of SB420

As noted in our previous public comment letters, we continue to believe that the PO as outlined in SB420 is problematic and will not result in any meaningful increase in insurance coverage to Nevadans. There is also concern that the PO may not generate the projected savings and is likely to realize negative results including a reduction in provider participation of government-sponsored plans.

We are also concerned with the points below.

- ***Public Option Experiences in other States*** – Plans in other states have not been able to meet the premium reduction goals and/or provider reimbursement reduction goals. These states have

focused on attempting to reduce hospital/facility and provider costs without addressing the overall cost of health care, such as the cost of pharmaceuticals.

- **Unlimited enrollment eligibility** – Without eligibility being defined, enrollment could hurt the existing individual and small group market if businesses are discouraged from providing coverage through the small group market. We are concerned that the state may unintentionally destabilize the existing individual and small group health insurance markets in Nevada.

Our coalition members will continue to review the 1332 Waiver Application and may provide additional comments prior to December 20, 2023.

We look forward to working with the State as it continues to move forward with the implementation of the Market Stabilization Program and Public Option.

Thank you.

Helen Foley
Legislative Advocate
Nevada Association of Health Plans
702-234-6500



December 13, 2023

Nevada Department of Health and Human Services
Division of Health Care Financing and Policy
1100 East William Street, Suite 101
Carson City, NV 89701

RE: Nevada Draft Section 1332 State Innovation Waiver Application [Public Notice](#)

Thank you to the Nevada Division of Health Care Financing and Policy for the opportunity to provide comments on Nevada's section 1332 State Innovation Waiver application to create the Nevada Coverage and Market Stabilization Program.

The Committee to Protect Health Care is a mobilization of doctors committed to expanding access to affordable health care. **We support the framework proposed by the Division of Health Care Financing and Policy (“the Division”) to create a public health insurance option in Nevada.** We believe this proposal is a strong foundation to increase health coverage options for Nevadans while building upon existing state efforts to promote health care affordability. We are excited to see the continued efforts to ensure access to affordable health insurance coverage through the creation of Battle Born State Plans and appreciate the opportunity to share our perspective on the design of the state's federal 1332 waiver.

Current Coverage and Affordability Landscape in Nevada

Even with expanded access to public and private health insurance coverage during the pandemic, Nevada suffers the [highest uninsured rate](#) of any state that has expanded Medicaid. More than 340,000 (11%) Nevadans are uninsured, with Hispanic (20%) and American Indian/Alaskan Native (21%) populations being disproportionately impacted. [Nearly half](#) of uninsured Nevadans report the major reason they are uninsured is due to coverage being “too expensive.” For those who are able to access health insurance, individual marketplace premiums have continued to [rise](#). Many insured Nevadans [report](#) experiencing health care affordability burdens, while even more worry about affording health care costs both now and in the future. Due to this, [more than half](#) of Nevadans reported delaying or going without health care due to cost in 2022.

Increasing Affordability for Nevadans

We are supportive of the state taking a unique approach to strengthen the long term sustainability of the market in Nevada by leveraging the savings created by the Public Option for three new initiatives – a state-based reinsurance program, quality incentive payment program tied to improved outcomes for participating carriers and providers and the “Practice in Nevada” provider incentive program. Nevada's Coverage and Market Stabilization Program aims to lower the cost of health insurance for more than [100,000](#) Nevadans on the individual market, while bringing up to \$310 million in federal passthrough funding into the state in the first five years.

One of the overarching goals of the Public Option was to reduce the cost of health coverage and the number of Nevada residents forced to go without health insurance because they can't afford it. With the Public Option and reinsurance working together, individual marketplace premiums will fall 15% over four years. For those without access to coverage, this premium reduction will be a lifeline that will save people money and allow them to more easily plan and budget for their family's needs.

To further lower out-of-pocket costs for Nevada residents, the state should consider leveraging any additional funding available to provide direct subsidies and financial support to people eligible for premium tax credits to offset premium and out-of-pocket costs, which can be targeted by income, age, geography or other factors the state decides. [Several](#) other states have implemented a state-based Marketplace subsidy, with New Jersey and Colorado successfully combining premium subsidies with their reinsurance programs. Direct to consumer subsidies are [known to](#) expand coverage, support the market risk pool and reduce premiums for enrollees.

Maintaining Access to Care for People

Reimbursement for providers who participate in one of Nevada's public option plans are expected to meet or exceed Medicare rates, with special attention paid to critical safety net providers, including critical access hospitals, federally qualified health centers, and rural health clinics, to ensure access to these essential providers. Furthermore, the quality incentive payment targets through the Marketplace Stabilization Program's "waterfall" approach will incentivize better care delivery that prioritizes positive health care outcomes and shifts away from [costly](#) fee-for-service. Carriers will have the option to leverage several incentive models, such as offering providers valued-based payment bonuses tied to quality metrics, setting primary care spending targets or engaging in efforts to increase health care workforce capacity. These programs are [proven](#) to improve health outcomes for people, all while providing financial certainty for providers and ensuring Nevadans maintain access to robust provider networks and health plan choices.

Addressing the Provider Shortage in Nevada

Nevadan's health coverage issues are exacerbated by the state [not having enough](#) physicians to meet Nevada's growing health needs. Every county in Nevada is experiencing a shortage of medical professionals, and in 2021, Nevada was ranked [48th](#) in the nation with regard to the availability of primary care physicians per 100,000 residents, leading to [long wait times](#) for primary and specialty care. Drawing doctors to complete their graduate medical education in Nevada [has become more difficult](#) as the state's population has increased but graduate residency spots have not. Thus, many of Nevada's 300 medical school graduates [complete their residency](#) elsewhere, [never](#) returning to practice in Nevada.

To ensure that the quality incentive payment and "Practice in Nevada" programs are effective in addressing the state's unique health care challenges, **the state should create funding benchmarks for these programs that define "sufficient funding"**. This can be done by allocating percentages of how much federal pass through funding will be dedicated to the carrier and provider quality incentive programs once reinsurance is "fully funded" to ensure they

receive the necessary funding to be impactful for patients. For example, the affordability programs funded, in part, through the Colorado 1332 waiver, [limits funding](#) for reinsurance at 73% of pass through funds or approximately \$90 million, ensuring \$18 million of the leftover passthrough funding is allocated for state subsidies and 10% is allocated for payments to carriers. Applying these funding requirements not only ensures that patients will receive the maximum benefits of this program – instead of carriers themselves – but because of the percentage allocations tied to the dollar amounts (i.e. "73% of remaining funds"), allows the program to ebb and flow as the total waiver funds change from year to year.

Program Improvement

In addition to the policy recommendations made above, it is critical that the Division has the tools and data to successfully implement the waiver and oversee Battle Born State Plans as intended. The Division should use regulatory authority where needed to create mechanisms to measure the success of the proposed programs in stabilizing Nevada’s market and reducing costs and provide data informed recommendations as needed to improve program effectiveness.

Thank you for the opportunity to provide comments on the section 1332 waiver application in support of Nevada’s Coverage and Market Stabilization Program. If you have any questions or are interested in further discussion of our comments on the proposed 1332 waiver application, please do not hesitate to reach out to Jodi Helsel at jodi@committeetoprotect.org.

Sincerely,

Dr. Rob Davidson
Executive Director
Committee to Protect Health Care

Dr. Harpreet Tsui
Nevada Lead
Committee to Protect Health Care



[EXTERNAL] Please do not reply, click links, or open attachments unless you recognize the source of this message and know the content is safe.

From: Jonkey, Ashley <ashley.jonkey@elevancehealth.com>
Sent: Wednesday, December 13, 2023 10:12 AM
To: Stacie Weeks <sweeks@dhcp.nv.gov>
Subject: Feedback - Reinsurance

WARNING - This email originated from outside the State of Nevada. Exercise caution when opening attachments or clicking links, especially from unknown senders.

Administrator Weeks – Elevance Health (Anthem BCBS) provides the below feedback regarding reinsurance parameters. Additionally, we provided additional comments through our trade association on the 1332 waiver via a letter that was submitted on 12/8/23 to the Division.

Should you have any questions, please let me know.

Reinsurance Issues/Questions/Comments:

- The tiered structure of the reinsurance program will make the premium reduction targets in rating area 1 that much harder to meet.
- Per the state’s actuarial report, reinsurance will reduce premium by 7.2% on average across the entire state.
- Individual market state-based reinsurance program parameters. \$60K attachment point with \$1M cap per member. Coinsurance b/w attachment point and cap varies by rating area.
Coinsurance:
 - Rating area 1: 20%
 - Rating area 2: 35%
 - Rating areas 3 & 4: 70%
- By the state’s design, reinsurance will have a much lower impact on premiums than 7.2% in rating areas 1 and 2. Will the state look to the public option to have an even greater impact on premiums than 7.8% in rating areas 1 and 2?

As you know, we do not believe the public option premium reduction requirements are realistic with or

without reinsurance. This is even more acute in ratings area 1 and 2 where the less generous reinsurance parameters will have a lesser impact on premiums and providers are at or generally near the 100% of Medicare aggregate reimbursement levels already, per the floor in the statute.

Thank you! Ashley



Ashley Jonkey

Government Affairs Director, Nevada

M: 775.842.2367

Ashley.Jonkey@elevancehealth.com

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From: [Jodi Helsel](#)
To: [DHCFP 1332waiverprogram](#)
Cc: [Jerry Zebrack](#)
Subject: 1332 Waiver Comments from Jerry Zebrack, MD
Date: Wednesday, December 13, 2023 3:42:35 PM

WARNING - This email originated from outside the State of Nevada. Exercise caution when opening attachments or clicking links, especially from unknown senders.

The below comments are from Dr. Jerry Zebrack (cc'd):

To the Nevada Division of Health Care Financing and Policy,

As a cardiologist, I'm supportive of the framework the Division has proposed to create a public health insurance option in Nevada. It will build a strong foundation to increase health coverage options for Nevadans while promoting health care affordability.

Doctors hear all the time from our patients how the high cost of health care prevents them from seeking care. Some patients come in after suffering for months, even years, from a problem that could have been treated earlier. Others stop coming because they lose their insurance. Too many patients fall in a gap, not qualifying for federal premium support but also not able to afford coverage.

That's why the public option is so important, and why doctors like me support the design of the federal 1332 waiver. The public option will increase health care affordability and access for patients like mine. With a public option and reinsurance, individual marketplace premiums will decrease 15 percent over four years. Nevada's Coverage and Market Stabilization Program can lower the cost of health insurance for up to, or even more than, 100,000 Nevadans on the individual market.

The state can, and should, help patients even further by leveraging additional available funding to directly subsidize premium tax credits to offset premium and out-of-pocket costs.

When patients are better able to afford and access care, they're better able to live, work, learn, and care for their families. That makes our communities and our whole state healthier and stronger. Thank you for your work to help my patients.

Jerry Zebrack M.D.
Reno, NV

--

Jodi Helsel
she/her
Organizing Director | Committee to Protect Health Care
619-433-9258
www.committeetoprotect.org

From: [Randi Lampert](#)
To: [DHCFP 1332waiverprogram](#)
Subject: public option comments
Date: Thursday, December 14, 2023 6:06:20 PM

WARNING - This email originated from outside the State of Nevada. Exercise caution when opening attachments or clicking links, especially from unknown senders.

To the Nevada Division of Health Care Financing and Policy,

Thank you for the opportunity to share comments on Nevada's section 1332 State Innovation Waiver application to create the Nevada Coverage and Market Stabilization Program. As a pediatrician in Las Vegas, I support the framework proposed to create a public health insurance option in Nevada. I believe it will help increase health coverage options for Nevadans, including my patients.

Furthermore, I support the state leveraging the savings created by the public option for the "Practice in Nevada" provider incentive program. This program can help address the dire shortage of health care providers in our state — a shortage being felt by providers like me and our patients every day.

This shortage is especially acute for developmental and behavioral health in our state. My patients have often waited over a year to receive a diagnosis of autism. While they are waiting they are missing out on critical services; these services are most effective when started at as early an age as possible. I saw one patient recently that had been expelled from kindergarten for behavioral issues while waiting to see a child psychiatrist. When he finally saw us 9 months later, he was diagnosed with ADHD which is easily treatable with medication. But in that time period he has fallen over a year behind academically. Stories like these are all too common for pediatricians in our state.

My patients and all Nevadans deserve to be able to access care affordably and when they need it. Your division can help ensure greater access to affordable care across the state. Thank you for your work to do so.

Sincerely,

Dr. Randi Lampert
Pediatrics
Las Vegas

From: [Amy Brenner](#)
To: [DHCFP 1332waiverprogram](#)
Subject: Sign Up for Market Stabilization ListServ
Date: Saturday, December 16, 2023 9:57:32 PM

WARNING - This email originated from outside the State of Nevada. Exercise caution when opening attachments or clicking links, especially from unknown senders.

Hello,

I am not in favor of a state run health insurance program., if it is administrated by The Nevada Department of Insurance (NDI). The NDI's stipulations for auto insurers have caused auto insurance premiums to become some of the highest in the nation. I do not want to see this happened to public health insurance offerings in the state of Nevada.

Amy K. Hebel-Brenner, M.Ed.

775-357-6734

amykbrenner@gmail.com

From: [Jamie Uriaga](#)
To: [DHCFP 1332waiverprogram](#)
Subject: Practice in Nevada program
Date: Sunday, December 17, 2023 4:57:23 PM

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Practice in Nevada program

I am interested in finding out more about this program for MD loan repayment- who is eligible, when and how to apply, any pertinent details. Please provide a website or brochure with details if available.

Thanks

Grassroots NV Public Option Written Comment

12/16/23

Nevada Department of Health and Human Services
400 West King Street, Suite 300
Carson City, Nevada 89703

RE: Nevada Draft Section 1332 State Innovation Waiver Application Public Notice

Thank you to the Nevada Department of Health and Human Services (DHHS) and the Nevada Division of Health Care Financing and Policy for the opportunity to provide comments on Nevada's section 1332 State Innovation Waiver application.

Even with expanded access to public and private health insurance coverage during the pandemic, Nevada suffers the highest uninsured rate of any state that has expanded Medicaid. [Nearly half](#) of uninsured Nevadans report the major reason they are uninsured is due to coverage being "too expensive". For those who can access health insurance, individual marketplace premiums have continued to [rise](#). As a result, many Nevadans, like myself, go without care or are forced to make difficult choices between necessities like food, rent, and getting the care we need.

My husband found cancer in his liver and had to have a doctor for every organ of his body. He was put on the transplant list and given extensive medication. It cost around 500 to 600 dollars a month. In a short period we almost lost our house; while my family lived in and out of California in hotels. Fortunately a friend of mine had loaned me an RV to make living in California possible during his treatment. Having a public health insurance option would have saved us the time and efforts to find adequate coverage instead of bouncing around health insurances to cover my husband's medical expenses.

I support Nevada's creation of a Public Option that meets the same standards and offers the same essential benefits as private plans offered in the individual market. For those without access to coverage, this new affordable coverage option will be a lifeline that will save people money and allow them to more easily plan and budget for their family's needs.

Thank you for the opportunity to provide comments on the section 1332 waiver application in support of Nevada's Public Option.

Sincerely,
[Ethelinda Fincher](#)
[7024618281](#)

From: [Keiara Katz](#)
To: [DHCFP 1332waiverprogram](#)
Cc: jclark@forourfuturefund.org
Subject: RE: Nevada Draft Section 1332 State Innovation Waiver Application Public Notice
Date: Tuesday, December 19, 2023 11:08:08 AM

WARNING - This email originated from outside the State of Nevada. Exercise caution when opening attachments or clicking links, especially from unknown senders.

12/19/2023

Nevada Department of Health and Human Services
400 West King Street, Suite 300
Carson City, Nevada 89703

RE: Nevada Draft Section 1332 State Innovation Waiver Application Public Notice

Thank you to the Nevada Department of Health and Human Services (DHHS) and the Nevada Division of Health Care Financing and Policy for the opportunity to provide comments on Nevada's section 1332 State Innovation Waiver application.

Even with expanded access to public and private health insurance coverage during the pandemic, Nevada suffers the highest uninsured rate of any state that has expanded Medicaid. [Nearly half](#) of uninsured Nevadans report the major reason they are uninsured is due to coverage being "too expensive". For those who are able to access health insurance, individual marketplace premiums have continued to [rise](#). As a result, many Nevadans, like myself, go without care or are forced to make difficult choices between necessities like food, rent and getting the care we need.

As a Nevadan diagnosed with Relapsing-Remitting MS in 2017 and serving as a District Activist Leader with the National MS Society, I strongly endorse the passage of the bill to implement the Public Option in our state. Having personally grappled with the challenges of insurance pre-authorizations and witnessed the struggles of countless individuals facing high healthcare costs, I believe the Public Option is a vital step towards addressing the gaps in our current system. The bill's enactment would signify a significant stride towards accessible and affordable healthcare for all Nevadans. By sharing my story and advocating for this crucial change, I hope to contribute to a progressing healthcare system that prioritizes the well-being of individuals over financial barriers. I urge policymakers to consider the transformative impact the Public Option can have on the lives of people like me and to actively support its passage to benefit our community's health and prosperity.

I support Nevada's creation of a Public Option that meets the same standards and offers the same essential benefits as private plans offered in the individual market. For those without access to coverage, this new affordable coverage option will be a lifeline that will save people money and allow them to more easily plan and budget for their family's needs.

Thank you for the opportunity to provide comments on the section 1332 waiver application in support of Nevada's Public Option.

Sincerely,

Keiara Katz
NV District Activist Leader
National MS Society

702-528-1734

www.linkedin.com/in/keiarakatz

nationalmssociety.org

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"The journey of a thousand miles begins with a single step."

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From: [Kevin Clarke](#)
To: [DHCFP 1332waiverprogram](#)
Subject: 1332WaiverProgram@dhcfp.nv.gov
Date: Tuesday, December 19, 2023 2:58:42 PM

WARNING - This email originated from outside the State of Nevada. Exercise caution when opening attachments or clicking links, especially from unknown senders.

Thank you to the Nevada Department of Health and Human Services (DHHS) and the Nevada Division of Health Care Financing and Policy for the opportunity to provide comments on Nevada's section 1332 State Innovation Waiver application.

I have spent the majority of my life being the sole provider of my household of 7. In 2017 I found myself out of the job I held my entire adult life which had given the entirety of my family insurance. Searching in the job market found me relocating myself, my wife, and 5 children to the Las Vegas Valley in pursuit of a more affordable life. The new job didn't have health insurance provided as my previous job did, so for my first 3 years in the Valley we bit the bullet and went without Health Insurance as a family. That meant no check ups or doctor's appointments, my youngest son accrued 6 cavities in this time.

My eldest son passed out due to heat exhaustion in this time period, after his visit to the emergency room we found a medical bill towering over the cost of \$8,000 which we couldn't afford. I wouldn't wish this uncertainty and economic anxiety on any Nevadan. Having a Public Option would mean that families like mine would have never had to look down the barrel of a world without access to Health Care. The well being of myself and my children wouldn't be left at the hands of the job I am employed by and provide a lifeline to those of us who can't afford it. I support Nevada's creation of a Public Option that'll make sure no one will have to go through what I went through.

Thank you for the opportunity to provide comments on the section 1332 waiver application in support of Nevada's Public Option.

Sincerely,

Kevin Clarke Sr
nivek177@yahoo.com



*Sowjanya Reganti, MD, President
Joseph Adashek, MD, President-Elect
Andy Eisen, MD, Immediate Past President
Jeffrey Roth, MD, Secretary
Jay Morgan, MD, Treasurer
Steve Lore, MD, Rural Representative
Florence Jameson, MD, Chief AMA Delegate
Andy Pasternak, MD, AMA Delegate
Joseph Adashek, MD, AMA Alternate Delegate
Peter Fenwick, MD, AMA Alternate Delegate
Sarah Watkins, Executive Director
Jacqueline L. Nguyen, JD, Policy Director*

December 18, 2023

Nevada Department of Health
and Human Services
Richard Whitley, Director

Via Email: 1332WaiverProgram@dhcfp.nv.gov

Division of Health Care Finance and
Policy Department of Health and Human Services
Stacie Weeks, Administrator

Re: 1332 Waiver Program

Dear Director Whitley and Administrator Weeks:

On behalf of the Nevada State Medical Association (NSMA), the state's largest and oldest organization representing physicians and physician assistants, we are writing to express concerns regarding Nevada's proposed public option 1332 waiver and its potential implications for patients, physicians, and the healthcare landscape within our state.

NSMA and our physicians are dedicated to providing quality care to our community. We are deeply invested in the welfare of our patients and the viability of healthcare delivery systems. While the intention behind the proposed public option policy is commendable in aiming to increase accessibility and affordability of healthcare, there are several key concerns that need to be addressed to ensure its successful implementation without compromising the quality of care provided.

NSMA is committed to the goal of improving access to, and affordability of, health insurance for all in Nevada. We believe that public options should have the goals of maximizing patient choice of health plans and that there should be health plan marketplace competition. However, this must be done with guardrails in place to protect physicians and their patients. Especially in Nevada, which has a dire physician shortage, any efforts to implement the public option without prioritizing quality access to care and physician workforce expansion will have the ultimate effect of harming patients in our state.

Since the inception of this policy, NSMA has stood with its healthcare allies in thoughtful opposition, but we understand the Administration is required by law to move forward and would ask the Division to consider the following concerns we continue to underscore when submitting the final waiver.

First, the reimbursement rates outlined in the proposed policy are alarming. As a crucial component of sustaining medical practices, fair and sustainable reimbursement rates are essential to support the comprehensive care we offer to patients. In the public option, provider rates are tied to Medicare, which is set to receive a 3.36% cut in 2024, after having just received a 2% cut in 2023. In fact, since 2001, Medicare physician payments have been cut 26% once you calculate in inflation. This is not a feasible benchmark. Additionally, for any services not covered by Medicare, the policy states that reasonable rates will be calculated against the Public Employees Benefits Program rates or Medicaid. Mandating a proposed rate, as they stand, negates any negotiating position for physicians and poses a significant threat to the financial viability of medical practices, potentially leading to reduced access to care and jeopardizing the sustainability of healthcare services across the state. Therefore, while we understand Medicare rates are required by NRS 695k, we would ask that in the waiver, physicians have the ability to negotiate rates NOT covered within Medicare.

Additionally, the administrative burdens associated with the implementation of the public option policy are a cause for concern. Additional bureaucratic complexities and regulatory requirements may impose substantial burdens on physicians and healthcare facilities, diverting valuable resources away from patient care and contributing to physician burnout. Requiring physicians who currently care for Nevadans who need to access their worker's compensation or Public Employee Benefits Program benefits to join a network without the ability to negotiate their own contracts will likely hurt all state programs and drive physicians from the market.

The reality is this- physicians who take Medicaid currently are already doing so to provide a service to our community. In most instances, the Medicaid portion of their practice is a loss for the provider. This loss can only be supported by a carefully considered payor mix. To increase their Medicaid patient population by mandating participation in the public option disrupts their practices' payor mix that allows them to keep their practices open. By mandating any physician that already does a service to the community by taking Medicaid to participate in the public option may have the unintended consequence of driving many providers from the Medicaid system as a whole. We would ask for a waiver, beyond the rural populations, for physicians to opt out of mandated service in the public option.

Finally, the lack of clear mechanisms for addressing these concerns and actively involving healthcare stakeholders, particularly physicians, in the policymaking process is discouraging. Collaborative dialogue and input from frontline healthcare providers are essential to develop policies that effectively address the needs of both patients and healthcare professionals.

We urge the Division to consider these concerns seriously and engage in open dialogue with healthcare stakeholders to collaboratively devise solutions that ensure the success of the public option policy while safeguarding the quality of healthcare delivery. Preserving a sustainable and thriving healthcare environment in Nevada requires thoughtful consideration of these issues and a concerted effort to address them in the policy framework.

Regarding the specific waiver proposals:

State-Based Reinsurance Program:

NSMA acknowledges that a reinsurance program may help alleviate any disruptions to the insurance market. However, since the plan is tied to the public option, which mandates the new Battle Born State Plans to meet annual premium reduction targets, NSMA is concerned that there will be cost shifting to the contracted physicians. As stated in our public comments during the hearings for Senate Bill 420, NSMA urges for safeguards for providers that ensure that the premium reduction targets are mandated to be sourced from efficiencies in carrier management.

Quality Incentive Program (QIP) for Issuers:

NSMA agrees that a QIP program will work to incentivize carriers to use value-based measures to improve health outcomes. However, these measures cannot be made on the backs of an already stretched provider population. NSMA recommends that any quality incentive payment made to carriers also incorporates the criteria that such carriers demonstrate that they pay providers at a rate comparable to commercial rates. This will then be a dual incentive to carriers to accomplish the goals of improved health outcomes for patients while also recognizing the important goal of maintaining and then increasing the provider workforce.

“Practice in Nevada” Incentive Program for Health Care Providers:

NSMA applauds the state’s plan to finance a new “Practice in Nevada” program. In the Waiver Application, the state asserts that “increasing the number of providers is essential to addressing poor health outcomes and health disparities. It is also important for controlling the rise in the cost of health care and ensuring the stability of the State’s insurance market.” NSMA wholeheartedly agrees.

Therefore, we would assert that the creation of the Practice in Nevada program should receive higher priority to receive money from the pass-through funding. Additionally, it would be critical to have the NSMA take a significant stakeholder position in the creation, maintenance, and oversight of the program as our physician members are on the front lines of recruitment of physicians into the state.

We also urge that the Practice in Nevada program be expanded to not only areas that are designated federal Health Professional Shortage Areas but opened to all of Nevada as our provider shortages are statewide.

We understand submission of a waiver is required by law, but we strongly urge thorough consideration and thoughtful revision of the proposed 1332 waiver to safeguard the interests of our residents and preserve the integrity of our healthcare system. It is imperative that any changes made prioritize maintaining and enhancing the accessibility, affordability, and quality of healthcare for all Nevadans.

Thank you for your consideration of these critical matters. The Nevada State Medical Association and our physicians are available and eager to contribute to constructive discussions aimed at improving our healthcare system for the benefit of all Nevadans.

Sincerely,

Jacqueline L. Nguyen

Jacqueline L. Nguyen, JD
Policy Director
Nevada State Medical Association



December 19, 2023

Stacie Weeks, Administrator
Division of Health Care Financing and Policy (DHCFP, Nevada Medicaid)
1100 East William Street, Suite 101
Carson City, NV 89701

Dear Administrator Weeks,

As the largest and broadest-based business organization in Nevada, the Vegas Chamber is focused on helping Nevada businesses succeed and grow. It has been part of the core mission of the Vegas Chamber to support employers, their employees, and the Southern Nevada community since its founding in 1911.

Overwhelmingly, our members identify healthcare as one of their biggest challenges regarding employee retention and recruitment in our community. That is why the Chamber has been a longtime proponent that every Nevadan should have access to affordable healthcare coverage.

However, the Chamber believes that Senate Bill 420, since its introduction and adoption by the State Legislature in 2021, does not support that objective. Instead, it will hinder and impede Nevadans' access to quality, affordable healthcare and have many unintended consequences. The reality is that expanding access to affordable healthcare needs to be a market-driven process with sustainable solutions and should not be reliant on government mandates and directives.

The Chamber maintains that Nevada's Public Option program will not reduce health care costs, but rather, it will shift costs onto other Nevadans, which is not equitable and can be devastating to Nevadans. It is a program that will not help Nevada's families but has the potential to harm access to health providers and services. Furthermore, mandating a state insurance plan to offer a rate five percent lower than commercial rates is another cost-shift. As you know, evidence from other states that have implemented similar Public Option programs indicates that insurance costs go up, which is very concerning to employers and employees and their families. Our priority is to support Nevadans and their families, and that is why the Chamber continues to be opposed to the program.

While the State is trying to mitigate many of the above-mentioned concerns with its 1332 Waiver Application, the need for the waiver application highlights the challenges and problems associated with the Public Option program and the negative impact it will have on Nevadans' access to healthcare. Please note that the Chamber does appreciate the efforts by Governor Lombardo and the agency to mitigate the negative effects on SB 420. But unfortunately, this does not go far enough in addressing the fundamental flaws of the legislation and the program.

If we can provide any further assistance or information, please contact us at 702.641.5822. Thank you for your time and consideration on this important policy matter.

Sincerely,

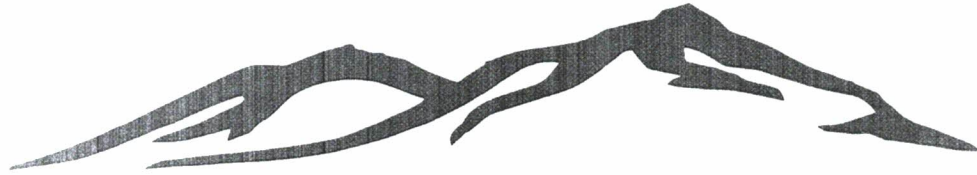
A handwritten signature in cursive script that reads 'Mary Beth Sewald'.

Mary Beth Sewald
President & CEO

A handwritten signature in cursive script that reads 'Hugh Anderson'.

Hugh Anderson
Government Affairs Committee, Chairman

575 Symphony Park Ave., Ste. 100
Las Vegas, NV 89106
702.641.5822 • VegasChamber.com



PHILIP MALINAS, M.D. & ASSOCIATES

Child, Adolescent and Adult Psychiatry

Dear Nevada Division of Health Care Financing and Policy,

I'm a psychiatrist from Reno in support of the framework proposed to create a public health insurance option in Nevada.

Health care in Nevada has become more expensive and difficult to access for too many. Eleven percent of Nevadans are uninsured, and even insured Nevadans report experiencing health care affordability burdens. At the same time, patients seeking care are experiencing long wait times for both primary and specialty visits. In 2021, Nevada was ranked 48th in the United States with regard to primary care physician availability per 100,000 residents. To get an appointment with a psychiatrist can take many months, if you can get in to see one.

Thankfully, the public option and its proposed initiatives can help alleviate these issues, which are impacting patients like mine on a daily basis. By making health care coverage more affordable and encouraging more physicians to "Practice in Nevada" this framework will make it easier for patients to get care when they need it, not just when they can afford it or months down the line when a doctor is finally available. The public option will also encourage competition, incentivizing better care delivery that prioritizes positive health outcomes.

I look forward to the implementation of this framework and the health benefits it will bring to my patients and community. I encourage the Nevada Department of Health and Human Services to continue looking at ways to bring health care providers into Nevada, make healthcare more affordable, and increase access.

Thank you for the opportunity to provide these comments.

Sincerely,

A handwritten signature in black ink, appearing to read "Philip Malinas", written over a horizontal line.

Philip Malinas, MD
Child, Adolescent and Adult Psychiatrist
Reno

December 19, 2023

Department of Health and Human Services
Division of Health Care Financing and Policy (DHCFP)
1100 East William Street, Suite 101
Carson City, NV 89701

Submitted electronically to: 1332WaiverProgram@dhcfp.nv.gov

RE: Nevada Coverage and Market Stabilization Program

Dear DHCFP:

The Nevada Hospital Association (NHA) is grateful for the work of Governor Lombardo's Office and DHCFP in developing the new Nevada Market Stabilization Program. This new and innovative program addresses many of the concerns the NHA has raised since the passage of SB420. However, we still have a few concerns stemming from the original legislation.

Working together, we hope to overcome the significant challenges posed by the original legislation in introducing a new health insurance product to the market.

1. Premium Reductions

SB420 required health insurance premium reductions of 15% in the first four years of the Public Option. This is a significant reduction in a short period of time. In trying to meet this requirement, insurance companies will likely lower reimbursement to healthcare providers who currently experience extremely low reimbursement rates from Medicaid and Medicare and have significant costs related to uninsured and underinsured patients.

These lower rates will exacerbate an already severe physician shortage. Nevada needs 1,589 physicians to meet the national average¹, and ranks 45th for active physicians among U.S. states². Nearly 70% of the state's population resides in a Primary Medical Health Professional Shortage Area (HPSA)³. Moving patients from commercial rates to lower

¹ Nevada Health Workforce Research Center, "Physician Workforce in Nevada: A Chartbook," 2022 edition

² Nevada Health Workforce Research Center, "Physician Workforce in Nevada: A Chartbook," 2022 edition

³ UNR School of Medicine, Office of Statewide Initiatives, Nevada Rural and Frontier Health Data Book, 11th Edition

reimbursement rates will incentivize physicians to leave the state, reduce the scope of services they provide, or stop practicing all together. This dramatic premium cut may have the opposite effect of what the program is intended to do, which is to increase access.

Patients will be harmed by this as well. In addition to decreased access to physicians, patients will likely experience coverage denials as insurance companies work to control expenses. A forced reduction in premiums may have unintended consequences.

2. Reimbursement Rates

SB420 set a baseline for reimbursement. It required providers to be paid at least Medicare rates. This requirement is often referred to as a “floor” for rates. We are concerned that Medicare rates will also become the “ceiling” for rates paid to providers.

The State recognized that Medicare rates may be the maximum reimbursement that providers will receive under SB420. Medicaid Administrator Bierman wrote in her guidance issued on October 4, 2022, when revising the “reference premium” from a 5% reduction to 4%:

“[...] the 15 percent target in subsection 5 would create a direct conflict with the Director's duty to meet the express mandate in NRS 695K.240, which is to ensure **provider reimbursement rates in the Public Option are no lower than Medicare rates** (i.e., the express provider-reimbursement mandate). This is because the definition of “reference premium” in subsection 6 creates an unintended and unreasonable result with respect to premium reductions in the Public Option, where **health carriers would be required to lower premiums to levels that risk actuarial soundness and full compliance with the express provider-reimbursement mandate under NRS 695K.240.**” (Emphasis added)⁴

The Public Option of SB420 may not be actuarially sound if providers are actually paid above Medicare rates.

Currently, Medicare does not reimburse healthcare providers for the full cost of care. It only covers approximately 87% of a hospital's cost⁵ to provide services to a Medicare Beneficiary. This contributes to the cost shifting problem plaguing Nevada and many other states. Cost shifting occurs when healthcare costs are shifted from governmental payors and the low and uninsured patient populations to those who have commercial insurance.

The Market Stabilization Program can help alleviate this significant issue through an incentive encouraging insurance providers to offer healthcare providers reimbursement rates that are

⁴ General Guidance Letter 22-001

⁵ *Medicare Information, 2019, Fortune Magazine, Spring 2021*

comparable to the self-insured and commercial markets. Those incentives can be optimized by reinsurance metrics that reward their use.

3. Limiting Enrollment

Limiting enrollment in the program is imperative. It is essential to preserve our commercial health insurance markets. The more Nevadans who enroll in the Public Option, the greater the cost shift to Nevadans who maintain commercial health insurance. Eventually, commercial insurance will be unaffordable. People will move to the Public Option because it is cheaper. This will cause commercial insurance to disappear, and providers will leave the state due to poor reimbursement rates for their services. Again, this adversely affects patient access.

The program should focus on providing health insurance to those who are ineligible for other programs or who pay extraordinary premiums and deductibles.

While there are many challenges that lie ahead, we look forward to collaborating with the Administration and legislators to address them while maintaining and enhancing access to healthcare for all Nevada communities.

Very truly yours,



Patrick D. Kelly
President and CEO
Nevada Hospital Association



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Washington, D.C. 20004 ahip.org

December 20, 2023

Stacie Weeks, Administrator
Nevada Department of Health and Human Services
Division of Health Care Financing and Policy
1100 East William Street, Suite 101
Carson City, NV 89701

Re: Comments on 1332 Waiver Application

Dear Administrator Weeks:

AHIP and its member plans appreciate the opportunity to provide comments on the Nevada Coverage and Market Stabilization Program Section 1332 waiver application. Every Nevadan deserves affordable coverage and access to high-quality care -regardless of income, health status or preexisting conditions. We agree that hardworking Nevadans who purchase their coverage in the individual market increasingly find health care costs and as a result premium costs out of reach if they do not qualify for premium subsidies. We believe that the foundation of the Section 1332 waiver application – implementation of the public option - will not address these concerns or the underlying factors driving health care costs. Instead, it would eliminate competition and choice and ultimately undermine health care affordability for Nevadans.

As noted during the December 5th public workshop, AHIP appreciates the Administration's efforts towards "reformulating" the public option through a unique market stabilization plan. However, the proposed waiver at its core remains an attempt to implement SB 420's public option, and it therefore continues to suffer from many of the same shortcomings and fundamental flaws that AHIP and other stakeholders previously identified when SB 420 was under debate. We remain very concerned on key problematic items, discussed below, and would request the Division address these concerns prior to submitting the 1332 waiver application.

Public Option

AHIP has repeatedly expressed concerns about the implementation of a government-controlled health insurance plan with unrealistic targets for premium reduction. We have historically supported state actions that reduce premiums and out-of-pocket costs, including Section 1332 reinsurance waivers across the country and state programs that reduce cost-sharing. However, as designed, the Nevada public option program would not achieve this goal.

The Public Option program intends to lower premiums by at least 15% through reductions in provider reimbursement, reductions in administrative costs by health insurance providers, and improved cost efficiencies through value-based purchasing. We have significant concerns about the proposed administrative cost constraints and provider reimbursement reductions:

Administrative Cost Constraints

Under the administrative cost constraint, health insurance providers would be required to reduce a portion of their administrative expenses for public option plans, referred to as Battle Born State Plans (BBSPs), in a manner that is stricter than prevailing individual market QHP administrative expense loads. However, there are no provisions of the public option that lower administrative costs, in fact, additional requirements for health insurance providers may increase costs. Administrative costs are not just profit. Administrative costs include spending that is important to patient care and include programmatic patient services that help lower the cost of care, increase access, and improve outcomes. Such programs include 24/7 nurse lines, medical interpreters and translation services, fraud/waste/abuse programs, and interactive technology and transparency tools. Health insurance providers are already subject to strict medical-loss

ratio (MLR) requirements under the Affordable Care Act (ACA) and those requirements are successfully working to place guardrails around administrative costs. As a result, the number of MLR rebates issued to Nevadans has substantially decreased over recent years. Reducing administrative costs beyond the current ACA MLR requirements will limit the ability of health insurance providers to design and offer programs that directly benefit patients.

A recent [actuarial analysis](#) conducted by Wakely Consulting Group found that a 3% increase in loss ratio could reduce a low-cost health insurance provider's risk margins to 0%. Such a risk margin does not allow for an actuarially appropriate margin of error in estimating claims and risk adjustment expenses. This could have negative implications for competition, deterring new entrants to the market, and potentially causing health insurance providers to exit the market.

Provider Reimbursement Reductions

Setting reimbursement rates for doctors and hospitals at below-commercial market rates is unsustainable and will result in cost-shifting to other purchasers of health insurance coverage, including employers. Federal price-cap proposals have repeatedly been dismissed because they posed too many risks to the health care delivery system. To recoup the burden of these under-compensated costs, providers will shift to other purchasers of health insurance coverage in the form of higher reimbursement rates. These higher rates will, in turn, put upward pressure on premiums paid by small and large employer groups, self-insured plans, and Taft-Hartley trust plans, such as the state of Nevada Public Employees' Benefits Program (PEBP) and those covered under the Culinary Union and School District self-funded plans.

The impact of provider reimbursement reductions as a significant source of the premium reduction is not adequately explored in the waiver application actuarial analysis conducted by Milliman. It is unclear the amount of the reimbursement reductions, and how they will be distributed among different geographies and specialties. The Wakely analysis notes that physician rates, on average, are likely already at or near 100% of Medicare Fee-for-Service. With the public option floor for average physician reimbursement at 100% Medicare FFS, little to no premium savings can be expected via physician reimbursement cuts. Significant reductions would disincentivize providers from participating in BBSPs, and present real potential for a formation of two tiers of individual insurance products—more expensive individual market plans with greater provider participation and BBSPs with less provider participation and the perception of having “lower quality doctors”. The Milliman analysis enrollment projections assume similar levels of the perceived provider quality and access in the BBSPs and other types of individual market products. If consumers perceive differences in provider quality, breadth, and access, we anticipate some consumers would prefer to remain in individual market plans with better provider access rather than switching to lower-cost BBSPs. Consumers who enroll in BBSPs may experience dissatisfaction with provider quality, breadth, and access. If so, this would affect both the growth projection in the BBSPs and the savings.

Additionally, reducing reimbursements to these providers would exacerbate the state's already significant access issues. The recent Nevada State Health [Assessment](#) from the Division of Public and Behavioral Health reported that access to care continues to be a major problem due to physicians shortages in all areas of the state. Nevada ranks 45th in the nation for active physicians per 100,000 population, 49th for primary care physicians, and 49th for general surgeons. The question of how BBSPs will ensure adequate provider networks, especially in rural areas of the state, when there is an existing provider shortage is not answered in the actuarial analysis.

Experience in Other States

We do not believe the public option will produce the desired results, and we can look to examples from other states that have implemented similar programs, such as Washington and Colorado, where the public option has yet to show it has been successful in driving down costs, increasing competition and choice, making healthcare more affordable. As an example, Colorado only had one small health insurer, Denver Health, that could meet the 5% premium reduction requirements for its public option plans in 2023 in the Denver metro area and those plans were priced at a loss. For 2024, no carrier, including Denver Health, is able to meet the state's public option premium reduction requirements.

Rather than creating a government-controlled health insurance plan, Nevada should continue to focus on strategies to enroll Nevadans in coverage options that are available today, including Medicaid and federally subsidized plans offered on Nevada Health Link. Our members stand ready to work with you and other stakeholders to make coverage more affordable, but we must do it in ways that do not destabilize or jeopardize the state's health insurance market for all Nevadans and provide real, immediate assistance to improve health insurance coverage options for all Nevadans.

Medicaid Managed Care

AHIP has concerns with deeply problematic language connecting the state's Medicaid managed care plans with public option plans. The waiver requires health insurance providers bidding to participate in Nevada's Medicaid Managed Care program to also submit bids to offer individual market BBSPs in a concurrent statewide procurement. We are especially concerned that *scoring* for Medicaid managed care procurement would be based on the issuer's public option bid, which goes above and beyond existing requirements for managed care issuers to offer a silver and gold QHP.

This requirement could potentially deter new entrants into the market and jeopardizes competition and patient choice. The Medicaid market in Nevada is relatively small compared to other states. While some health insurance providers may excel at providing a great Medicaid managed care product, they may not be positioned to do as well on the individual market. Medicaid and individual coverage are distinct products and markets, tailored for specific populations, with their own unique regulatory structures and risk pools. Health insurance providers with experience offering Medicaid managed care products may struggle to meet the required premium targets and benefit designs in the individual market. No other state that has pursued a public option that ties the public option contracts with Medicaid managed care.

The Medicaid market in Nevada is relatively small compared to other states. The currently proposed regulations could disincentivize health insurance providers from participating in Medicaid bidding--potentially leading to a chilling effect of insurers choosing not to participate in the Medicaid program, which means less competition and choice for Nevadans.

Additionally, health insurance providers that remain in the Medicaid market will have to attract providers in their BBSP network despite the lower reimbursement rate. To do so, they will have to leverage their Medicaid provider network by requiring providers to be in-network for both programs. Medicaid providers may be reluctant to join networks accepting the lower-reimbursed public option patients and drop out of networks, leading to access and appointment wait time issues. Although SB 420 gives the state authority to waive these provisions, this is likely to add undue burden on DHCFP and PEBP. In short, the tying of the participation in the Nevada Medicaid and the BBSP creates a potentially significant impact on Medicaid, and the magnitude and consequences of this impact are not explored in the Milliman report. Doing so could potentially increase provider shortages and destabilize the Nevada Medicaid program.

Marketplace Stabilization

AHIP supports state reinsurance programs that lower premiums for individuals and families. Successful state reinsurance programs with broad-based funding mechanisms allow health insurance providers to offer more affordable coverage in the individual market and increase competition and the number of plan options for residents. We want to partner with the Department as they design the reinsurance program to ensure maximum premium relief while also maximizing the state's investment and securing adequate funding.

While we are generally supportive of the proposal to establish a state reinsurance program, we are concerned that the waiver application does not meet federal requirements. Federally-approved reinsurance programs require funds for the first year of operation. As noted in the waiver application, the operation of the reinsurance program would be reliant on the amount of federal pass-through funds available starting in year two. Relying on public option premium reductions is not a viable model for financing the state's portion of reinsurance. If assumed premium reductions do not materialize, funding for

the reinsurance program will not be available. Corrections to the reinsurance funding are necessary to demonstrate that the program doesn't lead to unforeseen adverse impacts on affordability or access.

AHIP has concerns with the tiered structure of the reinsurance program and differing coinsurance levels in specified rating areas. As specified in the Milliman analysis, the proposed tiering has significantly lower coinsurance for rating areas 1 and 2, than for rating area 3. This would result in the reinsurance program having a much lower impact on premiums in those rating areas, making it challenging for health insurance providers to meet the 15% premium reduction targets in those locations.

We are also concerned that utilizing a state reinsurance program does not overcome the numerous and fundamental flaws of a public option. While we appreciate the Executive Branch's attempt to mitigate the harmful impacts the public option would have on the state's health care sector, we believe the proposed waiver application cannot avoid the fundamental defects AHIP and other stakeholders previously identified with the public option itself.

Our members are eager to work with the Department to pursue policies that will work. However, we do not believe the public option is a sustainable, long-term solution for Nevada's health care affordability issues. Please do not hesitate to contact me with any questions at lrich@ahip.org.

Sincerely,

A handwritten signature in blue ink that reads "Laura Rich". The signature is written in a cursive, flowing style.

Laura Rich
Regional Director

AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone. Visit www.ahip.org to learn how working together, we are Guiding Greater Health.

From: [Ellen Eversole](#)
To: [DHCFP 1332waiverprogram](#)
Subject: 1332 Waiver Application Public Comment Submission
Date: Wednesday, December 20, 2023 1:41:34 PM

WARNING - This email originated from outside the State of Nevada. Exercise caution when opening attachments or clicking links, especially from unknown senders.

To the Nevada Department of Health and Human Services,

My name is Ellen Eversole and I have been working as a registered nurse in Clark County since 1985. I now volunteer as an Advance Practice Registered Nurse in Clark County. Additionally, I am an assistant professor of nursing at a university in Henderson.

In the 38 years that I have been delivering healthcare to Nevadans, I have witnessed patient delays in receiving care or patients going without care due to them not being able to afford to pay the bill. Furthermore, these patients were unable to get access to quality insurance or could not find much needed specialty care. How did these patients eventually get treated? The answer is emergency rooms. I cannot state enough how emergency rooms have become the defacto source of primary care for thousands of Nevadans, simply because coverage or affordable care is out of reach.

Instead of having a chance at treating and preventing serious illnesses, Nevadans have been forced to seek medical care at the most dire times of their lives, because without quality insurance, they did not have access to primary care providers and routine wellness checks

I am now speaking up and sharing my voice because these individuals are my neighbors and are a part of my community. They are NEVADANS and need help and support. Finally, we have a policy solution that can assist them with the Nevada Public Option!

I am very supportive of the Public Option and the 1332 Waiver application as it will deliver real results that support the patients. The reduction in premiums of 16% over five years will make healthcare more affordable for Nevadans, who are currently being priced out of the market, and it will keep insurance for them affordable. The end result will be access to affordable healthcare; hence, the prevention of chronic diseases that could cost thousands of dollars to them and to the state.

Additionally, I am excited to see the savings our state will see through Public Option's investment in healthcare workforce development. We have seen Nevadans suffer from a shortage of healthcare professionals including nurses, primary care providers and specialty providers. This we have seen for decades. Now, with the hundreds of millions of dollars that we will see from Public Option, we can invest in workforce development that will result in optimal training and gainful pay for a healthcare industry that has been sorely underfunded. While the largest insurance

corporations in the world extract millions and millions of dollars from Nevadan families, we do not see those dollars being reinvested in the state to improve care, attract healthcare providers or modernize treatment protocols. We can change this with 1332 Waiver. This is something that Nevadan desperately needs. I am absolutely thrilled to see the state work with the federal government to deliver real results that will help Nevadans.

Thank you so much for allowing me to share my voice and for submitting this 1332 Waiver Application to help my patients and families in communities across Nevada. This will enable everyday people get the healthcare they need, save lives and will provide hope that healthcare can get better in this state.

Sincerely,

Ellen Eversole, APRN, FNP-C
Phone: 702-371-5566
2680 Parisian Ct.
Henderson, NV 89044
ellen.eversole@yahoo.com

From: [Nita Schwartz](#)
To: [DHCFP 1332waiverprogram](#); [Jodi Helsel](#); [Nita Schwartz](#)
Subject: Public Option Comments
Date: Wednesday, December 20, 2023 2:07:01 PM

WARNING - This email originated from outside the State of Nevada. Exercise caution when opening attachments or clicking links, especially from unknown senders.

Dear Division of Health Care Financing and Policy,

I'm writing to support the state's section 1332 State Innovation Waiver application to create the Nevada Coverage and Market Stabilization Program. As a doctor in Douglas County, I support the framework proposed to create a public health insurance option in our state.

In my 33 years of practice, I've seen countless patients harmed by Nevada's high health care costs and lack of insurance coverage. I have seen many times where people had to choose between prescription medications and other essentials like food or utilities. I have seen bad outcomes because of delays in diagnostic or therapeutic care. These problems are vastly magnified in sparsely populated and underserved areas.

The public option will prevent Nevadans from having to suffer in these ways. With the state taking this unique approach, it will:

- Make health care coverage more affordable and accessible for tens of thousands of Nevadans
- Reduce premiums and lower out-of-pocket costs for patients
- Increase access to essential providers, including in rural areas Winnemucca, where I have provided emergency department care, rural Douglas county where I live, as well as Lyon and Storey counties where I still provide medical services.
- Incentivize better care delivery that shifts away from costly fee-for-service toward better health outcomes
- Encourage more health care providers to practice in Nevada, reducing our shortage and increasing access

All these benefits will mean healthier patients and a state that leads on health care and improving health outcomes. Doctors thank you for your work toward these goals and for the opportunity to comment on the section 1332 waiver application.

Sincerely,

Dr. Nita Schwartz
Hospice Medical Director
Carson City



December 20, 2023

Richard Whitley
Director
Nevada Department of Health and Human Services
1100 E William St, Ste 101
Carson City, NV 89701

Re: Nevada Section 1332 Waiver Application

Dear Director Whitley:

Thank you for the opportunity to provide feedback on the Nevada Section 1332 Waiver Application.

The undersigned organizations represent millions of individuals facing serious, acute and chronic health conditions in Nevada. We have a unique perspective on what individuals and families need to prevent disease, cure illness and manage chronic health conditions. The diversity of our organizations and the populations we serve enable us to draw upon a wealth of knowledge and expertise that is an invaluable resource regarding any decisions affecting healthcare programs and the people that they serve. We urge the state to make the best use of the recommendations, knowledge and experience our organizations offer here.

Our organizations are committed to ensuring that Nevada's healthcare programs provide quality and affordable healthcare coverage. We appreciate that this waiver is moving forward and support the state's commitment, as codified by Senate Bill 420, to implement a new coverage program for improving access to affordable coverage. However, we urge the state to use pass-through funds generated by the waiver to support a premium subsidy program for Nevadans with low-incomes. We believe a subsidy program best aligns with the purposes of the state statute and will be far more effective at improving coverage access and affordability than the state's current proposal.

Senate Bill 420 declares that the state's new coverage program is intended to lower premiums and other healthcare costs by leveraging the state's purchasing power, improve access to high-quality and affordable healthcare, reduce disparities in access to health care, and increase competition in the individual health insurance market.¹ To support the program, state law also requires the submission of a Section 1332 waiver. The statute also identifies, as a purpose for such a waiver, securing federal financial support to subsidize health coverage for low-income residents.

Consistent with the statute, Nevada originally planned to use a Section 1332 waiver to fund a state premium subsidy program directed towards low-income enrollees.² We support this approach. Nevada ranks in the top ten states with the highest uninsured rate. Among individuals with incomes from 200-399% of the federal poverty level, Nevada's uninsured rate is nearly 15%; for those with incomes from 100-199% FPL, the rate is nearly 19%; for people under 100% FPL, it is about 20%.³ Research consistently shows that higher cost-sharing, including premiums, is associated with decreased use of preventive services and medical care among low-income populations.⁴ Nevadans, particularly those at low incomes, would better be able to afford quality coverage and to access care with the assistance of premium subsidies.

The new waiver draft proposes to use most pass-through funds to support a reinsurance program. Though we agree that reinsurance can play a role in addressing affordability, the benefits of such a program flow primarily to individuals at higher incomes who are not eligible for federal premium tax credits. It does not make coverage cheaper for people — generally at lower incomes — who already qualify for federal subsidies.⁵

As the state's own analyses demonstrate, a premium subsidy program would do far more to increase access and affordability — particularly for low-income residents — than reinsurance would. According to the state, a waiver with a premium subsidy program could be expected to increase individual market enrollment by 5,900 in 2027, rising to 12,200 by 2030. These benefits greatly exceed the predicted effects of the new reinsurance-focused waiver, which may raise enrollment by about 1,800-2,100 annually (with much of these gains concentrated among residents at higher incomes).

Once again, our organizations thank you for releasing this draft application for public comment and moving forward with the waiver process outlined in state law. We encourage you to use pass-through funds to support a premium subsidy that would maximize the number of patients and consumers who gain coverage under the waiver. Thank you for the opportunity to provide comments.

Sincerely,

American Heart Association
American Lung Association
Child Neurology Foundation
Cystic Fibrosis Foundation

Epilepsy Foundation of America
Hemophilia Federation of America
National Bleeding Disorders Foundation
National Multiple Sclerosis Society
National Patient Advocate Foundation
The Leukemia & Lymphoma Society

¹ Nevada State Legislature. Chapter 695K-Public Option. Available at: <https://www.leg.state.nv.us/nrs/NRS-695K.html>

² Section 1332 Waiver Application Nevada Public Option. Nevada Department of Health and Human Services. December 27, 2022. Available at: https://dhcfnv.gov/uploadedFiles/dhcfpnavgov/content/MarketStabilization/Archive_1332_Application_Consolidated_Remediated.pdf

³ KFF, Uninsured Rates for the Nonelderly by Federal Poverty Level (FPL), 2022. Available at:

<https://www.kff.org/uninsured/state-indicator/nonelderly-uninsured-rate-federal-poverty-level-fpl>.

⁴ Artiga, Samantha, Ubrri, Petry, and Zur, Julia. The Effects of Premiums and Cost-Sharing on Low-Income Populations: Updated Review of Research Findings. KFF. June 1, 2027. Available at:

<https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/>

⁵ This is because of how ACA premium tax credits are calculated. In practice, from a consumer standpoint, reinsurance functions as a premium subsidy for people who are otherwise unsubsidized: in general, it lowers premiums for those who earn too much to qualify for a federal premium tax credit but does not improve affordability for those who, because they are at lower incomes, receive the premium tax credit.



Our Mission

The Health Services Coalition is dedicated to improving the quality, affordability and accessibility of health care in Southern Nevada for its members and the community at large.

Better: [#BetterCareNevada](#)

December 18, 2023

Mr. Richard Whitley, Director
Nevada Department of Health and Human Services
400 West King Street, Suite 300
Carson City, Nevada 89703

Via email (1332WaiverProgram@dhcfp.nv.gov)

RE: 1332 Waiver Application and Actuarial Analysis (Public Option/Market Stabilization Program)

We have been tracking the Nevada Public Option since it was created by a group called “New Day,” and then proposed by Senate Majority Leader Nicole Cannizzarro as SB420 in 2021. It has now been rebranded and restructured by the Governor Lombardo Administration as the “Nevada Coverage and Market Stabilization Program.” The Health Services Coalition, representing 280,000 lives in Nevada, remained neutral but shared ongoing concerns about the impact of the enacted SB420 on the overall healthcare market and provider shortages. We now oppose this first-in-nation federal waiver request for an additional commercial insurance subsidy program in Nevada.

First and foremost, the proposed Coverage and Market Stabilization Program completely reverses the potential positive impact of creating accountability within the commercial insurance industry for their high prices and profits. Instead, it becomes a costly taxpayer commitment to the already highly profitable commercial insurance industry. The revised proposal overwhelmingly uses the federal pass-through savings generated by the public option to fund a state-based reinsurance program. This basically means the insurance industry will now have the taxpayer pay for their claims, for which they still receive premiums, enriching rather than reforming their profit margins. It also appears to create a new taxpayer paid bonus, all without legislative approval.

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Las Vegas, NV 89146
702-474-4418 office

www.lvhsc.org

Boyd Gaming Corporation
Bricklayers
Caesars Entertainment
Cement Masons and Plasterers
Health and Welfare Trust
City of Henderson
Clark County Self-funded
Clark County Firefighters
Construction Industry and Laborers
Health and Welfare Trust
Culinary Health Fund

Employee Painters Trust
Golden Nugget Hotel and Casino
IBEW 357 Electricians
Las Vegas Firefighters
Las Vegas Metropolitan Police
Dept Health and Welfare Trust
MGM Resorts International
Mirage Hotel
Nevada HAND
NV Energy
N. Las Vegas Firefighters
Operating Engineers Local 501

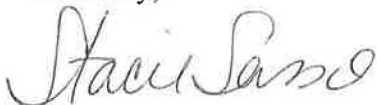
Plumbers and Pipefitters Health
and Welfare Fund
Switch
Teamsters Local 14 – Security Fund
for Southern Nevada
Teamsters Local 631 – Security Fund
for Southern Nevada
Teamsters Security Fund for So. NV - Hotel
& Casino Workers (Formerly Teamsters 995)
UFCW Local 711 and Retail Food
Employers Benefit Fund Plumbers and Pipef

Nevada's individual market exchange insurers include UnitedHealthcare, Centene, Aetna BCBS, and Elevance. These are some of the companies that, per the legislation, must submit a good faith bid to offer a public option plan on the state exchange. The new proposed waiver to create a reinsurance program will now divert the lion's share of the federal savings pass through monies, estimated to range from \$760 to \$844 million over ten years, to pay high-cost claims in the individual insurance market, further padding the insurance company profits, moving risk to the taxpayer rather than the commercial insurers. These insurers are already receiving significant federal taxpayer subsidies on the exchange through the existing structure of the ACA.

This proposed reinsurance model will now significantly reduce (or eliminate) the premium reduction targets built into the enacted Public Option program, while diverting federal savings from other uses to improve access and affordability. The commercial insurers are already heavily subsidized and profitable. UnitedHealthcare generated \$210.5 billion in revenues during the first three quarters of 2023 and \$13.2 billion in earnings from operations with a 6.3% operating margin.ⁱ The insurer's parent has returned over \$11.5 billion to its shareholders during this period through dividends and share repurchases.ⁱⁱ Centene had \$114.5 billion in revenues and \$3.1 billion in operating revenuesⁱⁱⁱ and spent \$1.6 billion to repurchase its shares.^{iv}

Unfortunately, the waiver application's inclusion of a reinsurance program – as well as a second taxpayer bite at the taxpayer apple through a new payment for quality of some kind, provides for clear favorites in Nevada's healthcare market, and they are the highly profitable insurance industry. Rather than putting the brakes on the profits of these companies in order to help contain rising prices, it steps on the gas. The Health Services Coalition opposes this use of public funding.

Sincerely,



Stacie Sasso
Executive Director

ⁱ <https://www.unitedhealthgroup.com/content/dam/UHG/PDF/investors/2023/UNH-Q3-2023-Release.pdf>

ⁱⁱ <https://www.unitedhealthgroup.com/content/dam/UHG/PDF/investors/2023/UNH-Q3-2023-Release.pdf>

ⁱⁱⁱ https://filecache.investorroom.com/mr5ir_centene/433/CNC%20%28Centene%20Corporation%29%20%20%2810-Q%29%202023-10-24.pdf_.pdf

^{iv} <https://investors.centene.com/2023-10-24-CENTENE-CORPORATION-REPORTS-THIRD-QUARTER-2023-RESULTS>



NEVADA'S
HEALTH CARE FUTURE

December 20, 2023

VIA ELECTRONIC MAIL

Stacie Weeks, Administrator
Nevada Department of Health and Human Services
Division of Health Care Financing and Policy
1100 East William Street, Suite 101
Carson City, NV 89701

Dear Administrator Weeks:

Thank you for the opportunity to offer comments on the implementation of the Nevada Public Option and the state's revised 1332 waiver application. Nevada's Health Care Future (NVHCF) is committed to working together to ensure every Nevadan has access to the affordable, high-quality health coverage and care they need and deserve.

The evidence continues to show that Nevada Senate Bill 420, which established the Nevada Public Option, will harm Nevadans' access to affordable, high-quality health coverage and care. Unfortunately, the state's proposed market stabilization program does nothing to remedy SB 420's fundamental structural flaws, nor will it shield Nevadans from the negative consequences of implementing SB 420.

When it comes to the underlying policy of SB 420, research clearly demonstrates that the consequences of creating the Public Option, an unaffordable new state government-controlled health insurance system, will be harmful to Nevadans.

Before the state's revised 1332 waiver application, NVHCF engaged Wakely Actuarial Consulting to perform an actuarial analysis of SB 420. The analysis finds that the 2021 law risks worsening Nevada's already significant health care provider shortage. Nevada has been suffering from a physician shortage, ranking 48th in the nation in primary care physicians per capita.

Among other key findings, the report warns that the law could also reduce health care competition in Nevada, cause some insurers to exit the market, deter new entrants, put increased financial hardship on hospitals, and ultimately threaten access to care for Nevada patients.

Not only does the state's revised waiver application do nothing to change the underlying flaws of SB 420, but the revisions themselves – including an attempt to mitigate the burden on providers and carriers through reinsurance, and the softening of premium reduction targets – demonstrate the harmful and burdensome consequences that SB 420 will cause.

Further, the revised waiver application relies on many misguided assumptions, the results of which could prove harmful to Nevadans. Key concerns include:

- With many providers and hospitals already at or close to 100% of Medicare fee-for-service (FFS) reimbursement rates, and without any meaningful drivers contained in this policy to lower the cost of care, there is very little chance of carriers meeting the state's premium reduction targets.
- The many new requirements and mandates for payers that SB 420 imposes could increase, rather than decrease, administrative costs, depending on factors such as unique network requirements or unique benefit design requirements. Even worse, any reduction in carriers' required risk margins could pose a significant threat to competition and consumer choice in the state, the complete opposite of the purported objectives of SB 420.
- Particularly in light of the above concerns, the assumption that the creation of Public Option plans will help lower non-public option premiums is deeply misguided.
- The degree to which the waiver ties the procurement process for Medicaid contracts directly to carriers' submission of Public Option plans for Nevada's individual market could destabilize the Medicaid program.
- With its revised application the state proposes putting into place a market stabilization program that implements and relies upon the Public Option. Tying the state's proposed reinsurance program to the creation of the Public Option is a risky strategy, and the facts suggest this is not a viable model for financing the reinsurance program.

Simply put, the revised waiver application does not fix the problems inherent in SB 420's Public Option provisions. And, given its substantial risk to Nevadans' health care access and affordability, it is notable that by the state's own calculations, this proposal would decrease the number of uninsured Nevadans by a mere 2,200 – a result which could be better achieved by private coverage and existing public programs working together.

Since our inception, we have been focused on building on what's working in health care to improve access rather than starting over. We stand ready to support policy proposals that accomplish these goals. Thank you again for this opportunity to express our serious concerns related to these policy proposals.

Sincerely,



Kelley M. Robertson

Executive Director

Partnership for America's Health Care Future Action

Nevada's Health Care Future