Questions & Answers (Q&A) for the Nevada Public Option (Senate Bill 420)

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Disclaimer: This Q&A is intended to serve as a helpful reference and resource for the public and key stakeholders regarding the Nevada Public Option as defined by Senate Bill (SB) 420. SB 420 was passed by the Nevada Legislature and signed into State law by Governor Steve Sisolak in 2021. This Q&A is intended to address many of the questions raised by stakeholders during the State's public design sessions regarding the implementation and operations of the Nevada Public Option. It also intended to provide general background on the requirements of SB 420 with respect to the design and operation of the Nevada Public Option. DHHS will continue to update this Q&A as needed to provide the most current information to the public and stakeholders.

Contents

A. Overview of the Nevada Public Option

1. What is the Nevada Public Option?

Beginning in 2026, all Nevadans who shop for health insurance in the State's individual health insurance market (which includes Nevada Health Link) will have access to a new health insurance option known as the Public Option. The Public Option is being established pursuant to Senate Bill (SB) 420 of the 2021 Legislative Session, authored by Senator Nicole Cannizaro and signed into State law by Governor Steve Sisolak on June 9, 2021.

2. What are the goals of the Public Option?

Per the stated purpose of the policy of the Legislature in section 2 of SB 420, the key goals for establishing the Nevada Public Option are to:

- Leverage the State's purchasing (contracting) power to lower premiums and costs for health care for all Nevadans;
- Improve access and reduce disparities related to quality of care and outcomes for historically marginalized communities;
- Increase competition in individual health insurance rating areas to improve availability of coverage for rural Nevadans; and
- Promote value-based health care financing.

3. Who is responsible for implementing the Public Option?

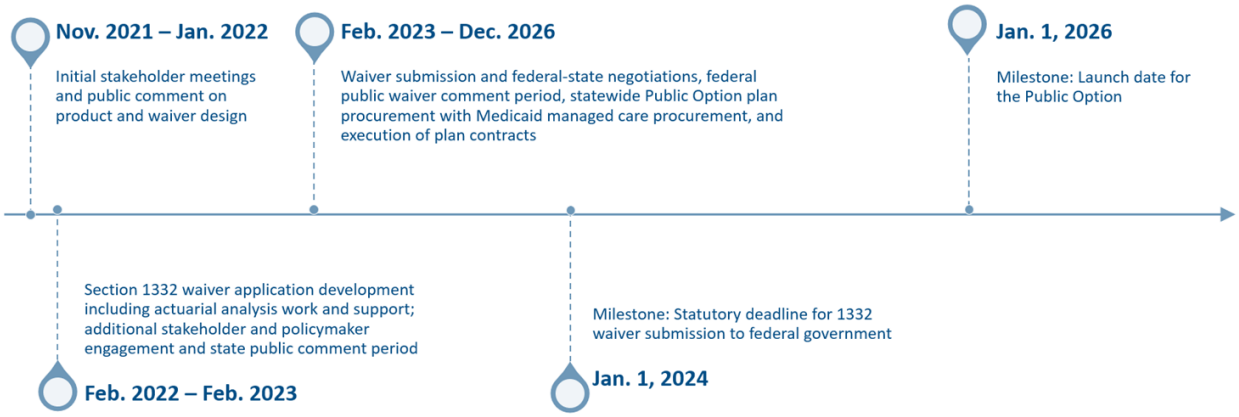
The Director of the Nevada Department of Health and Human Services (DHHS), in consultation with the Executive Director of the Silver State Health Insurance Exchange (the Exchange) and the Insurance Commissioner, is responsible for designing, establishing, and operating the Nevada Public Option in accordance with the requirements of SB 420.

4. What is the timeline for the Nevada Public Option?

The Nevada Public Option is anticipated to be available in the marketplace (https://www.nevadahealthlink.com/sshix/) for consumers to purchase beginning in January 2026 as required by SB 420. In the period leading up to this date, the State will engage in

various implementation activities including, at a minimum, engaging stakeholders on product and waiver design, developing a 1332 waiver application, negotiating the waiver application with federal officials, and conducting a new statewide public procurement for the Nevada Public Option to identify qualified carriers to offer the new Nevada Public Option plans to consumers.

Below is an estimated timeline that outlines the phases, key milestones, and implementation activities over the next five years, with the expectation that some of these timelines may need to be adjusted to address various changes or issues that may arise either at the State or federal level.



B. Key Elements of the Nevada Public Option

1. Who will be able to purchase a Nevada Public Option plan?

All Nevada residents will be able to purchase a Nevada Public Option plan. The State may also make the Public Option available to small employers or their employees to the extent permitted by federal law.

2. Where will consumers shop for and purchase Nevada Public Option plans?

Nevada consumers will be able to shop for and purchase Nevada Public Option plans through the Nevada Health Link or directly from a health carrier selling health insurance in the State's individual market.

3. Will consumers who buy the Nevada Public Option be eligible for federal subsidies under the Affordable Care Act (ACA)?

Consumers with certain income levels may receive federal ACA subsidies to help offset the cost of a Nevada Public Option plan if they purchase the plan through the Nevada Health Link. However, if a consumer purchases a Nevada Public Option plan directly from the health carrier in the private individual market (i.e., outside of the Nevada Health Link), they will not be eligible for federal ACA subsidies.

4. Who will offer the new Nevada Public Option plans?

SB 420 provides the Director with new State authority to contract with health insurance carriers to offer the new Nevada Public Option plans to consumers. This concept is similar to the approach used in Medicaid Managed Care, where the State contracts with health plans to provide coverage and services through a network of providers to Medicaid beneficiaries.

Health carriers will be selected by the Director through a statewide competitive procurement process. This process will take place at the same time as the next Medicaid Managed Care procurement, and all carriers that wish to participate in the State's Medicaid Managed Care program will be required to submit a good faith bid to contract with the State to offer and administer Nevada Public Option plans. The State may also invite non-Medicaid insurers to submit bids for the new Nevada Public Option plans.

5. Is the Director of DHHS required to administer the Nevada Public Option plans directly to consumers?

Under the requirements of SB 420, the Director of DHHS is required to design, establish, and operate the Nevada Public Option. However, it does not require that the Director of DHHS operate the Nevada Public Option directly. Instead, section 12 of SB 420 specifies that the Director of DHHS must operate the Nevada Public Option by contracting with a health carrier or other qualified entity to administer the new Nevada Public Option plans. The only exception to this requirement is if direct administration by the Director of DHHS is **necessary for the operation** of the Nevada Public Option.

Furthermore, if the Director of DHHS were to directly administer the new Nevada Public Option plans, the Director would be unable to fulfill his responsibilities in section 12 to contract with

health carriers or other qualified entities to offer the new Nevada Public Option plans in addition to the other criteria and procedures for a new statewide procurement prescribed by the new law for selecting such an administrator or administrators. It also renders the other provisions in SB 420 moot that require health carriers seeking to participate (or to continue to participate) in the State's Medicaid Managed Care program to offer good faith bids to the Director of DHHS to administer the Nevada Public Option.

6. What type of health insurance policy will the Nevada Public Option qualify as under State law?

SB 420 requires that the Nevada Public Option plans be qualified health plans (as defined in the Affordable Care Act) and sold on and off the Exchange as individual policies of health insurance on the individual market. All State and federal requirements and procedures for qualified health plans and nongroup plans would apply to the new Nevada Public Option plans.

SB 420 further provides that the Director **may** choose to offer the new Nevada Public Option plans to small businesses, or their employees, as permitted by, and in accordance with, federal and State law for small group health insurance policies.

7. How will the State select the health carriers to administer Nevada Public Option plans?

The Director of DHHS will oversee the selection of health carriers through a statewide competitive procurement process. When selecting health carriers, the Director will prioritize applicants whose proposals:

- Demonstrate alignment of networks of providers between the Nevada Public Option and Medicaid Managed Care, where applicable;
- 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 Nevada Public Option and Medicaid Managed Care, where applicable;
- Strengthen the State health care workforce, particularly in rural areas for providers of primary care, mental health care, and treatment for substance use disorders;
- Use payment models for providers included in the networks of providers for the Nevada Public Option that increase value for persons enrolled in the new plans and the State; and

- 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.

8. How will the State help to ensure that the Nevada Public Option plans are affordable?

SB 420 provides for a temporary target on consumer premiums for Nevada Public Option plans for the first four years of operation. Specifically, Nevada Public Option premiums must be at least 5 percent lower than the cost of premiums for plans used by the federal government to calculate federal ACA subsidies (i.e., the cost of the second-lowest cost silver level plan). In addition, the premium for a Nevada Public Option plan may not increase in any year by a percentage greater than the increase in the Medicare Economic Index for that year.

The Director of DHHS may revise these requirements, provided that, over the first four years in which the Public Option is in operation, the average premiums for the Nevada Public Option are at least 15 percent lower.

These targets expire on January 1, 2030.

9. How will the State use the Nevada Public Option to promote value-based health care financing, improve outcomes, lower cost, and achieve other State objectives?

Under SB 420, the Director of DHHS is directed to use the Nevada Public Option (via the procurement and contracting process with health carriers) to:

- Ensure that care for persons who were previously covered by Medicaid or the Children's Health Insurance Program and enroll in the Nevada Public Option is minimally disrupted;
- Encourage the use of payment models that increase value for persons enrolled in the Public Option and the State;
- Improve health outcomes for persons enrolled in the Nevada Public Option;
- Reward providers of health care and medical facilities for delivering high-quality services; and
- Lower the cost of care in both urban and rural areas of this State.

SB 420 also seeks to increase the leverage of the Director to achieve these objectives by requiring that the procurement process for Medicaid Managed Care and the Nevada Public

Option take place concurrently, and by requiring that health insurance carriers seeking to provide Medicaid Managed Care plans also submit good faith bids to provide Nevada Public Option plans.

10. Will the State set reimbursement rates for health care providers who participate in the new Nevada Public Option plans?

SB 420 provides that, subject to the limited exceptions discussed below, reimbursement rates under the Nevada Public Option must be, in the aggregate, comparable to or better than reimbursement rates available under Medicare. This **does not** establish Medicare rates as a cap or ceiling on provider reimbursement for Nevada Public Option plans. Instead, the intent of this requirement is to establish a floor for provider reimbursement that can act as a level-playing field for providers who negotiate their rates with health carriers for the Nevada Public Option plans.

Health carriers seeking to participate in the Nevada Public Option may find it advantageous for the procurement process to offer a bid that provides for higher provider reimbursement rates than those paid in Medicare in order to attract a more robust provider network. For example, SB 420 directs the Director of DHHS to give greater consideration (or preference) to bids by health carriers that would provide consumers with improved access to providers. This includes more robust provider networks that consist of rural and safety-net providers, provider arrangements that seek to address workforce challenges, and networks that provide for greater alignment of providers between Medicaid and private markets.

For purposes of this requirement, the aggregate reimbursement rate under Medicare includes any add-on payments or other subsidies that a provider receives under Medicare.

There are exceptions to this requirement, including:

- Providers that receive cost-based reimbursement from Medicare must receive reimbursement under the Nevada Public Option that is comparable to or better than the cost-based reimbursement rates provided for that provider by Medicare;
- The reimbursement rates for a federally qualified health center or a rural health clinic under the Nevada 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; and

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

C. Provider Participation and Consumer Access to Care

1. In implementing the Nevada Public Option, how will the State seek to ensure adequate access to providers, particularly in rural areas, and address shortages in the health care workforce?

To ensure that consumers covered under the Nevada Public Option have adequate access to providers, SB 420 requires health care providers who participate in the State's Medicaid program, Public Employees' Benefits Program (PEBP), or who provide care to injured employees under the State's workers' compensation program to enroll as a participating provider in at least one network of providers established for the Nevada Public Option.

These providers under contract to participate in these other insurance programs must also accept new patients who are enrolled in the Nevada Public Option to the same extent as they accept new patients not enrolled in the Nevada Public Option. The Director of DHHS and the Executive Officer of the PEBP do have authority to waive these requirements when necessary to ensure that Medicaid enrollees and individuals who receive benefits under the PEBP have sufficient access to covered services.

In addition, SB 420 directs the Director of DHHS to prioritize health carrier proposals in the Nevada Public Option procurement process that include critical access hospitals, rural health clinics, certified community behavioral health clinics, and federally-qualified health centers in their Nevada Public Option and Medicaid Managed Care networks (where applicable) in addition to proposals that would strengthen the health care workforce in Nevada, particularly in rural areas of the State for providers of primary care, mental health care, and treatment for substance use disorders.

2. Is Nevada the only state using a "provider participation" requirement for a public insurance program?

At least three states have similar requirements on the books that leverage existing contractual arrangements with providers to ensure adequate access to providers under certain public

programs. For example, Washington recently updated its State law for its Public Option to provide that, if there is not a Public Option plan in each county by 2022, all hospitals in the State that accept Medicaid or public employee health benefits will be required to participate in the provider network of at least one of the State's Public Option plans. [1]

Under Colorado's Public Option (which will take effect in 2023), if a health insurance carrier contracted to provide a Public Option plan cannot meet the premium or network adequacy requirements that apply to Public Option plans, the Commissioner of Insurance may require a hospital to participate in the carrier's Public Option plan.[2]

In Minnesota, providers who participate in the State employees' health insurance plans, workers' compensation insurance, public employees' insurance program, or health insurance plans offered to city, county, or school district employees must also participate in the State's Medicaid program.[3]

3. Will the Nevada Public Option help to lower prescription drug costs for consumers?

SB 420 does not directly address prescription drug costs. But it does provide opportunities for the State to seek new alignment and coordination in the procurement processes for Medicaid Managed Care and the Nevada Public Option to increase the purchasing power of the State and allow it to leverage this power to achieve a number of State aims, including but not limited to, lowering prescription drug costs.

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[1] Washington Session Law, Chapter 246: Increasing Affordability of Standardized Plans (April 19, 2021). Available at https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/Senate/5377-S2.SL.pdf?q=20210625082437

[2] Colo. Rev. Stat. § 25-1.5-117. Available at: https://casetext.com/statute/colorado-revised-statutes/title-25-public-health-and-environment/administration/article-15-powers-and-duties-of-the-department-of-public-health-and-environment/part-1-general-powers-and-duties/section-25-15-117-hospitals-standardized-health-benefit-plan-participation-penalties; Colo. Rev. Stat. § 10-16-1306. Available at: https://casetext.com/statute/colorado-revised-statutes/title-10-insurance/health-care-coverage/article-16-health-care-coverage/part-13-colorado-standardized-health-benefit-plan/section-10-16-1306-rate-filings-failure-to-meet-premium-requirements-notice-public-hearing-rules

[3] Minn. Admin Rules 9505.5220. Available at: https://www.revisor.mn.gov/rules/9505.5220/; Minnesota Department of Human Services, , Provider Manual: Provider Participation Requirements – Rule 101. Available at: https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16_152332;

D. Section 1332 Waivers and the Actuarial Analysis

1. What is a Section 1332 waiver?

Section 1332 waivers permit States to implement innovative strategies for providing high-quality, affordable health coverage to State residents and receive waivers from certain requirements of the ACA as needed to implement these strategies. Section 1332 waivers must be approved by the Centers for Medicare and Medicaid Services (CMS) and comply with certain guardrails designed to preserve the number of individuals covered in the State, and the comprehensiveness and affordability of coverage offered. These are known as the comprehensive coverage requirement, the affordability requirement, and the scope of coverage requirement. In addition, the waiver must not increase the federal deficit.

Using Section 1332 waivers, states may implement policies that will reduce premium rates for plans offered on the State's health insurance exchange, which in turn reduces the amount the federal government must pay for premium tax credits under the ACA. Importantly, Section 1332 waivers permit states to capture these savings, which would otherwise accrue to the federal government, through what is known as "pass-through" federal funding.

2. When must the State submit its Section 1332 waiver?

Under SB 420, the State must submit its Section 1332 waiver to CMS no later than January 1, 2024.

3. What are the benefits of requesting a 1332 waiver for the Nevada Public Option?

The benefits of requesting a Section 1332 waiver include the opportunity to receive federal pass-through funding, which can be used to further increase the affordability of the Nevada Public Option for Nevadans, and to waive certain provisions of the ACA as needed.

According to the new State law, this funding will be deposited in a Nevada Public Option Trust Fund, to be administered by the State Treasurer and used to implement the Nevada Public Option. If the State Treasurer determines there are sufficient funds, monies in the Nevada Public Option Trust Fund may also be used to increase the affordability of the State's Public Option plans. For example, one way this new funding could be used by the State is to reduce premiums and out-of-pocket costs for Nevadans who purchase Nevada Public Option plans,

including those who are low-income but not eligible for Medicaid or premium tax credits under the ACA.

4. Is the State required to conduct an actuarial analysis for the Section 1332 waiver? If so, what must it include?

Yes, under federal rules, all Section 1332 waiver applications must include an actuarial analysis and actuarial certifications to support State assertions that the waiver will comply with the comprehensive coverage requirement, the affordability requirement, and the scope of coverage requirement.

SB 420 further directs the Director of DHHS, the Commissioner of Insurance, and the Director of the Exchange to utilize an "independent actuary," when contracting for actuarial services in developing its 1332 waiver application. It also provides that the actuarial analysis pursuant to the development of its 1332 waiver application must be completed before the waiver application is submitted and must include an analysis of the effect on premiums for health insurance in the State with respect to the "provider participation" requirement set forth in SB420.

To assist in the preparation of a 1332 waiver application, the State has secured the actuarial services of Milliman—an actuarial vendor that meets the qualifications outlined in section 11 of SB 420 for an independent contractor—through a subcontract with Manatt. Pursuant to section 39 of SB 420, this actuarial analysis will be completed and available for public review before the waiver application is submitted and will also address the likely effect on premiums in the health insurance market with and without the "provider participation requirement" in section 13 of SB 420. Milliman will be evaluating this requirement and other requirements in SB 420 that are likely to impact premiums when determining the actuarial assumptions and corresponding values necessary to complete the actuarial analysis.

5. What happens if the State's 1332 waiver application is denied?

Per SB 420, a federal denial of the 1332 waiver application does not mean that the Nevada Public Option will not be implemented. It only means that the State will not receive pass-through funding under Section 1332 or waiver of provisions of the ACA. This is because SB 420 does not condition the implementation of the Nevada Public Option on approval of a Section 1332 waiver. All core provisions of the Nevada Public Option, and its goals of increased

affordability, improved access and reduction in disparities, increased competition in individual health insurance, and the promotion of value-based health care financing can be achieved absent approval of the State's Section 1332 waiver. If the waiver is denied, the State may need to reconsider whether future State resources will be needed to support DHHS operations or to subsidize premium costs for the Nevada Public Option plans.

E. Public Waiver Input and Stakeholder Engagement

1. **What are the mechanisms for public input at the State and federal levels with respect to the 1332 waiver application?**

The public will have many opportunities to provide input into the design and implementation of the Nevada Public Option, beginning with six public design sessions. Information regarding all upcoming public meetings regarding the Nevada Public Option, including dates and times, links to join meetings, agendas, minutes, and video recordings, are posted at DHHS.nv.gov/PublicOption

The State has also established an email address, NVpublicoption@dhhs.nv.gov, for questions or comments regarding the Nevada Public Option. There will be future opportunities to provide public feedback regarding the waiver application. The State is accepting ongoing public written comments at the email listed above and will review all feedback in support of its efforts to implement the Nevada Public Option.

2. **What are the federal requirements for engaging the public regarding the State's 1332 waiver application?**

Prior to submitting a Section 1332 waiver for review and consideration, a State must provide public notice and a comment period sufficient to ensure a meaningful level of public input on the application. During the public comment period, the State must conduct public hearings regarding the State's application. In addition, a State with one or more federally recognized Tribes within its borders must conduct a separate process for meaningful consultation with the Tribes as part of the notice and comment process. There is also a federal notice and comment period for the public once the State's waiver application has been formally submitted.

3. **How can the public stay informed and receive updates about the State's design and implementation of the Nevada Public Option?**

Nevada DHHS has established a website that will provide regular updates on the design and implementation of the Nevada Public Option: http://dhhs.nv.gov/PublicOption/. The website also includes a link where you can sign up for email notifications regarding implementation of the Nevada Public Option.

4. **Will the Legislature have an opportunity to adjust for any issues identified from the State's 1332 waiver, actuarial analysis, and/or implementation process?**

Yes, because the Nevada Public Option is not scheduled to launch until January 1, 2026, there will be adequate time for the Legislature to revise SB 420 as needed to address any issues that arise from the waiver development and actuarial analysis, or otherwise. Furthermore, the waiver application and actuarial analysis are slated to be completed in February 2023 which is aligned with the State's next legislative session.

F. Other Topics or Questions

1. **How does the design of the Nevada Public Option attempt to avoid some of the early pitfalls of Washington's Public Option rollout?**

In its first year, premiums in Washington for the Public Option were reportedly higher than existing products in the individual market. To avoid this issue for Nevada's first year, SB 420 requires that Nevada Public Option premiums meet certain premium reduction targets and caps their growth over time (see Question B8).

It was also reported that participation by health carriers and providers was problematic for the State. Therefore, to help ensure carrier participation statewide, SB 420 requires carriers that wish to participate in the State's Medicaid Managed Care program to submit a good faith bid to contract with the State to offer and administer products for the Nevada Public Option. It also requires that providers participating in current public insurance programs to also participate in the new Nevada Public Option networks.

2. **Is the State considering the longer-term savings to the market from lowering the uninsured rate in Nevada as part of the actuarial analysis?**

The State will be working with its independent actuary to determine whether the potential for savings from the uninsured can be considered in the actuarial analysis in a manner that meets actuarial standards.

3. Is there a second actuarial analysis in SB 420? What is it for?

Pursuant to subsection 1 in section 16.5 of SB 420, a second actuarial analysis is required as part of a 1332 waiver application that is separate from the efforts underway for the Nevada Public Option. Specifically, this section requests that Nevada Health Link seek federal approval to waive the federal rules necessary to permit certain labor and agricultural organizations to offer a product for direct purchase as a policy of individual health insurance in Nevada. Efforts to engage stakeholders regarding the design and analysis for this effort will be led by the Nevada Health Link and are separate from the process and activities underway for the Nevada Public Option.