MILLIMAN REPORT

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

Prepared for Nevada Department of Health and Human Services

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EXHIBITS

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.

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 marketplace 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/gov2022nvgov/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. These uses of the remaining PTF have no effect on our modeling.

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 same[4] 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	**$311,000**	**($250,000)**	**NA***
10-Year Deficit Neutrality Window	**$846,000**	**($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.

Subsidized enrollees who currently receive no-cost bronze plans could continue to have zero net premium (after subsidies) depending on their plan selection. 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 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. Therefore, non-premium cost-sharing will be at least as affordable under the waiver as it is without the waiver.

- 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).

Table 2
State of Nevada
NMSP Actuarial and Economic Analysis
Projected SLCS 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%

**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, 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

	No Waiver	Enrollment Increase Due to Waiver		
Year	**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. 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)*

	Advanced PTCs		Total Pass-Through Funding		
Year	**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 wavier 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.

[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/gov2022nvgov/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.

- Lightly subsidized enrollees (generally higher-income and / or younger ages) are more likely to see increases in net premiums while maintaining bronze coverage 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.

- 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

[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.

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.

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.

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 areas[9] 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. However, in such a situation, the impact to PTF would be zero as 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)	*Assumed Annualized Trend*		5.1%	4.0%	4.0%	4.0%
(3)	Reference Premium	$ 541.47	$598.26	$622.19	$647.07	$672.96
(4)	*Assumed Annualized Trend*		5.1%	4.0%	4.0%	4.0%
(5)	BBSP Premium		$579.23	$547.61	$559.45	$571.99
(6)	*Cumulative Difference From Reference Premium*		(3.2%)	(12.0%)	(13.5%)	(15.0%)
(7)	*Cumulative Difference From Baseline*		(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

[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). 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.

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.

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.

Table 7
State of Nevada
NMSP Actuarial and Economic Analysis
Illustration of Reference Premium Trended Below Market Rate

		2024	2026	2027	2028	2029
(1)	Second Lowest Cost Silver* (Baseline)	$ 541.47	$ 598.26	$ 622.19	$ 647.07	$ 672.96
(2)	*Assumed Annualized Trend*		5.1%	4.0%	4.0%	4.0%
(3)	Reference Premium	$541.47	$574.44	$591.67	$609.42	$627.71
(4)	*Assumed Annualized Trend*		3.0%	3.0%	3.0%	3.0%
(5)	BBSP Premium		$556.17	$520.75	$526.90	$533.53
(6)	*Cumulative Difference From Reference Premium*		(3.2%)	(12.0%)	(13.5%)	(15.0%)
(7)	*Cumulative Difference From Baseline*		(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 rate.[13] 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

[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.

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.

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 subsides 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 subsides.

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

[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.

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 (CCIIO).

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.

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.

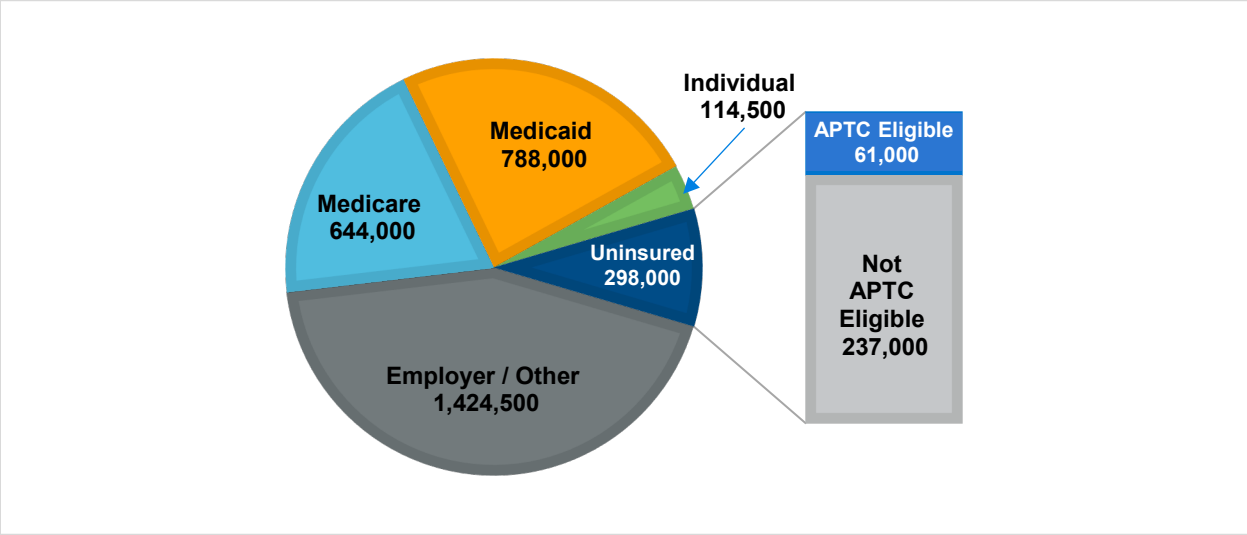
5. Additional federal requirements that the State of Nevada will need to consider, but that do not impact the actuarial analysis, are shown in Appendix D for reference.

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.

[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.

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 on marketplace plans to 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 subsides 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 net[21] 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	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. End of PHE: 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. End of ARP: The exit of enrollees who leave the individual market due to the expiration of ARP subsidies is assumed to increase morbidity by 2.5%. Increased enrollment due to BBSP appeal: 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.
	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	We assume reinsurance will reflect the following parameters: ▪ 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 Based on these reinsurance parameters, we estimate reinsurance will decrease premiums by approximately the following percentages: ▪ 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

[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

under the Baseline scenario will be expected to purchase a bronze-level BBSP under the Market Stabilization scenario. 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 marketplace 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 marketplace, but a separate material share of the market may not take up BBSP coverage for various reasons. 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.

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:

[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 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 Market Stabilization 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%). Our high-level 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.

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 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.[25] 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. 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.

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

[25] See https://www.gpo.gov/fdsys/pkg/FR-2015-12-16/pdf/2015-31563.pdf for more information.

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 6 demonstrates the waiver provides coverage to at least as many residents as without the waiver, as required by the guardrail.

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.[26]

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)[27] and then applying an adjustment to account for the tax reconciliation process. This adjustment is 10%.[28]

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:

[26] 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.

[27] 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.

[28] 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 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.
- 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

	On-Exchange			Off-Exchange	
Year	(1) PTC-Eligible	(2) Non-PTC-Eligible	(3) Total	(4) Total	(5) Total Individual Market
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 PMPM projection under the Baseline scenario. 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 all scenarios.

Table 14
State of Nevada
NMSP Actuarial and Economic Analysis
Baseline Scenario
Summary of Enrollment and Premium by BBSP and Standard QHP Segments

	BBSP			Standard QHP		Total	
Year	BBSP Take-Up %	Enrollment	Premium	Enrollment	Premium	Enrollment	Premium PMPM
2026	0%	0	0	101,400	$608	101,400	$608
2027	0%	0	0	102,700	$633	102,700	$633
2028	0%	0	0	104,000	$658	104,000	$658
2029	0%	0	0	105,300	$685	105,300	$685
2030	0%	0	0	106,800	$711	106,800	$711
2031	0%	0	0	108,200	$740	108,200	$740
2032	0%	0	0	109,600	$770	109,600	$770
2033	0%	0	0	111,000	$801	111,000	$801
2034	0%	0	0	112,400	$833	112,400	$833
2035	0%	0	0	113,900	$866	113,900	$866

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.[29]
- *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.

[29] 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
Premiums and Member Subsidies Per Member Per Month (PMPM)

	On-Exchange					
	PTC-Eligible			Non-PTC-Eligible	Off-Exchange	Total Individual Market
Year	(1) Gross Premium	(2) APTC	(3) Enrollee Net Premium	(4) Enrollee Gross Premium	(5) Enrollee Gross Premium	(6) 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.

Table 16
State of Nevada
NMSP Actuarial and Economic Analysis
Baseline Scenario
Annual Change in Premiums and Member Subsidies PMPM

	On-Exchange					
	PTC-Eligible			Non-PTC-Eligible	Off-Exchange	Total Individual Market
Year	(1) Gross Premium	(2) APTC	(3) Enrollee Net Premium	(4) Enrollee Gross Premium	(5) Enrollee Gross Premium	(6) 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:

- Gross premiums, as noted earlier, are increasing at 4% per year (within tolerance for rounding), for both on-exchange enrollees and off-exchange enrollees.

- 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.
- APTCs, being the balancing item, are increasing more than gross premium annually.
- Non-PTC-eligible exchange enrollee 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 coefficient[30] 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..[31] 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.

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.

[30] 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.

[31] 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 State of Nevada NMSP Actuarial and Economic Analysis Market Stabilization Scenario Individual Market Enrollment by Segment					
	On-Exchange			Off-Exchange	
Year	(1) PTC-Eligible	(2) Non-PTC-Eligible	(3) Total	(4) Total	(5) Total Individual Market
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 target[32] 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 for enrollees. Note, membership mix differences (e.g., by metal, age, etc.) 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.

[32] 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							
		BBSP		Standard QHP		Total	
Year	Take-Up %	Enrollment	Premium	Enrollment	Premium	Enrollment	Premium
2026	29%	29,100	$601	72,900	$601	102,000	$601
2027	33%	35,000	$573	69,500	$576	104,500	$575
2028	41%	43,800	$585	62,200	$594	106,000	$590
2029	47%	50,700	$598	56,700	$613	107,400	$606
2030	47%	51,300	$621	57,400	$636	108,700	$629
2031	47%	52,000	$644	58,200	$659	110,200	$652
2032	47%	52,700	$668	58,900	$685	111,600	$677
2033	47%	53,400	$693	59,700	$710	113,100	$702
2034	47%	54,100	$718	60,400	$737	114,500	$728
2035	47%	54,800	$745	61,100	$765	115,900	$755

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 a BBSP becoming the SLCS plan.

Table 21 State of Nevada NMSP Actuarial and Economic Analysis Market Stabilization Scenario Premiums and Member Subsidies Per Member Per Month (PMPM)						
	On-Exchange					
	PTC-Eligible			Non-PTC-Eligible	Off-Exchange	Total Individual Market
Year	(1) Gross Premium	(2) APTC	(3) Enrollee Net Premium	(4) Enrollee Gross Premium	(5) Enrollee Gross Premium	(6) 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

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

	On-Exchange					
	PTC-Eligible			Non-PTC-Eligible	Off-Exchange	Total Individual Market
Year	(1) Gross Premium	(2) APTC	(3) Enrollee Net Premium	(4) Enrollee Gross Premium	(5) Enrollee Gross Premium	(6) 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:

- 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 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.
- Enrollee Net Premiums in column (3) are increasing relative to the Baseline scenario, as we assume only approximately 50% of the individual market adopts a BBSP in year 4 and after. This implies that a subset of consumers' net premiums (after subsidy) will increase because they have not switched to the SLCS plan, which is assumed to be a BBSP. In this case, 50% of consumers are assumed to not enroll in a BBSP. The average net premium for subsidized members is sensitive to the BBSP take-up rate. If all consumers enroll in a BBSP, the Enrollee Net Premiums will be less than in the Baseline scenario in each year. To illustrate how a higher BBSP adoption rate reduces the net member premium increase, 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.[33] 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.

[33] 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.[34]

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.

Table 24
State of Nevada
NMSP Actuarial and Economic Analysis
Modeling Assumptions
Individual Market Enrollment Increase Due to Expiration of the PHE

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**

[34] 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/taxnvgov/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 Nevada[35] (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.

[35] 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%22colId%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.

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.

EXHIBITS

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

	21-Year Old Monthly Premium				40-Year Old Monthly Premium			
Year	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 3
State of Nevada
NMSP 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
NMSP 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
NMSP 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 may not sum to the Total due to rounding.*

Exhibit 6
State of Nevada
NMSP 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.*

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

November 20, 2023
Date

APPENDIX B

State Legislation

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 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 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 ~~[,]~~ ***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 ~~[,]~~ ***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 ~~[,]~~ ***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; ~~[or]~~

(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 ~~[.]~~ ***; 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(l)(2)(B).

~~[(b)]~~ ***(c)*** "Health maintenance organization" has the meaning ascribed to it in NRS 695C.030.

~~[(c)]~~ ***(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.

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)[36] 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

[36] 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.	**45 CFR 155.1308(f)(4)(i)-(iii)** Actuarial analyses and actuarial certifications Economic analyses Data and assumptions **Note a state can combine the elements of an actuarial analysis and economic analysis into one report or submit separate actuarial and economic reports*	1. See Appendix A for the actuarial certification. i. See Section IV.B for a demonstration that the Nevada Section 1332 waiver complies with the coverage requirement. a. See the Exhibits section ii. See Sections IV.A and IV.C for a demonstration that the Nevada Section 1332 waiver complies with the comprehensiveness and affordability requirements. a. See the Exhibits section b. See the Exhibits section 2. See Section V 3. See Section VI 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. The required analyses are included as noted below: ▪ 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. Nevada is not considering establishing a Risk Stabilization Waiver Concept as part of this 1332 waiver application.
6.	**45 CFR 155.1308(f)(4)(iv)** Draft timeline for implementation of the proposed waiver.	See Section 1D of waiver application
7.	**45 CFR 155.1308(f)(4)(v)(A)-(E)** Additional Information.	See Section 5 of waiver application
8.	**45 CFR 155.1308(f)(4)(vi)** Reporting targets.	See Section 5E of waiver application
9.	**83 FR 53575** Administration's Principles.	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

	On-Exchange					
	PTC Eligible			Non-PTC Eligible	Off-Exchange	Total Individual Market
Year	Gross Premiums	APTC	Enrollee Net Premiums	Enrollee Gross Premiums	Enrollee Gross Premiums	Gross Premiums
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

	On-Exchange					
	PTC Eligible			Non-PTC Eligible	Off-Exchange	Total Individual Market
Year	Gross Premiums	APTC	Enrollee Net Premiums	Enrollee Gross Premiums	Enrollee Gross Premiums	Gross Premiums
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%)