SECTION 1332 WAIVER APPLICATION:

NEVADA COVERAGE AND MARKET STABILIZATION PROGRAM

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

DRAFT WAIVER FOR PUBLIC COMMENT

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Section 1: Nevada Program Overview and Waiver Request

A. Overview

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

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

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

The major difference between BBSPs and other QHPs offered on the SSHIX is that carriers offering BBSPs must contract with the State to meet certain state priorities and requirements, including an annual premium

[1] Nev. Rev. Stat., Chap. 695K.
[2] ASPE, National Uninsured Rate Reaches an All-Time Low in Early 2023 After the Close of the ACA Open Enrollment Period, August 2023, available at: https://aspe.hhs.gov/sites/default/files/documents/e06a66dfc6f62afc8bb809038dfaebe4/Uninsured-Record-Low-Q12023.pdf.
[3] Nevada Dept. of Behavioral and Public Health, Health Professional Shortage Areas, available at: https://dpbh.nv.gov/Programs/HPSA/Health_Professional_Shortage_Area_Designations_-_Home/
[4] America's Health Rankings, Nevada Summary, 2022, available at: https://assets.americashealthrankings.org/app/uploads/allstatesummaries-ahr22.pdf
[5] Commonwealth Fund 2023 Scorecard on State Health System, Nevada: Ranking Highlights, available at: https://www.commonwealthfund.org/publications/scorecard/2023/jun/2023-scorecard-state-health-system-performance.
[6] Nev. Rev. Stat. § 695K.200.

reduction target. To initiate these new contracts with carriers, the Director must conduct a state procurement process that coincides with the statewide procurement for Nevada's Medicaid Managed Care plans. State law requires that carriers bidding to participate in Nevada's Medicaid Managed Care program as a Managed Care Organization (MCO) to also submit a "good faith bid" to offer BBSPs in the SSHIX. A good faith bid must, at a minimum, meet the annual premium reduction target for the BBSPs and include a formal certification from the carrier's actuary that the proposed premium rates will meet actuarial soundness principles, as further outlined in this waiver request. The carrier must also commit to submitting their rate filings for BBSPs to the Division of Insurance (DOI) for review and approval. This customary state process will verify actuarial soundness and confirm that solvency standards and all other requirements of standard QHPs have been met. As with every other carrier offering a QHP on the SSHIX, carriers must also commit to filing network adequacy information with the DOI for review and approval and must seek formal QHP certification of their BBSPs each year from SSHIX. However, carriers that offer BBSPs in the SSHIX must meet the annual premium reduction target. The DOI will evaluate the rate filing in the same manner as other rate filings to determine with actuarially soundness and solvency and to ensure plans meet all other requirements of QHPs.

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

- **State-Based Reinsurance Program:** This program is aimed at alleviating any unexpected financial risk to participating carriers and their provider networks with the introduction of the BBSPs that meet premium reduction targets. Under reinsurance, the State will subsidize (or "reinsure") certain high-cost claims for all carriers in the individual market. The State intends to adjust the size of the reinsurance parameters as needed to ensure that it can be fully funded by the pass-through funding generated in the prior year.

- **Quality Incentive Payment Program:** If there is remaining pass-through funding in any year of the waiver period after financing reinsurance, the State intends to use this funding to establish a Quality Incentive Payment Program for participating carriers. This program would be designed to reward carriers and their providers for utilizing value-based efforts to improve health outcomes and quality of care. Through this new program, the State will be able to, for the first-time ever, drive changes in how health care is delivered and paid for in the individual market. Over time, these efforts should lead to a healthier population and therefore reduced risk to carriers. It should also lead to shared savings and financial rewards for network providers that are successful in these efforts with carriers.

- **"Practice in Nevada" Incentive Program for Health Care Providers:** If there is sufficient pass-through funding to finance reinsurance and the quality incentive payment program, the State intends to use such funding to finance a new "Practice in Nevada" program. Nevada faces critical challenges in attracting many types of health care providers, including primary care physicians, obstetricians, behavioral health practitioners, and other allied health professionals, to practice in the State. For example, Nevada ranks last

for the number of primary care providers per 100,000 individuals.[7] Increasing the number of providers is essential to addressing poor health outcomes and health disparities. It is also important for controlling the rise in the cost of health care and ensuring the stability of the State's insurance market. Because of the steep demand and supply gap for health care professionals in Nevada, having more medical professionals could help insurers avoid facing unreasonable price hikes from network providers that are in low supply in the State. For example, carriers with smaller market shares (i.e., covered lives) are likely to struggle to negotiate reasonable rates for certain services where only one provider entity is available in a region or the State to provide such services to its members. Most recently, this challenge was notable in the State's Medicaid Managed Care program, where a carrier with a smaller portion of enrollment in the program faced unreasonable prices as compared to other carriers from a certain specialty provider type that is in low supply in the State.

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

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

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

B. Federal Provisions to Be Waived

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

Section 1312(c)(1) and its implementing regulations limit the factors by which issuers can vary premium rates for a particular plan from the index rate. The goal of the premium reduction targets for the BBSPs in the Exchange is to control health care costs and support coverage by reducing insurance premiums. Through

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

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

A waiver of Section 1312(c)(1) will also allow implementation of the State's new reinsurance program in year two of this waiver (CY 2027). The waiver of this provision is necessary for Nevada to include pass-through funding from the state reinsurance program when determining the market-wide index rate in 2027. The reinsurance program will have a geographic tiered structure that is designed to reduce premiums more in the highest-cost geographic areas (i.e., Rating Areas 3 and 4). The reinsurance program is expected to reduce premiums market-wide by 7.2% by 2030, contributing to plans' ability to meet the premium reduction targets in the years 2027 through 2030 and further generating federal savings.

Section 2: Nevada Section 1332 Waiver Proposal

A. Enabling Statutory Authority

Enabling legislation requires the Director to apply for a Section 1332 waiver no later than January 1, 2024, to implement the reforms and requirements of NRS 695K to establish a new Public Option program and to capture all pass-through funds made available to the State with such reforms. See NRS 695K.210.

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

NRS 695K.300(5) also provides the Director with broad express authority to spend federal pass-through funding made available to pay for the costs associated with administering the reforms of Chapter 695K and any associated waivers. It provides the Director with the authority to spend the remaining federal pass-through funding to improve the affordability of the new coverage options established under the Public Option program. The State has determined that this includes a state-based reinsurance program among the other programs described herein.

In addition to the Director's authority, the Commissioner of Insurance has specific authority in SB 482 (2019), Section 45, to apply for a Section 1332 waiver and implement a state plan that meets the waiver requirements

as approved by the Departments.[8] Further, the Commissioner has broad authority in NRS 679B.400 to "develop measures to stabilize prices" and to "establish a mechanism to ensure the provision of adequate insurance at reasonable rates to the residents of this state."[9] This includes the ability to establish a reinsurance program.

B. The New Battle Born State Plans

Nevada Senate Bill (SB) 420 (2021) was signed into law on June 9, 2021, and later codified in NRS Chapter 695K. Under this new law, the Director is required to design and establish a Public Option program in the individual market.[10] The statutory design of this new program relies heavily on a state purchasing and contracting strategy of the State's Medicaid Managed Care program. The State will undertake a Medicaid Managed Care procurement for a five-year contract that begins on January 1, 2026.

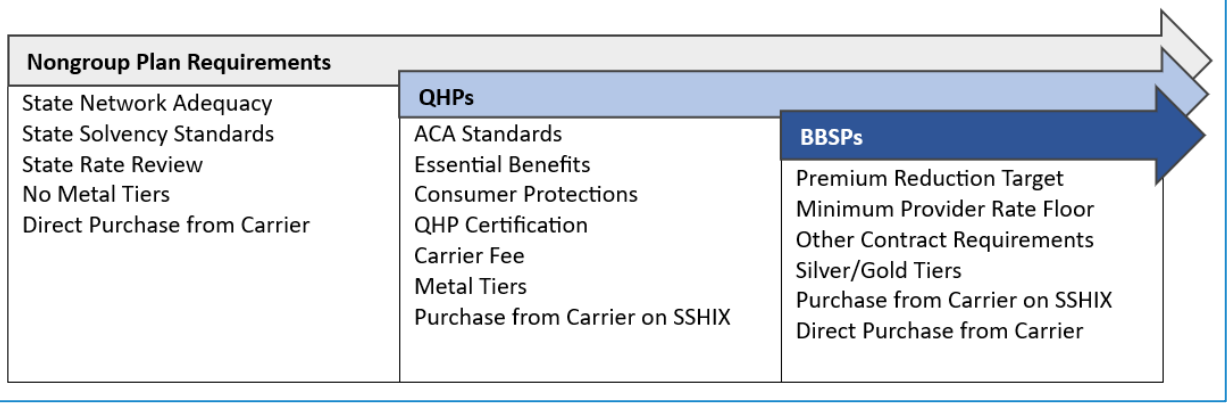
The State must require that carriers selected through the Medicaid Managed Care procurement also produce a good faith bid to offer at least a silver and gold BBSP annually on the SSHIX. (The State also assumes that these carriers would also voluntarily offer bronze plan products.[11]) The State's goal is to align these markets and, during the joint statewide BBSP and MCO procurement process, would score carriers based on whether they offer good faith bids to enter into contracts with the State for both: (1) a Medicaid Managed Care contract and (2) a separate contract to offer the new BBSP QHPs statewide in SSHIX to consumers who shop for their own health insurance. Currently, the MCO carriers must offer an SSHIX product under existing MCO contracts. The difference between current contracting practices with MCO carriers and the new BBSP program is that the State will be asking MCO carriers to continue to offer SSHIX products, but through the BBSP program.

1. Product Design Overview

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

[8] Senate Bill 482 (2019), available at: https://www.leg.state.nv.us/App/NELIS/REL/80th2019/Bill/6923/Text.
[9] Nev. Rev. Stat., Chap. 679B, available at: https://www.leg.state.nv.us/nrs/NRS-679B.html#NRS679BSec400.
[10] The authorizing state legislation also permits the state to offer the plans in the small group market, but currently the state is not taking up this option.
[11] All four current Medicaid Managed Care plans participate in SSHIX, and we anticipate that their existing products would continue.

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



The BBSP will include the same benefits as other QHPs.[12] In addition, BBSPs must meet certain statutory requirements for premium reductions and a reimbursement floor for providers, ensuring rates, in the aggregate, are no lower than those paid by Medicare.

The two major differences between BBSPs and standard QHPs include:

- **New Premium Reduction Targets**: Under NRS 695K, carriers offering the new BBSPs must satisfy a new premium reduction target on their silver plan rates that is at least 15 percent lower (cumulatively) than the average reference premium over the first four years. The average reference premium will be based on the SLCSP QHP available in the SSHIX during the 2024 plan year by county, trended forward for inflation according to the Consumer Price Index for Medical Care (CPI-M) and any adjustments necessary to reflect local changes in utilization and morbidity. See Nevada DHCFP Guidance and Bulletin Update 23-003.

  To ensure annual premium rates for the BBSPs will be actuarially sound and meet provider reimbursement floor requirements, the Director has determined the premium reduction target should be no more than 15 percent over the first four years as permitted by state law.[13] In the event that carriers cannot meet premium targets in any given year while meeting actuarial soundness or solvency requirements, the Director may revise the premium reduction rate targets to ensure BBSPs are offered at a rate that is actuarially sound. As further described in the milestones section, the Director will also require carriers to attest to the actuarial soundness of their proposed rates in their bids for the BBSP contracts similar to how the State verifies bids for the State's Medicaid Managed Care program.

  In the fifth and final year of the five-year MCO and BBSP contracts with carriers and the 1332 waiver period, the Director intends to include a continuation of the premium reduction targets for BBSP premium rates to ensure the projected reduced trend achieved in the first four years is sustained over

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

[13] Pursuant to the Director's revision authority under Subsection 5 of NRS 695K.200, the Director issued updated guidance on November 20, 2023 revising the premium reduction requirements to require that carriers establish plans that are "lower than the average reference premium in each county by a percentage that increases each year"

time. The Director will use the State's contract authority with carriers offering the BBSPs to enforce these new targets with associated penalties and sanctions as outlined further in Subsection 3.

- **Provider Reimbursement Floor**: State law requires carriers offering the new BBSPs to ensure that their negotiated rates with network providers are the same or better, in the aggregate, than the rates paid by Medicare.[14] The Director intends to establish reasonable rates for services not covered in Medicare (e.g., pregnancy-related coverage). These rates will be calculated annually as a percentage of Public Employees' Benefits Program (PEBP) or Medicaid rates for the same or similar service, where a Medicare rate is unavailable. Carriers must attest in their bids on the BBSP contract that they are in compliance with this requirement with respect to the rates they negotiate with their provider networks.

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

2. New Protections for Consumers and Providers

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

- **Provider Participation Requirement** – Any provider who participates in the PEBP, Medicaid, or the State's workers' compensation program must agree to participate in at least one provider network for a BBSP or risk its participation as a network provider in these other public programs. This requirement will be enforced through the State's contractual or enrollment agreements with providers to participate in-network in these programs.[15]

- **Consumer Access Requirement** – Participating providers or facilities must accept new patients enrolled in a BBSP to the same extent as the provider or facility accepts new patients enrolled in a standard QHP. The Director intends to require carriers in the BBSP contract to monitor providers for compliance and to notify consumers of this protection and a way to report any expected violations. The Nevada Division of Health Care and Financing (Nevada Medicaid), which oversees contracts with these carriers today, will provide the same oversight of the BBSP contracts.

Nevada Medicaid, which sits under the Director, oversees the State's contracts with these carriers today and will provide the same oversight of compliance with respect to these new requirements for the BBSP contracts. The Director may waive the provider participation and consumer access requirements if needed

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

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

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

3. New State-Carrier Contracts

To enforce the statutory requirements for the BBSPs (including the premium reduction targets), the Director will utilize the legal tools under its new contracts with carriers, similar to the ways in which Nevada Medicaid enforces its existing contracts with carriers for its Medicaid Managed Care program. For example, MCO contracts include corrective action plans, financial penalties, and/or sanctions that can be imposed by the Director when carriers do not meet their contractual obligations.[16]

Like MCO contracts, the new contractual arrangements with carriers for the BBSPs enable the State to impose additional requirements that go beyond those set forth in state law to meet state health care goals and priorities for the population served. This may include, for example, aligned quality metrics and value-based payment design requirements across MCO and BBSP programs and heightened network adequacy standards, if geographic areas are underserved, including requiring carriers to leverage their existing provider networks in Medicaid Managed Care to ensure adequate access for those enrolled in a BBSP. The State is also exploring requiring carriers to meet an administrative cost constraint through the new contracts with carriers offering BBSPs that are stricter than prevailing individual market QHP administrative expense loads (based on most recent publicly available rate filing data).

Under an administrative cost constraint, carriers offering BBSPs would need to reduce a portion of their administrative expenses (such as salary, profits, and other administrative expenses) for the BBSP offerings, which will help reduce prices relative to non-BBSP offerings, all else being equal. These administrative efficiencies at the carrier level could count toward the required premium reduction target, reducing the share of premium reductions that must be achieved by carriers through provider reimbursement reductions in BBSPs. This will also help mitigate the risk of carriers cost shifting the burden of meeting an annual premium reduction target onto their provider networks.

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

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

C. Use of Federal Pass-Through Funds

The State understands that, if this waiver application is approved, an initial estimate of the federal pass-

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

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

State law requires that any federal pass-through funds received by the State as a result of the approval of this waiver must be reserved to first cover the State administrative costs to implement and operate the program and waiver.[17] These funds would replace the state's initial investment of state general funds to cover the "start-up" costs associated with implementation. As shown in the proposed budget (see Appendix B) these costs include staffing and vendor-related costs for both the Nevada Department of Health and Human Services (DHHS) and the DOI.

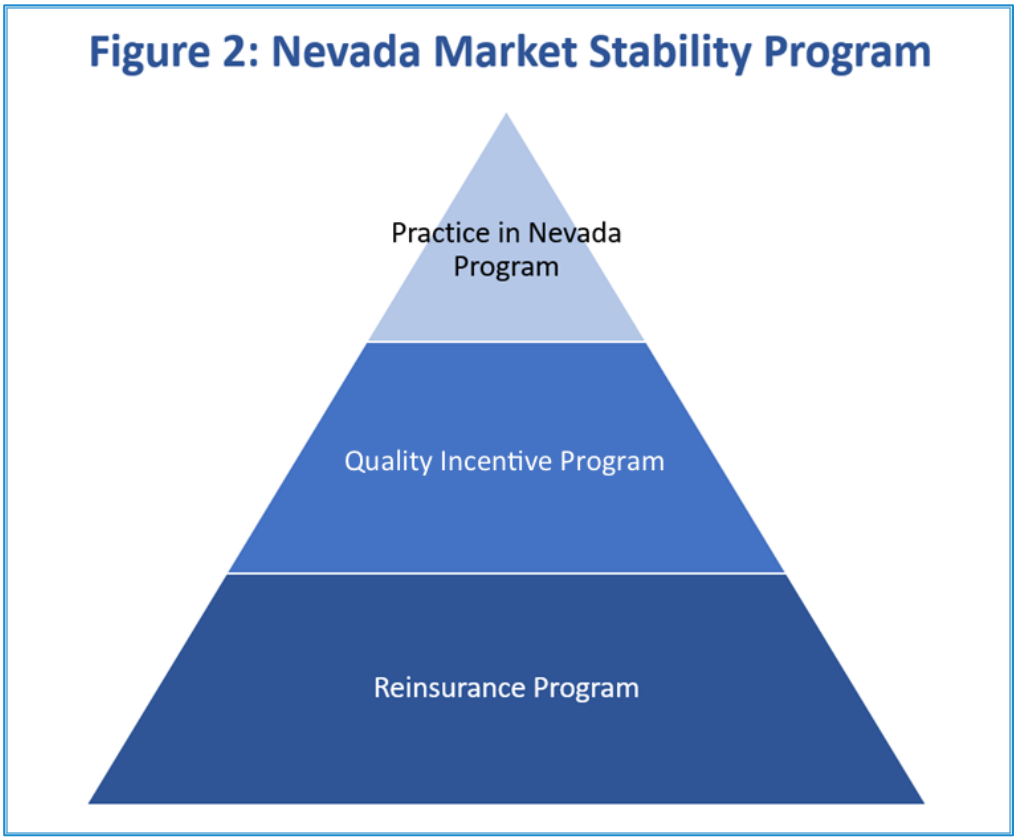
Once the state administrative costs have been paid for with the new federal pass-through funds, state law permits the Director to use a portion of the funding as determined by the State Treasurer to increase consumer affordability. For this waiver's purposes, the State has determined that the remaining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

D. Nevada Market Stabilization Program

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

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

[17] See NRS 695K.300.



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

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

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

Based on an actuarial analysis by Milliman, it is anticipated that, as a result of the entry of the BBSPs into the market, the federal savings generated in CY 2026 would cover the cost of financing the state-based reinsurance program across the individual market, including premium reductions in BBSPs that would help offset the impact of the premium reduction target, with over $2 million remaining to spend on the other two programs outlined below in year two (2027). Each year that the State receives pass-through funding, the State intends to prioritize the financing of the reinsurance program. This means, after covering state administrative costs for the waiver, the Director would first cover the costs of the reinsurance program

before using any of the funds to finance the additional efforts outlined below for the Market Stabilization Program.

If in any given year the federal savings is inadequate with respect to fully financing the reinsurance program for the upcoming waiver/plan year, the State intends to reduce the amount it projects to spend on the two other programs that make up the Market Stabilization Program. If such a reduction is still not enough to cover the cost of a reinsurance program, the State would adjust the attachment point and coinsurance to equal the exact amount of pass-through funding available from the previous waiver/plan year. In turn, this also shifts more of the burden back on carriers in meeting the statutorily required premium reduction target of 15 percent over the first four years of the waiver period. The State's contracts with carriers for the BBSPs would therefore include two sets of agreed-upon certified rates for achieving the premium reduction target– with and without reinsurance—to ensure the mandatory four-year statutory target can be achieved. Based on an actuarial analysis by Milliman, it is anticipated that, as a result of the entry of the BBSPs into the market, the federal savings generated in CY 2026 would cover the cost of financing a reinsurance program across the individual market, including premium reductions for BBSP carriers that would help offset the impact of the premium reduction target.

Table 1: Projected Pass-Through Funding (PTF) and Cost of Reinsurance

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

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

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

Currently, the State uses a quality incentive or "bonus" payment program in its Medicaid Managed Care program to reward carriers for achieving certain quality targets or goals. To be successful in these scenarios, carriers must partner with providers around value-based initiatives focused on improving care delivery, promoting better quality, increasing efficiencies, and improving health outcomes.

Examples of quality incentive payment programs the State is considering during the 1332 waiver period include:

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

3. Practice in Nevada Incentive Program for Providers

One of the significant drivers of high health care costs and poor health outcomes in Nevada is the alarming provider workforce shortage in the State. The State proposes to utilize federal pass-through funds to finance a new workforce initiative—a loan repayment program that ties payment to a four-year commitment to live and work in Nevada. Anyone violating the loan repayment agreement would be required to pay back the financial assistance received from the State.

E. Implementation Milestones

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

The second step is for the Director to conduct a statewide procurement for the new BBSPs alongside its next statewide Medicaid Managed Care procurement, which is anticipated to begin no later than January 1, 2025. The alignment of this procurement process with the Medicaid Managed Care procurement is intended to leverage the State's purchasing authority and its billion-dollar contracts with carriers.[18] Specifically, state law requires any carrier seeking to be eligible to do business with Nevada Medicaid as an MCO to also submit a good faith bid to offer at least two BBSPs per rating region (i.e., one silver-level plan and one gold-level plan). Other carriers not seeking an award as an MCO in the state's Medicaid managed care program may also submit a bid to offer a BBSP. The State does not anticipate any carriers opting to offer a bid for a BBSP contract unless they are also offering a bid for the MCO contract with the State.

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

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

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

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

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

Besides the milestones set forth in state law for the BBSPs, implementation of the Market Stability Program will also take place in 2026, with a rollout date of 2027 upon receipt of new federal pass-through funds, pending federal approval. As described in Section 2(A), the authority to establish this program can be found in the Commissioner of Insurance's broad authority to seek a Section 1332 waiver at any time to implement any plan for the individual market that is in accordance with federal requirements for a Section 1332 waiver.

State authority to finance reinsurance with the pass-through funds from the BBSP's premium reduction target can be found in NRS 695K, which gives the Director the ability to determine uses for the pass-through funding if the uses can be tied to improved affordability for consumers. The Director is also permitted under state law to seek all necessary federal waiver authority to further subsidize the cost of health insurance.

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

Table 2: Nevada Battle Born State Plan Implementation Timeline and Milestones

Quarter 4, 2021	• Public workshops on product design held by the State.
Quarters 1-3, 2022	• Actuarial analysis and waiver development.
Quarter 4, 2022	• Nevada Medicaid hosts weekly "office hours" for the Public Option.
Quarter 3, 2023	• Development of a new Market Stabilization Program for waiver.
Quarter 4, 2023	• Finalize actuarial analysis and waiver draft. • Draft waiver application released November 20, 2023. • Two hybrid (in-person and virtual) public workshops/hearings on draft waiver (November 27 and December 5). • DHHS issues new bulletin to carriers on BBSP revised target and reinsurance program (November 20). • DHHS submits waiver application (December 31, 2023).
Quarter 1, 2024	• CMS/Treasury determine completeness within 45 days and hold 30-day public comment period. • DHHS begins development of procurement materials and contracts for BBSPs. • DHHS hosts stakeholder meetings to gather input on procurement for BBSPs.
Quarter 2, 2024	• CMS/Treasury continues a 180-day review/determination period. • DHHS continues development of procurement materials and contracts for BBSPs.
Quarter 3, 2024	• CMS/Treasury make final determination on waiver application. • DHHS finalizes procurement materials and contract for BBSPs
Quarter 4, 2024	• MCO/BBSP statewide procurement begins.
Quarter 1, 2025	• State evaluators for procurement review bids for MCOs and BBSPs.
Quarter 2, 2025	• Continued procurement process.
Quarter 3, 2025	• DHHS sends Letter of Intent to Award MCO and BBSP contracts. • Negotiation and awards final for BBSP contracts. • BBSP carriers submit rate filings to DOI for review/approval. • DOI completes rate analyses and approval processes. • DOI submits final rate filings to the Center for Consumer Information and Insurance Oversight (CCIIO). • BBSP carriers submit for SSHIX certification.
Quarter 4, 2025	• BBSPs are offered for enrollment during Open Enrollment.
Quarter 1, 2026	• BBSPs available on SSHIX for Plan Year 2026.
Quarter 2, 2026	• DHHS/DOI guidance to carriers on reinsurance and quality incentive payment program.

Quarter 3, 2026	• BBSP carriers submit rate filings to DOI for Plan Year 2027 for review/approval. • DOI completes rate analyses and approval processes. • DOI submits final rate filings to CCIIO. • BBSP carriers submit for SSHIX certification.
Quarter 4, 2026	• BBSP are offered for enrollment during Open Enrollment
Quarter 1, 2027	• BBSP available on SSHIX for Plan Year 2027. • Reinsurance program begins for Plan Year 2027.

F. Inter-agency Coordination

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

1. Nevada DOI

The Commissioner of Insurance will continue to lead the rate review process for plans offered in the individual health insurance market, which includes the new BBSPs. Like other rate filings submitted by carriers, including the rate filings with reinsurance for plan year 2027, the DOI will review the rate filings submitted by Nevada carriers and oversee compliance with rate and form requirements, network adequacy, and solvency and reserve standards.

2. SSHIX

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

3. Nevada DHHS

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

DHHS will also determine whether a good faith bid has been submitted by a carrier as required by State law as part of the State MCO purchasing review process and coordinate with DOI during the rate review process to ensure carriers offering the BBSPs remain on track to meet annual premium reduction targets as agreed to under their contracts with the State. If a carrier cannot meet the target set forth in its contractual agreement with DHHS, the Director may utilize a corrective action plan (if deemed a viable option for the carrier, in order to allow the carrier to make up some of the reduction in future years) and any other penalties set forth in such agreement, including a financial penalty that is worth all or some of the value of the federal pass-through funding that the State would have otherwise received if the carrier had met their agreed-upon premium reduction target(s). Another more serious option is finding a carrier out of

compliance or in breach of contract, and therefore terminating the carrier's existing BBSP and MCO contracts with DHHS and/or deeming the carrier ineligible to participate in a future MCO procurement and contract period.

Regarding the reinsurance program, DHHS and DOI will be responsible for collaborating and coordinating resources and staff to implement and operate the new program. For the quality bonus payment, DHHS will be responsible for establishing criteria and issuing payments to qualifying carriers. DHHS will work with the appropriate entity or entities as necessary to implement the new loan repayment program for health care providers.

G. Expected Federal Savings and Enrollment Changes

The actuarial analysis conducted by Milliman, Inc. estimates that the introduction of new BBSPs into the SSHIX with the support of a reinsurance program for the State's individual market could achieve nearly $279–$310 million in federal savings in the first five years and $760–$844 million at the end of the first ten years.[19]

For purposes of the actuarial review conducted by Milliman, it is assumed that the enhanced federal subsidies available on SSHIX for consumers will expire on January 1, 2026, at the time the new BBSPs enter the Nevada market and SSHIX.[20] Table 3 below shows the projected federal pass-through funding from the BBSPs (i.e., specifically from the new premium reduction target for waiver years 2026–2030) and the new reinsurance program (for waiver years 2027–2030).

Table 3: Summary of Projected Pass-Through Funding by Scenario

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

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

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

[19] See Nevada 1332 Waiver Actuarial Report by Milliman, Inc., 2023.

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

reinsurance. This analysis also assumes that, with their premium reduction target and the introduction of reinsurance, the BBSPs will be the SLCSP in the SSHIX each year of the waiver period.

Table 4: Impact of Waiver Compared to Baseline

Year	Premiums	Total Change Individual Market Enrollment	Federal Savings (Thousands)
2026	(3.2%)	600	$15,000
2027	(12.0%)	1,800	$58,000
2028	(13.5%)	2,000	$69,000
2029	(15.0%)	2,100	$81,000
2030	(15.2%)	1,900	$87,000

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

Table 5: Projected SSHIX Enrollment Change from Baseline

Year	BBSPs Only	Reinsurance	Total
2026	300	0	300
2027	400	800	1,200
2028	500	800	1,300
2029	600	800	1,400
2030	400	800	1,200
2031	600	800	1,400
2032	500	800	1,300
2033	500	900	1,400
2034	500	900	1,400
2035	400	900	1,300

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

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

If the amount of federal savings, and therefore pass-through funds, is lower than estimated, the State intends to adjust its reinsurance program and its attachment point and coinsurance to ensure that there are adequate

funds to support the program for the upcoming plan/waiver year. If the amount of federal savings, and therefore pass-through funds, is significantly greater than estimated, the State intends to utilize such funding to fund the State's new Quality Incentive Payment Program and its "Practice in Nevada" incentive program, each of which is described in Section 2(D).

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

Section 3: Actuarial Analysis of Proposed Waiver

A: Impact on Section 1332 Guardrails

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

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

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

The waiver satisfies the affordability requirement as follows:

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

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

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

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

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

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

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

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

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

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

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

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

Table 8: Projected Pass-Through Funding by Scenario

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

B. Impact on Health Equity

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

The Director must also prioritize bids for the BBSP that include strategies to reduce health disparities and demonstrate alignment of provider networks between BBSP and MCO programs, where applicable, to help ensure continuity of care as people move up the income ladder and purchase health insurance in the individual market.

By leveraging a unified state purchasing strategy, Nevada can improve outcomes for historically marginalized

communities. The State is exploring including some or all the below contact provisions for Public Option plans:

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

These contractual requirements will empower the State to measure, track, and act on health care disparities, furthering the authorizing legislation's goal of improved access to health care and better health outcomes for historically marginalized communities.

Section 4: Additional Information

A. Administrative Burden

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

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

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

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

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

- Review documented complaints, if any, related to the waiver.

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

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

B. Implementation of Non-waived ACA Provisions

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

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

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

D. Compliance, Waste, Fraud, and Abuse

The Director of DHHS, in consultation with the Commissioner of DOI and the Executive Director of the SSHIX, shall implement and oversee the administration of the BBSPs from their respective administrative roles. Under state law, the BBSPs shall operate as individual health insurance products that comply with state and federal requirements for QHPs and all state health insurance laws and regulations.

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

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

DOI will continue to lead its rate review and network adequacy processes for private health insurance plans in the individual market, which as of 2026 will include the BBSP products. DOI is responsible for regulating, ensuring compliance of, and monitoring the solvency of all carriers; performing market conduct analysis,

examinations, and investigations; and providing consumer outreach and protection. The DOI investigates all complaints that fall within the agency's regulatory authority.

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

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

E. State Reporting Requirements and Targets

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

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

Each quarterly report will include the following:

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

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

annual report. Once the final annual report is approved by CMS, DHHS will publish the final annual report on its website within 30 days of approval.

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

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

F. Evidence of Public Notice and Tribal Consultation Requirements

The State of Nevada is holding a public comment period beginning on November 20, 2023 and ending on December 20, 2023. The public hearings and public comment period were announced through an official public hearing announcement and posted on the Section 1332 waiver web page. During the public comment period, DHHS will hold two public hearings (November 27 and December 5) and two Tribal consultations (November 29, 2023 and December 7, 2023). The public hearing notice, hearings and Tribal consultation comply with 31 C.F.R. 112 and 45 C.F.R. 155.1312. A copy of the notice is in the Appendix.

[This waiver narrative will be updated to reflect a description of the public forums, including attendees and comments representative of participants' views.]

Appendix

Appendix A: Proposed State Operations Budget for Waiver Program

Estimated Annual SFY Budget Costs for State Operations, Starting SFY2026

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

Nevada Division of Insurance Operation Costs for Public Option	
Increased Rate Review Program Costs	
Additional Staffing Costs for Reinsurance Program	
Increase Vendor Costs	
Estimated subtotal	**$1,000,000.00 per SFY**
Nevada Medicaid Operation Costs for Public Option	
New Staffing Costs for Contracts/Waiver	$400,000.00 per SFY
New Actuary and Transaction Fees	$1,600,000.00 per SFY
Estimated subtotal	**$2,000,000.00 per SFY**
Estimated Total Operational Costs	**$3,000,000.00 per SFY**

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

Appendix B. State Legislation

Nevada Revised Statute Chapter 695K – Public Option

GENERAL PROVISIONS

NRS 695K.010 Purpose and policy of Legislature in enacting chapter. [Effective January 1, 2026.]

NRS 695K.020 Definitions. [Effective January 1, 2026.]

NRS 695K.030 “Certified community behavioral health clinic” defined. [Effective January 1, 2026.]

NRS 695K.040 “Commissioner” defined. [Effective January 1, 2026.]

NRS 695K.050 “Director” defined. [Effective January 1, 2026.]

NRS 695K.060 “Exchange” defined. [Effective January 1, 2026.]

NRS 695K.070 “Federally qualified health center” defined. [Effective January 1, 2026.]

_____

GENERAL PROVISIONS

NRS 695K.010 Purpose and policy of Legislature in enacting chapter. [Effective January 1, 2026.] It is hereby declared to be the purpose and policy of the Legislature in enacting this chapter to:

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

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

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

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

(Added to NRS by 2021, 3616, effective January 1, 2026)

NRS 695K.020 Definitions. [Effective January 1, 2026.] As used in this chapter, unless the context otherwise requires, the words and terms defined in NRS 695K.030 to 695K.110, inclusive, have the meanings

ascribed to them in those sections.

(Added to NRS by 2021, 3616, effective January 1, 2026)

NRS 695K.030 "Certified community behavioral health clinic" defined. [Effective January 1, 2026.] "Certified community behavioral health clinic" means a community behavioral health clinic certified in accordance with section 223 of the Protecting Access to Medicare Act of 2014, Public Law No. 113-93.

(Added to NRS by 2021, 3616, effective January 1, 2026)

NRS 695K.040 "Commissioner" defined. [Effective January 1, 2026.] "Commissioner" means the Commissioner of Insurance.

(Added to NRS by 2021, 3616, effective January 1, 2026)

NRS 695K.050 "Director" defined. [Effective January 1, 2026.] "Director" means the Director of the Department of Health and Human Services.

(Added to NRS by 2021, 3616, effective January 1, 2026)

NRS 695K.060 "Exchange" defined. [Effective January 1, 2026.] "Exchange" means the Silver State Health Insurance Exchange.

(Added to NRS by 2021, 3617, effective January 1, 2026)

NRS 695K.070 "Federally qualified health center" defined. [Effective January 1, 2026.] "Federally qualified health center" has the meaning ascribed to it in 42 C.F.R. § 405.2401.

(Added to NRS by 2021, 3617, effective January 1, 2026)

NRS 695K.080 "Provider of health care" defined. [Effective January 1, 2026.] "Provider of health care" has the meaning ascribed to it in NRS 695G.070.

(Added to NRS by 2021, 3617, effective January 1, 2026)

NRS 695K.090 "Public Option" defined. [Effective January 1, 2026.] "Public Option" means the Public Option established pursuant to NRS 695K.200.

(Added to NRS by 2021, 3617, effective January 1, 2026)

NRS 695K.100 "Rural health clinic" defined. [Effective January 1, 2026.] "Rural health clinic" has the meaning ascribed to it in 42 C.F.R. § 405.2401.

(Added to NRS by 2021, 3617, effective January 1, 2026)

NRS 695K.110 "Trust Fund" defined. [Effective January 1, 2026.] "Trust Fund" means the Public Option Trust Fund created by NRS 695K.300.

(Added to NRS by 2021, 3617, effective January 1, 2026)

ADMINISTRATION; OPERATION

NRS 695K.200 Design, establishment and operation; availability; requirements; premiums. [Effective

January 1, 2026, through December 31, 2029.]

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

2. The Director:

(a) Shall make the Public Option available:

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

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

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

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

3. The Public Option must:

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

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

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

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

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

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

6. As used in this section:

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

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

(c) "Medicare Economic Index" means the Medicare Economic Index, as designated by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services pursuant to

42 C.F.R. § 405.504.

(d) "Reference premium" means, for any zip code, the lower of:

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

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

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

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

(Added to NRS by 2021, 3617, effective January 1, 2026)

NRS 695K.200 Design, establishment and operation; availability; requirements. [Effective January 1, 2030.]

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

2. The Director:

(a) Shall make the Public Option available:

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

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

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

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

3. The Public Option must:

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

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

4. As used in this section:

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

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

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

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

(Added to NRS by 2021, 3617; A 2021, 3645, effective January 1, 2030)

NRS 695K.210 Application for federal waivers and approvals; acceptance of gifts, grants and donations; deposit of money; contracts for services. [Effective January 1, 2026.]

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

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

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

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

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

2. In preparing an application for any waiver described in subsection 1, the Director, the Commissioner and the Executive Director of the Exchange may contract with an independent actuary to assess the impact of the Public Option on the markets for health care and health insurance in this State and health coverage for natural persons, families and small businesses. The actuary must have specialized expertise or experience with state health insurance exchanges, the type of waiver for which the application is being made, measures to contain the costs of providing health coverage, reforming procedures for the purchasing and delivery of governmental services and Medicaid managed care programs. A contract pursuant to this subsection is exempt from the provisions of chapter 333 of NRS.

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

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

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

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

advanced payment of premium tax credits pursuant to 42 U.S.C. § 18082 for such a purchase.

5. The Director may:

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

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

(Added to NRS by 2021, 3618, effective January 1, 2026)

NRS 695K.220 Administration: Contract with health carrier or other qualified person or entity or performance by Director; duties of administrator; deposit of money. [Effective January 1, 2026.]

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

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

3. Each proposal submitted pursuant to subsection 2 must demonstrate that the applicant is able to meet the requirements of NRS 695K.200.

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

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

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

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

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

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

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

6. Any health carrier or other person or entity with which the Director contracts to administer the Public Option pursuant to this section or the Director, if the Director directly administers the Public Option pursuant to subsection 5, shall take any measures necessary to make the Public Option available as described in paragraph (a) of subsection 2 of NRS 695K.200 and, if required by the Director, paragraph (b) of that subsection. Such measures include, without limitation:

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

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

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

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

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

8. As used in this section:

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

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

(Added to NRS by 2021, 3619, effective January 1, 2026)

NRS 695K.230 Duties of certain providers of health care; exception. [Effective January 1, 2026.]

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

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

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

2. The Director and the Executive Officer of the Public Employees' Benefits Program may waive the requirements of subsection 1 when necessary to ensure that recipients of Medicaid and officers, employees

and retirees of this State who receive benefits under the Public Employees' Benefits Program have sufficient access to covered services.

(Added to NRS by 2021, 3620, effective January 1, 2026)

NRS 695K.240 Establishment of networks and reimbursement of providers of health care: Requirements. [Effective January 1, 2026.]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(Added to NRS by 2021, 3621, effective January 1, 2026)

PUBLIC OPTION TRUST FUND

NRS 695K.300 Creation; administration; sources of money; interest; nonreversion; uses.

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

2. The Trust Fund consists of:

(a) Any money deposited in the Trust Fund pursuant to NRS 695K.210 and 695K.220;

(b) Any money appropriated by the Legislature for the purpose of carrying out the provisions of this chapter; and

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

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

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

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

(Added to NRS by 2021, 3621)

Excerpt: Nevada SB 482 (2019)

Sec. 45.

1. The Commissioner may apply to the Secretary of Health and Human Services pursuant to 42 U.S.C. § 18052 for a waiver for state innovation of applicable provisions of the Patient Protection and Affordable Care Act, Public Law 111-148, with respect to health insurance coverage in this State for a plan year beginning on or after January 1, 2020.

2. The Commissioner may implement a state plan that meets the waiver requirements in a manner consistent with state and federal law and as approved by the Secretary of Health and Human Services.

Excerpt: Nevada Revised Statute Chapter 679B.120

The Commissioner shall:

1. Organize and manage the Division, and direct and supervise all its activities;

2. Execute the duties imposed upon him or her by this Code;

3. Enforce the provisions of this Code;

4. Have the powers and authority expressly conferred upon him or her by or reasonably implied from the provisions of this Code"

Excerpt: Nevada Revised Statute Chapter 679B.400

1. The Legislature finds and declares that:

   (a) Stabilizing the cost of insurance is of vital concern to the residents of this state; and

   (b) It is necessary to establish a comprehensive system to collect, analyze and distribute information concerning the cost of insurance in order to stabilize that cost effectively.

2. The purposes of NRS 679B.400 to 679B.460, inclusive, are to:

   (a) Promote the public welfare by studying the relationship of premiums and related income of insurers to costs and expenses of insurers;

   (b) Develop measures to stabilize prices for insurance while continuing to provide insurance of high quality to the residents of this state;

   (c) Permit and encourage competition between insurers on a sound financial basis to the fullest extent possible;

   (d) Establish a mechanism to ensure the provision of adequate insurance at reasonable rates to the residents of this state; and

   (e) Protect the rights of customers of insurance in this state.

Appendix C. Public Notice and Tribal Consultation

See Narrative Attachment A.

NARRATIVE ATTACHMENT A:

PUBLIC NOTICE AND TRIBAL CONSULTATION NOTIFICATION

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

November 6, 2023

Inter-Tribal Council of Nevada
Serrell Smokey, ITCN President
Tribal Chairman of Washoe Tribe
919 Highway 395 South
Gardnerville, Nevada 89410

Dear Tribal Members:

In accordance with established consultation guidelines, the Division of Health Care Financing and Policy (DHCFP) is notifying Nevada tribes of the following:

The 2021 Legislature signed into law the "Public Option" through Senate Bill 420. This bill requires the Nevada Department of Health and Human Services (Department) to contract with health carriers to offer a public health insurance option no later than January 1, 2026. This reform aligns with the state's efforts to control the growth of health care costs, while improving access to coverage for Nevadans. The state-contracted health plans (i.e., Nevada Qualified Health Plans (NQHPs) will be available for purchase through Nevada Health Link marketplace, starting January 1, 2026. These plans must meet certain premium reduction targets and pay their providers at or more than Medicare rates.

To implement this new option, the Department must seek the state's first-ever Section 1332 Waiver of the Affordable Care Act in coordination with the Nevada Department of Insurance and Nevada Health Link. This letter is intended to provide formal notice of this waiver and the opportunity for tribes to provide feedback and comment prior to the state's submission on January 1, 2024.

As part of this waiver request, the Governor is seeking to establish a new Market Stabilization Program to mitigate some of the concerns raised by stakeholders about the risk of cost shifting onto providers as a result of the premium reduction targets. This program includes a new reinsurance program to help control high costs in the individual, nongroup market, along with a quality bonus payment for high performing plans and a loan repayment program for providers willing to live and work in the state of Nevada for at least four years.

The draft application for the waiver will be posted online on the Division of Health Care Financing and Policy (DHCFP) website for a 30-day public comment period on November 15, 2023. To receive federal approval of this new waiver, the new option or program must satisfy four federal requirements. These include:

- Health coverage will be as affordable as without the waiver;
- Coverage under the waiver will be available to at least as many people as would be expected to be covered without the waiver;
- Coverage under the waiver will be as comprehensive as it would have been without the waiver; and
- The waiver is deficit neutrality for the federal government.

The Department looks forward to hearing from Tribal Leaders about any questions and/or feedback they may have. We would like to offer the following meeting times during this period for DHCFP to present to Tribal Leaders:

Wednesday, November 29, 2023 at 9am (calendar invite to follow)

Thursday, December 7, 2023 at 1:30pm (calendar invite to follow)

DHCFP will enter into a 30-day public comment period upon completion of the Nevada Plan for Market Stability Waiver within the next two weeks and looks forward to meeting with Tribal Leaders during this period of time to present and take back any feedback.

There is no anticipated fiscal impact to Tribal Governments.

Please look for calendar invites from Monica Schiffer to discuss the Nevada Plan for Market Stability. If you would like a consultation regarding this proposed change in policy, please contact Monica at (775) 684-3653 or mschiffer@dhcfp.nv.gov who will schedule a meeting. We would appreciate a reply within 30 days from the date of this letter. If we do not hear from you within this time, we will consider this an indication that no individual consultation is requested.

Sincerely,

Casey Angres
Casey Angres (Nov 6, 2023 08:48 PST)

Casey Angres
Division Compliance Chief, DHCFP

cc: Sandie Ruybalid, CPM, Deputy Administrator, DHCFP
Malinda Southard, D.C., CPM, Deputy Administrator, DHCFP
Michael Gorden, Waiver & Stakeholder Director, DHCFP
Monica Schiffer, Tribal & Community Liaison, DHCFP

Si necesitas ayuda traduciendo este mensaje, por favor escribe a dhcfp@dhcfp.nv.gov, o llame (702) 668-4200 o (775) 687-1900
如果希望获得本文件的翻译版本，请提交申请至 dhcfp@dhcfp.nv.gov; (702) 668-4200 o (775) 687-1900

REVISED NOTICE OF PUBLIC WORKSHOP

1332 Waiver Application Presentation and Public Comment ~~Workshop~~ Meeting

Date of Publication:	November 9, 2023
Date of Revision:	**November 13, 2023**
Date and Time of Meeting:	November 27, 2023, at 1:00 PM to 3:00 PM
Name of Organization:	The State of Nevada, Department of Health and Human Services (DHHS), Division of Health Care Financing and Policy (DHCFP)
Place of Meeting:	Division of Public and Behavioral Health (DPBH) 4150 Technology Way Third Floor Conference Room #303 Carson City, Nevada 89706 Note: This Public Meeting will be held in person at the DPBH location listed above. Please use the teleconference/Microsoft Teams options provided below for the virtual option. If accommodations are requested, please advise using the information at the end of this agenda.

Note: *If at any time during the meeting an individual who has been named on the agenda or has an item specifically regarding them included on the agenda is unable to participate because of technical or other difficulties, please email Michael Gorden at michael.gorden@dhcfp.nv.gov and note at what time the difficulty started so that matters pertaining specifically to their participation may be continued to a future agenda if needed or otherwise addressed.*

*General Public Comments (No action may be taken upon a matter raised under public comment period unless the matter itself has been specifically included on an agenda as an action item. To provide public comment telephonically, you may join the meeting by dialing (775) 321-6111 and when prompted to provide the Meeting ID, enter 816 527 440#. You may then press *5 to raise your hand during the public comment periods to provide your comment. Comments will be limited to three minutes per person. Persons making comment will be asked to begin by stating their name for the record and to spell their last name. Those who wish to provide a written comment may submit their comment via mail to 1100 E. William Street, Ste. 101, Carson City, Nevada 89701 or via email to ~~documentcontrol@dhcfp.nv.gov~~1332WaiverProgram@dhcfp.nv.gov). Written comments will be accepted between November 20, 2023, and December 20, 2023.*

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Webinar: https://tinyurl.com/PW112723

Select "Join," enter your name and email and then select "Join."
The meeting should not require a password.

Audio Only: (775) 321-6111
Conference ID: 816 527 440#

PLEASE DO NOT PUT THIS NUMBER ON HOLD (*hang up and rejoin if you must take another call*)

YOU MAY BE UNMUTED BY THE HOST WHEN SEEKING PUBLIC COMMENT, PLEASE HANG UP AND REJOIN IF YOU ARE HAVING SIDE CONVERSATIONS DURING THE MEETING OR THOSE MAY BE HEARD BY OTHERS AND RECORDED

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Agenda

1. Presentation and public comment on the State's Section 1332 Innovation Waiver~~Nevada Market Stability Program (previously known as Public Option)~~

   a. The purpose of this workshop is to bring awareness that Nevada ~~will~~ is seeking a State Innovation Waiver under Section 1332 of the Affordable Care Act (ACA) (also known as a Section 1332 Waiver) in accordance with State statutory requirements of Chapter 695K of the Nevada Revised Statutes (NRS). State law requires the Director of Health and Human Services to establish a Public Option program, in which the Director contracts with health carriers to offer new health insurance options in the State's health exchange, starting January 1, 2026. The state-contracted health plans ~~(i.e., Nevada Qualified Health Plans – NQHPs)~~ must meet certain premium reduction targets and pay providers at or above Medicare rates.

   As part of this waiver request, the Governor is seeking federal authority to also establish and finance a new Market Stabilization Program (MSP). The key ~~goals~~provisions of this new program would ~~be to~~: (1) implement a reinsurance program to stabilize the individual health insurance marked and mitigate ~~the~~ any financial risk of the new premium reduction targets on health carriers and their provider networks; (2) reward health carriers and their provider networks for efforts to improve health outcomes and quality; and (3) ~~ensure greater stability for health carriers in Nevada's individual health insurance market~~increase the State's health care provider base with a "Practice in Nevada" incentive program.

   Consistent with federal requirements, the Section 1332 Waiver program will provide coverage to at least as many Nevadans; be at least as affordable with comparable benefits that are at least as comprehensive as they otherwise would have been without the waiver under federal law – all without increasing the federal deficit.

   Waiver application text and actuarial analysis will be posted on November 20, 2023, for public review and comment. All public comments are due by December 20, 2023. Please submit your public comments during this 30-day period to: 1332WaiverProgram@dhcfp.nv.gov.

   The waiver text, notice of public comment and Tribal consultation, and public comments

received will be posted at the Division's Market Stabilization Program webpage located here: https://dhcfp.nv.gov/marketstabilization/.

b. Public comment regarding subject matter.

2. Public comment regarding any other issue

3. Adjournment

NOTE: To use the long link to the meeting in the event there are issues with the URL shortener, please use the following complete link:
https://teams.microsoft.com/l/meetup-join/19%3ameeting_ZmM5ODBjOTAtZmFjMC00ZGIyLTllMWItMWVlMjQzMDUwZGY2%40thread.v2/0?context=%7b%22Tid%22%3a%22e4a340e6-b89e-4e68-8eaa-1544d2703980%22%2c%22Oid%22%3a%22cc4c7a00-e2be-4dda-a27b-3405a8271b9c%22%7d

Nevada Medicaid is unaware of any financial impact to other entities or local government due to this public hearing, other than as stated above.
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The DHCFP is exempt from Chapter 233B according to NRS 233B.039 and is not required to comply with the Nevada Administrative Procedure Act in this process. This meeting is conducted by and with state agency staff which is not a public body for purposes of NRS 241 related to Nevada Open Meeting Law but every effort is made to be transparent in notice and information provided to encourage public awareness and participation.

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DHCFP, 1100 E. William St., Suite 101, Carson City, Nevada 89701
DHCFP, 1010 Ruby Vista Drive, Suite 103, Elko, Nevada 89801
DHCFP, 1210 S. Valley View, Suite 104, Las Vegas, Nevada 89102
DHCFP, 745 W. Moana Lane, Suite 200, Reno, Nevada 89509

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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

Si necesitas ayuda traduciendo este mensaje, por favor escribe a dhcfp@dhcfp.nv.gov, o llame (702) 668-4200 o (775) 687-1900
如果希望获得本文件的翻译版本，请提交申请至 dhcfp@dhcfp.nv.gov; (702) 668-4200 o (775) 687-1900

NOTICE OF PUBLIC WORKSHOP

1332 Waiver Application Presentation and Public Comment Meeting

Date of Publication: November 15, 2023

Date and Time of Meeting: December 5, 2023, at 1:00 PM to 3:00 PM

Name of Organization: The State of Nevada, Department of Health and Human Services (DHHS), Division of Health Care Financing and Policy (DHCFP)

Place of Meeting: Division of Health Care Financing and Policy (Las Vegas District Office)
1210 S. Valley Blvd, Suite #104
Las Vegas, Nevada 89102

Note: This Public Meeting will be held in person at the DPBH location listed above. Please use the teleconference/Microsoft Teams options provided below for the virtual option. If accommodations are requested, please advise using the information at the end of this agenda.

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Webinar: https://tinyurl.com/PW12052023

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Audio Only: (775) 321-6111
Conference ID: 676 196 451#

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    b. Public comment regarding subject matter.

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https://teams.microsoft.com/l/meetup-join/19%3ameeting_M2VlNzZhZWQtMDFlZC00MzdjLWFlYjYtZmFhZDNmYWIxYWFj%40thread.v2/0?context=%7b%22Tid%22%3a%22e4a340e6-b89e-4e68-8eaa-1544d2703980%22%2c%22Oid%22%3a%22cc4c7a00-e2be-4dda-a27b-3405a8271b9c%22%7d

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