SECTION 1332 WAIVER APPLICATION

NEVADA PUBLIC OPTION

DEPARTMENT OF
HEALTH AND HUMAN SERVICES

DIVISION OF HEALTH CARE FINANCING & POLICY

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Section 1: Waiver Submission Request and Nevada Public Option Overview

A: High-Level Summary

The state of Nevada is seeking approval of a Section 1332 waiver application in accordance with *Nevada Revised Statutes* (NRS) 695K.210 as part of the state's effort to establish a public health insurance option. The Public Option aligns with the state's efforts to control the growth of health care costs while improving access to coverage for Nevadans.[1] The authority to establish this new program was passed by the 2021 Nevada State Legislature and signed into law on June 9, 2021.[2] The waiver requested would be in effect from January 1, 2026 to December 31, 2030 and, as further explained below, seeks to waive Section 1312(c)(1) of the Affordable Care Act (ACA) in order to implement the Public Option's statutorily required premium reductions.

For the Nevada Public Option to meet the federal requirements for a 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 Nevada's Public Option waiver meets these federal requirements for a 1332 waiver under each scenario modeled and estimates the potential for federal savings of $341M to $464M in the first five years, most of which can be reinvested in Nevada's health care system by virtue of this waiver.

State law requires that the Public Option be offered as a qualified health plan (QHP) (as defined by 42 U.S.C. § 18021) in the state's nongroup market starting January 1, 2026. Nevada consumers will be able to shop for and purchase Public Option plans through the state's online health insurance marketplace known as Nevada Health Link (the Silver State Health Insurance Exchange) or directly from a health carrier selling health insurance in the state's individual market. Qualifying consumers

Actuarial and Economic Analysis - Highlights

Financial Estimates

- Potential for up to $341 to $464 million in savings in the first five years, a significant portion of which could be passed on to State under 1332 waiver depending on use of new federal funds and Exchange enrollment.
- Savings passed on to State in first 10 years estimated near $1 billion.

Affordability Gains

- Public Option expected to provide more affordable health care coverage to 55,300 Nevadans in year one and up to 92,500 (Yr. 5).

Coverage Estimates

- Uninsured who are eligible for Exchange coverage decreases by 10-12% (Yr. 5) with new Public Option.

Provider Revenue Impact

- Minimal impact to provider revenue expected with new Public Option plans as individual market revenue makes up smallest portion of provider payor mix in Nevada (at 3%).
- Revenue decreases will be partially offset by higher volume of service utilization and reductions in uncompensated care costs.
- State also intends to impose a limit on spending by carriers on administrative costs (includes profits, salaries, overhead, etc.); this will ensure carriers do not fully offset the cost of the premium reduction targets on providers and that carriers must absorb a fair portion of these costs.

[1] Other state policies focused on reducing health care costs for Nevadans include the December 2021 Executive Order establishing cost control benchmarks and the September 20222 implementation of a statewide drug discount card program.
[2] Senate Bill 420 (2021); Nev. Revised Stat. 695K.

purchasing the Public Option on the State Exchange can receive federal Affordable Care Act (ACA) subsidies to help offset the cost of the Public Option plan.

State law directs the Nevada Department of Health and Human Services (Nevada DHHS) to establish the Public Option program in consultation with the Executive Director of the Silver State Health Insurance Exchange (Exchange) and the Commissioner of the Nevada Division of Insurance (DOI). To administer and operate the program, state law requires that Nevada DHHS seek to contract directly with health insurance carriers to serve as vendors for offering the new Public Option plans through its state procurement process, which must be held simultaneously with its Medicaid managed care procurement. The resulting contract arrangements for the Public Option plans between DHHS and health carriers creates a public-private operations model for Nevada's Public Option, where the carrier maintains its private role as the risk-bearing entity and insurer and the state plays a new purchasing and oversight role seeking to enforce state law and priorities for these plans on behalf of consumers in the individual health insurance market.

State law also provides that any health carrier seeking to do business with Nevada Medicaid as a managed care organization (MCO) must submit a "good faith bid" to offer a Nevada Public Option product. These provisions will allow the state to leverage its more than $2 billion in purchasing power in Medicaid managed care with health carriers to drive and enforce reforms in the individual health insurance market.

As further outlined in this waiver application, state law requires insurance carriers, under contract to offer the Public Option, to meet certain premium reduction targets.[3] These targets are slated to achieve at least a 16% reduction in premiums over the first four years of the program. In turn, this will generate new federal pass-through funds for the state of Nevada as provided for under Section 1332 of the ACA. The state must use these new federal funds as outlined under state law to pay for all state operational costs for the Public Option (which includes covering the cost of new agency staffing and vendor costs in addition to costs for the state's Exchange navigator program). Such requirement makes the state's operations of the new program after implementation contingent on 1332 waiver approval.

The remaining federal pass-through funds can be utilized by the state to increase affordability of coverage for consumers as set forth in state law. Therefore, the state intends to use the remaining federal pass-through funds to pay for additional premium subsidies to be provided by the state to further reduce the cost of health care for consumers who shop for health insurance through Nevada Health Link (the State Exchange), which will include the new Public Option plans. These new state premiums also come at a critical time when the expanded federal premium subsidies available under the American Rescue Plan (ARPA) for State Exchanges are set to expire. If these enhanced federal subsidies expire as scheduled in 2025, the new state premium subsidies will be essential to mitigating the increase in premium costs to consumers who purchase coverage through Nevada Health Link.

To enforce the statutory requirements for the Public Option (like the premium reduction targets), state officials intend to utilize the new contracts with health carriers which will include certain financial penalties and/or sanctions that can be imposed by the state when carriers do not meet their contractual obligations. The new contractual arrangements also enable the state to impose requirements that go above and beyond those set forth in state law, including, for example, heightened network adequacy

[3] This premium reduction target expires on January 1, 2030.

standards, limits on administrative spending for plans, and/or new quality improvement standards that will be specific to the Public Option plans.

B: Waivable Provision

Nevada seeks a federal waiver of Section 1312(c)(1) of the ACA to implement the premium reduction targets and obtain the necessary funding to carry out the provisions of the state law. This section, which has implementing regulations at 45 CFR 156.80, limits the factors on which issuers can justify premium rate variations for a particular plan from the index rate.

Under 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," which include:

- the actuarial value and cost-sharing design of the plan;
- the plan's provider network, delivery system characteristics, and utilization management practices;
- the benefits provided under the plan that are in addition to the essential health benefits;
- administrative costs, excluding Exchange user fees; and
- with respect to catastrophic plans, the expected impact of the specific eligibility categories for those plans.

A federal waiver of Section 1312(c)(1) will allow Public Option plans to make plan-level adjustments to the market-wide adjusted index rate, which otherwise would be impermissible under 45 CFR 156.80(d)(2). Waiving this federal requirement and associated regulations would permit carriers to adjust premiums to meet premium reduction targets for Public Option plans, satisfying the state law requirement (NRS 695K.200) to impose premium reduction targets and allowing Nevada to obtain the necessary federal pass-through funding to fund the required state-administrative duties and activities necessary to operate the program as outlined under state law.

C: Nevada Public Option Detailed Description

The Public Option was established by Senate Bill (SB) 420 (2021) and signed into law on June 9, 2021, and later codified in NRS Chapter 695K. The stated statutory purpose of the Public Option is to:

- Leverage the combined purchasing power of the State to lower premiums and costs relating to health insurance for residents of this State
- Improve access to high-quality, affordable health care for residents of this State, including residents of this State who are employed by small businesses
- Reduce disparities in access to health care and health outcomes and increase access to health care for historically marginalized communities; and
- 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.

This section provides background on the affordability and access challenges that motivated the adoption of the Public Option, followed by a description of the key requirements for the new program, as set forth in the authorizing statute. Additional requirements, consistent with the statute, will be included as part of the request for proposal (RFP) for carriers seeking to contract with the state to offer the Public Option.

Background and Context for Nevada's Public Option

Several challenges in Nevada's health insurance market and system led the state legislature to adopt a Public Option. A key reason was the rising cost of health care and the state's high uninsured rate. Nevada's uninsured rate has been among the highest in the nation over the past several years, with disproportionate representation from the state's Hispanic/Latino population.[4] Lack of access to affordable coverage and care, most acute for minority and rural populations, has led to significant disparities in health outcomes. Although coverage is important to helping people access care, the capacity of the provider system in a state is also essential. Both health equity and provider workforce issues were central to the Public Option design as further described below.

Finally, motivating the state legislature was a desire to advance the adoption of value-based provider payment models across the state's health insurance market, a shift that has the potential to further contribute to the control of health care costs and progress on improving quality and health outcomes.

These goals—improving affordability, increasing access to coverage and care, addressing workforce shortages, reducing inequity, and advancing value-based payment—are all central to the design of Nevada's Public Option. As described in detail below, the key requirements of the authorizing legislation were designed to support these aims.

Key Statutory Requirements

1. Availability of the Public Option

The authorizing legislation provides that the Public Option must be available statewide as a QHP on the state Exchange online marketplace, Nevada Health Link and for direct purchase from health carriers in the private individual health insurance market. The authorizing state legislation also permits the state to offer the Public Option plans in the small group market, but currently the state is not taking up this option.

2. Benefit and Actuarial Value Requirements

The authorizing legislation provides that the Public Option must qualify as a QHP, be certified by the Exchange, and provide levels of coverage consistent with the actuarial value of at least one silver plan and one gold plan.

3. Premium Reduction Targets

State law outlines new premium reduction targets for health carriers offering Public Option plans to ensure the new products offer consumers cheaper premiums than what is available today in the current market. These requirements are time-limited and will begin on January 1, 2026, and end on December 31, 2029.

Pursuant to the Nevada DHHS Director's revision authority under Subsection 5 of NRS 695K.200, DHHS issued guidance on December 28, 2022, revising the premium reduction requirements to require that carriers establish Public Options plans that are:

- Lower than the average reference premium in each county by a percentage that increases each year, starting with 4% in year 1 and growing by at least 4% each year until it reaches at least 16% in year 4.

[4] Nevada's Uninsured Population. Guinn Center. 2019.

- Do not increase in any given year by a percentage greater than the increase in the Consumer Price Index for Medical Care plus any adjustments necessary to reflect local changes in utilization and morbidity.[5]

The state also defines "average reference premium" as the "second lowest-cost silver plan (SLCSP) available through the state's health insurance exchange during the 2024 plan year by county trended forward for inflation according to the Consumer Price Index for Medical Care and any adjustments to reflect local changes in utilization and morbidity."

The purpose of the December Nevada DHHS guidance is to ensure that the Public Option premiums will be actuarially sound, meaning that they can reasonably cover the projected cost of health care claims and the growth of medical inflation in the state's individual health insurance market. This guidance also ensures that the Director of DHHS can meet his statutory obligation under NRS 695K.240(2) which requires health carriers to pay providers in Public Option networks no lower than what they are paid in Medicare.

The State intends to hire an actuarial consultant to calculate the average reference premium, including defining the morbidity index and a historical utilization trend, to support Nevada DHHS in procurement requirements for carriers, and to provide ongoing modeling support of additional premium subsidies.

The Public Option's premium reduction targets will lower premium costs for consumers and reduce federal premium tax credit expenditures, generating new federal pass-through funds to the state of Nevada that are necessary to finance the cost of carrying out the provisions of the new state law and to expand access to affordable coverage for Nevadans.

4. Health Plan Rate Review and Coordination Among Implementing Agencies

The Director of Nevada DHHS, the Commissioner of DOI, and the Executive Director of the Silver State Health Insurance Exchange (Nevada Health Link) are responsible for certain activities necessary for offering the Public Option plans to consumers.

For example, DOI will continue to lead the rate review process for plans offered in the individual health insurance market, which includes the new Public Option plans. Like other rate filings submitted by health carriers, DOI will review the rate filings submitted by Public Option carriers and oversee compliance with rate and form requirements, network adequacy, and solvency and reserve standards. Nevada DHHS will coordinate with DOI during the rate review process to ensure carriers offering the Public Option plans remain on track to meet premium reduction targets as agreed to under their contracts with the state of Nevada.

Nevada Health Link will continue to certify qualified health plans like it does today. For Coverage Year 2026 and beyond, qualified health plans offerings will include Public Option plans. Additionally, Nevada Health Link will determine whether Public Option plans are eligible for premium tax credits and ensure that carriers offering Public Option plans through the marketplace pay their assessment fee, like they do for all other qualified health plans.

[5] For more detail, see Public Option Guidance Memo 22-001 contained in the 1332 Waiver Actuarial Economic Analysis and Certification for Nevada's Public Option, by Milliman.

Nevada DHHS will oversee the procurement and contracting process for the Public Option and provide contract monitoring and oversight of compliance with requirements set forth in the contract between the state and the carriers selected to provide Public Option plans.

5. Oversight Authority Through Aligned Procurement with Medicaid Managed Care

The main premise behind the Public Option in Nevada is that the State, as a purchaser of health care, can leverage its purchasing power with health carriers to drive their performance. Such performance includes promoting affordability and other reforms in the individual health insurance market. For Nevada, the state's broadest leverage as a purchaser of health care stems from its Medicaid managed care contracts with four national health plans (Anthem, United Healthcare, Molina, and Centene). These contracts are worth more than $2 billion in total, as compared to the less than half a billion (<$500 million) in premium revenue that carriers receive through Nevada Health Link.[6] As Nevada Medicaid continues to grow, the value of Medicaid managed care contracts to health carriers will increase. In return, the State can leverage this value to secure the participation of health carriers in the Public Option program.

To capture this leverage with carriers, the new state law requires that Nevada DHHS establish a statewide procurement for the Public Option program that must take place simultaneously with the state's Medicaid managed care procurement on an ongoing basis. Specifically, state law provides that any carrier seeking to do business with Nevada Medicaid as an MCO must submit a "good faith bid" to offer a Public Option product that complies with state law. If an applicant seeking a contract as a Medicaid MCO fails to submit a good faith bid (or a bid altogether) to offer the Public Option, the MCO will be ineligible to receive an award for a Medicaid MCO contract in Nevada.

Other health carriers not seeking an award as an MCO in the state's Medicaid managed care program may also choose to submit a bid to participate in the Public Option. The state anticipates that the newly aligned procurement processes for Medicaid MCOs and Public Option products will begin no later than January 1, 2025. The new contract period for the Public Option must begin on January 1, 2026; the state intends to do a four-year contract period for both Medicaid managed care and Public Option programs.

State officials will also be able to use the contractual arrangements with health carriers to enforce requirements for the Public Option plans, including the mandated premium reductions. The state also seeks to drive additional improvements in the individual market around access, quality and equity, and the adoption of value-based payments through explicit contract requirements (see section 8). Like state MCO contracts, the new Public Option contracts can provide for penalties and/or sanctions that can be imposed on health carriers by the state when health carriers do not meet their contractual obligations.

For example, the state is considering contract provisions that would establish a corrective-action process in the Public Option contracts that is similar to the one the state uses with health carriers in its Medicaid managed care program as outlined in Section 7.15.2 of the state's current MCO contract.[7] MCOs determined to be out of compliance with the state MCO contract must, upon request by the state, develop a corrective-action plan. The state MCO contract also provides the state with the legal authority needed to impose monetary and nonmonetary penalties and other sanctions as determined appropriate for any continued noncompliance under the contract. For example, the state could choose to impose monetary penalties in addition to more serious sanctions on carriers that do not meet the required premium

[6] Silver State Health Exchange Fiscal and Operational Report. June 2022.
[7] State-MCO contract

reduction target of at least 16% by year 4 of the contract period. An example of a more serious sanction could include disqualifying health carriers as eligible respondents for future state Medicaid managed care procurements in Nevada.

The State intends to issue a request for information (RFI) in the Spring of 2023 to receive feedback from public stakeholders regarding the state's oversight approach and contractual mechanisms for enforcing the Public Option's heightened requirements.

6. Use of Pass-Through Funds

The authorizing state legislation also establishes the Public Option Trust Fund, a non-reverting trust fund in the state treasury that will consist of money appropriated by the state legislature for deposit in the fund, all federal pass-through funding received by the state from the 1332 waiver, any potential monetary penalties assessed against Public Option carriers for not meeting contractual requirements, and any income and interest earned on the money in the fund.

Additionally, the State will receive an initial estimate of the federal pass-through funding amount in the fall of each year (before the beginning of the plan year). The final federal pass-through funding amount or final administrative determination by CMS will be shared in a letter prior to the payment of the pass-through funding amount as provided in the specific terms and conditions of the approval letter (typically before the end of April of the plan year). As required by NRS 695K.300, the state must first use federal pass-through funding to cover the cost of carrying out the provisions of the new state law, including the annual administrative costs associated with the program launch and providing oversight. These funds would replace the state's initial investment of state general funds to cover the "start-up" costs associated with implementation. Once the state administrative costs have been paid for with the new pass-through funds, the Director of Nevada DHHS may use a portion of the fund as determined by the State Treasurer to increase consumer affordability.

Therefore, there are two types of approved uses for any new federal pass-through funds received by state of Nevada under state law. The first is mandatory and directed at covering the costs to the state associated with running the Public Option program (i.e., procurement, waiver and contract monitoring and carrier compliance, and any increased costs to Nevada Health Link and its navigator program). The second use is discretionary under state law and applies to all remaining pass-through funds. The clear limitation on these funds is the requirement that they be used to improve consumer affordability. For purposes of this waiver, the state is proposing two discretionary uses of remaining pass-through funds as further described below.

A. Mandatory Use: State Administrative Costs Associated with Public Option

- The state must first use pass-through funding to cover the cost of carrying out the provisions of the new state law, including the annual state administrative costs associated with program launch, providing oversight of the Public Option contracts, and any related costs to the state for the new Public Option plans. As shown in the proposed budget, see Appendix B, these costs include staffing and vendor related costs for both DHHS and the Nevada Health Link, in addition to costs associated with the state's navigator program to assist people with enrollment.

B. Optional Use #1: State Premium Wrap to Improve Consumer Affordability or Mitigate Impact of the Expiration of federal ARPA Premium Subsidies in 2026

- The first approach would consist of applying the funds available to the state for Contract Year 1 of the Public Option (2026) in a manner that would act as a state premium wrap in 2027 for consumers who shop in the Nevada Health Link. The goal would be to fill the affordability gap in the Nevada Health Link with the sunset of the enhanced federal premium subsidies from ARPA. Per the federal Inflation Reduction Act, these subsidies are set to expire at the end of 2025, leaving consumers facing significant increases in premium costs for health insurance through state exchanges.

C. Optional Use #2: Incentive Bonus Payment Program for Public Option Carriers

- Depending on the amount of federal pass-through funds available to the state of Nevada under the waiver, Nevada DHHS is also considering the establishment of a bonus incentive program for Public Option carriers that achieve certain state goals and priorities, like improvements in health care quality metrics, health equity, provider network capacity, and health outcomes in the individual health insurance market. This would be similar to the bonus payment programs offered to Medicaid managed care plans for high performance in the managed care program. The amount of these bonus payments available to high performing carriers is yet to be determined.

7. Network Adequacy and Provider Reimbursement Guardrails

The new state law provides certain guardrails intended to ensure that the premium reduction targets for the Public Option plans do not undermine provider networks or access to care consumers. For example, any provider who participates in the Public Employee's Benefits Program (PEBP), Medicaid, or the state's workers' compensation program must agree to participate in at least "one provider network" for a Public Option plan. These providers must also 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. These requirements may be waived by the Director of Nevada DHHS if needed to ensure that individuals who receive benefits through these other programs have sufficient access to covered services.

Second, the state has two mechanisms to shield provider reimbursement rates from burdensome cuts.

- State law establishes a floor for provider reimbursement by requiring Public Option carriers to pay providers rates, in the aggregate, that are comparable to or better than Medicare rates. The 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.
- The state is exploring implementing an administrative cost constraint through the Public Option contracts that is stricter than prevailing individual market QHP expense (based on most recent publicly available rate filing data). Health carriers will need to reduce administrative expenses (salary, profits, and other administrative expenses) for the Public Option offerings, which will help reduce prices relative to non-Public Option offerings, all else equal. These administrative efficiencies at the carrier level will account for a portion of the required premium reductions, reducing the share of premium reductions that must be achieved by carriers through provider reimbursement reductions in Public Option plans.

Furthermore, in a separate analysis, Milliman found that the Public Option is not projected to meaningfully impact provider revenue on an aggregate level and that providers are not expected to exit other state coverage networks due to the law's provider participation requirements. The marginal impact to provider revenue is driven by the fact that the individual market makes up the smallest portion of the provider payor mix in Nevada (at approximately 3-4%) and that any provider revenue decreases in this market will be partially offset by increased utilization of services and reductions in uncompensated care costs.[8]

Finally, the law directs Nevada DHHS to prioritize applicants in the procurement for Public Option plans that meet certain criteria designed to ensure adequate access to services for consumers who purchase a Public Option plan. Specifically, the state law provides for the prioritization of carrier applicants that: (1) demonstrate alignment of networks of providers between the Public Option and Medicaid managed care, where applicable, with the goal of improving continuity of care for consumers; (2) provide for the inclusion of critical access hospitals, FQHCs, RHCs, and CCBHCs in the networks of providers for the Public Option and Medicaid managed care, where applicable; and (3) include proposals for strengthening the workforce in Nevada, particularly in rural areas for providers of primary care, mental health care, and treatment of substance use disorders.

8. Advancement of Value-Based Payment, Health Equity, and Other State Goals Through Procurement

Nevada's Public Option is designed not only to provide an additional, affordable health insurance option for state residents but also to support the state's broader goals of advancing value-based payment and health equity and lowering health care costs and improving quality across the state.

The authorizing legislation seeks to achieve this goal by creating the conditions for a unified state purchasing strategy, one that aims to leverage the state's purchasing power in the Medicaid managed care and Public Option procurements to drive statewide improvements in priority areas. Through greater alignment between the Medicaid managed care and individual health insurance markets, the state also expects to see greater administrative efficiencies in the system for both health carriers and providers (e.g., aligned provider networks and value-based payment design).

The state law requires Nevada DHHS to prioritize bids from health carriers during the procurement 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

[8] For more detail, see the Provider Participation Requirement Memo in Appendix B.

Table 1 outlines design features designated as mandatory v. optional under law in addition to other optional design features that the state is considering advancing through the procurement process.

Table 1: Nevada Public Option: Overview of Product Design		
Features	**Mandatory**	**Optional***
Nongroup Product (State Health Exchange)	**X**	
QHP Standards, Fee Assessment, and Certification	**X**	
Statewide Coverage via Procurement Process	**X**	
Medicare as Floor for Provider Rates	**X**	
Premium Reduction Target Compliance	**X**	
Network Alignment with MCO Networks	**X**	
Value-Based Provider Payment Targets	**X**	
Provider Workforce Enhancement Strategies	**X**	
Strategies for Addressing Health Disparities	**X**	
Cultural Competency Strategy for Provider Network	**X**	
Implement lower administrative costs through PO Plans		**X**
Value-Based, Prospective Payments to Expand Access to Care via Telehealth		**X**
Plan Quality Strategy (metrics stratified by race/ethnicity)		**X**
New Financial Reporting Requirements for Carriers		**X**
Requirement for Quality-Tied Payments for Certain Providers		**X**
Incentive Bonus Payments Program for Carriers Achieving Targets/Goals		**X**
Metal Tiers		
Bronze Metal Offerings		**X**
Silver Metal Offerings	**X**	
Gold Metal Offerings	**X**	

**Optional design features would be implemented with the state's procurement process and enforced through the contract. At this time, those listed as optional are under consideration; DHHS intends to seek public feedback in an upcoming RFI in 2023.*

Informed by cross-agency design meetings and six public design sessions the state hosted during the months of December 2021 and January 2022, the state has decided not to move forward with implementing the Public Option in the small group market. Public support for the small group offering was limited, and the state is prioritizing the strategic use of finite state resources for effective implementation and oversight of the Public Option.

Additionally, the state will not require Public Option carriers to include additional non-essential health benefits in their benefit packages. Through the public design sessions, the state heard that stakeholders were primarily concerned with accessing their current, covered services and had fewer concerns about uncovered benefits. Across all markets, Nevadans face health care access challenges, particularly in rural counties which experience the lowest provider-to-population ratios.[9] Stakeholders also expressed concerns that expanding benefits would place a tension on achieving premium reduction targets due to provider capacity being limited today.

D: Nevada Public Option Implementation Timeline

State law provides that the Public Option must be available for purchase by consumers through Nevada Health Link on January 1, 2026. State implementation activities began in the fall of 2021 with planning for

[9] Silver State Solutions: Expanding Medicaid Access in Nevada. Princeton University 2019.

stakeholder engagement and early preparation for the development of this Section 1332 waiver application and associated actuarial analyses. Between December 2021 and January 2022, the state held six public design sessions to solicit input from stakeholders and members of the public on key elements of the Public Option. These six design sessions focused on soliciting public feedback on design decisions related to:

- Identifying the Target Population
- Affordability Policies
- Benefits
- Premium Reduction Targets
- Value-based Payment and Cost Containment
- Provider Contracting and Networks
- Health Plan Rate Setting and Rate Review
- Licensure and Oversight
- Strengthening the Individual Marketplace
- Offering the Public Option in the Small Group Market

Table 2: Implementation Activities	
Quarter 4, 2022, and Quarters 1-2, 2023	• DHHS posts waiver application 60-day public comment period • DHHS holds two state public comment meetings and one Tribal consultation meeting • State submits Section 1332 waiver application to federal agencies • State request for information to Public Option stakeholders on contractual mechanisms used for enforcement
Quarters 3-4, 2023, and Quarters 1-4, 2024	• Federal completeness review and federal comment period • State negotiations waiver application with federal agencies • Federal waiver decision (approval scenario) • DHHS drafts procurement and contract materials • DHHS Actuarial Consultant determines reference premium, medical inflation, and utilization trend factor for premium reduction targets • DHHS issues Request for Proposals & begins procurement process for Public Option alongside Medicaid managed care procurement
Quarter 1, 2025	• DHHS conducts reviews bids • DHHS conducts readiness reviews of carriers that submitted bids • DHHS sends notice of intent to award contracts to top scoring carriers in procurement • State Exchange makes technology changes to offer Public Option plans
Quarter 2, 2025	• DOI releases guidance on carrier rate filing • Final awards sent to carriers for Public Option • Carriers submit rate and form filings for Public Option plans • Carriers submit necessary network information to DOI for approval
Quarter 3, 2025	• DOI conducts rate analyses on filings • DOI completes the rate approval process • DOI approves networks for plans • State Exchange certifies Public Option plans qualifying as QHPs • CMS and Treasury conduct initial analysis on pass-through amounts based on approved rates, estimating pass-through amounts for the next plan year
Quarter 4, 2025	• Public Option plans are offered for sale during Open Enrollment
January 1, 2026	• Coverage year begins for Public Option plans

Additionally, an overview of the actuarial analysis and update on the Section 1332 waiver development was provided to the public at a virtual public meeting held on September 23, 2022. Beginning in October 2022, the state also hosted numerous weekly office hours open to the public and stakeholders regarding the Public Option. Information regarding these activities is available on the DHHS/DHCFP webpage for the Public Option at: https://dhhs.nv.gov/PublicOption/.

The intent behind these weekly office hours is to offer the public an opportunity to ask state staff questions about the implementation of the Public Option and the status of the waiver application and associated actuarial study. In the remainder of 2022, the state developed this Section 1332 waiver application in partnership with Milliman, who has provided the required actuarial analysis. A timeline for the activities that will be required to prepare for the January 1, 2026, launch date is provided in Table 2.

E: Expected Federal Savings

The actuarial analysis conducted by Milliman, Inc. estimates that the Public Option could achieve nearly $1 billion in federal pass-through savings in the first ten years.[10] The amount of these savings available to the state depends on how the state decides to use its pass-through funds. As shown in table 3 below, Milliman, Inc. reviewed two key scenarios for the Public Option (with (#1) and without (#2) the enhanced federal ARPA subsidies available through Nevada Health Link). Each scenario has a base scenario accounting the accumulation of all federal pass-through funds available to the state—1A and 2A—before the funds are used by the state for a premium wrap. These scenarios are described in more detail below.

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

	Total Pass-Through Funding (PTF) (In Thousands)			
Time Period	**1A – ARPA, PTF Accumulation**	**1B – ARPA, Prem. Wrap**	**2A – No ARPA, PTF Accumulation**	**2B – No ARPA, Prem. Wrap**
Five-Year Waiver Window	$464,000	$344,000	$341,000	$191,000
Five-Year Waiver Window (With 10% Margin)*	$417M	$310M	$307M	$172M
Ten-Year Deficit Neutrality Window	$1,300,000	$969,000	$952,000	$540,000
Ten-Year Deficit Neutrality Window (With 10% Margin)*	$1,169M	$873M	$858M	$486M

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

The federal policy landscape will have significant implications for how the state may consider targeting federal pass-through funds to expand access to affordable coverage for Nevadans. While the 2022 Inflation Reduction Act extended the enhanced premium subsidies enacted under the ARPA, this temporary extension ends on December 31, 2025—the year preceding the implementation of the

[10] This estimate assumes the extension of federal premium subsidies beyond 2025 and the "Pass-Through Funding Accumulation Scenario."

Nevada's Public Option plans. The actuarial analysis conducted by Milliman, therefore, models the potential implementation of a state premium wrap under two frameworks:

1. With enhanced federal premium subsidies extended beyond 2025
2. Without enhanced federal premium subsidies extended beyond 2025

For each framework, the analysis considers two policy designs, modeling a total of four scenarios in addition to the Baseline scenarios:

- **Baseline Scenarios:** Scenarios 1 and 2 are without waiver, or "Baseline" scenarios.
- **Pass-Through Funding Accumulation Scenarios:** Scenarios 1A and 2A assume that the federal pass-through funds generated by the 1332 waiver are set aside for future use and reflect the total amount of the pass-through funds.
- **State Premium Wrap Scenarios:** Scenarios 1B and 2B assume that starting in plan year 2, federal pass-through funds are used to enhance federal premium tax credits with a new state premium wrap and thereby reduce net premium costs (after all subsidies). At the state of Nevada's direction, the report assumes that premium subsidies will be directed toward lower-income enrollees and available on both Public Option and non-Public Option plans.

Table 4: Overview of Actuarial Analysis Scenarios

Framework	Scenario	Description
With the ARPA Subsidies Extended	Scenario 1	Baseline – No Waiver
	Scenario 1A	Pass-Through Funding Accumulation
	Scenario 1B	State Premium Wrap
Without ARPA Subsidies Extended	Scenario 2	Baseline – No Waiver
	Scenario 2A	Pass-Through Funding Accumulation
	Scenario 2B	State Premium Wrap

Further, the actuarial analysis models the design of Scenarios 1B and 2B (state premium wrap) differently based on whether federal premium subsidies are extended:

Table 5: State Premium Wrap Design in Milliman Modeling

Framework	Scenario	State Premium Wrap Design
With ARPA Subsidies Extended	1B State Premium Wrap	State premium wrap builds on extended federal premium subsidies, targeted to those earning between 150% and 300% of the federal poverty level (FPL)
Without ARPA Subsidies Extended	2B State Premium Wrap	State premium wrap acts as a backfill to the expired federal premium subsidies, targeted to those earning between 0% and 200% of FPL

The Nevada Public Option is anticipated to significantly reduce federal expenditures on premium tax credits due to the state law's mandated premium reductions in the first four years of the program. The table below outlines the projected federal savings as a result of the approval of this waiver and the

implementation of Public Option plans. This table assumes the continuation of ARPA's enhanced premium subsidies, that Public Option carriers meet the premium reduction targets, and that starting in plan year 2, the state implements a premium wrap using federal pass-through funds.

Table 6: Impact of Waiver Compared to Baseline
Assuming ARPA subsidy extension and implementation of state premium wrap

Year	Premiums	Total Change Individual Market Enrollment	Federal Savings (Thousands)
2026	(4.0%)	400	$28,000
2027	(8.3%)	4,100	$45,000
2028	(12.4%)	8,100	$63,000
2029	(16.2%)	8,500	$102,000
2030	(16.2%)	8,700	$106,000

Nevada projects the following enrollment progression in the individual health insurance market.

Table 7: Individual Market Enrollment by Segment
Assuming ARPA subsidy extension and implementation of state premium wrap

Year	On-Exchange			Off-Exchange	Total Individual Market
	(1) *APTC-Eligible	(2) Non-APTC-Eligible	(3) Total	(4) Total	(5) Total Individual Market
2026	117,900	4,000	121,900	15,600	137,500
2027	122,700	4,400	127,100	15,900	143,000
2028	127,900	4,700	132,600	16,200	148,800
2029	129,000	5,400	134,400	16,600	151,000
2030	131,100	5,100	136,200	16,800	153,000

**APTC means advanced premium tax credits which are federal ACA premium subsidies made available to consumers based on their income levels in state exchanges.*

Section 2: 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 1332 waiver under all four scenarios modeled (outlined in detail in Table 4). While the state may offer the Public Option product in the small group market per state law, as previously stated, the state is not currently pursuing this option, and therefore the actuarial analysis did not model the impacts of offering a Public Option for the small group market.

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

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

- Table 8 shows that Public Option is expected to offer gross premium rates each year of the five-year window and the 10-year deficit neutrality window that are lower than premiums under the Baseline.
- *Available* 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 Public Option in waiver scenarios, will realize no (zero) change in net premium relative to the Baseline scenario.

- Likewise, subsidized enrollees on bronze plans will often see no change in net premiums (after subsidies) whether they switch to a Public Option bronze plan or not. In certain situations where subsidies are smaller (e.g., lower-cost areas, younger ages) and the Public Option offers a bronze plan, bronze enrollees may see premium decreases when they switch to a Public Option plan.
- Pass-through funds may be used by to increase premium subsidies, thereby further lowering out-of-pocket premium costs for enrollees.
- Cost sharing for Public Option and non-Public Option plans is not expected to change under the waiver. Therefore, non-premium cost sharing will be at least as affordable under waiver as without the waiver.

Table 8: Projected Second-Lowest-Cost Silver Premium Change from Baseline				
	Scenario			
Year	1A – ARPA PTF Accumulation	1B – ARPA Prem. Wrap	2A – No ARPA PTF Accumulation	2B – No ARPA Prem. Wrap
2026	(4.0%)	(4.0%)	(4.0%)	(4.0%)
2027	(8.3%)	(8.3%)	(8.3%)	(8.9%)
2028	(12.2%)	(12.4%)	(12.2%)	(13.4%)
2029	(16.0%)	(16.2%)	(16.0%)	(17.1%)
2030	(16.0%)	(16.2%)	(16.0%)	(17.1%)
2031	(16.0%)	(16.2%)	(16.0%)	(17.1%)
2032	(16.0%)	(16.2%)	(16.0%)	(17.1%)
2033	(16.0%)	(16.2%)	(16.0%)	(17.1%)
2034	(16.0%)	(16.2%)	(16.0%)	(17.1%)
2035	(16.0%)	(16.2%)	(16.0%)	(17.1%)

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

Table 9: Projected Individual Market Enrollment Change from Baseline				
	Scenario			
Year	1A – ARPA PTF Accumulation	1B – ARPA Prem. Wrap	2A – No ARPA PTF Accumulation	2B – No ARPA Prem. Wrap
2026	400	400	800	800
2027	600	4,100	1,200	5,900
2028	800	8,100	1,600	11,500
2029	1,200	8,500	2,000	12,100
2030	1,300	8,700	2,000	12,200
2031	1,100	8,700	2,000	12,300
2032	1,100	8,700	2,100	12,600
2033	1,100	8,800	2,100	12,700
2034	1,100	9,000	2,200	12,900
2035	1,200	9,100	2,200	13,100

Coverage under the waiver must be available to at least as many people as would be projected to be covered without the waiver. Table 9 shows how waiver satisfies the scope of coverage standard under all four scenarios modeled and for all waiver and deficit neutrality years. The actuarial report expects modest increases in enrollment under the Pass-Through Funding Accumulation scenarios, mainly from uninsured

individuals who would find unsubsidized premiums under waiver more affordable due to gross premium reductions related to Public Option offerings, as noted in Table 8. Under Premium Wrap scenarios, pass-through funding is used to reduce net premiums for consumers who already qualify for subsidies. There is a material subpopulation within the overall uninsured population who are not enrolled that the analysis assumes will enroll due to the availability of lower net premiums. Therefore, we expect higher increases in enrollment as premiums will be more affordable (on a post-subsidy basis) for an even larger population.

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

The 1332 waiver must provide coverage at least as comprehensive (as defined by the ACA's essential health benefits) as would be projected without the waiver. The Nevada 1332 waiver complies with this standard because it does not make any changes to the essential health benefits, nor does it alter any other coverage requirements for QHPs, for either Public Option plans or non-Public Option plans.

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

The 1332 waiver must be deficit-neutral to the federal government as compared to projections without the waiver. Table 10 shows how the Public Option satisfies the deficit neutrality standard under all four scenarios modeled. The annual projected pass-through funding amounts represent best estimates of the savings in each year. The Milliman report reduces the projected pass-through funding over the five-year waiver and 10-year deficit neutrality windows by a 10% margin to account for unknown contingencies.

Table 10: Projected Pass-Through Funding by Scenario

	Total Pass-Through Funding (Thousands)			
Year	1A – ARPA PTF Accumulation	1B – ARPA Prem. Wrap	2A – No ARPA PTF Accumulation	2B – No ARPA Prem. Wrap
2026	$28,000	$28,000	$21,000	$21,000
2027	$61,000	$45,000	$46,000	$25,000
2028	$97,000	$63,000	$71,000	$29,000
2029	$136,000	$102,000	$99,000	$57,000
2030	$142,000	$106,000	$104,000	$59,000
2031	$150,000	$113,000	$110,000	$63,000
2032	$158,000	$119,000	$115,000	$66,000
2033	$167,000	$124,000	$122,000	$70,000
2034	$176,000	$131,000	$129,000	$73,000
2035	$185,000	$138,000	$135,000	$77,000
Five-Year Waiver Window	$464,000	$344,000	$341,000	$191,000
Ten-Year Deficit Neutrality Window	$1,300,000	$969,000	$952,000	$540,000
Five-Year Waiver Window – 10% Margin	**$417,000**	**$310,000**	**$307,000**	**$172,000**
Ten-Year Deficit Neutrality Window – with 10% Margin	**$1,169,000**	**$873,000**	**$858,000**	**$486,000**

B: Impact on Health Equity

The authorizing legislation Nevada's Public Option includes, 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 Public Option will be specifically designed to increase access and improve outcomes for historically marginalized communities. The state law directs Nevada DHHS to prioritize

awards to carriers that respond to the Public Option procurement that contract with providers in a manner that helps to decrease disparities in access and outcomes and that supports culturally competent care. Nevada DHHS must also prioritize bids for the Public Option that include strategies to reduce health disparities and demonstrate alignment of provider networks between the Public Option and Medicaid managed care, 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 Public Option carriers to collect and report on race, ethnicity, and language data
- Requirements for Public Option carriers to report on enrollees' out-of-pocket spending annually[11]
- Quality metrics that align with Medicaid to measure progress towards closing health disparities
- Rewards for Public Option 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 3: Authority Under State Law

State law provides that the Director shall design and establish the Public Option and will collaborate with the Insurance Commissioner and the Executive Director of the Exchange to apply for a 1332 waiver and, if possible, "obtain pass-through federal funding to carry out the provisions [under state law for the Public Option]."[12]

Funding for state operations associated with the establishing and overseeing the Public Option per the state law is also contingent on approval of a 1332 waiver. NRS 695K.210 requires state officials "to obtain pass-through federal funding *to carry out the provisions* of this chapter." [Emphasis added.] Without pass-through funding, the chapter's provisions cannot be carried out beyond the initial start-up phase as funded by the state's general fund. The provisions that cannot be carried out absent the waiver form the entirety of the plan, including the design, establishment, and operation of the Public Option that requires the state to establish a competitive bidding process for the Public Option and ensure carriers meet their contract obligations, including offering a premium lower than the average reference premium.

NRS 695K.300 also establishes a state trust fund for the deposit of federal funds (disbursed as a grant which can be used for approved uses of pass-through funding according to the special terms and conditions pursuant to the state's Section 1332 approval), the state competitive bidding process, any money appropriated by the legislature for the purpose of carrying out the provisions of this chapter, and income and interest earned on the trust fund.

[11]Due to the substantial racial wealth disparities in the U.S. driven by structural barriers and systemic racism, communities of color suffer disproportionately from medical debt. Tracking and monitoring the toll of out-of-pocket health care costs can act as an important tool in measuring and addressing these affordability challenges.

[12] NRS 695K.210

Although state funds have been appropriated to pay for vendor and staffing to assist with implementation, the intent was to ensure that the program would be self-sustaining once it was fully operating through the use of available federal pass-through funding as approved under a 1332 waiver.

Section 4: Evidence of Public and Tribal Consultation and Comment

DHHS will complete this section following the public comment period.

Section 5: 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 rate and form development and submission for approval.

With the new federal pass-through funds, Nevada will be able to sustain the necessary resources and staff to carry out the following administrative tasks that would be required under the waiver:

- Distribute federal pass-through funds
- Enforce the provisions of the premium reduction requirement by leveraging aligned Public Option-Medicaid procurement processes
- Administer the subsidy program
- Monitor compliance with federal 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 any documented complaints related to the waiver
- Review state reports
- Periodically evaluate the waiver program
- Calculate and facilitate the transfer of pass-through funds to the state

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 generally 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 Exchange, shall implement and oversee the administration of the Public Option. Under state law, the Public Option plans shall operate as individual health insurance products that comply with state and federal requirements for qualified health plans (QHPs) and all state health insurance laws and regulations.

DHHS will oversee the procurement of the Public Option and oversee compliance with the requirements set forth in the contract between the state and the carriers selected to provide Public Option plans, such as the premium reduction targets required in the first four years of the program. DHHS intends to hire an actuarial consultant to determine the reference premium, including defining the morbidity index and a historical utilization trend, to review proposed rates for the Nevada Public Option during the procurement process for reasonableness and actuarial soundness, similar to the process it uses for the MCO procurement, and to provide ongoing modeling support of additional premium subsidies.

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

DOI will continue to lead its rate review and network adequacy processes for private health insurance plans in the individual market, which as of 2025 will include the Public Option products. DOI is responsible for regulating and ensuring regulatory compliance and monitoring the solvency of all issuers; 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 Public Option issuers 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 Public Option 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 (CAFR) 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 Public Option, and federal passthrough funding, will be subject to audit under the State's Annual Comprehensive Financial Report. The subsidy programs will be subject to audit by the Nevada State Controller. The federal government is responsible for calculating the 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 Nevada Public Option's premium reduction implementation progress will be submitted by March 31, 2026.

DHHS will report on the operation of the waiver quarterly, including, but not limited to, providing reports of any ongoing operational challenges, and 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 Section 2 of 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 as well as 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 that 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)(I):
    - 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 Second Lowest Cost Silver Plan (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 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.

Section 6: Actuarial and Economic Analysis of Waiver

MILLIMAN REPORT

1332 Waiver Actuarial / Economic Analysis and Certification for Nevada's Public Option

Prepared for Nevada Department of Health and Human Services

December 16, 2022

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EXHIBITS

I. EXECUTIVE SUMMARY

Pursuant to Manatt's contract with the State of Nevada, Milliman, Inc. (Milliman) has been subcontracted by Manatt to provide actuarial and consulting services to the State of Nevada. The State of Nevada is seeking a Section 1332 waiver to obtain pass-through funding (PTF) related to the establishment and operation of a Public Option (PO) on the Silver State Health Insurance Exchange beginning in 2026. The legislation that establishes the PO was introduced through Nevada Senate Bill 420 as passed during the 2021 State Legislative Session (SB420) and is described in more detail in Section 2 of this report.

Based on Section 2 of SB420, which can be found in Appendix B, the stated purpose of the PO is to lower individual market health insurance premiums and consumer out-of-pocket costs, improve access to health care, reduce disparities in health care access and outcomes, and improve the availability of coverage for residents of rural areas. Furthermore, the PO offerings are expected to provide the opportunity for many Nevadans to obtain a lower-priced product through reduced provider reimbursement, reduced issuer administrative expenses, and value-based purchasing initiatives designed to drive efficiency in utilization. With lower gross premiums, it is expected that a PO offering will become the benchmark plan in all rating areas in Nevada, thereby lowering federal outlays for premium subsidies, which then become available to the State of Nevada as pass-through funds under the Section 1332 waiver.

The State of Nevada's Division of Health Care Financing and Policy (DHCFP) and Department of Health and Human Services (DHHS) issued guidance that clarifies the methodologies and assumptions the state intends to use when implementing the PO premium reduction targets. It is our understanding, based on conversations with DHCFP and DHHS that the revisions and clarifications in this guidance are intended to align the PO implementation with the intent of SB420. The agency's memorandum of guidance is provided in Appendix C. Any changes to this approach or guidance, subsequent to the date of this analysis, may affect the applicability of the findings in this report.

This report provides the required actuarial analysis, economic analysis, and certification to support the State of Nevada's determination that the PO meets the requirements of a Section 1332 waiver. At the request of the State of Nevada, and to address the possibility of an additional extension of the American Rescue Plan Act of 2021 (ARP) subsidies beyond 2025 and into the budget window, we provide the actuarial and economic analyses under two frameworks:

- With ARP: Premium subsidy amounts implemented by the ARP[1] for calendar year (CY) 2021 and (CY) 2022 and extended through 2025 by the Inflation Reduction Act (IRA) are made permanent or are extended through 2035.
- Without ARP: Beginning in CY 2026, premium subsidy amounts for marketplace coverage under the Patient Protection and Affordable Care Act (ACA) revert to levels similar to those in place prior to the temporary increase in premium subsidy amounts authorized by the ARP.

The modeled PO scenarios are consistent with our understanding of the statutory language of SB420 and the State of Nevada's guidance in Appendix C. In addition, the analyses in this report assume the COVID-19 public health emergency (PHE) will end prior to the implementation of the PO. Table 1 summarizes the scenarios modeled in this report:

Table 1
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenarios

Framework	Scenario	Description
With ARP	Scenario 1	Baseline – No Waiver
	Scenario 1A	PTF Accumulation
	Scenario 1B	State Premium Wrap
Without ARP	Scenario 2	Baseline – No Waiver
	Scenario 2A	PTF Accumulation
	Scenario 2B	State Premium Wrap

[1] Busch, F., Karcher, J., Fink, J. et al. (March 2021). "A" Is for Affordable. Milliman White Paper. Retrieved November 8, 2022, from https://us.milliman.com/-/media/milliman/pdfs/2021-articles/3-17-21-a-is-for-affordable.ashx.

The initial scenario under each framework assumes the state does not have a 1332 waiver, and thereby does not have a PO. We refer to these scenarios (Scenarios 1 and 2) as the "Baseline" scenarios. The PO scenarios are compared to the Baseline scenarios to measure the projected pass-through funding available to the State of Nevada after the introduction of the PO. These scenarios and the calculation of premium tax credits (PTCs) are also required to demonstrate compliance with federal 1332 waiver deficit neutrality requirements.

The first PO scenario under each of the ARP frameworks assumes the pass-through savings generated by the Section 1332 waiver are unused by the State of Nevada; therefore, pass-through funds will accumulate over time. We refer to these scenarios (Scenarios 1A and 2A) as the "PTF Accumulation" scenarios. We assume the second lowest cost silver (SLCS) plan in these scenarios will be a PO offering. We assume minimal change in total individual market enrollment under the PTF Accumulation scenarios, as PTC-eligible individuals' net premiums will be largely the same[2] as in the Baseline scenarios assuming they are enrolled in the SLCS Public Option offering.

The second scenario under each framework assumes the pass-through savings are used to enhance federal subsidies with a state-funded premium subsidy wrap and thereby reduce net premium costs (after all subsidies) for enrollees. We refer to these scenarios (Scenarios 1B and 2B) as the "State Premium Wrap" scenarios. Enrollment impacts under the State Premium Wrap scenarios are larger due to the incentives provided by the additional state-funded premium subsidies and the lower, consumer-facing net premium.

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

A. SUMMARY OF RESULTS

For the Public Option to meet the federal requirements for a 1332 waiver, the program must meet four guardrails: affordability, scope of coverage, comprehensiveness, and deficit neutrality. Our analysis indicates that Nevada's Public Option waiver meets the federal requirements for a 1332 waiver under all four scenarios we modeled.

We summarize the key results of our analysis of each of these standards below, and additional detail is provided in Sections 4 and 5 of this report.

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

- Table 2 illustrates that the PO is expected to offer gross premium rates in all years of the five-year waiver window and the 10-year deficit neutrality window that are lower than premiums under the Baseline scenarios.

- *Available* net premiums (after subsidies) for subsidized silver plan enrollees are expected to be no higher than in the Baseline scenarios. Enrollees who *actually* switch to the SLCS option, which is assumed to be a PO offering in the waiver scenarios, will realize no (zero) change in net premium relative to the Baseline scenarios. Moreover, for younger or higher-income silver plan enrollees who typically have smaller subsidies, PO premiums may be below their current net premiums, providing an opportunity for lightly subsidized individuals to realize premium savings.

  Subsidized enrollees who currently receive no-cost bronze plans could continue to pay no net premium (after subsidies) whether they switch to a PO bronze plan 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).

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

- Pass-through savings may be used by the State of Nevada to increase premium subsidies, thereby further lowering out-of-pocket premium costs for enrollees.

- Cost-sharing for both PO and non-PO plans is not expected to change under the waiver. Therefore, non-premium cost-sharing will be at least as affordable under the waiver as it is without the waiver.

Table 2
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Projected SLCS Premium Change From Baseline

	Scenario			
Year	1A – ARP PTF Accumulation	1B – ARP Prem Wrap	2A – No ARP PTF Accumulation	2B – No ARP Prem Wrap
2026	(4.0%)	(4.0%)	(4.0%)	(4.0%)
2027	(8.3%)	(8.3%)	(8.3%)	(8.9%)
2028	(12.2%)	(12.4%)	(12.2%)	(13.4%)
2029	(16.0%)	(16.2%)	(16.0%)	(17.1%)
2030	(16.0%)	(16.2%)	(16.0%)	(17.1%)
2031	(16.0%)	(16.2%)	(16.0%)	(17.1%)
2032	(16.0%)	(16.2%)	(16.0%)	(17.1%)
2033	(16.0%)	(16.2%)	(16.0%)	(17.1%)
2034	(16.0%)	(16.2%)	(16.0%)	(17.1%)
2035	(16.0%)	(16.2%)	(16.0%)	(17.1%)

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

We expect modest increases in enrollment under the PTF Accumulation scenarios, mainly from individuals who were uninsured, but who would find unsubsidized premiums under the waiver more affordable due to the gross premium reductions related to the PO offering, noted in Table 2 above.

Under the State Premium Wrap scenarios, pass-through funding is used to reduce net premiums for consumers who already qualify for subsidies. There is a material subpopulation within the overall uninsured population who are not currently enrolled who we assume will enroll due to the availability of even lower net premiums. Therefore, we expect higher increases in enrollment as premiums will be more affordable (on a post-subsidy basis) for an even larger population.

Table 3
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Projected Individual Market Enrollment Change From Baseline

	Scenario			
Year	1A – ARP PTF Accumulation	1B – ARP Prem Wrap	2A – No ARP PTF Accumulation	2B – No ARP Prem Wrap
2026	400	400	800	800
2027	600	4,100	1,200	5,900
2028	800	8,100	1,600	11,500
2029	1,200	8,500	2,000	12,100
2030	1,300	8,700	2,000	12,200
2031	1,100	8,700	2,000	12,300
2032	1,100	8,700	2,100	12,600
2033	1,100	8,800	2,100	12,700
2034	1,100	9,000	2,200	12,900
2035	1,200	9,100	2,200	13,100

Comprehensiveness: The 1332 waiver must provide coverage at least as comprehensive, as defined by the ACA's essential health benefits (EHBs), as would be projected without the waiver. The Nevada 1332 waiver complies with this standard because SB420 requires the new PO plans to meet all qualified health plan (QHP) standards under the Affordable Care Act, which includes providing the full set of essential health benefits. It does not make any changes to these benefits nor does it alter any other coverage requirements for QHPs, for either PO plans or non-PO plans.

Deficit neutrality: The 1332 waiver must be deficit neutral to the federal government compared to projections without the waiver. Table 4 shows how the PO satisfies the deficit neutrality standard under all four scenarios we modeled. The PO reduces federal outlays for premium subsidies relative to the Baseline scenarios 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 to the state) are no greater than subsidies paid to enrollees without the waiver. The annual projected pass-through funding amounts represent our best estimates of the savings in each year. Additionally, we provide the projected pass-through funding over the five-year waiver and 10-year deficit neutrality windows, where a 10% margin to account for unknown contingencies has been applied.

Table 4
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Projected Pass-Through Funding by Scenario

	Total Pass-Through Funding (thousands)			
Year	1A – ARP PTF Accumulation	1B – ARP Prem Wrap	2A – No ARP PTF Accumulation	2B – No ARP Prem Wrap
2026	$28,000	$28,000	$21,000	$21,000
2027	$61,000	$45,000	$46,000	$25,000
2028	$97,000	$63,000	$71,000	$29,000
2029	$136,000	$102,000	$99,000	$57,000
2030	$142,000	$106,000	$104,000	$59,000
2031	$150,000	$113,000	$110,000	$63,000
2032	$158,000	$119,000	$115,000	$66,000
2033	$167,000	$124,000	$122,000	$70,000
2034	$176,000	$131,000	$129,000	$73,000
2035	$185,000	$138,000	$135,000	$77,000
5-Year Waiver Window	$464,000	$344,000	$341,000	$191,000
10-Year Deficit Neutrality Window	$1,300,000	$969,000	$952,000	$540,000
5-Year Waiver Window – With 10% Margin	$417,000	$310,000	$307,000	$172,000
10-Year Deficit Neutrality Window – With 10% Margin	$1,169,000	$873,000	$858,000	$486,000

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

- In Section 2 of this report, we describe the federal requirements in more detail and provide additional information to demonstrate how the Nevada waiver satisfies these federal requirements. We provide information related to the requirements of Nevada's SB240, give background into how the bill creates savings in the individual market versus a non-waiver scenario, and explain how pass-through funding is ultimately generated under a 1332 waiver.

- Section 3 describes the scenarios with and without the waiver, as well as detailed discussion on important dynamics within the scenarios that impact pass-through funding. These dynamics are somewhat unique to a Public Option offering versus a reinsurance-type waiver.

- Section 4 provides the actuarial analysis required by CMS, as well as detailed descriptions and data to demonstrate compliance with the affordability, comparable coverage, and comprehensive coverage requirement.

- Section 5 provides the required economic analysis for waiver approval. We model the expected pass-through funding (premium tax credit savings to the federal government) under four different scenarios and describe the assumptions and results under each.

- In Section 6, we detail the data, assumptions, and methodology used in our modeling.
- The Exhibits section provides detailed exhibits to support the actuarial analysis in Section 4.
- Appendices provide our certification of waiver analysis and various other documentation items, including the CCIIO checklist.

B. DATA RELIANCE AND IMPORTANT CAVEATS

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

The models rely on data and information as input to the models. We relied upon certain data and information provided by the Nevada Department of Health and Human Services (DHHS), the Silver State Health Insurance Exchange, and publicly available data published by the State of Nevada and federal agencies to develop the analyses shown in this report. We did not audit this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. We performed a limited review of the data used directly in our analysis for reasonableness and consistency, and we did not find material defects in the data. If there are material defects in the data, it is possible they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable, or for relationships that are materially inconsistent. Such a review was beyond the scope of our engagement. Please see Section 6 below for a list of the data relied upon to produce the analyses in this report.

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

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

There is heightened uncertainty concerning future insurance market enrollment due to the current COVID-19 public health emergency and its associated policies, which may change materially in the future.

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

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

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

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

The terms of Milliman's subcontract with Manatt, signed January 26, 2022, to provide services to the Nevada Department of Health and Human Services Division of Health Care Financing and Policy apply to this report and its use.

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

A. NEVADA SB420 PUBLIC OPTION PROGRAM AND STATE REQUIREMENTS

Nevada Senate Bill 420 (SB420) was signed into law on June 9, 2021.[3] This law establishes a health benefit plan that will be administered by the State of Nevada through contracts with issuers. The PO plans must be made available as qualified health plans through the Silver State Health Insurance Exchange beginning in 2026. Some provisions of SB420 specifically related to the PO premium targets will expire on December 31, 2029. Therefore, some analyses in this report related to the premium targets focus on the first four years of the PO and assume the same level of savings thereafter, through the remaining duration of both the 5-year wavier window and the 10-year budget neutrality window. A reference to the full text of SB420 is provided in Appendix B.

The stated objectives of SB420 are to lower health insurance premiums and costs, improve access to health care, reduce disparities in health care access and outcomes, and improve the availability of coverage for residents of rural areas. The legislation intends to achieve these objectives through the PO by lowering enrollee costs, improving access to health care, and improving health care coverage in rural areas. The key aspects of SB420 that influence the actuarial analysis provided in this report are summarized below.

Coverage

Section 10.3(b) of SB420 requires that the PO provide "at least levels of coverage consistent with the actuarial value of one silver plan and one gold plan." This section of the legislation ensures a minimum threshold of coverage and plan choices for PO offerings. The key impact of this requirement on the actuarial and economic analyses is that it increases the probability that the SLCS premium will decrease by guaranteeing the PO will include at least one silver plan. Because other state requirements discussed below place upper limits on the PO premium amounts, the PO premiums are expected to be lower than premiums for non-PO silver plans that would be otherwise available on the Silver State Health Insurance Exchange.[4]

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

- Lower-income enrollees with larger subsidies who currently have zero premium bronze plans could keep a zero premium by switching to a PO bronze plan, depending on market pricing of bronze plans.
- Lightly subsidized (generally higher-income and / or younger ages) might see some increase in net premiums when switching to a PO bronze plan, depending on how subsidies change relative to market pricing of PO bronze plans.
- Higher-income enrollees who are unsubsidized will see decreases in premium by switching to a PO bronze plan.

A bronze plan offering under the PO increases pass-through funding (see Section 3B for additional discussion), all else equal.

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

Access

Section 13.1 of SB420 includes a provision requiring health care providers who currently participate in certain state coverage programs to enroll in at least one provider network for a PO plan. This provider participation requirement, also called the provider tying requirement, is intended to ensure enough providers participate in the PO such that the PO can fulfill any anticipated growth in the demand for health care services arising from the PO. SB420 gives the State

[3] See https://www.leg.state.nv.us/App/NELIS/REL/81st2021/Bill/8151/Overview.
[4] Non-PO plans could, in response to the PO offerings, reduce prices or curtail rate increases to remain competitive against PO plans. We do not attempt to model various issuers' reactions or behaviors in our analysis.

of Nevada authority to waive this requirement as necessary to ensure access for enrollees in other state programs is sufficient.

Based on the State of Nevada's guidance outlined in Appendix C, we do not expect the tying provision to have a significant impact on PO premiums, total (across all health insurance markets) provider reimbursement, or access to care for consumers. Therefore, we do not make any explicit adjustments in our analysis of the PO related to the tying provision. A detailed analysis of the anticipated financial implications of the tying provision is provided in Appendix D.

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

Premium amounts

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

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

2. The SLCS premium in the prior year.

As outlined in Appendix C, the Director can revise the inflation index in the first clause as long as the premium reduction is at least 15% over the first four years. Our modeling assumes an inflation index based on the Consumer Price Index – Medical (CPI-M) plus an adjustment for utilization and morbidity changes in the local Nevada individual market, as described in Appendix C. Furthermore, based on the State of Nevada's methodology outlined in Appendix C, the reference premium defined in Section 10.6(d) is replaced by an "average reference premium" as defined in the guidance. The "average reference premium" is not tied to the second clause. Our modeling assumes that the non-PO plan premiums will trend at the medical inflation index each year.

Further, SB420 allows the Director to change the requirement of 5% savings in the first year. At the direction of the State of Nevada, our modeling assumes that the requirement will be 4% in the first year of the PO.

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

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

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

The third constraint in Section 10.5 of SB420 targets at least a 15% reduction in the PO premiums versus the average reference premium in year 4. We modeled this target premium reduction consistent with the State of Nevada's methodology outlined in Appendix C, which targets a 16% reduction in PO premiums versus the average reference premium in year 4.

The analyses in this report assume the SLCS Public Option premium in 2029 will be at least 16% lower than the 2024 SLSC premium trended to 2029 with expected general medical inflation.

Based on discussions with DHHS and the requirements of SB420, we expect the premium reductions to be driven from three sources: provider reimbursement decreases, lower issuer premium expense loads required for PO plans, and value-based purchasing initiatives. These premium reduction drivers are discussed in more detail in Appendix D.

Provider reimbursement

SB420 requires that provider reimbursement rates for the PO be, in the aggregate, comparable to or better than Medicare rates. The law includes exceptions for certain safety net providers for whom specific payment methodologies apply, including for federally qualified health centers (FQHCs), rural health centers (RHCs), and the Medicaid State Plan rate for certified community behavioral health clinics (CCBHCs). 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.

B. GENERATING PASS-THROUGH SAVINGS UNDER A 1332 WAIVER

The assumption that the PO generates pass-through savings is based on two key modeling assumptions that we describe below.

Public Option becomes the benchmark silver plan

Our modeling assumes more than one PO will be offered in each rating area; therefore, a PO offering is expected to become the SLCS plan in all rating areas[5] in Nevada in 2026. While a PO being the SLCS plan is highly likely in all years of the program, it becomes even more likely in the second through fourth years of the PO program, as the discounts relative to the reference premium and non-PO offerings increase. It is possible that a benchmark (i.e., SLCS) plan would not be a PO offering under the following circumstances:

- If a county had only a single issuer prior to the PO offering in 2026, it is possible that a single PO offering in such a county in 2026 would not become the SLCS plan. In this case, the PO offering would become the lowest-cost silver plan and the benchmark plan would be unchanged (i.e., the single non-PO offered prior to 2026) and drive no savings in federal subsidies. This circumstance is highly unlikely to occur in the two largest rating areas, which include roughly 90% of the State of Nevada's population and individual market enrollees. If this circumstance occurs in the smaller counties, the overall impact would be small because there are few QHP enrollees in these counties. We expect the overall impact on the results related to the risk of a non-PO offering being the SLCS plan to be minimal.

- In the first year of the PO program, when required discounts to the reference premium are only 4% per the State of Nevada's guidance in Appendix C, issuers could choose to price non-PO offerings very competitively or recontract provider agreements underlying the non-PO offerings to reduce underlying cost structure, or both. However, in such a situation, the impact to pass-through savings, assuming the PO is given credit by CMS for the change in non-PO plan pricing and provider contracting, would be zero as this behavior would not appear in the Baseline (no waiver) scenario.

The competitive situation as of 2022, shown in Table 5 below, shows that there are at least two issuers offering plans with premiums within 5% of the lowest-cost silver (LCS) plan in all rating areas in Nevada. Assuming these issuers also offer PO plans that are compliant with the required premium reductions in SB420, it is highly likely and a reasonable modeling assumption that the benchmark plan will be a PO plan and at least 4% lower than in a Baseline (no waiver) scenario. Although SB420 requires issuers of Medicaid managed care plans to participate in the PO, it does not preclude non-managed care plans from participating in the PO.

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

Table 5
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Nevada 2022 Individual Exchange Market
Top 10 Lowest-Cost Silver Plans by Rating Area

	Rating Area 1		Rating Area 2		Rating Area 3		Rating Area 4	
Rank	Issuer Name	% Difference to LCS	Issuer Name	% Difference to LCS	Issuer Name	% Difference to LCS	Issuer Name	% Difference to LCS
1	SilverSummit	0.0%	Friday Health	0.0%	Friday Health	0.0%	SilverSummit	0.0%
2	SilverSummit	0.1%	SilverSummit	0.2%	Anthem	0.5%	SilverSummit	0.1%
3	Friday Health	0.8%	SilverSummit	0.2%	Anthem	1.8%	SilverSummit	3.1%
4	SilverSummit	3.1%	SilverSummit	3.3%	SilverSummit	3.0%	Friday Health	4.3%
5	SelectHealth	3.3%	Friday Health	3.7%	SilverSummit	3.1%	SilverSummit	5.6%
6	SelectHealth	4.2%	SilverSummit	5.8%	Hometown Health	3.4%	SilverSummit	5.6%
7	SilverSummit	4.5%	SilverSummit	5.8%	Anthem	3.5%	SilverSummit	7.2%
8	Friday Health	4.5%	SilverSummit	7.4%	Friday Health	3.7%	Friday Health	8.1%
9	SilverSummit	4.6%	SilverSummit	9.0%	Anthem	4.5%	SilverSummit	8.8%
10	SilverSummit	7.2%	Aetna	9.1%	Anthem	5.8%	SilverSummit	10.9%

Reference premium tracks closely to individual market

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

Table 6 shows a simple illustration of the mechanics behind how the PO generates pass-through savings under a 1332 waiver, given the requirements of SB420 and the State of Nevada's methodology outlined in Appendix C. Table 6 uses a 4% overall market trend (Line 2) and a 4% trend rate on the reference premium for the PO.

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

		2024	2026	2027	2028	2029
(1)	Second Lowest Cost Silver Plan* (non-PO)	$ 546.21	$590.78	$614.41	$638.99	$664.55
(2)	*Assumed Annualized Trend*		4.0%	4.0%	4.0%	4.0%
(3)	Reference Premium	$ 546.21	$590.78	$614.41	$638.99	$664.55
(4)	*Assumed Annualized Trend*		4.0%	4.0%	4.0%	4.0%
(5)	Public Option Premium		$567.01	$563.66	$560.89	$558.14
(6)	*Cumulative Difference From Reference Premium*		-4.0%	-8.3%	-12.2%	-16.0%
(7)	*Cumulative Difference From Baseline*		-4.0%	-8.3%	-12.2%	-16.0%

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

We note the following in Table 6:

- Line 1 shows the projection for the SLCS in 2024, trended at 4% through 2029.[6] The 4% trend is based on projections of per capita spending in the private insurance markets from CMH National Health care Expenditure data, reduced by approximately 1% for value-based care initiatives in the Nevada market. Additional references and information on this can be found in Section 6 of this report.

[6] The modeled 2024 premium is based on actual 2022 premiums, trended forward two years at 6% for the first year based on expected average 2023 rate increases and at the 4% projected trend assumption for the second year. Premium amounts in 2025 do not have a direct bearing on our modeling. Therefore, we intentionally do not include a column for 2025 in Tables 6 and 7.

This represents a forecast of the individual market premiums in absence of the PO.

- Line 3 is the calculated reference premium as defined by SB420 and reflecting the State of Nevada's methodology and guidance outlined in Appendix C. It is assumed that medical unit costs will trend at the CPI-M index, which we estimate in this modeling at 3.7%.[7] We also assume that an appropriate utilization and morbidity adjustment will be chosen that will be consistent with overall individual market dynamics in Nevada. In this case that adjustment is assumed to be 0.3% *such that the reference premium trend equals the overall market change in premiums.* Additional information and references on this can be found in Section 6 of this report.

- Line 6 shows that the Public Option premium, in accordance with the requirement of SB420 and the State of Nevada's methodology and guidance outlined in Appendix C, is 4% less than the calculated reference premium in year 1 of the program and 16% less by year 4.

- Line 7 illustrates that the difference between PO offerings and the estimated individual market premium without the waiver is also 4% in year 1 and 16% by year 4, as intended. This difference is identical to the PO's difference to the reference premium (Line 6) because the reference premium is assumed to be indexed at a rate that is reflective of the overall individual market in Nevada, in this case 4%.

As Table 6 illustrates, PO plans have achieved the required 16% savings relative to the reference premium and because the reference premium tracks to the market, the PO is also 16% below non-PO plans.

By contrast, it is *not* the intent of SB420 and the DHHS guidance outlined in Appendix C for the PO offerings to be any lower than 16% below non-PO plans by year 4. PO savings relative to non-PO plans of greater than 16% could occur if an inflation index applied to the reference premium does not appropriately reflect local individual market dynamics.

For example, if the reference premium were to be trended at a rate lower than the overall individual market, PO plans would end up being lower than 16% below non-PO plans. In Table 7 below, we assume, for illustrative purposes, a reference premium trend of 3%, which is 1% below the overall individual market trend of 4%.

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

		2024	2026	2027	2028	2029
(1)	Second Lowest Cost Silver* (non-PO)	$546.21	$590.78	$614.41	$638.99	$664.55
(2)	*Assumed Annualized Trend*		4.0%	4.0%	4.0%	4.0%
(3)	Reference Premium	$546.21	$579.48	$596.86	$614.77	$633.21
(4)	*Assumed Annualized Trend*		3.0%	3.0%	3.0%	3.0%
(5)	Public Option Premium		$556.16	$547.56	$539.63	$531.81
(6)	*Cumulative Difference From Reference Premium*		-4.0%	-8.3%	-12.2%	-16.0%
(7)	*Cumulative Difference From Baseline*		-5.9%	-10.9%	-15.5%	-20.0%

In the example above, the reference premium is only trending at 3% (Line 4) while the overall individual market is trending at 4% (Line 2). This implies that the PO plans could be as much as 20% lower (Line 7) than the overall market rather than the 16% described in DHHS guidance in Appendix C.

Assuming PO savings beyond the 16% by year 4 or to assume increasing annual savings in perpetuity is not realistic nor required by SB420 and, for modeling purposes herein, would overstate pass-through funding. Such an assumption implies that PO offerings would or could find additional cumulative savings in PO plans above and beyond the 16%. This could be challenging as it puts undue burden on providers, issuers, or both. If cost savings above 16% were not found, PO plans would have to be underpriced, which could destabilize the market and provide disincentives for issuers to offer a PO plan in the first place.

[7] BLS Data Viewer data pulled May 10, 2022. See https://beta.bls.gov/dataViewer/view/timeseries /CUSR0000SAM2;jsessionid=FF163662AB94EE4B0BD0F2F327CCEAD.

In summary, SB420 generates pass-through funding primarily through a) the requirement that PO plans are a certain percentage below the reference premium over the course of the first four years of the program, and b) the likelihood that this requirement results in a PO offering as the SLCS or benchmark premium in all areas. We assume no additional savings from the PO related to annually indexing the reference premium to an artificially low measure of health care inflation (illustrated in Table 7) that is not reflective of the overall individual market. Nor do we assume that PO offerings will contain materially greater advantages in provider reimbursement cost structure, medical management, or value-based purchasing (VBP) to support lower premiums beyond the 16%. Under the assumption that the reference premium is properly indexed to the overall individual market, as is the intent of the DHHS Guidance in Appendix C, the PO will continue to generate pass-through funding under the waiver beyond the first four years of the program.

Sources of PO premium savings

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

- *Reductions in provider reimbursement unit costs*: It is expected that unit costs paid to facilities and professional providers in Nevada will be reduced to support the lower PO premium targets. See the provider tying analysis in Appendix D to review more information on the estimated impact of these premium reductions on provider revenue and participation.

- *Reductions in administrative costs*: Issuers will be required to price PO plans with a smaller expense load relative to non-PO plans. Reductions in administrative expenses will reduce premiums for PO plans relative to non-PO plans. The expense loads to achieve this premium differential will be set by the Director and will grade in over the course of the first four years of the program.

- *Improved cost structures and efficiencies due to value-based purchasing initiatives*: Based on discussions with DHHS and the provisions in SB420 related to value-based purchasing, it is expected that the state will see an increased use of these initiatives with providers across both Medicaid managed care organizations (MCOs) and PO plans. When these initiatives are aligned across markets in this manner, it increases the likelihood that providers will experience success with respect to their patient populations and outcomes, in addition to reduced administrative burden. The actual scope and impact of these initiatives will likely vary by issuers participating in the PO and specific estimates of these issuers are outside the scope of this analysis.

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

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

C. FEDERAL 1332 WAIVER REQUIREMENTS

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

Section 1332 waiver guardrails

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

1. Affordability of premiums and cost-sharing

   Section 31 CFR 33.108(f)(3)(iv)(B) requires that premiums and cost-sharing under the waiver must be at least as affordable overall as premiums and cost-sharing absent the waiver. The PO satisfies this requirement by requiring that the PO premiums be lower than the reference premium by a specified percentage. By statute, the reference premium cannot be greater than the 2024 SLCS, trended to the benefit year based on a medical inflation index plus an adjustment for local market utilization and morbidity changes (see Appendix C), for the first four years of

the PO program. Because we assume the non-PO premiums in the individual market trend at this index (assumed to be 4%, as noted above), these constraints on the reference premium and PO premiums ensure that the PO premium does not exceed projected premium amounts without the waiver.

The State of Nevada will not force enrollees to select a PO offering; however, **the premiums and cost-sharing *available* under the waiver will be at least as affordable as premiums and cost-sharing absent the waiver for all enrollees**. In short, the affordability guardrail is fulfilled because all enrollees will have *access* to a PO offering.

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

- ***Unsubsidized:*** Current enrollees who are not eligible for any subsidies will realize the entire premium savings driven by the PO if they switch to a PO plan. If they elect a non-PO plan, they will not realize any direct impact due to the PO, unless market dynamics cause the PO to influence premium rates for non-PO plans.

- ***Lightly subsidized:*** Current enrollees who receive small subsidies may realize some premium savings if the PO premium falls below the enrollee's current net (after subsidy) premium and they elect a PO plan. Any savings driven by the PO for these enrollees will be shared with the federal government, which is then passed through to the State of Nevada under the waiver. If they elect a non-PO plan, these enrollees may pay higher premiums because they will be paying the difference between the pre-PO subsidies (based on a higher benchmark silver plan) and the lower post-PO subsidies (based on a lower PO benchmark plan). Add similar sentence to heavily…

- ***Heavily or fully subsidized:*** The impact of the PO on premiums for current enrollees who receive substantial subsidies will depend on whether they elect a PO plan or a non-PO plan. If they switch to PO plan, their net premium will remain the same as without the PO. If they do not elect a PO plan, their net premium will likely increase to offset the decrease in federal subsidies. However, given the State's intent to use pass-through funding to provide additional premium subsidies, the final net premiums (after all subsidies) will be lower than without the waiver, on average.

The federal premium subsidy structure will remain unchanged with the introduction of the PO plans. The out-of-pocket premium cost for the SLCS for a member will continue to be limited to a percentage of household income prescribed under the ACA. Additionally, the State of Nevada may decide to use some of the pass-through savings from the PO to increase premium and / or cost-sharing subsidies. *Therefore, the consumer premiums or cost-sharing requirements under the PO will be no greater than, and possibly lower than, the cost-sharing required absent the PO.*

The mechanics of a PO offering and corresponding 1332 waiver are different from a reinsurance waiver in at least one important way. Under the latter, premiums for *all plans* offered in the market will be reduced by the effects of the reinsurance program, as the index rate[8] is lowered by the expected reinsurance program receipts. Therefore, all premiums are reduced, regardless of QHP issuer, although in practice issuers can and often do price somewhat different impacts into their premiums to account for their anticipated issuer-specific receipts under the program. The savings from these lower gross premiums accrue to either the consumer (in the case of an unsubsidized enrollee) or the federal government (in the case of a subsidized enrollee) or a mix of both. [9]

This contrasts with a PO program where PO offerings are brought into the market and one of these offerings is assumed to become the lowest-cost silver plan. All other non-PO offerings are assumed to be largely unaffected in terms of price.[10] In this case, both the unsubsidized and the subsidized enrollee may not see any reductions in their premiums *unless they switch to the PO offering that has become the lowest-cost or second lowest cost silver plan.*

Section 5 of this report illustrates the projected premium reductions under each PO scenario in Section 3 below, based on the SLCS plan, which is the benchmark plan used to determine premium subsidies.

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

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

[10] As noted earlier, the entrance and / or presence of PO offerings could affect pricing of non-PO offerings depending on issuer responses.

2. Comparable number of state residents covered

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

   Section 4B of this report illustrates the projected coverage for State of Nevada residents under each PO scenario in Section 3 below.

3. Comparable coverage

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

4. No increase to federal deficit

   Section 31 CFR 33.108(f)(3)(iv)(D) states that the waiver will not increase the federal deficit, either over the five-year waiver period or the 10-year federal deficit neutrality window. CMS requires the total of various costs to be considered when determining the impact on the federal deficit. Section 5 of this report details those costs and the treatment of them in this waiver modeling. It also shows the projected federal subsides during the 10-year federal deficit neutrality window under each scenario described in Section 3 below, including the Baseline scenarios without the waiver. The PO scenarios presented in this report illustrate that the Nevada 1332 waiver is not expected to increase the federal deficit when compared to the Baseline scenarios without the waiver. The analysis shows that federal costs are expected to decline due to the lowering of the SLCS benchmark premium, which lowers the aggregate federal subsides, even after accounting for additional subsidized enrollment.

Other federal requirements

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

1. Current law requirement

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

2. Health coverage analysis

   Section 31 CFR 33.108(f)(4)(ii)(B) requires that the 1332 waiver include a detailed analysis of the impact of the waiver on health insurance coverage in the State of Nevada. Based on the provisions of the PO legislation, we reasonably assume the Nevada PO will not have a material impact on enrollment in other markets. Specifically, the populations eligible to enroll in the PO are the individual market and the uninsured. Employer groups, including small employers, are not eligible to enroll in the PO.[11] The enrollment changes in the markets other than the individual and uninsured that are modeled in the actuarial analysis are attributable to forces unrelated to the PO, including population growth and shifts, the expiration of ARP, and the end of the PHE.

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

3. Demographic information

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

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

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

4. Explanation of assumptions

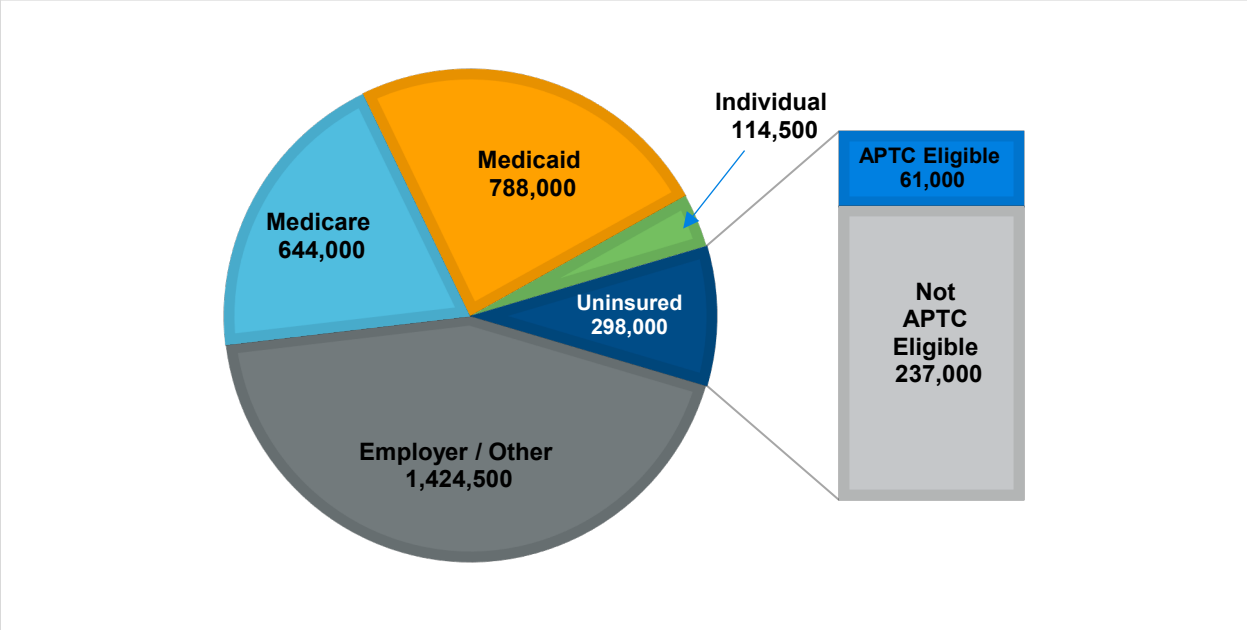
   Section 31 CFR 33.108(f)(4)(iii)(B) requires that the 1332 waiver include an explanation of the key assumptions used to develop the estimates of the effect of the waiver on coverage and the federal budget, such as individual and employer participation rates, behavioral changes, premium and price effects,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

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

D. CURRENT NEVADA COVERAGE LANDSCAPE

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

Figure 1: Sources of Coverage for Nevada Residents in 2022



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

In 2022, approximately 90.1% of Nevadans had health insurance coverage through one of the public or private markets shown above, leaving approximately 9.1% of Nevadans uninsured. The stated intent of the PO is to increase coverage for currently uninsured residents, particularly those who are currently eligible for PTCs, but are not enrolled.

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

Medicare

The primary source of coverage for older Americans and those with qualifying disabilities is Medicare. Based on the program design of the PO, we do not assume any enrollment will transition between Medicare and the individual market because of the PO offering. Although some individual market enrollees will become eligible for Medicare based on age between 2022 and 2026, we assume the overall enrollment distribution among insurance markets in Nevada, excluding the uninsured population and individual market, will remain consistent over time under the non-waiver Baseline scenarios and the waiver scenarios.[12]

Employer-sponsored

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

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

Medicaid

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

As a result of the Families First Coronavirus Response Act (FFCRA), state Medicaid programs are subject to Maintenance of Eligibility (MOE) requirements to qualify for a temporary 6.2-percentage-point Federal Medical Assistance Percentage (FMAP) increase.[13] States are not permitted to disenroll anyone from Medicaid until the PHE expires unless the member is deceased, moves out of state, or asks the state to be disenrolled. Enrollment in Medicaid populations where eligibility is tied to income has grown significantly since the beginning of the PHE, particularly among adults. Once the PHE expires, assumed in this analysis to occur sometime between the date of this analysis and the beginning of the PO in 2026, states will be required to redetermine Medicaid eligibility and disenroll those who no longer qualify. We expect some of these disenrolled members to be eligible for individual insurance and premium tax credits through the Silver State Health Insurance Exchange. Although the exact date the PHE will expire is still uncertain, the PHE is generally expected to expire well enough in advance of the Nevada PO that MOE disenrollment will be completed prior to the PO effective date. This waiver analysis assumes a portion of 2022 Medicaid enrollees will enroll in the Silver State Health Insurance Exchange during 2023. Provided the PHE expires by late 2024 and the disenrollment process is completed prior to 2026, we do not expect the exact timing of the expiration of the PHE to have a material impact on the results of the waiver analysis. This transition from Medicaid to the Silver State Health Insurance Exchange is reflected in all Baseline and PO scenarios.

Individual coverage

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

Prior to the PHE, qualifying enrollees with household incomes up to 400% FPL were eligible for federal subsidies to offset part or all of their premium payments. The American Rescue Plan Act of 2021 (ARP) legislation passed in response to the PHE extended federal subsidies on marketplace plans to enrollees with incomes greater than 400% FPL and enhanced subsidies for those below 400% FPL. These enhanced subsidies were renewed through 2025 with the Inflation Reduction Act.

The potential end of the PHE and enhanced subsides under ARP will both have significant impacts on the individual market in Nevada. In particular, material changes in enrollment and morbidity could occur that will affect pass-through funding estimates modeled in this report. As with Medicaid, we assume these changes will occur between now and the beginning of the PO in 2026.

In 2021, the Biden administration announced administrative changes that affected certain individuals previously unable to enroll in exchange coverage due to the so called “family glitch.” Proposed rules for these changes were released in October 2022. These changes made it easier for these individuals and their families to enroll, in many cases. This may result in a potential increase in enrollment in Nevada’s individual market, coming primarily from the uninsured.[14] However, the increase would be small and would appear in both the Baseline and waiver scenarios, with an immaterial impact overall on pass-through funding. Therefore, we do not make any specific assumptions on the impact of this change in our modeling, assessing it to be relatively small, with the estimated effect being similar with or without the waiver.

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

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

Uninsured

The number of uninsured in Nevada will fluctuate for various reasons over time, but for purposes of this analysis material fluctuations can be expected due to the end of the PHE and the end of enhanced subsidies under ARP. Specifically, we assume a portion of those disenrolled from Medicaid due to the ending of the PHE will become uninsured. Likewise, if ARP ends, some people on the individual market may disenroll and become uninsured.

The number of uninsured in Nevada becomes important in the modeling of pass-through funding as the uninsured are the exclusive pool from which we assume new individual enrollment will enter when the PO is offered under the waiver scenarios.

E. PROJECTED 2026 NEVADA COVERAGE LANDSCAPE

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

Table 8
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Estimated Nevada Market Enrollment Shifts 2022-2026: With ARP

	Individual	Uninsured PTC-Eligible*	Uninsured Non-PTC-Eligible**	Medicaid / CHIP	Employer-Sponsored / Medicare / Other	Total
2022 Enrollment	114,500	61,000	237,000	788,000	2,068,500	3,269,000
PHE Ends	15,700	33,000	0	(191,000)	142,300	0
Population Growth	6,100	3,200	12,600	41,800	109,700	173,400
2026 Enrollment	136,300	97,200	249,600	638,800	2,320,500	3,442,400

**Includes members who may not qualify for subsidies based on income and gross SLCS premium*
***Includes members eligible for employer-sponsored insurance or Medicaid, or who do not qualify for the individual market due to immigration status*

We note the following regarding Table 8:

- We estimate Medicaid disenrollment by looking at historical Medicaid data over the past two years to estimate the enrollment increase due to the PHE. We assume some of the enrollment growth during the PHE remains, but enrollment will revert closer to pre-PHE levels. Further, we assume that beneficiaries disenrolled from Medicaid who transition to the individual market will all be PTC-eligible.
- We assume beneficiaries disenrolled from Medicaid will enroll in employer-sponsored and individual coverage or go uninsured approximately in proportion to current market sizes (i.e., proportional allocation).
- We assume population growth at 1.3% annually.[15]

Table 9 illustrates the projected 2026 coverage landscape assuming both the PHE and ARP expire before 2026. These values are rounded for the same reasons as in Table 8.

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

Table 9
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Estimated Nevada Market Enrollment Shifts 2022-2026: Without ARP

	Individual	Uninsured PTC-Eligible*	Uninsured Non-PTC-Eligible**	Medicaid / CHIP	Employer-Sponsored / Medicare / Other	Total
2022 Enrollment	114,500	61,000	237,000	788,000	2,068,500	3,269,000
PHE Ends	15,700	33,000	0	(191,000)	142,300	0
ARP Ends	(30,000)	16,000	14,000	0	0	0
Population Growth	6,100	3,200	12,600	41,800	109,700	173,400
2026 Enrollment	106,300	113,200	263,600	638,800	2,320,500	3,442,400

**Includes members who may not qualify for subsidies based on income and gross SLCS premium*
***Includes members eligible for employer-sponsored insurance or Medicaid, or who do not qualify for the individual market due to immigration status*

We note the following regarding Table 9:

- We assume the expiration of ARP subsidies at the end of 2025 will result in some current individual market enrollees transitioning to uninsured PTC-eligible status because required out-of-pocket premiums will increase for many enrollees.
- Moreover, given the structure of ARP subsidies, specifically that those with incomes over 400% FPL are eligible for subsidies, the ending of ARP subsidies will make these enrollees ineligible for subsidies. Hence, a material portion of the uninsured over 400% FPL move into the uninsured non-PTC-eligible segment.
- We estimate the total number of enrollees transitioning out of individual coverage (30,000) by reviewing the change in historical enrollment from 2019 to the open enrollment of 2022 in the State of Nevada. The detailed assumptions used to develop these projected enrollment impacts are described in more detail in Section 6 below.

III. DESCRIPTION OF SCENARIOS

Due to uncertainty regarding the future of ARP subsidies, we prepared our analysis under two frameworks. The first framework (With ARP) assumes the continuance of ARP subsidies. The ARP framework is the starting point for our analysis because the most current enrollment data used in our analysis reflects the existence of ARP subsidies. The second framework (Without ARP) assumes the ARP subsidies expire sometime before 2026. As of this writing, ARP subsidies are set to expire at the end of 2025; therefore, the Without ARP framework represents current law. We modeled a Baseline scenario under each framework to illustrate the projected enrollment, premiums, and federal costs without the Public Option (PO). From there, we modeled two PO scenarios under each framework to illustrate the potential impact of the PO on enrollment, premiums, and pass-through savings with additional State of Nevada premium subsidies (State Premium Wrap) and without them (PTF Accumulation).

A. DESCRIPTION OF SCENARIOS

The scenarios are summarized in Table 1, as shown in the Executive Summary and reproduced here for convenience. The scenarios are described in additional detail throughout this section.

Table 1
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenarios

Framework	Scenario	Description
With ARP	Scenario 1	Baseline – No Waiver
	Scenario 1A	Public Option – PTF Accumulation
	Scenario 1B	Public Option – State Premium Wrap
Without ARP	Scenario 2	Baseline – No Waiver
	Scenario 2A	Public Option – PTF Accumulation
	Scenario 2B	Public Option – State Premium Wrap

All PO scenarios assume the PO will achieve the gross premium savings targets, namely 4% in the first program year (required) and growing by at least 4% per year to at least 16% by year 4, consistent with direction from the State of Nevada, SB420, and the State of Nevada's methodology outlined in Appendix C. All PO scenarios also assume at least one bronze PO offering will be available in each rating area. Also, PO plans will be available to off-exchange enrollees at full-cost (unsubsidized).

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

- PTF Accumulation scenarios: Scenarios 1A and 2A assume the pass-through funding is not used to directly impact the individual market in the State of Nevada. They are intended to provide additional context since the state has not yet finalized how the pass-through funds will be used. The PTF Accumulation scenarios illustrate the minimum additional enrollment expected to result from the introduction of the PO and the maximum pass-through funding that may be available before pass-through funding is used for other subsidies or outreach efforts. The state can use the pass-through savings to offset enrollee out-of-costs in the individual market (e.g., through cost-sharing or supplemental premium wraps) or to fund other initiatives (e.g., outreach to uninsured who may be eligible for coverage through the state's exchange).

- State Premium Wrap scenarios: Scenarios 1B and 2B assume the federal pass-through funds are used to reduce enrollee premiums via additional state premium tax credits "wrapped" around federal premium tax credits. Although the state has not yet determined how the pass-through funds will be used, these scenarios illustrate how pass-through funding may be impacted if the funds are used to reduce member costs. At the State of Nevada's direction, we assumed the state premium subsidies will be directed toward lower-income

enrollees and available on both PO and non-PO plans purchased through the exchange. See Section 3B below for further discussion of PO take-up rates in the presence or absence of state subsidy wraps.

Table 10 shows the range of the member premium amount for the second lowest cost silver plan as a percentage of income modeled in each of the scenarios. For example, the maximum member premium amount for a member who earns between 151% to 200% FPL will be between 0% and 1.99% of the member's income under Scenarios 1 and 1A, and the maximum member premium under Scenario 1B will be between 0% and 1.0% of the member's income. The State Premium Wrap scenarios in columns (2) and (4) with bold font and shading indicate where the maximum member premium amount with the state premium wrap is modeled to be different from federal subsidies only.

Table 10
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Maximum Member Premium for Second Lowest Cost Silver as a Percentage of Household Income Levels by Scenario

	With ARP		Without ARP	
	Federal Only (Scenarios 1 and 1A)	With State Premium Wrap (Scenario 1B)	Federal Only (Scenarios 2 and 2A)	With State Premium Wrap (Scenario 2B)
	(1)	(2)	(3)	(4)
Member Income as % of FPL	Max Member Premium as % of Income	Max Member Premium as % of Income	Max Member Premium as % of Income	Max Member Premium as % of Income
0% to 100%	0.00%	0.00%	2.07%	**0.25%**
100% to 133%	0.00%	0.00%	2.07%	**0.25%**
134% to 150%	0.00%	0.00%	3.10% to 4.13%	**0.75% to 1.74%**
151% to 200%	0.00% to 1.99%	0.00% to **1.00%**	4.14% to 6.51%	**1.75% to 3.74%**
201% to 250%	2.00% to 3.99%	**1.01% to 1.99%**	6.52% to 8.32%	**3.75%** to 8.32%
251% to 300%	4.00% to 5.99%	**2.00% to 3.99%**	8.33% to 9.82%	8.33% to 9.82%
301% to 400%	6.00% to 8.49%	**4.00% to** 8.49%	9.83%	9.83%
401% to No Limit	8.50%	8.50%	NA	NA

Note: The federal-only percentages (Scenarios 2 and 2A) reflect the maximum member premium percentage for CY 2021. These percentages are indexed each year. For example, the percentage for 300% FPL will decrease from 9.83% to 9.12% in CY 2023. For modeling purposes, the CY 2021 percentages were used for each year of the 10-year projections.

The premium wrap structure shown in Table 10 is not final, but it reflects the general intentions of DHHS to differentially direct subsidies by the various income levels under either the ARP or non-ARP situations. As the beginning of the PO program approaches, it is certain that updated population by income data will be used to restructure the state premium wraps, possibly substantially. In particular, DHHS has indicated a preference to mitigate large percentage increases in PTC-eligible enrollees' net premiums at lower income levels. The assumptions used in this modeling are reasonable estimates given the purpose of this analysis and these broad goals.

Table 11 lists the key assumptions that impact each scenario. A brief description of each is provided below. Detailed methodology and sourcing can be found in Section 6 of this report.

Table 11
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario Assumptions

	With ARP			Without ARP		
	Baseline	PTF Accumulation	State Premium Wrap	Baseline	PTF Accumulation	State Premium Wrap
Enrollment						
General population growth	X	X	X	X	X	X
Expiration of the PHE	X	X	X	X	X	X
Expiration of ARP subsidies				X	X	X
PO appeal		X	X		X	X
State premium subsidy wrap			X			X
PO bronze offering		X	X		X	X
Premiums						
Non-PO premium increases	X	X	X	X	X	X
Expiration of the PHE (morbidity)	X	X	X	X	X	X
Expiration of ARP (morbidity)				X	X	X
Increased enrollment due to option appeal (morbidity)		X	X		X	X
Increased enrollment due to premium wrap (morbidity)			X			X
Premium reduction target		X	X		X	X
Subsidies						
Indexed FPL	X	X	X	X	X	X
Indexed ACA affordability limits				X	X	X
PO adoption rate		X	X		X	X
State wrap only on PO			X			X

Table 12
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario Assumption Descriptions

	Assumption	Brief Description
Enrollment	General population growth	Individual market enrollment after 2022 is assumed to grow at the statewide population growth rate, or 1.3%, at a minimum. This growth is assumed to apply uniformly (e.g., across income levels, age groups, metallic levels).
	Expiration of the PHE	We assume the COVID-19 public health emergency (PHE) expires and the Medicaid disenrollment process that will follow the expiration of the PHE is completed prior to the effective date of the PO in 2026, most likely in 2023. Individual market enrollment is assumed to increase due to the expiration of the PHE as Medicaid disenrollment occurs. The impact varies by income level to account for Medicaid eligibility categories.
	Expiration of ARP subsidies	If ARP subsidies expire in 2025, as currently scheduled, a portion of current Silver State Individual Health Exchange enrollees are assumed to disenroll from individual coverage at the beginning of 2026, driven by increases in net (post-subsidy) premiums. This decreases enrollment in the individual market and increases the uninsured pool.
	PO appeal	Some previously uninsured Nevadans who are not subsidy-eligible (mainly near or above 400% FPL) are assumed to enroll in the ACA coverage, either on or off the exchange, due to the lower premiums available through the PO and heightened awareness of the exchange due to PO marketing and communications. This impact is separate from any increased financial incentives from additional state subsidies (described below) and occurs whether additional state premium subsidies are offered or not.
	State premium subsidy wrap	The state-based premium subsidies (funded by the pass-through funding received under the 1332 waiver) are assumed to result in incremental enrollment growth in the individual market due to the lower point-of-purchase premiums. Available pass-through funding is offset by the subsidy expenditures for new enrollees. Our

Table 12 State of Nevada Nevada Public Option Actuarial and Economic Analysis Scenario Assumption Descriptions		
		modeling assumes the state premium subsidy wrap will begin in the second program year (2027). See additional discussion in Section 5 below related to price elasticity.
	PO bronze offering	The PO, by legislation, is only required to have silver and gold level offerings. We assume the PO also offers a bronze plan. See Section 3B for a detailed discussion.
Premiums	Non-PO premium trend	Premiums for non-PO plans are assumed to increase 4%[16] per year both with and without the waiver. This assumption is based on CMS projections of per capita national health expenditures and the impact of additional value-based purchasing initiatives that will be part of Nevada's broader efforts to move a larger share of Medicaid and PO payments to a value-based purchasing framework.
	Individual market morbidity	Morbidity is the overall illness burden of a population, independent of the population's average age. Higher morbidity increases prices in a risk pool such as Nevada's Individual market, all else equal. End of PHE: We assume premiums for existing non-PO plans on the Silver State Individual Health Exchange decrease by 0.4% in 2023 due to improved morbidity from the additional enrollment transitioning from Medicaid after the expiration of the PHE. End of ARP: The exit of enrollees who leave the individual market due to the expiration of ARP subsidies is assumed to increase morbidity by 2.5%. Increased enrollment due to PO appeal: Morbidity is projected to improve 0.2% in 2026 and 0.1% in 2027 relative to the baseline due to additional enrollment from the lower-priced PO. No additional morbidity changes are assumed to happen beyond 2027. Increased enrollment due to premium wrap: Morbidity is projected to improve by between 0.1% and 0.5% relative to the baseline (varying by framework and year) if the State of Nevada uses pass-through savings to provide an additional premium wrap.
	Premium reduction target	We assume the PO will achieve the premium reduction target described in the agency's memorandum of guidance in Appendix C.
Subsidies	Indexed FPL	The federal poverty level (FPL) is assumed to increase by 6% in 2023 and 2.5% every year after.[17]
	ACA affordability limits	The maximum amount of premium for which an ACA enrollee is responsible as a percentage of their income (see Table 10 above) is indexed in the non-ARP framework based on National Health Expenditure data and projections published by CMS. We analyzed the changes in these values year over year prior to ARP subsidies becoming available in 2021. Based on the historical change, we projected income limits through the duration of the 10-year deficit neutrality window. For the ARP framework, we assume the percentages remain constant in all years.
	PO adoption rate	Fully subsidized enrollees are assumed to enroll in a PO plan at a higher rate than lower or nonsubsidized enrollees.
	State wrap only on PO	We assume additional subsidies are only available on both PO and non-PO offerings under scenarios involving a state premium subsidy wrap. See Section 3B for additional discussion.

Each of the assumptions in Table 12 is developed independently based on our best estimates; however, actual experience relative to each assumption will most likely differ to varying degrees. Furthermore, the amount of time between this analysis and the beginning of the PO introduces additional potential for variability to the projected impact of the PO on enrollment and costs because it extends the duration of the projection and the opportunity for unforeseen events. We apply an additional 10% discount to the five-year waiver and 10-year deficit estimates to reflect cumulative conservatism across all assumptions. The potential variances include, but are not limited to, enrollment volume and distribution, plan selection, regulatory changes, utilization and cost trend, and member agency.

[16] CMS. Download: NHE Projections - Tables (ZIP), Table 1, Line 34, Private Health Insurance Expenditures. National Health Expenditure Data: Projected. Retrieved November 9, 2022, from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.

[17] Ibid.

Additional details about the data sources, methodology, and assumptions used to model each of these scenarios are provided in Section 6 of this report below.

B. DISCUSSION OF PUBLIC OPTION TAKE-UP RATE ASSUMPTIONS

The impact of a PO bronze offering

As noted earlier, a PO offering is assumed to become the SLCS plan across all rating areas in Nevada in all of the PO's first four years of operation and throughout the five-year waiver and 10-year deficit neutrality windows. The two driving factors in the calculation of premium tax credit (PTC) savings in this analysis are (1) the percentage by which the PO, as the SLCS, is below what would otherwise be the SLCS plan in the Baseline – No Waiver scenarios, and (2) the total enrollment of PTC-eligible individuals. However, there is an additional factor that impacts the pass-through funding, which is whether or not PO offerings are available to consumers at the bronze plan level.

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

Under a waiver scenario where PO offerings become the SLCS plan, silver plan consumers under a Baseline scenario will likely switch to the benchmark plan or something close in price to that plan. Likewise, many bronze purchasers under a Baseline scenario will be expected to purchase a bronze-level PO plan under a waiver scenario. If PO issuers do not have a bronze offering available, some amount of previous bronze purchasers will be assumed to take coverage under a PO silver plan, thereby using up the entire available subsidy.

The primary downstream implication of including bronze PO offerings for this waiver analysis is that the take-up assumption in the PO does impact the overall pass-through funding calculation. A higher assumed take-up rate in the PO increases pass-through funding, as it is assumed more bronze purchasers will also take up PO coverage and use only a portion (as opposed to all) of their available subsidy.[18] Said differently, if the PO only offered silver and gold plans, take-up in the PO would have no impact at all on pass-through funding. The actual take-up of the PO offerings will only be impactful on pass-through funding if we assume bronze-level PO plans are offered.

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

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

Notwithstanding, we assume that some material share of the market will respond to the lower prices of PO offerings in the individual marketplace, but a separate material share of the market may not take up PO coverage for various reasons.

Therefore, under the PTF Accumulation and State Premium Wrap scenarios, we assume an ultimate take-up rate of 60% realized by the fourth year of the PO. Under the State Premium Wrap scenarios, we would likely assume a higher PO take-up rate by year 4 if the additional incentives of the premium wraps were available only in the PO plans. However, at this time, the state intends to offer the premium wraps to qualifying individuals in both PO and non-PO on the exchange.

To understand the relative impact of PO take-up on the 10-year pass-through funding, the estimated impact of a 60% versus a 70% take-up assumption for each scenario is shown in Table 13. Note, the impact of PO take-up varies by

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

scenario for various reasons, including the size of available subsidies (ARP versus non-ARP) and the amount of enrollment increase (State Premium Wrap versus PTF Accumulation).

Table 13
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Public Option Take- Up Sensitivity on Pass-Through Funding Through 10-Year Budget Window

Scenario	PO Take-Up 60%	PO Take-Up 70%	Change in PTF	Change in PO Take-Up (60% to 70%	PTF Impact of 1% Increase in Take-up
ARP PTF Accumulation	$1,300,000	$1,309,000	0.69%	17%	0.04%
ARP State Premium Wrap	$969,000	$975,000	0.62%	17%	0.04%
No ARP PTF Accumulation	$704,000	$707,000	0.43%	17%	0.03%
No ARP State Premium Wrap	$251,000	$252,000	0.40%	17%	0.02%

Note: All dollar values in thousands.

As can be seen in Table 13, the change from a 60% to a 70% assumed take-up in the PO has only a small impact on pass-through funding, as expected. Appendix D shows additional analysis on the PO take-up rate's impact to provider reimbursement.

The assumption of a 60% public option take-up rate is based on actuarial judgement given that no Public Option program similar to Nevada's program and that has enrollment experience exists. Colorado's program is approved to begin in 2023 and Washington's program does not have key features that will distinguish Nevada's program, such as enforceable premium targets and procurement ties to the Medicaid program. Therefore, the 60% assumption is based on balancing considerations already noted above but, for clarity, we repeat here:

- The PO will offer a material price advantage over non-PO plans
- However, not all consumers shop on price
- Some features of the PO product offering are not known at this time

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

Premium wrap structure

Based on the analysis shown above, it is clear that the higher the take-up rate in the PO, the higher the pass-through funding due to the bronze plan mechanics described above, albeit the effect is small. These same results can be used to draw inferences about the structure of the pass-through funding for the State Premium Wrap scenarios.

The State of Nevada could make premium subsidy wraps available to all subsidized enrollees on the exchange or they could target them at only those enrollees on PO plans. The former would likely result in a lower PO adoption rate, and the latter would result in a higher rate. Alternatively, the additional state subsidy may entice some current enrollees in bronze plans to purchase a silver PO plan. This migration to silver plans could reduce pass-through funding. We did not attempt to model all possible variations of consumer behavior in response to the PO, but we believe the 10% margin applied to the five-year waiver and 10-year deficit amounts is sufficient to address possible variations caused by these situations.

From Table 13 above, we can see that a 1% increase in PO take-up is worth between a 0.40% and 0.69% increase in pass-through funding. However, pass-through funding is only one component of a broader set of considerations. There may be other reasons to offer or not offer the premium wraps only to PO enrollees besides the financial reason noted above, a discussion of which is beyond the scope of this report.

The scenarios shown in this report assume premium subsidy wraps are available to qualified enrollees on the exchange who choose either a PO or non-PO plan.

Small employer migration

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

While a detailed analysis of gross premiums between the individual and small group markets in Nevada is beyond the scope of this report, we reviewed general price levels and concluded that the small group market in 2022 has a material price advantage over the individual market. This implies that employers may have little incentive, based on the cost of coverage alone, to adopt an ICHRA-based employee benefits approach. We assume that, over the course of the first four years of the PO program, this price advantage decreases, but remains significant enough that an assumption of the same migration in the Baseline scenarios and the waiver scenarios is reasonable.

IV. ACTUARIAL ANALYSIS

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

A. AFFORDABILITY OF PREMIUMS AND COST-SHARING

As required under 45 CFR 155.1308(f)(3)(iv)(B), a state's proposed 1332 waiver must provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable under Title I of the ACA. As described in CMS-9936-N, increasing the number of state residents with large health care spending burdens relative to their incomes would result in a waiver proposal failing to meet the affordability requirement of the 1332 waiver application.[19] Additionally, regulations state an evaluation of the affordability requirement will take into account the impact of the waiver proposal to "vulnerable residents, including low-income individuals, elderly individuals, and those with serious health issues or who have a greater risk of developing serious health issues." The exhibits referenced in this section are shown in the Exhibits section at the end of the report.

With ARP

Scenario 1A: ARP Public Option – PTF Accumulation

The ARP Public Option – PTF Accumulation premium projections are shown on the following exhibits:

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

Exhibit 1A.2 demonstrates the waiver provides coverage that is at least as affordable as the coverage available without the waiver, as required by the guardrail. We conservatively assume some enrollees will not choose to enroll in PO plans. The projected decrease in member premiums under the waiver shown in Exhibit 1A.1 is attributable to the PO adoption rate assumption. Table 14 illustrates how these projected member premiums change based on different aggregate PO adoption rate assumptions. If all eligible enrollees choose a PO plan, member premiums will decrease by the same amount as the SLCS plan premium decreases in Exhibit 1A.1.

Note, Table 14 assumes the PO take-up rate applies in all years, whereas the scenarios modeled in this report assume PO take-up rates increase over the first four years of the PO. Therefore, the premiums shown in Table 14 will not match any of the scenario results for the first three projection years.

Table 14
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
ARP Public Option – PTF Accumulation Sensitivity Illustration
Individual Market Composite Monthly Premium by Public Option Take-Up Rate

	Public Option Take-Up Rate				
Year	**50%**	**60%**	**70%**	**80%**	**90%**
2026	$579.19	$576.10	$574.42	$572.04	$569.65
2027	$589.28	$582.68	$579.11	$574.03	$568.94
2028	$600.24	$590.10	$584.59	$576.77	$568.94
2029	$611.32	$597.53	$590.02	$579.36	$568.71
2030	$635.58	$621.23	$613.42	$602.35	$591.27
2031	$661.35	$646.42	$638.29	$626.77	$615.24
2032	$687.79	$672.27	$663.82	$651.83	$639.84
2033	$715.40	$699.25	$690.46	$677.99	$665.52
2034	$744.16	$727.36	$718.22	$705.25	$692.28
2035	$773.75	$756.29	$746.78	$733.30	$719.81

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

Scenario 1B: ARP Public Option – State Premium Wrap

The ARP Public Option – State Premium Wrap premium projections are shown on the following exhibits:

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

Exhibit 1B.2 demonstrates the waiver provides coverage that is at least as affordable as the coverage available without the waiver, as required by the guardrail. Similar to the ARP Public Option – PTF Accumulation scenario, the projected decrease in member premiums shown in Exhibit 1B.1 under the waiver is attributable to the PO adoption rate assumption. If all eligible enrollees choose a PO plan, member premiums will decrease further as a result of the waiver.

Without ARP

Scenario 2A: No ARP Public Option – PTF Accumulation

The No ARP Public Option – PTF Accumulation premium projections are shown on the following exhibits:

- Exhibit 2A.1: Statewide 10-year premium projection and change from No ARP Baseline scenario
- Exhibit 2A.2: Ten-year SLCS projection and change from No ARP Baseline scenario

Exhibit 2A.2 demonstrates the waiver provides coverage that is at least as affordable as the coverage available without the waiver, as required by the guardrail. Similar to the With ARP framework, we conservatively assumed some enrollees will not choose to enroll in PO plans. The projected decrease in member premiums shown in Exhibit 2A.1 under the waiver is attributable to the PO adoption rate assumption. If all eligible enrollees choose a PO plan, member premiums will decrease further under the waiver.

Scenario 2B: No ARP Public Option – State Premium Wrap

The No ARP Public Option – State Premium Wrap premium projections are shown on the following exhibits:

- Exhibit 2B.1: Statewide 10-year premium projection and change from No ARP Baseline scenario
- Exhibit 2B.2: Ten-year SLCS projection and change from No ARP Baseline scenario

Exhibit 2B.2 demonstrates the waiver provides coverage that is at least as affordable as the coverage available without the waiver, as required by the guardrail. Like the other scenarios, the projected decrease in member premiums shown in Exhibit 2B.1 under the waiver is attributable to the PO adoption rate assumption. If all eligible enrollees choose a PO plan, average member premiums will decrease under the waiver.

B. COMPARABLE NUMBER OF STATE RESIDENTS COVERED

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

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

With ARP

Scenario 1A: ARP Public Option – PTF Accumulation

The ARP Public Option – PTF Accumulation enrollment projections compared to the ARP Baseline scenario are shown on the following exhibits:

- Exhibit 1A.3: Ten-year projected enrollment by income level
- Exhibit 1A.4: Ten-year projected enrollment by metallic level
- Exhibit 1A.5: Ten-year projected enrollment by age group
- Exhibit 1A.6: Ten-year projected enrollment by subsidy eligibility

Exhibit 1A.6 demonstrates the waiver provides coverage to at least as many residents as without the waiver, as required by the guardrail.

Scenario 1B: ARP Public Option – State Premium Wrap

The ARP Public Option – State Premium Wrap enrollment projections compared to the ARP Baseline scenario are shown on the following exhibits:

- Exhibit 1B.3: Ten-year projected enrollment by income level
- Exhibit 1B.4: Ten-year projected enrollment by metallic level
- Exhibit 1B.5: Ten-year projected enrollment by age group
- Exhibit 1B.6: Ten-year projected enrollment by subsidy eligibility

Exhibit 1B.6 demonstrates the waiver provides coverage to at least as many residents as without the waiver, as required by the guardrail.

Without ARP

Scenario 2A: No ARP Public Option – PTF Accumulation

The No ARP Public Option – PTF Accumulation enrollment projections compared to the No ARP Baseline scenario are shown on the following exhibits:

- Exhibit 2A.3: Ten-year projected enrollment by income level
- Exhibit 2A.4: Ten-year projected enrollment by metallic level
- Exhibit 2A.5: Ten-year projected enrollment by age group
- Exhibit 2A.6: Ten-year projected enrollment by subsidy eligibility

Exhibit 2A.6 demonstrates the waiver provides coverage to at least as many residents as without the waiver, as required by the guardrail.

Scenario 2B: No ARP Public Option – State Premium Wrap

The No ARP Public Option – State Premium Wrap enrollment projections compared to the No ARP Baseline scenario are shown on the following exhibits:

- Exhibit 2B.3: Ten-year projected enrollment by income level
- Exhibit 2B.4: Ten-year projected enrollment by metallic level
- Exhibit 2B.5: Ten-year projected enrollment by age group
- Exhibit 2B.6: Ten-year projected enrollment by subsidy eligibility

Exhibit 2B.6 demonstrates the waiver provides coverage to at least as many residents as without the waiver, as required by the guardrail.

C. COMPARABLE COVERAGE

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

V. ECONOMIC ANALYSIS

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

a. **Income, payroll, and excise taxes**: The excise tax to fund the Patient-Centered Outcomes Research Initiative (PCORI) for 2022 is $2.79 per enrolled member per year. Given that the range of enrollment increases expected from the proposed waiver is between approximately 1,500 and 10,000 for all 10 years of the deficit neutrality window, the expected increase in federal revenue is at most $30,000 in a year. Relative to the premium tax credit (PTC) reductions, which are in the hundreds of millions, the PCORI fee change is immaterial to the economic analysis and was not modeled explicitly.

b. **User fees:** Nevada's exchange has been a state-based exchange since 2020 and does not utilize the federal platform at all.[20]

c. **Changes in PTCs and other tax credits:** Our modeling includes the changes to the premium tax credits for those exchange enrollees qualifying for subsidies. We estimate premium tax credits by modeling advanced premium tax credits (APTCs)[21] and then applying an adjustment to account for the tax reconciliation process. This adjustment is 10%.[22]

d. **Changes in CSRs and Medicaid spending:** Cost-sharing reductions (CSRs) are not a federal obligation and, therefore, are not modeled. It is assumed that the Public Option (PO) does not impact Medicaid spending in the waiver scenarios relative to the Baseline scenarios.

e. **Changes in employer mandate penalties:** Because the PO is not expected to affect the employer group markets, the employer mandate revenue impact is zero. If the PO were to cause an increase in the migration of employees of small group employers utilizing ICHRAs, the employer mandate does not apply to this market.

f. **Changes in individual mandate penalties:** The impact to individual mandate penalty revenue is zero because the penalty is set to $0.

g. **Tax deductions for employer premiums and medical expenses:** Because the PO is not expected to affect the employer group markets, the federal costs from the tax deductibility of employer premiums and other medical expenses are expected to be zero.

h. **Changes in IRS administrative costs, healthcare.gov administrative costs, and any other federal administrative costs that may be affected by the waiver:** We are not aware of, nor do we anticipate, any impact from Nevada's waiver to IRS administrative costs.

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

At a high level, changes in PTCs related to the implementation of SB420 and the PO will be driven by overall enrollment of PTC-eligible individuals and families, as well as the percentage savings the PO will drive relative to non-PO plans as it becomes the second lowest cost silver plan in each of the rating areas in Nevada. In addition, as noted in Section 3B above, the effect on pass-through funding will be influenced by the actual enrollment in PO bronze plans. Therefore, we illustrate the development of PTC savings and pass-through funding for each scenario by using a series of four exhibits:

- Projected enrollment of PTC-eligible enrollees in the individual market. In the waiver scenarios (1A, 1B, 2A, and 2B), we also show the change in enrollment from the Baseline scenarios.
- Projected gross premiums, split by PO and non-PO plan enrollment and then a composite market-wide premium, based on the assumed take-up of PO plans.

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

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

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

- Composite gross premiums split by PTC eligibility, with the APTC and net premium portions of an PTC-eligible enrollee's premium shown separately.
- Calculation of total APTCs and final estimated PTCs after tax reconciliation. Per member per month (PMPM) values are multiplied by membership values for each year to obtain the 10-year deficit neutrality window totals.

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

A. PROJECTED CHANGES IN PTCS WITH ARP

All scenarios under the With ARP framework, including the Baseline, assume the following:

- Enhanced subsidies provided by ARP are extended through the entire 10-year deficit neutrality window.
- Enhanced subsidies are unchanged in terms of percentages of income, as detailed in Table 10 above (i.e., they are not indexed).
- No change in overall individual risk pool morbidity.

Scenario 1: ARP Baseline – No Waiver

Enrollment

Table 15 shows the 10-year enrollment projection under the ARP Baseline – No Waiver scenario for enrollees both on- and off-exchange. The enrollment projection for enrollees on-exchange is further split between members with and without PTC.

Table 15
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 1: ARP Baseline – No Waiver
Individual Market Enrollment by Segment

	On-Exchange			Off-Exchange	
Year	(1) PTC-Eligible	(2) Non-PTC-Eligible	(3) Total	(4) Total	(5) Total Individual Market
2026	117,700	4,000	121,700	15,400	137,100
2027	119,400	3,900	123,300	15,600	138,900
2028	121,300	3,600	124,900	15,800	140,700
2029	123,100	3,400	126,500	16,000	142,500
2030	124,800	3,300	128,100	16,200	144,300
2031	126,600	3,200	129,800	16,500	146,300
2032	128,400	3,100	131,500	16,700	148,200
2033	130,100	3,100	133,200	16,900	150,100
2034	132,000	3,000	135,000	17,100	152,100
2035	133,800	2,900	136,700	17,300	154,000
Average Annual Change	**1.4%**	**-3.5%**	**1.3%**	**1.3%**	**1.3%**

- The 2026 Total Individual Market enrollment shown in column (5) for the beginning of the 10-year deficit neutrality window is consistent with Table 8, which illustrates the development of the 2026 number from 2022.
- Column (1) values increase due to population growth and for some movement from column (2).
- Under ARP, the Non-PTC-Eligible in column (2) actually decreases because the income affordability limits under ARP are not indexed. That means more people become eligible for at least some federal subsidy amounts and move to column (1), as premiums in the individual market grow faster than income affordability limits and projected federal poverty levels. Column (4) enrollees, like those in column (2), are not eligible for subsidies. However, we assume these enrollees to be significantly higher-income and, therefore, less likely to become eligible for subsidies in the same way column (2) enrollees would.
- Column (4) includes the individual market catastrophic plan enrollment.
- Columns (4) and (5) values beyond 2026 increase at the annual population growth estimate of 1.3%.

Premiums

The following assumptions apply to projected premiums under the ARP Baseline – No Waiver scenario:

- *Non-PO premium trend:* Gross premiums for the individual market are projected with a 4% annual increase. See Section 6 below for a detailed description of the development of this factor.

Table 16 shows the statewide 10-year premium PMPM projection under the ARP Baseline – No Waiver scenario. (There is no PO offering in the Baseline scenario, so PO enrollment and premiums are shown as zero to keep the format of exhibits consistent across all scenarios.)

Table 16
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 1: ARP Baseline – No Waiver
Summary of Enrollment and Premium by Public Option and Non-Public Option Segments

	Public Option			Non-Public Option		Total	
Year	Public Option Take-Up %	Enrollment	Premium	Enrollment	Premium	Enrollment	Premium PMPM
2026	0%	0	0	137,100	$591	137,100	$591
2027	0%	0	0	138,900	$615	138,900	$615
2028	0%	0	0	140,700	$639	140,700	$639
2029	0%	0	0	142,500	$665	142,500	$665
2030	0%	0	0	144,300	$692	144,300	$692
2031	0%	0	0	146,300	$719	146,300	$719
2032	0%	0	0	148,200	$748	148,200	$748
2033	0%	0	0	150,100	$778	150,100	$778
2034	0%	0	0	152,100	$809	152,100	$809
2035	0%	0	0	154,000	$841	154,000	$841

Subsidies

The following assumptions apply to projected subsidies under the ARP Baseline – No Waiver scenario:

- *FPL increases:* The 100% federal poverty level (FPL), used to calculate a PTC-eligible person's subsidy, is increased in 2023 by 6% and by 2.5% annually thereafter.[23]
- *Income affordability limits:* These limits are not indexed over time. Because ARP subsidy levels were originally set to expire at the end of 2022, and are now set to expire at the end of 2025, no values for ARP subsidies in 2026 and beyond have been published by any regulatory agency to date.

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

Table 17
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 1: ARP Baseline – No Waiver
Premiums and Member Subsidies Per Member Per Month (PMPM)

	On-Exchange					
	PTC-Eligible			Non-PTC-Eligible	Off-Exchange	Total Individual Market
Year	(1) Gross Premium	(2) APTC	(3) Enrollee Net Premium	(4) Enrollee Gross Premium	(5) Enrollee Gross Premium	(6) Gross Premium
2026	$611	$494	$118	$356	$512	$591
2027	$635	$514	$121	$372	$533	$615
2028	$660	$534	$125	$386	$554	$639
2029	$686	$556	$130	$387	$576	$665
2030	$713	$580	$134	$409	$599	$692
2031	$742	$604	$138	$418	$623	$719
2032	$771	$629	$142	$436	$648	$748
2033	$802	$655	$146	$455	$674	$778
2034	$833	$682	$151	$471	$701	$809
2035	$866	$711	$155	$491	$729	$841

Note: Total Individual Market Gross Premiums in column (6) are consistent with Table 16 above. Column (4) values are materially lower than gross premiums in the rest of the individual market as the catastrophic plans are included and constitute approximately 25% of the enrollment. Table 18 below illustrates the changes in each of the PMPM values in Table 17.

Table 18
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 1: ARP Baseline – No Waiver
Annual Change in Premiums and Member Subsidies PMPM

	On-Exchange					
	PTC-Eligible			Non-PTC-Eligible	Off-Exchange	Total Individual Market
Year	(1) Gross Premium	(2) APTC	(3) Enrollee Net Premium	(4) Enrollee Gross Premium	(5) Enrollee Gross Premium	(6) Gross Premium
2026	--	--	--	--	--	--
2027	3.9%	4.1%	3.0%	4.6%	4.0%	4.0%
2028	3.9%	4.0%	3.5%	3.7%	4.0%	4.0%
2029	4.0%	4.1%	3.6%	0.1%	4.0%	4.0%
2030	4.0%	4.2%	2.9%	5.9%	4.0%	4.0%
2031	4.0%	4.1%	3.2%	2.0%	4.0%	4.0%
2032	3.9%	4.1%	3.0%	4.3%	4.0%	4.0%
2033	4.0%	4.2%	2.9%	4.6%	4.0%	4.0%
2034	3.9%	4.1%	3.1%	3.4%	4.0%	4.0%
2035	4.0%	4.2%	3.1%	4.2%	4.0%	4.0%

We note the following regarding the annual changes illustrated in Table 18:

- Gross premiums, as noted earlier, are increasing at 4% per year (within tolerance for rounding), for both on-exchange enrollees and off-exchange enrollees.
- Enrollee net premiums are indexed to federal poverty levels, which are assumed to increase at 2.5% per year, and therefore are increasing less than gross premiums.
- APTCs, being the balancing item, are increasing more than gross premium annually.

- Non-PTC-eligible exchange enrollee gross premiums are more volatile due their small size and a changing mix of enrollees from year to year. This volatility occurs as various enrollees will move from non-PTC-eligible to PTC-eligible over time because ARP subsidy income limits are not indexed.

Scenario 1A: ARP Public Option – PTF Accumulation

This scenario reflects expected premiums, enrollment, and federal subsidies, assuming the indefinite extension of ARP subsidies and the commencement of the PO in 2026, with no state premium subsidy wraps.

Enrollment

The ARP Public Option – PTF Accumulation scenario reflects the same enrollment assumptions as the ARP Baseline scenario plus the following assumptions:

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

  Starting with Scenario 1A and throughout this analysis, projected enrollment is based on a simple linear elasticity coefficient[24] of between -0.003 and -0.005, meaning that a 1% rate decrease will result in an approximately 0.3% to 0.5% increase in coverage take-up in the target enrollment population.[25] Table 19 shows the development of the enrollment increases based on the estimated size of the uninsured population in Nevada in 2026 that will have incomes near or above 400% FPL and the resulting elasticity coefficient.

Table 19
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 1A: ARP Public Option – PTF Accumulation
2026 Enrollment Elasticity – Members Above 400% FPL

		Scenario 1A
(a)	PO Appeal Enrollment Increase – Over 400%	400
(b)	Uninsured – Above 400% FPL	19,900
I =(a) / (b)	% Increased Assumed	2.0%
(d)	Premium Reduction	(4.0%)
(e) = (c) / (d)	Elasticity	-0.500

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

Table 20 shows the 10-year enrollment projection under Scenario 1A. Table 21 shows the change in enrollment from Scenario 1: ARP Baseline – No Waiver to Scenario 1A: ARP Public Option – PTF Accumulation.

[24] Elasticity is defined as a consumer's sensitivity to price changes in making purchasing decisions. An elasticity of -1.00 indicates that a 1% price decrease will result in 1% more eligible consumers purchasing coverage. Elasticity of 0.00 means price changes do not affect purchasing decisions at all. Elasticity between -1.00 and 0.00 means that consumers have at least some sensitivity to price changes. Moreover, elasticity is very likely different at different income levels. However, we use a simple linear mechanism that ignores the income level aspect of consumer behavior as the additional complexity does not add additional precision of results or change our conclusions. Moreover, we do not intend to be prescriptive by using a single elasticity coefficient across all of the waiver scenarios, only that the elasticities are reasonably within range of a published benchmark.

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

Table 20
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 1A: ARP Public Option – PTF Accumulation
Individual Market Enrollment by Segment

	On-Exchange			Off-Exchange	
Year	(1) PTC-Eligible	(2) Non-PTC-Eligible	(3) Total	(4) Total	(5) Total Individual Market
2026	117,900	4,000	121,900	15,600	137,500
2027	119,200	4,400	123,600	15,900	139,500
2028	120,700	4,600	125,300	16,200	141,500
2029	121,700	5,400	127,100	16,600	143,700
2030	123,900	4,900	128,800	16,800	145,600
2031	125,600	4,800	130,400	17,000	147,400
2032	127,300	4,800	132,100	17,200	149,300
2033	129,000	4,800	133,800	17,400	151,200
2034	131,000	4,500	135,500	17,700	153,200
2035	132,700	4,600	137,300	17,900	155,200
Average Annual Increase	**1.3%**	**1.6%**	**1.3%**	**1.5%**	**1.4%**

- The 2026 Total Individual Market enrollment shown in column (5) for the beginning of the 10-year deficit neutrality window is slightly higher than Table 8 in Section 2D above, which illustrates the development of the 2026 number from 2022, due to the expected additional enrollment from PO appeal.
- Column (1) enrollment increases due to population growth and some movement from column (2), as in the Baseline scenario.
- Under ARP, the annual change in Non-PTC Eligible in column (2) has a net effect. Enrollment in this category decreases due the income affordability limits under ARP not being indexed (as in the ARP Baseline scenario), but it increases due to the "Public Option Appeal" of lower prices to uninsured who do not qualify for PTCs.
- Column (4) increases relative to the Baseline scenario due to the "Public Option Appeal" as well.

The net total enrollment changes from ARP Baseline are shown in Table 21.

Table 21
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 1A: ARP Public Option – PTF Accumulation
Impact of PO on Individual Enrollment

Year	Change in PTC Eligible	Change in Non-PTC Eligible	Total Change
2026	200	200	400
2027	(200)	800	600
2028	(600)	1,400	800
2029	(1,400)	2,600	1,200
2030	(900)	2,200	1,300
2031	(1,000)	2,100	1,100
2032	(1,100)	2,200	1,100
2033	(1,100)	2,200	1,100
2034	(1,000)	2,100	1,100
2035	(1,100)	2,300	1,200

Table 21 shows that the PO is expected to increase the nonsubsidized enrollment as gross premiums will be cheaper and nonsubsidized consumers will reap the full savings of a PO offering (i.e., the "Public Option Appeal"). Subsidized enrollment is projected to decrease slightly as subsidies decrease under a PO environment and current enrollees with small subsidies no longer qualify.

Premiums

Scenario 1A: ARP Public Option – PTF Accumulation reflects the same premium assumptions as the ARP Baseline – No Waiver scenario for non-PO plans plus the following assumptions:

- *PO adoption rate:* New and existing individual market enrollment is assumed to shift into the PO due to lower gross prices for unsubsidized consumers and lower net premiums (i.e., after subsidy) for PTC-eligible consumers. Adoption of a PO plan is assumed to increase over the course of the first four program years and level out at 60% of the individual market in the PTF Accumulation scenarios. See comments in Section 3B above on PO take-up. The shift to the PO causes composite market-wide premiums to be lower, all else equal.

- *PO premium rate progression:* Table 22 assumes the reference premium increases by 4% annually in the first four years, and the PO discount relative to the reference premium is approximately 4%, 8%, 12%, and 16% in the first through fourth years of the program, respectively. (Note, this has the overall effect of keeping PO premiums mostly flat over this time.)

- *Morbidity of individual market:* Market morbidity is assumed to decrease (improve) slightly due to the increased enrollment as a result of the PO.

Table 22 shows the 10-year premium projection under Scenario 1A: ARP Public Option – PTF Accumulation for enrollees. Note, membership mix differences between the PO and non-PO mean the actual premium differences will not match the 4% annual targets.

Table 22
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 1A: ARP Public Option – PTF Accumulation
Summary of Enrollment and Premium by Public Option and Non-Public Option Segments

		Public Option		Non-Public Option		Total	
Year	Take-Up %	Enrollment	Premium	Enrollment	Premium	Enrollment	Premium
2026	40%	55,300	$574	82,200	$586	137,500	$581
2027	46%	63,900	$569	75,600	$608	139,500	$590
2028	55%	78,100	$565	63,400	$630	141,500	$594
2029	60%	86,200	$561	57,500	$653	143,700	$598
2030	60%	87,300	$583	58,300	$678	145,600	$621
2031	60%	88,400	$607	59,000	$706	147,400	$646
2032	60%	89,600	$631	59,700	$735	149,300	$672
2033	60%	90,700	$656	60,500	$764	151,200	$699
2034	60%	91,900	$683	61,300	$795	153,200	$727
2035	60%	93,100	$710	62,100	$826	155,200	$756

Subsidies

Premiums under the ARP Public Option – PTF Accumulation scenario reflect the same key assumptions as the ARP Baseline – No Waiver scenario plus the following assumptions:

- PO offerings become the SLCS plan across the state and achieve targeted savings relative to the reference premium and relative to the SLCS plan assumed in the ARP Baseline – No Waiver scenario. See additional discussion in Section 2B above related to the PO becoming the SLCS plan.

Table 23
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 1A: ARP Public Option – PTF Accumulation
Premiums and Member Subsidies Per Member Per Month (PMPM)

	On-Exchange					
	PTC-Eligible			Non-PTC-Eligible	Off-Exchange	Total Individual Market
Year	(1) Gross Premium	(2) APTC	(3) Enrollee Net Premium	(4) Enrollee Gross Premium	(5) Enrollee Gross Premium	(6) Gross Premium
2026	$601	$471	$130	$358	$503	$581
2027	$612	$467	$145	$340	$511	$590
2028	$616	$462	$154	$337	$515	$594
2029	$624	$460	$164	$297	$518	$598
2030	$645	$477	$168	$345	$538	$621
2031	$671	$498	$173	$371	$560	$646
2032	$697	$519	$178	$391	$582	$672
2033	$725	$541	$184	$412	$606	$699
2034	$752	$563	$189	$463	$630	$727
2035	$782	$587	$195	$477	$655	$756

Table 24
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 1A: ARP Public Option – PTF Accumulation
Change vs. Baseline in Premiums and Member Subsidies PMPM

	On-Exchange					
	PTC-Eligible			Non-PTC-Eligible	Off-Exchange	Total Individual Market
Year	(1) Gross Premium	(2) APTC	(3) Enrollee Net Premium	(4) Enrollee Gross Premium	(5) Enrollee Gross Premium	(6) Gross Premium
2026	(1.8%)	(4.6%)	10.3%	0.6%	(1.7%)	(1.7%)
2027	(3.7%)	(9.2%)	19.4%	(8.8%)	(4.0%)	(4.0%)
2028	(6.6%)	(13.5%)	22.8%	(12.9%)	(7.1%)	(7.1%)
2029	(9.1%)	(17.4%)	26.1%	(23.1%)	(10.1%)	(10.1%)
2030	(9.5%)	(17.7%)	25.7%	(15.7%)	(10.1%)	(10.2%)
2031	(9.6%)	(17.6%)	25.4%	(11.1%)	(10.1%)	(10.1%)
2032	(9.6%)	(17.5%)	25.4%	(10.2%)	(10.1%)	(10.1%)
2033	(9.6%)	(17.4%)	25.5%	(9.5%)	(10.1%)	(10.1%)
2034	(9.7%)	(17.4%)	25.2%	(1.7%)	(10.1%)	(10.1%)
2035	(9.7%)	(17.3%)	25.2%	(2.8%)	(10.1%)	(10.1%)

Commentary on Table 24:

- Gross Premiums in column (1) decline under Scenario 1A relative to the ARP Baseline – No Waiver scenario. The difference grows over time as PO discounts relative to both the reference premium and PO take-up increase through year 4 of the program.
- The change in APTCs in column (2) relative to the Baseline scenario tracks closely to the PO discounts relative to both the reference premium by year (as noted in Table 6 in Section 2D above) and to the Baseline SLCS plan, as expected.
- Enrollee Net Premiums in column (3) are increasing relative to the Baseline scenario, as we assume that only 60% of the individual market adopts the PO in year 4 and after. This implies that a subset of consumers' net premiums (after subsidy) will increase because they have not switched to the SLCS plan, which is assumed to be a PO offering. In this case, 40% of consumers are assumed to not enroll in a PO plan. The average net premium for subsidized members is sensitive to the PO take-up rate. If all consumers enroll in a PO plan, the Enrollee Net Premiums will be less than the Baseline scenario in each year. To illustrate how a higher PO adoption rate reduces the net member premium increase, Exhibits F-1 and F-2 in Appendix F present the same results as shown in Tables 23 and 24 assuming an 80% PO adoption rate.

Finally, we calculate the savings in premium tax credits (PTCs) by multiplying APTC PMPMs by membership for the Baseline and Scenario 1A, taking the difference in APTCs between the two scenarios, and adjusting for tax reconciliation.[26] The PTC membership under Scenario 1A reflects the decrease shown in Table 21 above due to some current enrollees with small subsidies who will no longer qualify.

Table 25
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 1A: ARP Public Option – PTF Accumulation
Impact of Public Option on Premium and Subsidies

	Scenario 1: Baseline – No Waiver			Scenario 1A: Public Option – PTF Accumulation			Change	
Year	PTC Membership	APTC PMPM	Annual APTC (thousands)	PTC Membership	APTC PMPM	Annual APTC (thousands)	Change in APTC	PTC Savings
2026	117,700	$494	$697,000	117,900	$471	$666,000	($31,000)	$28,000
2027	119,400	$514	$736,000	119,200	$467	$668,000	($68,000)	$61,000
2028	121,300	$534	$778,000	120,700	$462	$670,000	($108,000)	$97,000
2029	123,100	$556	$822,000	121,700	$460	$671,000	($151,000)	$136,000
2030	124,800	$580	$868,000	123,900	$477	$710,000	($158,000)	$142,000
2031	126,600	$604	$917,000	125,600	$498	$750,000	($167,000)	$150,000
2032	128,400	$629	$969,000	127,300	$519	$793,000	($176,000)	$158,000
2033	130,100	$655	$1,023,000	129,000	$541	$838,000	($185,000)	$167,000
2034	132,000	$682	$1,080,000	131,000	$563	$885,000	($195,000)	$176,000
2035	133,800	$711	$1,141,000	132,700	$587	$935,000	($206,000)	$185,000
	5-Year Waiver Window							$464,000
	10-Year Deficit Neutrality Window							$1,300,000
	5-Year Waiver Window – With 10% Margin							$418,000
	10-Year Deficit Neutrality Window – With 10% Margin							$1,170,000

We estimate the federal PTC savings under Scenario 1A: ARP Public Option – PTF Accumulation to be $418 million over the five-year waiver period and $1.2 billion over the 10-year deficit neutrality period.

As required by CMS, the federal subsidies under Scenario 1A: ARP Public Option – PTF Accumulation do not exceed the federal subsidies in the ARP Baseline – No Waiver scenario over the 10-year deficit neutrality period.

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

Scenario 1B: ARP Public Option – State Premium Wrap

This scenario reflects expected premiums, enrollment, and federal subsidies assuming the indefinite extension of ARP subsidies and the commencement of the PO in 2026, with additional premium subsidies funded by the State of Nevada starting in the second program year (2027). These additional subsidies are funded with pass-through funding from the 1332 waiver.

Enrollment

The ARP Public Option – State Premium Wrap scenario reflects the same key assumptions as the ARP Baseline scenario plus the following assumptions, which are described in more detail in Section 6 below:

- *"Public Option Appeal" increases unsubsidized enrollment*: Identical to Scenario 1A: ARP Public Option-PTF Accumulation, we assume unsubsidized enrollment will increase because unsubsidized consumers will absorb the full benefit of the cheaper gross premiums of a PO offering. See Table 19 for the enrollment elasticity development for this cohort.

- *Additional premium subsidies:* At the State of Nevada's direction, we assume additional premium subsidies will be targeted only toward lower-income enrollees who are not already fully subsidized due to ARP. The maximum enrollee premium costs by income level with the additional subsidies are shown in column (2) in Table 10. Based on projections of pass-through funding amounts available in the early years of the program, we assume these additional premium subsidies will be offered beginning in 2027 (not in 2026).

  We assume the additional premium subsidies will be available to enrollees in both PO and non-PO plans. See additional comments related to offering the state premium subsidy wrap broadly or only to PO enrollees in Section 3B above.

- *Incremental enrollment growth due to additional premium subsidies:* Uninsured Nevadans who are eligible for PTCs are expected to be further incentivized to enroll in the individual coverage due to the additional state premium subsidies that lower consumer-facing net premiums.

  Lower-income enrollees (0-150% FPL) are already fully subsidized due to the ARP subsidies, and higher-income enrollees (above 400% FPL) are not assumed to receive the additional subsidies funded by the State of Nevada. Therefore, we assume moderate enrollment increases at middle-income levels. See Table 10, column (2), for detailed affordability limits by income level underlying the assumed state premium subsidy wrap.

  Similar to the elasticity for the non-PTC-eligible uninsured (Table 19), we use a simple linear elasticity function to estimate individual market enrollment growth in the PTC-eligible caused by decreased net premiums from PO offerings becoming the SLCS plan. Table 26 shows the development of this coefficient using program year 2028. We use 2028 as we assume that the state premium subsidy wraps start in 2027 and peak in 2028.

Table 26
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 1B: ARP Public Option – State Premium Wrap
Illustrative 2028 Enrollment Elasticity With State Premium Wrap

		Scenario
		1B
(a)	Premium Wrap Enrollment Increase	7,300
(b)	Uninsured – PTC-Eligible	99,700
(c) =(a) / (b)	% Increased Assumed	7.3%
(d)	Average Premium Reduction	(24.1%)
(e) = (c) / (d)	Elasticity	-0.303

Tables 27 and 28 show the enrollment progression through the 10-year deficit neutrality window for Scenario 1B: ARP Public Option — State Premium Wrap.

Table 27
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 1B: ARP Public Option – State Premium Wrap
Individual Market Enrollment by Segment

	On-Exchange			Off-Exchange	
Year	(1) PTC-Eligible	(2) Non-PTC-Eligible	(3) Total	(4) Total	(5) Total Individual Market
2026	117,900	4,000	121,900	15,600	137,500
2027	122,700	4,400	127,100	15,900	143,000
2028	127,900	4,700	132,600	16,200	148,800
2029	129,000	5,400	134,400	16,600	151,000
2030	131,100	5,100	136,200	16,800	153,000
2031	133,100	4,900	138,000	17,000	155,000
2032	134,900	4,800	139,700	17,200	156,900
2033	136,700	4,800	141,500	17,400	158,900
2034	138,800	4,600	143,400	17,700	161,100
2035	140,600	4,600	145,200	17,900	163,100

Table 28
State of Nevada Public Option
Nevada Public Option Actuarial and Economic Analysis
Scenario 1B: ARP Public Option – State Premium Wrap
Impact of PO on Individual Enrollment

Year	Change in PTC-Eligible	Change in Non-PTC-Eligible	Total Change
2026	200	200	400
2027	3,300	800	4,100
2028	6,600	1,500	8,100
2029	5,900	2,600	8,500
2030	6,300	2,400	8,700
2031	6,500	2,200	8,700
2032	6,500	2,200	8,700
2033	6,600	2,200	8,800
2034	6,800	2,200	9,000
2035	6,800	2,300	9,100

Premiums

Scenario 1B: ARP Public Option – State Premium Wrap reflects the same premium assumptions as Scenario 1: ARP Baseline – No Waiver for non-PO plans plus the following assumptions:

- *PO adoption rate:* New and existing individual market enrollment is assumed to shift into the PO due to lower gross prices for unsubsidized consumers and lower net premiums (i.e., after subsidy) for PTC-eligible consumers relative to non-PO plans. Adoption of a PO plan is assumed to increase over the course of the first four program years and level out at 60% of the individual market in the State Premium Wrap scenarios. This is consistent with Scenario 1A because the premium subsidy wrap is available to all enrollees, regardless of whether they elect the PO. See additional comments in Section 3B above on PO take-up rates. The shift to the PO causes composite market-wide premiums to be lower, all else equal.

- *PO premium rate progression:* Consistent with Table 28 above, Table 29 assumes the reference premium increases by 4% annually in the first four years and the PO discount relative to the reference premium is approximately 4%, 8%, 12%, and 16% in the first through fourth years of the program, respectively.

- *Morbidity of individual market:* Market morbidity is assumed to decrease (improve) by a larger amount than in Scenario 1A due to the increased enrollment as a result of the state premium wrap.

Table 29 shows the 10-year premium projection under Scenario 1B: ARP Public Option – State Premium Wrap for enrollees. Note, membership mix differences between the PO and non-PO plans mean the actual premium differences will not match the 4% annual targets.

Table 29
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 1B: ARP Public Option – State Premium Wrap
Summary of Enrollment and Premium by Public Option and Non-Public Option Segments

	Public Option			Non-Public Option		Total Enrollment	
Year	Take-Up %	Enrollment	Premium	Enrollment	Premium	Enrollment	Premium PMPM
2026	40%	55,300	$574	82,200	$586	137,500	$581
2027	46%	65,700	$568	77,300	$608	143,000	$590
2028	55%	82,400	$564	66,400	$629	148,800	$593
2029	60%	90,900	$560	60,100	$653	151,000	$597
2030	60%	92,100	$582	60,900	$679	153,000	$621
2031	60%	93,300	$605	61,700	$706	155,000	$645
2032	60%	94,500	$629	62,400	$735	156,900	$672
2033	60%	95,700	$655	63,200	$765	158,900	$699
2034	60%	97,000	$681	64,100	$795	161,100	$726
2035	60%	98,200	$708	64,900	$827	163,100	$755

Subsidies

Premiums under Scenario 1B reflect the same key assumptions as the ARP Baseline scenario plus the following assumptions:

- PO offerings become the SLCS plan across the state and achieve targeted savings relative to the reference premium and relative to the SLCS plan assumed in the ARP Baseline. See additional discussion in Section 2D related to the PO becoming the SLCS plan.
- State premium subsidy wrap direct costs are not considered in Table 32 below as they are not a part of the deficit neutrality guardrail. However, the enrollment impact is detailed in the Enrollment section Tables 27 and 28 above and the corresponding increase in federal subsidies is considered in Table 32.
- For informational purposes, Table 30 does show the estimated PMPM State Premium Wrap in column (3). Also, column for shows consumer net premiums that includes the effect of the premium subsidy wrap.

Table 30
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 1B: ARP Public Option – State Premium Wrap
Premiums and Member Federal Subsidies Per Member Per Month (PMPM)

	On-Exchange					Off-Exchange	Total Individual Market
	PTC-Eligible				Non-PTC-Eligible		
Year	(1) Gross Premium	(2) APTC	(3) State Premium Wrap	(4) Enrollee Net Premiums	(5) Enrollee Gross Premiums	(6) Enrollee Gross Premiums	(7) Gross Premiums
2026	$601	$471	$0	$130	$358	$503	$581
2027	$611	$466	$32	$145	$340	$511	$590
2028	$615	$461	$34	$154	$330	$513	$593
2029	$622	$458	$35	$163	$298	$517	$597
2030	$644	$477	$36	$168	$332	$537	$621
2031	$669	$496	$37	$173	$365	$559	$645
2032	$695	$517	$38	$178	$392	$581	$672
2033	$723	$539	$39	$183	$413	$604	$699
2034	$750	$561	$39	$188	$454	$629	$726
2035	$780	$586	$40	$194	$478	$654	$755

Table 31
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 1B: ARP Public Option – State Premium Wrap
Change vs. Baseline in Premiums and Member Subsidies PMPM

	On-Exchange					
	PTC-Eligible			Non-PTC-Eligible	Off-Exchange	Total Individual Market
Year	(1) Gross Premium	(2) APTC	(3) Enrollee Net Premiums	(4) Enrollee Gross Premiums	(5) Enrollee Gross Premiums	(6) Gross Premiums
2026	(1.8%)	(4.6%)	10.3%	0.6%	(1.7%)	(1.7%)
2027	(3.9%)	(9.3%)	(7.4%)	(8.7%)	(4.1%)	(4.1%)
2028	(6.9%)	(13.7%)	(4.4%)	(14.5%)	(7.3%)	(7.2%)
2029	(9.4%)	(17.6%)	(1.3%)	(22.9%)	(10.3%)	(10.2%)
2030	(9.7%)	(17.8%)	(1.4%)	(18.8%)	(10.3%)	(10.3%)
2031	(9.8%)	(17.8%)	(1.6%)	(12.7%)	(10.3%)	(10.3%)
2032	(9.8%)	(17.7%)	(1.5%)	(10.0%)	(10.3%)	(10.2%)
2033	(9.8%)	(17.7%)	(1.2%)	(9.3%)	(10.3%)	(10.2%)
2034	(10.0%)	(17.7%)	(1.3%)	(3.6%)	(10.3%)	(10.2%)
2035	(10.0%)	(17.6%)	(1.2%)	(2.5%)	(10.3%)	(10.2%)

Table 32
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 1B: ARP Public Option – State Premium Wrap
Impact of Public Option on Premium and Subsidies

	Scenario 1: Baseline – No Waiver			Scenario 1B: Public Option – State Premium Wrap			Change	
Year	PTC Membership	APTC PMPM	Annual APTC (thousands)	PTC Membership	APTC PMPM	Annual APTC (thousands)	APTC Savings	PTC Savings
2026	117,700	$494	$697,000	117,900	$471	$666,000	($31,000)	$28,000
2027	119,400	$514	$736,000	122,700	$466	$686,000	($50,000)	$45,000
2028	121,300	$534	$778,000	127,900	$461	$708,000	($70,000)	$63,000
2029	123,100	$556	$822,000	129,000	$458	$709,000	($113,000)	$102,000
2030	124,800	$580	$868,000	131,100	$477	$750,000	($118,000)	$106,000
2031	126,600	$604	$917,000	133,100	$496	$792,000	($125,000)	$113,000
2032	128,400	$629	$969,000	134,900	$517	$837,000	($132,000)	$119,000
2033	130,100	$655	$1,023,000	136,700	$539	$885,000	($138,000)	$124,000
2034	132,000	$682	$1,080,000	138,800	$561	$935,000	($145,000)	$131,000
2035	133,800	$711	$1,141,000	140,600	$586	$988,000	($153,000)	$138,000
	5-Year Waiver Window							$344,000
	10-Year Deficit Neutrality Window							$969,000
	5-Year Waiver Window – With 10% Margin							$310,000
	10-Year Deficit Neutrality Window – With 10% Margin							$872,000

To illustrate how a higher PO adoption rate reduces the net member premium increase, Exhibits F-3 and F-4 in Appendix F present the same results as shown in Tables 30 and 31 assuming an 80% PO adoption rate.

Relative to the Scenario 1: ARP Baseline – No Waiver, Scenario 1B results in federal PTC savings of $310 million in the five-year waiver window and $872 million in the 10-year deficit neutrality window.

B. PROJECTED CHANGES IN PTCS WITHOUT ARP

All scenarios under the Without ARP framework assume the enhanced subsidies provided by ARP expire at the end of 2025.

Scenario 2: No ARP Baseline – No Waiver

Enrollment

The No ARP Baseline – No Waiver scenario reflects the same key assumptions as the ARP Baseline plus the following assumptions:

- *Enrollment decrease due to the expiration of ARP:* Individual market enrollment decreases by approximately 30,000 members between 2025 and 2026 due to the expiration of ARP. This brings the 2026 uninsured starting point higher as well. See Table 9 in Section 2E above for details on the enrollment movements across the Nevada markets from the expiration of the PHE and ARP.
- *Morbidity of individual market:* Market morbidity is assumed to increase (worsen) due to the exit of enrollees losing ARP subsidies. We assumed a 2.5% increase in morbidity.

Table 33 shows the 10-year enrollment projection under the No ARP Baseline – No Waiver scenario. The enrollment projection for enrollees on-exchange is further split between members with and without PTCs.

Table 33
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2: No ARP Baseline – No Waiver
Individual Market Enrollment by Segment

	On-Exchange			Off-Exchange	
Year	(1) PTC-Eligible	(2) Non-PTC-Eligible	(3) Total	(4) Total	(5) Total Individual Market
2026	83,100	8,000	91,100	15,400	106,500
2027	84,200	8,100	92,300	15,600	107,900
2028	85,500	8,000	93,500	15,800	109,300
2029	86,600	8,100	94,700	16,000	110,700
2030	87,800	8,200	96,000	16,200	112,200
2031	88,900	8,300	97,200	16,500	113,700
2032	90,100	8,300	98,400	16,700	115,100
2033	91,300	8,400	99,700	16,900	116,600
2034	92,500	8,500	101,000	17,100	118,100
2035	93,700	8,600	102,300	17,300	119,600
Average Annual Change	**1.3%**	**0.8%**	**1.3%**	**1.3%**	**1.3%**

- The 2026 Total Individual Market enrollment shown in column (5) for the beginning of the 10-year deficit neutrality window is consistent with Table 9 in Section 2E above, which illustrates the development of the 2026 number from 2022. Column (5) values beyond 2026 are projected with an underlying annual population growth estimate of 1.3% (within tolerance for rounding).
- Column (1) values increase due to population growth and for some movement from column (2).
- Under a non-ARP scenario, the non-PTC-eligible enrollment in column (2) increases, albeit at a slower rate than other segments. This is because federal poverty levels and the income affordability limits are indexed such that they increase slower than overall individual market premium growth; therefore, more people become eligible for at least some federal subsidy amounts and move to column (1). Note, these are the same mechanics as in the ARP Baseline scenario except that the income affordability limits are assumed to index

at about 0.05% of income per year (instead of not indexing at all and causing a decrease in non-PTC-eligible enrollees in the ARP Baseline scenario).

- Column (4) enrollees, like those in column (2), are not eligible for subsidies. However, we assume these enrollees to be significantly higher-income and, therefore, less likely to become eligible for subsidies in the same way column (2) enrollees would. Therefore, growth for that segment is solely due to underlying population growth.

- Finally, column (2) is higher (between 8,000 and 9,000) than in the ARP Baseline scenario (which is between 3,000 and 4,000) due to enrollees who qualify for subsidies under ARP, but upon expiration of ARP, no longer will.

Premiums

The following assumptions apply to projected premiums under Scenario 2: No ARP Baseline – No Waiver:

- *Non-PO premium trend:* Gross premiums for the individual market are projected with a 4% annual increase. See Section 6 below for a detailed description of the development of this factor.

Table 34 shows the statewide 10-year premium per member per month (PMPM) projection under the ARP Baseline – No Waiver scenario.

Table 34
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2: No ARP Baseline – No Waiver
Summary of Enrollment and Premiums

		Public Option		Non-Public Option		Total Enrollment	
Year	Public Option Take-Up %	Enrollment	Premium	Enrollment	Premium	Enrollment	Premium PMPM
2026	0%	0	0	106,500	$600	106,500	$600
2027	0%	0	0	107,900	$624	107,900	$624
2028	0%	0	0	109,300	$649	109,300	$649
2029	0%	0	0	110,700	$675	110,700	$675
2030	0%	0	0	112,200	$702	112,200	$702
2031	0%	0	0	113,700	$730	113,700	$730
2032	0%	0	0	115,100	$760	115,100	$760
2033	0%	0	0	116,600	$790	116,600	$790
2034	0%	0	0	118,100	$822	118,100	$822
2035	0%	0	0	119,600	$855	119,600	$855

Subsidies

The following assumptions apply to projected subsidies under the No ARP Baseline scenario:

- *FPL increases*: The 100% federal poverty level, used to calculate a PTC-eligible person's subsidy, is increased by 2.5% annually.

- *Income affordability limits*: These limits are indexed over time. We based our indexing on a conservative estimate of past indexing (i.e., generating less pass-through funding) projected into the 10-year deficit neutrality window. We assume the annual increase in the income affordability limits is approximately 0.05% of income per year.

Table 35
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2: No ARP Baseline – No Waiver
Premiums and Member Subsidies Per Member Per Month (PMPM)

	On-Exchange					
	PTC-Eligible			Non-PTC-Eligible	Off-Exchange	Total Individual Market
Year	(1) Gross Premium	(2) APTC	(3) Enrollee Net Premiums	(4) Enrollee Gross Premiums	(5) Enrollee Gross Premiums	(6) Gross Premiums
2026	$621	$441	$180	$563	$523	$600
2027	$646	$460	$186	$586	$544	$624
2028	$671	$479	$193	$612	$566	$649
2029	$698	$499	$199	$637	$589	$675
2030	$726	$520	$206	$662	$612	$702
2031	$755	$542	$213	$688	$637	$730
2032	$785	$565	$220	$719	$662	$760
2033	$817	$589	$227	$747	$689	$790
2034	$849	$614	$235	$778	$716	$822
2035	$883	$640	$243	$809	$745	$855

Note, Total Individual Market Gross Premiums in column (6) are consistent with Table 34 above. Table 36 illustrates the changes in each of the PMPM values in Table 35 above.

Table 36
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2: No ARP Baseline – No Waiver
Annual Changes in Gross Premiums, Subsidies, and Member Net Premiums

	On-Exchange					
	PTC-Eligible			Non-PTC-Eligible	Off-Exchange	Total Individual Market
Year	(1) Gross Premiums	(2) APTC	(3) Enrollee Net Premiums	(4) Enrollee Gross Premiums	(5) Enrollee Gross Premiums	(6) Gross Premiums
2026	-	-	-	-	-	-
2027	4.0%	4.2%	3.3%	4.0%	4.0%	4.0%
2028	3.9%	4.0%	3.7%	4.6%	4.0%	4.0%
2029	4.0%	4.3%	3.3%	4.0%	4.0%	4.0%
2030	3.9%	4.2%	3.3%	3.8%	4.0%	3.9%
2031	4.1%	4.3%	3.4%	4.0%	4.0%	4.0%
2032	4.0%	4.2%	3.5%	4.5%	4.0%	4.1%
2033	4.0%	4.2%	3.3%	3.9%	4.0%	4.0%
2034	4.0%	4.3%	3.3%	4.1%	4.0%	4.0%
2035	4.0%	4.3%	3.3%	4.0%	4.0%	4.0%

We note the following with regard to the annual changes illustrated in Table 36:

- Gross premiums, as noted earlier, are increasing at 4% per year (within tolerance for rounding), for both on-exchange enrollees and off-exchange enrollees.
- PTC-Eligible Enrolled Net Premiums in column (3) are indexed to federal poverty levels, which are assumed to increase at 2.5% per year, and to income affordability limits; therefore, the net premiums are increasing by less than gross premiums.
- APTCs, being the balancing item, are increasing more than gross premiums annually.

- Non-PTC-Eligible Enrollee Gross Premiums in column (4) are more volatile due to a changing mix of enrollees being modeled. Various enrollees will move from non-PTC-eligible to PTC-eligible over time as the income limits increase slower than premiums.

Scenario 2A: No ARP Public Option – PTF Accumulation

This scenario reflects expected premiums, enrollment, and federal subsidies assuming the expiration of the enhanced ARP subsidies and the commencement of the PO in 2026, with no state premium subsidy wraps.

Enrollment

Scenario 2A reflects the same key assumptions as the No ARP Baseline scenario described above plus the following assumptions:

- *"Public Option Appeal" increases unsubsidized enrollment*: Identical to Scenario 1A: ARP Public Option – PTF Accumulation, we use a simple linear elasticity model to project the increase in unsubsidized enrollment due to the price changes caused by the introduction of the PO. Table 37 shows the derivation of the effective elasticity coefficient for 2026.

Table 37
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2A: No ARP Public Option – PTF Accumulation
2026 Public Option Appeal Elasticity – Members Above 400% FPL

		Scenario 2A
(a)	PO Appeal Enrollment Increase – Over 400%	800
(b)	Uninsured – Above 400% FPL	27,100
I =(a) / (b)	% Increased Assumed	3.0%
(d)	Premium Reduction	(4.0%)
(e) = (c) / (d)	Elasticity	-0.737

- *Decrease in subsidized enrollment*: Subsidized enrollment decreases relative to the No ARP Baseline as the introduction of the PO lowers the SLCS plan and causes subsidies to drop. As a result, some enrollees (mainly younger and/or with higher incomes) will lose subsidies.

Tables 38 and 39 show the enrollment under Scenario 2A and the change versus the No ARP Baseline scenario, respectively.

Table 38
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2A: No ARP Public Option – PTF Accumulation
Individual Market Enrollment by Segment

	On-Exchange			Off-Exchange	
Year	(1) PTC-Eligible	(2) Non-PTC-Eligible	(3) Total	(4) Total	(5) Total Individual Market
2026	83,100	8,400	91,500	15,800	107,300
2027	83,500	9,400	92,900	16,200	109,100
2028	84,500	9,700	94,200	16,700	110,900
2029	85,600	10,000	95,600	17,100	112,700
2030	86,800	10,100	96,900	17,300	114,200
2031	87,900	10,200	98,100	17,600	115,700
2032	89,100	10,300	99,400	17,800	117,200
2033	90,200	10,500	100,700	18,000	118,700
2034	91,400	10,600	102,000	18,300	120,300
2035	92,700	10,600	103,300	18,500	121,800

Table 39
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2A: No ARP Public Option – PTF Accumulation
Impact of PO on Individual Enrollment

Year	Change in PTC-Eligible	Change in Non-PTC-Eligible	Total Change
2026	0	800	800
2027	(700)	1,900	1,200
2028	(1,000)	2,600	1,600
2029	(1,000)	3,000	2,000
2030	(1,000)	3,000	2,000
2031	(1,000)	3,000	2,000
2032	(1,000)	3,100	2,100
2033	(1,100)	3,200	2,100
2034	(1,100)	3,300	2,200
2035	(1,000)	3,200	2,200

We note the following related to Table 39:

- The non-PTC-eligible enrollment increase is larger relative to the Baseline scenario when comparing to Table 21 under the ARP scenario. This is because there is a larger pool of PTC-eligible uninsured for the PO to draw from if ARP ends.

Premiums

Scenario 2A: No ARP Public Option – PTF Accumulation reflects the same premium assumptions as the No ARP Baseline scenario for non-PO plans plus the following assumptions:

- *PO adoption rate:* New and existing individual market enrollment is assumed to shift into the PO due to lower gross prices for unsubsidized consumers and lower net premiums (i.e., after subsidy) for subsidized consumers who switch to a PO offering. Adoption of a PO plan is assumed to increase over the course of the first four program years and level out at 60% of the individual market. The shift to the PO causes composite market-wide premiums to be lower, all else equal.

  The adoption rate of PO plans is likely important for various other aspects of program management, provider satisfaction, and overall success of the program. For that reason, we assume adoption will be relatively high but that, for various reasons, a material percentage of the market may not choose a PO plan (in this case, 40%). The assumption of an ultimate rate of 60% is consistent with Appendix D assumptions related to impact of the provider participation requirement.

- *PO premium rate progression:* Consistent with Table 22 for Scenario 1A, Table 40 assumes the reference premium increases by 4% annually in the first four years and the PO discount relative to the reference premium is approximately 4%, 8%, 12%, and 16% in the first through fourth years of the program, respectively. Note, this has the overall effect of keeping PO premiums mostly flat over this time period (2026 through 2029), and then PO premiums increase at the rate of the reference premium increase, which is assumed to be equal to overall individual market premium growth.

- *Morbidity of individual market:* Assumed to decrease (improve) slightly due to the increased enrollment as a result of the PO.

Table 40 shows the 10-year premium projection for enrollees under Scenario 2A: No ARP Public Option – PTF Accumulation. Note, membership mix differences between the PO and non-PO plans mean the actual premium differences will not match the 4% annual targets.

Table 40
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2A: No ARP Public Option – PTF Accumulation
Summary of Enrollment and Premium

		Public Option		Non-Public Option		Total Enrollment	
Year	Take-Up %	Enrollment	Premiums	Enrollment	Premiums	Enrollment	Premiums PMPM
2026	39%	42,200	$585	65,100	$593	107,300	$590
2027	45%	49,000	$579	60,100	$614	109,100	$599
2028	54%	60,200	$574	50,700	$636	110,900	$603
2029	59%	66,500	$570	46,200	$660	112,700	$607
2030	59%	67,400	$592	46,800	$686	114,200	$631
2031	59%	68,300	$616	47,400	$714	115,700	$656
2032	59%	69,100	$641	48,100	$741	117,200	$682
2033	59%	70,000	$667	48,700	$771	118,700	$710
2034	59%	71,000	$693	49,300	$803	120,300	$738
2035	59%	71,900	$720	49,900	$836	121,800	$768

Subsidies

Premiums under the No ARP Public Option – PTF Accumulation scenario reflect the same key assumptions as the No ARP Baseline scenario plus the following assumptions:

- *PO offerings:* Become the SLCS plan across the state and achieve targeted savings relative to the reference premium and relative to the SLCS plan assumed in the No ARP Baseline scenario. See additional discussion in Section 2D above related to the PO becoming the SLCS plan.

Table 41
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2A: No ARP Public Option – PTF Accumulation
Premiums and Member Subsidies Per Member Per Month (PMPM)

	On-Exchange					
	PTC-Eligible			Non-PTC-Eligible	Off-Exchange	Total Individual
Year	Gross Premium PMPM	APTC PMPM	Enrollee Net Premium PMPM	Enrollee Gross Premium PMPM	Enrollee Gross Premium PMPM	Gross Premium PMPM
2026	$610	$418	$192	$551	$514	$590
2027	$625	$413	$212	$515	$523	$599
2028	$630	$406	$224	$519	$526	$603
2029	$635	$398	$237	$523	$529	$607
2030	$659	$415	$244	$545	$551	$631
2031	$686	$433	$253	$569	$573	$656
2032	$713	$451	$261	$594	$596	$682
2033	$742	$471	$271	$613	$619	$710
2034	$771	$492	$280	$640	$644	$738
2035	$801	$512	$289	$674	$670	$768

Table 42
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2A: No ARP Public Option – PTF Accumulation
Change vs. Baseline in Premiums and Member Subsidies PMPM

	On-Exchange					
	PTC-Eligible			Non-PTC-Eligible	Off-Exchange	Total Individual Market
Year	(1) Gross Premiums	(2) APTC Subsidies	(3) Enrollee Net Premiums	(4) Enrollee Gross Premiums	(5) Enrollee Gross Premiums	(6) Gross Premiums
2026	(1.7%)	(5.2%)	6.9%	(2.2%)	(1.7%)	(1.8%)
2027	(3.2%)	(10.1%)	14.1%	(12.0%)	(4.0%)	(4.1%)
2028	(6.1%)	(15.2%)	16.5%	(15.3%)	(7.1%)	(7.2%)
2029	(9.1%)	(20.2%)	18.9%	(17.9%)	(10.1%)	(10.2%)
2030	(9.1%)	(20.2%)	18.9%	(17.6%)	(10.1%)	(10.2%)
2031	(9.1%)	(20.2%)	19.0%	(17.3%)	(10.1%)	(10.2%)
2032	(9.2%)	(20.1%)	18.8%	(17.4%)	(10.1%)	(10.2%)
2033	(9.1%)	(20.0%)	19.0%	(17.9%)	(10.1%)	(10.2%)
2034	(9.2%)	(20.0%)	19.1%	(17.7%)	(10.1%)	(10.2%)
2035	(9.3%)	(20.0%)	19.1%	(16.6%)	(10.1%)	(10.2%)

Comments on Table 42:

- Gross Premiums in column (1) decline under Scenario 2A relative to the No ARP Baseline – No Waiver scenario. The difference grows over time by increasing amounts as PO discounts relative to both the reference premium and PO take-up increase through year 4 of the program.
- Subsidies in column (2) decline by 20.2% by year 4 of the program, as compared to Scenario 1A where subsidies decreased by approximately 17.4%. The reason for this difference is that under a non-ARP situation, subsidies are lower and the fixed-cost leveraging effect of reducing subsidies due to the PO is greater, producing a large decrease.
- Changes in APTCs in column (2) relative to the Baseline scenario track closely to the PO discounts to both the reference premium by year (as noted in Table 6 in Section 2D above) and the Baseline SLCS plan, as expected.
- Enrollee Net Premiums in column (3) are increasing relative to the Baseline scenario as we assume that only 60% of the individual market adopts the PO in year 4 and after. This implies that a subset of consumers' net premiums (after subsidy) will increase because they have not switched to the SLCS plan assumed to be a PO offering. In this case, 40% of consumers are assumed to not enroll in a PO plan. If all consumers enroll in a PO plan, the Enrollee Net Premiums will be less than the baseline in each year. To illustrate how a higher PO adoption rate reduces the net member premium increase, Exhibits F-5 and F-6 in Appendix F present the same results as shown in Tables 41 and 42 assuming an 80% PO adoption rate.

Finally, we calculate the savings in premium tax credits (PTCs) by multiplying APTC PMPMs by membership for the Baseline scenario and Scenario 2A, taking the difference in APTCs between the two scenarios, and adjusting for tax reconciliation. The PTC membership under Scenario 2A reflects the decrease shown in Table 39 due to some current enrollees with small subsidies no longer qualifying.

Table 43
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2A: No ARP Public Option – PTF Accumulation
Impact of Public Option on Premium and Subsidies

	Scenario 2: Baseline – No Waiver			Scenario 2A: No ARP Public Option With PTF Accumulation			Change	
Year	PTC Membership	APTC PMPM	Annual APTC (thousands)	PTC Membership	APTC PMPM	Annual APTC (thousands)	APTC Savings (thousands)	PTC Savings (thousands)
2026	83,100	$441	$440,000	83,100	$418	$417,000	($23,000)	$21,000
2027	84,200	$460	$465,000	83,500	$413	$414,000	($51,000)	$46,000
2028	85,500	$479	$491,000	84,500	$406	$412,000	($79,000)	$71,000
2029	86,600	$499	$519,000	85,600	$398	$409,000	($110,000)	$99,000
2030	87,800	$520	$548,000	86,800	$415	$432,000	($116,000)	$104,000
2031	88,900	$542	$579,000	87,900	$433	$457,000	($122,000)	$110,000
2032	90,100	$565	$611,000	89,100	$451	$483,000	($128,000)	$115,000
2033	91,300	$589	$646,000	90,200	$471	$510,000	($136,000)	$122,000
2034	92,500	$614	$682,000	91,400	$492	$539,000	($143,000)	$129,000
2035	93,700	$640	$720,000	92,700	$512	$570,000	($150,000)	$135,000
	5-Year Waiver Window							$341,000
	10-Year Deficit Neutrality Window							$952,000
	5-Year Waiver Window – With 10% Margin							$307,000
	10-Year Deficit Neutrality Window – With 10% Margin							$857,000

We estimate the federal PTC savings under Scenario 2A: No ARP Public Option – PTF Accumulation to be $307 million over the five-year waiver period and $857 million over the 10-year deficit neutrality period.

As required by CMS, the federal subsidies under Scenario 2A: No ARP Public Option – PTF Accumulation do not exceed the federal subsidies in the No ARP Baseline – No Waiver scenario over the 10-year deficit neutrality period.

Scenario 2B: No ARP Public Option – State Premium Wrap

This scenario reflects expected premiums, enrollment, and federal subsidies, assuming the expiration of the enhanced ARP subsidies and the commencement of the PO in 2026, with additional premium subsidies funded by the State of Nevada for PO enrollees starting in program year 2 (2027). These additional subsidies are funded with pass-through funding from the 1332 waiver.

Enrollment

The No ARP Public Option – State Premium Wrap scenario reflects the same key assumptions as the No ARP Baseline scenario plus the following assumptions:

- *"Public Option Appeal" increases unsubsidized enrollment*: Identical to Scenario 1A: ARP Public Option – PTF Accumulation, because unsubsidized consumers will absorb the full benefit of lower premiums from a PO offering, we assume those uninsured who are not eligible for PTCs will see more value in enrolling and enrollment will increase relative to the Baseline. See Table 37 for the enrollment elasticity development for this cohort.

- *Additional premium subsidies:* At the State of Nevada's direction, we assumed additional premium subsidies will be targeted toward lower-income enrollees in PO plans. We assumed the additional premium subsidies will be available only to all PTC-eligible individual market enrollees. See additional comments related to offering the state premium subsidy wrap broadly or only to PO enrollees in Section 3B above.

  The maximum PO enrollee premium costs as a percentage of income with the additional subsidies are shown in Table 10. These subsidies are directed at the lowest income levels under 400% FPL as the intent would

be, to the extent possible, to replace ARP subsidies. Based on our estimates of available pass-through funding, we assume these additional premium subsidies will be offered beginning in 2027.

- *Incremental enrollment growth due to additional premium subsidies:* In addition to the unsubsidized enrollment growth noted above, uninsured Nevadans who are eligible for premium subsidies but not taking up coverage are expected to be more incentivized, relative to the Baseline scenario, to enroll in the individual coverage due to the lower net premiums (post-subsidy) made possible by the state Premium Wrap. Table 44 shows the implied elasticity of unsubsidized enrollees in this scenario.

Table 44
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2B: No ARP Public Option – State Premium Wrap
Illustrative 2028 Enrollment Elasticity with State Premium Wrap

		Scenario 2B
(a)	Premium Wrap Enrollment Increase	9,900
(b)	Uninsured – PTC-Eligible	116,200
(c) =(a) / (b)	% Increased Assumed	8.5%
(d)	Average Premium Reduction	(37.8%)
(e) = (c) / (d)	Elasticity	-0.226

Tables 45 and 46 illustrate enrollment in the individual market over the 10-year deficit neutrality window and the change in enrollment from the No ARP Baseline scenario, respectively.

Table 45
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2B: No ARP Public Option – State Premium Wrap
Individual Market Enrollment by Segment

	On-Exchange			Off-Exchange	
Year	(1) PTC-Eligible	(2) Non-PTC-Eligible	(3) Total	(4) Total	(5) Total Individual Market
2026	83,100	8,400	91,500	15,800	107,300
2027	88,000	9,600	97,600	16,200	113,800
2028	94,000	10,100	104,100	16,700	120,800
2029	94,400	11,300	105,700	17,100	122,800
2030	96,500	10,600	107,100	17,300	124,400
2031	97,800	10,600	108,400	17,600	126,000
2032	99,100	10,800	109,900	17,800	127,700
2033	100,400	10,900	111,300	18,000	129,300
2034	101,700	11,000	112,700	18,300	131,000
2035	103,100	11,100	114,200	18,500	132,700

Table 46
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2B: No ARP Public Option – State Premium Wrap
Impact of PO on Individual Enrollment

Year	Change in PTC Eligible	Change in Non-PTC Eligible	Total Change
2026	-	800	800
2027	3,800	2,100	5,900
2028	8,500	3,000	11,500
2029	7,800	4,300	12,100
2030	8,700	3,500	12,200
2031	8,900	3,400	12,300
2032	9,000	3,600	12,600
2033	9,100	3,600	12,700
2034	9,200	3,700	12,900
2035	9,400	3,700	13,100

Premiums

Scenario 2B: No ARP Public Option – PTF Accumulation reflects the same premium assumptions as Scenario 2A.

Scenario 2B: No ARP Public Option – State Premium Wrap reflects the same premium assumptions as Scenario 2.

No ARP Baseline – No Waiver for non-PO plans plus the following assumptions:

- *PO premium rate progression:* Consistent with Table 46, Table 47 assumes the reference premium increases by 4% annually in the first four years and the PO discount relative to the reference premium is approximately 4%, 8%, 12%, and 16% in the first through fourth years of the program, respectively.

Table 47 shows the 10-year premium projection under Scenario 2B: No ARP Public Option – State Premium Wrap for enrollees. Note, membership mix differences between the PO and non-PO plans mean the actual premium differences will not match the 4% annual targets.

Table 47
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2B: No ARP Public Option – State Premium Wrap
Summary of Enrollment and Premium

		Public Option		Non-Public Option		Total Enrollment	
Year	Take-Up %	Enrollment	Premiums	Enrollment	Premiums	Enrollment	Premiums PMPM
2026	39%	42,200	$585	65,100	$593	107,300	$590
2027	45%	51,600	$577	62,200	$616	113,800	$598
2028	55%	66,500	$570	54,300	$641	120,800	$602
2029	60%	73,500	$566	49,300	$664	122,800	$605
2030	60%	74,400	$589	50,000	$689	124,400	$629
2031	60%	75,400	$612	50,600	$718	126,000	$655
2032	60%	76,400	$637	51,300	$746	127,700	$681
2033	60%	77,400	$662	51,900	$777	129,300	$708
2034	60%	78,400	$689	52,600	$808	131,000	$737
2035	60%	79,400	$716	53,300	$840	132,700	$766

Subsidies

Premiums under the No ARP Public Option – State Premium Wrap scenario reflect the same key assumptions as the No ARP Baseline scenario plus the following assumptions:

- PO offerings become the SLCS plan across the state and achieve targeted savings relative to the reference premium and relative to the SLCS plan assumed in the No ARP Baseline scenario. See additional discussion in Section 2D above related to the PO becoming the SLCS plan.
- State premium subsidy wrap direct costs are not considered in Table 50 below as they are not a part of the deficit neutrality guardrail. However, the enrollment impact is detailed in the Enrollment section Tables 45 and 46 above and the corresponding increase in federal subsidies is considered in Table 50.
- For informational purposes, Table 48 does show the estimated PMPM State Premium Wrap in column (3). Also, column (4) shows consumer net premiums that include the effect of the premium subsidy wrap.

Table 48
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2B: No ARP Public Option – State Premium Wrap
Premiums and Member Federal Subsidies Per Member Per Month (PMPM)

	On-Exchange					Off-Exchange	Total Individual Market
	PTC-Eligible				Non-PTC-Eligible		
Year	(1) Gross Premiums	(2) APTC	(3) State Premium Wrap	(4) Enrollee Net Premiums	(5) Enrollee Gross Premiums	(6) Enrollee Gross Premiums	(7) Gross Premiums
2026	$610	$418	$0	$192	$551	$514	$590
2027	$624	$414	$27	$183	$514	$522	$598
2028	$628	$407	$28	$193	$519	$524	$602
2029	$637	$403	$29	$205	$481	$527	$605
2030	$656	$416	$29	$211	$540	$548	$629
2031	$682	$434	$30	$218	$569	$570	$655
2032	$709	$452	$31	$226	$589	$593	$681
2033	$737	$472	$32	$234	$614	$616	$708
2034	$767	$492	$33	$242	$641	$641	$737
2035	$797	$513	$33	$251	$670	$667	$766

Table 49
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2B: No ARP Public Option – State Premium Wrap
Change vs. Baseline in Premiums and Member Subsidies PMPM

	On-Exchange				Off-Exchange	Total Individual Market
	PTC-Eligible			Non-PTC-Eligible		
Year	(1) Gross Premium	(2) APTC	(3) Enrollee Net Premiums	(4) Enrollee Gross Premiums	(5) Enrollee Gross Premiums	(6) Gross Premiums
2026	(1.7%)	(5.2%)	10.3%	(2.2%)	(1.7%)	(1.8%)
2027	(3.3%)	(10.1%)	(7.4%)	(12.2%)	(4.1%)	(4.2%)
2028	(6.5%)	(15.0%)	(4.4%)	(15.3%)	(7.5%)	(7.3%)
2029	(8.8%)	(19.3%)	(1.3%)	(24.5%)	(10.5%)	(10.4%)
2030	(9.6%)	(20.0%)	(1.4%)	(18.3%)	(10.5%)	(10.4%)
2031	(9.7%)	(20.0%)	(1.6%)	(17.2%)	(10.5%)	(10.3%)
2032	(9.7%)	(20.0%)	(1.5%)	(18.1%)	(10.5%)	(10.5%)
2033	(9.7%)	(19.9%)	(1.2%)	(17.7%)	(10.5%)	(10.4%)
2034	(9.7%)	(19.9%)	(1.3%)	(17.5%)	(10.5%)	(10.4%)
2035	(9.8%)	(19.9%)	(1.2%)	(17.2%)	(10.5%)	(10.4%)

Table 50
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2B: No ARP Public Option – State Premium Wrap
Impact of Public Option on Premium and Subsidies

Year	Scenario 2: Baseline – No Waiver			Scenario 2B: Public Option – State Premium Wrap			Change	
	PTC Membership	APTC PMPM	Annual APTC (thousands)	PTC Membership	APTC PMPM	Annual APTC (thousands)	APTC Savings	PTC Savings
2026	83,100	$441	$440,000	83,100	$418	$417,000	($23,000)	$21,000
2027	84,200	$460	$465,000	88,000	$414	$437,000	($28,000)	$25,000
2028	85,500	$479	$491,000	94,000	$407	$459,000	($32,000)	$29,000
2029	86,600	$499	$519,000	94,400	$403	$456,000	($63,000)	$57,000
2030	87,800	$520	$548,000	96,500	$416	$482,000	($66,000)	$59,000
2031	88,900	$542	$579,000	97,800	$434	$509,000	($70,000)	$63,000
2032	90,100	$565	$611,000	99,100	$452	$538,000	($73,000)	$66,000
2033	91,300	$589	$646,000	100,400	$472	$568,000	($78,000)	$70,000
2034	92,500	$614	$682,000	101,700	$492	$601,000	($81,000)	$73,000
2035	93,700	$640	$720,000	103,100	$513	$635,000	($85,000)	$77,000
	5-Year Waiver Window							$191,000
	10-Year Deficit Neutrality Window							$540,000
	5-Year Waiver Window - With 10% Margin							$172,000
	10-Year Deficit Neutrality Window - With 10% Margin							$486,000

To illustrate how a higher PO adoption rate reduces the net member premium increase, Exhibits F-7 and F-8 in Appendix F present the same results as shown in Tables 48 and 49 assuming an 80% PO adoption rate.

Relative to Scenario 2A: No ARP Public Option – PTF Accumulation, the State Premium Wrap scenario results in federal PTC savings of $172 million in the five-year waiver window and the $486 million in the 10-year deficit neutrality window.

VI. DATA AND METHODOLOGY

DATA SOURCES AND ADJUSTMENTS

Health care coverage and enrollment

The Silver State Health Insurance Exchange provided 2022 enrollment data as of March 2022. The exchange data included the following elements:

- Exchange individual identifier
- Household case identifier
- Federal poverty level (FPL) percentage
- Age
- ZIP Code
- County
- Plan level
- Net premium
- Advance premium tax credit (APTC) amount
- Health Insurance Oversight System (HIOS) issuer identifier
- CMS plan identifier
- Relationship to subscriber
- Enrollee status
- Second lowest cost silver (SLCS) plan premium amount
- Status start date
- Status end date
- Last update date
- Flags for the following:
  - Active re-enrollees
  - Automatic re-enrollees
  - Total re-enrollees
  - New consumers
  - Total enrollees

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

In our review, we noticed irregularities in the SLCS plan premium amount by member for contracts with more than one member. We accounted for this by mapping in each member's and contract's total SLCS plan premium amount from the publicly available Public Use Files (PUFs) based on their county. We also excluded a minimal amount of membership with invalid or missing entries for key fields such as county, age, and premium.

The exchange data represented a snapshot as of March 2022, and thus will not match the full year 2022 due to new enrollment, terminations, and midyear plan changes, among other reasons. We did account for membership that terminated prior to March 2022.

Publicly available data

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

Other

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

METHODOLOGY

We summarize the 2022 exchange enrollment and premium information to create a baseline, grouped by metallic, rating area, age band, FPL, and contract size to produce approximately 3,000 model cells. In 2022, we calculate subsidies based on the member's selected premium, premium of SLCS plan available, household FPL, and current premium limits (based on the expanded ARP levels). For 2023 through 2035, we project enrollment and premium increases for each scenario, and calculate the corresponding subsidies for each model cell. The following sections provide further detail on the assumptions for enrollment and premium changes.

Based on each scenario's ACA premium limits, we calculate revised subsidies for each model cell and year. The difference between the total subsidies in each PO scenario is compared to the corresponding baseline scenario to calculate the estimated pass-through funding.

Enrollment assumptions

Population-driven enrollment growth

We assume the exchange will grow by the population growth rate, at a minimum. The population of the State of Nevada is assumed to grow 1.3% annually after 2022.[27]

Enrollment growth due to expiration of the PHE

We assume exchange enrollment will increase in each income level between 2022 and 2026 due to the expiration of the PHE, as shown in Table 51. First, we estimated the total membership at each income level that we expect to lose Medicaid coverage upon expiration of the PHE by reviewing growth in Nevada Medicaid enrollment since the PHE started compared to pre-PHE enrollment. Although Medicaid disenrollment after the end of the PHE will impact all income levels and eligibility groups, we expect the impact to be greater for higher-income members and for the Childless Adults eligibility group. For each cohort, we estimate the percentage that will take up group coverage, individual exchange coverage, or go uninsured upon disenrollment from Medicaid. We expect higher-income individuals will be more likely to have commercial group insurance available, and less likely to enter the individual market.

Table 51 State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Modeling Assumptions
Individual Market Enrollment Increase Due to Expiration of the PHE

Income (% FPL)	Member Increase
Under 100%	302
100 to 133%	1,277
133 to 150%	1,993
150 to 200%	3,401
200 to 250%	4,032
250 to 300%	2,426
300 to 400%	1,026
Over 400%	1,243
Total	**15,700**

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

Enrollment decrease due to the expiration of ARP

We assume exchange enrollment will increase in each income level between 2022 and 2026 due to the expiration of ARP, as shown in Table 52. To develop these assumptions, we estimated the increase in members due to ARP by measuring the 2021 and 2022 increases in enrollment. We assume that a relatively comparable number of members will disenroll due to the expiration of ARP.

Table 52
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Modeling Assumptions
Enrollment Decrease Due to Expiration of ARP

Income (% FPL)	Member Decrease
Under 100%	1,487
100 to 133%	2,617
133 to 150%	6,381
150 to 200%	5,402
200 to 250%	4,757
250 to 300%	4,117
300 to 400%	2,582
Over 400%	2,800
Total	**30,143**

Incremental enrollment growth due to additional premium subsidies

We assume the additional premium subsidies in the State Premium Wrap scenarios will result in incremental enrollment growth. Because enrollment growth in the Silver State Individual Health Exchange was higher in the second year after the additional ARP subsidies were introduced than the first year and outreach and marketing efforts may take time to reach the appropriate groups, we believe it is reasonable to assume the enrollment increase due to the PO may not all occur in the first year. Therefore, we assume this enrollment growth will be spread over two years. The assumed total enrollment growth due to PO appeal under each ARP framework is shown by income level in Table 53.

Table 53
State of Nevada
Nevada Public Option Actuarial and Economic Analysis

	State Premium Wrap Enrollment Impact	
	With ARP	Without ARP
Under 100%	0%	38%
100 to 133%	0%	30%
133 to 150%	0%	23%
150 to 200%	9%	16%
200 to 250%	11%	6%
250 to 300%	7%	0%
300 to 400%	3%	0%
Over 400%	0%	0%

Premium assumptions

Consumer Price Index – Medical

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

Non-PO premium increases

From 2018 through 2022, the average annual change in SLCS plan premiums on the individual exchange is -1.58% nationwide (decreasing each year) and -2.0% in Nevada[28] (decreasing in three of the four years). The actual annual percentage changes fluctuated widely in many states during this time due to market circumstances that are not expected to recur. Therefore, we do not assume the recent decreases and fluctuations in exchange premiums will continue in the future.

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

Morbidity changes due to the expiration of the PHE

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

Morbidity changes due to the expiration of ARP

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

Demographic and distribution assumptions

PO adoption rate

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

Subsidized members under 100% FPL

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

Income levels

The FPL in 2021 and 2022 is $12,880 and $13,590.29, respectively. For modeling purposes, we assume all enrollees in each income level have the same FPL percentage, based on the approximate distribution of 2022 exchange enrollment within each bucket. The modeled FPL percentages for 2022 in each bucket are shown in Table 54.

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

[29] Office of the Assistant Secretary for Planning and Evaluation (ASPE). Prior HHS Poverty Guidelines and Federal Register References. Retrieved November 9, 2022, from https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines/prior-hhs-poverty-guidelines-federal-register-references.

Table 54
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Modeling Assumptions
Modeled Household Income Levels

Income (% FPL)	Modeled FPL %	Modeled 2022 Household Income
Under 100%	100.0%	less than $13,590
100 to 133%	120.0%	$16,308
133 to 150%	142.0%	$19,298
150 to 200%	180.0%	$24,462
200 to 250%	230.0%	$31,257
250 to 300%	280.0%	$38,052
300 to 400%	355.0%	$48,245
Over 400%	625.0%	$84,938

FPL increases

We assume the FPL will increase each year with trend. The FPL is assumed to increase by 6% in 2023 due to recent inflation trends, and 2.5% every year after, based on CMS projections.

ACA affordability limits

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

EXHIBITS

Exhibit 1A.1
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 1A: ARP Public Option - PTF Accumulation
Individual Market Composite Monthly Premium

Year	Baseline	Waiver	Difference
2026	$591.08	$580.87	-1.7%
2027	$614.64	$590.03	-4.0%
2028	$639.24	$594.02	-7.1%
2029	$664.93	$597.53	-10.1%
2030	$691.74	$621.23	-10.2%
2031	$719.18	$646.42	-10.1%
2032	$747.90	$672.27	-10.1%
2033	$777.88	$699.25	-10.1%
2034	$808.64	$727.36	-10.1%
2035	$841.30	$756.29	-10.1%

Exhibit 1A.2
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 1A: ARP Public Option - PTF Accumulation
Individual Market Changes in SLCS Plan Monthly Premium from 1332 Waiver Implementation

	21-Year Old Monthly Premium				40-Year Old Monthly Premium			
Year	Baseline	Waiver	Difference	Percent Change	Baseline	Waiver	Difference	Percent Change
2026	$348.67	$334.59	-$14.08	-4.0%	$445.60	$427.61	-$17.99	-4.0%
2027	$362.62	$332.59	-$30.03	-8.3%	$463.42	$425.05	-$38.37	-8.3%
2028	$377.12	$330.93	-$46.19	-12.2%	$481.96	$422.93	-$59.03	-12.2%
2029	$392.21	$329.28	-$62.92	-16.0%	$501.24	$420.83	-$80.41	-16.0%
2030	$407.89	$342.46	-$65.44	-16.0%	$521.29	$437.66	-$83.63	-16.0%
2031	$424.21	$356.15	-$68.06	-16.0%	$542.14	$455.16	-$86.98	-16.0%
2032	$441.18	$370.40	-$70.78	-16.0%	$563.83	$473.37	-$90.46	-16.0%
2033	$458.83	$385.22	-$73.61	-16.0%	$586.38	$492.31	-$94.07	-16.0%
2034	$477.18	$400.62	-$76.55	-16.0%	$609.83	$512.00	-$97.84	-16.0%
2035	$496.27	$416.65	-$79.62	-16.0%	$634.23	$532.48	-$101.75	-16.0%

Exhibit 1A.3
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 1A: ARP Public Option - PTF Accumulation
Individual Market Estimated Enrollees: 2026 through 2035 by FPL

Total Enrollment by FPL % - Baseline

Income Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Under 100%	3,170	3,210	3,250	3,300	3,340	3,380	3,430	3,470	3,520	3,560
100 to 133%	6,710	6,790	6,880	6,970	7,060	7,150	7,250	7,340	7,440	7,530
133 to 150%	20,680	20,940	21,220	21,490	21,770	22,060	22,340	22,630	22,930	23,220
150 to 200%	27,850	28,210	28,580	28,950	29,320	29,700	30,090	30,480	30,880	31,280
200 to 250%	24,340	24,650	24,970	25,300	25,630	25,960	26,300	26,640	26,990	27,340
250 to 300%	22,270	22,560	22,860	23,150	23,460	23,760	24,070	24,380	24,700	25,020
300 to 400%	11,960	12,110	12,270	12,430	12,590	12,760	12,920	13,090	13,260	13,430
Over 400%	20,120	20,390	20,650	20,920	21,190	21,470	21,750	22,030	22,320	22,610
Total Individual	137,090	138,870	140,680	142,510	144,360	146,240	148,140	150,070	152,020	153,990

Total Enrollment by FPL % - With Waiver

Income Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Under 100%	3,180	3,220	3,270	3,320	3,360	3,400	3,450	3,490	3,540	3,580
100 to 133%	6,710	6,800	6,890	6,980	7,070	7,160	7,250	7,350	7,440	7,540
133 to 150%	20,680	20,950	21,230	21,510	21,790	22,070	22,360	22,650	22,940	23,240
150 to 200%	27,870	28,250	28,630	29,020	29,400	29,780	30,170	30,560	30,950	31,360
200 to 250%	24,360	24,690	25,020	25,360	25,690	26,020	26,360	26,700	27,050	27,400
250 to 300%	22,300	22,600	22,910	23,220	23,520	23,830	24,140	24,450	24,770	25,090
300 to 400%	12,050	12,250	12,460	12,670	12,840	13,000	13,170	13,340	13,520	13,690
Over 400%	20,380	20,770	21,170	21,580	21,860	22,150	22,430	22,720	23,020	23,320
Total Individual	137,530	139,540	141,580	143,650	145,520	147,410	149,330	151,270	153,230	155,230

Change in Enrollment Due to Waiver

Income Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Under 100%	10	10	20	20	20	20	20	20	20	20
100 to 133%	0	10	10	10	10	10	0	10	0	10
133 to 150%	0	10	10	20	20	10	20	20	10	20
150 to 200%	20	40	50	70	80	80	80	80	70	80
200 to 250%	20	40	50	60	60	60	60	60	60	60
250 to 300%	30	40	50	70	60	70	70	70	70	70
300 to 400%	90	140	190	240	250	240	250	250	260	260
Over 400%	260	380	520	660	670	680	680	690	700	710
Total Individual	440	670	900	1,140	1,160	1,170	1,190	1,200	1,210	1,240

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

Exhibit 1A.4
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 1A: ARP Public Option - PTF Accumulation
Individual Market Estimated Enrollees: 2026 through 2035 by Metal

Total Enrollment by Metal - Baseline

Plan Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Catastrophic	810	820	830	840	850	870	880	890	900	910
Bronze	54,580	55,280	56,000	56,730	57,470	58,220	58,970	59,740	60,520	61,300
Silver	75,570	76,550	77,550	78,550	79,580	80,610	81,660	82,720	83,800	84,880
Gold	6,140	6,220	6,300	6,380	6,460	6,550	6,630	6,720	6,800	6,890
Total Individual	137,090	138,870	140,680	142,510	144,360	146,240	148,140	150,070	152,020	153,990

Total Enrollment by Metal - With Waiver

Plan Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Catastrophic	810	820	830	840	850	870	880	890	900	910
Bronze	54,830	55,680	56,540	57,410	58,160	58,910	59,680	60,450	61,240	62,040
Silver	75,710	76,770	77,840	78,930	79,960	81,000	82,050	83,120	84,200	85,290
Gold	6,160	6,250	6,340	6,440	6,520	6,610	6,690	6,780	6,870	6,960
Total Individual	137,520	139,520	141,560	143,620	145,490	147,380	149,300	151,240	153,210	155,200

Change in Enrollment Due to Waiver

Plan Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Catastrophic	0	0	0	0	0	0	0	0	0	0
Bronze	250	400	540	680	690	690	710	710	720	740
Silver	140	220	290	380	380	390	390	400	400	410
Gold	20	30	40	60	60	60	60	60	70	70
Total Individual	430	650	880	1,110	1,130	1,140	1,160	1,170	1,190	1,210

** Changes at the Metal level may not sum to the Total due to rounding.*

Exhibit 1A.5
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 1A: ARP Public Option - PTF Accumulation
Individual Market Estimated Enrollees: 2026 through 2035 by Age Group

Total Enrollment by Age Group - Baseline

Age Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
0-14	17,000	17,220	17,440	17,670	17,900	18,130	18,370	18,610	18,850	19,090
14-20	7,460	7,560	7,660	7,760	7,860	7,960	8,060	8,170	8,280	8,380
21-25	6,340	6,420	6,510	6,590	6,680	6,760	6,850	6,940	7,030	7,120
26-30	10,150	10,280	10,420	10,550	10,690	10,830	10,970	11,110	11,260	11,400
31-35	11,380	11,530	11,680	11,830	11,990	12,140	12,300	12,460	12,620	12,790
36-40	11,250	11,400	11,550	11,700	11,850	12,000	12,160	12,320	12,480	12,640
41-45	10,560	10,700	10,830	10,980	11,120	11,260	11,410	11,560	11,710	11,860
46-50	11,330	11,480	11,620	11,780	11,930	12,080	12,240	12,400	12,560	12,720
51-55	14,060	14,240	14,430	14,620	14,810	15,000	15,190	15,390	15,590	15,800
56-60	17,470	17,700	17,930	18,160	18,400	18,640	18,880	19,130	19,370	19,630
60-65	17,780	18,010	18,250	18,480	18,720	18,970	19,210	19,460	19,720	19,970
Over 65	2,300	2,330	2,360	2,390	2,420	2,450	2,490	2,520	2,550	2,580
Total	137,100	138,900	140,700	142,500	144,400	146,200	148,100	150,100	152,000	154,000

Total Enrollment by Age Group - With Waiver

Age Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
0-14	17,050	17,300	17,550	17,810	18,040	18,280	18,510	18,750	19,000	19,250
14-20	7,480	7,590	7,690	7,800	7,900	8,010	8,110	8,220	8,320	8,430
21-25	6,350	6,440	6,540	6,630	6,710	6,800	6,890	6,980	7,070	7,160
26-30	10,180	10,330	10,480	10,630	10,770	10,910	11,050	11,190	11,340	11,480
31-35	11,420	11,580	11,750	11,920	12,080	12,240	12,390	12,560	12,720	12,880
36-40	11,290	11,450	11,620	11,790	11,940	12,100	12,250	12,410	12,580	12,740
41-45	10,590	10,740	10,900	11,060	11,200	11,350	11,500	11,650	11,800	11,950
46-50	11,360	11,530	11,700	11,870	12,020	12,180	12,340	12,500	12,660	12,820
51-55	14,110	14,310	14,520	14,740	14,930	15,120	15,320	15,520	15,720	15,920
56-60	17,530	17,790	18,060	18,320	18,560	18,800	19,050	19,300	19,550	19,800
60-65	17,850	18,110	18,380	18,650	18,890	19,140	19,390	19,640	19,900	20,160
Over 65	2,310	2,340	2,370	2,400	2,430	2,470	2,500	2,530	2,560	2,600
Total	137,520	139,520	141,560	143,620	145,490	147,380	149,300	151,240	153,210	155,200

Change in Enrollment Due to Waiver

Age Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
0-14	50	80	110	140	140	150	140	140	150	160
14-20	20	30	30	40	40	50	50	50	40	50
21-25	10	20	30	40	30	40	40	40	40	40
26-30	30	50	60	80	80	80	80	80	80	80
31-35	40	50	70	90	90	100	90	100	100	90
36-40	40	50	70	90	90	100	90	90	100	100
41-45	30	40	70	80	80	90	90	90	90	90
46-50	30	50	80	90	90	100	100	100	100	100
51-55	50	70	90	120	120	120	130	130	130	120
56-60	60	90	130	160	160	160	170	170	180	170
60-65	70	100	130	170	170	170	180	180	180	190
Over 65	10	10	10	10	10	20	10	10	10	20
Total	420	620	860	1,120	1,090	1,180	1,200	1,140	1,210	1,200

** Changes at the Age Group may not sum to the Total due to rounding.*

Exhibit 1A.6
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 1A: ARP Public Option - PTF Accumulation
Individual Market Estimated Enrollees: 2026 through 2035 by APTC Eligibility

Total Enrollment by Subsidy Eligibility - Baseline

Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Subsidized	117,710	119,370	121,290	123,090	124,770	126,620	128,410	130,100	131,960	133,800
Unsubsidized	19,380	19,510	19,390	19,420	19,590	19,620	19,730	19,970	20,050	20,190
Total	137,090	138,870	140,680	142,510	144,360	146,240	148,140	150,070	152,020	153,990

Total Enrollment by Subsidy Eligibility - With Waiver

Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Subsidized	117,880	119,230	120,710	121,710	123,860	125,580	127,290	129,040	131,020	132,720
Unsubsidized	19,650	20,310	20,870	21,940	21,660	21,830	22,040	22,230	22,220	22,500
Total	137,530	139,540	141,580	143,650	145,520	147,410	149,330	151,270	153,230	155,230

Change in Enrollment Due to Waiver

Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Subsidized	170	(140)	(580)	(1,380)	(910)	(1,040)	(1,120)	(1,060)	(940)	(1,080)
Unsubsidized	270	800	1,480	2,520	2,070	2,210	2,310	2,260	2,170	2,310
Total	440	670	900	1,140	1,160	1,170	1,190	1,200	1,210	1,240

** Changes at the Subsidized level may not sum to the Total due to rounding.*

Exhibit 1B.1
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 1B: ARP Public Option - State Premium Wrap
Individual Market Composite Monthly Premium

Year	Baseline	Waiver	Difference
2026	$591.08	$580.87	-1.7%
2027	$614.64	$589.73	-4.1%
2028	$639.24	$593.08	-7.2%
2029	$664.93	$596.94	-10.2%
2030	$691.74	$620.62	-10.3%
2031	$719.18	$645.33	-10.3%
2032	$747.90	$671.56	-10.2%
2033	$777.88	$698.50	-10.2%
2034	$808.64	$726.13	-10.2%
2035	$841.30	$755.49	-10.2%

Exhibit 1B.2
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 1B: ARP Public Option - State Premium Wrap
Individual Market Changes in SLCS Plan Monthly Premium from 1332 Waiver Implementation

	21-Year Old Monthly Premium				40-Year Old Monthly Premium			
Year	Baseline	Waiver	Difference	Percent Change	Baseline	Waiver	Difference	Percent Change
2026	$348.67	$334.59	-$14.08	-4.0%	$445.60	$427.61	-$17.99	-4.0%
2027	$362.62	$332.37	-$30.24	-8.3%	$463.42	$424.77	-$38.65	-8.3%
2028	$377.12	$330.50	-$46.62	-12.4%	$481.96	$422.38	-$59.58	-12.4%
2029	$392.21	$328.85	-$63.36	-16.2%	$501.24	$420.27	-$80.97	-16.2%
2030	$407.89	$342.00	-$65.89	-16.2%	$521.29	$437.08	-$84.21	-16.2%
2031	$424.21	$355.69	-$68.53	-16.2%	$542.14	$454.57	-$87.58	-16.2%
2032	$441.18	$369.91	-$71.27	-16.2%	$563.83	$472.75	-$91.08	-16.2%
2033	$458.83	$384.71	-$74.12	-16.2%	$586.38	$491.66	-$94.72	-16.2%
2034	$477.18	$400.10	-$77.08	-16.2%	$609.83	$511.32	-$98.51	-16.2%
2035	$496.27	$416.10	-$80.16	-16.2%	$634.23	$531.78	-$102.45	-16.2%

Exhibit 1B.3
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 1B: ARP Public Option - State Premium Wrap
Individual Market Estimated Enrollees: 2026 through 2035 by FPL

Total Enrollment by FPL % - Baseline

Income Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Under 100%	3,170	3,210	3,250	3,300	3,340	3,380	3,430	3,470	3,520	3,560
100 to 133%	6,710	6,790	6,880	6,970	7,060	7,150	7,250	7,340	7,440	7,530
133 to 150%	20,680	20,940	21,220	21,490	21,770	22,060	22,340	22,630	22,930	23,220
150 to 200%	27,850	28,210	28,580	28,950	29,320	29,700	30,090	30,480	30,880	31,280
200 to 250%	24,340	24,650	24,970	25,300	25,630	25,960	26,300	26,640	26,990	27,340
250 to 300%	22,270	22,560	22,860	23,150	23,460	23,760	24,070	24,380	24,700	25,020
300 to 400%	11,960	12,110	12,270	12,430	12,590	12,760	12,920	13,090	13,260	13,430
Over 400%	20,120	20,390	20,650	20,920	21,190	21,470	21,750	22,030	22,320	22,610
Total Individual	137,090	138,870	140,680	142,510	144,360	146,240	148,140	150,070	152,020	153,990

Total Enrollment by FPL % - With Waiver

Income Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Under 100%	3,180	3,220	3,270	3,320	3,360	3,400	3,450	3,490	3,540	3,580
100 to 133%	6,710	6,800	6,890	6,980	7,070	7,160	7,250	7,350	7,440	7,540
133 to 150%	20,680	20,950	21,230	21,510	21,790	22,070	22,360	22,650	22,940	23,240
150 to 200%	27,870	29,470	31,160	31,580	31,990	32,400	32,820	33,250	33,680	34,120
200 to 250%	24,360	26,000	27,750	28,120	28,490	28,860	29,230	29,610	30,000	30,390
250 to 300%	22,300	23,380	24,520	24,850	25,170	25,500	25,830	26,170	26,510	26,850
300 to 400%	12,050	12,430	12,820	13,040	13,210	13,380	13,550	13,730	13,910	14,090
Over 400%	20,380	20,770	21,170	21,580	21,860	22,150	22,430	22,720	23,020	23,320
Total Individual	137,530	143,020	148,800	150,970	152,940	154,920	156,940	158,980	161,050	163,140

Change in Enrollment Due to Waiver

Income Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Under 100%	10	10	20	20	20	20	20	20	20	20
100 to 133%	0	10	10	10	10	10	0	10	0	10
133 to 150%	0	10	10	20	20	10	20	20	10	20
150 to 200%	20	1,260	2,580	2,630	2,670	2,700	2,730	2,770	2,800	2,840
200 to 250%	20	1,350	2,780	2,820	2,860	2,900	2,930	2,970	3,010	3,050
250 to 300%	30	820	1,660	1,700	1,710	1,740	1,760	1,790	1,810	1,830
300 to 400%	90	320	550	610	620	620	630	640	650	660
Over 400%	260	380	520	660	670	680	680	690	700	710
Total Individual	440	4,150	8,120	8,460	8,580	8,680	8,800	8,910	9,030	9,150

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

Exhibit 1B.4
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 1B: ARP Public Option - State Premium Wrap
Individual Market Estimated Enrollees: 2026 through 2035 by Metal

Total Enrollment by Metal - Baseline

Plan Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Catastrophic	810	820	830	840	850	870	880	890	900	910
Bronze	54,580	55,280	56,000	56,730	57,470	58,220	58,970	59,740	60,520	61,300
Silver	75,570	76,550	77,550	78,550	79,580	80,610	81,660	82,720	83,800	84,880
Gold	6,140	6,220	6,300	6,380	6,460	6,550	6,630	6,720	6,800	6,890
Total Individual	137,090	138,870	140,680	142,510	144,360	146,240	148,140	150,070	152,020	153,990

Total Enrollment by Metal - With Waiver

Plan Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Catastrophic	810	820	830	840	850	870	880	890	900	910
Bronze	54,830	57,090	59,470	60,380	61,160	61,960	62,770	63,580	64,410	65,240
Silver	75,710	78,660	81,770	82,910	83,990	85,080	86,190	87,310	88,440	89,590
Gold	6,160	6,430	6,710	6,810	6,900	6,990	7,080	7,170	7,270	7,360
Total Individual	137,520	143,010	148,780	150,950	152,910	154,900	156,910	158,950	161,020	163,110

Change in Enrollment Due to Waiver

Plan Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Catastrophic	0	0	0	0	0	0	0	0	0	0
Bronze	250	1,810	3,470	3,650	3,690	3,740	3,800	3,840	3,890	3,940
Silver	140	2,110	4,220	4,360	4,410	4,470	4,530	4,590	4,640	4,710
Gold	20	210	410	430	440	440	450	450	470	470
Total Individual	430	4,140	8,100	8,440	8,550	8,660	8,770	8,880	9,000	9,120

** Changes at the Metal level may not sum to the Total due to rounding.*

Exhibit 1B.5
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 1B: ARP Public Option - State Premium Wrap
Individual Market Estimated Enrollees: 2026 through 2035 by Age Group

Total Enrollment by Age Group - Baseline

Age Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
0-14	17,000	17,220	17,440	17,670	17,900	18,130	18,370	18,610	18,850	19,090
14-20	7,460	7,560	7,660	7,760	7,860	7,960	8,060	8,170	8,280	8,380
21-25	6,340	6,420	6,510	6,590	6,680	6,760	6,850	6,940	7,030	7,120
26-30	10,150	10,280	10,420	10,550	10,690	10,830	10,970	11,110	11,260	11,400
31-35	11,380	11,530	11,680	11,830	11,990	12,140	12,300	12,460	12,620	12,790
36-40	11,250	11,400	11,550	11,700	11,850	12,000	12,160	12,320	12,480	12,640
41-45	10,560	10,700	10,830	10,980	11,120	11,260	11,410	11,560	11,710	11,860
46-50	11,330	11,480	11,620	11,780	11,930	12,080	12,240	12,400	12,560	12,720
51-55	14,060	14,240	14,430	14,620	14,810	15,000	15,190	15,390	15,590	15,800
56-60	17,470	17,700	17,930	18,160	18,400	18,640	18,880	19,130	19,370	19,630
60-65	17,780	18,010	18,250	18,480	18,720	18,970	19,210	19,460	19,720	19,970
Over 65	2,300	2,330	2,360	2,390	2,420	2,450	2,490	2,520	2,550	2,580
Total	137,090	138,870	140,680	142,510	144,360	146,240	148,140	150,070	152,020	153,990

Total Enrollment by Age Group - With Waiver

Age Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
0-14	17,050	17,800	18,580	18,850	19,100	19,350	19,600	19,850	20,110	20,370
14-20	7,480	7,770	8,080	8,190	8,300	8,410	8,520	8,630	8,740	8,850
21-25	6,350	6,600	6,860	6,950	7,040	7,130	7,230	7,320	7,420	7,510
26-30	10,180	10,600	11,030	11,190	11,340	11,480	11,630	11,780	11,940	12,090
31-35	11,420	11,880	12,360	12,540	12,700	12,870	13,030	13,200	13,370	13,550
36-40	11,290	11,740	12,220	12,400	12,560	12,720	12,890	13,060	13,230	13,400
41-45	10,590	11,020	11,480	11,640	11,790	11,950	12,100	12,260	12,420	12,580
46-50	11,360	11,820	12,300	12,480	12,640	12,810	12,970	13,140	13,310	13,490
51-55	14,110	14,660	15,250	15,470	15,670	15,880	16,080	16,290	16,500	16,720
56-60	17,530	18,210	18,920	19,200	19,450	19,700	19,960	20,220	20,480	20,740
60-65	17,850	18,550	19,280	19,570	19,820	20,080	20,340	20,610	20,870	21,150
Over 65	2,310	2,360	2,430	2,460	2,490	2,520	2,560	2,590	2,620	2,660
Total	137,520	143,010	148,780	150,950	152,910	154,900	156,910	158,950	161,020	163,110

Change in Enrollment Due to Waiver

Age Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
0-14	50	580	1,140	1,180	1,200	1,220	1,230	1,240	1,260	1,280
14-20	20	210	420	430	440	450	460	460	460	470
21-25	10	180	350	360	360	370	380	380	390	390
26-30	30	320	610	640	650	650	660	670	680	690
31-35	40	350	680	710	710	730	730	740	750	760
36-40	40	340	670	700	710	720	730	740	750	760
41-45	30	320	650	660	670	690	690	700	710	720
46-50	30	340	680	700	710	730	730	740	750	770
51-55	50	420	820	850	860	880	890	900	910	920
56-60	60	510	990	1,040	1,050	1,060	1,080	1,090	1,110	1,110
60-65	70	540	1,030	1,090	1,100	1,110	1,130	1,150	1,150	1,180
Over 65	10	30	70	70	70	70	70	70	70	80
Total	430	4,140	8,100	8,440	8,550	8,660	8,770	8,880	9,000	9,120

** Changes at the Age Group may not sum to the Total due to rounding.*

Exhibit 1B.6
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 1B: ARP Public Option - State Premium Wrap
Individual Market Estimated Enrollees: 2026 through 2035 by APTC Eligibility

Total Enrollment by Subsidy Eligibility - Baseline

Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Subsidized	117,710	119,370	121,290	123,090	124,770	126,620	128,410	130,100	131,960	133,800
Unsubsidized	19,380	19,510	19,390	19,420	19,590	19,620	19,730	19,970	20,050	20,190
Total	137,090	138,870	140,680	142,510	144,360	146,240	148,140	150,070	152,020	153,990

Total Enrollment by Subsidy Eligibility - With Waiver

Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Subsidized	117,880	122,710	127,900	129,000	131,100	133,060	134,870	136,720	138,800	140,610
Unsubsidized	19,650	20,320	20,900	21,970	21,830	21,860	22,070	22,260	22,240	22,530
Total	137,530	143,020	148,800	150,970	152,940	154,920	156,940	158,980	161,050	163,140

Change in Enrollment Due to Waiver

Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Subsidized	170	3,340	6,610	5,910	6,330	6,440	6,460	6,620	6,840	6,810
Unsubsidized	270	810	1,510	2,550	2,240	2,240	2,340	2,290	2,190	2,340
Total	440	4,150	8,120	8,460	8,580	8,680	8,800	8,910	9,030	9,150

** Changes at the Subsidized level may not sum to the Total due to rounding.*

Exhibit 2A.1
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2A: No ARP Public Option - PTF Accumulation
Individual Market Composite Monthly Premium

Year	Baseline	Waiver	Difference
2026	$600.49	$589.52	-1.8%
2027	$624.42	$598.55	-4.1%
2028	$649.40	$602.78	-7.2%
2029	$675.47	$606.68	-10.2%
2030	$702.06	$630.65	-10.2%
2031	$730.38	$656.16	-10.2%
2032	$760.03	$682.28	-10.2%
2033	$790.30	$709.55	-10.2%
2034	$821.91	$737.93	-10.2%
2035	$854.90	$767.65	-10.2%

Exhibit 2A.2
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2A: No ARP Public Option - PTF Accumulation
Individual Market Changes in SLCS Plan Monthly Premium from 1332 Waiver Implementation

	21-Year Old Monthly Premium				40-Year Old Monthly Premium			
Year	Baseline	Waiver	Difference	Percent Change	Baseline	Waiver	Difference	Percent Change
2026	$358.04	$343.60	-$14.44	-4.0%	$457.57	$439.12	-$18.45	-4.0%
2027	$372.36	$341.54	-$30.81	-8.3%	$475.87	$436.49	-$39.38	-8.3%
2028	$387.25	$339.84	-$47.41	-12.2%	$494.91	$434.32	-$60.59	-12.2%
2029	$402.74	$338.15	-$64.59	-16.0%	$514.70	$432.15	-$82.55	-16.0%
2030	$418.85	$351.67	-$67.18	-16.0%	$535.29	$449.44	-$85.85	-16.0%
2031	$435.61	$365.74	-$69.87	-16.0%	$556.70	$467.42	-$89.29	-16.0%
2032	$453.03	$380.37	-$72.66	-16.0%	$578.97	$486.11	-$92.86	-16.0%
2033	$471.15	$395.58	-$75.57	-16.0%	$602.13	$505.56	-$96.57	-16.0%
2034	$490.00	$411.41	-$78.59	-16.0%	$626.22	$525.78	-$100.44	-16.0%
2035	$509.60	$427.86	-$81.73	-16.0%	$651.27	$546.81	-$104.45	-16.0%

Exhibit 2A.3
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2A: No ARP Public Option - PTF Accumulation
Individual Market Estimated Enrollees: 2026 through 2035 by FPL

Total Enrollment by FPL % - Baseline

Income Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Under 100%	1,660	1,690	1,710	1,730	1,750	1,780	1,800	1,820	1,850	1,870
100 to 133%	4,050	4,110	4,160	4,210	4,270	4,330	4,380	4,440	4,500	4,550
133 to 150%	14,210	14,400	14,580	14,770	14,970	15,160	15,360	15,560	15,760	15,960
150 to 200%	22,370	22,660	22,960	23,260	23,560	23,870	24,180	24,490	24,810	25,130
200 to 250%	19,520	19,770	20,030	20,290	20,550	20,820	21,090	21,370	21,640	21,920
250 to 300%	18,100	18,340	18,580	18,820	19,060	19,310	19,560	19,820	20,070	20,340
300 to 400%	9,340	9,460	9,590	9,710	9,840	9,970	10,100	10,230	10,360	10,490
Over 400%	17,290	17,510	17,740	17,970	18,200	18,440	18,680	18,920	19,170	19,420
Total Individual	106,560	107,940	109,350	110,770	112,210	113,670	115,140	116,640	118,160	119,690

Total Enrollment by FPL % - With Waiver

Income Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Under 100%	1,680	1,710	1,740	1,770	1,800	1,820	1,840	1,870	1,890	1,920
100 to 133%	4,060	4,110	4,170	4,230	4,280	4,340	4,390	4,450	4,510	4,570
133 to 150%	14,220	14,420	14,610	14,810	15,000	15,190	15,390	15,590	15,790	16,000
150 to 200%	22,420	22,740	23,060	23,390	23,690	24,000	24,310	24,630	24,950	25,270
200 to 250%	19,560	19,830	20,110	20,390	20,660	20,930	21,200	21,470	21,750	22,040
250 to 300%	18,150	18,410	18,670	18,930	19,180	19,430	19,680	19,940	20,200	20,460
300 to 400%	9,490	9,690	9,890	10,090	10,230	10,360	10,490	10,630	10,770	10,910
Over 400%	17,720	18,170	18,640	19,120	19,370	19,620	19,880	20,130	20,400	20,660
Total Individual	107,300	109,080	110,890	112,730	114,200	115,680	117,190	118,710	120,250	121,820

Change in Enrollment Due to Waiver

Income Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Under 100%	20	20	30	40	50	40	40	50	40	50
100 to 133%	10	0	10	20	10	10	10	10	10	20
133 to 150%	10	20	30	40	30	30	30	30	30	40
150 to 200%	50	80	100	130	130	130	130	140	140	140
200 to 250%	40	60	80	100	110	110	110	100	110	120
250 to 300%	50	70	90	110	120	120	120	120	130	120
300 to 400%	150	230	300	380	390	390	390	400	410	420
Over 400%	430	660	900	1,150	1,170	1,180	1,200	1,210	1,230	1,240
Total Individual	740	1,140	1,540	1,960	1,990	2,010	2,050	2,070	2,090	2,130

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

Exhibit 2A.4
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2A: No ARP Public Option - PTF Accumulation
Individual Market Estimated Enrollees: 2026 through 2035 by Metal

Total Enrollment by Metal - Baseline

Plan Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Catastrophic	810	820	830	840	850	870	880	890	900	910
Bronze	43,830	44,400	44,980	45,560	46,160	46,760	47,360	47,980	48,600	49,240
Silver	57,130	57,870	58,620	59,390	60,160	60,940	61,730	62,530	63,350	64,170
Gold	4,790	4,850	4,910	4,980	5,040	5,110	5,170	5,240	5,310	5,380
Total Individual	106,560	107,940	109,350	110,770	112,210	113,670	115,140	116,640	118,160	119,690

Total Enrollment by Metal - With Waiver

Plan Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Catastrophic	810	820	830	840	850	870	880	890	900	910
Bronze	44,270	45,070	45,880	46,710	47,320	47,930	48,560	49,190	49,830	50,480
Silver	57,380	58,260	59,150	60,060	60,840	61,630	62,430	63,240	64,060	64,900
Gold	4,820	4,900	4,980	5,070	5,130	5,200	5,270	5,340	5,400	5,470
Total Individual	107,280	109,050	110,850	112,680	114,140	115,630	117,130	118,650	120,200	121,760

Change in Enrollment Due to Waiver

Plan Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Catastrophic	0	0	0	0	0	0	0	0	0	0
Bronze	440	670	900	1,150	1,160	1,170	1,200	1,210	1,230	1,240
Silver	250	390	530	670	680	690	700	710	710	730
Gold	30	50	70	90	90	90	100	100	90	90
Total Individual	720	1,110	1,500	1,910	1,930	1,960	1,990	2,010	2,040	2,070

** Changes at the Metal level may not sum to the Total due to rounding.*

Exhibit 2A.5
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2A: No ARP Public Option - PTF Accumulation
Individual Market Estimated Enrollees: 2026 through 2035 by Age Group

Total Enrollment by Age Group - Baseline

Age Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
0-14	13,490	13,660	13,840	14,020	14,200	14,390	14,570	14,760	14,950	15,150
14-20	5,760	5,840	5,920	5,990	6,070	6,150	6,230	6,310	6,390	6,470
21-25	4,870	4,930	5,000	5,060	5,130	5,200	5,260	5,330	5,400	5,470
26-30	7,910	8,020	8,120	8,230	8,330	8,440	8,550	8,660	8,770	8,890
31-35	8,870	8,980	9,100	9,220	9,340	9,460	9,580	9,710	9,830	9,960
36-40	8,770	8,880	9,000	9,110	9,230	9,350	9,470	9,600	9,720	9,850
41-45	8,220	8,330	8,430	8,540	8,650	8,770	8,880	9,000	9,110	9,230
46-50	8,820	8,940	9,060	9,170	9,290	9,410	9,540	9,660	9,780	9,910
51-55	10,930	11,070	11,210	11,360	11,510	11,660	11,810	11,960	12,120	12,280
56-60	13,530	13,710	13,880	14,070	14,250	14,430	14,620	14,810	15,000	15,200
60-65	13,840	14,020	14,200	14,380	14,570	14,760	14,950	15,150	15,340	15,540
Over 65	1,550	1,570	1,590	1,610	1,640	1,660	1,680	1,700	1,720	1,740
Total	106,560	107,940	109,350	110,770	112,210	113,670	115,140	116,640	118,160	119,690

Total Enrollment by Age Group - With Waiver

Age Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
0-14	13,580	13,800	14,030	14,260	14,450	14,630	14,820	15,020	15,210	15,410
14-20	5,790	5,890	5,980	6,070	6,150	6,230	6,310	6,390	6,480	6,560
21-25	4,900	4,980	5,050	5,130	5,200	5,270	5,340	5,410	5,480	5,550
26-30	7,960	8,090	8,220	8,360	8,460	8,570	8,690	8,800	8,910	9,030
31-35	8,930	9,070	9,220	9,370	9,500	9,620	9,740	9,870	10,000	10,130
36-40	8,820	8,970	9,120	9,270	9,390	9,510	9,630	9,760	9,890	10,010
41-45	8,270	8,410	8,550	8,690	8,800	8,920	9,030	9,150	9,270	9,390
46-50	8,880	9,030	9,180	9,330	9,450	9,570	9,700	9,830	9,950	10,080
51-55	11,000	11,190	11,370	11,560	11,710	11,870	12,020	12,180	12,330	12,490
56-60	13,630	13,860	14,100	14,330	14,520	14,710	14,900	15,090	15,290	15,490
60-65	13,940	14,180	14,420	14,660	14,850	15,050	15,240	15,440	15,640	15,850
Over 65	1,560	1,590	1,610	1,640	1,660	1,680	1,700	1,720	1,740	1,770
Total	107,280	109,050	110,850	112,680	114,140	115,630	117,130	118,650	120,200	121,760

Change in Enrollment Due to Waiver

Age Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
0-14	90	140	190	240	250	240	250	260	260	260
14-20	30	50	60	80	80	80	80	80	90	90
21-25	30	50	50	70	70	70	80	80	80	80
26-30	50	70	100	130	130	130	140	140	140	140
31-35	60	90	120	150	160	160	160	160	170	170
36-40	50	90	120	160	160	160	160	160	170	160
41-45	50	80	120	150	150	150	150	150	160	160
46-50	60	90	120	160	160	160	160	170	170	170
51-55	70	120	160	200	200	210	210	220	210	210
56-60	100	150	220	260	270	280	280	280	290	290
60-65	100	160	220	280	280	290	290	290	300	310
Over 65	10	20	20	30	20	20	20	20	20	30
Total	720	1,110	1,500	1,910	1,930	1,960	1,990	2,010	2,040	2,070

** Changes at the Age Group may not sum to the Total due to rounding.*

Exhibit 2A.6
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2A: No ARP Public Option - PTF Accumulation
Individual Market Estimated Enrollees: 2026 through 2035 by APTC Eligibility

Total Enrollment by Subsidy Eligibility - Baseline

Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Subsidized	83,130	84,210	85,530	86,640	87,780	88,930	90,140	91,330	92,520	93,750
Unsubsidized	23,430	23,730	23,820	24,120	24,430	24,740	25,010	25,310	25,640	25,950
Total	106,560	107,940	109,350	110,770	112,210	113,670	115,140	116,640	118,160	119,690

Total Enrollment by Subsidy Eligibility - With Waiver

Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Subsidized	83,120	83,460	84,480	85,590	86,780	87,920	89,060	90,220	91,430	92,690
Unsubsidized	24,180	25,620	26,410	27,140	27,420	27,760	28,120	28,490	28,820	29,130
Total	107,300	109,080	110,890	112,730	114,200	115,680	117,190	118,710	120,250	121,820

Change in Enrollment Due to Waiver

Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Subsidized	(10)	(750)	(1,050)	(1,050)	(1,000)	(1,010)	(1,080)	(1,110)	(1,090)	(1,060)
Unsubsidized	750	1,890	2,590	3,020	2,990	3,020	3,110	3,180	3,180	3,180
Total	740	1,140	1,540	1,960	1,990	2,010	2,050	2,070	2,090	2,130

** Changes at the Subsidized level may not sum to the Total due to rounding.*

Exhibit 2B.1
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2B: No ARP Public Option - State Premium Wrap
Individual Market Composite Monthly Premium

Year	Baseline	Waiver	Difference
2026	$600.49	$589.52	-1.8%
2027	$624.42	$598.39	-4.2%
2028	$649.40	$602.22	-7.3%
2029	$675.47	$605.18	-10.4%
2030	$702.06	$629.27	-10.4%
2031	$730.38	$654.87	-10.3%
2032	$760.03	$680.60	-10.5%
2033	$790.30	$708.00	-10.4%
2034	$821.91	$736.54	-10.4%
2035	$854.90	$765.83	-10.4%

Exhibit 2B.2
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2B: No ARP Public Option - State Premium Wrap
Individual Market Changes in SLCS Plan Monthly Premium from 1332 Waiver Implementation

	21-Year Old Monthly Premium				40-Year Old Monthly Premium			
Year	Baseline	Waiver	Difference	Percent Change	Baseline	Waiver	Difference	Percent Change
2026	$358.04	$343.60	-$14.44	-4.0%	$457.57	$439.12	-$18.45	-4.0%
2027	$372.36	$339.32	-$33.04	-8.9%	$475.87	$433.65	-$42.22	-8.9%
2028	$387.25	$335.43	-$51.83	-13.4%	$494.91	$428.67	-$66.23	-13.4%
2029	$402.74	$333.75	-$68.99	-17.1%	$514.70	$426.54	-$88.17	-17.1%
2030	$418.85	$347.10	-$71.75	-17.1%	$535.29	$443.60	-$91.69	-17.1%
2031	$435.61	$360.99	-$74.62	-17.1%	$556.70	$461.34	-$95.36	-17.1%
2032	$453.03	$375.43	-$77.60	-17.1%	$578.97	$479.80	-$99.17	-17.1%
2033	$471.15	$390.45	-$80.71	-17.1%	$602.13	$498.99	-$103.14	-17.1%
2034	$490.00	$406.06	-$83.93	-17.1%	$626.22	$518.95	-$107.27	-17.1%
2035	$509.60	$422.31	-$87.29	-17.1%	$651.27	$539.71	-$111.56	-17.1%

Exhibit 2B.2
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2B: No ARP Public Option - State Premium Wrap
Individual Market Estimated Enrollees: 2026 through 2035 by FPL

Total Enrollment by FPL % - Baseline

Income Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Under 100%	1,660	1,690	1,710	1,730	1,750	1,780	1,800	1,820	1,850	1,870
100 to 133%	4,050	4,110	4,160	4,210	4,270	4,330	4,380	4,440	4,500	4,550
133 to 150%	14,210	14,400	14,580	14,770	14,970	15,160	15,360	15,560	15,760	15,960
150 to 200%	22,370	22,660	22,960	23,260	23,560	23,870	24,180	24,490	24,810	25,130
200 to 250%	19,520	19,770	20,030	20,290	20,550	20,820	21,090	21,370	21,640	21,920
250 to 300%	18,100	18,340	18,580	18,820	19,060	19,310	19,560	19,820	20,070	20,340
300 to 400%	9,340	9,460	9,590	9,710	9,840	9,970	10,100	10,230	10,360	10,490
Over 400%	17,290	17,510	17,740	17,970	18,200	18,440	18,680	18,920	19,170	19,420
Total Individual	106,560	107,940	109,350	110,770	112,210	113,670	115,140	116,640	118,160	119,690

Total Enrollment by FPL % - With Waiver

Income Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Under 100%	1,680	1,910	2,170	2,210	2,240	2,270	2,300	2,330	2,360	2,390
100 to 133%	4,060	4,700	5,460	5,530	5,600	5,680	5,750	5,820	5,900	5,980
133 to 150%	14,220	16,010	18,040	18,280	18,510	18,750	19,000	19,250	19,500	19,750
150 to 200%	22,420	24,460	26,700	27,070	27,420	27,780	28,140	28,510	28,880	29,250
200 to 250%	19,560	20,400	21,280	21,580	21,860	22,140	22,430	22,720	23,020	23,320
250 to 300%	18,150	18,410	18,670	18,930	19,180	19,430	19,680	19,940	20,200	20,460
300 to 400%	9,490	9,690	9,890	10,090	10,230	10,360	10,490	10,630	10,770	10,910
Over 400%	17,720	18,170	18,640	19,120	19,370	19,620	19,880	20,130	20,400	20,660
Total Individual	107,300	113,760	120,840	122,820	124,410	126,030	127,670	129,330	131,010	132,710

Change in Enrollment Due to Waiver

Income Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Under 100%	20	220	460	480	490	490	500	510	510	520
100 to 133%	10	590	1,300	1,320	1,330	1,350	1,370	1,380	1,400	1,430
133 to 150%	10	1,610	3,460	3,510	3,540	3,590	3,640	3,690	3,740	3,790
150 to 200%	50	1,800	3,740	3,810	3,860	3,910	3,960	4,020	4,070	4,120
200 to 250%	40	630	1,250	1,290	1,310	1,320	1,340	1,350	1,380	1,400
250 to 300%	50	70	90	110	120	120	120	120	130	120
300 to 400%	150	230	300	380	390	390	390	400	410	420
Over 400%	430	660	900	1,150	1,170	1,180	1,200	1,210	1,230	1,240
Total Individual	740	5,820	11,490	12,050	12,200	12,360	12,530	12,690	12,850	13,020

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

Exhibit 2B.2
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2B: No ARP Public Option - State Premium Wrap
Individual Market Estimated Enrollees: 2026 through 2035 by Metal

Total Enrollment by Metal - Baseline

Plan Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Catastrophic	810	820	830	840	850	870	880	890	900	910
Bronze	43,830	44,400	44,980	45,560	46,160	46,760	47,360	47,980	48,600	49,240
Silver	57,130	57,870	58,620	59,390	60,160	60,940	61,730	62,530	63,350	64,170
Gold	4,790	4,850	4,910	4,980	5,040	5,110	5,170	5,240	5,310	5,380
Total Individual	106,560	107,940	109,350	110,770	112,210	113,670	115,140	116,640	118,160	119,690

Total Enrollment by Metal - With Waiver

Plan Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Catastrophic	810	820	830	840	850	870	880	890	900	910
Bronze	44,270	45,930	47,710	48,560	49,190	49,830	50,480	51,140	51,800	52,480
Silver	57,380	62,000	67,120	68,130	69,020	69,920	70,820	71,750	72,680	73,620
Gold	4,820	4,970	5,140	5,220	5,290	5,360	5,430	5,500	5,570	5,640
Total Individual	107,280	113,730	120,800	122,760	124,360	125,980	127,610	129,270	130,950	132,660

Change in Enrollment Due to Waiver

Plan Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Catastrophic	0	0	0	0	0	0	0	0	0	0
Bronze	440	1,530	2,730	3,000	3,030	3,070	3,120	3,160	3,200	3,240
Silver	250	4,130	8,500	8,740	8,860	8,980	9,090	9,220	9,330	9,450
Gold	30	120	230	240	250	250	260	260	260	260
Total Individual	720	5,790	11,450	11,990	12,150	12,310	12,470	12,630	12,790	12,970

** Changes at the Metal level may not sum to the Total due to rounding.*

Exhibit 2B.2
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2B: No ARP Public Option - State Premium Wrap
Individual Market Estimated Enrollees: 2026 through 2035 by Age Group

Total Enrollment by Age Group - Baseline

Age Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
0-14	13,490	13,660	13,840	14,020	14,200	14,390	14,570	14,760	14,950	15,150
14-20	5,760	5,840	5,920	5,990	6,070	6,150	6,230	6,310	6,390	6,470
21-25	4,870	4,930	5,000	5,060	5,130	5,200	5,260	5,330	5,400	5,470
26-30	7,910	8,020	8,120	8,230	8,330	8,440	8,550	8,660	8,770	8,890
31-35	8,870	8,980	9,100	9,220	9,340	9,460	9,580	9,710	9,830	9,960
36-40	8,770	8,880	9,000	9,110	9,230	9,350	9,470	9,600	9,720	9,850
41-45	8,220	8,330	8,430	8,540	8,650	8,770	8,880	9,000	9,110	9,230
46-50	8,820	8,940	9,060	9,170	9,290	9,410	9,540	9,660	9,780	9,910
51-55	10,930	11,070	11,210	11,360	11,510	11,660	11,810	11,960	12,120	12,280
56-60	13,530	13,710	13,880	14,070	14,250	14,430	14,620	14,810	15,000	15,200
60-65	13,840	14,020	14,200	14,380	14,570	14,760	14,950	15,150	15,340	15,540
Over 65	1,550	1,570	1,590	1,610	1,640	1,660	1,680	1,700	1,720	1,740
Total	106,560	107,940	109,350	110,770	112,210	113,670	115,140	116,640	118,160	119,690

Total Enrollment by Age Group - With Waiver

Age Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
0-14	13,580	14,190	14,860	15,110	15,300	15,500	15,700	15,910	16,110	16,320
14-20	5,790	6,210	6,670	6,780	6,860	6,950	7,040	7,130	7,230	7,320
21-25	4,900	5,260	5,670	5,760	5,830	5,910	5,980	6,060	6,140	6,220
26-30	7,960	8,460	9,000	9,140	9,260	9,380	9,500	9,630	9,750	9,880
31-35	8,930	9,450	10,030	10,190	10,320	10,460	10,590	10,730	10,870	11,010
36-40	8,820	9,340	9,910	10,070	10,200	10,330	10,460	10,600	10,740	10,880
41-45	8,270	8,760	9,300	9,450	9,580	9,700	9,830	9,950	10,080	10,210
46-50	8,880	9,420	10,000	10,170	10,300	10,430	10,570	10,700	10,840	10,980
51-55	11,000	11,680	12,420	12,630	12,790	12,960	13,130	13,300	13,470	13,640
56-60	13,630	14,460	15,370	15,620	15,830	16,030	16,240	16,450	16,670	16,880
60-65	13,940	14,760	15,660	15,920	16,130	16,340	16,550	16,760	16,980	17,200
Over 65	1,560	1,720	1,910	1,940	1,960	1,990	2,010	2,040	2,060	2,090
Total	107,280	113,730	120,800	122,760	124,360	125,980	127,610	129,270	130,950	132,660

Change in Enrollment Due to Waiver

Age Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
0-14	90	530	1,020	1,090	1,100	1,110	1,130	1,150	1,160	1,170
14-20	30	370	750	790	790	800	810	820	840	850
21-25	30	330	670	700	700	710	720	730	740	750
26-30	50	440	880	910	930	940	950	970	980	990
31-35	60	470	930	970	980	1,000	1,010	1,020	1,040	1,050
36-40	50	460	910	960	970	980	990	1,000	1,020	1,030
41-45	50	430	870	910	930	930	950	950	970	980
46-50	60	480	940	1,000	1,010	1,020	1,030	1,040	1,060	1,070
51-55	70	610	1,210	1,270	1,280	1,300	1,320	1,340	1,350	1,360
56-60	100	750	1,490	1,550	1,580	1,600	1,620	1,640	1,670	1,680
60-65	100	740	1,460	1,540	1,560	1,580	1,600	1,610	1,640	1,660
Over 65	10	150	320	330	320	330	330	340	340	350
Total	720	5,790	11,450	11,990	12,150	12,310	12,470	12,630	12,790	12,970

** Changes at the Age Group may not sum to the Total due to rounding.*

Exhibit 2B.2
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2B: No ARP Public Option - State Premium Wrap
Individual Market Estimated Enrollees: 2026 through 2035 by APTC Eligibility

Total Enrollment by Subsidy Eligibility - Baseline

Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Subsidized	83,130	84,210	85,530	86,640	87,780	88,930	90,140	91,330	92,520	93,750
Unsubsidized	23,430	23,730	23,820	24,120	24,430	24,740	25,010	25,310	25,640	25,950
Total	106,560	107,940	109,350	110,770	112,210	113,670	115,140	116,640	118,160	119,690

Total Enrollment by Subsidy Eligibility - With Waiver

Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Subsidized	83,120	87,960	94,040	94,370	96,500	97,830	99,120	100,420	101,730	103,100
Unsubsidized	24,180	25,800	26,800	28,450	27,910	28,200	28,550	28,910	29,280	29,610
Total	107,300	113,760	120,840	122,820	124,410	126,030	127,670	129,330	131,010	132,710

Change in Enrollment Due to Waiver

Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Subsidized	(10)	3,750	8,510	7,730	8,720	8,900	8,980	9,090	9,210	9,350
Unsubsidized	750	2,070	2,980	4,330	3,480	3,460	3,540	3,600	3,640	3,660
Total	740	5,820	11,490	12,050	12,200	12,360	12,530	12,690	12,850	13,020

** Changes at the Subsidized level may not sum to the Total due to rounding.*

APPENDIX A
Actuarial Certification

Appendix A

State of Nevada
Section 1332 Waiver Application
Actuarial Certification

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

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

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

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

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

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

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

December 16, 2022
Date

APPENDIX B
State Legislation

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

Joint Sponsors: Assemblymen Benitez-Thompson and Frierson

CHAPTER.....

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

Legislative Counsel's Digest:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 4. *"Commissioner" means the Commissioner of Insurance.*

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

Sec. 6. *"Exchange" means the Silver State Health Insurance Exchange.*

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

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

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

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

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

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

2. The Director:

(a) Shall make the Public Option available:

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

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

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

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

3. The Public Option must:

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

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

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

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

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

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

6. As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5. The Director may:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8. As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. The Trust Fund consists of:

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

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

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

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

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

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

Sec. 16. NRS 683A.176 is hereby amended to read as follows:

683A.176 "Third party" means:

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

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

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

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

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

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

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

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

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

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

2. Any group or blanket policy.

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

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

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

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

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

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

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

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

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

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

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

4. As used in this section:

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

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

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

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

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

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

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

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

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

4. As used in this section:

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

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

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

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

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

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

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

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

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

4. As used in this section:

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

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

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

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

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

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

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

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

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

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

4. As used in this section:

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

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

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

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

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

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

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

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

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

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

4. The Executive Director shall prescribe:

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

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

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

(2) Persons who have recently lost their jobs.

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

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

695I.210 1. The Exchange shall:

(a) Create and administer a health insurance exchange;

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

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

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

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

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

2. The Exchange may:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) A coroner.

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

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

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

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

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

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

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

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

(k) Every social worker.

(l) Any person who owns or is employed by a funeral home or mortuary.

(m) Every person who operates or is employed by a peer support recovery organization, as defined in NRS 449.01563.

(n) Every person who operates or is employed by a community health worker pool, as defined in NRS 449.0028, or with whom a community health worker pool contracts to provide the services of a community health worker, as defined in NRS 449.0027.

(o) Every person who is enrolled with the Division of Health Care Financing and Policy of the Department of Health and Human Services to provide doula services to recipients of Medicaid pursuant to section 26 of this act.

5. A report may be made by any other person.

6. If a person who is required to make a report pursuant to subsection 1 knows or has reasonable cause to believe that an older person or vulnerable person has died as a result of abuse, neglect, isolation or abandonment, the person shall, as soon as reasonably practicable, report this belief to the appropriate medical examiner or coroner, who shall investigate the cause of death of the older person or vulnerable person and submit to the appropriate local law enforcement agencies, the appropriate prosecuting attorney, the Aging and Disability Services Division of the Department of Health and Human Services and the Unit for the Investigation and Prosecution of Crimes his or her written findings. The written findings must include the information required pursuant to the provisions of NRS 200.5094, when possible.

7. A division, office or department which receives a report pursuant to this section shall cause the investigation of the report to commence within 3 working days. A copy of the final report of the investigation conducted by a division, office or department, other than the Aging and Disability Services Division of the Department of Health and Human Services, must be forwarded within 30 days after the completion of the report to the:

(a) Aging and Disability Services Division;

(b) Repository for Information Concerning Crimes Against Older Persons or Vulnerable Persons created by NRS 179A.450; and

(c) Unit for the Investigation and Prosecution of Crimes.

8. If the investigation of a report results in the belief that an older person or vulnerable person is abused, neglected, exploited,

isolated or abandoned, the Aging and Disability Services Division of the Department of Health and Human Services or the county's office for protective services may provide protective services to the older person or vulnerable person if the older person or vulnerable person is able and willing to accept them.

9. A person who knowingly and willfully violates any of the provisions of this section is guilty of a misdemeanor.

10. As used in this section, "Unit for the Investigation and Prosecution of Crimes" means the Unit for the Investigation and Prosecution of Crimes Against Older Persons or Vulnerable Persons in the Office of the Attorney General created pursuant to NRS 228.265.

Sec. 18. NRS 232.320 is hereby amended to read as follows:

232.320 1. The Director:

(a) Shall appoint, with the consent of the Governor, administrators of the divisions of the Department, who are respectively designated as follows:

(1) The Administrator of the Aging and Disability Services Division;

(2) The Administrator of the Division of Welfare and Supportive Services;

(3) The Administrator of the Division of Child and Family Services;

(4) The Administrator of the Division of Health Care Financing and Policy; and

(5) The Administrator of the Division of Public and Behavioral Health.

(b) Shall administer, through the divisions of the Department, the provisions of chapters 63, 424, 425, 427A, 432A to 442, inclusive, 446 to 450, inclusive, 458A and 656A of NRS, NRS 127.220 to 127.310, inclusive, 422.001 to 422.410, inclusive, ***and sections 24 to 28, inclusive, of this act,*** 422.580, 432.010 to 432.133, inclusive, 432B.6201 to 432B.626, inclusive, 444.002 to 444.430, inclusive, and 445A.010 to 445A.055, inclusive, and all other provisions of law relating to the functions of the divisions of the Department, but is not responsible for the clinical activities of the Division of Public and Behavioral Health or the professional line activities of the other divisions.

(c) Shall administer any state program for persons with developmental disabilities established pursuant to the Developmental Disabilities Assistance and Bill of Rights Act of 2000, 42 U.S.C. §§ 15001 et seq.

(d) Shall, after considering advice from agencies of local governments and nonprofit organizations which provide social services, adopt a master plan for the provision of human services in this State. The Director shall revise the plan biennially and deliver a copy of the plan to the Governor and the Legislature at the beginning of each regular session. The plan must:

(1) Identify and assess the plans and programs of the Department for the provision of human services, and any duplication of those services by federal, state and local agencies;

(2) Set forth priorities for the provision of those services;

(3) Provide for communication and the coordination of those services among nonprofit organizations, agencies of local government, the State and the Federal Government;

(4) Identify the sources of funding for services provided by the Department and the allocation of that funding;

(5) Set forth sufficient information to assist the Department in providing those services and in the planning and budgeting for the future provision of those services; and

(6) Contain any other information necessary for the Department to communicate effectively with the Federal Government concerning demographic trends, formulas for the distribution of federal money and any need for the modification of programs administered by the Department.

(e) May, by regulation, require nonprofit organizations and state and local governmental agencies to provide information regarding the programs of those organizations and agencies, excluding detailed information relating to their budgets and payrolls, which the Director deems necessary for the performance of the duties imposed upon him or her pursuant to this section.

(f) Has such other powers and duties as are provided by law.

2. Notwithstanding any other provision of law, the Director, or the Director's designee, is responsible for appointing and removing subordinate officers and employees of the Department.

Sec. 19. NRS 232.459 is hereby amended to read as follows:

232.459 1. The Advocate shall:

(a) Respond to written and telephonic inquiries received from consumers and injured employees regarding concerns and problems related to health care and workers' compensation;

(b) Assist consumers and injured employees in understanding their rights and responsibilities under health care plans, including, without limitation, the Public Employees' Benefits Program ~~[,]~~ ***and the Public Option,*** and policies of industrial insurance;

(c) Identify and investigate complaints of consumers and injured employees regarding their health care plans, including, without limitation, the Public Employees' Benefits Program ~~[,]~~ ***and the Public Option,*** and policies of industrial insurance and assist those consumers and injured employees to resolve their complaints, including, without limitation:

(1) Referring consumers and injured employees to the appropriate agency, department or other entity that is responsible for addressing the specific complaint of the consumer or injured employee; and

(2) Providing counseling and assistance to consumers and injured employees concerning health care plans, including, without limitation, the Public Employees' Benefits Program ~~[,]~~ ***and the Public Option,*** and policies of industrial insurance;

(d) Provide information to consumers and injured employees concerning health care plans, including, without limitation, the Public Employees' Benefits Program ~~[,]~~ ***and the Public Option,*** and policies of industrial insurance in this State;

(e) Establish and maintain a system to collect and maintain information pertaining to the written and telephonic inquiries received by the Office for Consumer Health Assistance;

(f) Take such actions as are necessary to ensure public awareness of the existence and purpose of the services provided by the Advocate pursuant to this section;

(g) In appropriate cases and pursuant to the direction of the Advocate, refer a complaint or the results of an investigation to the Attorney General for further action;

(h) Provide information to and applications for prescription drug programs for consumers without insurance coverage for prescription drugs or pharmaceutical services;

(i) Establish and maintain an Internet website which includes:

(1) Information concerning purchasing prescription drugs from Canadian pharmacies that have been recommended by the State Board of Pharmacy for inclusion on the Internet website pursuant to subsection 4 of NRS 639.2328;

(2) Links to websites of Canadian pharmacies which have been recommended by the State Board of Pharmacy for inclusion on the Internet website pursuant to subsection 4 of NRS 639.2328; and

(3) A link to the website established and maintained pursuant to NRS 439A.270 which provides information to the general public concerning the charges imposed and the quality of the services provided by the hospitals and surgical centers for ambulatory patients in this State;

(j) Assist consumers with accessing a navigator, case manager or facilitator to help the consumer obtain health care services;

(k) Assist consumers with scheduling an appointment with a provider of health care who is in the network of providers under contract to provide services to participants in the health care plan under which the consumer is covered;

(l) Assist consumers with filing complaints against health care facilities and health care professionals;

(m) Assist consumers with filing complaints with the Commissioner of Insurance against issuers of health care plans; and

(n) On or before January 31 of each year, compile a report of aggregated information submitted to the Office for Consumer Health Assistance pursuant to NRS 687B.675, aggregated for each type of provider of health care for which such information is provided and submit the report to the Director of the Legislative Counsel Bureau for transmittal to:

(1) In even-numbered years, the Legislative Committee on Health Care; and

(2) In odd-numbered years, the next regular session of the Legislature.

2. The Advocate may adopt regulations to carry out the provisions of this section and NRS 232.461 and 232.462.

3. As used in this section:

(a) "Health care facility" has the meaning ascribed to it in NRS 162A.740.

(b) "Navigator, case manager or facilitator" has the meaning ascribed to it in NRS 687B.675.

(c) "Public Option" means the Public Option established pursuant to section 10 of this act.

Sec. 20. NRS 233B.039 is hereby amended to read as follows:

233B.039 1. The following agencies are entirely exempted from the requirements of this chapter:

(a) The Governor.

(b) Except as otherwise provided in NRS 209.221, the Department of Corrections.

(c) The Nevada System of Higher Education.

(d) The Office of the Military.

(e) The Nevada Gaming Control Board.

(f) Except as otherwise provided in NRS 368A.140 and 463.765, the Nevada Gaming Commission.

(g) Except as otherwise provided in NRS 425.620, the Division of Welfare and Supportive Services of the Department of Health and Human Services.

(h) Except as otherwise provided in NRS 422.390, the Division of Health Care Financing and Policy of the Department of Health and Human Services.

(i) Except as otherwise provided in NRS 533.365, the Office of the State Engineer.

(j) The Division of Industrial Relations of the Department of Business and Industry acting to enforce the provisions of NRS 618.375.

(k) The Administrator of the Division of Industrial Relations of the Department of Business and Industry in establishing and adjusting the schedule of fees and charges for accident benefits pursuant to subsection 2 of NRS 616C.260.

(l) The Board to Review Claims in adopting resolutions to carry out its duties pursuant to NRS 445C.310.

(m) The Silver State Health Insurance Exchange.

(n) The Cannabis Compliance Board.

2. Except as otherwise provided in subsection 5 and NRS 391.323, the Department of Education, the Board of the Public Employees' Benefits Program and the Commission on Professional Standards in Education are subject to the provisions of this chapter for the purpose of adopting regulations but not with respect to any contested case.

3. The special provisions of:

(a) Chapter 612 of NRS for the adoption of an emergency regulation or the distribution of regulations by and the judicial review of decisions of the Employment Security Division of the Department of Employment, Training and Rehabilitation;

(b) Chapters 616A to 617, inclusive, of NRS for the determination of contested claims;

(c) Chapter 91 of NRS for the judicial review of decisions of the Administrator of the Securities Division of the Office of the Secretary of State; and

(d) NRS 90.800 for the use of summary orders in contested cases,

➥ prevail over the general provisions of this chapter.

4. The provisions of NRS 233B.122, 233B.124, 233B.125 and 233B.126 do not apply to the Department of Health and Human Services in the adjudication of contested cases involving the issuance of letters of approval for health facilities and agencies.

5. The provisions of this chapter do not apply to:

(a) Any order for immediate action, including, but not limited to, quarantine and the treatment or cleansing of infected or infested animals, objects or premises, made under the authority of the State

Board of Agriculture, the State Board of Health, or any other agency of this State in the discharge of a responsibility for the preservation of human or animal health or for insect or pest control;

(b) An extraordinary regulation of the State Board of Pharmacy adopted pursuant to NRS 453.2184;

(c) A regulation adopted by the State Board of Education pursuant to NRS 388.255 or 394.1694;

(d) The judicial review of decisions of the Public Utilities Commission of Nevada;

(e) The adoption, amendment or repeal of policies by the Rehabilitation Division of the Department of Employment, Training and Rehabilitation pursuant to NRS 426.561 or 615.178;

(f) The adoption or amendment of a rule or regulation to be included in the State Plan for Services for Victims of Crime by the Department of Health and Human Services pursuant to NRS 217.130;

(g) The adoption, amendment or repeal of rules governing the conduct of contests and exhibitions of unarmed combat by the Nevada Athletic Commission pursuant to NRS 467.075; ~~[or]~~

(h) The adoption, amendment or repeal of regulations by the Director of the Department of Health and Human Services pursuant to NRS 447.335 to 447.350, inclusive ~~[.]~~ ***; or***

(i) The adoption, amendment or repeal of any rule or policy governing the Public Option established pursuant to the chapter created by sections 2 to 15, inclusive, of this act.

6. The State Board of Parole Commissioners is subject to the provisions of this chapter for the purpose of adopting regulations but not with respect to any contested case.

Sec. 20.5. NRS 287.04335 is hereby amended to read as follows:

287.04335 If the Board provides health insurance through a plan of self-insurance, it shall comply with the provisions of NRS 687B.409, ***689B.0353,*** 689B.255, ***695C.1723,*** 695G.150, 695G.155, 695G.160, 695G.162, 695G.164, 695G.1645, 695G.1665, 695G.167, 695G.170 to 695G.174, inclusive, 695G.177, 695G.200 to 695G.230, inclusive, 695G.241 to 695G.310, inclusive, and 695G.405, in the same manner as an insurer that is licensed pursuant to title 57 of NRS is required to comply with those provisions.

Sec. 21. NRS 287.0434 is hereby amended to read as follows:

287.0434 The Board may:

1. Use its assets only to pay the expenses of health care for its members and covered dependents, to pay its employees' salaries and to pay administrative and other expenses.

2. Enter into contracts relating to the administration of the Program, including, without limitation, contracts with licensed administrators and qualified actuaries. Each such contract with a licensed administrator:

(a) Must be submitted to the Commissioner of Insurance not less than 30 days before the date on which the contract is to become effective for approval as to the licensing and fiscal status of the licensed administrator and status of any legal or administrative actions in this State against the licensed administrator that may impair his or her ability to provide the services in the contract.

(b) Does not become effective unless approved by the Commissioner.

(c) Shall be deemed to be approved if not disapproved by the Commissioner within 30 days after its submission.

3. Enter into contracts with physicians, surgeons, hospitals, health maintenance organizations and rehabilitative facilities for medical, surgical and rehabilitative care and the evaluation, treatment and nursing care of members and covered dependents. The Board shall not enter into a contract pursuant to this subsection unless:

(a) Provision is made by the Board to offer all the services specified in the request for proposals, either by a health maintenance organization or through separate action of the Board.

(b) The rates set forth in the contract are based on:

(1) For active and retired state officers and employees and their dependents, the commingled claims experience of such active and retired officers and employees and their dependents for whom the Program provides primary health insurance coverage in a single risk pool; and

(2) For active and retired officers and employees of public agencies enumerated in NRS 287.010 that contract with the Program to obtain group insurance by participation in the Program and their dependents, the commingled claims experience of such active and retired officers and employees and their dependents for whom the Program provides primary health insurance coverage in a single risk pool.

(c) For a contract with a physician, surgeon, hospital or rehabilitative facility, the physician, surgeon, hospital or rehabilitative facility has also complied with the requirements of section 13 of this act.

4. Enter into contracts for the services of other experts and specialists as required by the Program.

5. Charge and collect from an insurer, health maintenance organization, organization for dental care or nonprofit medical service corporation, a fee for the actual expenses incurred by the Board or a participating public agency in administering a plan of insurance offered by that insurer, organization or corporation.

6. Charge and collect the amount due from local governments pursuant to paragraph (b) of subsection 4 of NRS 287.023. If the payment of a local government pursuant to that provision is delinquent by more than 90 days, the Board shall notify the Executive Director of the Department of Taxation pursuant to NRS 354.671.

Sec. 22. NRS 333.705 is hereby amended to read as follows:

333.705 1. Except as otherwise provided in this section, a using agency shall not enter into a contract with a person to provide services for the using agency if:

(a) The person is a current employee of an agency of this State;

(b) The person is a former employee of an agency of this State and less than 2 years have expired since the termination of the person's employment with the State; or

(c) The person is employed by the Department of Transportation for a transportation project that is entirely funded by federal money and the term of the contract is for more than 4 years,

➥ unless the using agency submits a written disclosure to the State Board of Examiners indicating the services to be provided pursuant to the contract and the person who will be providing those services and, after reviewing the disclosure, the State Board of Examiners approves entering into a contract with the person. The requirements of this subsection apply to any person employed by a business or other entity that enters into a contract to provide services for a using agency if the person will be performing or producing the services for which the business or entity is employed.

2. The provisions of paragraph (b) of subsection 1 apply to employment through a temporary employment service. A temporary employment service providing employees for a using agency shall provide the using agency with the names of the employees to be provided to the agency. The State Board of Examiners shall not approve a contract pursuant to paragraph (b) of subsection 1 unless the Board determines that one or more of the following circumstances exist:

(a) The person provides services that are not provided by any other employee of the using agency or for which a critical labor shortage exists; or

(b) A short-term need or unusual economic circumstance exists for the using agency to contract with the person.

3. The approval by the State Board of Examiners to contract with a person pursuant to subsection 1:

(a) May occur at the same time and in the same manner as the approval by the State Board of Examiners of a proposed contract pursuant to subsection 7 of NRS 333.700; and

(b) Must occur before the date on which the contract becomes binding on the using agency.

4. A using agency may contract with a person pursuant to paragraph (a) or (b) of subsection 1 without obtaining the approval of the State Board of Examiners if the term of the contract is for less than 4 months and the head of the using agency determines that an emergency exists which necessitates the contract. If a using agency contracts with a person pursuant to this subsection, the using agency shall submit a copy of the contract and a description of the emergency to the State Board of Examiners, which shall review the contract and the description of the emergency and notify the using agency whether the State Board of Examiners would have approved the contract if it had not been entered into pursuant to this subsection.

5. Except as otherwise provided in subsection 9, a using agency shall, not later than 10 days after the end of each fiscal quarter, report to the Interim Finance Committee concerning all contracts to provide services for the using agency that were entered into by the using agency during the fiscal quarter with a person who is a current or former employee of a department, division or other agency of this State.

6. Except as otherwise provided in subsection 9, a using agency shall not contract with a temporary employment service unless the contracting process is controlled by rules of open competitive bidding.

7. Each board or commission of this State and each institution of the Nevada System of Higher Education that employs a consultant shall, at least once every 6 months, submit to the Interim Finance Committee a report setting forth:

(a) The number of consultants employed by the board, commission or institution;

(b) The purpose for which the board, commission or institution employs each consultant;

(c) The amount of money or other remuneration received by each consultant from the board, commission or institution; and

(d) The length of time each consultant has been employed by the board, commission or institution.

8. A using agency, board or commission of this State and each institution of the Nevada System of Higher Education:

(a) Shall make every effort to limit the number of contracts it enters into with persons to provide services which have a term of more than 2 years and which are in the amount of less than $1,000,000; and

(b) Shall not enter into a contract with a person to provide services without ensuring that the person is in active and good standing with the Secretary of State.

9. The provisions of subsections 1 to 6, inclusive, do not apply to:

(a) The Nevada System of Higher Education or a board or commission of this State.

(b) The employment of professional engineers by the Department of Transportation if those engineers are employed for a transportation project that is entirely funded by federal money.

(c) Contracts in the amount of $1,000,000 or more entered into:

(1) Pursuant to the State Plan for Medicaid established pursuant to NRS 422.063.

(2) For financial services.

(3) Pursuant to the Public Employees' Benefits Program.

(4) Pursuant to the Public Option established pursuant to section 10 of this act.

(d) The employment of a person by a business or entity which is a provider of services under the State Plan for Medicaid and which provides such services on a fee-for-service basis or through managed care.

(e) The employment of a former employee of an agency of this State who is not receiving retirement benefits under the Public Employees' Retirement System during the duration of the contract.

Sec. 23. Chapter 422 of NRS is hereby amended by adding thereto the provisions set forth as sections 24 to 28, inclusive, of this act.

Sec. 24. ***1. The Director shall, to the extent authorized by federal law, include in the State Plan for Medicaid authorization for a pregnant woman who is determined by a qualified provider to be presumptively eligible for Medicaid to enroll in Medicaid until the last day of the month immediately following the month of enrollment without submitting an application for enrollment in Medicaid which includes additional proof of eligibility.***

2. To the extent that money is available, the Director shall, to the extent authorized by federal law, include in the State Plan for Medicaid authorization for a pregnant woman whose household income is at or below 200 percent of the federally designated level signifying poverty to enroll in Medicaid.

3. Unless otherwise required by federal law, the Director shall not include in the State Plan for Medicaid a requirement that a pregnant woman who resides in this State and who is otherwise eligible for Medicaid must reside in the United States for a prescribed period of time before enrolling in Medicaid.

4. As used in this section, "qualified provider" has the meaning ascribed to it in 42 U.S.C. § 1396r-1(b)(2).

Sec. 25. ***1. The Director shall include in the State Plan for Medicaid a requirement that the State, to the extent authorized by federal law, pay the nonfederal share of expenditures incurred for the services of a community health worker who provides services under the supervision of a physician, physician assistant or advanced practice registered nurse.***

2. As used in this section, "community health worker" has the meaning ascribed to it in NRS 449.0027.

Sec. 26. ***1. The Director shall, to the extent authorized by federal law, include in the State Plan for Medicaid a requirement that the State pay the nonfederal share of expenditures incurred for doula services provided by an enrolled doula.***

2. The Department shall apply to the Secretary of Health and Human Services for a waiver granted pursuant to 42 U.S.C. § 1315 or apply for an amendment of the State Plan for Medicaid that authorizes the Department to receive federal funding to include in the State Plan for Medicaid coverage of doula services provided by an enrolled doula. The Department shall fully cooperate in good faith with the Federal Government during the application process to satisfy the requirements of the Federal Government for obtaining a waiver or amendment pursuant to this section.

3. A person who wishes to receive reimbursement through the Medicaid program for doula services provided to a recipient of Medicaid must submit to the Division:

(a) An application for enrollment in the form prescribed by the Division; and

(b) Proof that he or she possesses the required training and qualifications prescribed by the Division pursuant to subsection 4.

4. The Division, in consultation with community-based organizations that provide services to pregnant women in this

State, shall prescribe the required training and qualifications for enrollment pursuant to subsection 3 to receive reimbursement through Medicaid for doula services.

5. As used in this section:

(a) "Doula services" means services to provide education and support relating to childbirth, including, without limitation, emotional and physical support provided during pregnancy, labor, birth and the postpartum period.

(b) "Enrolled doula" means a doula who is enrolled with the Division pursuant to this section to receive reimbursement through Medicaid for doula services.

Sec. 27. *1. To the extent that money is available, the Director shall include in the State Plan for Medicaid a requirement that, except as otherwise provided in subsection 2, the State must provide reimbursement for the services of an advanced practice registered nurse, including, without limitation, a certified nurse-midwife, to the same extent as if the services were provided by a physician.*

2. The provisions of subsection 1 do not apply to services provided to a recipient of Medicaid who receives health care services through a Medicaid managed care program.

3. As used in this section, "certified nurse-midwife" means a person who is:

(a) Certified as a nurse-midwife by the American Midwifery Certification Board, or its successor organization; and

(b) Licensed as an advanced practice registered nurse pursuant to NRS 632.237.

Sec. 28. *1. To the extent that money is available, the Director shall include in the State Plan for Medicaid a requirement that the State pay the nonfederal share of expenditures incurred for:*

(a) Supplies for breastfeeding a child until the child's first birthday. Such supplies include, without limitation, electric or hospital-grade breast pumps that:

(1) Have been prescribed or ordered by a qualified provider of health care; and

(2) Are medically necessary for the mother or the child.

(b) Such prenatal screenings and tests as are recommended by the American College of Obstetricians and Gynecologists, or its successor organization.

2. The Director shall include in the State Plan for Medicaid a requirement that, to the extent that money and federal financial participation are available, the State must pay the nonfederal

share of expenditures incurred for lactation consultation and support.

3. As used in this section:

(a) "Medically necessary" has the meaning ascribed to it in NRS 695G.055.

(b) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 29. NRS 422.2372 is hereby amended to read as follows:

422.2372 The Administrator shall:

1. Supply the Director with material on which to base proposed legislation.

2. Cooperate with the Federal Government and state governments for the more effective attainment of the purposes of this chapter.

3. Coordinate the activities of the Division with other agencies, both public and private, with related or similar activities.

4. Keep a complete and accurate record of all proceedings, record and file all bonds and contracts, and assume responsibility for the custody and preservation of all papers and documents pertaining to the office of the Administrator.

5. Inform the public in regard to the activities and operation of the Division, and provide other information which will acquaint the public with the financing of Medicaid programs.

6. Conduct studies into the causes of the social problems with which the Division is concerned.

7. Invoke any legal, equitable or special procedures for the enforcement of orders issued by the Administrator or the enforcement of the provisions of this chapter.

8. ***Exclude from participation in Medicaid any provider of health care that fails to comply with the requirements of section 13 of this act.***

9. Exercise any other powers that are necessary and proper for the standardization of state work, to expedite business and to promote the efficiency of the service provided by the Division.

Sec. 30. NRS 422.273 is hereby amended to read as follows:

422.273 1. ***To the extent that money is available, the Department shall:***

(a) Establish a Medicaid managed care program to provide health care services to recipients of Medicaid in all geographic areas of this State. The program is not required to provide services to recipients of Medicaid who are aged, blind or disabled pursuant to Title XVI of the Social Security Act, 42 U.S.C. §§ 1381 et seq.

(b) Conduct a statewide procurement process to select health maintenance organizations to provide the services described in paragraph (a).

2. For any Medicaid managed care program established in the State of Nevada, the Department shall contract only with a health maintenance organization that has:

(a) Negotiated in good faith with a federally-qualified health center to provide health care services for the health maintenance organization;

(b) Negotiated in good faith with the University Medical Center of Southern Nevada to provide inpatient and ambulatory services to recipients of Medicaid; ~~[and]~~

(c) Negotiated in good faith with the University of Nevada School of Medicine to provide health care services to recipients of Medicaid ~~[.]~~ ***; and***

(d) Complied with the provisions of subsection 2 of section 12 of this act.

➥ Nothing in this section shall be construed as exempting a federally-qualified health center, the University Medical Center of Southern Nevada or the University of Nevada School of Medicine from the requirements for contracting with the health maintenance organization.

~~[2.]~~ ***3.*** During the development and implementation of any Medicaid managed care program, the Department shall cooperate with the University of Nevada School of Medicine by assisting in the provision of an adequate and diverse group of patients upon which the school may base its educational programs.

~~[3.]~~ ***4.*** The University of Nevada School of Medicine may establish a nonprofit organization to assist in any research necessary for the development of a Medicaid managed care program, receive and accept gifts, grants and donations to support such a program and assist in establishing educational services about the program for recipients of Medicaid.

~~[4.]~~ ***5.*** For the purpose of contracting with a Medicaid managed care program pursuant to this section, a health maintenance organization is exempt from the provisions of NRS 695C.123.

~~[5.]~~ ***6. To the extent that money is available, a Medicaid managed care program must include, without limitation, a state-directed payment arrangement established in accordance with 42 C.F.R. § 438.6(c) to require a Medicaid managed care organization to reimburse a critical access hospital and any federally-qualified health center or rural health clinic affiliated***

with a critical access hospital for covered services at a rate that is equal to or greater than the rate received by the critical access hospital, federally-qualified health center or rural health clinic, as applicable, for services provided to recipients of Medicaid on a fee-for-service basis.

7. The provisions of this section apply to any managed care organization, including a health maintenance organization, that provides health care services to recipients of Medicaid under the State Plan for Medicaid or the Children's Health Insurance Program pursuant to a contract with the Division. Such a managed care organization or health maintenance organization is not required to establish a system for conducting external reviews of adverse determinations in accordance with chapter 695B, 695C or 695G of NRS. This subsection does not exempt such a managed care organization or health maintenance organization for services provided pursuant to any other contract.

~~[6.]~~ ***8.*** As used in this section, unless the context otherwise requires:

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

(b) "Federally-qualified health center" has the meaning ascribed to it in 42 U.S.C. § 1396d(l)(2)(B).

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

~~[(c)]~~ ***(d)*** "Managed care organization" has the meaning ascribed to it in NRS 695G.050.

(e) "Rural health clinic" has the meaning ascribed to it in 42 C.F.R. § 405.2401.

Sec. 31. (Deleted by amendment.)

Sec. 32. NRS 427A.605 is hereby amended to read as follows:

427A.605 1. The Director may establish a program to negotiate discounts and rebates for hearing devices and related costs, including, without limitation, ear molds, batteries and FM systems, for children in this State who are deaf or hard of hearing on behalf of entities described in subsection 2 who participate in the program.

2. The following persons and entities may participate in a program established pursuant to subsection 1:

(a) The Public Employees' Benefits Program;

(b) A governing body of a county, school district, municipal corporation, political subdivision, public corporation or other local

governmental agency that provides health coverage to employees through a self-insurance reserve fund pursuant to NRS 287.010;

(c) An insurer that holds a certificate of authority to transact insurance in this State pursuant to chapter 680A of NRS;

(d) An employer or employee organization based in this State that provides health coverage to employees through a self-insurance reserve fund;

(e) A governmental agency or nonprofit organization that purchases hearing devices for children in this State who are deaf or hard of hearing;

(f) A resident of this State who does not have coverage for hearing devices; ~~[and]~~

(g) ***The Public Option established pursuant to section 10 of this act; and***

(h) Any other person or entity that provides health coverage or otherwise purchases hearing devices for children in this State who are deaf or hard of hearing.

3. A person or entity described in subsection 2 may participate in any program established pursuant to subsection 1 by submitting an application to the Department in the form prescribed by the Department.

Sec. 33. NRS 432B.220 is hereby amended to read as follows:

432B.220 1. Any person who is described in subsection 4 and who, in his or her professional or occupational capacity, knows or has reasonable cause to believe that a child has been abused or neglected shall:

(a) Except as otherwise provided in subsection 2, report the abuse or neglect of the child to an agency which provides child welfare services or to a law enforcement agency; and

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

2. If a person who is required to make a report pursuant to subsection 1 knows or has reasonable cause to believe that the abuse or neglect of the child involves an act or omission of:

(a) A person directly responsible or serving as a volunteer for or an employee of a public or private home, institution or facility where the child is receiving child care outside of the home for a portion of the day, the person shall make the report to a law enforcement agency.

(b) An agency which provides child welfare services or a law enforcement agency, the person shall make the report to an agency other than the one alleged to have committed the act or omission,

and the investigation of the abuse or neglect of the child must be made by an agency other than the one alleged to have committed the act or omission.

3. Any person who is described in paragraph (a) of subsection 4 who delivers or provides medical services to a newborn infant and who, in his or her professional or occupational capacity, knows or has reasonable cause to believe that the newborn infant has been affected by a fetal alcohol spectrum disorder or prenatal substance use disorder or has withdrawal symptoms resulting from prenatal substance exposure shall, as soon as reasonably practicable but not later than 24 hours after the person knows or has reasonable cause to believe that the newborn infant is so affected or has such symptoms, notify an agency which provides child welfare services of the condition of the infant and refer each person who is responsible for the welfare of the infant to an agency which provides child welfare services for appropriate counseling, training or other services. A notification and referral to an agency which provides child welfare services pursuant to this subsection shall not be construed to require prosecution for any illegal action.

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

(a) A person providing services licensed or certified in this State pursuant to, without limitation, chapter 450B, 630, 630A, 631, 632, 633, 634, 634A, 635, 636, 637, 637B, 639, 640, 640A, 640B, 640C, 640D, 640E, 641, 641A, 641B, 641C or 653 of NRS.

(b) Any personnel of a medical facility licensed pursuant to chapter 449 of NRS who are engaged in the admission, examination, care or treatment of persons or an administrator, manager or other person in charge of such a medical facility upon notification of suspected abuse or neglect of a child by a member of the staff of the medical facility.

(c) A coroner.

(d) A member of the clergy, practitioner of Christian Science or religious healer, unless the person has acquired the knowledge of the abuse or neglect from the offender during a confession.

(e) A person employed by a public school or private school and any person who serves as a volunteer at such a school.

(f) Any person who maintains or is employed by a facility or establishment that provides care for children, children's camp or other public or private facility, institution or agency furnishing care to a child.

(g) Any person licensed pursuant to chapter 424 of NRS to conduct a foster home.

(h) Any officer or employee of a law enforcement agency or an adult or juvenile probation officer.

(i) Except as otherwise provided in NRS 432B.225, an attorney.

(j) Any person who maintains, is employed by or serves as a volunteer for an agency or service which advises persons regarding abuse or neglect of a child and refers them to persons and agencies where their requests and needs can be met.

(k) Any person who is employed by or serves as a volunteer for a youth shelter. As used in this paragraph, "youth shelter" has the meaning ascribed to it in NRS 244.427.

(l) Any adult person who is employed by an entity that provides organized activities for children, including, without limitation, a person who is employed by a school district or public school.

(m) Any person who is enrolled with the Division of Health Care Financing and Policy of the Department of Health and Human Services to provide doula services to recipients of Medicaid pursuant to section 26 of this act.

5. A report may be made by any other person.

6. If a person who is required to make a report pursuant to subsection 1 knows or has reasonable cause to believe that a child has died as a result of abuse or neglect, the person shall, as soon as reasonably practicable, report this belief to an agency which provides child welfare services or a law enforcement agency. If such a report is made to a law enforcement agency, the law enforcement agency shall notify an agency which provides child welfare services and the appropriate medical examiner or coroner of the report. If such a report is made to an agency which provides child welfare services, the agency which provides child welfare services shall notify the appropriate medical examiner or coroner of the report. The medical examiner or coroner who is notified of a report pursuant to this subsection shall investigate the report and submit his or her written findings to the appropriate agency which provides child welfare services, the appropriate district attorney and a law enforcement agency. The written findings must include, if obtainable, the information required pursuant to the provisions of subsection 2 of NRS 432B.230.

7. The agency, board, bureau, commission, department, division or political subdivision of the State responsible for the licensure, certification or endorsement of a person who is described in subsection 4 and who is required in his or her professional or occupational capacity to be licensed, certified or endorsed in this State shall, at the time of initial licensure, certification or endorsement:

(a) Inform the person, in writing or by electronic communication, of his or her duty as a mandatory reporter pursuant to this section;

(b) Obtain a written acknowledgment or electronic record from the person that he or she has been informed of his or her duty pursuant to this section; and

(c) Maintain a copy of the written acknowledgment or electronic record for as long as the person is licensed, certified or endorsed in this State.

8. The employer of a person who is described in subsection 4 and who is not required in his or her professional or occupational capacity to be licensed, certified or endorsed in this State must, upon initial employment of the person:

(a) Inform the person, in writing or by electronic communication, of his or her duty as a mandatory reporter pursuant to this section;

(b) Obtain a written acknowledgment or electronic record from the person that he or she has been informed of his or her duty pursuant to this section; and

(c) Maintain a copy of the written acknowledgment or electronic record for as long as the person is employed by the employer.

9. Before a person may serve as a volunteer at a public school or private school, the school must:

(a) Inform the person, in writing or by electronic communication, of his or her duty as a mandatory reporter pursuant to this section and NRS 392.303;

(b) Obtain a written acknowledgment or electronic record from the person that he or she has been informed of his or her duty pursuant to this section and NRS 392.303; and

(c) Maintain a copy of the written acknowledgment or electronic record for as long as the person serves as a volunteer at the school.

10. As used in this section:

(a) "Private school" has the meaning ascribed to it in NRS 394.103.

(b) "Public school" has the meaning ascribed to it in NRS 385.007.

Sec. 34. NRS 439B.260 is hereby amended to read as follows:

439B.260 1. A major hospital shall reduce or discount the total billed charge by at least 30 percent for hospital services provided to an inpatient who:

(a) Has no policy of health insurance or other contractual agreement with a third party that provides health coverage for the charge;

(b) Is not eligible for coverage by a state or federal program of public assistance that would provide for the payment of the charge; and

(c) Makes reasonable arrangements within 30 days after the date that notice was sent pursuant to subsection 2 to pay the hospital bill.

2. A major hospital shall include on or with the first statement of the hospital bill provided to the patient after his or her discharge a notice of the reduction or discount available pursuant to this section, including, without limitation, notice of the criteria a patient must satisfy to qualify for a reduction or discount.

3. A major hospital or patient who disputes the reasonableness of arrangements made pursuant to paragraph (c) of subsection 1 may submit the dispute to the Bureau for Hospital Patients for resolution as provided in NRS 232.462.

4. A major hospital shall reduce or discount the total billed charge of its outpatient pharmacy by at least 30 percent to a patient who is eligible for Medicare.

5. As used in this section, "third party" means:

(a) An insurer, as that term is defined in NRS 679B.540;

(b) A health benefit plan, as that term is defined in NRS 687B.470, for employees which provides coverage for services and care at a hospital;

(c) A participating public agency, as that term is defined in NRS 287.04052, and any other local governmental agency of the State of Nevada which provides a system of health insurance for the benefit of its officers and employees, and the dependents of officers and employees, pursuant to chapter 287 of NRS; ~~[or]~~

(d) ***The Public Option established pursuant to section 10 of this act; or***

(e) Any other insurer or organization providing health coverage or benefits in accordance with state or federal law.

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

Sec. 35. NRS 439B.665 is hereby amended to read as follows:

439B.665 1. On or before February 1 of each year, a nonprofit organization that advocates on behalf of patients or funds medical research in this State and has received a payment, donation, subsidy or anything else of value from a manufacturer, third party or pharmacy benefit manager or a trade or advocacy group for manufacturers, third parties or pharmacy benefit managers during the immediately preceding calendar year shall:

(a) Compile a report which includes:

(1) For each such contribution, the amount of the contribution and the manufacturer, third party or pharmacy benefit manager or group that provided the payment, donation, subsidy or other contribution; and

(2) The percentage of the total gross income of the organization during the immediately preceding calendar year attributable to payments, donations, subsidies or other contributions from each manufacturer, third party, pharmacy benefit manager or group; and

(b) Except as otherwise provided in this paragraph, post the report on an Internet website that is maintained by the nonprofit organization and accessible to the public. If the nonprofit organization does not maintain an Internet website that is accessible to the public, the nonprofit organization shall submit the report compiled pursuant to paragraph (a) to the Department.

2. As used in this section, "third party" means:

(a) An insurer, as that term is defined in NRS 679B.540;

(b) A health benefit plan, as that term is defined in NRS 687B.470, for employees which provides coverage for prescription drugs;

(c) A participating public agency, as that term is defined in NRS 287.04052, and any other local governmental agency of the State of Nevada which provides a system of health insurance for the benefit of its officers and employees, and the dependents of officers and employees, pursuant to chapter 287 of NRS; ~~[or]~~

(d) ***The Public Option established pursuant to section 10 of this act; or***

(e) Any other insurer or organization that provides health coverage or benefits in accordance with state or federal law.

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

Sec. 36. NRS 439B.736 is hereby amended to read as follows:

439B.736 1. "Third party" includes, without limitation:

(a) The issuer of a health benefit plan, as defined in NRS 695G.019, which provides coverage for medically necessary emergency services;

(b) The Public Employees' Benefits Program established pursuant to subsection 1 of NRS 287.043; ~~[and]~~

(c) ***The Public Option established pursuant to section 10 of this act; and***

(d) Any other entity or organization that elects pursuant to NRS 439B.757 for the provisions of NRS 439B.700 to 439B.760,

inclusive, to apply to the provision of medically necessary emergency services by out-of-network providers to covered persons.

2. The term does not include the State Plan for Medicaid, the Children's Health Insurance Program or a health maintenance organization, as defined in NRS 695C.030, or managed care organization, as defined in NRS 695G.050, when providing health care services through managed care to recipients of Medicaid under the State Plan for Medicaid or insurance pursuant to the Children's Health Insurance Program pursuant to a contract with the Division of Health Care Financing and Policy of the Department.

Sec. 37. NRS 449A.162 is hereby amended to read as follows:

449A.162 1. Except as otherwise provided in subsection 3, if a hospital provides hospital care to a person who has a policy of health insurance issued by a third party that provides health coverage for care provided at that hospital and the hospital has a contractual agreement with the third party, the hospital:

(a) Shall proceed with any efforts to collect on any amount owed to the hospital for the hospital care in accordance with the provisions of NRS 449A.159.

(b) Shall not collect or attempt to collect from the patient or other responsible party more than the sum of the amounts of any deductible, copayment or coinsurance payable by or on behalf of the patient under the policy of health insurance.

(c) Shall not collect or attempt to collect that amount from:

(1) Any proceeds or potential proceeds of a civil action brought by or on behalf of the patient, including, without limitation, any amount awarded for medical expenses; or

(2) An insurer other than an insurer that provides coverage under a policy of health insurance or an insurer that provides coverage for medical payments under a policy of casualty insurance.

2. If the hospital collects or receives any payments from an insurer that provides coverage for medical payments under a policy of casualty insurance, the hospital shall, not later than 30 days after a determination is made concerning coverage, return to the patient any amount collected or received that is in excess of the deductible, copayment or coinsurance payable by or on behalf of the patient under the policy of health insurance.

3. This section does not apply to:

(a) Amounts owed to the hospital which are not covered under the policy of health insurance; or

(b) Medicaid, Medicare, the Children's Health Insurance Program or any other public program which may pay all or part of the bill.

4. This section does not limit any rights of a patient to contest an attempt to collect an amount owed to a hospital, including, without limitation, contesting a lien obtained by a hospital.

5. As used in this section, "third party" means:

(a) An insurer, as defined in NRS 679B.540;

(b) A health benefit plan, as defined in NRS 687B.470, for employees which provides coverage for services and care at a hospital;

(c) A participating public agency, as defined in NRS 287.04052, and any other local governmental agency of the State of Nevada which provides a system of health insurance for the benefit of its officers and employees, and the dependents of officers and employees, pursuant to chapter 287 of NRS; ~~[or]~~

(d) ***The Public Option established pursuant to section 10 of this act; or***

(e) Any other insurer or organization providing health coverage or benefits in accordance with state or federal law.

Sec. 38. Section 10 of this act is hereby amended to read as follows:

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

2. The Director:

(a) Shall make the Public Option available:

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

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

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

(c) Shall comply with all state and federal laws and regulations applicable to insurers when carrying out the

provisions of sections 2 to 15, inclusive, of this act, to the extent that such laws and regulations are not waived.

3. The Public Option must:

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

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

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

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

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

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

~~6.]~~ As used in this section:

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

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

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

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

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

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

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

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

Sec. 38.3. 1. There is hereby appropriated from the State General Fund to the Division of Welfare and Supportive Services of the Department of Health and Human Services the sum of $167,850 to pay the costs for enhancements to the information technology system of the Division that are necessary to carry out the provisions of sections 24 to 28, inclusive, of this act.

2. Any remaining balance of the appropriation made by subsection 1 must not be committed for expenditure after June 30, 2023, by the entity to which the appropriation is made or any entity to which money from the appropriation is granted or otherwise transferred in any manner, and any portion of the appropriated money remaining must not be spent for any purpose after September 15, 2023, by either the entity to which the money was appropriated or the entity to which the money was subsequently granted or transferred, and must be reverted to the State General Fund on or before September 15, 2023.

Sec. 38.6. 1. There is hereby appropriated from the State General Fund to the Public Option Trust Fund created by section 15 of this act the sum of $1,639,366 to pay the costs of carrying out the provisions of sections 2 to 15, inclusive, and 39 of this act.

2. Any remaining balance of the appropriation made by subsection 1 must not be committed for expenditure after June 30, 2023, by the entity to which the appropriation is made or any entity to which money from the appropriation is granted or otherwise transferred in any manner, and any portion of the appropriated money remaining must not be spent for any purpose after September 15, 2023, by either the entity to which the money was appropriated or the entity to which the money was subsequently granted or transferred, and must be reverted to the State General Fund on or before September 15, 2023.

Sec. 38.8. 1. There is hereby appropriated from the State General Fund to the Silver State Health Insurance Exchange the sum of $600,000 to pay the costs of carrying out the provisions of sections 2 to 15, inclusive, and 39 of this act.

2. Any remaining balance of the appropriation made by subsection 1 must not be committed for expenditure after June 30, 2023, by the entity to which the appropriation is made or any entity to which money from the appropriation is granted or otherwise

transferred in any manner, and any portion of the appropriated money remaining must not be spent for any purpose after September 15, 2023, by either the entity to which the money was appropriated or the entity to which the money was subsequently granted or transferred, and must be reverted to the State General Fund on or before September 15, 2023.

Sec. 39. 1. The Director of the Department of Health and Human Services, the Commissioner of Insurance and the Executive Director of the Silver State Health Insurance Exchange shall apply for the waiver described in paragraph (a) of subsection 1 of section 11 of this act not later than January 1, 2024.

2. In preparing the initial application for the waiver described in paragraph (a) of subsection 1 of section 11 of this act, the Director of the Department of Health and Human Services, the Commissioner of Insurance and the Executive Director of the Silver State Health Insurance Exchange shall contract with an independent actuary to conduct an actuarial assessment pursuant to subsection 2 of section 11 of this act. The actuarial assessment:

(a) Must be completed before the application for the waiver is submitted; and

(b) Must include, without limitation, an analysis of the likely effect on premiums for health insurance in this State of:

(1) The provisions of subsection 1 of section 13 of this act, as those provisions apply to providers of health care, as defined in NRS 695G.070, who participate in the Public Employees' Benefits Program established pursuant to subsection 1 of NRS 287.043 or provide care to an injured employee pursuant to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS, and the amendatory provisions of section 21 of this act; and

(2) Repealing the provisions described in subparagraph (1).

3. The Director of the Department of Health and Human Services shall make the Public Option available to natural persons who reside in this State in accordance with the provisions of section 10 of this act for the coverage year that begins on January 1, 2026.

4. As used in this section, "Public Option" has the meaning ascribed to it in section 8 of this act.

Sec. 39.5. On or before January 1, 2025, the Executive Director of the Silver State Health Insurance Exchange, in collaboration with the Department of Health and Human Services, shall:

1. Apply for the waiver described in subsection 1 of section 16.5 of this act; and

2. Submit to the Director of the Legislative Counsel Bureau for transmittal to the 83rd Session of the Legislature a report of recommendations concerning any revisions to Nevada law necessary to:

(a) Authorize an organization described in section 501(c)(5) of the Internal Revenue Code to offer a policy of insurance described in subsection 1 of section 16.5 of this act for direct purchase outside the Exchange as a policy of individual health insurance;

(b) Align state law concerning individual health insurance with the requirements in the request for the waiver described in subsection 1 of section 16.5 of this act; and

(c) Ensure that any state subsidies available to reduce the cost of premiums for individual health insurance are available for a policy of insurance described in subsection 1 of section 16.5 of this act.

Sec. 40. Notwithstanding the provisions of NRS 218D.430 and 218D.435, a committee, other than the Assembly Standing Committee on Ways and Means and the Senate Standing Committee on Finance, may vote on this act before the expiration of the period prescribed for the return of a fiscal note in NRS 218D.475. This section applies retroactively from and after March 22, 2021.

Sec. 40.5. The provisions of NRS 354.599 do not apply to any additional expenses of a local government that are related to the provisions of this act.

Sec. 41. 1. This section and sections 16.3, 16.5, 16.8 and 39 to 40.5, inclusive, of this act become effective upon passage and approval.

2. Sections 1 to 14, inclusive, 16, 19, 20, 21, 22, 29 to 32, inclusive, and 34 to 37, inclusive, of this act become effective:

(a) Upon passage and approval for the purposes of procurement and any other preparatory administrative tasks necessary to carry out the provisions of those sections; and

(b) On January 1, 2026, for all other purposes.

3. Sections 15, 16.35 to 16.47, inclusive, 20.5, 38.3 and 38.6 of this act become effective on July 1, 2021.

4. Sections 17, 18, 23 to 28, inclusive, 33 and 38.8 of this act become effective on January 1, 2022.

5. Section 38 of this act becomes effective on January 1, 2030.

APPENDIX C
State of Nevada Guidance Memorandum

Steve Sisolak
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.

Suzanne Bierman, JD MPH
Administrator

GENERAL GUIDANCE LETTER 22-001

Date: October 4, 2022

From: Richard Whitley, DHHS Director
Suzanne Bierman, Administrator

Subject: Requirements for the Public Option Premiums

PURPOSE: This letter is intended to clarify the premium requirements of NRS 695K.200 for the Public Option products. As provided in state law, these requirements will be effective as of January 1, 2026 and expire on December 31, 2029. Pursuant to the Director's express authority in subsection 5 of NRS 695K.200, the Director revises the premium requirements in subsection 4 to mean that premiums for the Public Option:

- Must be lower than the average reference premium in each county by a percentage that increases each year, starting with 4% in year 1 and growing by at least 4% each year until it reaches at least 16% in year 4; and
- Must not increase in any given year by a percentage greater than the increase in the Consumer Price Index for Medical Care plus any adjustments necessary to reflect local changes in utilization and morbidity.

Also, for the purposes of these revisions and as further explained in this guidance, the average reference premium shall mean "the average second-lowest cost silver level plan available through the Exchange during the 2024 plan year by county trended forward for inflation according to the Consumer Price Index for Medical Care and any adjustments to reflect local changes in utilization and morbidity."

AUTHORITIES:

NRS 695K.200: [...]

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: [...]

(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.

NRS 695K.240: [...]

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.

APPLICATION

As provided in state statute, the premium-reduction requirements for the Public Option products are time-limited and will begin on January 1, 2026 and end on December 31, 2029. The plain language of subsection 5 under NRS 695K.200 provides that the Director may revise these requirements as long as the average premiums for the Public Option are at least 15 percent lower than the average reference premium in the State over the first four years of the program. For the reasons listed below, the Director revises the premium-reduction requirements in subsection 4 as follows:

> 4. Except as otherwise provided in this section, the premiums for the Public Option:
>
> (a) Must be ~~at least 5 percent~~ lower than the average reference premium in each county by a percentage that increases each year, starting with 4% in year 1 and growing by at least 4% each year until it reaches at least 16% in year 4 ~~for that zip code~~; and
>
> (b) Must not increase in any year by a percentage greater than the increase in the ~~Medicare Economic Index~~ Consumer Price Index for Medical Care for that year plus any adjustments necessary to reflect local changes in utilization and morbidity.

The purpose of these revisions is to ensure that the Public Option premiums will be actuarially sound, meaning that they can reasonably cover the projected cost of health care claims and growth of medical inflation in the state's individual health insurance market. For example, subsection 4 of NRS 695K.200, as originally written, applies the Medicare Economic Index (MEI) as a trend factor for controlling the cost of inflation in the Public Option products. Upon review and in consultation with the Department of Insurance, Exchange, and independent actuarial experts—the Department has determined that MEI does not adequately reflect the high rate of growth in medical inflation in the State's individual

health insurance market, where the Public Option products must be offered. Therefore, pursuant to the Director's authority under subsection 5 of NRS 695K.200, the Director revises subsection 4 of NRS 695K.200 to replace MEI with Consumer Price Index for Medical Care (CPI-M) to better reflect the cost of inflation in this market. The revision also allows the Department to make any adjustments deemed necessary to reflect local changes in utilization and morbidity.

The Director also defines "average reference premium" for purposes of implementing these revisions to subsection 4 and meeting the 15 percent premium-reduction target in the first four years in subsection 5 as follows:

> The average reference premium means the second-lowest cost silver level plan available through the Exchange during the 2024 plan year by county trended forward for inflation according to the Consumer Price Index for Medical Care and any adjustments to reflect local changes in utilization and morbidity.

Such an interpretation is consistent with Nevada rules of statutory construction, which provide that "provisions within a common statutory scheme [must be interpreted] harmoniously with one another in accordance with the general purpose of those statutes and to avoid unreasonable or absurd results, thereby giving effect to the Legislature's intent." Dezzani v. Kern & Assocs., Ltd., 134 Nev. 61, 64 (2018) (quoting Torrealba v. Kesmetis, 124 Nev. 95, 101 (2008)). Construing the "reference premium" definition in subsection 6 to apply to the revised premium-reduction requirements for subsection 4 and the 15 percent target in subsection 5 would create a direct conflict with the Director's duty to meet the express mandate in NRS 695K.240, which is to ensure provider reimbursement rates in the Public Option are no lower than Medicare rates (i.e., the express provider-reimbursement mandate). This is because the definition of "reference premium" in subsection 6 creates an unintended and unreasonable result with respect to premium reductions in the Public Option, where health carriers would be required to lower premiums to levels that risk actuarial soundness and full compliance with the express provider-reimbursement mandate under NRS 695K.240.

For example, applying the definition of reference premium in subsection 6, as written, would result in a target that relies either on: (1) MEI, which as previously stated is unworkable and therefore has been replaced by CPI-M in accordance with the Director's revision authority; or (2) a target based on the preceding year, each year, which has a compounding effect and would drive down premiums exponentially (i.e., at a rapid, additive rate). This creates an absurd and unintended result, where the Director must use a definition that relies on the elements deemed revisable under subsection 5 and applies a target based on a reference point that can only be reasonably achieved by risking compliance with the express provider-reimbursement mandate under NRS 695K.240. Unlike the premium-reduction requirements in NRS 695K.200 and other key statutory provisions related to the operation of the Public Option, the express provider-reimbursement mandate in NRS 695K.200 can neither be revised nor waived by the Director.

For all these reasons, the Director interprets "average reference premium" in a separate and distinct manner from "reference premium," as permitted by Nevada rules of statutory construction, to balance and give effect to the legislature's intent, which was to allow the Director to revise the premium-reduction requirements and meet a 15 percent reduction target in the first four years, all while ensuring such reductions do not result in provider reimbursement rates in the Public Option that are below those paid by Medicare.

Signature: Suzanne Bierman
Suzanne Bierman (Oct 31, 2022 11:21 PDT)

Email: suzanne.bierman@dhcfp.nv.gov

Signature:

Email: rwhitley@dhhs.nv.gov

APPENDIX D
Provider Participation Analysis

Summary of the Provider Participation Requirement in SB420 (Nevada Public Option) and its Impact on Provider Reimbursement

Executive Summary

Nevada Senate Bill 420 (SB420 and subsequent guidance as issued by the state on December 27, 2023 require premiums in the new Nevada Public Option (PO) plans to be at least 16% lower than the average reference premium by year four of the Public Option program (2029). Given that the structure of a typical premium rate in the individual market consists predominantly of payments to providers for facility and professional services, and prescription drugs, PO offerings on Nevada's exchange will need to have provider reimbursement that is lower than the current average reimbursement for Qualified Health Plans (QHPs) on Nevada's exchange to meet the premium reduction targets in the bill and related guidance.[1]

The prospect of lower reimbursement might influence a provider's decision to contract with any or all PO issuers. Therefore, to reduce the possibility of inadequate networks under PO offerings, SB420 included a provision (referred to interchangeably as the "provider participation requirement" or the "provider tying provision") that requires providers to participate in at least one PO offering if they are participating in either Medicaid, the public employees benefit program, or the state's workers' compensation program. Moreover, the bill requires that an evaluation be done to assess the impact on premiums[2] if the provider participation requirement (PPR) were waived by the Director of DHHS, as permitted by SB420.

Our approach to conducting the evaluation required by SB420 is to assess the overall impact of the PO on provider revenue and then determine the likelihood that the impact would lead providers to elect not to participate in the program. *If the impact to provider revenue is small, then the PPR may be less impactful on provider engagement with the PO and network adequacy as providers might be willing to contract with issuers offering PO plans at the provider reimbursement levels required to meet the premium targets.* To assess the impact of the PPR on provider revenue, we simulate the estimated provider reimbursement in Year 4 of the PO and compare this to current provider reimbursement, applied to a 2022 health insurance market environment and expressed as a percentage of Medicare reimbursement. Year 4 of the PO represents the greatest premium savings requirement under the SB420 and thus the greatest potential impact to provider revenue.

Based on discussions with the State, we understand that the state's intent is to utilize the contracting process with issuers to shift some of the burden of the required premium reduction targets under SB420 from the providers to issuers. Therefore, in addition to reduced provider reimbursement, we assume lower issuer premium expense loads on PO offerings relative to non-PO offerings on the exchange. Lower expense loads in PO premiums, by themselves, decrease premium rates for PO offerings, and thereby reduce the amount of provider reimbursement reductions otherwise needed to meet the premium targets under SB420.

In our best estimate modeling, we assume about 60% of individual market members in Nevada will switch to a Public Option offering. We assume that individuals who switch from a non-PO exchange offering to a PO offering will decrease provider revenue from 169% of Medicare reimbursement to 139% of Medicare reimbursement, or about 17.3% across facility and professional services combined. Consistent with estimates used in our 1332 waiver analysis, we further assume that 16% of the uninsured who are eligible for premium tax credits will take up coverage under the PO because of additional state-based premium subsidies. Coverage for these individuals will lead to increased provider revenue for several reasons that we outline in detail in our analysis, but that are attributable to anticipated changes in consumer behavior and realized provider reimbursement levels for individuals who transition from no coverage to having coverage.

The combined impact of these member migrations to the Public Option is an estimated provider revenue reduction of approximately $25 million in aggregate or approximately 0.11% of total provider revenue (facility and professional services combined). The providers' average payment rate (excluding volume changes) expressed as a percentage of Medicare reimbursement is estimated to decline by 0.94%. These results are summarized in the table below:

[1] The bill and subsequent guidance are included as Appendices B and C, respectively, in Milliman's 1332 Waiver Actuarial / Economic Analysis and Certification for Nevada's Public Option report

[2] The text of the bill does not specify which premiums in which market. We interpret it to mean individual market and public option premiums.

Table 1
Provider Participation Requirement in SB420
Summary of PPR Impact on Facility and Professional Provider Revenue
CY 2022 Basis (for Illustrative Purposes Only)

Public Option Take-Up %		Public Option Take-Up #			Key Financial Metrics			
From Individual Market	From APTC Uninsured	From Individual Market	From APTC Uninsured	Total PO	% Total Uninsured Take Up	Change in Provider Revenue	Change in Provider Revenue % of Total	Change in Average Payment Rate
60%	16%	68,700	9,742	78,442	3.3%	-25 M	-0.11%	-0.94%

All results in this memo are based on a CY 2022 market environment, unless otherwise noted, for illustrative purposes only. Using a CY 2022 basis isolates the impact of the provider participation requirement on provider revenue from other projection assumptions that would otherwise be required to model the Public Option in future years.

We conducted sensitivity analysis on provider revenue projections, producing a range of financial impacts that vary based on the assumed PO take-up rates from the individual market (which has a negative impact on provider revenue) and PO take-up from the uninsured (which has a positive effect). The impact on total provider revenue ranges from a maximum impact of -0.29% of revenue to minimum of 0.0%.

Overall, the introduction of the PO has a small negative impact on provider revenue under our best estimate assumptions. This minor impact to overall provider revenue is driven in large part by the fact that the PO is being targeted at the individual market in Nevada and a sub-segment of the uninsured (those that are eligible for ACA coverage but are not enrolled) that combined are only about 3% to 4% of the total Nevada population and thus represent a very small proportion of a provider's revenue.

Given the small target markets, *we conclude that the impact of a provider participation requirement, whether implemented or repealed, would likely have little effect on provider participation in PO offerings, that providers would be likely to contract with the PO at the required rates to achieve premium targets, and that as a result PO premium rates in the individual market would not be materially affected by the repeal of the requirement.*

Providers may have other reasons for not participating in a PO offering aside from revenue concerns. Our analysis does not reflect any other potential provider considerations beyond the revenue impacts described in this report. In addition, while this analysis is done on a market-wide basis, effects of the public option will vary by region, by provider type (professional or facilities), and by individual provider.

Introduction

The legislation establishing Nevada's Public Option (PO) includes a provision that requires providers who participate in the state's Medicaid program or the Public Employees' Benefits Program (PEBP) to also participate in at least one PO offering.

Section 13.1 of the legislation reads as follows:

"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."

Further, Section 39.2 reads as follows related to the actuarial analysis to be submitted for the purposes for getting an approved 1332 Waiver from the federal government:

"The actuarial assessment:

(a) Must be completed before the application for the waiver is submitted; and

(b) Must include, without limitation, an analysis of the likely effect on premiums for health insurance in this State of:

(1) The provisions of subsection 1 of section 13 of this act, as those provisions apply to providers of health care, as defined in NRS 695G.070, who participate in the Public Employees' Benefits Program established pursuant to subsection 1 of NRS 287.043 or provide care to an injured employee pursuant to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS, and the amendatory provisions of section 21 of this act; and

(2) Repealing the provisions described in subparagraph (1).

In short, the bill requires an actuarial analysis evaluate the impact of the provider participation requirement on premiums for health insurance in the state and the impact of repealing such a provision.

General Assumptions on the Effect of the Provider Participation Requirement

All else being equal, SB420's provider participation requirement (PPR) is intended to maintain provider participation across all PO offerings at levels at least equal to current participation levels in either the Medicaid or PEBP. If the PPR remains in effect, providers who choose not to participate in the PO may see reduced revenue from the loss of their Medicaid and / or PEBP patients.

The PPR would only be needed if participating in the PO had effects on providers that were perceived to be materially negative, in particular, negative effects on their revenue which may lead providers to opt out of participation. If providers were disinclined to participate due to negative provider revenue impacts and the PPR were not in place, there could be upward pressure on provider reimbursement under the PO to provide a greater incentive for providers to join the PO networks to ensure network adequacy. This upward pressure on provider reimbursement would make it more challenging for PO issuers to meet the premium targets under the bill. With the PPR in place, providers may be more likely to participate even at lower reimbursement levels to avoid the negative impact of lost Medicaid / PEBP patients.

However, if the PO has a neutral or only a modest negative effect on provider revenue, then providers would be inclined to participate with or without the PPR. In other words, the PPR or its repeal would have little or no impact as there would be incentives, or at least the lack of disincentives, associated with participating in PO networks.

Therefore, the key question for determining the need for the PPR is: what are the effects of participating in the PO on provider revenue, including both average reimbursement rates and overall provider revenue volume?

Estimated Impacts on Public Option Unit Costs

To understand the impact of the PO on provider revenue, we first model the unit cost or fee schedule changes, measured as a percentage of what reimbursement would be under Medicare fee-for-service (FFS), that would be required to reach the premium target of a 16% reduction in Year 4 of the PO. Medicare FFS reimbursement is often used as a basis for standardized comparisons of reimbursement under various scenarios. We use Year 4 because under SB420, the Year 4 price requirement for PO offerings is 16% below the reference

premium.[3] Beyond Year 4, there are no additional price reductions required relative to the reference premium. Thus, Year 4 represents the maximum potential effect on provider revenue that the bill requires from the PO.

In addition to reductions in provider reimbursement for services rendered to PO enrollees, the Nevada Department of Health and Human Services (DHHS) intends to require PO issuers to reduce administrative expenses attributable to PO plan offerings relative to non-public option plan offerings, although the final required expense reduction from DHHS is to be determined.

Required reductions in provider reimbursement and issuer expenses are modeled by first using an estimated average market premium of approximately $500, taken from the 2021 CMS Risk Adjustment Report,[4] and trended for the average rate 2022 rate increase of 4.1%[5] to $520.50. We assume the PO will not drive savings on pharmacy claims through provider contracts. Information from Nevada's 2022 Unified Rate Review Templates[6] was used to estimate average issuer administrative expense loads. Medical and prescription drug claims relationships were inferred from Milliman's *Health Cost Guidelines*™. From these data and assumptions, the structure of an average premium in the Nevada individual ACA for the 2022 market is simulated.

Next, based on guidance from DHHS, we model the expense reductions by PO issuers to affect a 3% difference in medical loss ratio (row 6 of Table 2 below), which translates to a 4.5% rate decrease on premiums (row 3 in Table 2 below) when combined with reductions in medical costs. The required reduction in provider reimbursement to reach a premium reduction target of 16% is calculated as the balancing item, specifically 17.6% shown in Row 1 of Table 2 below:

Table 2
Provided Participation Requirement in SB420
ACA Premium Structure and Estimated
Rate Impacts of Claims and Admin Reductions

		Pre-PO	Year 4 of PO Program	Change	Effect on Premium
(1)	Medical Claims	$314.64	$259.22	**-17.6%**	-10.6%
(2)	Rx Claims	$103.43	$103.43	0.0%	0.0%
(3)	Fixed Issuer Administration	$73.16	$49.93	-31.8%	**-4.5%**
(4)	Variable Issuer Administration & Profit	$29.27	$24.58	-16.0%	-0.9%
(5)	Total Premium	$520.50	$437.15	-16.0%	
(6)	Pricing Loss ratio	80%	83%		

Although not illustrated here, these assumptions provide for a reasonable sharing of the cost of the public option program on a dollar basis (not a percentage basis). Said differently, based on a 60% PO take-up rate, the dollar cost of the PO program is shared roughly evenly between providers and issuers. The ultimate impact of the PO on provider reimbursement levels may vary by issuer and will depend on the impact of other value-based purchasing initiatives required by DHHS on PO offerings, including those that might affect prescription drug costs (which are not captured here), as well as any incremental medical management or administrative efficiency practices the PO might have versus non-PO plans.

Estimated Impacts on Overall Provider Revenue Volume

The overall change in provider revenue volume, assuming unit cost or fee schedule reductions shown above will depend on actual enrollment in the PO. This enrollment is expected to come from two segments: the current ACA individual market and the uninsured who are eligible for ACA coverage but are currently forgoing that coverage. We discuss the impact to overall provider revenue of each of these below.

Enrollment from other ACA-Compliant Plans

Unless a non-PO plan's cost structure is modified, we assume a PO plan will be the second lowest cost silver plan on the Nevada exchange in all regions by Year 4 due to the premium reduction requirements of SB420 and related guidance. This also assumes that there will be more than one PO offering in each region.[7] Therefore, most of the PO enrollment is expected to come from current enrollees in ACA plans that become more expensive on a net (after federal premium subsidy) basis because federal premium subsidies have decreased due to the introduction of the PO. Smaller enrollment in the PO will also come from those currently enrolled in an ACA plan but are unsubsidized. For purposes of this demonstration, we assume the premiums for the new PO benchmark plans are 16% lower

[3] For additional analysis of the reference premiums, please see Milliman's full report "1332 Waiver Actuarial / Economic Analysis and Certification for Nevada's Public Option .

[4] https://www.cms.gov/files/document/appendix-2021-benefit-year-risk-adjustment-summary-report-hhs-risk-adjustment-program-state-specific.xlsx

[5] https://acasignups.net/21/10/01/nevada-avg-2022-aca-premium-rate-changes-41-indy-market-53-sm-group-market#:~:text=Overall%2C%20for%20Plan%20Year%202022%20consumers%20can%20choose,off%20the%20Exchange%2C%20is%204.4%20percent.%20On-%20Exchange%3A

[6] https://www.cms.gov/files/zip/2022-urr-puf2.zip

[7] See Section 2 of our full report

than the reference premium by the fourth year of the PO, consistent with the requirements of SB420 Section 2 and related guidance, although the actual differential could be greater.[8]

Due to the lower premiums of the PO and the increase in out-of-pocket net premium for non-PO plans among the population receiving federal premium tax credits, we assume that approximately 60% of the existing ACA market will migrate to PO plans for purposes of this demonstration. Because Nevada's PO is only one of three in the nation (Washington and Colorado being the other two), is structurally different than either of these, and has certain program and product offering parameters that are as of yet undefined, there is material uncertainty at this time around PO take-up levels. For example, the migration to PO plans may be lower if underlying provider reimbursement for non-PO plans is modified and, correspondingly, non-PO premiums are lowered in response to the introduction of the PO to the market. Conversely, take-up in the PO offerings could be higher if, for example, the State of Nevada uses pass-through funding to provide premium subsidy wraps only for lower income enrollees in the PO. We have sensitivity tested different take up scenarios in Tables 4 and 5 further below.

Enrollment in Public Option Plans from the Uninsured

We also assume a certain percentage of the uninsured who are eligible for tax credits will enroll in the PO. Using population data from various public sources, we estimate the total uninsured population in 2022 in Nevada at nearly 300,000 individuals.[9] Using data from the Guinn Center, we estimate approximately 61,000 of the total uninsured are eligible for tax credits under the ACA.[10] This is the population that would most likely respond to a PO offering, particularly if additional state-sponsored premium or cost sharing subsidies are offered.

Three factors cause the *total volume of revenue* paid to providers from uninsured persons to be materially lower than for the population enrolled in ACA plans currently. If these uninsured persons obtain coverage under the PO, these factors are mitigated or eliminated.

1. Uninsured persons generally use fewer healthcare services overall as they face financial barriers to care relative to insureds. According to Kaiser Health Foundation research, uninsured individuals use 50% fewer services overall relative to insured individuals.[11] We assume healthcare utilization for the previously uninsured will increase by a factor of 2.00 (1 / 0.5) under the PO, thereby increasing revenue to providers.

2. About 70% of uninsured costs are uncompensated care to providers.[12] Once insured, most costs for these previously uninsured individuals will be compensated by insurer payments, which will increase provider revenue. However, as uncompensated care decreases, payments intended to offset these costs, such as Uncompensated Care (UCC) payments under Medicare, will decrease as well. Our analysis includes an adjustment to account for UCC payments of 20.7%. The net effect of increasing collectability and decreased UCC payments is 1.971 (1 / (0.30+0.207).

3. Net provider reimbursement for self-pay patients, after provider discounts, is lower than typical individual market or employer group market provider reimbursement, estimated to be around 100% of Medicare FFS reimbursement.[13] In the ACA, we estimate the reimbursement to be 169% of Medicare FFS reimbursement.[14]

Finally, reimbursement under the PO is expected to be lower than the non-Public Option ACA market. We estimate average reimbursement will decrease by approximately 17.6% under the Public Option relative to the individual ACA market, from 169% of Medicare FFS reimbursement to 139% of Medicare FFS reimbursement in Year 4 of the PO (1.39/1.69 = 0.821).

We summarize the factors (a) through (c) plus the impact of reimbursement under the PO on a PMPM basis in Table 3.

Table 3
Provider Participation Requirement in SB420
Uninsured to Public Option Enrollee
Average Incremental Change in Provider Revenue

	PMPM*	Increase Factor**
Estimated Uninsured Revenue at 100% of Medicare	$55.73	
(a) Full insured utilization	$111.46	2.000
(b) Net impact of improved collectability and decreased UCC	$219.68	1.971
(c) Impact of higher ACA reimbursement	$371.26	1.690
(d) Change to PO Reimbursement	$304.92	0.821
Total PMPM Change in Revenue	$249.19	

[8] SB420 does not put constraints on how much lower PO premiums could be, only how low they must be. It is possible that PO plans could achieve greater savings than the minimums prescribed in the bill.
[9] Milliman research using American Community Survey (ACS) data and Current Population Survey data, calibrated using 2021 information where appropriate.
[10] Guinn-Center-NV-Uninsured-Population-abridged.pdf (guinncenter.org)
[11] Uncompensated Care for the Uninsured in 2013: A Detailed Examination | KFF
[12] Uncompensated Care for the Uninsured in 2013: A Detailed Examination | KFF
[13] Hospital Pricing And The Uninsured: Do The Uninsured Pay Higher Prices? | Health Affairs
[14] Milliman proprietary research.

For modeling purposes, Table 3 shows providers, on average, are estimated to see an additional $249 PMPM in revenue ($304.92 - $55.13) when an uninsured person obtains insurance under the PO due to higher overall reimbursement, less uncompensated care, and higher utilization.

We combine the impacts of migrating ACA members to the PO and the associated decrease in revenue for providers with the migration of uninsured to the PO and the associated increase in revenue in Table 4. Please note, this is an illustration using reasonable assumptions across the entire market. Individual providers will have different results.

Table 4
Provider Participation Requirement in SB420
Estimated Provider Revenue Impacts in Year 4 of the Public Option applied to CY 0222 (in Millions)

	From ACA	From Uninsured	Total
Members Transferring to PO	68,700	9,700	78,400
Pre-PO Allowed Costs (Provider Revenue)	$305 M	$7 M	$312 M
		Incremental $'s	
Increase in Utilization	$0 M	$7 M	$7 M
Improved Collectability (Net of UCC decrease)	$0 M	$13 M	$13 M
Subtotal before Reimbursement Change	$0 M	$19 M	
Pre-PO Reimbursement			
PO Reimbursement			
Change in Reimbursement	-$54 M	$10 M	-$44 M
Total	-$54 M	$29 M	-$25 M

**Numbers may not foot due to rounding.*

Table 4 shows that total provider revenue will decrease as ACA enrollees migrate to the PO and increase as uninsured obtain coverage under the PO. In total, under our best estimate modeling, provider revenue is expected to decrease when considering the combined impact of these two population segments. The results of various stress tests involving different migration assumptions can be seen in Table 5:

Table 5
Provider Participation Requirement in SB420
Estimated Provider Revenue Impacts in Year 4 of the Public Option Applied to CY 2022 (in Millions)
Sensitivity to ACA and Uninsured Migration

			APTC Eligible Uninsured Take-Up Rate		
			Low	**Medium**	**High**
			5%	**16%**	**29%**
ACA Migration	**High**	**85%**	-$67 M	-$47 M	-$23 M
	Medium	**60%**	-$45 M	-$25 M	$-1 M
	Low	**50%**	-$37 M	-$16 M	$8 M

Based on this range of results, it is likely that overall provider revenue volume will decline under the Public Option in absolute dollars. Table 6 shows these results as a percentage of total provider revenue, indicating a relatively immaterial estimated provider revenue change on a percentage basis.

Table 6
Provider Participation Requirement in SB420
Estimated Provider Revenue Impacts in Year 4 of the Public Option
(% of Total Provider Revenue)
Sensitivity to ACA and Uninsured Migration

			APTC Eligible Uninsured Take-Up Rate		
			Low	**Medium**	**High**
			5%	**16%**	**29%**
ACA Migration	**High**	**85%**	-0.30%	-0.21%	-0.11%
	Medium	**60%**	-0.20%	-0.11%	0.0%
	Low	**50%**	-0.16%	-0.07%	0.04%

Impacts on Average Provider Payment Rate Across Entire Nevada Market

In addition to overall revenue volume, providers may also be concerned that the average payment rate across their entire population may be adversely affected.

To understand this, we model the overall market-wide *average payment rate* (measured as a percentage of Medicare) before and after the introduction of the PO. We estimated non-pharmacy claims volumes across all Nevada insurance markets and the uninsured populations in 2022 and assigned a payment index for each of these markets, taken from various public and private / proprietary sources. The index is relative to Medicare (1.00) and the composite for the entire state is calculated by taking a provider revenue weighted average across all markets. Detailed methodology and sourcing of data and assumptions can be found in the Data Sources and Methodology section.

We then shift enrollment from the ACA and the uninsured into the PO, and recalculate the payment index. Note, we do not shift or increase any enrollment in the Medicaid, Medicare, Employer, or Other categories in order to isolate the impact of the introduction of the PO which, as currently written, will not involve these market segments.

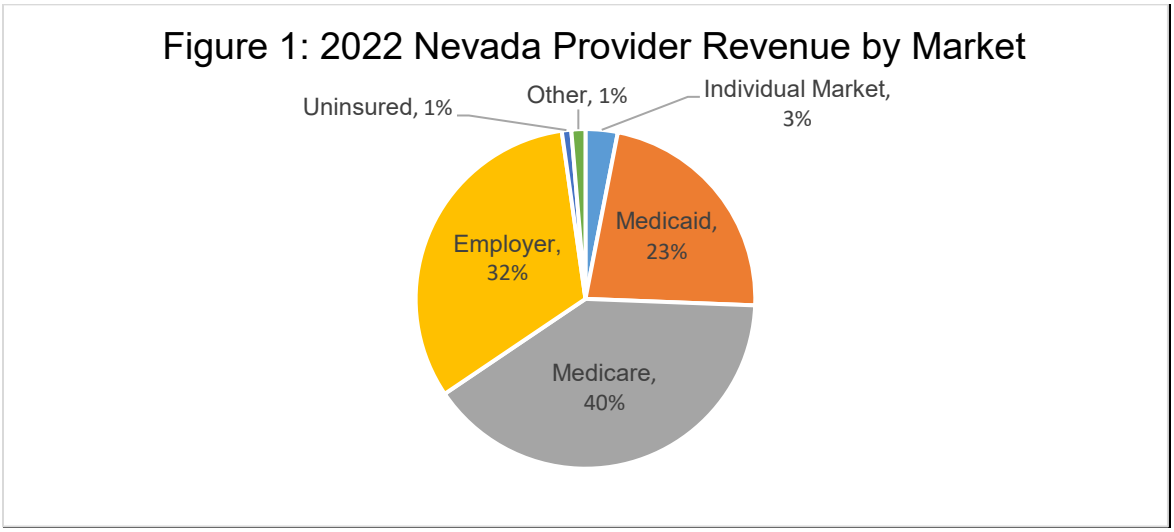
Table 7 below summarizes the calculation of the payment index in 2022 without a PO and the corresponding payment index in the presence of a Public Option.

Table 7
Provider Participation Requirement in SB420
Estimated Average Provider Payment Rate After Introduction of a Public Option
Using CY 2022 Enrollment and Medical Expenses

		Individual Market	Medicaid	Medicare	Employer	Uninsured	Other	Public Option	Total**
No PO	Enrollees	115 K	788 K	644 K	1,368 K	298 K	57 K	0 K	3,269 K
	Medical Expense*	676 M	4,981 M	8,822 M	7,114 M	199 M	295 M	0 M	22,087 M
	% State Provider Revenue	3%	23%	40%	32%	1%	1%	0%	100%
	(a) Payment Index	169%	90%	100%	183%	100%	183%	0%	127.9%
PO Year 4	Enrollees	46 K	788 K	644 K	1,368 K	288 K	57 K	78 K	3,269 K
	Medical Expense*	270 M	4,981 M	8,822 M	7,114 M	193 M	295 M	402 M	22,077 M
	% State Provider Revenue	1%	25%	38%	32%	1%	1%	2%	100%
	(b) Payment Index	169%	90%	100%	183%	100%	183%	139%	126.7%
	Change in Payment Index = (b) / (a) -1								***-0.94%***

**Excludes pharmacy spend for all markets.*
*** Medical expense weighted average.*

Figure 1 below shows the estimated distribution of 2022 Nevada provider revenue by insurance market. The Medicaid, Medicare, and employer markets combine for approximately 95% of current revenue, with the individual market comprising only 3%. The size of the individual market relative to other markets limits the impact of any reimbursement changes specific to the individual market on the total payment index.



Note, the payment rate assumed for the Public Option in Year 4 is 139% of Medicare FFS reimbursement, which is 30 points lower (169% - 139%) than the individual market. However, offsetting this is an increase in payment rate for the uninsured who enroll in the PO. This is an increase in payment rate of 39 points (139%-100%). The net effect of this population movement to the PO is to decrease the average payment rate across all markets in Nevada by 0.94%.

SB420 requires that provider reimbursement rates for the PO be, in the aggregate, comparable to or better than Medicare rates, with some exceptions for certain types of providers. Table 7 illustrates that the PO can satisfy this state requirement and still achieve the premium reduction targets.

Conclusions

Overall, the introduction of the PO has a small negative impact on provider revenue under our best estimate assumptions. This minor impact to overall provider revenue is driven in large part by the fact that the PO is being targeted at the individual market in Nevada and a sub-segment of the uninsured (those that are eligible for ACA coverage but are not enrolled) that, when combined, comprise only about 3% to 4% of the total Nevada population and thus represent a very small proportion of providers' revenue.

Given the small target markets, *we conclude that the impact of a provider participation requirement, whether implemented or repealed, would likely have little effect on provider participation in PO offerings, that providers would be likely to contract with the PO at the required rates to achieve premium targets, and that as a result PO premium rates in the individual market would not be materially affected by the repeal of the requirement.*

Providers may have other reasons for not participating in a PO offering aside from revenue concerns. Our analysis does not reflect any other potential provider considerations beyond the revenue impacts described in this report. In addition, while this analysis is done on a market-wide basis, effects of the public option will vary by region, by provider type (professional or facilities), and by individual provider.

Data Sources and Methodology

Data Sources

The following is a list of data sources used to construct modeling to calculate Nevada's overall provider reimbursement in total dollars and average reimbursement as a percentage of Medicare in Tables 7.

Enrollment by Market Segment

- Individual Market – on exchange enrollment relied on data requested from the Silver State Exchange, March 2022. Off exchange data was estimated based on NAIC MLR reports and CMS Risk Adjustment files (see web sources below).
- Medicaid – Nevada Department of Health and Human Services Chart Pack, accessed November 8th, 2022. https://app.powerbigov.us/view?r=eyJrIjoiZGQ0NTE5ZmUtYjAxNi00NjQzLTliNzktOGM4YjgxYjgwODY2IiwidCI6ImU0YTM0MGU2LWI4OWUtNGU2OC04ZWFhLTE1NDRkMjcwMzk4MCJ9 "Medicaid by Category" for January of 2022. We assume this contains dual eligible of 86,000, received from DHHS on November 8th, 2022, and netted these from the Chart Pack numbers.
- Medicare – Kaiser Health Foundation https://www.kff.org/medicare/state-indicator/total-medicare-beneficiaries/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D plus dual eligible of 86,000.
- Employer – Estimated from American Community Survey data indicating employer-sponsored coverage as well as total population estimates, backing out estimates for other markets and uninsured.
- Uninsured – Guinn Center "Nevada's Uninsured Population," page 24, with adjustments to 2022 shifts due to the population changes and the American Rescue Plan (ARP).
- Other (Tricare etc.) – American Community Survey data, derived from coverage not falling into other market categories

Allowed Costs PMPM

- Individual Market – Estimated by applying 80.3% loss ratio to 2021 Risk Adjustment Revenue PMPM found at https://www.cms.gov/files/document/appendix-2021-benefit-year-risk-adjustment-summary-report-hhs-risk-adjustment-program-state-specific.xlsx. 2021 values were trended at 0% for one year. Estimated pricing loss ratio of 80.3% taken from 2022 URRT data found here: https://www.cms.gov/files/zip/2022-urr-puf2.zip.
- Medicaid – https://www.medicaid.gov/state-overviews/scorecard/how-much-states-spend-per-medicaid-enrollee/index.html 2019 values were trend at NHE per capita increases for 2020-2022. NHE data can be found here: https://www.cms.gov/files/zip/nhe-projections-tables.zip Table 1
- Medicare – Per capita expenditures from National Health Expenditures tables found at https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountsstatehealthaccountsresidence; specifically, the "Health expenditures by state of residence.zip" and the "Medicare_per_enrollee20.xls" files. 2020 values are trended at historical average of 4.7% annually, also taken from this source.
- Employer – Premium PMPM calculated from NAIC MLR data found at https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr for the small group and large group markets in Nevada and by applying an estimated loss ratio of 85%. Values for both small group and large group markets for 2020 were trended at NHE trend rates from 2020 to 2022.
- Uninsured – Based on individual market allowed costs adjusted for lower utilization, lower percentage of Medicare, patient pay collectability, and uncompensated care payments. See Table 2 and corresponding footnotes.
- Other (Tricare etc.) – Assumed to be similar to employer group costs.

Provider Reimbursement by Market Segment

- Individual Market – We use Milliman proprietary discount analysis for commercial markets to estimate individual market reimbursement levels. An adjustment is made to account for the general practice of contracting at lower rates in the individual market than in the employer market to account for the prevalence of narrow networks.
- Medicaid – Physician reimbursement rate as a percentage of Medicare is estimated from Kaiser Family Foundation data found here: https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Hospital reimbursement as a percentage of Medicare is estimated from MACPAC report found here: https://www.macpac.gov/wp-content/uploads/2017/04/Medicaid-Hospital-Payment-A-Comparison-across-States-and-to-Medicare.pdf

- Medicare – We assume 100% of Medicare for all Medicare revenue.
- Employer – Based on Milliman's proprietary discount analysis.
- Uninsured – Collected uninsured payments (cash) were assumed to be 100% of Medicare based on data found here: https://www.healthaffairs.org/doi/10.1377/hlthaff.27.2.w116
- Other (Tricare etc.) - As this is a very small population for which no data exists to analyze attributable reimbursement and any assumption is immaterial to the result, reimbursement for these programs was assumed to be similar to the employer market.

Table 2 Methodology

We use enrollment estimates multiplied by estimated allowed costs by market segment to calculate estimated total provider revenue. Allowed costs are calculated by taking premium values by market multiplied by an expected long term loss ratio (ignoring year by year fluctuations) by market and then dividing by an average-paid-to-allowed ratio by market. Total allowed costs for the state of Nevada in 2022 were reviewed for reasonableness using National Health Expenditure data by state found here: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/res-tables.zip

The composite payment index is calculated as the allowed-cost-weighted average of the market specific payment indexes.

Caveats and Limitations

Milliman developed certain models to estimate the values included in this paper. The intent of the models was to estimate the impact of the provider participation requirement and its potential repeal or nonenforcement on the Nevada PO premiums. We reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

The models rely on data and information as input to the models. We relied upon certain data and information provided by, the Nevada Exchange, and publicly available data published by State and federal agencies to develop the analyses shown in this paper. We did not audit this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. We performed a limited review of the data used directly in our analysis for reasonableness and consistency, and we did not find material defects in the data. If there are material defects in the data, it is possible they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable, or for relationships that are materially inconsistent. Such a review was beyond the scope of our engagement.

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

There is heightened uncertainty concerning future insurance market enrollment due to the current COVID-19 public health emergency and its associated policies that may change materially in the future.

Milliman prepared this report for the specific purpose of evaluating the financial impact of the Nevada PO provider participation requirement. This paper should not be used for any other purpose. This paper has been prepared solely for the internal business use of, and is only to be relied upon by, the management of the Nevada Department of Health and Human Services. We understand this report may be shared with other interested parties. Milliman does not intend to benefit or create a legal duty to any third-party recipient of its work. This paper should only be reviewed in its entirety. The results of this analysis may not be appropriate for every stakeholder.

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

The authors of this paper are actuaries for Milliman, members of the American Academy of Actuaries, and meet the Qualification Standards of the Academy to render the actuarial opinion contained herein. To the best of their knowledge and belief, this report is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices. The terms of Milliman's subcontract with Manatt, signed January 26, 2022, to provide services to the Nevada Department of Health and Human Services Division of Health Care Financing and Policy apply to this paper and its use.

Appendix F
Sensitivity Test of 80% PO Take-up

Exhibit 3
State of Nevada Public Option
Scenario 1B: ARP Public Option - Premium Wrap
Premiums and Member Subsidies Assuming 80% PO Take-up

	On-Exchange					
		PTC Eligible		Non-PTC Eligible		Total Individual Market
Year	Gross Premiums	APTC	Enrollee Net Premiums	Enrollee Gross Premiums	Off-Exchange Enrollee Gross Premiums	Gross Premiums
2026	$599	$471	$128	$357	$502	$579
2027	$604	$466	$139	$337	$505	$584
2028	$601	$460	$141	$324	$502	$580
2029	$599	$457	$142	$289	$498	$575
2030	$621	$475	$146	$323	$518	$598
2031	$644	$495	$150	$354	$539	$622
2032	$670	$516	$154	$380	$560	$647
2033	$696	$538	$159	$401	$583	$673
2034	$723	$560	$163	$441	$606	$700
2035	$752	$584	$168	$464	$630	$728

Exhibit 4
State of Nevada Public Option
Scenario 1B: ARP Public Option - Premium Wrap
Impact of Public Option on Premium and Subsidies Assuming 80% PO Take-up

	On-Exchange					
		PTC Eligible		Non-PTC Eligible		Total Individual Market
Year	Gross Premiums	APTC	Enrollee Net Premiums	Enrollee Gross Premiums	Off-Exchange Enrollee Gross Premiums	Gross Premiums
2026	(2.1%)	(4.7%)	8.7%	0.3%	(2.1%)	(2.1%)
2027	(4.9%)	(9.4%)	14.3%	(9.5%)	(5.1%)	(5.1%)
2028	(8.9%)	(13.9%)	12.6%	(16.0%)	(9.3%)	(9.2%)
2029	(12.7%)	(17.9%)	9.4%	(25.2%)	(13.6%)	(13.5%)
2030	(12.9%)	(18.0%)	9.1%	(21.2%)	(13.6%)	(13.5%)
2031	(13.1%)	(18.1%)	8.6%	(15.3%)	(13.6%)	(13.5%)
2032	(13.1%)	(17.9%)	8.4%	(12.6%)	(13.6%)	(13.5%)
2033	(13.1%)	(17.9%)	8.4%	(12.0%)	(13.6%)	(13.4%)
2034	(13.2%)	(17.9%)	8.0%	(6.4%)	(13.6%)	(13.4%)
2035	(13.2%)	(17.8%)	7.8%	(5.4%)	(13.6%)	(13.4%)

Exhibit 5
State of Nevada Public Option
Scenario 2A: No ARP Public Option - PTF Accumulation
Premiums and Member Subsidies Assuming 80% PO Take-up

	On-Exchange					
		PTC Eligible		Non-PTC Eligible		Total Individual Market
Year	Gross Premiums	APTC	Enrollee Net Premiums	Enrollee Gross Premiums	Off-Exchange Enrollee Gross Premiums	Gross Premiums
2026	$608	$418	$190	$549	$513	$588
2027	$619	$413	$206	$510	$517	$592
2028	$617	$406	$211	$508	$515	$590
2029	$612	$398	$214	$506	$511	$585
2030	$636	$415	$221	$527	$531	$608
2031	$661	$433	$229	$550	$552	$633
2032	$687	$451	$236	$574	$574	$658
2033	$715	$471	$244	$593	$597	$684
2034	$744	$491	$252	$619	$621	$712
2035	$773	$512	$261	$652	$646	$740

Exhibit 6
State of Nevada Public Option
Scenario 2A: No ARP Public Option - PTF Accumulation
Impact of Public Option on Premium and Subsidies Assuming 80% PO Take-up

	On-Exchange					
		PTC Eligible		Non-PTC Eligible		Total Individual Market
Year	Gross Premiums	APTC	Enrollee Net Premiums	Enrollee Gross Premiums	Off-Exchange Enrollee Gross Premiums	Gross Premiums
2026	(2.1%)	(5.3%)	5.8%	(2.5%)	(2.1%)	(2.1%)
2027	(4.2%)	(10.2%)	10.7%	(12.9%)	(5.0%)	(5.1%)
2028	(8.1%)	(15.2%)	9.6%	(17.0%)	(9.0%)	(9.1%)
2029	(12.3%)	(20.3%)	7.6%	(20.6%)	(13.3%)	(13.4%)
2030	(12.4%)	(20.2%)	7.5%	(20.3%)	(13.3%)	(13.4%)
2031	(12.4%)	(20.2%)	7.5%	(20.0%)	(13.3%)	(13.4%)
2032	(12.5%)	(20.2%)	7.3%	(20.1%)	(13.3%)	(13.4%)
2033	(12.4%)	(20.0%)	7.4%	(20.6%)	(13.3%)	(13.4%)
2034	(12.4%)	(20.0%)	7.5%	(20.4%)	(13.3%)	(13.4%)
2035	(12.5%)	(20.1%)	7.4%	(19.3%)	(13.3%)	(13.4%)

Exhibit 7
State of Nevada Public Option
Scenario 2B: No ARP Public Option - Premium Wrap
Premiums and Member Subsidies Assuming 80% PO Take-up

		On-Exchange				
		PTC Eligible		Non-PTC Eligible		Total Individual Market
Year	Gross Premiums	APTC	Enrollee Net Premiums	Enrollee Gross Premiums	Off-Exchange Enrollee Gross Premiums	Gross Premiums
2026	$608	$418	$190	$549	$513	$588
2027	$617	$413	$204	$509	$516	$592
2028	$613	$407	$206	$507	$512	$588
2029	$612	$402	$210	$464	$507	$582
2030	$631	$416	$215	$521	$527	$605
2031	$656	$434	$222	$549	$548	$630
2032	$682	$452	$230	$568	$570	$655
2033	$709	$472	$238	$593	$593	$681
2034	$738	$492	$246	$619	$616	$708
2035	$766	$513	$254	$646	$641	$737

Exhibit 8
State of Nevada Public Option
Scenario 2B: No ARP Public Option - Premium Wrap
Impact of Public Option on Premium and Subsidies Assuming 80% PO Take-up

		On-Exchange				
		PTC Eligible		Non-PTC Eligible		Total Individual Market
Year	Gross Premiums	APTC	Enrollee Net Premiums	Enrollee Gross Premiums	Off-Exchange Enrollee Gross Premiums	Gross Premiums
2026	(2.1%)	(5.3%)	5.8%	(2.5%)	(2.1%)	(2.1%)
2027	(4.4%)	(10.1%)	9.7%	(13.1%)	(5.2%)	(5.2%)
2028	(8.7%)	(15.0%)	7.2%	(17.1%)	(9.6%)	(9.4%)
2029	(12.3%)	(19.4%)	5.5%	(27.1%)	(14.0%)	(13.8%)
2030	(13.0%)	(20.0%)	4.6%	(21.2%)	(14.0%)	(13.8%)
2031	(13.1%)	(20.1%)	4.6%	(20.2%)	(14.0%)	(13.8%)
2032	(13.2%)	(20.0%)	4.4%	(21.0%)	(14.0%)	(13.9%)
2033	(13.2%)	(20.0%)	4.5%	(20.6%)	(14.0%)	(13.8%)
2034	(13.1%)	(19.9%)	4.6%	(20.4%)	(14.0%)	(13.8%)
2035	(13.2%)	(19.9%)	4.5%	(20.1%)	(14.0%)	(13.8%)

Section 7: Attached Materials

- Appendix A: 1332 Waiver Checklist
- Appendix B: State Operations Budget for the Public Option
- Appendix C: Public Session Materials
- Appendix D: Additional Public Engagement Materials

APPENDIX A:

CCIIO Checklist for Section 1332 State Relief and Empowerment Waivers

CCIIO Checklist for Section 1332 State Relief and Empowerment Waivers

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

	HHS Citation and Description	Actuary Response
1.	**45 CFR 155. 1308(a), (b), (c), (d)** Application format, application timing, preliminary review, notification of preliminary determination.	This report is intended to be an attachment to Nevada's 1332 waiver application. The actual application submission date is not known as of the date of this report.
2.	**45 CFR 155.1308(f)(2)** Written evidence of the state's compliance with the public notice and comment requirements, set forth in 45 CFR 155.1312.	See Section 4 of waiver application
	Written evidence of the state's compliance with the public hearing's requirements, set forth in 45 CFR 155.1312.	See Section 4 of waiver application
	Written evidence of state's compliance with the meaningful Tribal consultation requirements (if the state has one or more Federally-recognized Indian tribes), set forth in 45 CFR 155.1312.	See Section 4 of waiver application
3.	**45 CFR 155.1308(f)(3)(i), (ii)** Comprehensive description of state's enacted legislation and program to implement a plan meeting the requirements for a section 1332 waiver and a copy of the state's enacted legislation	See Appendices B and C
4.	**45 CFR 155.1308(f)(3)(iii)** List of provision(s) of the law that the state seeks to waive and reason for the specific request(s).	See Section 1B of waiver application

	HHS Citation and Description	Actuary Response
5.	**45 CFR 155.1308(f)(4)(i)-(iii)** Actuarial analyses and actuarial certifications Economic analyses Data and assumptions **Note a state can combine the elements of an actuarial analysis and economic analysis into one report or submit separate actuarial and economic reports*	1. See Appendix A for the actuarial certification. i. See Section 4B for a demonstration that the Nevada Section 1332 waiver complies with the coverage requirement. a. See the Exhibits section ii. See Sections 4A and 4C for a demonstration that the Nevada Section 1332 waiver complies with the comprehensiveness and affordability requirements. a. See the Exhibits section b. See the Exhibits section 2. See Section 5 3. See Section 6 The Nevada 1332 waiver impacts the individual market. The baseline projection and a comparison to the projection under the waiver are included in Sections 4 and 5. The required analyses are included as noted below: ▪ Exhibits 1A.3, 1B.3, 2A.3, and 2B.3: Non-group market enrollees by income as a share of FPL. ▪ Exhibits 1A.1, 1B.1, 2A.1, and 2B.1: Overall average non-group market premium rate. ▪ Exhibits 1A.2, 1B.2, 2A.2, and 2B.2: SLCS plan rate. ▪ The State of Nevada uses the federal default age rating curve. ▪ Section 5: Aggregate premiums and PTC. ▪ The State of Nevada uses a state-based platform. Costs are assumed to be the same both with and without the waiver. ▪ Sections 4 through 6: Documentation of all assumptions and methodologies used to develop the projections and growth of healthcare spending. Nevada is not considering establishing a Risk Stabilization Waiver Concept as part of this 1332 waiver application.
6.	**45 CFR 155.1308(f)(4)(iv)** Draft timeline for implementation of the proposed waiver.	See Section 1D of waiver application
7.	**45 CFR 155.1308(f)(4)(v)(A)-(E)** Additional Information.	See Section 5 of waiver application
8.	**45 CFR 155.1308(f)(4)(vi)** Reporting targets.	See Section 5.E of waiver application
9.	**83 FR 53575** Administration's Principles.	See waiver narrative

APPENDIX B:

State Operations Budget for the Public Option

Estimated Annual SFY Budget Costs for State Operations, Starting SFY2026

NRS 695K.300 provides that 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.

Silver State Health Insurance Exchange Operation Costs for Public Option	
Increased Navigator Program Costs	$500,000.00 per SFY
Additional Staffing Costs for Certification/Policy	$250,000.00 per SFY
Increase Technology Vendor Costs (GetInsured)	$1,000,000.00 per SFY
Estimated subtotal	**$1,750,000.00 per SFY**
Nevada Medicaid Operation Costs for Public Option	
New Staffing Costs for Contracts/Waiver	$400,000.00 per SFY
New Legal Fees for Deputy Attorney General	$100,000.00 per SFY
New Public Option Actuary Fees	$1,500,000.00 per SFY
Estimated subtotal	**$2,000,000.00 per SFY**
Estimated Total Operational Costs	**$3,750,000.00 per SFY**

Furthermore, NRS 695K.200 also provides that any additional federal dollars received as pass-through funds pursuant to a 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 new state premium subsidies to improve affordability of qualified health plans in the Exchange.

APPENDIX C:

Public Comment Materials

Public comment materials include:

1. The materials from the six public design sessions DHHS hosted in December 2021 and January 2022
2. Tribal consultation and public comment materials, to be added to the application following the state public comment period

APPENDIX D:

Additional Public Engagement Materials

- Public comment letters submitted by stakeholders during the six design sessions held in December 2021 and January 2022: Link
- September 2021 Actuarial Study Informational Webinar: Slides and Recording
- Questions and Answers for the Nevada Public Option: Link
- Fact Sheet – Nevada Public Option: Link

DRAFT

Joe Lombardo
Governor

Richard Whitley
Director

State of Nevada

Department of Health and Human Services

Nevada Public Option

Public Hearing

January 24, 2023 and February 3, 2023

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

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Agenda

- Nevada Public Option Overview
- Public Comment
- Next Steps

DRAFT

Meeting Participation Overview

Written Comments:
Participants may submit comments and questions through the **Zoom Q&A box**; all comments will be recorded and reviewed by the State. To submit questions or comments outside of today's session, write to: **NVpublicoption@dhhs.nv.gov**

Spoken Comments:
Participants must "raise their hand" for Zoom facilitators to unmute them to share comments; the facilitators will notify participants of the appropriate time to volunteer feedback.

If you logged on via phone-only

Press "*9" on your phone to "raise your hand"

Listen for your phone number to be called by moderator

If selected to share your comment, please ensure you are "unmuted' on your phone by pressing "*6"

If you logged on via Zoom interface

Press "Raise Hand" in the "Reactions" button on the screen

If selected to share your comment, you will receive a request to "unmute;" please ensure you accept before speaking

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Purpose & Agenda

In its effort to implement state law, Division is holding two public hearings to engage stakeholders on the state's 1332 waiver application for the Public Option.

Agenda

- Nevada Public Option & Waiver Overview
- Collect Questions & Public Comment

See Nevada Revised Statutes (NRS) Chap. 695K.

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Background

- In 2021, Nevada State Legislature passed into law a Public Option.
- State law charges the Director of the Department of Health and Human Services (DHHS) with overseeing the implementation of the Public Option.
- Public Option plans must be available to consumers for purchase in Nevada Health Link on January 1, 2026.

Statutory goals include:

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

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Overview of State Statutory Requirements

State law requires the Director contract with health carriers to offer the new Public Option plans and use the Medicaid contracting authority to enforce certain state requirements, such as:

- Participating carriers must offer the Public Option plans through the Nevada Health Link and **meet all federal and state standards for qualified health plans** under the Affordable Care Act.
- Participating carriers must offer **one Silver and one Gold Public Option plan**, which means these products cover at least 70 and 80 percent of consumer health care costs, annually, respectively.
- Participating carriers must offer public options plans that meet certain premium reduction targets which are set at 16% percent over the first four years.
- Participating carriers must pay providers rates that are no lower than Medicare rates.

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New State Procurement Process

- Under state law, the Director must establish **a new procurement process** to establish the new contracts with health carriers creating a state-private model for operating the new Public Option plans.
- This procurement must take place at same time as the state's next Medicaid managed care procurement (2025).
- Any health carriers seeking to participate in the State's Medicaid managed care program must submit **a good faith bid** to also contract with the state to offer and administer Public Option plans.
- Currently, the Division contracts with **four health carriers** for its Medicaid managed care program (Anthem, Health Plan of Nevada, Silver Summit, Molina).
- The Division will use the **contract as its enforcement tool** for the statutory requirements for the Public Option plans.

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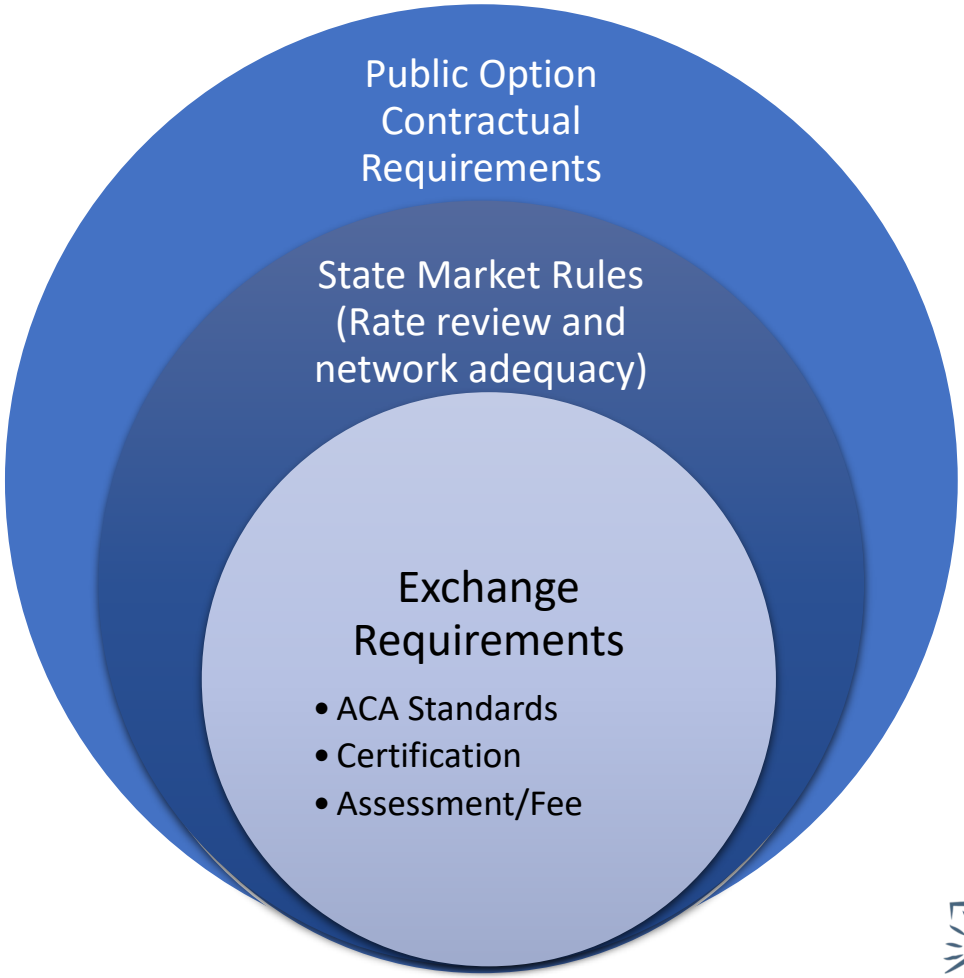
Nevada Public Option Design

This slides provides a visual for what the new public option plans will look like as compared to other qualified health plans offered in the exchange.

The two inner rings reflect today's current plans and the rules they must meet; the public option plans will include need to comply with these rules and an **additional layer** of new requirements set forth in a contract with the state.



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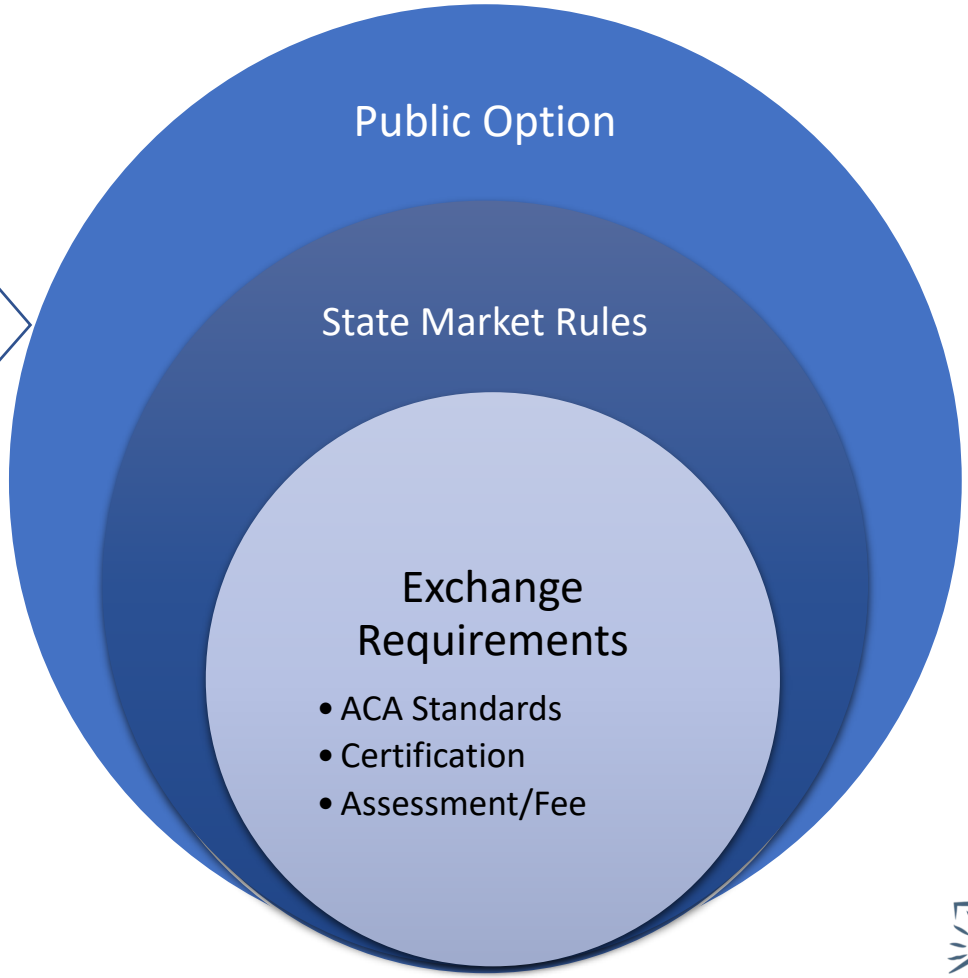
Nevada Public Option Design

Statutory mandates:

- Premium reduction targets
- Minimum plan offerings (silver/gold)
- Provider network alignment with Medicaid networks
- Value-based payment design
- Cultural workforce plans

Contract requirements:

- Administrative spend caps
- Quality metrics
- Penalties for not meeting targets, etc.



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Other New State Requirements

- Providers under contract with the State as network providers in other state-contracted health insurance programs must participate **as an in-network provider within at least one network** with one of the State's contracted PO carriers**.**
- These providers must also apply policies to **accept new patients** enrolled in public option plans like they apply to other patients enrolled in other forms of health insurance.
- State law requires Director to **promote in its contracting process** with strategies with health carriers that:
  - Better align networks between Medicaid and individual market
  - Address health disparities in the individual market
  - Improve cultural competency in the provider workforce
  - Increase the use of value-based payment models with providers
  - Address the gaps in Nevada's health care workforce

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1332 Waiver & Actuarial Study

- 1332 waiver allows states to capture federal savings in advanced premium tax credits (APTCs) (i.e., pass-through funds (PTF)).[1]
- Final actuarial report will provide estimate of resulting federal PTF plus analysis of effect of the provider participation requirement.
- Actuarial Findings
  - **$341-$464 million** estimated savings in first five years
  - **Minimal impact to providers** – higher volume of service use and less uncompensated care costs
  - **55,300** estimated to enroll in year 1
  - **92,500** estimated to enroll by year 5

The Process

1. Stakeholder input
2. Actuarial study & waiver development
3. Tribal notice
4. Post for state public comment period
5. Federal submission
6. Federal public comment period
7. Completeness review
8. Negotiations/ Federal Decision

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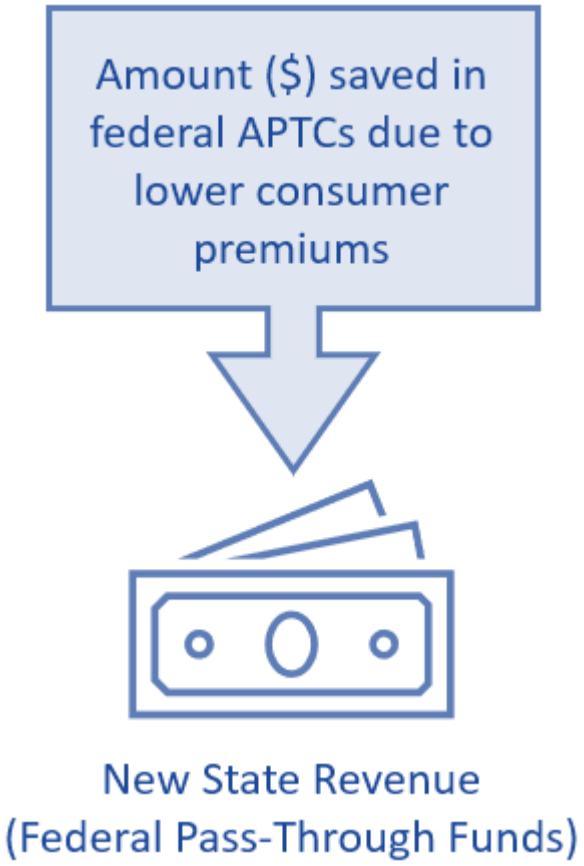
New Funds for Affordability Policies

- State law requires federal PTF to be deposited into state trust fund to support state operations and to improve affordability.
- After Year 1, state operations for Public Option will be self-funded by federal PTF
  - Division costs for staff for contract oversight and waiver compliance; actuarial support
  - Nevada Health Link costs for technology vendor, staff, and navigator program
- Leftover PTF can be used by Director of DHHS to establish new affordability policies:
  - New state premium wraps for consumers in Nevada Health Link to further reduce premium costs
  - Bonus incentive payment program for carriers and network providers who meet certain quality metrics or state goals in market



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Public Comment

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Public Comment

- Public comment will be limited to the total amount of time allocated for public comment on particular issues.
- Individuals will be recognized for up to two minutes and are asked to state their name and organizational affiliation at the top of their statements.
- Participants are encouraged to use the comment box to ensure all feedback is captured or email their comments to **NVpublicoption@dhhs.nv.gov**

Spoken Comments:

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Press "Raise Hand" in the "Reactions" button on the screen

If selected to share your comment, you will receive a request to "unmute;" please ensure you accept before speaking

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Next Steps

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Next Steps

- Public comments will be accepted through February 27, 2023.
- The 1332 waiver application will be submitted to the federal government in March 2023.

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Contact Information

Stacie Weeks – Deputy Administrator, Division of Health Care Financing and Policy; sweeks@dhcfp.nv.gov

Ky Plaskon – DHCFP Public Information Officer; kyplaskon@dhcfp.nv.gov

State of Nevada

Department of Health and Human Services

Section 1332 Waiver Application for Public Option: Tribal Consultation

January 11, 2023

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

Purpose & Agenda

In its effort to implement state law, the Division is soliciting feedback and comments from Nevada tribal communities on the state's 1332 waiver application for the public option.

Agenda

- Nevada Public Option & Waiver Overview
- Impact to Tribal Communities
- Collect Questions & Public Comment

See Nevada Revised Statutes (NRS) Chap. 695K.

Background

- In 2021, Nevada State Legislature passed into law a public option.
- State law charges the Director of the Department of Health and Human Services (DHHS) with overseeing the implementation of the public option.
- Public option plans must be available to consumers for purchase in Nevada Health Link on January 1, 2026.

Statutory goals include:

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

Overview of State Statutory Requirements

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- Participating carriers must offer public options plans that meet certain premium reduction targets which are set at 16% percent over the first four years.
- Participating carriers must pay providers rates that are no lower than Medicare rates.

New State Procurement Process

- Under state law, the Director must establish **a new procurement process** to establish the new contracts with health carriers creating a state-private model for operating the new public option plans.
- This procurement must take place at same time as the state's next Medicaid managed care procurement (2025)
- Any health carriers seeking to participate in the State's Medicaid managed care program must submit **a good faith bid** to also contract with the state to offer and administer public option plans.
- Currently, the Division contracts with **four health carriers** for its Medicaid managed care program (Anthem, Health Plan of Nevada, Silver Summit, Molina)
- The Division will use the **contract as its enforcement tool** for the statutory requirements for the public option plans.

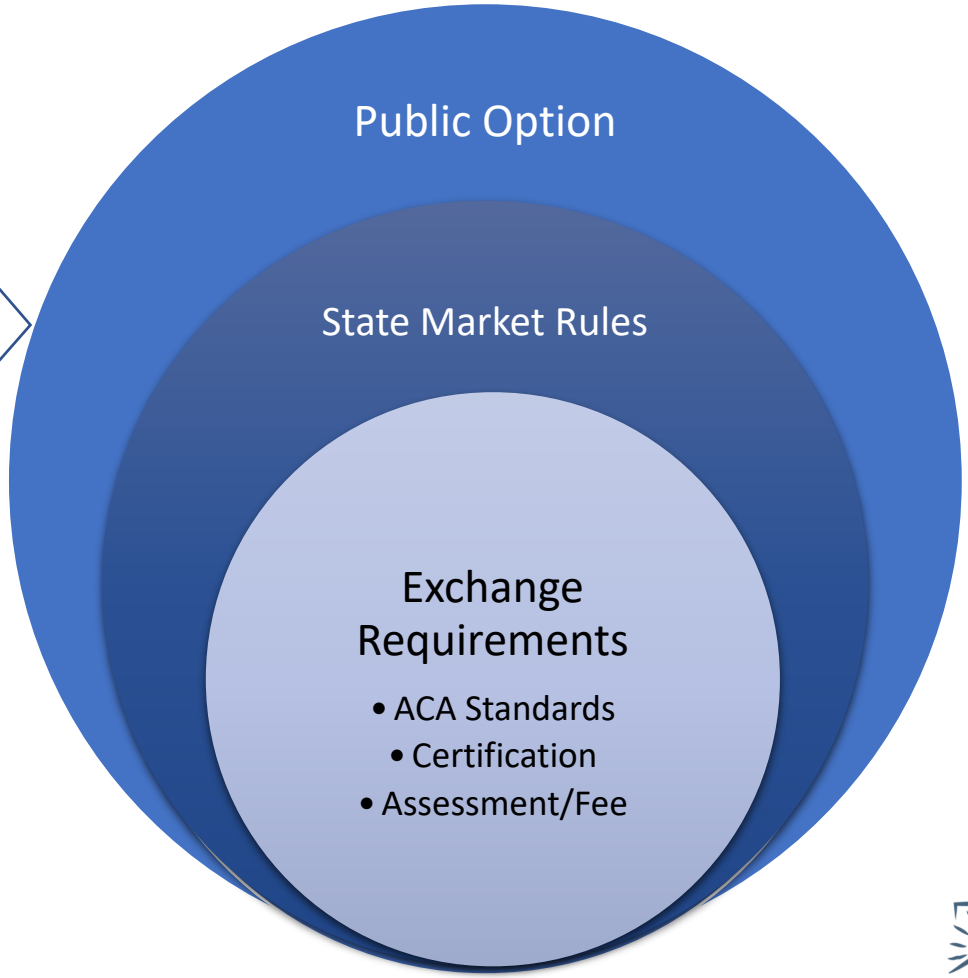
Nevada Public Option Design

Statutory mandates:

- Premium reduction targets
- Minimum plan offerings (silver/gold)
- Provider network alignment with Medicaid networks
- Value-based payment design
- Cultural workforce plans

Contract requirements:

- Administrative spend caps or MLR
- Quality metrics
- Penalties for not meeting targets, etc
- TBD



Other New State Requirements

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  - Address the gaps in Nevada's health care workforce

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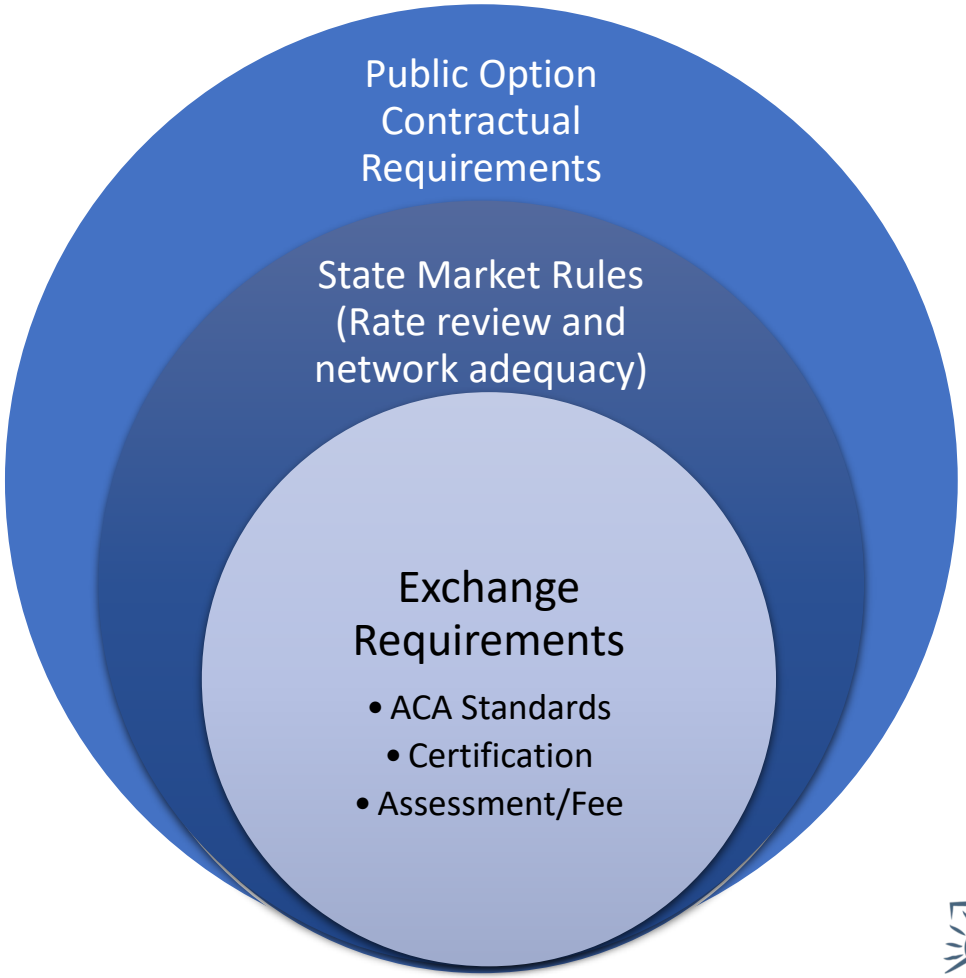


1332 Waiver & Actuarial Study

- State law requires a 1332 waiver to be submitted to U.S. Department of Treasury and HHS/CCIIO to implement the program.
- 1332 waiver allows states to capture federal savings in advanced premium tax credits (APTCs) (i.e., pass-through funds (PTF)).[1]
- States applying for 1332 waiver must include an actuarial analysis and certification.[2]
- Nevada contracted with independent actuarial firm—Milliman—which has experience in evaluating proposals for public option.[3]
- Final actuarial report will provide estimate of resulting federal PTF plus analysis of effect of the provider participation requirement.

The Process

1. Stakeholder input
2. Actuarial study & waiver development
3. Tribal notice
4. Post for state public comment period
5. Federal submission
6. Federal public comment period
7. Completeness review
8. Negotiations/ Federal Decision

Sources

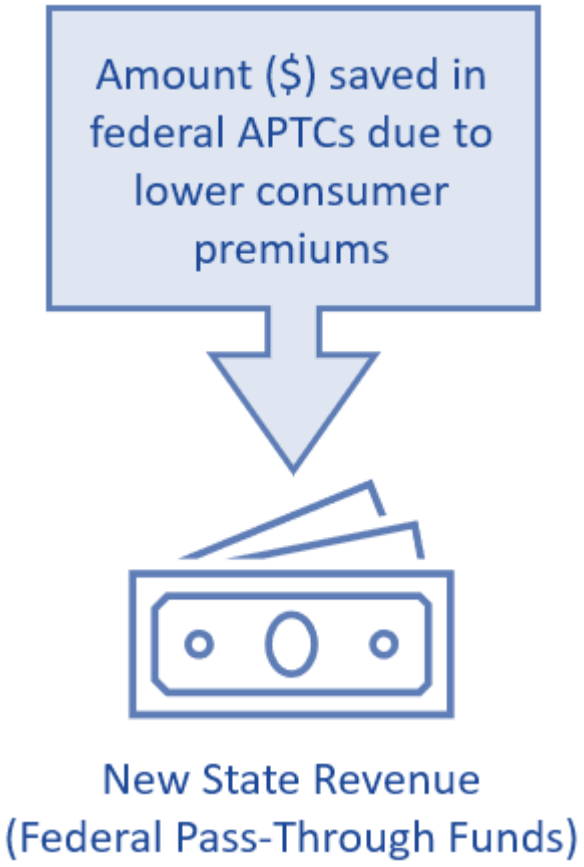
1: NRS 695K.210.

2: 45 CFR § 155.1308.

3. See Fritz Busch & Paul Houchens, *Milliman Report: Evaluation of a Colorado Public Option,* prepared for the Kaiser Permanente, 2019.

New Funds for Affordability Policies

- State law requires federal PTF to be deposited into state trust fund to support state operations and to improve affordability.
- After Year 1, state operations for Public Option will be self-funded by federal PTF
  - Division costs for staff for contract oversight and waiver compliance; actuarial support
  - Nevada Health Link costs for technology vendor, staff, and navigator program
- Leftover PTF can be used by Director of DHHS to establish new affordability policies:
  - New state premium wraps for consumers in Nevada Health Link to further reduce premium costs
  - Bonus incentive payment program for carriers and network providers who meet certain quality metrics or state goals in market



Impact to Tribal Communities

Impact to Tribal Communities

- The public option's mandated premium reductions will reduce premiums for consumers purchasing public option plans, which includes **American Indians and Alaskan Natives (AI/AN)**
  - According to the 2022 Open Enrollment Public Use File, **there are 765 AI/AN Non-Hispanic members** enrolled in coverage through Nevada Health Link in Nevada 2022.
- The public option program does not impact existing protections available to American Indians through the Nevada Health Link:
  - AI/AN who earn less than 300% of the Federal Poverty Level (FPL) remain exempt from cost sharing and qualify for premium tax credits
  - The calculation of Modified Adjusted Gross Income for AI/AN will still exempt some revenue earned on reservations and from Federal Trust payments
  - AI/AN may still change Qualified Health Plans (QHP) once a month without worrying about enrollment dates

Impact to Tribal Communities (continued)

- The public option will not impact existing financial assistance provided under the Division of Health Care Financing and Policy (Medicaid) in which AI/ANs eligible for Medicaid do not pay premiums and do not have any other cost sharing.
- The public option will not impact health care services provided through IHS, Tribal or urban Indian health programs.
- The public option plans do require more robust and aligned networks with Medicaid, including essential community providers.
- As a reminder, qualified health plans (which will include public option plans) must include at least 30% of available essential community providers in in each plan's service area in the provider network and must offer contracts in "good faith" to all Indian Health Service providers.
- Participating health carriers will also not be able to pay tribal providers participating in public option networks any lower than what they pay in Medicare.

Questions & Comments

The Division will now collect questions and comments from the tribal represent regarding the waiver application and new public option plans.

Any questions will be answered in writing in the next two weeks. The Division will be accepting written public comment on the state's 1332 waiver application until February 27, 2023.

Waiver materials can be found online at:
https://dhhs.nv.gov/PublicOption/

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