601 Pennsylvania Avenue, NW
South Building, Suite 500
Washington, D.C. 20004

T 202.778.3200
F 202.331.7487
ahip.org

September 25, 2024

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

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

Submitted electronically via stateinnovationwaivers@cms.hhs.gov

RE: Nevada Section 1332 Waiver Application Addendum – AHIP Comments

Dear Secretary Becerra and Secretary Yellen:

On behalf of AHIP and our member plans, thank you for the opportunity to offer comments on Nevada's Section 1332 State Innovation Waiver Application Addendum ("Waiver Application Addendum") to implement the Nevada Coverage and Market Stabilization Program ("Market Stabilization Program"). AHIP is the national association whose members provide quality, affordable health care coverage to hundreds of thousands of Nevadans through Medicaid managed care plans, qualified health plans (QHPs) offered through the Silver State Health Insurance Exchange, in addition to providing coverage to employers and labor unions. We are committed to making health care better and coverage more affordable and accessible for everyone.

All Nevadans deserve access to affordable, comprehensive coverage. AHIP is committed to working with Nevada on efforts to ensure health insurance coverage—premiums and cost-sharing—are affordable for all Nevadans by addressing the underlying costs of care. AHIP supports state innovation and 1332 waiver flexibilities that allow states to implement programs tailored to their health insurance markets.

Earlier this year, AHIP submitted comments urging the Departments to not approve Nevada's State Innovation Waiver Application, citing significant problem with the Waiver Application and the Market Stabilization Program.[1] Specifically, the waiver would:

1. Set unrealistic and unattainable premium reduction targets;
2. Exacerbate Nevada's existing provider shortage;

[1] Public Comments on Waiver during the Federal Comment Period. https://www.cms.gov/files/document/1332-nv-federal-public-comments-received.pdf

3. Force reductions in programs directly benefiting patients;
4. Establish an unfunded reinsurance program that is contingent on meeting aggressive premium reduction targets in year one; and
5. Threaten competition and access to care in both the individual health insurance markets and Medicaid managed care.

The State's recently submitted Waiver Application Addendum makes some changes updates to the original waiver application. Namely, it adopts uniform reinsurance parameters across all geographic rating regions. AHIP and others had raised concerns about the proposed tiered reinsurance parameters, which would have made it even harder to achieve premium reductions in Rating Areas 1 and 2. We appreciate the state's acknowledgement of this problematic design and changes proposed in the Waiver Application Addendum. Additionally, the Waiver Application Addendum adjusts the premium reduction targets for issuers with 2025 premiums further from the second lowest cost silver plan premium additional time, allowing them to achieve the full 15 percent premium reduction target over the first four years of the waiver, rather than a single year.

Despite these changes, none of the foundational challenges of the Waiver Application and Market Stabilization Program have been addressed. The Waiver Application Addendum and Market Stabilization Program remain fundamentally flawed and would undermine the goals of ensuring access to affordable, comprehensive health insurance coverage for Nevadans. In fact, new program information and data that have been released since the initial Waiver Application comment period further highlight that the Market Stabilization Program cannot meet these goals. **We recommend the Departments not approve the Nevada Waiver Application Addendum.**

Provider Reimbursement and Network Adequacy Limitations

The Waiver Application Addendum does nothing to address challenges with the program's provider reimbursement reductions. AHIP remains concerned that the Market Stabilization program would exacerbate Nevada's existing provider shortages and make it more difficult for Nevadans to access the care they need.

A Wakely analysis showed that current commercial reimbursement rates for the average Nevada physician are already at or near 100 percent Medicare FFS, limiting the ability to achieve premium savings through hospital reimbursement cuts.[2] We also remain concerned that providers are only required to contract with one BBSP. Providers will have little incentive to contract with more than one BBSP and will maintain higher rates with other issuers with whom they contract. This will make it difficult for issuers to develop adequate BBSP provider networks because providers will have little incentive to participate in more than one issuer's BBSP network.

[2] https://nevadashealthcarefuture.org/wp-content/uploads/2023/10/Wakely-Nevada-Public-Option-Actuarial-Analysis.pdf

New Administrative Cost Requirements Put Premium Reduction Targets Further Out of Reach
In comments submitted to the Departments in response to the state's initial Waiver Application, we raised concerns that programs that directly benefit consumers would be adversely affected by administrative cost reduction requirements. There is nothing in the Waiver Application Addendum and Market Stabilization program that will lower issuer's administrative costs to offer plans on the Nevada Silver State Exchange including the costs to design, implement and offer new bronze, silver, and gold BBSP plans.

It is important to repeat that the Affordable Care Act's medical loss ratio (MLR) standard is working as intended. The ACA MLR standard requires that issuers in the individual market spend at least 80 cents of every premium dollar on medical costs and quality improvements activities. If issuers do not meet this threshold, they must issue rebates to consumers. The AHIP Health Care Dollar shows issuers spend 4.2 cents of every dollar on other administrative expenses and only 3.6 cents of every dollar account for profit.[3] Administrative expenses include programs that directly benefit consumers, including 24/7 nurse call lines, translation, interpretation, and language access services, fraud waste and abuse programs, and interactive technology and transparency tools. Forcing Nevada issuers to reduce administrative costs would limit the ability of issuers to meet the needs of their enrollees.

Evidence from Other States Shows Premium Reduction Targets are Unattainable
Recent experience in Colorado underscores that state public option proposals do not address the underlying costs of care and are ineffective at reducing premium costs. Data recently published by the Centers for Medicare and Medicaid Services shows that the Colorado Option has fallen far short of its 10 percent premium reduction target in year two.[4] Data from Colorado's experience also shows it is unlikely Nevada's public option will reduce premiums by three percent in year one. In the overwhelming majority of Colorado service areas the Colorado Option reduced premiums by less than one percent. In Denver, which encompasses 40 percent of the market in its service area, Colorado Option reduced premiums by less than 0.2 percent whereas reinsurance reduced premiums by 15 percent. In 23 of Colorado's 34 service areas, which together encompass the vast majority of the state's market, the Colorado Option reduced premiums by less than 0.5 percent, while reinsurance lowered premiums by 15-32 percent.[5]

There is no evidence that Nevada's public option program will be more successful at achieving premium reduction targets than Colorado. In Colorado, the provider

[3] https://www.ahip.org/resources/where-does-your-health-care-dollar-go
[4] CMS. State-Specific Premium Data for Section 1332 Waiver 2024 Pass-Through Calculations. September 3, 2024. https://www.cms.gov/files/document/1332-state-specific-premium-dataaugust-2024.xls
[5] Colorado's Health Care Future. Despite New Federal Pass-Through Funding, the Colorado Option is Still Failing to Increase Affordability. September 16, 2024. https://coloradoshealthcarefuture.org/the-colorado-option-is-still-failing-to-increase-affordability/

reimbursement floors are duplicative of what issuers have achieved through a competitive market in urban areas, which is why this mechanism has not been effective in lowering premiums. In Nevada, as a condition of receiving Medicaid, state employee plan, or correctional plan payments, providers have to contract with at least one private insurance carrier offering the public option. Rates are still negotiated between the insurance carrier and the provider and cannot be below 100 percent of Medicare in the aggregate across the state. As AHIP has previously noted, provider reimbursement levels for many providers in the state are already at or near 100 percent of Medicare fee-for-service reimbursement rates. Without any meaningful provisions to lower the underlying costs of care, there is no reason to expect that Nevada will achieve premium reduction targets and, taking Colorado's experience into consideration, there is strong evidence that it will not.

Unfunded Reinsurance Program is Not a Viable Model

We repeat our significant concerns, discussed at length in AHIP's comments submitted in response to the initial Waiver Application, about the state's proposal to establish an unfunded reinsurance program that is contingent on meeting aggressive premium reduction targets in year one.[6] Nevada proposes to establish a reinsurance program without contributing any state funds. Instead, the reinsurance program would be delayed until year two of the Market Stabilization Program and would rely on premium reductions and resulting federal pass-through funds achieved by anticipated savings to fund the state's portion of reinsurance funding.

Relying on unproven and unrealistic premium reductions jeopardizes the ability of reinsurance to lower premiums and would make the individual market extremely fragile. In fact, if evidence from Colorado's experience tells us anything, premium reduction targets are not attainable and the state will not achieve the level of pass-through funding needed to support reinsurance. It is important to note that if issuers assume a fully-funded reinsurance program but actual passthrough funding cannot support the program, rates will be inadequate.

We are deeply concerned that the issues AHIP has raised around this unfunded premium model have not been addressed. AHIP recommends the Departments not approve this reinsurance model or, at minimum, work with Nevada to require a strong contingency financing model to support the reinsurance program if premium reduction targets are not met.

Recommendations

AHIP supports the use of 1332 waivers to innovate and allow states to adopt approaches tailored to their health insurance markets. However, such approaches should be based on sound policy and achievable, sustainable standards. Nevada's Updated Waiver Application does not address fundamental flaws with the Market Stabilization Program and will undermine stability of the

[6] Public Comments on Waiver during the Federal Comment Period. https://www.cms.gov/files/document/1332-nv-federal-public-comments-received.pdf

Nevada individual market. **Thus, we strongly recommend the Departments not approve the Nevada 1332 Waiver Application Addendum.**

Sincerely,

Adam Beck
Senior Vice President, Commercial, Employer & Product Policy

CC: Chiquita Brooks-LaSure, Administrator, CMS
Dr. Ellen Montz, Deputy Administrator and Director, Center for Consumer Information and Insurance Oversight, CMS
Jeff Wu, Deputy Director Policy, Center for Consumer Information and Insurance Oversight, CMS

September 25, 2024

BlueCross BlueShield Association

750 9th Street NW
Washington, D.C. 20001-4524
202.626.4800
www.BCBS.com

Dr. Ellen Montz
Deputy Administrator and Director
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Submitted via the Web Portal, stateinnovationwaivers@cms.hhs.gov.

RE: Nevada Section 1332 Waiver Application

Dear Deputy Administrator Montz:

The Blue Cross Blue Shield Association (BCBSA) appreciates the opportunity to provide comments on Nevada's application for a waiver under Section 1332 of the Affordable Care Act (section 1332 waiver).

BCBSA is a national federation of independent, community-based and locally operated BCBS companies (Plans) that collectively cover, serve, and support 1 in 3 Americans in every ZIP code across all 50 states and Puerto Rico. BCBS Plans contract with 96% of hospitals and 95% of doctors across the country and serve those who are covered through Medicare, Medicaid, an employer, or purchase coverage on their own.

BCBSA has long advocated for commonsense solutions to ensure a robust, competitive private marketplace that offers individuals a broad range of choices to meet their needs at the best possible price. We have supported the development of reinsurance programs through section 1332 waivers to stabilize markets allowing states to deliver quality and affordable health coverage.

Thank you for reopening the comment period for Nevada's application for a section 1332 waiver and providing BCBSA the opportunity to submit comments on the revised application. On March 14, 2024, BCBSA submitted a comment letter recommending that the Department of Health and Human Services not approve the Nevada waiver application as it does not provide adequate support to demonstrate that the projected savings from the proposed public option are reasonably achievable. This is important because the state is relying entirely on those savings to fund the reinsurance program under the waiver. In addition to addressing the Nevada projections directly, BCBSA noted that experiences with public options in other states have not achieved the savings projected in their initial applications.

Additional relevant information has become available since BCBSA submitted our initial comment letter. On September 3, the Centers for Medicare & Medicaid Services (CMS) published data and assumptions on the pass-through calculations for states with approved 1332 waivers, including premium savings data for Colorado. This data included premiums for the second-lowest cost Silver plan in each rating area, calculated without the waiver, with the waiver, and with the public Colorado Option only (i.e., without reinsurance). By comparing these premiums, you can see the financial impact of the public option separately from the impact of the reinsurance program. Based on our review, we believe the data provides further support for concerns raised by BCBSA in our initial comment letter that the public option savings projected in the Nevada waiver application are unlikely to be achieved.

According to our analysis of the CMS data, the overwhelming source of premium savings is from the reinsurance program, not the Colorado Option. Savings from the public option are minimal in urban rating areas, and while higher in rural areas, still do not meet the 10% Colorado Option program target for the 2024 benefit year. In fact, the second-lowest cost Silver plan did not meet the 10% premium reduction target in *any* service area.

Further, Nevada estimates that the first year of its public option will result in 3% premium savings and the federal pass-through funding from those premium savings will be used to fund the state's portion of the reinsurance program costs. We would note that over 84% of the Colorado market (as a percentage of Exchange enrollees) saw less than 1% premium savings in the second year of Colorado's public option program, calling into significant question whether Nevada's 3% projected savings for its public option program is realistic and achievable.
☐

Colorado Service Areas	Colorado Option Premiums Savings	Reinsurance Premium Savings	2024 Exchange Enrollment[1]
Service Area 1 (Denver, Jefferson, Adams, and Arapaho Counties).	0.11%	15.95%	93,726 (40% Enrollment)
22 of 33 Service Areas (2, 4, 5, 6, 7, 8, 9, 13, 14, 15, 16, 17, 18, 20, 23, 24, 25, 26, 27, 28, 29, and 34).	0.11% to 0.70%	15.01% to 32.29%	104,597 (44% Enrollment)
7 of 34 Service Areas (11,12,21, 22,30,31, 32).	2.08% to 3.99%	17.26% to 30.02%	26,985 (11% Enrollment)
4 of 34 Services Areas (3, 10, 19, 33).	7.67% to 8.55%	29.42% to 29.68%	11,640 (5% Enrollment)

[1] Connect for Health Colorado Open Enrollment Report for PY 24

We appreciate your consideration of our comments and urge you to reconsider the viability of the funding method proposed for the Nevada waiver in light of this new data. If you have any questions or want additional information, please contact Andrea Cooke at andrea.cooke@bcbsa.com.

Sincerely,

Kris Haltmeyer
Vice President, Policy Analysis
Policy & Advocacy

COMMITTEE TO PROTECT HEALTH CARE

September 24, 2024

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

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

Submitted via stateinnovationwaivers@cms.hhs.gov

RE: Updated Nevada Section 1332 State Innovation Waiver Application

Dear Secretary Becerra and Secretary Yellen,

The Committee to Protect Health Care is pleased to again submit comments to the Center for Medicare & Medicaid Services (CMS) and Department of the Treasury regarding Nevada's updated Section 1332 State Innovation Waiver application to create the Nevada Coverage and Market Stabilization Program.

The Committee to Protect Health Care is a mobilization of doctors committed to expanding access to affordable health care. We support the framework proposed by Nevada's Division of Health Care Financing and Policy ("the Division") to utilize a federal 1332 waiver as part of the creation and development of the new public option. We believe this updated proposal is a strong foundation to increase affordable health coverage options for Nevadans while building upon existing state efforts to promote health care affordability. We strongly urge The Departments to approve the waiver. We are excited to see the continued efforts to ensure access to affordable health insurance coverage through the amended waiver application and appreciate the opportunity to share our perspective on the design of the state's federal 1332 waiver.

Proposal Updates

We appreciate the commitment from CMS and Nevada to take the time necessary to ensure the proposed 1332 waiver and its analyses capture the experiences of all Nevadans under this waiver. Pausing to address the considerations raised in previous comment periods allowed The Division to update their analysis and provide additional premium relief for consumers. Importantly, Nevada's updated waiver application prioritizes pass-through funding to be used for a premium relief program which ensures Nevadans, primarily middle-income consumers, are protected from any increases in premium costs due to the creation of new Battle Born State Plans (BBSPs) in 2026.

This updated application builds on the strong policies included in the initial application, which includes three new initiatives – a reinsurance program, quality incentive payment program tied to improved outcomes for participating carriers and providers, and the "Practice in Nevada" provider incentive program. Taken together, this waiver proposal improves affordability, increases access to quality care, and reduces health disparities, while also supporting providers in Nevada and alleviating workforce shortages.

Coverage and Affordability

This waiver will bring needed improvements to health care by reducing premiums and introducing a new, quality coverage option for Nevadans to enroll in. The status quo is not working for too many Nevadansm who have been struggling to afford their health care. For example, people of color in Nevada report worrying about their health insurance becoming unaffordable at higher rates than White Nevadans. Additionally, rural respondents and those living in households with a person with a disability are more likely to report concern about losing their health insurance than their non-rural and non-disabled counterparts. Nevadans' concerns about *affording* health coverage exceed their fears about *losing* health care coverage across all income groups, disability statuses, coverage types, and geographical settings.

Nevada will leverage the state's Medicaid infrastructure to provide people with access to new Battle Born State Plans (BBSPs), which are required to meet premium reduction targets of 15% over four years and ongoing thereafter. These premium reductions not only provide relief for consumers, but the savings they produce also enable Nevada to receive pass-through funding from the federal government. ***The proposed waiver and public option are expected to lower the cost of health insurance for the more than 100,000 Nevadans on the individual market, while bringing up to $310 million in federal passthrough funding into the state in the first five years.***

Nevada is making strides to address health care disparities in the state with this proposal as well. Importantly, these premium reductions provide the greatest relief for populations that have continued to face inequities, including:

- Lower-income individuals, who are disproportionately Hispanic, African American, American Indian, and Asian-Pacific Islanders,
- Older individuals, including individuals 65 and older, and
- Residents who live in rural and frontier/remote areas of the State (outside of Clark and Washoe Counties).

Consumer Outreach and Awareness

Nevada is expected to eventually see BBSP takeup comprise 80% of total marketplace enrollment, due in large part to the updated waiver request now including plans to implement several consumer outreach strategies to help ensure Nevadans know about these new plans and are able to enroll. Promoting active shopping, differentiating BBSPs from other plans during plan selection, leveraging the tools and flexibility offered by the Silver State Health Insurance Exchange, and partnering with carriers and the community to promote consumer outreach will help drive enrollment and ensure Nevadans are enrolled in plans that meet their needs and budget.

Thank you for the opportunity to provide comments in support of the updated section 1332 waiver application to create Nevada's Public Option and Market Stabilization Program. We urge the Administration to approve the waiver so Nevada has the federal tools and resources needed to decrease costs and increase competition, choice, and market stability for their state. If you have any questions or are interested in further discussion of our comments on the updated 1332 waiver application, please do not hesitate to reach out to Jodi Helsel at jodi@committeetoprotect.org.

Sincerely,

Rob Davidson, MD, MPH

Executive Director

Committee to Protect Health Care

Harpreet Tsui, DO, FACOI, DABOM

Nevada Lead

Committee to Protect Health Care

September 25, 2024

Administrator Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Submitted to: stateinnovationwaivers@cms.hhs.gov

Re: Nevada Remediated Section 1332 State Innovation Waiver Addendum, 2024

Dear Administrator Brooks-LaSure,

On behalf of the Medicaid Health Plans of America (MHPA), we thank you for the opportunity to provide input on Nevada's recently re-submitted Section 1332 State Innovation Waiver.

MHPA is the only national trade association with a sole focus on Medicaid, representing more than 150 MCOs serving nearly 47 million Medicaid beneficiaries in 40 states, the District of Columbia and Puerto Rico. MHPA's members include both for-profit and non-profit, national, regional, as well as single-state health plans that compete in the Medicaid market. Nearly three-quarters of all Medicaid beneficiaries receive health care through MCOs, and the Association provides research and advocacy services that support policy solutions to enhance the delivery and coordination of comprehensive, cost-effective, and quality health care for Medicaid beneficiaries.

Summary of Previous Comments

MHPA previously submitted written comments regarding Nevada's 1332 Waiver application in March, commenting on the state's requirement of Battle Born State Plans (BBSP) to meet a 15% premium reduction target and provide formal attestation and rate certification that rates are actuarially sound as part of a "good faith" bid. This good faith bid was required to participate in the state's Medicaid program. In our prior comments MHPA noted that:

- The good faith bid requirement would stifle competition and negatively impact beneficiary choice in the Medicaid program and individual market; and
- The expected provider reimbursement reductions are likely to exacerbate the existing workforce shortage in Nevada and would not align with CMS' goal of improving access and addressing provider workforce shortages, including in the Medicaid program.

For these reasons, we continue to recommend that CMS reject this waiver application and work with the state of Nevada to develop an alternative 1332 waiver which improves access without negatively impacting provider participation and member choice in the state. The recently amended 1332 waiver application does not address MHPA's core concerns. Attached to this letter are our full comments that were submitted on March 14, 2024.

Remediated 1332 Application Requirement Summary – Premium Reduction

In response to public comments, Nevada amended the premium reduction target requirement, allowing MCOs participating in the individual market with less competitive 2025 premiums an opportunity to achieve the full 2029 premium reduction target of 15% over the first 4 years of the

waiver, instead of 1 year. The reductions are still expected to be achieved through a combination of lower provider rates, administrative efficiencies and reinsurance.

Additional MHPA Comments on the Updated Premium Reduction Requirements

MHPA appreciates the state's efforts to create a more level playing field for MCOs participating in the individual market by phasing in the 15% premium reduction requirement over 4 years. While this is a step in the right direction, it still does not alleviate our concerns. The new requirement only delays the issues noted in our previous comments. Even with these changes, plans will not have the necessary time to develop the infrastructure and workforce to submit a competitive bid, leading to the state being unlikely to attract new MCOs to its Medicaid program and individual market.

Further, making Medicaid procurement contingent on a good faith bid to offer the BBSP, can create a barrier to entry for new competition in the Medicaid market both initially and on an ongoing basis. Phasing in the 15% premium reduction requirement does not address this concern in the near- or longer-term.

In these comments we would like to reaffirm our recommendation that CMS reject the requirement that MCOs who wish to participate in the state's Medicaid program submit a good faith bid on a BSSP.

Closing

Again, thank you for the opportunity to provide additional comments on Nevada's 1332 State Innovation Waiver. It is important to MHPA that Nevadans have access to high quality, high value, affordable health coverage. We appreciate the ability to share our perspective and look forward to working with CMS and the state of Nevada to make a meaningful difference in the lives of Medicaid beneficiaries.

Please feel free to reach out to me directly at sattanasio@mhpa.org with any questions or should you need any additional information.

Sincerely,

/s/

Shannon Attanasio
Senior Vice President, Government Relations, Policy and Advocacy

Attachments:
MHPA Comments on the Nevada 1332 State Innovation Waiver, March 14, 2024

September 25, 2024

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

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

RE: Addendum to Nevada's Section 1332 State Innovation Waiver Request, dated August 23, 2024

Dear Secretaries Yellen and Becerra:

On behalf of the Nevada Association of Health Plans (NvAHP), we appreciate the opportunity to provide comments on Nevada's 1332 State Innovation Waiver Application Addendum ("Waiver Application"). The NvAHP is a statewide trade association representing ten member companies that provide commercial health insurance and government programs to Nevadans. Our primary goal is to create a statutory and regulatory environment that permits our carriers to meet the needs of consumers, employers and public purchasers. We are a unified voice advocating for issues important to our health plans and carriers. We remain concerned with the Waiver Application that seeks to implement the Nevada Coverage and Market Stabilization Program and the operation of a Public Option health insurance offering on the Silver State Exchange as required by statute ("Public Option program").

On March 14, 2024, we submitted comments dictating the mission of our trade, which entails ensuring the growth and development of a high-quality and affordable health care delivery system throughout the State of Nevada ("State"). We remain steadfast in our position that a state government-controlled Public Option program will not drive greater access and more affordable health care but will instead have the opposite effect.

As previously noted, the NvAHP has actively engaged with the State throughout the multi-year public participation process since the passage of Senate Bill 420 in 2021. We have offered ten (10) public comment letters on the Public Option program, beginning with the public design phase, several state and federal stakeholder engagement sessions, and feedback on the initial and revised Waiver Application. Our members continue to have serious concerns about the Public Option program and do not agree that it will achieve greater health care affordability and coverage for Nevadans.

Consistent with the comments we submitted in March 2024, and in response to the addendum dated August 23, 2024, we continue to have concerns with the Public Option program design elements as briefly outlined below.

- **Medicaid Managed Care "Good Faith Bid" Requirement**: The NvAHP remains concerned with the approach the State is taking in conditioning the eligibility for participation in the Medicaid managed care procurement on how successful carriers are in meeting the "good faith bid" requirements the State outlines in the Public Option program procurement. We strongly believe that the selection of Medicaid managed care organizations should be based on the individual responses to the procurement requirements independent of the Public Option program.

- **Reinsurance and Premium Reduction Targets**: The NvAHP reiterates that a successful reinsurance program should not solely rely on federal pass-through funds to support its viability, especially if the reinsurance program is expected to help meet premium reduction targets as required in Senate Bill 420. Per the waiver application, premiums are expected to be reduced by 3% in year one, to ultimately achieve a 15% reduction by year four (and such reduction is expected to continue past year four). Though the program design and statutory mandates differ in certain respects, we urge you to review the Colorado Public Option program in-depth because the same dynamics Colorado is experiencing in achieving its targeted premium savings, which are far short of what was projected, also come into play in Nevada.

  The Colorado premium reduction targets are at the county level. As a result, any Colorado Public Option plan offered in multiple counties will have multiple premium reduction targets for each county, which means that there are 468 plan/county combinations to assess whether carriers are or are not meeting the 10% premium reduction target for the 2024 benefit year. In reviewing carriers NAIC SERFF filing for actual 2024 benefit year rates, only 0.6 percent (three plan/county combinations out of 468 total) met the 10% premium reduction target.[1]

  Further, data recently published by the Centers for Medicare and Medicaid Services shows that the Colorado Public Option program for the majority of service areas and enrolled Exchange population achieved less than one percent of a premium reduction.[2] Specifically:

    - Denver, which encompasses 40 percent of the market in its service area, shows less than a 0.2 percent in Colorado Option premium savings.
    - Twenty-three of the 34 service areas, which encompass the vast majority of the state's market by population and enrollment, show less than 0.5 percent in Colorado Option premium savings.

  The experience in Colorado is significant to review because it is strong evidence that the Nevada Public Option premium savings will be far short of the 3% in year one and 15% in year four. It also reinforces the market instability that will be created by relying on overly optimistic premium savings and federal pass-through funding to fund the State's portion of reinsurance. If carriers assume a fully funded reinsurance program but actual pass-through funding is insufficient to support the program, then all Public Option and Qualified Health Plan rates in the individual market will be inadequate.

  The Colorado Public Option experience highlights the substantial risk for Nevada's market, and underscores how Nevada's Public Option premium reduction requirements are unrealistic.

[1] SERFF: Carrier 2024 Rate Filings – BY24 Colorado Option Rate Reduction Notice Templates

[2] Colorado's Health Care Future. Despite New Federal Pass-Through Funding, the Colorado Option is Still Failing to Increase m Affordability. September 16, 2024. https://coloradoshealthcarefuture.org/the-colorado-option-is-still-failing-to-increase-affordability/

- **Provider Participation and Network Requirement:** The NvAHP also raises the issue that Senate Bill 420 only requires providers to join at least one Public Option program network, which limits the pool of providers and increases the difficulty of achieving the mandated premium reduction targets. It will be challenging to create a sustainable network with a limited pool of providers, and when a reduction in provider reimbursement is not statutorily mandated.

  The State has made it clear that it will not intervene in reimbursement negotiations if providers refuse to negotiate reimbursement rates (while still ensuring compliance with the statutory requirement of the Medicare fee schedule) in order to assist with achieving the premium reduction targets for the Public Option program.[3]

QUESTION_TEXT	ANSWER_TEXT
Is there any intervention from regulators to assist in a scenario where providers do not agree to the requisite provider reimbursement reductions necessary in order to achieve the premium reduction targets?	The State will not directly intervene in reimbursement negotiations between providers and BBSP carriers. The State is, however, requiring any provider who participates in (contracts with) the State's Public Employees' Benefits Program, Medicaid, or workers' compensation program to agree to participate in at least one provider network for a BBSPs or risk their participation as a network provider in these other public programs. This serves as a lever to bring providers to the table to negotiate rates and participate in BBSP networks.

  In reviewing Colorado's experience with provider reimbursements, the provider reimbursement floors are duplicative of what carriers have achieved through a competitive market in urban areas, which is why this mechanism has not been effective in lowering premiums.

  In Nevada, as a condition to receiving Medicaid, state employee, or worker's compensation plan payments, providers must contract with at least one carrier offering a Public Option plan. While contracted rates are still negotiated between the carrier and the provider, the contracted rates cannot be below 100 percent of Medicare in the aggregate across the State. As NvAHP has previously noted, provider reimbursement levels for many providers in the State are already at or near 100 percent of Medicare fee-for-service reimbursement rates.

  Further, since providers are only required to contract with one Public Option plan, we remain concerned that providers will have little incentive to contract with more than one Public Option plan and will maintain higher rates with other carriers with whom they contract with. This will make it difficult for carriers to develop adequate Public Option provider networks and achieve the premium reduction targets. Without any meaningful provisions to lower the underlying costs of care, there is no reason to expect that Nevada will achieve premium reduction targets.

- **Administrative Cost Constraint:** Administrative costs are essential for the operation and management of health benefit plans. Our members work hard to reduce unnecessary costs to ensure that dollars are used efficiently for direct patient care. Activities such as quality improvement, enrollee outreach, care management, and support services (like call centers and nurse lines) also serve a crucial role in the overall health care delivery system ensuring that members receive timely information, support, and management of their care, which leads to better health outcomes.

[3] NV EPRO, Bid Solicitation 40DHHS-S2910: August 23, 2024 FAQ Spreadsheet

In March 2024, the NvAHP raised concerns with the concept that administrative costs for the Public Option program will be further limited. The updates made in the addendum have exacerbated our concerns given the additional administrative work the State will require. In the addendum, the State explains that carriers offering Public Option program plans will "be required to reduce a portion of their administrative expenses for the BBSP offerings" and that they are "considering potential exclusions from what qualifies as an administrative expense, including activities related to quality improvement, enrollee outreach, care management, call centers, or nurse lines."

However, the State also included new requirements for the Public Option program that carriers are expected to implement. Requirements, such as marketing and outreach requirements, the administration of the new "Targeted Premium Relief Program," the mandate to build and now offer a Bronze BBSP plan, and the Medicare floor rate provider notification and monitoring expectation that will require significant administrative costs.

As you are aware, the Affordable Care Act's Medical Loss Ratio (MLR) standard requires health plan carriers that operate in the individual market to spend at least 80 cents of every premium dollar on medical costs. If that threshold is not met, the dollars are rebated back to consumers.

When considering limiting the MLR beyond what is already in place, it is important keep in mind the new and added program requirements the State also expects carriers to implement and the higher administrative expenses that are inevitable with such implementation. Finally, when determining what to exclude from administrative costs, it's important to recognize the value our programs and services that add to the quality and efficiency of care for our members.

We urge you to prioritize the benefits Nevadans receive through direct and indirect services and programs that administrative costs help fund and not limit the MLR further simply to achieve an arbitrary premium target.

Recommendation

The NvAHP applauds innovation, and we are constantly working towards making healthcare more accessible and affordable. However, to successfully do so, sound policy is necessary. We stand behind our position that the Public Option program, inclusive of the changes made in the addendum, remains fundamentally flawed. Therefore, we strongly recommend the Departments **not approve** the Nevada waiver application.

Sincerely,
/s/ Shelly Capurro
NvAHP, Legislative Representative

CC: Chiquita Brooks-LaSure, Administrator, CMS
Dr. Ellen Montz, Deputy Administrator and Director, Center for Consumer Information and Insurance Oversight, CMS
Jeff Wu, Deputy Director Policy, Center for Consumer Information and Insurance Oversight, CM

NEVADA'S
HEALTH CARE FUTURE

September 25, 2024

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

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

RE: Nevada's Health Care Future's Comment on Nevada's Section 1332 State Innovation Waiver Application

Dear Secretary Yellen and Secretary Becerra,

We appreciate the opportunity to comment on the State of Nevada's Section 1332 State Innovation Waiver application to implement a Nevada Public Option program. Nevada's Health Care Future (NVHCF) is committed to increasing access to affordable, high-quality health care for all Nevadans by championing solutions that build on what is working in our health care system today while fixing what isn't.

We urge you to deny Nevada's application for a 1332 waiver, as the facts show that a Public Option will decrease access to affordable, high-quality care that residents across the state rely on. While some advocates for the Public Option point to Nevada's proposed market stabilization program, evidence indicates it will be unsuccessful in addressing the structural flaws at the core of SB 420 (the bill creating the Public Option program), the state's guidance and the 1332 waiver application. Nevadans will still experience the damaging effects of this flawed system.

Research conducted by subject matter experts clearly shows that the Public Option program will harm Nevadans. NVHCF engaged Wakely Actuarial Consulting to perform an actuarial analysis of SB 420 in advance of the state's revised 1332 waiver application.[1] Wakely's experts determined the Public Option would likely worsen Nevada's already significant health care provider shortage. The state is currently ranked 48th nationally for primary care physicians per capita and further deterioration would have devastating consequences. Additionally, the program would also put financial hardships on hospitals, further threatening access to care for patients in need.

Wakely also found a Public Option could reduce competition in the state's marketplace by forcing insurance providers to exit the market while deterring new ones from doing business in the state. We have seen this

[1] Wakely Consulting Group, "Nevada Public Option Actuarial Analysis," October 2023.

scenario play out in Colorado, one of the two states that have implemented a Public Option program. Four health insurers announced they would fully or partially exit the Colorado market, forcing thousands of residents to find new plans and even change doctors.[2]

In addition to harming competition, premiums have continued to rise in Colorado. In fact, individual market premiums rose an average of 10 percent this year after a similar double-digit increase last year.[3] Into its second year, the vast majority of service areas in Colorado have had premium savings of less than one percent. CMS data shows that Colorado's reinsurance program is the overwhelming source of much of the premium savings experienced in the state.[4]

The State of Washington also implemented a state government-controlled Public Option, but with very little success. Washington's Public Option has done practically nothing to lower the uninsured rate despite promises from advocates. After three years, only four of Washington State's 39 counties have Public Option plans that have met the state's premium targets for bronze-level plans; only one county has met the target for silver-level plans.[5]

It is not a coincidence the Public Option has failed in every state where it has been tried and there is no evidence to suggest Nevada would fare differently. Just as it has played out in Washington and Colorado, a Nevada Public Option would threaten health care choice, affordability and access for patients.

SB 420 was passed hastily into law and is significantly flawed. Despite the state submitting a revised waiver application, it seems the waiver application still relies on many misguided assumptions that could lead to harmful consequences for Nevada patients and their families:

- The state has proposed in its revised application putting into place a market stabilization program that implements and relies upon the Public Option. Tethering the state's proposed reinsurance program to the creation of the Public Option is a risky strategy, especially with the facts suggesting this is not a viable model for financing the reinsurance program.
- Rather than decreasing administrative costs, the many new requirements and mandates for payers will increase administrative costs. This includes the new requirements that carriers have dedicated marketing and promotion of the Public Option plans, the requirement that the state intends to administer the premium relief program outlined in the waiver at the carrier level, and other requirements that will increase administrative costs including implementing new bronze, silver and gold Public Option plans with unique network requirements. Worse, any reduction in carriers' required risk margins could pose a major threat to consumer choice and competition in the state, completely counter to the objectives of SB 420.
- With many hospitals and other providers already at or near 100% of Medicare fee-for-service (FFS) reimbursement rates – and without any meaningful drivers in the policy to lower the cost of care – there is a slim chance carriers will be able to meet the state's premium reduction targets.

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[2] Colorado Politics, "Fourth Health Insurance Company To Leave Colorado," June 2023.
[3] Colorado Politics, "Stakeholders Must Acknowledge 'Colorado Option' Harms Affordability," June 2024.
[4] CMS, "1332 State Specific Premium Data," August 2024.
[5] Partnership for America's Health Care Future, "Promises Unmet: The Early Experience of State Public Option Plans," April 2024.

- The assumption that the creation of Public Option plans will help lower non-Public Option premiums is deeply misguided – particularly after its failure to do so in both Colorado and Washington.
- The degree to which this waiver ties the procurement process for Medicaid contracts directly to insurance carriers' submission of Public Option plans for Nevada's individual market could destabilize the Medicaid program.

Nevada's Health Care Future raised many of the same concerns in our March 2024 comment letter, but in reviewing the state's updated waiver application, we are disappointed to see that none of the core concerns we highlighted were addressed by Nevada's Department of Health and Human Services.

Simply put, Nevada's revised 1332 waiver application fails to address the fundamental flaws contained in SB 420's Public Option provision. Advocates for the Public Option have pointed to the projected impact in reducing the uninsured population by 2,200, but that impact is minimal at best and is far outweighed by the concerning projections from Wakely Consulting Group's study regarding decreased access to doctors and affordable care. In fact, increasing access to coverage and care is more likely to be achieved through private coverage and existing public programs coming together to build on what is working in our current system.

Nevada's Health Care Future respectfully urges you to deny Nevada's Section 1332 State Innovation Waiver application to protect Nevadans from the harmful effects of a Public Option program that has failed in every state that has attempted to implement one.

Our focus has always been and will remain building on what is working in health care to improve access to affordable, high-quality care rather than starting over with one-size-fits-all, unproven systems. We will continue to support health care policy proposals that align with this goal. NVHCF appreciates the opportunity share our concern regarding SB 420 and Nevada's Section 1332 State Innovation Waiver application.

Sincerely,

Kelley M. Robertson
Executive Director
Partnership for America's Health Care Future Action
Nevada's Health Care Future

September 25, 2024

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

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

Re: Nevada Section 1332 Innovation Waiver Request

Dear Secretary Yellen and Secretary Becerra:

Thank you for the opportunity to provide feedback on Nevada's Section 1332 Innovation Waiver Request.

The undersigned organizations represent millions of individuals facing serious, acute and chronic health conditions. We have a unique perspective on what individuals and families need to prevent disease, cure illness and manage chronic health conditions. The diversity of our organizations and the populations we serve enable us to draw upon a wealth of knowledge and expertise that is an invaluable resource regarding any decisions affecting the Affordable Care Act and the people that it serves. We urge the Department of the Treasury and the Department of Health and Human Services (the Departments) to make the best use of the recommendations, knowledge and experience our organizations offer here.

Nevada's waiver application seeks some pass-through funding to provide targeted premium subsidies to marketplace enrollees who would otherwise face higher premiums due to other features of the proposed waiver. The waiver further intends to use these funds to support an individual market reinsurance program. Our organizations support these proposed. Reinsurance does not make coverage cheaper for people — generally at lower incomes — who already qualify for federal subsidies.[1] For this reason, our organizations are pleased to see that the state will be addressing marketplace affordability

with targeted premium subsidies, though we urge the Departments to work with the state to continue to address affordability for all enrollees. Additionally, as this waiver's programs are implemented, it is important that the state continues to affirm its commitment to safeguarding access to care for low-income residents and reducing health disparities.

Our organizations support the state's commitment to improving awareness and take-up of Battle Born State Plans (BBSPs) through improved marketing and outreach, emphasis on active shopping, and more thoughtfulness regarding plan display. These strategies are all likely to help consumers make more informed enrollment decisions and to meaningfully increase take-up in a manner that produces modestly lower net premiums for marketplace enrollees.

Finally, our organizations support the state's guaranteed pass-through funding for the carrier and provider incentive programs. We note, for example, that the state has signaled it will use these policy levers to ensure BBSP plans have adequate networks and to promote continuity of care. Uninterrupted access to a robust network of providers is essential for the patients we represent to get the primary and specialty care that they need to manage their health conditions. If well designed, the BBSP contracting process and these programs could help to increase access to providers. The state's application also emphasizes that it will use these initiatives to improve health equity, including for rural and historically marginalized communities. It is critical for the state to follow through with and expand upon these commitments. Our organizations encourage the Departments to work with the state to do this, and to ensure that the policy tools necessary to realize these gains are sufficiently funded.

Our organizations urge the Departments to work with the state to ensure that affordable and equitable access to care for all marketplace enrollees continues to be prioritized if this waiver is approved.

Thank you for the opportunity to provide comments.

Sincerely,

American Lung Association
Asthma and Allergy Foundation of America
Cancer*Care*
Epilepsy Foundation
Hemophilia Federation of America
Lupus Foundation of America
National Bleeding Disorders Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
The Leukemia & Lymphoma Society
WomenHeart

[1] This is because of how ACA premium tax credits are calculated. In practice, from a consumer standpoint, reinsurance functions as a premium subsidy for people who are otherwise unsubsidized: in general, it lowers

premiums for those who earn too much to qualify for a federal premium tax credit but does not improve affordability for those who, because they are at lower incomes, receive the premium tax credit.

NICOLE J. CANNIZZARO
SENATOR
District No. 6

MAJORITY LEADER

LEGISLATIVE BUILDING:
401 S. Carson Street
Carson City, Nevada 89701-4747
Office: (775) 684-1475 or
(775) 684-1400
Fax No.: (775) 684-6522
Nicole.Cannizzaro@sen.state.nv.us
www.leg.state.nv.us

Nevada Senate

September 9, 2024

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

The Honorable Chiquita Brooks-LaSure
Administrator for Centers for Medicare and Medicaid Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Secretary Becerra and Administrator Brooks-LaSure,

I write to express my strong support for the revised Section 1332 Waiver Application for Nevada's Coverage and Market Stabilization Program. The waiver application was initially submitted on December 28, 2023 by the State of Nevada through its Department of Health and Human Services, and a revised application was submitted on August 23, 2024. The application seeks a waiver of certain requirements of the Affordable Care Act (ACA) to implement a new public option on January 1, 2026 and a state-based reinsurance program on January 1, 2027. Together, these new reforms aim to drive down premium costs and protect the stability of the marketplace, while improving health outcomes for Nevadans.

NICOLE J. CANNIZZARO
SENATOR
District No. 6

MAJORITY LEADER

LEGISLATIVE BUILDING:
401 S. Carson Street
Carson City, Nevada 89701-4747
Office: (775) 684-1475 or
(775) 684-1400
Fax No.: (775) 684-6522
Nicole.Cannizzaro@sen.state.nv.us
www.leg.state.nv.us

Nevada Senate

Although the implementation of the ACA's Medicaid expansion and a state-based health insurance exchange significantly improved access to health insurance in Nevada, too many residents still struggle to find affordable, quality health care. Nevada continues to rank among the top ten states with the "highest" uninsured rates in the country. Nevada's health care system also faces significant workforce gaps and continues to perform poorly on national quality metrics and scores.

Maintaining the status quo is not enough for Nevada. This waiver represents the state's effort to take a new and innovative approach to its individual health insurance market within the confines of Section 1332 of the ACA. Approval of this waiver application would allow Nevada to leverage a novel purchasing strategy with health carriers that is designed to drive premiums down in the state's health insurance exchange and save hundreds of millions of federal dollars in reduced premium tax credits.

The waiver application includes a request for approval to invest the new federal savings in a state-based reinsurance program and other state initiatives aimed at attracting and retaining providers and improving quality in the state's health care system. As provided in its waiver application, the state intends to use its new contractual levers with health carriers to promote value-based payment design with providers, health equity strategies in care delivery, workforce development, and network alignment with Medicaid managed care to promote continuity of care—all of which align with the goals of the ACA.

For all these reasons, I strongly support the State of Nevada's Section 1332 Waiver Application and respectfully request your consideration of this application within all applicable rules and regulations of your agencies.

NICOLE J. CANNIZZARO
SENATOR
District No. 6

MAJORITY LEADER

LEGISLATIVE BUILDING:
401 S. Carson Street
Carson City, Nevada 89701-4747
Office: (775) 684-1475 or
(775) 684-1400
Fax No.: (775) 684-6522
Nicole.Cannizzaro@sen.state.nv.us
www.leg.state.nv.us

Nevada Senate

If I can be of any assistance, please do not hesitate to contact my office.

Sincerely,

Senator Nicole J. Cannizzaro
Majority Leader
Nevada State Senate

9/24/2024

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

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

Submitted via stateinnovationwaivers@cms.hhs.gov

RE: Updated Nevada Section 1332 State Innovation Waiver Application

Dear Secretary Becerra and Secretary Yellen,

United States of Care (USofCare) is pleased to again submit comments to the Centers for Medicare & Medicaid Services (CMS) and Department of the Treasury regarding Nevada's updated Section 1332 State Innovation Waiver application to create the Nevada Coverage and Market Stabilization Program.

USofCare is a non-partisan, non-profit organization working to ensure everyone has access to quality, affordable health care, regardless of health status, social need, or income. We have seen through our research that the high cost of care is the biggest issue of concern to people, across demographic backgrounds, such as race, ethnicity, and geography. The high price of care impacts every part of people's experience with the health care system, from rising premiums to high deductibles and cost-sharing. Due to this, USofCare has continued to support efforts to create and implement the new public health insurance option ("public option"), including submitting federal comments in February 2024 in support of the proposed waiver.

Nevada's updated 1332 waiver application addresses many of the concerns outlined by previous commenters, providing a solution to lower health care costs for hundreds of thousands of Nevadans. **USofCare supports the framework proposed by Nevada's Division of Health Care Financing and Policy ("the Division") to utilize a federal 1332 waiver as part of the creation and development of the new public option. We believe this updated proposal is a strong foundation to increase affordable health coverage options for Nevadans while building upon existing state efforts to promote health care affordability. We strongly urge The Departments to approve the waiver.** We are excited to see the continued efforts to ensure access to affordable health insurance coverage through the amended waiver application and appreciate the opportunity to share our perspective on the design of the state's federal 1332 waiver.

Updates to Waiver Proposal

We appreciate the commitment from CMS and Nevada to take the time necessary to ensure the proposed 1332 waiver and its analyses capture the experiences of all Nevadans under this waiver. Pausing to address the considerations raised in previous comment periods allowed The Division to update their analysis and provide additional premium relief for consumers. Importantly, Nevada's updated waiver application prioritizes pass-through funding to be used for a premium relief program which ensures Nevadans, primarily middle-income consumers, are protected from any increases in premium costs due to the creation of new Battle Born State Plans (BBSPs) in 2026.

This updated application builds on the strong policies included in the initial application, which includes three new initiatives – a reinsurance program, quality incentive payment program tied to improved outcomes for participating carriers and providers, and the "Practice in Nevada" provider incentive program. **Taken together, this waiver proposal improves affordability, increases access to quality care, and reduces health disparities, while also supporting providers in Nevada and alleviating workforce shortages.**

Coverage and Affordability

This waiver will bring needed improvements to health care by reducing premiums and introducing a new, quality coverage option for Nevadans to enroll in. The status quo is not working for Nevadans who have been struggling to afford their health care. For example, people of color in Nevada report worrying about their health insurance becoming unaffordable at higher rates than White Nevadans. Additionally, rural respondents and those living in households with a person with a disability are more likely to report concern about losing their health insurance than their non-rural and non-disabled counterparts. Nevadans' concerns about *affording* health coverage exceed their fears about *losing* health care coverage across all income groups, disability statuses, coverage types, and geographical settings.

Nevada will leverage the state's Medicaid infrastructure to provide people with access to new Battle Born State Plans (BBSPs), which are required to meet premium reduction targets of 15% over four years and ongoing thereafter. These premium reductions not only provide relief for consumers, but the savings they produce also enable Nevada to receive pass-through funding from the federal government. **The proposed waiver and public option are expected to lower the cost of health insurance for more than 100,000 Nevadans on the individual market, while bringing up to $310 million in federal passthrough funding into the state in the first five years.**

Nevada is making strides to address health care disparities in the state with this proposal as well. Importantly, these premium reductions provide relief for populations that have continued to face inequities, including:

- Lower-income individuals, who are disproportionately Hispanic, African American, American Indian, and Asian-Pacific Islanders,
- Older individuals, including individuals 65 and older, and

- Residents who live in rural and frontier/remote areas of the State (outside of Clark and Washoe Counties).

Leveraging the Medicaid managed care infrastructure to provide this new source of coverage enables Nevada to replicate and complement approaches currently being used within Medicaid managed care to improve health outcomes, advance equity, and lower the cost of care for Nevadans. For example, by aligning MCOs and BBSPs requirements, the state helps ease the transition for those churning between coverage sources. Further, this alignment enhances Nevada's negotiating power, ensuring that state investments into these programs are successfully meeting the access and affordability needs of Nevadans.

Consumer Outreach and Enrollment Assistance

Nevada is expected to eventually see BBSP takeup comprise 80% of total marketplace enrollment, due in large part to the updated waiver request now including plans to implement several consumer outreach and enrollment strategies to help ensure Nevadans know about these new plans and are able to enroll. Many consumers report challenges comparing plan coverage and in-network providers, selecting appropriate plans, and understanding their eligibility for financial assistance, and, with the addition of BBSPs into the market, consumers will benefit from additional outreach and assistance navigating their new plan offerings. For example, these tools can help consumers compare BBSPs offered by different plans and metal levels with other qualified health plans offered on the exchange so they understand the benefits and potential drawbacks of their options.

Nevada's plan to promote active shopping, help consumers differentiate between BBSPs and other qualified health plans (QHPs), leverage the tools and flexibility offered by the Silver State Health Insurance Exchange, and partner with BBSP carriers and the community to promote consumer outreach will help drive enrollment and ensure Nevadans are enrolled in plans that meet their needs and budget. It's critical that Nevada's pass-through funding is partially reinvested in outreach and enrollment efforts, and, in doing so, Nevada can look to lessons learned from the Administration's robust investments in outreach and enrollment efforts and the historic number of people enrolled in ACA coverage.

Looking Forward

United States of Care has also been engaged in the 1332 waiver Colorado has implemented as part of their Colorado Option, which has seen great success since beginning in 2023. And while each state approach is distinct, both leverage the public infrastructure to provide meaningful, affordable coverage and care in innovative ways. As Nevada continues to implement the Coverage and Market Stabilization Program, it can partially look to Colorado's recent experiences:

- Like Nevada, Colorado requires public option plans to meet premium reduction targets as a way to lower costs and generate federal pass-through funding, and consumers in Colorado are expected to save 23% in premiums in 2025 due to the Colorado Option and 1332 waiver.

- Enrollment has exceeded expectations, with 35,000 people enrolling in coverage in the first year alone, now up to 80,000 people, comprising 34% of enrollment in their state exchange.
- Coverage is robust and built with equity in mind, including services with limited or no out-of-pocket costs, such as primary care and substance use disorder services.
- Plans are required to build provider networks that are culturally responsive and that include access to critically-important providers, such as certified nurse midwives and essential community providers.

Thank you for the opportunity to provide comments in support of the updated section 1332 waiver application to create Nevada's Public Option and Market Stabilization Program. We urge the Administration to approve the waiver so Nevada has the federal tools and resources needed to decrease costs and increase competition, choice, and market stability for their state. If you have any questions or are interested in further discussion of our comments on the updated 1332 waiver application, please do not hesitate to reach out.

Sincerely,

Kelsey Wulfkuhle
State Advocacy Manager
kwulfkuhle@usofcare.org

Liz Hagan
Director of Policy Solutions
ehagan@usofcare.org