Joe Lombardo
Governor

DEPARTMENT OF
HEALTH AND HUMAN SERVICES
DIRECTOR'S OFFICE
Helping people. It's who we are and what we do.

Richard Whitley, MS
Director

August 23, 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 1332 Innovation Waiver Request – Battle Born State Plans and Market Stabilization Program

Dear Secretaries Yellen and Becerra:

The State of Nevada respectfully requests that the U.S. Department of Treasury and U.S. Department of Health and Human Services resume consideration of Nevada's Section 1332 State Innovation Waiver and grant its approval as soon as possible to maintain adherence to timelines defined in State law for the Department's implementation of a Public Option program. Both the Public Option health plans, called "Battle Born State Plans" (BBSPs), and the State's Market Stabilization Program, will be implemented upon the approval of this waiver application. These policies represent new initiatives aimed at improving access to and affordability of health insurance while ensuring a healthy and stable marketplace for those who purchase insurance through the individual health insurance market.

As you may recall, Nevada is seeking to waive Section 1312(c)(1) of the Affordable Care Act (ACA) and its implementing regulations for a five-year period to establish the BBSPs and Market Stabilization Program detailed in the application. The BBSPs and Market Stabilization Program are intrinsically related; therefore, the State is seeking federal waiver authority for these initiatives in one waiver request. Presently, Section 1312(c)(1) and its implementing regulations limit issuers' ability to vary premium rates for certain health plans from the index rate. Nevada wishes to waive this requirement for the BBSPs, which will ultimately control health care costs by reducing premiums in the health insurance marketplace and generating federal savings on premium tax credits. A waiver of Section 1312(c)(1) will also allow implementation of the State's new Market Stabilization Program, which includes a reinsurance program in year two of this waiver (CY 2027). Nevada seeks approval to utilize federal pass-through funds to finance in full the new reinsurance program and two other programs designed to improve quality, increase the number of health providers, and lower health care costs in Nevada.

The application request lies within the authority of the Director of the Nevada Department of Health and Human Services, as stated in NRS 695K.210, to request a Section 1332 waiver and "to subsidize the cost of health insurance" and "improve affordability" for Nevadans. It is also consistent with the broad authority of the Nevada

Division of Insurance Commissioner to seek a Section 1332 waiver.

Enclosed please find a revised version of Nevada's initial December 29, 2023, State Innovation Waiver Application (Application). The revised Application outlines new State initiatives, including strategies to encourage consumers to actively shop for their health insurance coverage and promote consumer awareness of lower-cost BBSPs, with updated actuarial analysis reflecting these State initiatives. It also includes a consumer premium rebate program to ensure that no Nevadan experiences an unavoidable increase in premium costs because of the new BBSPs being introduced into the market in 2026.

Granting this waiver will allow Nevada to make important investments in increasing access to affordable health insurance coverage and lowering health care costs. Thank you for considering our application and supporting Nevada's health care affordability and market stabilization goals.

Sincerely,

Richard Whitley
Director
Nevada Department of Health and Human Services

SECTION 1332 WAIVER APPLICATION ADDENDUM:

NEVADA COVERAGE AND MARKET STABILIZATION PROGRAM

DEPARTMENT OF

HEALTH AND HUMAN SERVICES

DIVISION OF HEALTH CARE FINANCING & POLICY

WAIVER APPLICATION ADDENDUM

Re-Submission Date: August 23, 2024

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Section 1: Summary of Changes to Revised Waiver Application

A. Overview

On December 29, 2023, the State of Nevada submitted a Section 1332 State Innovation Waiver application, requesting to waive Section 1312(c)(1) of the Affordable Care Act in order to implement new public option plans, known as Battle Born State Plans (BBSPs), and a Market Stabilization Program for the individual market for plan years 2026 through 2030. On February 12, 2024, the Center for Consumer Information and Insurance Oversight (CCIIO), on behalf of the U.S. Department of Treasury and U.S. Department of Health and Human Services (the Departments), deemed Nevada's waiver application complete. A federal public comment period for the application was held from February 12, 2024 to March 14, 2024. On March 21, 2024, Nevada requested the Departments pause review of the waiver application while the State implemented updates to its proposal in response to the comments shared during the federal public comment period.

This revised application reflects updates made to the waiver application as follows:

1. Redesigned the reinsurance program to include uniform parameters across rating regions;
2. Adjustments to premium reduction targets to create a more level playing field for carriers;
3. Addition of a targeted premium relief program for enrollees experiencing unavoidable premium increases due to the BBSP premium reduction targets;
4. Strategies to promote active plan shopping and awareness of BBSPs and lower-cost options; and
5. New plan offering requirements.

B. Summary of Key Changes

1. Reinsurance Program with Uniform Parameters Across Rating Regions

In response to public comments received during the federal public comment period, Nevada has revised the application to assume uniform reinsurance parameters across all rating areas. Commenters shared that a tiered coinsurance design would make it more challenging for carriers to achieve the overall 15 percent premium reduction target in these areas, where provider reimbursement rates are already lower due to heightened provider competition. To address concerns expressed by commenters regarding the feasibility of meeting the premium reduction target, Nevada has decided to implement flat coinsurance parameters across all geographic rating areas for all carriers.

2. Adjustments to Premium Reduction Targets

In response to public comments, the State of Nevada will implement adjusted premium targets that will give carriers with less competitive 2025 premiums an opportunity to achieve the full 2029 premium reduction target of 15 percent over the first four years of the waiver program, rather than a single year. The Actuarial and Economic Analysis conducted by Milliman, Inc. assumes the adjusted premium targets will not impact the SLCS premium or pass-through funding (PTF) because at least two issuers will achieve the unadjusted premium reduction target.

3. Targeted Premium Relief Program

In response to public comments urging the State to consider providing premium support to enrollees to improve affordability, Nevada will institute a premium relief program for certain qualifying individuals who are

enrolled in Nevada's state-based health insurance exchange—the Silver State Health Insurance Exchange (SSHIX)—as of December of 2025 and reenroll in 2026 coverage. Premium relief will be provided to renewing individuals whose net premium is higher under the waiver program than it would have been without the waiver due to reductions in the second-lowest cost silver (SLCS) premium driven by lower gross premiums under the state statutorily-required BBSP premium reduction targets.

4. Strategies to Promote Active Plan Shopping and Awareness of BBSPs

Nevada will enact a suite of strategies to (1) encourage consumers to actively shop for their health insurance coverage and (2) promote awareness of the new BBSPs and lower cost options for coverage. These outreach strategies, summarized below, are intended to help Nevadans gravitate towards lower cost options, which will likely be the BBSPs in most geographic areas, as BBSPs will more often be less costly relative to other plans available on the marketplace.

- **BBSP Carrier Marketing and Outreach Requirements:** The State will require carriers under their BBSP contracts to widely market and promote their BBSP offerings during open enrollment. For instance, the State is exploring including contractual requirements for carriers to develop their own outreach campaigns and meeting certain parameters to be approved by the State prior to open enrollment.
- **Integrating Active Shopping Promotion into SSHIX Marketing Campaign:** Promotion of active plan selection will be woven into SSHIX's fall marketing campaign. For instance, SSHIX can include static messaging on the Nevada Health Link website to urge consumers to review the health coverage options available to them prior to SSHIX standard auto-enrollment procedures to remind consumers that premiums may be lower in other plans if they shop for coverage. This will complement any strategies SSHIX undertakes to encourage shopping due to the impending loss of enhanced premium subsidies.
- **Differentiating BBSPs and Plan Display:** The State plans to create a BBSP logo or some similar differentiating moniker for use on its website, plan preview tool, and application plan selection pages. SSHIX can require carriers to include "Battle Born State Plan" in plan names to differentiate the products on the Nevada Health Link. Additionally, the Nevada Health Link's default plan sorting mechanism, which sorts plans from lowest to highest net premium, will work to increase the visibility of BBSPs for consumers since BBSP premiums will be lower than other plan options in most geographic areas of the state.

Based on the expansion of planned State initiatives described above, the Actuarial Analysis' BBSP take-up rate for SSHIX enrollees was increased to 80%. This change in assumption has a small impact on PTF, but it materially reduces projected enrollee gross and net premiums with waiver.

5. New Plan Offering Requirements

The revised application also newly states that Nevada is requiring each BBSP carrier to offer at least one bronze BBSP, in addition to the statutory requirement to offer one silver and one gold BBSP. Nevada has decided to require carriers to offer a bronze BBSP—rather than simply encouraging it—to provide consumers an additional low-cost option within their existing metal-level.

Each BBSP carrier will also be required to offer one standard (i.e., non-BBSP) silver QHP in each geographical region it serves to allow the State to effectively estimate pass-through funding.

Section 2: Nevada Program Overview and Waiver Request

A. Overview

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

Nevada seeks to waive Section 1312(c)(1) of the ACA and its implementing regulations for the purpose of establishing the reforms described herein. If approved, the Section 1332 waiver is targeted to be effective January 1, 2026, for five years. The reforms will not affect any other provision of the ACA but are expected to result in a lower SLCS premium and a reduced market-wide index rate (relative to no waiver), thereby lowering gross premiums and reducing the federal cost of Premium Tax Credits (PTC).

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

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

The first initiative for addressing these issues is the development and implementation of a new Public Option program by the Nevada Director of Health and Human Services (the Director).[6] The Director must contract with carriers to offer new health insurance options to consumers through the SSHIX, which operates Nevada Health Link. These new options (hereinafter "Battle Born State Plans" [BBSP]) must be certified as Qualified Health Plans

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[1] Nev. Rev. Stat., Chap. 695K, available at: https://www.leg.state.nv.us/nrs/NRS-695K.html

[2] ASPE, National Uninsured Rate Reaches an All-Time Low in Early 2023 After the Close of the ACA Open Enrollment Period, August 2023, available at: https://aspe.hhs.gov/sites/default/files/documents/e06a66dfc6f62afc8bb809038dfaebe4/Uninsured-Record-Low-Q12023.pdf.

[3] Nevada Div. of Behavioral and Public Health, Health Professional Shortage Areas, available at: https://dpbh.nv.gov/Programs/HPSA/Health_Professional_Shortage_Area_Designations_-_Home/

[4] America's Health Rankings, Nevada Summary, 2022, available at: https://assets.americashealthrankings.org/app/uploads/allstatesummaries-ahr22.pdf

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

[6] Nev. Rev. Stat. § 695K.200.

(QHP) and meet all state and federal requirements as standard QHPs, including providing the same minimum benefits and cost sharing. A carrier must make a good faith bid to offer BBSPs in order to be permitted to bid as a Medicaid Managed Care Organization in the procurement for 2026 through 2030. BBSPs must also be offered off-Exchange.

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

First, to be considered for the Medicaid Managed Care procurement, carriers must submit a good faith bid that, at a minimum, meets their applicable Year 1 premium reduction target.[7] In Spring 2025 the final, updated reference premium for BBSPs will be released, with any pricing adjustments necessary based on information that was not known at the time of the release of the BBSP reference premium range. Carriers will adjust BBSP premiums as necessary to meet the premium reduction target and submit proposed rates to the Nevada Division of Insurance (DOI) for review, according to DOI's standard procedures.

Carriers that are certified to have offered a good faith bid will be notified by the State that they can proceed in the Medicaid Managed Care procurement. Following the good faith bid determination, the State will continue its review of carriers' proposals to determine which BBSPs will be offered in each geographic rating area, ultimately notifying carriers of their awards in Spring 2025.

As with every other carrier offering a QHP on the SSHIX, carriers must commit to fulfilling DOI requirements for operation as a commercial carrier in the State (including filing network adequacy information with the DOI) and must seek formal QHP certification of their BBSPs each year from SSHIX. Selected vendors will submit final BBSP premium rates for all metal levels for Plan Year 2026 to the DOI for review and approval.[8] This customary State process will verify actuarial soundness and confirm that solvency standards and all other requirements of standard QHPs have been met. The DOI will evaluate the rate filings for the BBSPs in the same manner as other rate filings to determine whether rates are excessive or inadequate and whether carrier solvency and all other requirements of QHPs have been met. The Division will also contract with an actuarial firm to ensure that carriers' BBSPs are on target to meet the Public Option law's premium reduction requirements.

While the introduction of the BBSPs and achieving the premium reduction targets are not expected to disrupt the insurance market, a suite of other initiatives are intended to mitigate any unexpected financial risk to carriers and limit the impact on provider networks, while strengthening the long-term sustainability of this market. This includes three new measures:

- **State-Based Reinsurance Program:** Reinsurance is aimed at alleviating any unexpected financial risk to participating carriers and their provider networks with the introduction of the BBSPs that meet premium reduction targets. The State intends to adjust the size of the reinsurance parameters as needed to ensure

[7] The preliminary reference premium released by September 2024 will account for carrier-specific rate positioning in 2025. The preliminary reference premium will be developed, in part, by reviewing published 2025 rates and benefit plans, projected to Plan Year 2026 using CPI-M plus an adjustment for local market factors.

[8] Any differences between a carrier's good faith bid for this RFP as it relates to the carrier's estimated premium rate for the silver BBSPs and the BBSP rates the carrier submits for review to the DOI for the rate review process should be attributable to quantifiable differences in factors that are uncertain at the time of the carrier's response or bid to this RFP. The carrier will provide documentation to support any such differences, if requested by the State.

that it can be fully funded by the pass-through funding (PTF) generated in the prior year after financing State administrative costs and the waiver's premium relief program.

- **Quality Incentive Payment Program:** If there is remaining PTF in any year of the waiver period after financing reinsurance, the State intends to use this funding to establish a Quality Incentive Payment Program for carriers offering BBSPs. This program will be designed to reward carriers and their providers for utilizing value-based efforts to improve health outcomes and quality of care. Through this new program, the State will be able to, for the first-time ever, drive changes in how health care is delivered and paid for in the individual market. Over time, these efforts should lead to a healthier population and therefore reduce risk to carriers. It should also lead to shared savings and financial rewards for network providers that are successful in these efforts with carriers.
- **"Practice in Nevada" Incentive Program for Health Care Providers:** If there is sufficient remaining PTF, the State intends to use such funding to finance a new state-run "Practice in Nevada" program. Nevada faces critical challenges in attracting health care providers—including primary care physicians, obstetricians, behavioral health practitioners, and other allied health professionals—to practice in the State. Currently, Nevada ranks last in the number of primary care providers per 100,000 individuals.[9] Therefore, increasing the number of providers through incentives is essential to addressing poor health outcomes and health disparities. It is also important for controlling the rise in the cost of health care and ensuring the stability of the State's insurance market. Because of the steep demand and supply gap for health care professionals in Nevada, having more medical professionals could help insurers avoid facing unreasonable price hikes from network providers that are in low supply in the State. For example, carriers with smaller market shares (i.e., covered lives) are likely to struggle to negotiate reasonable rates for certain services where only one provider entity is available in a region to provide such services to its members. Most recently, this challenge was notable in the State's Medicaid Managed Care program, where a carrier with a smaller portion of enrollment in the program faced unreasonable prices as compared to other carriers from a certain specialty provider type that is in low supply in the State.

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

B. Federal Provisions to Be Waived

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

Section 1312(c)(1) and its implementing regulations limit the factors by which issuers can vary premium rates for a particular plan from the index rate. The goal of the premium reduction targets for the BBSPs in SSHIX is to control health care costs and support coverage by reducing insurance premiums. Through NRS 695K and this waiver, the Director would condition eligibility to bid as an MCO carrier on submitting a good faith bid to offer a silver BBSP on the SSHIX that meets certain premium reduction targets each year, among other QHP

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

requirements.[10] These premium reductions are expected to be achieved through a combination of lower provider rates, administrative efficiencies, and the implementation of reinsurance. To allow these reductions, Nevada is requesting a waiver of the Single Risk Pool provision of the ACA, Section 1312(c)(1). Under the implementing regulations at 45 CFR 156.80(d)(2), an "issuer may vary premium rates for a particular plan from its market-wide index rate for a relevant state market based only on the following actuarially justified plan-specific factors." These regulations enumerate specific factors, including: (1) actuarial value and cost-sharing; (2) provider network; (3) delivery system; (4) utilization management practices; (5) benefits provided in addition to the EHB; (6) administrative costs; and (7) any expected impact of eligibility for catastrophic plans. A federal waiver of Section 1312(c)(1) will ensure carriers can make plan-level adjustments to the market-wide adjusted index rate for BBSP offerings that correspond to the new premium reduction targets.

Nevada's Section 1332 waiver application seeks to waive section 1312(c)(1) of the ACA in order to establish a state-based and state-administered reinsurance program. Section 1312(c)(1) requires "all enrollees in all health plans . . . offered by [an] issuer in the individual market . . . to be members of a single risk pool." The application calls for waiving the single risk pool requirement to the extent it would otherwise require excluding expected State reinsurance payments when establishing the market-wide index rate. A lower index rate will result in lower premiums for Nevada's SLCS plan, resulting in a reduction in the overall PTCs that the federal government is obligated to pay for subsidy-eligible consumers in Nevada.

The State intends to establish a reinsurance program with flat coinsurance across all regions. A flat reinsurance structure – as opposed to reinsurance in which coinsurance rates are higher in more rural rating areas – can mitigate carriers' concerns about meeting the premium reduction targets in Rating Area 1, the most populous region where provider reimbursement rates are already lower than in other regions. The reinsurance program is expected to reduce premiums market-wide by 7.3% by 2030, contributing to plans' ability to meet the premium reduction targets in the years 2027 through 2030 and generating further federal savings.

Section 3: Nevada Section 1332 Waiver Proposal

A. Enabling Statutory Authority

Enabling legislation requires the Director to apply for a Section 1332 waiver no later than January 1, 2024, to implement the reforms and requirements of NRS 695K to establish a new Public Option program and to capture all PTF made available to the State with such reforms.[11]

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

NRS 695K.300(5) also provides the Director with broad express authority to spend federal PTF made available to pay for the costs associated with administering the reforms of Chapter 695K and any associated waivers. It provides the Director with the authority to spend the remaining federal PTF to improve the affordability of the new coverage options established under the Public Option program. The State has determined that this includes the premium relief program and initiatives within the Nevada Market Stabilization Program, including a state-based

[10] Carriers are also required to offer a bronze and gold BBSP plan and a silver non-BBSP plan.
[11] NRS 695K.210, available at: https://www.leg.state.nv.us/nrs/NRS-695K.html#NRS695KSec210

reinsurance program, a Quality Incentive Payment Program for participating BBSP carriers, and the Practice in Nevada Incentive Program. Each of these initiatives under the Market Stabilization Program can help the State control the rise in the cost of health care in the individual insurance market and increase long-term affordability by improving the quality of health care among enrollees and bolstering the provider base in the State.

In addition to the Director's authority, the Commissioner of Insurance has specific authority in SB 482 (2019), Section 45, to apply for a Section 1332 waiver and implement a State plan that meets the waiver requirements as approved by the Departments.[12] Further, the Commissioner has broad authority in NRS 679B.400 to "develop measures to stabilize prices" and to "establish a mechanism to ensure the provision of adequate insurance at reasonable rates to the residents of this state."[13] This highlights an additional source of State authority to establish a reinsurance program, the Quality Incentive Payment Program, and the Practice in Nevada Incentive Program under the State's Market Stabilization Program.

B. The New Battle Born State Plans

Nevada Senate Bill (SB) 420 (2021) was signed into law on June 9, 2021, and later codified in NRS Chapter 695K. Under this new law, the Director is required to design and establish a Public Option program in the individual market.[14] The statutory design of this new program relies heavily on a State purchasing and contracting strategy of the State's Medicaid Managed Care program. The State will undertake a statewide Medicaid Managed Care procurement for a five-year contract that begins on January 1, 2026.

The State must require that carriers submitting a bid through the Medicaid Managed Care procurement also produce a good faith bid to offer silver and gold BBSP annually on the SSHIX. Using the contracting process, the State will also require carriers to offer a bronze BBSP. Currently, under existing MCO contracts, the MCO carriers must offer at least one silver and gold QHP on the SSHIX by the 2024 coverage year.[15] MCO carriers will still be required to offer a standard (i.e., non-BBSP) silver QHP on the SSHIX during the waiver period but will not be required to offer a standard gold QHP. The difference between current contracting practices with MCO carriers and the new BBSP program is that the State will be asking MCO carriers to offer QHPs that meet the new BBSP requirements. Carriers may offer other SSHIX products.

The State intends to define a good faith bid for a BBSP as any bid by a carrier that is deemed complete under State purchasing guidelines and complies with all State BBSP requirements. This includes submitting a bid that, at a minimum, meets the State-determined premium reduction requirements for each applicable county. The preliminary reference premium for the good faith bid determination process will be based on the SLCS plan available through the SSHIX during the 2024 plan year by county, projected to 2026 using CPI-M plus adjustments for local market factors. The bid must also include a commitment from the carrier that it can meet the annual premium reduction requirements established by DHCFP, as well as a commitment from the carrier's actuary that the rate proposal is reasonable within the bounds of data currently. This will include an attestation that the proposed rates for the BBSPs are a reasonable estimate and actuarially sound, given the information available. As noted above in Subsection 2A, following the good faith bid determination, the State will continue its review of

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[12] Senate Bill 482 (2019), available at: https://www.leg.state.nv.us/App/NELIS/REL/80th2019/Bill/6923/Text.

[13] Nev. Rev. Stat., Chap. 679B, available at: https://www.leg.state.nv.us/nrs/NRS-679B.html#NRS679BSec400.

[14] The authorizing state legislation also permits the state to offer the plans in the small group market, but currently the state is not taking up this option.

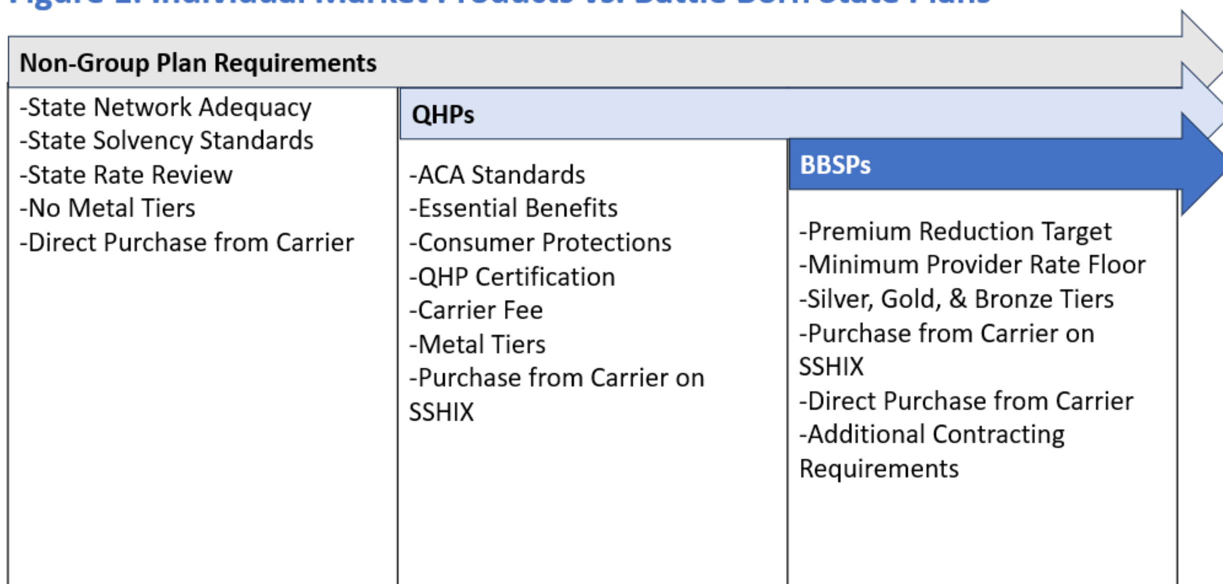
[15] See Section 7.1.5.1 in the State's Medicaid Managed Care contract, available at: https://nevadaepro.com/bso/external/purchaseorder/poSummary.sdo?docId=40DHHS-NV21-9279&releaseNbr=0&external=true&parentUrl=close

carriers' proposals to determine which BBSPs will be offered in each geographic rating area, ultimately notifying carriers of their awards in Spring 2025.

If a carrier bids on Medicaid and does not offer a good faith bid for a BBSP contract, the carrier will be ineligible to participate in the State's Medicaid Managed Care program for that upcoming contract period. The State expects at least four carriers, at a minimum, to submit bids to offer the new BBSPs for coverage year 2026 in order to be considered for a Medicaid Managed Care contract. The upcoming MCO contracts will be for a five-year period, beginning on January 1, 2026, and terminating on December 31, 2030. This timeline for the contract period aligns with this waiver request.

1. Product Design Overview and Premium Reduction Requirements

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



The BBSPs will include the same benefits as other QHPs.[16] In addition, BBSPs must meet certain statutory requirements for premium reductions and a reimbursement floor for network providers, ensuring rates, in the aggregate, are no lower than those paid by Medicare.

A key difference between BBSPs and non-BBSP QHPs is the requirement to meet premium reduction targets. Under NRS 695K, carriers offering the new BBSPs must satisfy a new premium reduction target on their silver plan rate

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

that is at least 15% lower than the average reference premium in each applicable geographic rating area by the fourth plan year (2029). The average reference premium will be based on the SLCS premium available in the SSHIX during the 2024 plan year by county, trended forward for inflation according to the Consumer Price Index for Medical Care (CPI-M) and any adjustments necessary to reflect local changes in utilization and morbidity. See Nevada DHCFP Guidance and Bulletin Update 23-003.[17]

To ensure annual premium rates for the BBSPs will be actuarially sound and meet provider reimbursement floor requirements, the Director has determined the premium reduction target should be 15% by the end of the first four years as permitted by State law.[18]

In the event that carriers cannot meet premium targets in any given year while meeting actuarial soundness or solvency requirements, the Director has the authority to adjust the premium reduction targets to ensure BBSPs are offered at a rate that is actuarially sound. DHHS guidance released in November 2023 outlines the State's approach to ensuring carriers are on track to meet premium reduction targets[19]:

- For Plan Year 2026, carrier premiums must be at least three percent lower than the reference premium. (The preliminary reference premium range for each geographic rating area will be released Quarter 3 of 2024. The final reference premiums will be released Spring 2025.)
- For Plan Year 2027 to Plan Year 2029, BBSP carriers must achieve a cumulative premium reduction of at least 15 percent as compared to the reference premium. For Plan Years 2027 and 2028, the premium reduction amounts will be negotiated by the Director as outlined under the BBSP contracts with carriers with the goal of ensuring that the 15 percent overall reduction target is achieved by participating carriers by Plan Year 2029.
- For Plan Year 2030, carriers must maintain a 15 percent premium reduction as compared to the reference premium.

In response to stakeholder feedback that some issuers may not be able to achieve the full required premium reduction targets in 2026, the State of Nevada will adjust premium targets for 2026 through 2028 based on the carrier's 2025 market position in each geographic area. These adjusted premium targets will be based on each issuer's 2025 lowest cost silver premium relative to the 2025 SLCS premium in each county. All issuers will be required to achieve the 15 percent BBSP premium reduction target in 2029; however, the adjusted premium targets will allow issuers in less competitive positions in 2025 to spread the premium reduction needed to achieve the 2029 target more evenly over the first four years of the NMSP. The Actuarial and Economic Analysis conducted by Milliman, Inc. assumes the adjusted premium targets will not impact the SLCS premium or PTF because at least two issuers will achieve the unadjusted premium reduction target.

The premium reduction targets and reference premium will be established by the State and shared with issuers before rates are required to be submitted to the State each year. Nevada will leverage the procurement and contracting process to ensure compliance with the statutorily defined premium requirements. The Director will

[17] General Guidance Letter 23-003 Notice of Revised Carrier Premium Reduction Targets for Plans Established in NRS 695K, available at: https://www.medicaid.nv.gov/Downloads/provider/web_announcement_3220_20231120.pdf

[18] Pursuant to the Director's revision authority under Subsection 5 of NRS 695K.200, the Director issued updated guidance on November 20, 2023, revising the premium reduction requirements to require that carriers establish plans that are "lower than the average reference premium in each county by a percentage that increases each year." See https://www.medicaid.nv.gov/Downloads/provider/web_announcement_3220_20231120.pdf.

[19] General Guidance Letter 23-003 Notice of Revised Carrier Premium Reduction Targets for Plans Established in NRS 695K, available at: https://www.medicaid.nv.gov/Downloads/provider/web_announcement_3220_20231120.pdf

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

2. New Protections for Providers and Consumers

State law provides for certain protections to ensure that the premium reduction targets for the BBSPs do not undermine provider networks or access to care for consumers. These include:

- **Provider Reimbursement Requirements:** State law requires carriers offering the new BBSPs to ensure that their negotiated rates with network providers are the same or better, in the aggregate, than the rates paid by Medicare.[20] The Director intends to require each BBSP carrier to provide notice to its network providers for the BBSP plans of the Medicare rate floor requirement and the process by which providers may appeal to the Department for review of noncompliance by a carrier.
    - The State will be responsive to complaints filed by providers that contend that payment by a BBSP, in the aggregate, is not in compliance with this provision. The State will request the necessary data to review a rate challenge. The State will also require issuers to attest annually that their provider rates are equivalent to or better than Medicare rates. Issuers that are not in compliance could receive a financial penalty per their contract with the State. Significant noncompliance could mean a breach of contract.
    - Where a Medicare rate is unavailable, the Director intends to utilize other program fee schedules to help guide providers and carriers. Such information will be calculated annually as a percentage of Public Employees' Benefits Program (PEBP) or Medicaid rates for the same or similar service, or the Average Commercial Rate to the extent data is available nationally or from the State's All-Payers Claims Database which should be available for this usage in 2026.
- **Provider Network Participation Requirement**: Any provider who participates in the PEBP, Medicaid, or the State's workers' compensation program must agree to participate in at least one provider network for a BBSP or risk participation as a network provider in these other public programs. This requirement will be enforced through the State's contractual or enrollment agreements with providers to participate in-network in these programs.[21] The State will amend its provider enrollment agreements by Fall 2025 to reflect the BBSP participation requirements. The State has authority to amend these contracts at any time.
    - The Director may waive the provider participation and consumer access requirements if needed to ensure individuals who receive benefits through the State's PEBP, Medicaid, or the workers' compensation program have sufficient access to covered services from network providers.
    - The Director intends to develop a process for providers to seek a waiver of the network participation requirements for the BBSP offerings. Providers seeking such a waiver from participation as a BBSP-network provider must show a significant monetary loss in their total

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

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

patient revenues from serving patients who enroll in a BBSP. Such a loss must also pose a substantial risk to their financial stability due to the new BBSP revenue displacing a sizable portion of their payor mix and associated commercial revenue.
    - This scenario is unlikely. Based on 2022 Nevada market data, Milliman estimates that the Medicaid, Medicare, and employer markets combine for approximately 95% of total provider revenue (excluding pharmacy), and the individual market comprises 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 aggregate payment index across all providers and services.
- **Consumer Access Requirement**: Participating providers or facilities in a BBSP network must accept new patients enrolled in a BBSP to the same extent as the provider or facility accepts new patients enrolled in a standard QHP. The Director intends to require in the BBSP contract that carriers monitor BBSP network providers for compliance and notify consumers of this protection and a way to report any violations. Noncompliant providers may risk their provider enrollment in BBSP and Medicaid if they are not compliant with State law which would include this requirement.

The Nevada Division of Health Care Financing and Policy (Nevada Medicaid), which sits under the Director, oversees the State's MCO contracts with these carriers today and will provide the same oversight of compliance with respect to these new requirements for the BBSP contracts.

3. New State-Carrier Contracts

To enforce the statutory requirements for the BBSPs (including the premium reduction targets), the Director will utilize the legal tools under its new BBSP contracts with carriers, similar to the ways in which Nevada Medicaid enforces its existing contracts with carriers for its Medicaid Managed Care program, including the existing contract requirement that MCOs offer a QHP in the SSHIX. For example, MCO contracts include corrective action plans, financial penalties, and/or sanctions that can be imposed by the Director when carriers do not meet their contractual obligations.[22]

Like the MCO contracts, the new contractual arrangements with carriers for the BBSPs enable the State to impose additional requirements that go beyond those set forth in State law to meet State health care goals and priorities for the population served. This may include, for example, aligned quality metrics and value-based payment design requirements across MCO and BBSP programs and heightened network adequacy standards, if certain geographic areas are underserved, including the potential for carriers to leverage their existing provider networks in Medicaid Managed Care to ensure adequate access for those enrolled in a BBSP.

The State will also require, via the BBSP contract, that carriers meet an administrative cost containment requirement that is lower than prevailing individual market and QHP administrative expense loads (based on most recent publicly available rate filing data). Under this requirement, carriers offering BBSPs would be required to reduce a portion of their administrative expenses for the BBSP offerings, which will help reduce prices relative to non-BBSP offerings, all else being equal. The State is considering potential exclusions from what qualifies as an administrative expense to ensure that enrollee services remain robust, including activities related to quality improvement, enrollee outreach, care management, call centers, or nurse lines.

The new required administrative cost containment requirement will be set by the Director in the new BBSP

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

contracts and may rise each year, over the first four years of the program. These administrative efficiencies at the carrier level would count toward the required premium reduction target, reducing the share of premium reductions that must be achieved through provider reimbursement reductions in BBSPs. This will also help mitigate the risk of carriers cost shifting the entire burden of meeting an annual premium reduction target onto their provider networks. For BBSP carriers that do comply with this new requirement, the Director may use all financial penalties and sanctions set forth in the contract to enforce compliance.

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

- Advance quality and value-based payment design with providers,
- Improve continuity of care through better alignment of provider networks in the individual market and Medicaid Managed Care program, and
- Help address the State's growing health care workforce shortages and health disparities.[23]

4. New Strategies to Increase Active Shopping and Promote Low-Cost BBSP Enrollment

The State will coordinate with carriers and the SSHIX to implement a variety of strategies that (1) encourage consumers to actively shop for their health insurance coverage and (2) promote consumer awareness of lower cost options, like the BBSPs. The strategies the State will implement to achieve these goals are described below.

- **BBSP Carrier Marketing and Outreach Requirements:** The State will require carriers under their BBSP contracts to widely market and promote their BBSP offerings during each open enrollment. For instance, the State is exploring including contractual requirements for carriers to develop their own outreach campaigns meeting certain parameters to be approved by the State prior to open enrollment. This could include communications notifying consumers of the availability of BBSPs and of potential savings by actively shopping rather than remaining in their current plan. Carriers could highlight BBSPs to consumers to mitigate any premium increases due to the expiration of Inflation Reduction Act's (IRA) enhanced premium subsidies.

- **Integrating Active Shopping Promotion into the Broader SSHIX Marketing Campaign:** Promotion of active plan selection will be woven into SSHIX's fall marketing campaign. For instance, SSHIX can include static messaging on the Nevada Health Link website to urge consumers to review the health coverage options available to them on the Nevada Health Link to remind consumers that their premiums may be lower if they actively shop online. The State is also exploring including active-shopping promotion language in the dynamic enrollment and eligibility notices that consumers receive from SSHIX immediately prior to open enrollment.

- **Default Sorting and Plan Display:** The Nevada Health Link's default sort option lists plans from lowest to highest net premium. Since BBSP premiums will be priced lower than other plan options, maintaining that sorting function should ensure that BBSPs will be among the first search results consumers see, thus increasing the visibility of BBSPs and the likelihood consumers enroll in a BBSP.

- **Differentiating BBSPs:** The State plans to create a BBSP logo or some similar differentiating moniker for use on its website, plan preview tool, and application plan selection screen. SSHIX can require plan names to incorporate the BBSP name. SSHIX and issuers can market BBSPs as 'quality assured products' brought to consumers by the State pending review and approval by the SSHIX Board.

By investing in the strategies outlined above, the State can better ensure that consumers—especially those who

[23] See NRS 695K.220, available at: https://www.leg.state.nv.us/nrs/NRS-695K.html#NRS695KSec210

may experience in a change in the value of their PTC as a result of the loss of IRA's enhanced subsidies in 2026—understand their choices for insurance coverage and can make informed decisions to select the most affordable coverage option to meet their needs.[24] These outreach strategies, combined with consumers' tendency to enroll in plans based on price, are likely to help Nevadans gravitate towards BBSPs, which will often be more affordable relative to other plans available on the marketplace.[25]

Considering the State initiatives described above among additional considerations outlined in Section 4(A) of the Narrative, the BBSP take-up rate for SSHIX enrollees has been increased to 80% in the actuarial analysis. This assumption change has a small impact on PTF, but it materially reduces projected enrollee gross and net premiums with waiver.

C. Use of Federal Pass-Through Funds

The State understands that, if this waiver application is approved, an initial estimate of the federal PTF amount will be made available to the State the first or early second quarter of the corresponding plan year or coverage year. The final federal PTF amount or final administrative determination by the Departments will be shared in a letter prior to the payment of the federal PTF amount as provided in the specific terms and conditions of the approval letter (typically before the end of April of the corresponding plan or coverage year).

State law requires that any federal PTF received by the State as a result of the approval of this waiver must be reserved to first cover the State administrative costs to implement and operate the program and waiver.[26] These funds would replace the State's initial investment of State general funds to cover the "start-up" costs associated with implementation. As shown in the proposed budget in this application, these costs include staffing and vendor-related costs for both the Nevada DHHS, the DOI, and SSHIX.

Once the State administrative costs have been paid for with the new federal PTF, State law permits the Director to use a portion of the funding as determined by the State Treasurer to increase consumer affordability. Funding for the State's premium relief program will be the second set of expenses funded after state administrative costs.

For this waiver's purposes, the State has determined that the remaining funds after financing administrative costs and the premium relief program should be used by the Director to support a Market Stabilization Program in order to improve affordability in the BBSPs, along with other nongroup plans, as further described in Section 2.E. below. The reinsurance program cannot be fully implemented and financed by the State without an approved Section 1332 waiver. There are no dedicated State funding sources to finance a full reinsurance program; it will be wholly financed with federal PTF. Without the implementation of the waiver and State receipt of federal PTF

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[24] The revised Actuarial and Economic Analysis in this application reflects the State's greater emphasis on increased shopping under the waiver program.

[25] Research suggests that Marketplace enrollees largely choose plans based on price. In 2023, 81.4% of individuals between 100 and 150% FPL selected silver plans, as compared to 15% that selected bronze plans and 3.5% that selected gold plans. People in this income range who are eligible for a premium tax credit currently pay no up-front premium when enrolling in the silver benchmark or lowest-cost silver plan and are eligible for cost-sharing subsidies that substantially reduce their out-of-pocket costs. Similar cost-conscious trends are seen at other income levels. During the same year, 67% of individuals with incomes above 400% FPL selected bronze plans—typically their lowest-cost option – as compared to 11.3% that selected silver plans and 21.7% that selected gold plans. Significant enrollment in bronze offerings among this population suggests consumers favored plans with lower premiums. See: Holahan, Wengle, and O'Brien. How Do People Make Choices among Marketplace Plans? Available at: https://www.urban.org/sites/default/files/2023-09/How%20Do%20People%20Make%20Choices%20among%20Marketplace%20Plans.pdf

[26] See NRS 695K.300

achieved by premium reductions, the State would not be able to move forward in funding and implementing the reinsurance program.

D. DHHS Consideration of Initial Public Feedback

During the months of December 2021 and January 2022, the State of Nevada hosted six public design sessions to gather initial stakeholder feedback on the design of the 1332 waiver application. These initial public sessions, which included topic areas such as value-based payment reforms and provider contracting, informed the design of the BBSPs and Market Stabilization Program and will continue to inform design as the State plans for the procurement of the BBSPs.

The following points raised by stakeholders during these sessions stood out to the State as key considerations to address via the Section 1332 waiver application:

- Commenters underscored the importance of improving affordability, including through reduced premiums, for Nevadans enrolled in health plans in the individual insurance market.
- Commenters urged the State to invest in the provider workforce to improve Nevadans' access to timely preventative care and reduce longer-term health care costs.
- Commenters raised concerns about the impact of the premium reduction target on carriers, providers, and market.
- Commenters suggested the State invest in strategies to improve longer-term population health, including alternative payment methodologies focused on high-value services to improve health.

Each of these points of feedback is addressed via the Nevada Market Stabilization program.

E. Targeted Premium Relief Program

The actuarial analysis shows that the enrollee net premium for about 24% of consumers will increase regardless of whether they switch to a BBSP or not. This is because of the BBSP premium reduction target's impact on the subsidies available to eligible consumers. More than 97% of these consumers are enrolled in bronze plans, and more than 75% have incomes between 200% and 400% FPL. The net premiums for these consumers under the waiver in 2026 are higher than without the waiver by less than $2 on average.

In response to public comment to provide premium support to improve affordability, State revised its waiver application to institute a premium relief program for certain qualifying individuals who are enrolled in the SSHIX as of December 2025 and renewing coverage in 2026. Premium relief will be granted to renewing individuals whose net premium each year of the waiver is higher under the waiver program than it would have been without the waiver due to PTC reductions driven by the BBSP gross premium reductions, and who cannot avoid this net premium increase by switching to a lower-priced plan within the same metal level.

New SSHIX enrollees or SSHIX enrollees with a gap in SSHIX enrollment in 2025 will not be eligible for the premium relief program. Milliman Inc. projects that approximately 20,000 enrollees could qualify for premium relief under the program in 2026.

The amount of premium relief available to consumers will not reflect changes in net premium that would have occurred without the waiver, including changes due to age, household size, household income as a percentage of FPL, ACA affordability limits, or metal selection. The Actuarial and Economic Analysis estimates the premium relief program will reduce the average aggregate enrollee net premium for PTC-eligible enrollees by

approximately $0.50 PMPM in 2026 and approximately $2 to $3 PMPM from 2027 through 2035. Premium relief payments will be paid for with federal PTF. Relief payments will be the second expense funded (after only state administrative expenses are paid for) and will be fully funded prior to reinsurance. The estimated annual costs of the premium relief program are outlined in Table 1 of Subsection 1 below.

Nevada intends to administer this premium relief program at the carrier level. Under this proposed design, the State would provide individual market carriers with a data file of eligible enrollees and the amount of their premium relief payment. Carriers would then lower the net premium for the individual enrollees by the premium relief amount. The State would retroactively reimburse carriers upon receipt of federal PTF. The timeline for reimbursements to carriers is under discussion and could be quarterly, semi-annually, or annually.

All carriers offering a QHP on the Nevada Health Link will be required to administer this program, as a condition of participation in the reinsurance program. Nevada is considering allowing small carriers with limited administrative capacity to apply for an exemption from this requirement, provided the carrier submits appropriate justification to the State. In such case, the State would administer the premium relief.

As a contingency, the State is also exploring administering the premium relief program directly to enrollees. This may be necessary during Plan Year 1 (2026) due to the timing of receipt of federal PTF. Under this program design, enrollees would receive direct outreach from the State. This approach imposes significant burden on the State to review and process enrollee applications. For these reasons, the State's preferred method is to pursue implementation via carriers.

Other details of the premium relief program are yet to be determined as of the date of waiver submission. The Actuarial and Economic Analysis's analysis of premium relief payments is based on preliminary estimates for the waiver application. The actual impact of the premium relief program may change once program details are defined, particularly at the individual level; however, Milliman, Inc. does not anticipate the impact of the final program design on aggregate average premiums to be materially different than the estimates provided in Table 7 of the Narrative. The State will seek stakeholder feedback as it continues to refine the design and administration of the premium relief program.

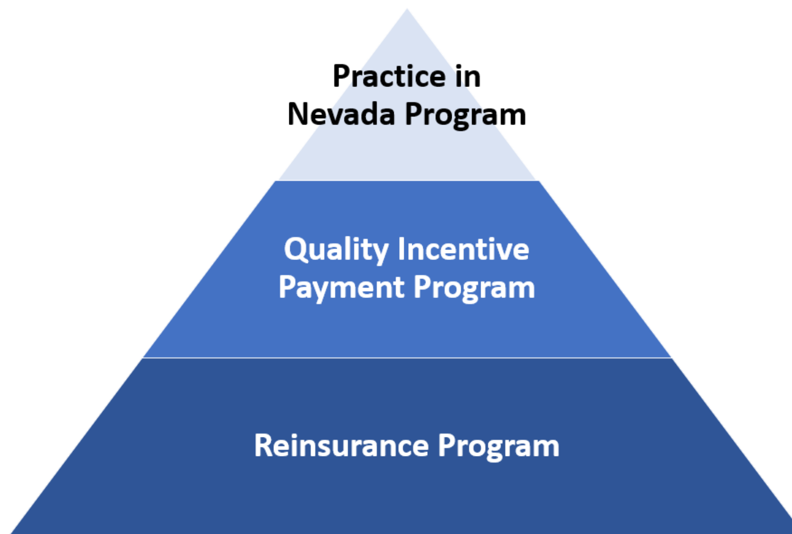
F. Nevada Market Stabilization Program

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

As summarized in Figure 2, the new Market Stabilization Program includes three core State market-focused investments. The operation and scale of these new investments would be reliant on the amount of federal PTF available to the State each year under an approved Section 1332 waiver, starting in year two. After funding all State operational costs and the premium relief program for the Section 1332 waiver program, the State intends to prioritize the remaining funds to finance these new programs.

The first of these investments consists of the establishment of a new state-based reinsurance program for all carriers operating in the State's individual market (i.e., offering nongroup plans). The second, if there is sufficient funding each year after fully financing a reinsurance program, includes a new Quality Incentive Payment Program to reward high-performing insurers that offer BBSPs and meet certain quality metrics or indicators tied to State priorities for the market. And third, if there is sufficient funding to fully finance a reinsurance and Quality Incentive Payment Program, the State intends to finance the Practice in Nevada Incentive Program, which would provide for loan repayment to certain health care providers willing to live and work for at least four years in a region of Nevada that qualifies as a federal HPSA. It is important to note that there are no dedicated State funding sources to finance these waiver programs; they will be wholly financed with federal PTF.

Figure 2: Nevada Market Stabilization Program



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

The State proposes to finance a new State reinsurance program for carriers operating in the State's individual market with the federal PTF. The program would reimburse issuers for a portion of the annual claims per enrollee that fall within the below specified range from a reinsurance pool. Through this new reinsurance program, the State seeks to share some of the financial risk with carriers for the cost of covering the individual market in a manner that would help lower costs for consumers ineligible for premium assistance. This, in turn, helps limit the potential risk and losses for carriers operating in the individual market.

In response to public comments received during the initial federal comment period, the State revised its application to implement flat coinsurance rates across all rating regions. In the initial draft waiver application, the State proposed to implement a reinsurance program in which coinsurance levels varied across the four rating areas in the State in order to provide greater relief to rural areas (rating areas 3 and 4), which have historically been exposed to higher gross premiums. Commenters highlighted that the tiered coinsurance rates require lower coinsurance for rating areas 1 and 2, resulting in the program having a smaller impact on premiums in those rating areas. Commenters expressed concern that it would be more challenging for carriers to achieve the overall 15 percent premium reduction target in these areas, where provider reimbursement rates are already lower due to heightened provider competition. For this reason, the State determined it will implement flat reinsurance parameters across all rating regions.

The reinsurance program will reflect the following parameters:

- Attachment point: $60,000
- Cap: $1,000,000
- Coinsurance: 28.5%

Based on the above reinsurance parameters, the Actuarial and Economic Analysis estimates that reinsurance will decrease premiums by approximately the following percentages:

- Rating area 1: 7.2%
- Rating area 2: 7.5%
- Rating area 3: 6.2%
- Rating area 4: 11.4%

The PTF generated by BBSPs in 2026 and 2027 will fund the state's cost of the administrative costs, the premium relief program, and reinsurance in 2027.

Table 1 below outlines projected pass-through funding and direct program costs for the premium relief and reinsurance programs. The cost of DHHS, SSHIX, and DOI administrative costs to run the NMSP is not reflected in Table 1.

Table 1
Projected Pass-Through Funding and Direct Program Costs (in Thousands)

Year	Pass-Through Funding	Premium Relief Program Costs	Cost of Reinsurance	Net Funding Remaining	Cumulative Net Funding Remaining*
2026	$15,000	($500)	$0	$14,500	$14,500
2027	$58,000	($2,000)	($54,000)	$2,000	$16,500
2028	$69,000	($2,000)	($58,000)	$9,000	$25,500
2029	$81,000	($3,000)	($62,000)	$16,000	$41,500
2030	$87,000	($2,000)	($67,000)	$18,000	$59,500
2031	$93,000	($2,000)	($74,000)	$17,000	$76,500
2032	$99,000	($2,000)	($80,000)	$17,000	$93,500
2033	$106,000	($2,000)	($87,000)	$17,000	$110,500
2034	$114,000	($3,000)	($95,000)	$16,000	$126,500
2035	$122,000	($3,000)	($104,000)	$15,000	$141,500
5-Year Waiver Window	**$310,000**	**($9,500)**	**($241,000)**	**NA***	**NA***
10-Year Deficit Neutrality Window	**$844,000**	**($21,500)**	**($681,000)**	**NA***	**NA***
5-Year Waiver Window – With 10% Margin on PTF and Premium Relief	**$279,000**	**($10,000)**	**($241,000)**	**NA***	**NA***
10-Year Deficit Neutrality Window – With 10% Margin on PTF and Premium Relief	**$760,000**	**($24,000)**	**($681,000)**	**NA***	**NA***

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

If in any given year the federal savings is insufficient for fully financing the reinsurance program for the upcoming

waiver/plan year, the State will adjust the parameters of the program. In turn, this also shifts more of the burden back on carriers in meeting the statutorily required premium reduction target of 15% over the first four years of the waiver period. In effect, the financing model of this reinsurance program is intended to have the effect of incentivizing carriers to meet the BBSP premium reduction targets so that sufficient funding is available each year to finance a robust reinsurance program.

The State's contracts with carriers for the BBSPs will include two sets of certified rates for achieving the premium reduction target—with and without reinsurance—to ensure the mandatory four-year statutory target can be achieved.

Table 2 below lists key dates for the State's implementation of the reinsurance program, pursuant to this waiver's approval.

Table 2: Proposed Reinsurance Implementation Timeline

	Plan Year			
	2026	**2027**	**2028**	**2029**
Preliminary Reinsurance Parameters Announced	NA	12/2025	12/2026	12/2027
PTF for Prior Year from CMS is Confirmed	NA	5/2026	5/2027	5/2028
Final Reinsurance Parameters Published	5/2025	5/2026	5/2027	5/2028
Rate Filings Due to Nevada DOI	6/2025	6/2026	6/2027	6/2028
Carriers Reimbursed for Claims from Previous Plan Year	NA	7/2028	7/2029	7/2030

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

Currently, the State uses a quality incentive or "bonus" payment program in its Medicaid Managed Care program to reward carriers for achieving certain quality targets or goals. For example, for Plan Year 2023, the State tied a bonus payment (equivalent to a 3% rate increase) for MCOs to a primary care spending target to incentivize MCOs to increase investment in the State's primary care provider system. The State is still analyzing MCO performance for this bonus payment, but early results show each of the four MCOs made significant progress in achieving this important goal for the State's Medicaid program. Additionally, for Plan Year 2023, the State tied a second bonus payment (equivalent to a 1% rate increase) for MCOs that achieved certain enhancements with provider networks to accelerate the use of value-based payment design across the recommended LAN Framework for alternative payment models. Early results of MCO performance indicate each MCO made significant progress in meeting the goals outlined for this bonus payment.

Through the Quality Incentive Payment Program for BBSPs, the State intends to require or incentivize carriers to align value-based initiatives across the Medicaid and individual markets and, if feasible and practical, with the value-based initiatives used in the Medicare market to achieve a best practice, "all-payer model" for these efforts in the State. An all-payer model is consistent with the best practices and models promoted by CMS' Center for

Medicare and Medicaid Innovation. See its recently released AHEAD model initiative. With this approach, the State can directly influence and improve how care is delivered and financed, aiming to stabilize Nevada's individual market by improving population health, which in turn reduces costs and risks to carriers.

As with the early MCO experience, the State expects the Quality Incentive Payment Program to guard against overly-restrictive provider networks in BBSPs and to improve their performance on the selected quality measures than might otherwise occur. These quality metrics will be chosen to advance one of the core goals of NRS 695K and the waiver program, which is to reduce health disparities in access to health care and health outcomes. By improving population health, this program can also help address another core goal of NRS 695K: to lower premiums and costs relating to health insurance for Nevadans enrolled in the BBSPs. Further, the Quality Incentive Payment Program's "bonus" payments can also help entice insurers to offer BBSPs, facilitating a smooth implementation of the 1332 waiver program.

Examples of Quality Incentive Payment Program the State is considering during the 1332 waiver period include:

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

The State will collaborate with stakeholders and policymakers to finalize the details of program design for the Quality Incentive Payment Program as the BBSP contracts are developed and finalized throughout 2024 and 2025. The State will condition participation in the Quality Incentive Payment Program on serving as a BBSP carrier. The State released a Request For Information (RFI) in May 2024 to seek further feedback on how best to implement and operate these new programs and will take this feedback into consideration in the design on the program.

The program is expected to be piloted in 2026 and 2027 for launch of bonus payments in 2028.

3. Practice in Nevada Incentive Program for Providers

One of the significant drivers of high health care costs and poor health outcomes in Nevada is the alarming provider workforce shortage in the State. The State proposes to utilize federal PTF to finance a new state-run workforce initiative—a loan repayment program that ties payment to a four-year commitment to live and work in Nevada. Anyone violating the loan repayment agreement would be required under the contract to pay back the financial assistance received from the State. As with the Quality Incentive Payment Program, the design features of the Practice in Nevada Incentive Program will be finalized via the development and finalization of the BBSP contracts. At a minimum, the State will require that providers live in the community in which they practice for at least four years and be willing to enter into a contract with the State to meet specific program requirements. The program will no supplant or duplicate federal workforce initiatives such as the National Health Service Corps loan repayment program.

This initiative advances several key goals of the waiver program. By dedicating resources to attract and retain providers—including primary care providers—the State can help expand access to health care services, especially among communities that have the most difficulty accessing providers, and drive improvements in health care outcomes for those and other communities.[27] Two key policy objectives of NRS 695K include improving access to high-quality, affordable health care for residents of the State and reducing health care disparities for historically marginalized communities. Additionally, pursuant to NRS 695K.220.4(c), the State must prioritize insurer applicants whose proposals strengthen the health care workforce in Nevada—particularly in rural areas. This incentive program for providers can serve as an effective strategy for accomplishing these goals outlined in statute. Further, by investing in providers and expanding access to primary care services, the State can help lower spending on unnecessary costs in the health care system, including spending on nonurgent emergency department utilization.[28]

G. Implementation Milestones

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

The second step is for the Director to conduct a statewide procurement for the new BBSPs alongside its next statewide Medicaid Managed Care procurement, which is anticipated to begin no later than January 1, 2025. The alignment of this procurement process with the Medicaid Managed Care procurement is intended to leverage the State's purchasing authority and its multi-billion-dollar contracts with carriers.[29] Specifically, State law requires any carrier seeking to be eligible to do business with Nevada Medicaid as an MCO to also submit a good faith bid to offer at least two BBSPs per rating region (i.e., one silver-level plan and one gold-level plan).[30] Other carriers not seeking an award as an MCO in the State's Medicaid Managed Care program may also submit a bid to offer a BBSP but are not required to do so.

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

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[27] There is substantial research evidence linking investments in primary care services to improved health care access as well as improvements in population health and health equity. See: Shi L. The Impact of Primary Care: A Focused Review available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3820521/.

[28] See: Shi L. The Impact of Primary Care: A Focused Review available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3820521/.

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

[30] Using the contracting process, the State will also require carriers to offer a Bronze BBSP and a silver standard QHP.

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

Besides the milestones set forth in State law for the BBSPs, implementation of the Market Stabilization Program will begin in 2026.

Table 3 below lists these milestones and key dates for the State's implementation of NRS 695K and the Market Stabilization Program, pursuant to this 1332 waiver approval.

Table 3: Nevada Battle Born State Plan Implementation Timeline and Milestones	
Quarter 4, 2021	• Public workshops on product design held by the State.
Quarters 1-3, 2022	• Actuarial analysis and waiver development.
Quarter 4, 2022	• Nevada Medicaid hosts weekly "office hours" for the Public Option.
Quarter 3, 2023	• Development of a new Market Stabilization Program for waiver.
Quarter 4, 2023	• Finalize actuarial analysis and waiver draft. • Draft waiver application released November 20, 2023 for 30-day State public comment period. • DHHS hosts two hybrid (in-person and virtual) public workshops/hearings on draft waiver (November 27 and December 5). • DHHS hosts two tribal consultations (November 29 and December 7). • DHHS issues new bulletin to carriers on BBSP revised target and reinsurance program (November 20). • DHHS submits waiver application on December 29, 2023. .
Quarter 1-2, 2024	• CMS/Treasury determine completeness by February 12, 2024 and hold a 30-day federal public comment period from February 12, 2024 to March 14, 2024. • DHHS requests the Departments pause review of the waiver application on March 21, 2024 while the State implements updates to its application. • DHHS begins development of procurement materials and contracts for BBSPs.

Quarter 2, 2024	• DHHS issues a Request for Information to gather stakeholder feedback on aspects of the Market Stabilization Program on May 23, 2024. • DHHS continues development of procurement materials and contracts for BBSPs.
Quarter 3, 2024	• BBSP statewide procurement begins: State releases initial Step 1 RFP BBSP materials on August 5, 2024. • Interested carriers submit a Letter of Interest to State for bidding on BBSPs in order to move forward in procurement process by August 23, 2024. • State releases Step 2 RFP materials by September. • Interested carriers submit good faith bids for a silver BBSP.
Quarter 4, 2024	• State makes good faith bid determination for BBSP bids by October. • State releases Medicaid Managed Care RFP in October. • Interested carriers submit bids for MCO procurement. • CMS/Treasury make final determination on waiver application.
Quarter 1, 2025	• State evaluators for BBSP procurement review BBSP bids for BBSPs. • State sends Letter of Intent to award BBSP contracts.
Quarter 2-3, 2025	• Negotiation and awards final for BBSP contracts. • BBSP carriers submit Plan Year 2026 rate filings to DOI for review/approval. • State evaluators review BBSP rates for compliance with network and administrative cost reductions to comply with premium savings targets. • DOI completes rate analyses and approval processes. • BBSP carriers submit for SSHIX certification.
Quarter 4, 2025	• BBSPs are offered for enrollment during Open Enrollment.
Quarter 1, 2026	• BBSPs available on SSHIX for Plan Year 2026.
Quarter 2, 2026	• DHHS/DOI guidance to carriers on reinsurance and Quality Incentive Payment Program. • BBSP carriers submit rate filings to DOI for Plan Year 2027 for review/approval.
Quarter 3, 2026	• DOI completes rate analyses and approval processes.
Quarter 4, 2026	• BBSPs are offered for enrollment during Open Enrollment.
Quarter 1, 2027	• BBSPs available on SSHIX for Plan Year 2027. • Reinsurance program begins for Plan Year 2027.

H. Inter-agency Coordination

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

1. Nevada DOI

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

2. SSHIX

The SSHIX will continue to annually certify QHPs for participation in its online platform with premium subsidies for consumer shopping as it does today. For Coverage Year 2026 and beyond, QHP offerings will include BBSPs. SSHIX will also implement strategies to promote active plan shopping to help consumers make informed enrollment choices as a new product – the BBSP – is introduced to the individual market.

3. Nevada DHHS

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

DHHS will also determine whether a good faith bid has been submitted by a carrier as required by State law as part of the State MCO purchasing review process and coordinate with DOI during the rate review process to ensure carriers offering the BBSPs remain on track to meet annual premium reduction targets as agreed to under their contracts with the State. If a carrier cannot meet the target set forth in its contractual agreement with DHHS, the Director may utilize a corrective action plan (if deemed a viable option for the carrier, in order to allow the carrier to make up some of the reduction in future years) and any other penalties set forth in such agreement, including a financial penalty that is worth all or some of the value of the federal PTF that the State would have otherwise received if the carrier had met its agreed-upon premium reduction target. In an extreme scenario, a carrier found out of compliance or in breach of contract could have their existing BBSP and MCO contracts with DHHS terminated and/or the carrier could be deemed ineligible to participate in a future MCO procurement.

Regarding the reinsurance program, DHHS and DOI will be responsible for collaborating and coordinating resources and staff to implement and operate the new program. For the Quality Incentive Payment Program, DHHS will be responsible for establishing criteria and issuing payments to qualifying carriers. DHHS will work with the appropriate entity or entities as necessary to implement the Practice in Nevada Program for health care providers.

I. Expected Federal Savings and Enrollment Changes

The Actuarial and Economic Analysis conducted by Milliman, Inc. estimates that the introduction of new BBSPs into the SSHIX with the support of a reinsurance program for the State's individual market could achieve nearly

$279–$310 million in federal savings in the first five years and $760–$844 million at the end of the first ten years.[31]

The Actuarial and Economic Analysis assumes BBSPs are likely to become the SLCS plan in every rating area (and county) within the state of Nevada. Currently there are four MCOs in the Managed Care Program. The State's Medicaid Managed Care awardees will be statewide starting in 2026 with at least two MCOs in each rating area. Carriers are informed of this change for the next contracting period and are reportedly expanding their provider networks to accomplish this and bid on the next MCO RFP, laying the groundwork for BBSP plans. Under the current Managed Care contracts, carriers are already required to offer a silver and gold plan in the SSHIX and therefore have familiarity with QHP product offerings. With MCOs' existing participation and further interest in SSHIX offerings, the State projects that among the carriers awarded MCO contracts, multiple (and possibly all) bids will be chosen to be offered as a BBSP in each rating area.[32] Therefore, we anticipate having more than one BBSP in each rating region. Moreover, multiple carriers offering BBSPs, combined with new premium reduction requirements and the State's contractual enforcement mechanisms in place indicate that the BBSPs are also likely to be the SLCS plan in each rating region.

The State plans to estimate the impact of the BBSP program for purposes of determining PTF through a multi-pronged approach. First, the State plans to conduct a Nevada-specific comparative analysis using historical data where the State will monitor the overall market trends before and after the implementation of the NMSP. The State anticipates this analysis will show lower rate increases, all else equal, starting in 2026. Next, the State will conduct a national comparative analysis where annual premium trends in Nevada will be compared against premium trends in other states, adjusting for various factors as appropriate.

Furthermore, Nevada will assess the rate filing information submitted by issuers in Nevada's individual marketplace, paying special attention to network factors and expense loads. We anticipate the network factor for BBSPs will be different than the network factor for standard QHPs, and BBSPs should have lower expense loads than standard QHPs.

Lastly, the State anticipates collecting industry medical and prescription drug pricing trend information in order to inform the establishment of the reference premium as required by SB420. Collectively, the analyses outlined above will be used by Nevada to estimate what rates would have been absent the waiver to isolate the impact of BBSPs.

For purposes of the actuarial review conducted by Milliman, it is assumed that the IRA's enhanced federal marketplace subsidies will expire on January 1, 2026, at the time the new BBSPs enter the Nevada market and SSHIX.[33]

Table 4 below shows the projected federal PTF from the BBSPs (i.e., specifically from the new premium reduction target for waiver years 2026–2030) and the new reinsurance program (for waiver years 2027 – 2030).

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[31] See Nevada 1332 Actuarial and Economic Analysis by Milliman, Inc., 2023.

[32] The State will require bronze BBSP offerings through the BBSP contracting process.

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

Table 4: Summary of Projected Pass-Through Funding by Scenario			
Total Pass-Through Funding (PTF), (in Thousands)			
Time Period	**BBSP Policy Only**	**Reinsurance Policy Incremental Impact**	**Total**
Five-Year Waiver Window	$ 167,000	$143,000	$310,000
Five-Year Waiver Window (With 10% Margin)*	$150,000	$129,000	$279,000
Ten-Year Deficit Neutrality Window	$442,000	$402,000	$844,000
Ten-Year Deficit Neutrality Window (With 10% Margin)*	$398,000	$362,000	$760,000

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

As a result of the new BBSPs in SSHIX and the state-based reinsurance program, Milliman, Inc. also estimates the following incremental changes in enrollment Table 5, with BBSPs serving as the SLCS plan in each rating area. The Actuarial and Economic Analysis projects modest increases in enrollment due to the introduction of the BBSPs and slightly larger incremental increases in enrollment due to the implementation of reinsurance. These increases mainly result from individuals who are not eligible for federal financial assistance (including those with higher health care cost burdens) enrolling in unsubsidized coverage, which would be more affordable due to the gross premium reductions under the waiver program.

Table 5: Projected Individual Market Enrollment Change from Baseline			
Year	**BBSPs Only**	**Reinsurance Policy Incremental Impact**	**Total**
2026	600	0	600
2027	700	1,100	1,800
2028	700	1,100	1,800
2029	800	1,100	1,900
2030	900	1,100	2,000
2031	900	1,100	2,000
2032	900	1,200	2,100
2033	900	1,200	2,100
2034	900	1,200	2,100
2035	1,100	1,200	2,300
Values are rounded to the nearest hundred			

Section 4: 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 and Economic Analysis conducted by Milliman, Inc., indicates that Nevada's waiver meets the federal requirements for a Section 1332 waiver under the scenarios modeled.

The Actuarial and Economic Analysis in this waiver application models two types of scenarios:

- Baseline Scenario ("Without Waiver"): The Baseline scenario illustrates projected enrollment, premiums, and federal costs without the Nevada Market Stabilization Program.
- Market Stabilization Scenario ("With Waiver"): This scenario illustrates the potential impact of the

Nevada Market Stabilization Program on enrollment, premiums, and PTF.

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

As required under 45 CFR 155.1308(f)(3)(iv)(B), the Section 1332 waiver must provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable as would be projected without the waiver. **The waiver satisfies this requirement by requiring that the BBSP premiums be lower than the reference premium by a specified percentage, incorporating initiatives to drive BBSP enrollment in those more affordable plans, and implementing a premium relief program for qualifying enrollees.**

By statute, the reference premium cannot be greater than the 2024 SLCS plan premium, trended to the benefit year based on a medical inflation index plus an adjustment for local market utilization and morbidity changes for the first four years of the waiver program. These constraints on the reference premium and BBSP premiums ensure that the BBSP premiums do not exceed projected premium amounts without the waiver. The State of Nevada will not force enrollees to select a BBSP; however, the SSHIX will encourage consumers to actively shop for the most affordable plans – which will likely be the BBSPs – and invest in marketing to distinguish the BBSPs from standard QHPs. The State will also require BBSP carriers to develop outreach campaigns to promote the BBSPs, which can include mailers and other communications notifying consumers of the availability of BBSPs and of potential savings by actively shopping rather than remaining in their current plan.

In response to public comments and in order to prioritize premium affordability for enrollees, the State is also implementing a premium relief program in which it will provide premium relief to consumers whose net premium increases under the waiver and who cannot avoid such an increase by switching to a lower-priced plan in their metal level.

Table 6 below shows the average gross premium under both the Baseline and With Waiver (i.e., Market Stabilization Plan) scenarios for both on and off-exchange enrollees. The average gross premiums under the With Waiver scenario reflect the projected BBSP take-up rate. **This table highlights that average gross premiums would fall due to the waiver relative to the Baseline scenario.**

Table 6
Projected Average Gross Premium Change From Baseline

Year	Baseline Scenario	Market Stabilization Scenario	Average Gross Premium Change Due to Waiver
2026	$593.38	$577.21	-2.7%
2027	$617.51	$547.60	-11.3%
2028	$641.90	$561.11	-12.6%
2029	$667.95	$575.80	-13.8%
2030	$695.02	$597.01	-14.1%
2031	$722.61	$619.01	-14.3%
2032	$751.41	$641.81	-14.6%
2033	$781.38	$664.97	-14.9%
2034	$812.76	$690.18	-15.1%
2035	$845.52	$714.63	-15.5%

Exhibits 1.1 through 1.5 in the Actuarial and Economic Analysis also show the projected average gross premium change each year by income, metal, age band, subsidized status, and rating area for on-exchange enrollees. **These exhibits show that the decrease in gross premiums under the waiver is generally greater for the following vulnerable populations in Nevada:**

- Lower-income individuals, who are disproportionately Hispanic, African American, American Indian, and Asian-Pacific Islander based on data regarding Nevada's earning disparities,[34]
- 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).

The average enrollee net premium is also projected to decrease relative to the Baseline in all years of the waiver period and the deficit neutrality window. Table 7 below highlights this, showing the average enrollee net premium under both the Baseline and Market Stabilization scenarios. **As shown in Table 7, the premium relief program will further reduce average net premiums under the waiver for some subsidized enrollees. In aggregate, the estimated impact of premium relief on average net premiums ranges from 0.2% in 2026 to roughly 0.5% thereafter.**

Table 7
Projected Average Net Premium Change From Baseline

	No Waiver	Market Stabilization Scenario				
Year	Baseline	BBSP Policy Only	BBSP with Reinsurance	BBSP with Reinsurance and Premium Relief	Average Net Premium Change Due to Waiver Before Premium Relief	Average Net Premium Change Due to Waiver After Premium Relief
2026	$276.03	$275.16	$275.16	$274.75	-0.3%	-0.5%
2027	$286.48	$285.19	$273.24	$271.64	-4.6%	-5.2%
2028	$297.19	$295.26	$282.43	$280.86	-5.0%	-5.5%
2029	$308.26	$305.57	$292.15	$289.82	-5.2%	-6.0%
2030	$319.65	$316.52	$302.16	$300.63	-5.5%	-5.9%
2031	$331.18	$328.13	$312.53	$311.02	-5.6%	-6.1%
2032	$343.17	$340.28	$323.50	$322.01	-5.7%	-6.2%
2033	$355.93	$352.27	$334.35	$332.88	-6.1%	-6.5%
2034	$368.89	$365.32	$346.44	$344.25	-6.1%	-6.7%
2035	$382.38	$378.62	$357.82	$355.67	-6.4%	-7.0%

The average net premium changes due to the waiver in Table 7 differ from average net premium changes in the initial waiver application submitted in February 2024 due to changes to the final BBSP take-up rate assumption. In revising the Actuarial and Economic Analysis, the State implemented a higher take-up rate on average that reflects the following factors:

- There will be more publicity around the BBSP offerings relative to simply being the SLCS plan in any given year.
- The State will require issuers under their BBSP contracts to widely market and promote their BBSP offerings during open enrollment.
- Active plan selection will be woven into the SSHIX Fall open enrollment campaign.
- For the same reasons that a BBSP is likely to be the SLCS plan, a BBSP will likely also be the lowest cost silver plan.
- On the Nevada Health Link's plan selection page, the default sort option lists plans by net premium from lowest to highest. This sorting function will ensure BBSPs are among the first plans visible to consumers on the platform.
- The BBSPs will be offered by well-established issuers, several of which already offer Marketplace plans,

[34] See U.S. Department of Labor. Earnings Disparities by Race and Ethnicity. Available at: https://www.dol.gov/agencies/ofccp/about/data/earnings/race-and-ethnicity

which are also Medicaid MCOs.
- Active enrollment in Colorado increased by almost 35% in the first year of the Colorado public option, from 47% in 2022 to 63% in 2023.
- BBSP plans will have a logo on the Nevada Health Link plan selection page that further draws attention to them.

In light of these State initiatives and considerations described above, the actuarial analysis' BBSP take-up rate was increased to 80% for SSHIX enrollees, which materially reduces projected enrollee net premiums.

- **Coverage (1332(b)(1)(C))**

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. The Actuarial and Economic Analysis estimates that under Nevada's 1332 waiver, the number of Nevadans with health insurance coverage will increase relative to without the waiver.

Table 8 below summarizes net total enrollment changes from the Baseline, demonstrating that **the waiver provides coverage to at least as many residents as without the waiver.**

Table 8: Projected Individual Market Enrollment Change from Baseline			
Year	BBSPs Only	Reinsurance Policy Incremental Impact	Total
2026	600	0	600
2027	700	1,100	1,800
2028	700	1,100	1,800
2029	800	1,100	1,900
2030	900	1,100	2,000
2031	900	1,100	2,000
2032	900	1,200	2,100
2033	900	1,200	2,100
2034	900	1,200	2,100
2035	1,100	1,200	2,300
Values are rounded to the nearest hundred			

Additionally, Exhibit 4.5 in the Actuarial and Economic Analysis demonstrates the impact on enrollment by rating area, which is greater in underserved rural areas on a percentage basis. The Actuarial and Economic Analysis projects enrollment in rating areas 3 and 4 to increase by more than 3% and 5%, respectively, by 2027 due to the waiver, whereas the Analysis projects enrollment in rating areas 1 and 2 to increase by approximately 1.5% and 2%, respectively.

- **Comprehensiveness (1332(b)(1)(A))**

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 Nevada 1332 waiver complies with this standard because SB 420 requires the new BBSPs to meet all QHP standards under the Affordable Care Act, which includes providing the full set of essential health benefits.**

The waiver does not make any changes to these benefits, nor does it alter any other coverage requirements for QHPs. Reinsurance does not have any impact on the comprehensiveness of coverage. Similarly, the use of PTF for provider quality incentives does not impact the comprehensiveness of coverage.

The waiver is not expected to impact comprehensiveness of coverage; therefore, by extension, there are no impacts to any specific populations of individuals or households, including those with higher health care cost burdens, low-income individuals, elderly individuals, or other vulnerable or underserved communities. The reductions in gross premiums may increase the ability for unsubsidized enrollees to purchase higher levels of coverage; however, based on the historically consistent enrollment by metal in Nevada despite changes in gross premiums, the Actuarial and Economic Analysis assumes enrollees choose to remain in the same metal as in the Baseline scenario.

- **Deficit Neutrality (1332(b)(1)(D))**

The 1332 waiver must be deficit neutral to the federal government compared to projections without the waiver. Table 9 below shows the projected Advanced Premium Tax Credits (APTCs) under the Market Stabilization scenario during the 10-year deficit neutrality window, demonstrating that **the waiver satisfies the deficit neutrality standard.**

The With Waiver scenario reduces federal outlays for premium subsidies relative to the Baseline scenario and these savings are paid to the state in the form of PTF such that total outlays under a waiver (subsidies paid to enrollees plus PTF to the state) are no greater than subsidies paid to enrollees without the waiver. The annual projected PTF amounts represent Milliman's best estimates of the savings in each year. Additionally, Milliman provides the projected PTF over the five-year waiver and 10-year deficit neutrality windows, and applies a 10% margin to account for unknown contingencies.

Table 9
Projected Pass-Through Funding (in Thousands)*

	Advanced PTCs		Total Pass-Through Funding**		
Year	**No Waiver**	**With Waiver**	**BBSP Policy Only**	**Reinsurance Policy Incremental Impact**	**Total**
2026	$386,000	$370,000	$15,000	$0	$15,000
2027	$408,000	$344,000	$26,000	$32,000	$58,000
2028	$431,000	$354,000	$35,000	$34,000	$69,000
2029	$455,000	$366,000	$44,000	$37,000	$81,000
2030	$481,000	$385,000	$47,000	$40,000	$87,000
2031	$508,000	$405,000	$50,000	$43,000	$93,000
2032	$537,000	$427,000	$52,000	$47,000	$99,000
2033	$567,000	$449,000	$55,000	$51,000	$106,000
2034	$599,000	$473,000	$57,000	$57,000	$114,000
2035	$633,000	$498,000	$61,000	$61,000	$122,000
5-Year Waiver Window			**$167,000**	**$143,000**	**$310,000**
10-Year Deficit Neutrality Window			**$442,000**	**$402,000**	**$844,000**
5-Year Waiver Window – With 10% Margin			**$150,000**	**$129,000**	**$279,000**
10-Year Deficit Neutrality Window – With 10% Margin			**$398,000**	**$362,000**	**$760,000**

** Values are rounded to the nearest million*

*** The Total Pass-Through Funding in each year is not equal to the difference between Advance PTCs with and without the waiver because of the 10% tax reconciliation factor that accounts for the difference in Advanced PTC and actual PTC claimed on tax filings.*

B. Impact on Health Equity

The authorizing legislation for the waiver and BBSP 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 BBSPs will be specifically designed to increase access and improve outcomes for historically marginalized communities. The State law directs the Director to prioritize awards to carriers that respond to the procurement with provider arrangements and strategies that will help decrease disparities in access and outcomes and support culturally competent care.

The Director must also prioritize bids for the BBSP that demonstrate alignment of provider networks between BBSP and MCO programs, where applicable, to help ensure continuity of care as people move up the income ladder and purchase health insurance in the individual market. In prioritizing alignment of provider networks, the State is minimizing the incidence of disruptions in care that disproportionately impact low-income Americans and lead to worse health outcomes and increased financial risk.[35]

Additionally, by leveraging a unified state purchasing strategy, Nevada can improve outcomes for historically marginalized communities. DHHS released a Request for Information May 2024 to gather stakeholder feedback on opportunities to reduce health disparities and improve health equity through the new BBSPs and other items for procurement and new contracts. The State is exploring the following contract provisions for BBSPs focused on health equity:

- Requirements for BBSP carriers to collect and report on race, ethnicity, and language data.
- Requirements for BBSP carriers to submit health care workforce development plans that align with strategies for the carriers' MCO products that increase access to health care providers where gaps exist and improve cultural competency among Nevada's provider workforce.
- Requirements for BBSP carriers to report on enrollees' out-of-pocket spending annually.
- Quality metrics that align with Medicaid Managed Care metrics that are stratified by race and ethnicity to measure progress toward closing health disparities.
- Financial rewards for BBSP carriers that achieve State goals related to addressing health disparities. These rewards would be financed through the Quality Incentive Payment Program.

Further, the above contractual provisions 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.

Findings from the Actuarial and Economic Analysis developed by Milliman also highlight positive impacts of the waiver for more marginalized populations in Nevada, including low-income individuals, elderly individuals, and residents in rural areas. For instance:

- Exhibits 1.1 through 1.5 in the Actuarial and Economic Analysis show that the decrease in gross premiums under the waiver is generally greater for low-income individuals, elderly individuals, and residents in rural areas.
- Exhibit 3.1 shows that the average net premium (before the impact of the premium relief program) for those earning under 200% FPL decreases due to the waiver in almost every year of the waiver period.
- Exhibit 4.5 in the Actuarial and Economic Analysis outlines the impact on enrollment by rating area, which is greater in underserved rural areas on a percentage basis. The Actuarial and Economic Analysis projects enrollment in rating areas 3 and 4, which are disproportionately rural, to increase by more than 3% and 5%, respectively, by 2027 due to the waiver, whereas the Analysis projects enrollment in rating areas 1 and 2 to increase by approximately 1.5% and 2%, respectively.

[35] Ben Sommers and others. Insurance Churning Rates for Low-Income Adults Under Health Reform available at: https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0455.

- The Actuarial and Economic Analysis highlights that the implementation of the premium relief program will further reduce average aggregate enrollee net premium for PTC-eligible enrollees, shielding primarily middle-income consumers from premium increases.
- Further, the waiver is not expected to impact comprehensiveness of coverage; therefore, by extension, there are no impacts to any specific populations of individuals or households, including those with higher health care cost burdens, low-income individuals, elderly individuals, or other vulnerable or underserved communities.

Section 5: Additional Information

A. Administrative Burden

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

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

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

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

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

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

Nevada believes that the above administrative tasks are similar to other administrative functions currently performed by the federal government, so 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 PTCs and PTC payments are calculated or paid.

B. Implementation of Non-Waived ACA Provisions

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

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

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

D. Compliance, Waste, Fraud, and Abuse

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

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

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

DOI will continue to lead its rate review and network adequacy processes for private health insurance plans in the individual market, which as of 2026 will include the BBSP products. DOI is responsible for regulating, ensuring compliance of, and monitoring the solvency of all carriers; performing market conduct analysis, examinations, and investigations; and providing consumer outreach and protection. The DOI investigates all complaints that fall within the agency’s regulatory authority.

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

DHHS and DOI are audited as part of the Annual Comprehensive Financial Report (ACFR) and are included in the State Audit. The Legislature's Audit Subcommittee contracts with an external firm to conduct the audits,

and the audits are presented to the Legislature. The Nevada BBSP program and federal PTF will be subject to audit under the State's ACFR and Single Audit. The reinsurance program will also be subject to those audits and will be part of the annual report. The federal government is responsible for calculating the federal savings resulting from this waiver and for ensuring that this waiver does not increase federal spending.

E. State Reporting Requirements and Targets

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

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

Each quarterly report will include the following:

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

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

The annual report prepared by DHHS will include the following metrics to assist evaluation of the waiver's compliance with the requirements found in Section 1332(b)(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 SLCS plan premium under the waiver and an estimate of the SLCS plan premium as it would have been without the waiver for a representative consumer (e.g., a 21-year-old nonsmoker) in each rating area.
- The actual amount of Advance Premium Tax Credit (APTC) paid, by rating area, for the plan year.
- The actual number of APTC recipients for the plan year. The number should be the number summed over all 12 months and divided by 12 to provide an annualized measure.

- Changes to the waiver programs, including the funding level the program will be operating at for the next plan year, or other program changes.
- Notification of changes to State law that may impact the waiver.
- Reporting of:
  - Federal PTF spent on subsidy programs adopted by DHHS. The unspent balance of federal PTF for the reporting year, if applicable.

F. Proposed State Operations Budget for Waiver Program

NRS 695K.300 provides that federal PTF 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 BBSPs as outlined under State law in NRS 695K.

Table 10: Estimated Annual SFY Budget Costs for State Operations, Starting SFY 2026[36]	
Nevada Division of Insurance Operation Costs for Public Option	
Reinsurance Program Manager	$80,000.00 per SFY
Outside Waiver Support and Administrative Services	$180,000.00 per SFY
Estimated subtotal	**$260,000.00 per SFY**
Nevada Silver State Health Exchange Costs for Public Option	
Revised Notices	**One-Time Set-Up Cost of $50,000.000**
Outreach Promoting Plan Shopping	**One-Time Set-Up Cost of $150,000.00**
Estimated subtotal	**$200,000.00 One Time Cost**
Nevada Medicaid Operation Costs for Public Option	
New Staffing Costs for Contracts Oversight /Waiver Management	$400,000.00 per SFY
New Actuary and Transaction Fees[37]	$1,600,000.00 per SFY
Estimated subtotal	**$2,000,000.00 per SFY**
Estimated Total Operational Costs per SFY	**$2,260,000.00 per SFY**

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

G. Evidence of Public Notice and Tribal Consultation Requirements

The State of Nevada held a public comment period beginning on November 20, 2023, and ending on December 20, 2023. The public comment period was announced through a posting on the DHCFP's website. The State also sent a press release to local media outlets and a similar notice through the Nevada Market Stabilization Program ListServ, announcing the beginning of the 30-day public comment period (see Appendix for this press release). The public hearings were also announced on DHCFP's website as public notices (see Appendix materials). During the public comment period, the Division of Health Care Financing and Policy held two tribal consultations (November

[36] Estimated costs are subject to change.

[37] The State requires dedicated funding for actuarial support focused on procurement and contract development as well as rate review technical assistance to ensure premium reduction targets are on track for being met.

29 and December 7), and two public hearings (November 27 and December 5). The presentations for the consultations and hearings are available in the Appendix.

The Division used several mechanisms to notify the public of the comment period and 1332 Waiver Application, offering significant opportunity to provide feedback to the State through both hybrid (in-person and virtual) meetings and written comments. The public notice for this Waiver complies with 31 CFR 33.112 and 45 CFR 155.1312. The Waiver Application was posted on the DHCFP's website on November 20, 2023.

The tribal consultations for the 1332 Waiver Application were held on November 29 and December 7, 2023, from 9:00 to 10:00 a.m. PST and 1:30 to 2:30 p.m. PST, respectively, both in-person and via Teams. The Division hosted the meetings and all Tribal Chairs and Tribal Health Clinic Directors from the Nevada Tribes were invited to the consultations.[38] During the consultations, staff members from the Division presented an overview of the 1332 Waiver Application and the anticipated impact of the Waiver on tribal communities. After the presentation, Division staff addressed questions from the meeting attendees. Commenters raised questions about the BBSPs, including network provider requirements, whether tribes would be able to sponsor premiums for BBSPs offered on the Exchange with federal funding, and if BBSPs would include an Indian Addendum to coordinate health coverage for tribes with providers in multiple states. The State confirmed that all requirements that apply to QHPs also apply to the BBSPs.

The public hearings for the 1332 Waiver Application were held on November 27 and December 5, 2023, from 1:00 to 3:00 p.m. PST, both in-person and via Teams. A total of 99 persons attended the November 27 hearing and 88 persons attended the December 5 hearing. At the hearings, staff members from the Division presented the details of the Waiver Application, including the BBSPs and Market Stabilization Program. Staff members then opened the floor for questions and comments from meeting attendees. Commenters provided positive feedback on the BBSPs as a mechanism to strengthen health equity in Nevada through improving health care affordability. Attendees also positively supported features of the State's Market Stabilization Program, including provisions to strengthen the health care workforce and implement a reinsurance program. Some commenters expressed concerns related to the required BBSP premium reduction targets, anticipated provider reimbursement reductions, and provider participation requirements. In the Appendix, the Division has identified public hearing comments pertinent to the Waiver Application and provided a response to themes from those comments. The Division also posted recordings of the two public hearings on the Coverage & Market Stabilization Program website.

The Division also accepted written comments during the 30-day comment period. Thirty-seven written comments were submitted during this period. Those submitting written comments expressed similar themes as outlined above during the public hearings. The State received several comments in support of the 1332 Waiver Application, highlighting the potential for the BBSPs to improve affordability and narrow health care disparities. Other commenters expressed concerns related to mandated premium reductions, anticipated provider reimbursement reductions, and certain provider participation requirements. The Appendix also includes responses to themes raised from written comments.

[38] Tribes invited to tribal consultations include: Battle Mountain Band Council, Carson Colony Community Council, Confederated Tribes of Goshute, Dresslerville Community Council, Duck Valley Shoshone-Paiute Tribe, Duckwater Shoshone Tribe, Elko Band Council, Ely Shoshone Tribe, Fallon Paiute Shoshone Tribe, Ft McDermitt Paiute-Shoshone Tribe, Fort Mojave Indian Tribe , Las Vegas Paiute Tribe, Lovelock Paiute Tribe, Moapa Band of Paiutes, Pyramid Lake Paiute Tribe, Reno-Sparks Indian Colony, South Fork Band Council, Stewart Community Council, Summit Lake Paiute Tribe, Te-Moak Tribe of Western Shoshone, Timbisha Shoshone Tribe, Walker River Paiute Tribe, Washoe Tribe of Nevada & California, Wells Band Council, Winnemucca Indian Colony, Woodfords Community Council, Yerington Paiute Tribe, Yomba Shoshone Tribe, Te-Moak Shoshone Tribe Bands, and Washoe Tribe of Nevada & California Councils.

MILLIMAN REPORT

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

Prepared for Nevada Department of Health and Human Services

August 19, 2024

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I. EXECUTIVE SUMMARY

Milliman, Inc. (Milliman) has been contracted by the State of Nevada to perform actuarial and economic analyses of the impact of a Section 1332 waiver and provide an actuarial certification that the waiver complies with federal guardrail requirements. The State of Nevada is seeking a 1332 waiver to obtain pass-through funding (PTF) related to the establishment of the Nevada Market Stabilization Program (NMSP) that includes the operation of a Public Option (PO) program on the Silver State Health Insurance Exchange (SSHIX, or the exchange) beginning in 2026 and a reinsurance program for the individual market beginning in 2027. Nevada's Section 1332 waiver application seeks to waive section 1312(c)(1) of the ACA in order to establish a state-based and state-administered reinsurance program. Section 1312(c)(1) requires "all enrollees in all health plans . . . offered by [an] issuer in the individual market . . . to be members of a single risk pool." The application calls for waiving the single risk pool requirement to the extent it would otherwise require excluding expected state reinsurance payments when establishing the market-wide index rate. A lower index rate will result in lower premiums for Nevada's second lowest cost silver (SLCS) plan, resulting in a reduction in the overall premium tax credits (PTCs) that the federal government is obligated to pay for subsidy-eligible consumers in Nevada.

The legislation that establishes a PO and grants authority for establishment of a reinsurance program was introduced through Nevada Senate Bill 420 as passed during the 2021 State Legislative Session (SB420) and is described in more detail in Section II of this report. The State of Nevada's Division of Health Care Financing and Policy (DHCFP) and Department of Health and Human Services (DHHS) issued guidance that clarifies the methodologies and assumptions the state intends to use when implementing the legislated premium reduction targets.

Based on Section 2 of SB420, which can be found in Appendix B, the stated purpose of the PO is to lower individual market health insurance premiums and consumer out-of-pocket premium costs, improve access to health care, reduce disparities in health care access and outcomes, and improve the availability of coverage for residents of rural areas. Furthermore, the PO plan offerings, hereafter referred to as Battle Born State Plans (BBSPs), are expected to provide the opportunity for 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. The lower gross premiums driven by the introduction of BBSPs will reduce the benchmark plan premium in all rating areas in Nevada, thereby lowering federal outlays for premium subsidies, which then become available to the State of Nevada as PTF under the Section 1332 waiver.

In addition to the introduction of BBSPs, the State of Nevada intends to implement a reinsurance program in the individual market beginning in 2027. The stated intent of the reinsurance program is to transform the PO into a market stabilization program by reinvesting 1332 waiver PTF back into Nevada's individual health insurance market.[1] The reinsurance program implementation will occur after the implementation of BBSPs to allow for the accumulation of sufficient PTF to cover the State of Nevada's portion of the reinsurance program costs.

The NMSP combines the mechanics of the BBSPs and reinsurance to lower the SLCS plan premiums, reduce federal subsidy outlays, and generate PTF under a 1332 waiver. Section V of this report illustrates the projected premium reductions under the Market Stabilization scenario described in Section III below, based on the SLCS plan, which is the benchmark plan used to determine premium subsidies.

It is our understanding, based on conversations with DHCFP and DHHS, that the revisions and clarifications in the DHHS guidance are intended to align the NMSP implementation with the intent of SB420. The agency's memorandum of guidance is provided in Appendix C. Any changes to this approach or guidance subsequent to the date of this analysis may affect the applicability of the findings in this report.

In response to stakeholder feedback, the State of Nevada will provide premium relief to certain qualifying individuals who are enrolled in the SSHIX as of December 2025 and reenroll in 2026 coverage. Premium relief will be granted to renewing individuals whose net premium (post-subsidy) is higher under the NMSP than it would have been without the NMSP due to PTC reductions driven by the NMSP premium reduction requirements. The specific details of the premium relief program are not yet determined as of the date of this report. Some considerations for the final program design include what can be accomplished operationally, assumptions used to calculate the premium relief, and how to communicate the amount of premium relief to consumers. The impact of the program modeled in this report reflects reasonable estimates based on preliminary discussions related to program design. The final structure of the premium relief program is not assumed to materially impact the PTF projections included in this report, but the details of the program will impact the PTF allocated for premium relief (see Table 1). If necessary, the reinsurance program parameters will be adjusted based on the actual surplus PTF remaining after funding the premium relief program to ensure sufficient PTF is available to fund the state's

[1] State of Nevada. "Governor Joe Lombardo Announces Plan to Transform the Nevada Public Option into NMSP." State of Nevada press release, October 11, 2023. https://gov.nv.gov/uploadedFiles/gov2022nvgov/content/Newsroom/PRs/2023/2023-10-11_DHHS_NVPublicOption-Memo.pdf . Accessed October 31, 2023.

share of the reinsurance program. As discussed in Section IV.A, the premium relief program will also reduce net premiums for some enrollees, and this impact may change depending on the final design of the premium relief program. Where applicable, we note the potential impact of the premium relief program on net premiums shown in this analysis. Estimates of annual costs for the premium relief program can be found in Table 1 below. We project ~20,000 enrollees could qualify for premium relief under the program in 2026.

This report provides the required actuarial and economic analyses and an actuarial certification to support the State of Nevada's determination that the NMSP meets the requirements of a Section 1332 waiver. Consistent with current law, we provide the actuarial and economic analyses assuming premium subsidy amounts for on-exchange coverage under the Patient Protection and Affordable Care Act (ACA), which were increased by the American Rescue Plan Act (ARP) for 2021 and 2022 and extended through 2025 by the Inflation Reduction Act (IRA), revert in calendar year (CY) 2026 to levels similar to those in place prior to the temporary increase in premium subsidy amounts authorized by ARP. We refer to these increased subsidies due to ARP and the IRA as "enhanced subsidies" throughout this report.

The parameters modeled in our analyses are consistent with our understanding of the statutory language of SB420 and the State of Nevada's guidance in Appendix C. Our analyses model the impact of the implementation of the NMSP. In addition, the analyses in this report assume Medicaid redeterminations following the expiration of the COVID-19 public health emergency (PHE) will be completed prior to the implementation of the NMSP.

The initial scenario assumes the state does not have a 1332 waiver, and thereby does not have BBSPs or a reinsurance program. We refer to this scenario as the "Baseline" scenario.

The "Market Stabilization" scenario is compared to the Baseline scenario to measure the projected PTF available to the State of Nevada after the introduction of the NMSP. This scenario, including the calculation of PTCs, is also required to demonstrate compliance of the NMSP with federal 1332 waiver deficit neutrality requirements. As noted above, reinsurance will be implemented after the BBSPs. The Market Stabilization scenario assumes BBSPs are available beginning in 2026 and reinsurance begins in 2027.

We model the incremental PTF available to the State of Nevada from the introduction of the BBSPs and then the reinsurance program separately. The PTF attributable to the introduction of BBSPs will be used, in conjunction with federal PTF generated by the reinsurance pool, to fully fund the reinsurance pool. Based on input from the State of Nevada, we assume any remaining PTF generated under the Market Stabilization scenario, after fully funding the reinsurance program and paying DHHS, SSHIX, and Department of Insurance (DOI) administrative costs to run the NMSP, will be used to fund provider quality incentives.

For simplicity and no loss of accuracy, we assume the second lowest cost silver (SLCS) plan in the Market Stabilization scenario will be a BBSP.[2] We assume minimal change in total individual market enrollment, as PTC-eligible individuals' net premiums (i.e., enrollee premium after subsidies) will be largely the same[3] as in the Baseline scenarios assuming they are enrolled in the SLCS.

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

[2] For modeling purposes, whether a BBSP or standard QHP becomes the second lowest cost silver is not material and we assume the same effect on subsidies. See Section III.C of this report for additional detail.

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

Overview of updates

Since the submission of Nevada's 1332 Waiver Application on December 29, 2023, the State of Nevada has made the following policy change to the proposed NMSP:

- In response to stakeholder feedback, the State of Nevada is adding a premium relief program. The premium relief program will provide compensation to individuals who face an unavoidable net premium increase (i.e., one that cannot be remedied by shopping for a lower-cost plan in their metal level) due to lower premium tax credits (PTC) driven by the NMSP premium reduction targets.
- Based on stakeholder input, the State of Nevada is implementing adjusted premium targets that will allow issuers to achieve the 2029 premium reduction target more evenly over the first four years of the NMSP.
- The State will also engage in strategies to encourage active shopping for the most appropriate or lowest cost plan for each enrollee.

In addition, the actuarial and economic analysis reflects the following assumption changes:

- Based on stakeholder feedback, reinsurance parameters are assumed to be the same across all rating areas. The aggregate impact of this assumption change is relatively small, but the impact varies across rating areas and individuals.
- Based on an expansion of planned state initiatives in response to stakeholder feedback, the BBSP take-up rate was increased to 80%. This assumption change has a small impact on PTF, but it materially reduces projected enrollee gross and net premiums.
- The estimated income level distribution of individual market growth due to Medicaid redeterminations was updated. The impact of this update is minimal
- The premium trend assumptions for bronze and gold plans were updated to reflect recent market observations. The impact of this update is minimal.

The narrative and results shown in this report reflect these changes.

A. SUMMARY OF RESULTS

Table 1 shows the estimated PTF, reinsurance cost, premium relief cost, and net funding available after paying the state's share of reinsurance and premium relief during each year during the 5-year waiver window and the 10-year deficit neutrality window. The State of Nevada plans to use the net funding available from 2026 to supplement the state's share of reinsurance costs in 2027. The net funding remaining in 2027 and beyond is the estimated amount of funding available to the State of Nevada to fund other initiatives, such as provider quality incentives.

The results presented In Table 1 and throughout this report assume the reinsurance program, beginning with 2027 and for the remainder of the 10-year deficit neutrality window, will reflect a $60,000 attachment point, $1,000,000 cap, and 28.5% coinsurance, as described in further detail in Section II.B of this report. Actual reinsurance parameters in each of those years will be adjusted, as directed by the Director of DHHS, to align with actual experience, available funding, and NMSP objectives.

Table 1 State of Nevada NMSP Actuarial and Economic Analysis Projected Pass-Through Funding and Direct Program Costs (in Thousands)					
Year	**Pass-Through Funding**	**Premium Relief Program Costs**	**Cost of Reinsurance**	**Net Funding Remaining**	**Cumulative Net Funding Remaining***
2026	$15,000	($500)	$0	$14,500	$14,500
2027	$58,000	($2,000)	($54,000)	$2,000	$16,500
2028	$69,000	($2,000)	($58,000)	$9,000	$25,500
2029	$81,000	($3,000)	($62,000)	$16,000	$41,500
2030	$87,000	($2,000)	($67,000)	$18,000	$59,500
2031	$93,000	($2,000)	($74,000)	$17,000	$76,500
2032	$99,000	($2,000)	($80,000)	$17,000	$93,500
2033	$106,000	($2,000)	($87,000)	$17,000	$110,500
2034	$114,000	($3,000)	($95,000)	$16,000	$126,500
2035	$122,000	($3,000)	($104,000)	$15,000	$141,500
5-Year Waiver Window	**$310,000**	**($9,500)**	**($241,000)**	**NA***	**NA***
10-Year Deficit Neutrality Window	**$844,000**	**($21,500)**	**($681,000)**	**NA***	**NA***
5-Year Waiver Window – With 10% Margin on PTF and Premium Relief	**$279,000**	**($10,000)**	**($241,000)**	**NA***	**NA***
10-Year Deficit Neutrality Window – With 10% Margin on PTF and Premium Relief	**$760,000**	**($24,000)**	**($681,000)**	**NA***	**NA***

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

The state will use accumulated surplus PTF, after paying DHHS, SSHIX, and DOI administrative costs to run the NMSP and funding the premium relief program, to fund the state's cost of reinsurance. For example, the PTF generated by BBSPs in 2026 and 2027 will be used to fund the state's cost of the reinsurance program in 2027. PTF surplus from 2027 will be combined with PTF generated in 2028 to fund the state's cost of the reinsurance program in 2028, and so forth. The cost of DHHS, SSHIX, and DOI administrative costs to run the NMSP is not reflected in Table 1.

For the NMSP to meet the federal requirements for a 1332 waiver, the program must meet four guardrails: affordability, scope of coverage, comprehensiveness, and deficit neutrality. Our analysis indicates that Nevada's waiver for the NMSP meets these federal requirements for a 1332 waiver.

The full scope of provider quality incentives is dependent on future PTF and reinsurance costs. Furthermore, these uses of PTF are longer-term investments in the health care sector, so it may take years to fully realize their benefits. Due to their interactions with the broader health care market, it is also difficult to isolate how much of the impact is attributable to the waiver. For these reasons, we did not explicitly evaluate the impact of provider quality incentives on the guardrails, but we provide general observations regarding their directional impact on each guardrail below.

We summarize the key results of our analysis of each of these standards below, with additional detail provided in Sections IV and V of this report.

Affordability: The 1332 waiver must provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable as would be projected without the waiver. Based on federal guidance issued in 2021,[4] the affordability and comprehensiveness guardrails (described below) are evaluated by CMS in aggregate based on the actual coverage purchased by enrollees. The NMSP satisfies the affordability requirement as follows:

- Table 2 shows how the BBSPs reduce the SLCS premiums, and reinsurance further improves affordability under the NMSP.

  As described in Appendix C, the BBSPs are expected to be at least 3% lower than the average reference premium (see Appendix C) in 2026 and 15% lower by 2029. The projected change in the SLCS plan premium due to the BBSP policy is slightly greater than the BBSP premium reduction targets in 2026 through 2029 (see Table 12)

[4] Final Rule: Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond; Accessed March 29, 2024. https://www.govinfo.gov/content/pkg/FR-2021-09-27/pdf/2021-20509.pdf

due to projected changes in morbidity due to enrollment growth resulting from the waiver. Gross premiums for BBSPs are projected to achieve the premium reductions in the Total column in Table 3, whereas gross premiums for standard QHPs will decrease by the reinsurance impact only.

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

Year	BBSP Policy Only	Reinsurance Policy Incremental Impact	Total*
2026	-3.2%	0.0%	-3.2%
2027	-5.2%	-6.9%	-12.1%
2028	-6.6%	-7.0%	-13.7%
2029	-8.0%	-7.1%	-15.1%
2030	-8.0%	-7.3%	-15.4%
2031	-8.0%	-7.6%	-15.6%
2032	-8.0%	-7.8%	-15.8%
2033	-8.0%	-8.1%	-16.1%
2034	-8.0%	-8.3%	-16.3%
2035	-8.0%	-8.6%	-16.6%

**Percentages by year are additive to illustrate the impact from Baseline. The percentage reduction in premiums driven by reinsurance noted in other sections of the analysis is slightly higher because it is applied to the lower BBSP premiums.*

- Table 3 illustrates that average gross premiums are projected to be lower in the Market Stabilization Scenario than in the Baseline scenario in all years of the five-year waiver window and the 10-year deficit neutrality window.

  The changes in average gross premiums in Table 3 below are slightly less than the target premium reductions for BBSPs shown in Table 2 because Table 3 reflects the projected aggregate gross premiums for enrollees who take up BBSP coverage and enrollees who remain enrolled in standard QHPs.

Table 3
State of Nevada
NMSP Actuarial and Economic Analysis
Projected Average Gross Premium Change From Baseline

	No Waiver	Market Stabilization Scenario		
Year	Baseline	BBSP Policy Only	BBSP with Reinsurance	Average Gross Premium Change Due to Waiver
2026	$593.38	$577.21	$577.21	-2.7%
2027	$617.51	$590.47	$547.60	-11.3%
2028	$641.90	$606.60	$561.11	-12.6%
2029	$667.95	$623.74	$575.80	-13.8%
2030	$695.02	$648.38	$597.01	-14.1%
2031	$722.61	$674.02	$619.01	-14.3%
2032	$751.41	$701.50	$641.81	-14.6%
2033	$781.38	$728.89	$664.97	-14.9%
2034	$812.76	$758.05	$690.18	-15.1%
2035	$845.52	$788.58	$714.63	-15.5%

- Table 4 illustrates that average net premiums are projected to be lower under the NMSP than in the Baseline scenario in all years of the five-year waiver window and the 10-year deficit neutrality window. The premium relief program will further reduce average net premiums under the waiver for some subsidized enrollees. In aggregate, the estimated impact of premium relief on average net premiums ranges from 0.2% in 2026 to roughly 0.5% thereafter.

The average net premium change is less than the average gross premium change due to the leveraging effect of subsidies for subsidized enrollees. For unsubsidized enrollees, the gross premium change and the net premium change are the same.

Table 4
State of Nevada
NMSP Actuarial and Economic Analysis
Projected Average Net Premium Change From Baseline

	No Waiver	Market Stabilization Scenario				
Year	Baseline	BBSP Policy Only	BBSP with Reinsurance	BBSP with Reinsurance and Premium Relief	Average Net Premium Change Due to Waiver Before Premium Relief	Average Net Premium Change Due to Waiver After Premium Relief
2026	$276.03	$275.16	$275.16	$274.75	-0.3%	-0.5%
2027	$286.48	$285.19	$273.24	$271.64	-4.6%	-5.2%
2028	$297.19	$295.26	$282.43	$280.86	-5.0%	-5.5%
2029	$308.26	$305.57	$292.15	$289.82	-5.2%	-6.0%
2030	$319.65	$316.52	$302.16	$300.63	-5.5%	-5.9%
2031	$331.18	$328.13	$312.53	$311.02	-5.6%	-6.1%
2032	$343.17	$340.28	$323.50	$322.01	-5.7%	-6.2%
2033	$355.93	$352.27	$334.35	$332.88	-6.1%	-6.5%
2034	$368.89	$365.32	$346.44	$344.25	-6.1%	-6.7%
2035	$382.38	$378.62	$357.82	$355.67	-6.4%	-7.0%

- Cost-sharing is not expected to be different under the waiver, for either BBSPs or standard qualified health plans (QHPs), than it is without the waiver.

  SB420 requires BBSPs to include both silver and gold plans, and DHHS intends to use the contracting process to require BBSP issuers to also offer a bronze BBSP. Since cost-sharing is based on an actuarial value (i.e., a percentage of plan costs) which is tied to the metal level, aggregate out-of-pocket costs for enrollees will decrease if they enroll in a plan with the same or higher metal level. As discussed in Section II.B, our modeling assumes all individuals enroll in a plan with the same metal due to the lower premiums available for the same coverage under the waiver. Therefore, non-premium cost-sharing will be at least as affordable under the waiver as it is without the waiver.

- Unsubsidized enrollees with large health care spending burdens relative to their incomes may be able to purchase plans with better coverage under the waiver due to the lower premiums under the NMSP.

- The use of PTF for provider quality initiatives may improve affordability further than what is shown in the results below to the extent they improve patient outcomes and reduce overall costs long term. However, we conservatively do not make any assumptions to reflect the potential impact of the quality incentive program during the 10-year deficit neutrality window (i.e., PTF could be understated).

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

We expect modest increases in enrollment due to the introduction of the BBSPs and slightly larger incremental increases in enrollment due to the implementation of reinsurance.

Table 5 shows the projected incremental enrollment increases due to the BBSPs and reinsurance separately. These increases mainly result from individuals who were uninsured (including those with higher health care cost burdens) but who would find unsubsidized premiums under the waiver more affordable due to the gross premium reductions related to the NMSP. We assume the use of PTF for provider quality incentives does not impact the scope of coverage.

Table 5 State of Nevada NMSP Actuarial and Economic Analysis Projected Individual Market Enrollment Change From Baseline				
	No Waiver	Enrollment Increase Due to Waiver		
Year	Baseline	BBSP Policy Only	Reinsurance Policy Incremental Impact	Total
2026	101,400	600	0	600
2027	102,700	700	1,100	1,800
2028	104,200	700	1,100	1,800
2029	105,500	800	1,100	1,900
2030	106,800	900	1,100	2,000
2031	108,200	900	1,100	2,000
2032	109,600	900	1,200	2,100
2033	111,100	900	1,200	2,100
2034	112,500	900	1,200	2,100
2035	113,900	1,100	1,200	2,300

** Values are rounded to the nearest hundred.*

Table 5 does not reflect projected enrollment in BBSPs versus standard QHPs. Rather, it reflects the projected enrollment growth attributable to the two primary policy components of the NMSP.

We project that individuals who enroll in the individual market in response to the BBSP policy component of the NMSP will enroll in BBSPs (as opposed to standard QHPs) since we assume the BBSPs' lower premiums are driving the decision to obtain coverage. Based on the BBSP premium reduction targets and reinsurance assumptions described throughout this report, enrollee net premiums for BBSPs are assumed to always be less expensive than enrollee net premiums for standard QHPs. Therefore, we assume individuals who enroll in SSHIX due to the waiver will enroll in a BBSP.

Comprehensiveness: The 1332 waiver must provide coverage at least as comprehensive, as defined by the ACA's essential health benefits (EHBs), as would be projected without the waiver. The Nevada 1332 waiver complies with this standard because SB420 requires the new BBSPs to meet all QHP standards under the Affordable Care Act, which includes providing the full set of essential health benefits. It does not make any changes to these benefits, nor does it alter any other coverage requirements for QHPs, for either BBSPs or standard QHPs. Reinsurance does not have any impact on the comprehensiveness of coverage. Similarly, the use of PTF for provider quality incentives does not impact the comprehensiveness of coverage.

The waiver is not expected to impact comprehensiveness of coverage; therefore, by extension, there are no disparate impacts to any specific populations of individuals or households, including those with higher health care cost burdens, low-income individuals, elderly individuals, or other vulnerable or underserved communities.

The reductions in gross premiums may increase the ability for unsubsidized enrollees to purchase higher levels of coverage; however, based on the historically consistent enrollment by metal in Nevada despite changes in gross premiums, we assume enrollees choose to remain in the same metal as in the Baseline scenario. Additional details are provided in Sections II and III of this report.

Deficit neutrality: The 1332 waiver must be deficit neutral to the federal government compared to projections without the waiver. Table 6 shows the projected Advanced Premium Tax Credits (APTCs) under the Market Stabilization scenario during the 10-year deficit neutrality window, demonstrating that the NMSP satisfies the deficit neutrality standard. The Market Stabilization scenario reduces federal outlays for premium subsidies relative to the Baseline scenario and these savings are paid to the state in the form of PTF, such that total outlays under a waiver (subsidies paid to enrollees plus PTF to the state) are no greater than subsidies paid to enrollees without the waiver. The annual projected PTF amounts represent our best estimates of the savings in each year. Additionally, we provide the projected PTF over the five-year waiver and 10-year deficit neutrality windows, and we apply a 10% margin to account for unknown contingencies.

The use of PTF for provider quality initiatives could reduce premiums in the waiver scenario further, including the SLCS, to the extent they improve patient outcomes and reduce overall costs. We conservatively do not make any assumptions to reflect the potential impact of the provider quality incentive program during the 10-year deficit neutrality window (i.e., PTF could be understated).

Table 6
State of Nevada
NMSP Actuarial and Economic Analysis
Projected Pass-Through Funding (in Thousands)*

	Advanced PTCs		Total Pass-Through Funding**		
Year	**No Waiver**	**With Waiver**	**BBSP Policy Only**	**Reinsurance Policy Incremental Impact**	**Total**
2026	$386,000	$370,000	$15,000	$0	$15,000
2027	$408,000	$344,000	$26,000	$32,000	$58,000
2028	$431,000	$354,000	$35,000	$34,000	$69,000
2029	$455,000	$366,000	$44,000	$37,000	$81,000
2030	$481,000	$385,000	$47,000	$40,000	$87,000
2031	$508,000	$405,000	$50,000	$43,000	$93,000
2032	$537,000	$427,000	$52,000	$47,000	$99,000
2033	$567,000	$449,000	$55,000	$51,000	$106,000
2034	$599,000	$473,000	$57,000	$57,000	$114,000
2035	$633,000	$498,000	$61,000	$61,000	$122,000
5-Year Waiver Window			**$167,000**	**$143,000**	**$310,000**
10-Year Deficit Neutrality Window			**$442,000**	**$402,000**	**$844,000**
5-Year Waiver Window – With 10% Margin			**$150,000**	**$129,000**	**$279,000**
10-Year Deficit Neutrality Window – With 10% Margin			**$398,000**	**$362,000**	**$760,000**

** Values are rounded to the nearest million.*
*** The Total Pass-Through Funding in each year is not equal to the difference between Advance PTCs with and without the waiver because of the 10% tax reconciliation factor that accounts for the difference in Advanced PTC and actual PTC claimed on tax filings.*

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

- In Section II of this report, we describe the federal requirements in more detail and provide additional information to demonstrate how the Nevada waiver satisfies these federal requirements. We provide information related to the requirements of Nevada's SB240, give background into how the bill creates savings in the individual market versus a non-waiver scenario, and explain how PTF is ultimately generated under a 1332 waiver.
- Section III describes the Market Stabilization (with waiver) and Baseline (without the waiver) scenarios and provides detailed discussions on important dynamics within the scenarios that impact PTF. These dynamics are somewhat unique to a PO offering versus a standalone reinsurance-type waiver.
- Section IV provides the actuarial analysis required by CMS, as well as detailed descriptions and data to demonstrate compliance with the affordability, comparable coverage, and comprehensive coverage requirement.
- Section V provides the required economic analysis for waiver approval. We model the expected PTF (premium tax credit savings to the federal government) under the waiver scenario and describe the assumptions and results.
- In Section VI, we detail the data, assumptions, and methodology used in our modeling.
- The Exhibits section provides detailed exhibits to support the actuarial analysis in Section IV and the economic analysis in Section V.
- Appendices provide our certification of waiver analysis and various other documentation items, including the CCIIO checklist.

B. DATA RELIANCE AND IMPORTANT CAVEATS

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

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

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

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

There is heightened uncertainty concerning future insurance market enrollment due to the Medicaid eligibility redeterminations occurring following the expiration COVID-19 public health emergency and its associated policies.

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

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

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

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

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

A. NEVADA SB420, NEVADA MARKET STABILIZATION PROGRAM, AND STATE REQUIREMENTS

Nevada Senate Bill 420 (SB420) was signed into law on June 9, 2021 and codified in Nevada Revised Statutes (NRS) 695K.[5] This law establishes a health benefit plan, the public option (PO) which is hereafter referred to as the Battle Born State Plan or BBSP, that will be administered by the State of Nevada through contracts with issuers. The BBSPs must be made available as qualified health plans through the Silver State Health Insurance Exchange (SSHIX) beginning in 2026. Some provisions of SB420 specifically related to the BBSP premium targets will expire on December 31, 2029. Therefore, some analyses in this report related to the premium targets focus on the first four years of the NMSP and assume the same level of savings thereafter, through the remaining duration of both the 5-year wavier window and the 10-year deficit neutrality window. A reference to the full text of SB420 is provided in Appendix B.

The stated objectives of SB420 are to lower health insurance premiums and costs, improve access to health care, reduce disparities in health care access and outcomes, and improve the availability of coverage for residents of rural areas. The legislation intends to achieve these objectives through the PO by lowering enrollee costs, improving access to health care, and improving health care coverage in rural areas.

In an October 11, 2023 press release,[6] the State of Nevada announced plans to transform the Nevada Public Option into the Nevada Market Stabilization Program (NMSP) by including a reinsurance program in the individual market. This reinsurance program is intended to increase stability in Nevada's individual market, and the program will be financed through pass-through funding (PTF) generated by the 1332 waiver. Section 11.1(b) of SB420 grants the Nevada Department of Health and Human Services (DHHS) the authority to apply for additional federal waivers or approvals, such as a reinsurance program.

The key aspects of SB420 that influence the actuarial analysis provided in this report are summarized below.

Levels of Coverage

Section 10.3(b) of SB420 requires that the PO provide "at least levels of coverage consistent with the actuarial value of one silver plan and one gold plan." This section of the legislation ensures a minimum threshold of coverage and plan choices for BBSPs. The key impact of this requirement on the actuarial and economic analyses is that it increases the probability that the second lowest cost silver (SLCS) premium will decrease by guaranteeing the PO will include at least one silver BBSP. Because other state requirements discussed below place upper limits on the BBSP premium amounts, the BBSP premiums are expected to be lower than premiums for standard qualified health plan (QHP) silver plans that would be otherwise available on the SSHIX.[7]

Reinsurance does not have any direct impact on levels of coverage, although some beneficiaries may switch to a higher level of coverage if a higher metal-level plan becomes more affordable due to reinsurance-driven premium decreases. Similarly, some enrollees may enroll in a different metal-level plan in response to lower subsidies or lower premiums available for BBSPs. There are several possible enrollment choices each enrollee could make. For simplicity and based on historical ACA market enrollment patterns described in Section III.B, we assume enrollees will either remain in their current plan or enroll in a BBSP at the same metal level as their current plan.

If unsubsidized enrollees choose a higher level of coverage in response to the lower premiums available because of the NMSP, actual coverage levels will increase but PTF will not be impacted. However, historical enrollment levels overall and by metal level in Nevada show that historical premium changes in the individual market have not resulted in material changes in enrollment by metal level. Furthermore, we assume most enrollees who are likely to disenroll due to net premium increases will disenroll upon the expiration of enhanced subsidies, so these disenrollments are reflected in the ARP enrollment change assumptions which are described further in Sections II.E and VI. Therefore, we assume enrollees included in the Baseline scenario would switch to a BBSP at their current metal level rather than change their coverage level or become uninsured.

[5] See https://www.leg.state.nv.us/App/NELIS/REL/81st2021/Bill/8151/Overview.

[6] State of Nevada. "Governor Joe Lombardo Announces Plan to Transform the Nevada Public Option into NMSP." State of Nevada press release, October 11, 2023. https://gov.nv.gov/uploadedFiles/gov2022nvgov/content/Newsroom/PRs/2023/2023-10-11_DHHS_NVPublicOption-Memo.pdf. Accessed October 31, 2023.

[7] Standard QHPs could, in response to the BBSPs, reduce prices or curtail rate increases to remain competitive against BBSPs. We do not attempt to model various issuers' reactions or behaviors in our analysis.

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

- Some lower-income enrollees with larger subsidies who currently have zero net premium bronze plans could maintain zero net premium either by keeping their plan or by switching to a bronze BBSP, depending on market pricing of bronze plans and changes in subsidies.
- Lightly subsidized enrollees (generally higher-income and / or younger ages) are more likely to see increases in net premiums while maintaining bronze coverage, particularly if they do not switch to a bronze BBSP. There may be fewer zero premium bronze plans available beginning in 2026 as subsidies decrease due to the expiration of enhanced subsidies, which is not related to the waiver. This impact on the availability of zero premium bronze plans due to the expiration of enhanced subsidies is modeled in both the Baseline and Market Stabilization scenarios.
- Enrollees with income above 400% FPL (i.e., unsubsidized after the expiration of enhanced subsidies) will be able to obtain premium decreases by switching to a bronze BBSP.

A bronze BBSP offering increases PTF (see Section III.D for additional discussion), all else equal.

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

Access

Section 13.1 of SB420 includes a provision requiring health care providers who currently participate in certain state coverage programs to participate in at least one provider network for an issuer offering a BBSP. This provider participation requirement is intended to ensure enough providers participate in a BBSP, such that the NMSP can fulfill any anticipated growth in the demand for health care services arising from the NMSP. SB420 gives the State of Nevada authority to waive this requirement as necessary to ensure access for enrollees in other state programs is sufficient.

Based on the State of Nevada's guidance outlined in Appendix C, we do not expect the provider participation provision to have a significant impact on BBSP premiums, total provider reimbursement across all health insurance markets, or access to care for consumers. Therefore, we do not make adjustments in our analysis of the NMSP related to this provision.

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

Reinsurance does not have a direct impact on access. However, since a portion of the premium target will be achieved through reinsurance, the reinsurance program decreases the amount of the premium reductions that need to be achieved through a combination of provider contracting and issuer administrative expense efficiencies. For every one percent of the premium reduction achieved through reinsurance or administrative expense efficiency, the provider reimbursement decrease required to meet the premium reduction target is reduced by approximately 1.67%.[8]

Therefore, the reinsurance program further contributes to market stability and access to health care services in Nevada by reducing the portion of the premium reductions that needs to be achieved through provider contracting.

Premium amounts

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

1. The 2024 premium for the SLCS available through the SSHIX, trended to the premium year at the Medicare Economic Index (MEI).

[8] Provider reimbursement, on average, is approximately 60% of premium. The remaining 40% covers prescription drug and insurer administrative expenses. Thus, it takes 1%/.6 = 1.67% decrease in provider reimbursement to effect a 1% change in total premium.

2. The SLCS premium in the prior year.

As outlined in Appendix C, the Director can revise the inflation index in the first clause as long as the premium reduction is at least 15% over the first four years. Our modeling assumes an inflation index based on the Consumer Price Index – Medical (CPI-M) plus an adjustment for utilization and morbidity changes in the local Nevada individual market, as described in Appendix C. Furthermore, based on the State of Nevada's methodology outlined in Appendix C, the reference premium defined in Section 10.6(d) is replaced by an "average reference premium" as defined in the guidance. The "average reference premium" is not tied to the second clause. Our modeling assumes that the standard QHP premiums will trend at the medical inflation index, based on CPI-M plus an adjustment for utilization and morbidity changes in the local Nevada individual market, each year. The adjustments for utilization and morbidity are intended to capture broader influences on health care costs in the individual market that are either beyond the control of BBSP or QHP issuers or otherwise not captured in the CPI-M.

Further, SB420 allows the Director to change the requirement that PO plans (i.e., BBSPs) generate 5% savings in the first year relative to the reference premium. At the direction of the State of Nevada, our modeling assumes that the requirement will be 3% in the first year of the NMSP.

DHHS will evaluate the premium requirements in SB420 on an ongoing basis to ensure the outcomes of the PO remain consistent with the intent of SB420. As appropriate, the Director will collaborate with key stakeholders, including issuers and providers, to develop reasonable assumptions and adjustments to the premium reduction targets and reinsurance parameters.

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

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

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

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

The analyses in this report assume the SLCS BBSP premium in 2029 will be at least 15% lower than the 2024 SLCS premium trended to 2029 with expected general medical inflation.

In response to stakeholder feedback that some issuers may not be able to achieve the full required premium reduction targets in 2026, the State of Nevada will adjust issuer and county-specific premium targets for 2026 through 2028 based on the issuer's 2025 market position. These adjusted premium targets will be based on the amount of each issuer's 2025 lowest-cost silver plan premium relative to the 2025 SLCS premium in each county. At least two issuers will be required to achieve the unadjusted premium target in each county, which will ensure the BBSP program will collectively achieve the required premium reduction of 3% below the reference premium in 2026. All issuers will be required to achieve the BBSP premium reduction target in 2029; however, the adjusted premium targets will allow issuers in less competitive positions in 2025 to spread the premium reduction needed to achieve the statutorily required 2029 target of 15% more evenly over the first four years of the NMSP.

The analyses in this report assume the adjusted premium targets will not impact the SLCS premium or PTF because at least two issuers will achieve the unadjusted premium reduction target.

SB420 does not include specific requirements for bronze and gold BBSP premiums. However, we assume premiums for BBSP bronze plans and BBSP gold plans will be based on the same underlying pricing assumptions as BBSP silver plans so projected premium relativities between metals remain similar to current premium relativities.

The analyses in this report assume assumptions applied to silver BBSP plans will also apply to bronze BBSP premiums and gold BBSP premiums, except as otherwise noted.

Based on discussions with DHHS, the requirements of SB420, and the introduction of the reinsurance program, we expect the BBSP premium reductions to be driven from four sources: provider reimbursement decreases, lower issuer premium expense loads required for BBSPs, value-based purchasing initiatives, and the reinsurance program.

Provider reimbursement

SB420 requires that provider reimbursement rates for the PO be, in the aggregate, comparable to or better than Medicare rates. The law includes exceptions for certain safety net providers for whom specific payment methodologies apply, including for federally qualified health centers (FQHCs), rural health centers (RHCs), and the Medicaid State Plan rate for certified community behavioral health clinics (CCBHCs). Per Sections 14.1(b) and 14.6 of SB420, the above-stated rate requirements do not apply to "payment models that increase value for persons enrolled in the Public Option," meaning that plans and providers may agree to alternative payment models.

Based on Milliman's proprietary research and Milliman's Consolidated Health Cost Guidelines (HCG) Source Database (CHSD), we estimate provider reimbursement (excluding pharmacy) for QHPs in Nevada in 2022 was approximately 169% of Medicare in aggregate.[9] We assume provider reimbursement for standard QHPs will remain the same as QHP provider reimbursement without the waiver, and provider reimbursement for BBSPs will be approximately 11% lower in aggregate by 2029 (i.e., approximately 150% of Medicare).

Based on 2022 Nevada market data, we estimate that the Medicaid, Medicare, and employer markets combine for approximately 95% of total provider revenue (excluding pharmacy), and the individual market comprises 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 aggregate payment index across all providers and services.

Nevada will leverage procurement and contracting requirements as enforcement mechanisms to ensure BBSP provider reimbursement levels are appropriate to achieve the NMSP premium reduction requirements.

The State will be responsive to complaints filed by providers that contend that payment by a BBSP, in the aggregate, is not in compliance with this provision. The State will request the necessary data to review a rate challenge. The State will also require issuers to attest annually that their provider rates are equivalent to or better than Medicare rates. Issuers that are not in compliance could receive a financial penalty per their contract with the State. Significant noncompliance could mean a breach of contract.

B. GENERATING PASS-THROUGH FUNDING UNDER A 1332 WAIVER

A PO program and a reinsurance program generate PTF through different mechanisms. The assumption that the PO generates PTF is based on two key modeling assumptions related to individual market dynamics, as well as assumptions regarding how BBSPs might achieve lower premiums. On the other hand, the reinsurance program generates PTF based on the parameters of the reinsurance program (i.e., attachment point, coinsurance, and cap) and is less dependent on other assumptions. We describe each of these drivers of PTF in the following four subsections.

Competitive landscape driven by BBSPs decreases the benchmark silver plan

Our modeling assumes more than one BBSP will be offered in each rating area for the reasons stated in the narrative section of the waiver application. Therefore, a BBSP is expected to become the SLCS plan in all rating areas[10] in Nevada in 2026. While a BBSP is highly likely to be the SLCS plan in all years of the program, it becomes even more likely in the second through fourth years of the NMSP, as the discounts relative to the reference premium and standard QHP premiums increase. It is possible that a benchmark (i.e., SLCS) plan would not be a BBSP under the following circumstances:

- If a county had only a single issuer prior to the NMSP implementation in 2026, it is possible that a single BBSP in such a county in 2026 would not become the SLCS plan. In this case, if only one BBSP is offered in the county, the BBSP would become the lowest-cost silver plan and the benchmark plan would be unchanged (i.e., the single standard QHP offered prior to 2026) and drive no savings in federal subsidies. This circumstance is highly unlikely to occur in the two largest rating areas, which include roughly 90% of the State of Nevada's population and individual market enrollees. If this circumstance occurs in the smaller counties, the overall impact would be small because there are few QHP enrollees in these counties. Moreover, the State's managed Medicaid program will be statewide starting in 2026 with at least two MCOs in each rating

[9] Aggregate provider reimbursement as a percentage of Medicare reimbursement is based on statewide Nevada individual market claims, excluding pharmacy claims. Average provider reimbursement levels will vary by issuer and by provider.

[10] 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.

area. Therefore, we expect at least two BBSPs will also be available in each rating area, so the overall impact on the results related to the risk of a standard QHP being the SLCS plan is expected to be minimal.

- In the first year of the NMSP, when required discounts to the reference premium are only 3% per the State of Nevada's guidance in Appendix C, issuers could choose to price standard QHPs very competitively or recontract provider agreements for standard QHPs to reduce underlying cost structure, or both. If this happens, the premiums for one or more standard QHPs could be lower than the premiums for some BBSPs, and a standard QHP could become the SLCS plan. However, in such a situation, the impact to PTF would be the same as if a BBSP were the SLCS plan since this behavior would not appear in the Baseline (no waiver) scenario, assuming the waiver is given credit by CMS for the change in standard QHP pricing and provider contracting.[11] We discuss this risk in more detail in Section III.C.

The competitive situation as of 2024, which is the most recent year for which premium data is publicly available, is shown in Table 7 below. Table 7 shows that, with the exception of Rating Area 2, there are at least two issuers offering plans with premiums within 5% of the SLCS plan.[12] Assuming these issuers also offer BBSP plans that are compliant with the required premium reductions in SB420 and Appendix C, it is highly likely and a reasonable modeling assumption that the benchmark plan will be a BBSP plan and at least 3% lower than in a Baseline (no waiver) scenario. In 2024, seven distinct issuers offer silver plans in Rating Area 2. We anticipate the current level of competition in Rating Area 2 combined with the integration of the BBSP procurement process with the Medicaid managed care procurement, we anticipate that the benchmark plan in Rating Area 2 will also be a BBSP plan and at least 3% lower than in a Baseline (no waiver) scenario. Although SB420 requires issuers of Medicaid managed care plans to submit good faith BBSP bids, it does not preclude non-managed care plans from bidding to offer BBSPs.

Table 7
State of Nevada
NMSP Actuarial and Economic Analysis
Nevada 2024 Individual Exchange Market
Top 10 Lowest-Cost Silver Plans by Rating Area

Rating Area 1		Rating Area 2		Rating Area 3		Rating Area 4	
Issuer Name	% Difference to SLCS	Issuer Name	% Difference to SLCS	Issuer Name	% Difference to SLCS	Issuer Name	% Difference to SLCS
Health Plan of Nevada*	-0.2%	SilverSummit*	-2.9%	Hometown Health	-0.6%	SilverSummit*	-2.9%
Health Plan of Nevada*	0.0%	SilverSummit*	0.0%	HMO Nevada*	0.0%	SilverSummit*	0.0%
HMO Nevada*	2.0%	SilverSummit*	1.9%	Hometown Health	0.1%	SilverSummit*	0.4%
HMO Nevada*	4.6%	SilverSummit*	3.7%	HMO Nevada*	0.2%	SilverSummit*	1.9%
HMO Nevada*	5.4%	SilverSummit*	6.8%	HMO Nevada*	0.5%	SilverSummit*	2.1%
Health Plan of Nevada*	5.7%	SilverSummit*	7.2%	Hometown Health	0.9%	HMO Nevada*	4.7%
SilverSummit*	6.7%	SilverSummit*	8.8%	Hometown Health	0.9%	HMO Nevada*	4.8%
Aetna	8.7%	Aetna	9.0%	Hometown Health	1.0%	HMO Nevada*	5.2%
SilverSummit*	9.9%	SilverSummit*	9.1%	Hometown Health	1.1%	SilverSummit*	5.2%
SilverSummit*	10.0%	Hometown Health	9.8%	HMO Nevada*	1.2%	SilverSummit*	5.6%

** Current Nevada Medicaid MCO.*

Eight issuers offer plans on the SSHIX in 2024, including all four current Medicaid MCOs (Anthem, Molina, SilverSummit, and United HealthCare). Three SSHIX plans do not offer one of the 10 lowest-cost silver plans in any rating area, so they are not mentioned in Table 7; these plans are Imperial, Molina, and SelectHealth. Anthem and United HealthCare are listed on SSHIX under the issuer names HMO Nevada and Health Plan of Nevada, respectively. Aetna plans are listed on the SSHIX as Altius.

Reference premium tracks closely to individual market before reinsurance

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

[11] CMS' interpretation of market responses to the BBSPs is not known. If CMS does not credit the BBSPs with market responses in standard QHP plan pricing, PTF may be impacted.

[12] Health Plan of Nevada and HMO Nevada in Rating Area 1, Hometown Health and HMO Nevada in Rating Area 3, and SilverSummit and HMO Nevada in Rating Area 4.

Table 8 shows a simple illustration of the mechanics behind how the NMSP generates PTF under a 1332 waiver, given the requirements of SB420 and the State of Nevada's methodology outlined in Appendix C.

Table 8
State of Nevada
NMSP Actuarial and Economic Analysis
Illustration of Reference Premium Trended at Market Rate

		2024	2026	2027	2028	2029
(1)	Second Lowest Cost Silver Plan* (Baseline)	$524.23	$579.23	$602.40	$626.49	$651.55
(2)	*Assumed Annualized Trend*		5.1%	4.0%	4.0%	4.0%
(3)	Reference Premium	$524.23	$579.23	$602.40	$626.49	$651.55
(4)	*Assumed Annualized Trend*		5.1%	4.0%	4.0%	4.0%
(5)	BBSP Premium		$560.80	$529.44	$540.91	$553.00
(6)	*Cumulative Difference From Reference Premium*		-3.2%	-12.1%	-13.7%	-15.1%
(7)	*Cumulative Difference From Baseline*		-3.2%	-12.1%	-13.7%	-15.1%

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

We note the following in Table 8:

- Line 1 shows the projection for the SLCS in 2024, trended at 5.1% annually through 2026 and 4% annually thereafter.[13] The 4% trend is based on projections of per capita spending in the private insurance markets from CMS National Health Care Expenditure data, reduced by approximately 1% for value-based care initiatives in the Nevada market. We assume the expiration of enhanced subsidies will increase morbidity by approximately 2.5% in 2026; however, we simplified this adjustment in Table 8 by increasing the annualized trend from 2024 to 2026 by 1.2%. Additional references and information on this can be found in Section VI of this report. This represents a forecast of the individual market premiums in the absence of the NMSP.

- Line 3 is the calculated reference premium as defined by SB420 and reflecting the State of Nevada's methodology and guidance outlined in Appendix C. It is assumed that medical unit costs will trend at the CPI-M index, which we estimate in this modeling at 3.7%.[14] We also assume that an appropriate utilization and morbidity adjustment will be chosen that will be consistent with overall individual market dynamics in Nevada. In this illustration, that adjustment is assumed to be approximately 1.4% annually between 2024 and 2026 and 0.3% thereafter, *such that the reference premium trend equals the overall market change in premiums in the absence of the NMSP.* Additional information and references on this can be found in Section VI of this report.

- Line 6 shows that the BBSP premium, in accordance with the requirements of SB420 and the State of Nevada's methodology and guidance outlined in Appendix C, is at least 3% less than the calculated reference premium in year 1 of the program and 15% less by year 4.

- Line 7 illustrates that the difference between BBSPs and the estimated individual market premium without the waiver is also approximately 3% in year 1 and approximately 15% by year 4. This difference is identical to the BBSPs' difference from the reference premium (Line 6) because the reference premium is assumed to be indexed at a rate that is reflective of the overall individual market in Nevada without the waiver, as shown in Lines 2 and 4.

Table 8 illustrates how BBSPs can achieve the required 15% savings relative to the reference premium. Because the reference premium tracks to the market, the BBSP premiums will also be 15% below the Baseline SLCS (i.e., the SLCS absent the waiver).

It is *not* the intent of SB420 and the DHHS guidance outlined in Appendix C for the BBSPs to be any lower than 15% below the Baseline premium by year 4. BBSP savings relative to the Baseline premium of greater than 15% could occur if an inflation index applied to the reference premium does not appropriately reflect local individual market dynamics.

[13] The modeled 2024 premium is based on actual 2023 premiums, trended forward one year at 3.6% based on observed average 2024 rate increases and a 0.4% decrease for anticipated market morbidity due to the redeterminations of Medicaid eligibility following the end of the PHE. After 2024, premium is trended at the 4% projected trend assumption. Premium amounts in 2025 do not have a direct bearing on our modeling. Therefore, we intentionally do not include a column for 2025 in Tables 6 and 7.

[14] BLS Data accessed November 19, 2023. Archived Consumer Price Index Supplemental Files: U.S. Bureau of Labor Statistics (bls.gov). CPI-M index starting in March of 2023 shows decreases in both professional and hospitals costs year over year. We do not believe this reflective of overall changes in underlying costs or premium increase into the future. The choice of CPI-M of 3.7% is more consistent with longer term averages and therefore a more reasonable assumption.

For example, if the reference premium were to be trended at a rate lower than the overall individual market, BBSP premiums would be lower than the Baseline SLCS premium by more than 15% by 2029. In Table 9 below, we assume a reference premium trend of 3%, which is below the overall individual market trend and is not adjusted for changes in morbidity, for illustrative purposes.

Table 9
State of Nevada
NMSP Actuarial and Economic Analysis
Illustration of Reference Premium Trended Below Market Rate

		2024	2026	2027	2028	2029
(1)	Second Lowest Cost Silver Plan* (Baseline)	$524.23	$579.23	$602.40	$626.49	$651.55
(2)	*Assumed Annualized Trend*		5.1%	4.0%	4.0%	4.0%
(3)	Reference Premium	$524.23	$556.16	$572.84	$590.03	$607.73
(4)	*Assumed Annualized Trend*		3.0%	3.0%	3.0%	3.0%
(5)	BBSP Premium		$538.47	$503.47	$509.43	$515.81
(6)	*Cumulative Difference From Reference Premium*		-3.2%	-12.1%	-13.7%	-15.1%
(7)	*Cumulative Difference From Baseline*		-7.0%	-16.4%	-18.7%	-20.8%

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

In the example in Table 9, the reference premium is only trending at 3% (Line 4) while the overall individual market is trending at 5.1% through 2026 and 4% thereafter (Line 2). This implies that the BBSP premiums could be as much as approximately 21% less (Line 7) than the overall market absent the waiver rather than the 15% described in SB420.

It is not realistic nor required by SB420 to assume NMSP savings beyond the 15% by year 4 or to assume increasing annual savings in perpetuity, and making this type of assumption would overstate PTF. Such an assumption implies that BBSPs would or could find additional cumulative savings above and beyond the required 15%. This could be challenging as it puts undue burden on providers, issuers, or both. If cost savings above 15% were not found, BBSPs would have to be underpriced, which could destabilize the market and provide disincentives for issuers to offer a BBSP.

In summary, SB420 generates PTF primarily through a) the requirement that BBSP premiums are a certain percentage below the reference premium over the course of the first four years of the NMSP, and b) the likelihood that this requirement results in the SLCS or benchmark premium in all areas being no greater than the BBSP target premium. We assume no additional savings from the BBSPs related to annually indexing the reference premium to an artificially low measure of health care inflation (illustrated in Table 9) that is not reflective of the overall individual market absent the waiver. Nor do we assume that BBSPs will contain materially greater advantages in provider reimbursement cost structure, medical management, or value-based purchasing (VBP) to support lower premiums beyond the required 15% reduction versus the reference premium. Under the assumption that the reference premium is properly indexed to the overall individual market without the waiver, as is the intent of the DHHS Guidance in Appendix C, the NMSP will continue to generate PTF under the waiver beyond the first four years of the program due to the availability of BBSPs.

Sources of BBSP premium savings

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

- *Reductions in provider reimbursement unit costs*: It is expected that unit costs paid to facilities and professional providers in Nevada will be reduced to support the lower BBSP premium targets.
- *Reductions in administrative costs*: Issuers will be required to price BBSPs with a smaller expense load relative to standard QHPs to reduce the portion of BBSP premium reductions placed on providers. The required administrative expense targets will be set by the Director and will grade in over the first four years of the program.
- *Improved cost structures and efficiencies due to value-based purchasing initiatives*: Based on discussions with DHHS and the provisions in SB420 related to value-based purchasing, it is expected that the state will see an increased use of these initiatives with providers across both Medicaid MCOs and BBSPs. When these initiatives are aligned across markets in this manner, it increases the likelihood that providers will experience success with respect to their patient populations and outcomes, in addition to reduced administrative burden. The actual scope and impact of these initiatives will likely vary by issuers offering BBSPs, and specific estimates of the impact of these initiatives are outside the scope of this analysis. Because of this variability in the expected impact of value-based purchasing initiatives, we do not explicitly model the impact of these

initiatives in this report. Our modeling implicitly accounts for premium savings generated by value-based purchasing initiatives through the provider reimbursement reductions.

Unlike other public option programs to date, the NMSP is based on statutorily defined premium reduction targets that are established at the program level. These targets will be known to the State and to issuers before rates are required to be submitted to the State each year. Nevada will leverage the procurement and contracting process to ensure compliance with the statutorily defined premium requirements.

Reinsurance program structure

The reinsurance program generates PTF by reducing the index rate and ultimately premiums for all plans on the individual market, including BBSPs and standard QHPs, by design. The program reimburses issuers for a portion of the annual claims per enrollee that fall within a specified range from a reinsurance pool. The specified range is defined by a minimum annual claim amount ("attachment point") and a maximum annual claim amount ("maximum" or "cap"). A percentage of each beneficiary's claims ("coinsurance") between the attachment point and maximum is reimbursed to the issuer by the reinsurance pool. Because this reimbursement lowers issuers' post-reinsurance liability, issuers can reduce premiums, including for the benchmark plan. These lower benchmark premiums reduce federal outlays for premium subsidies, and this federal savings is, in turn, passed to the state in the form of PTF.
The cost of a reinsurance program is funded by the 1332 federal PTF and some state funding. Under the Nevada 1332 waiver, the state share of the funding for the reinsurance program will be funded by the PTF attributable to the introduction of the BBSP plans.

The premium reduction driven by the reinsurance program will be combined with premium savings specific to BBSPs noted above to evaluate whether the premium reduction targets have been satisfied.

This analysis assumes that premium reduction targets under the NMSP will be achieved by some combination of the above initiatives. It should be noted that if any one of the sources of savings does not materialize or materializes less than expected, the remaining savings from other sources must increase for the BBSPs to achieve the statutorily required premium reduction by 2029.

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

C. FEDERAL 1332 WAIVER REQUIREMENTS

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

Waivable Provision

The NMSP is seeking a waiver of Section 1312(c)(1) related to the single risk pool in the individual market.

Section 1332 waiver guardrails

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

1. Affordability of premiums and cost-sharing

   Section 31 CFR 33.108(f)(3)(iv)(B) requires that premiums and cost-sharing under the waiver must be at least as affordable overall as premiums and cost-sharing absent the waiver. The NMSP satisfies this requirement by requiring that the BBSP premiums be lower than the reference premium by a specified percentage and incorporating initiatives to drive BBSP enrollment, as discussed further below. By statute, the reference premium cannot be greater than the 2024 SLCS, trended to the benefit year based on a medical inflation index plus an adjustment for local market utilization and morbidity changes (see Appendix C), for the first four years of the NMSP program. Because we assume the standard QHP premiums in the individual market trend at this index (assumed to be 4%, as noted above), these constraints on the reference premium and BBSP premiums ensure that the BBSP premiums do not exceed projected premium amounts without the waiver.

   The State of Nevada will not force enrollees to select a BBSP; however, the SSHIX will take steps to encourage consumers to actively shop for the most affordable plans – which will likely be the BBSPs - and invest in marketing to distinguish the BBSPs. In Sections IV and V, we demonstrate that the affordability of the waiver is consistent

with or better than affordability in the individual market without the waiver. The addition of reinsurance in 2027 ensures all gross premiums on the individual market will be more affordable with the waiver than without the waiver in the second year of the NMSP.

Although we project the affordability guardrail will be met, the actual premium savings realized by individuals may vary based on the enrollee's level of subsidy and plan selection. Note, "lightly subsidized" and "heavily subsidized" are qualitative, descriptive-only terms intended to provide relational context for the portion of an enrollee's gross premium that is subsidized by PTCs, but they are not defined by any specific subsidy amounts or income levels. For example, a lightly subsidized enrollee would receive a relatively small PTC as a percentage of the gross premium, whereas a heavily subsidized enrollee might receive PTCs that cover most or all of the gross premium.

- ***Unsubsidized:*** In 2026, current enrollees who are not eligible for any subsidies will realize the entire premium savings driven by the NMSP if they switch to a BBSP plan. Starting in 2027, if they elect a standard QHP, they will realize the savings attributable to the reinsurance portion of the NMSP. If they select a BBSP, they will realize the savings attributable to both the reinsurance and BBSP programs.

- ***Lightly subsidized:*** Current enrollees who receive small subsidies may realize some net premium savings (i.e., after subsidy) if the BBSP gross premium falls below the enrollee's current net premium and they elect a BBSP. Any savings driven by the NMSP for these enrollees will be shared with the federal government, which is then passed through to the State of Nevada under the waiver. If they elect a standard QHP instead of a lower-cost BBSP, these enrollees may pay higher net premiums because they will be paying the difference between the pre-NMSP subsidies (based on a higher benchmark silver plan) and the lower post-NMSP subsidies (based on a lower BBSP benchmark plan). Enrollees selecting a QHP with higher net premiums over a lower-cost option (i.e., a BBSP with a waiver) is a choice that currently exists in the marketplace (without a waiver).

- ***Heavily subsidized:*** The impact of the NMSP on net premiums for current enrollees who receive substantial subsidies will depend on whether they elect a lower-cost BBSP or a higher-cost standard QHP. The net premium for silver and gold plan enrollees and some bronze plan enrollees who switch to a BBSP may be less than without the NMSP. If they do not elect a BBSP, their net premium will likely increase to offset the decrease in federal subsidies. The net premium for some bronze plan enrollees may increase, even if they switch to a BBSP; however, the median net monthly premium increase for these enrollees versus the Baseline scenario is less than $2 in 2026 and less than $10 in 2029.

The federal premium subsidy structure will remain unchanged with the introduction of the BBSPs. The out-of-pocket premium cost for the SLCS plan for a member will continue to be limited to a percentage of household income prescribed under the ACA. *With the exception of some bronze plan enrollees and some subsidized enrollees who choose to remain enrolled in higher cost standard QHPs, the enrollee net premiums under the waiver will be no greater than, and in most cases lower than, enrollee net premiums absent the waiver in aggregate; and cost-sharing requirements will be unchanged by the waiver.*

2. Comparable number of state residents covered

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

   Section IV.B of this report illustrates the projected coverage for State of Nevada residents under the Market Stabilization scenario in Section III below.

3. Comparable coverage

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

4. No increase to federal deficit

   Section 31 CFR 33.108(f)(3)(iv)(D) states that the waiver will not increase the federal deficit, either over the five-year waiver period or the 10-year federal deficit neutrality window. CMS requires the total of various costs to be considered when determining the impact on the federal deficit. Section V of this report details those costs and

the treatment of them in this waiver modeling. It also shows the projected federal subsidies during the 10-year federal deficit neutrality window under both the Market Stabilization scenario and the Baseline scenario. The Market Stabilization scenario presented in this report illustrates that the Nevada 1332 waiver is not expected to increase the federal deficit when compared to the Baseline scenario without the waiver. The analysis shows that federal costs are expected to decline due to the lowering of the SLCS benchmark premium, which lowers the aggregate federal subsidies.

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. As of the date of this document, the enhanced subsidies are intended to sunset at the end of 2025. We cannot predict whether the enhanced subsidies will be further extended beyond 2025. Therefore, the actuarial and economic analysis is prepared based on current law under which enhanced subsidies expire after 2025. As previously mentioned, the waiver must assume current law (state and federal). This includes applying the State of 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.[15]

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 SB420 legislation, we reasonably assume the Nevada NMSP will not have a material impact on enrollment in other markets. Specifically, the populations eligible to enroll in BBSPs are the individual market and the uninsured. Employer groups, including small employers, are not eligible to enroll in the BBSPs.[16] The enrollment changes in the markets other than the individual and uninsured that are modeled in the actuarial analysis are attributable to forces unrelated to the NMSP, including population growth and shifts, the expiration of enhanced subsidies, and the end of the PHE.

3. Demographic information

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

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

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

[15] See NRS 695K.200; Section 10.5

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

4. Explanation of assumptions

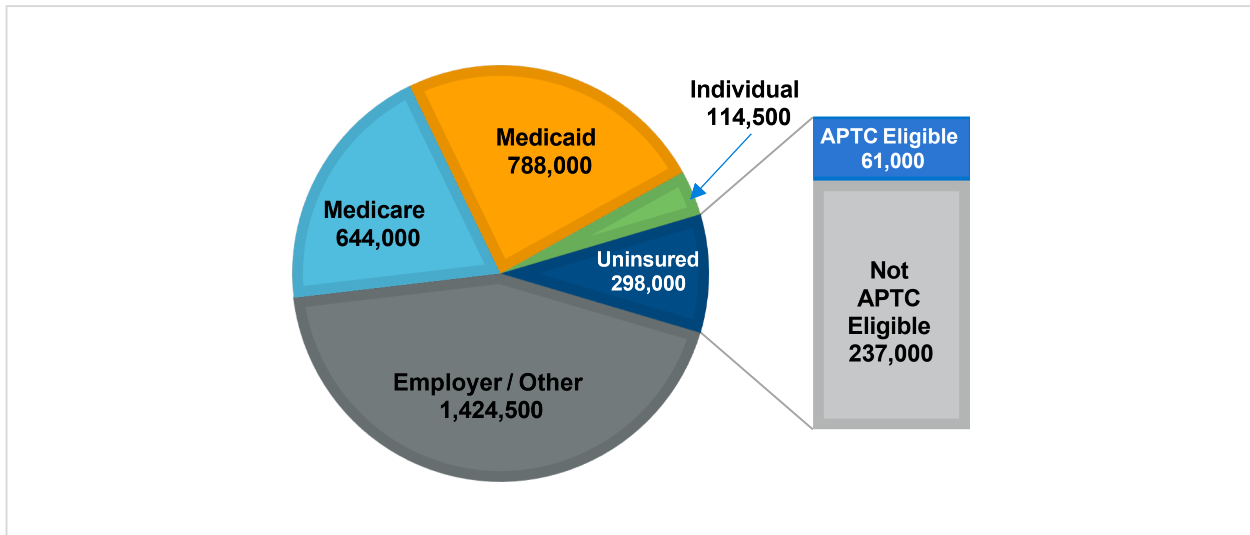
   Section 31 CFR 33.108(f)(4)(iii)(B) requires that the 1332 waiver include an explanation of the key assumptions used to develop the estimates of the effect of the waiver on coverage and the federal budget, such as individual and employer participation rates, behavioral changes, premium and price effects,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

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

D. CURRENT NEVADA COVERAGE LANDSCAPE

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

Figure 1: Sources of Coverage for Nevada Residents in 2022



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

In 2022, approximately 90.9% of Nevadans had health insurance coverage through one of the public or private markets shown above, leaving approximately 9.1% of Nevadans uninsured. The stated intent of SB420 is to increase coverage for currently uninsured residents, particularly those who are currently eligible for PTCs, but are not enrolled.

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

Medicare

The primary source of coverage for older Americans and those with qualifying disabilities is Medicare. Based on the program design of the NMSP, we do not assume any enrollment will transition between Medicare and the individual market due to the introduction of BBSPs or a state reinsurance program in the individual market. Although some individual market enrollees will become eligible for Medicare based on age between 2022 and 2026, we assume the overall enrollment distribution among insurance markets in Nevada, excluding the uninsured population and individual market, will remain consistent over time under the non-waiver Baseline scenario and the Market Stabilization waiver scenario.[17]

Employer-sponsored coverage

Based on the NMSP design, we do not assume any enrollment will transition between employer-sponsored coverage and the individual market, other than what would normally happen absent the waiver. Normal movement between these markets often occurs due to the affordability of employer-sponsored coverage. We assume these dynamics will remain consistent with past patterns and that these dynamics will be similar under the waiver and non-waiver scenarios because BBSP premiums are not expected to be sufficiently advantageous relative to the employer group market to incentivize movement to the BBSPs. We discuss the possible impact of small group migration and ICHRAs in Section III.D.

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 SSHIX. However, enrollment application increases on the exchange have sometimes led to increased Medicaid enrollment because some of the uninsured who apply for coverage on the exchange are redirected to the Medicaid program.

As a result of the Families First Coronavirus Response Act (FFCRA), state Medicaid programs were subject to Maintenance of Eligibility (MOE) requirements beginning in 2020 to qualify for a temporary 6.2-percentage-point Federal Medical Assistance Percentage (FMAP) increase.[18] States were not permitted to disenroll anyone from Medicaid until the PHE expired unless the member was deceased, moved out of state, or asked the state to be disenrolled. Enrollment in Medicaid populations where eligibility is tied to income has grown significantly since the beginning of the PHE, particularly among adults. The PHE ended May 11, 2023. Beginning in June 2023, states were allowed to disenroll those who no longer qualify for Medicaid. We expect some of these disenrolled members to be eligible for individual insurance and premium tax credits through the SSHIX. Medicaid eligibility redeterminations and associated disenrollments were required to be completed during 2024, which is prior to the NMSP effective date. This waiver analysis assumes a portion of 2022 Medicaid enrollees will enroll in the SSHIX prior to the implementation of the NMSP. We do not expect the exact timing of the Medicaid redetermination and disenrollment process to have a material impact on the results of the waiver analysis. This transition from Medicaid to the SSHIX is reflected in the Baseline and Market Stabilization scenarios.

Individual coverage

Since the inception of the ACA, health care coverage on the SSHIX 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. The SSHIX rating areas and their 2024 populations[19] are as follows:

- Rating Area 1 has a population of approximately 2.4 million in 2024 and includes Clark and Nye counties.
- Rating Area 2 has a population of approximately 500,000 in 2024 and includes Washoe county.
- Rating Area 3 has a population of approximately 175,000 in 2024 and includes Douglas, Lyon, and Storey counties.
- Rating Area 4 has a population of approximately 130,000 in 2024 and includes the following counties: Churchill, Esmerelda, Eureka, Humboldt, Lander, Lincoln, Elko, mineral, Pershing, and White Pine.

[17] Medicare enrollment does not impact the determination that Nevada's 1332 waiver meets the required guardrails discussed in this report.
[18] Dolan, R. et al. (December 17, 2020). Medicaid Maintenance of Eligibility (MOE) Requirements: Issues to Watch. Kaiser Family Foundation. Retrieved November 8, 2022, from https://www.kff.org/medicaid/issue-brief/medicaid-maintenance-of-eligibility-moe-requirements-issues-to-watch/
[19] World Population Review population of counties in Nevada. Retrieved May 1, 2024, from https://worldpopulationreview.com/states/nevada/counties

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

The expiration of the PHE and potential end to enhanced subsidies introduced under ARP and extended by the IRA will both have significant impacts on the individual market in Nevada. In particular, material changes in enrollment and morbidity could occur that will affect PTF estimates modeled in this report. As with Medicaid, we do not expect the exact timing of these events to have a material impact on the results of the waiver analysis, and we assume these changes will occur between 2022 and the beginning of the NMSP in 2026.

In 2021, the Biden administration announced administrative changes that affected certain individuals previously unable to enroll in exchange coverage due to the so called "family glitch." Proposed rules for these changes were released in October 2022. These changes made it easier for these individuals and their families to enroll, in many cases. This may result in a potential increase in enrollment in Nevada's individual market, coming primarily from the uninsured.[20] However, the increase would be small and would appear in both the Baseline and Market Stabilization scenarios, with an immaterial impact overall on PTF. Therefore, we do not make any specific assumptions for the impact of this change in our modeling, with the estimated effect being similar with or without the waiver.

Uninsured

The number of uninsured individuals in Nevada will fluctuate for various reasons over time, but for purposes of this analysis material fluctuations can be expected due to the expiration of the PHE and the end of enhanced subsidies under ARP. Specifically, we assume a portion of those disenrolled from Medicaid due to the expiration of the PHE will become uninsured. Likewise, if enhanced subsidies are not extended beyond 2025, some people on the individual market may disenroll and become uninsured.

The number of uninsured individuals in Nevada becomes important in the modeling of PTF as the uninsured population is the exclusive pool from which we assume new individual enrollment will enter when BBSPs are offered and reinsurance is introduced under the Market Stabilization scenario.

E. PROJECTED 2026 NEVADA COVERAGE LANDSCAPE

The NMSP will begin in 2026; however, as described above, we anticipate changes in the Nevada coverage landscape between 2022 and 2026 due to the expiration of the PHE and the impending expiration of enhanced subsidies. To advance the enrollment and population estimates from 2022 to 2026 for purposes of establishing a baseline scenario for modeling PTF, the impacts from the PHE, ARP, and general population growth are shown in Table 10. These values are rounded to emphasize that they are estimates of enrollment based on a four-year projection with material known changes to the coverage landscape during the projection timeframe, as well as potential unknown changes. There is uncertainty related to these projections, but they represent reasonable expectations given current information and for purposes of this modeling.

Table 10
State of Nevada
NMSP Actuarial and Economic Analysis
Estimated Nevada Market Enrollment Shifts 2022-2026

	Individual	Uninsured PTC-Eligible*	Uninsured Non-PTC-Eligible**	Medicaid / CHIP***	Employer-Sponsored / Medicare / Other	Total
2022 Enrollment	114,500	61,000	237,000	788,000	2,068,500	3,269,000
PHE Ends	15,700	33,000	0	(191,000)	142,300	0
ARP Ends	(29,800)	18,600	11,200	0	0	0
Population Growth	1,000	3,200	12,600	41,800	109,700	168,300
2026 Enrollment	101,400	115,800	260,800	638,800	2,320,500	3,437,300

**Includes members who may not qualify for subsidies based on income and gross SLCS premium.*
***Includes members eligible for employer-sponsored insurance or Medicaid, or who do not qualify for the individual market due to immigration status.*
****Excludes dual-eligible members to avoid double-counting; these members are included in the Medicare enrollment.*

[20] 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

We note the following regarding Table 10:

- The projected enrollment changes were developed prior to the initial waiver application submitted in January 2024. We reviewed the aspects of the enrollment projection that are directly relevant to this analysis, specifically the projected changes in the individual market and the uninsured PTC-eligible population, and we believe they remain reasonable for purposes of the actuarial and economic analysis for the Nevada 1332 waiver.

- We estimate Medicaid disenrollment by looking at historical Medicaid data over the past several years to estimate the enrollment increase due to the PHE. We assume some of the enrollment growth during the PHE remains, but enrollment will revert closer to pre-PHE levels. Further, we assume that beneficiaries disenrolled from Medicaid who transition to the individual market will all be PTC-eligible.

- We assume beneficiaries disenrolled from Medicaid will enroll in employer-sponsored and individual coverage or become uninsured approximately in proportion to current market sizes (i.e., proportional allocation).

- We assume the expiration of enhanced 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 the enhanced subsidies, specifically that those with incomes over 400% FPL are eligible for subsidies, the ending of enhanced subsidies will make these enrollees ineligible for subsidies. Hence, a material portion of the uninsured population over 400% FPL move into the uninsured non-PTC-eligible segment.

- We estimate the total number of enrollees transitioning out of individual coverage due to the expiration of enhanced subsidies (29,800) by reviewing the change in historical enrollment from 2019 to the open enrollment of 2022 in the State of Nevada. The detailed assumptions used to develop these projected enrollment impacts are described in more detail in Section VI below.

- We assume population growth at 1.3% annually,[21] except that we adjust population growth in the individual market to reflect observed enrollment changes from 2022 to 2023.

- The percentage by which enrollment increases following the expiration of the PHE (and associated resumption of Medicaid redeterminations) and decreases due to the expiration of enhanced subsidies is assumed to vary based on income level. These assumptions result in varying enrollment impacts by both income level and age. See the Data and Methodology in Section VI for more detail.

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

III. DESCRIPTION OF SCENARIOS

Under current law as of this writing, enhanced subsidies are set to expire at the end of 2025. Therefore, the scenarios modeled in our analysis assume enhanced subsidies expire after 2025. We modeled a Baseline scenario to illustrate the projected enrollment, premiums, and federal costs without the NMSP. From there, we modeled a Market Stabilization scenario to illustrate the potential impact of the NMSP on enrollment, premiums, and PTF. We identify the incremental impact of the two primary sources of pass-through funding (PTF), specifically the BBSPs and reinsurance.

A. DESCRIPTION OF SCENARIOS

The Market Stabilization scenario assumes the NMSP will achieve the gross premium savings targets, namely at least 3% in the first program year (required) and growing to at least 15% by year 4, consistent with direction from the State of Nevada, SB420, and the State of Nevada's methodology outlined in Appendix C. This scenario also assumes at least one bronze BBSP will be available in each rating area. Also, BBSPs will be available to off-exchange enrollees at full-cost (unsubsidized).

PTF is the difference between the net federal spending (outlays minus revenues) that would have been generated without the waiver (the Baseline scenario) and the net federal spending after the waiver. To the extent the Section 1332 waiver reduces net federal outlays[22] for premium tax credits, these savings can be passed through to the State of Nevada (i.e., PTF) to be used for various purposes, such as reducing enrollee out-of-pocket premium costs (either subsidized or unsubsidized) or providing further incentives to either enroll in coverage (if uninsured) or stay enrolled (if currently enrolled). SB420 does require that the state's PTF first be used to fund administrative costs to operate the BBSPs before it is used to fund other initiatives.

Table 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 VI of this report.

Table 11
State of Nevada
NMSP Actuarial and Economic Analysis
Scenario Assumptions

	Baseline	Market Stabilization
Enrollment		
General population growth	X	X
ACA family glitch	X	X
Expiration of the PHE	X	X
Expiration of enhanced subsidies	X	X
BBSP appeal		X
BBSP bronze offering		X
Reinsurance		X
Premiums		
Standard QHP premium trend	X	X
Expiration of the PHE (morbidity)	X	X
Expiration of enhanced subsidies (morbidity)	X	X
Increased enrollment due to BBSP appeal (morbidity)		X
Premium reduction target (per DHCFP contracting authority)		X
Reinsurance		X
Subsidies		
Indexed FPL	X	X
Indexed ACA affordability limits	X	X
BBSP adoption rate		X
Premium relief program		X

[22] Net federal outlays means after deductions for any other increases federal spending or reductions in federal revenues. We assume these deductions to be immaterially small.

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

	Assumption	Brief Description
Enrollment	General population growth	Individual market enrollment after 2023 is assumed to grow at the statewide population growth rate, or 1.3%, at a minimum. This growth is assumed to apply uniformly (e.g., across income levels, age groups, metallic levels).
	ACA family glitch	We do not model any impact on enrollment due to changes in the ACA family glitch regulation. See Section II.D for additional information.
	Expiration of the PHE	We assume the Medicaid disenrollment process due to the expiration of the PHE is completed prior to the effective date of the NMSP in 2026, most likely during 2024. Individual market enrollment is assumed to increase due to the expiration of the PHE as Medicaid disenrollment occurs. The impact varies by income level to account for Medicaid eligibility categories.
	Expiration of enhanced subsidies	If enhanced subsidies expire after 2025, as currently scheduled, a portion of current SSHIX enrollees are assumed to disenroll from individual coverage at the beginning of 2026, driven by increases in net (post-subsidy) premiums. The projected enrollment changes due to the expiration of enhanced subsidies decreases enrollment in the individual market and increases the uninsured pool.
	BBSP appeal	Some uninsured Nevadans who are not subsidy-eligible (mainly near or above 400% FPL) are assumed to enroll in the ACA coverage, either on or off the exchange, due to the lower premiums available through the BBSPs and heightened awareness of the exchange due to NMSP marketing and communications.
	BBSP bronze offering	The BBSPs, by legislation, are only required to have silver and gold level offerings. However, issuers will be contractually required to also offer bronze BBSPs. See Section III.C for a detailed discussion.
	Reinsurance	We assume some uninsured Nevadans who are not subsidy-eligible will enroll in ACA coverage due to lower premiums available after the implementation of reinsurance. We assume a higher enrollment growth percentage due to reinsurance in Rating Areas 3 and 4 than in Rating Areas 1 and 2 because the higher premiums in Rating Areas 3 and 4 result in a larger premium decrease.
Premiums	Standard QHP premium trend	Gross premiums (before reinsurance) for standard QHPs and off-exchange offerings are modeled consistent with actual 2024 premium rates in the SSHIX by metal level. In 2025, gross premiums (before reinsurance) for standard QHPs and off-exchange offerings are assumed to increase 4%[23] per year for silver plans both with and without the waiver and 4.25% for bronze and gold plans. Premium growth for bronze and gold offerings is projected to converge to 4% by 2030. The 4% assumption is based on CMS projections of per capita national health expenditures and the impact of additional value-based purchasing initiatives that will be part of Nevada's broader efforts to move a larger share of Medicaid and BBSP payments to a value-based purchasing framework. The trend variation for bronze and gold plans is based on observations of recent experience. We expect premium trends for all metals to converge to maintain reasonable relativities based on differences in actuarial value.
	Individual market morbidity	Morbidity is the overall illness burden of a population, independent of the population's average age. Higher morbidity increases prices in a risk pool such as Nevada's Individual market, all else equal. End of PHE: We assume premiums for existing standard QHPs on the SSHIX decrease by 0.4% in 2023 due to improved morbidity from the additional enrollment transitioning from Medicaid after the expiration of the PHE. Expiration of enhanced subsidies: The exit of enrollees who leave the individual market due to the expiration of enhanced subsidies is assumed to increase morbidity by 2.5%. Increased enrollment due to BBSP appeal: Morbidity is projected to improve 0.2% in 2026 and 0.1% in 2027 relative to the baseline due to additional enrollment from the lower-priced BBSPs. No additional morbidity changes are assumed to happen beyond 2027.
	Premium reduction target	We assume the NMSP will achieve the premium reduction targets described in the agency's memorandum of guidance in Appendix C. We assume the annual BBSP premium reduction targets (before reinsurance) are 3.0% in 2026, 5.0% in 2027, 6.5% in 2028, and 8.0% in 2029.

[23] CMS. Download: NHE Projections - Tables (ZIP), Table 1, Line 42, Private Health Insurance Expenditures. National Health Expenditure Data: Projected. Retrieved November 19, 2023, from https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/projected

Table 12 State of Nevada NMSP Actuarial and Economic Analysis Scenario Assumption Descriptions		
	Assumption	**Brief Description**
	Reinsurance	We assume reinsurance will reflect the following parameters: ▪ Attachment point: $60,000 ▪ Cap: $1,000,000 ▪ Coinsurance: 28.5% Based on these reinsurance parameters, we estimate reinsurance will decrease premiums by approximately the following percentages: ▪ Rating Area 1: 7.2% ▪ Rating Area 2: 7.5% ▪ Rating Area 3: 6.2% ▪ Rating Area 4: 11.4%
Subsidies	Indexed FPL	The federal poverty level (FPL) is assumed to increase by 2.5% every year after 2023.[24]
	ACA affordability limits	The maximum amount of premium for which an ACA enrollee is responsible as a percentage of their income is indexed based on National Health Expenditure data and projections published by CMS. We analyzed the changes in these values year over year prior to enhanced subsidies becoming available in 2021. Based on the historical change, we projected income limits through the duration of the 10-year deficit neutrality window.
	BBSP adoption rate	Fully subsidized enrollees are assumed to enroll in a BBSP at a higher rate than lower or nonsubsidized enrollees.
	Premium relief program	The estimated cost of the premium relief program each year is shown in Table 1.

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 NMSP introduces additional potential for variability to the projected impact of the NMSP on enrollment and costs because it extends the duration of the projection and the opportunity for unforeseen events. We apply an additional 10% discount to the five-year waiver and 10-year deficit estimates to reflect cumulative conservatism across all assumptions. The potential variances include, but are not limited to, enrollment volume and distribution, plan selection, regulatory changes, utilization and cost trend, and member agency.

Except for the variances in premium trend noted in Table 12, all premium and subsidy assumptions in Table 12 are applied equally to all metals. SB420 does not include specific requirements for bronze and gold BBSPs; however, we assume premiums for BBSP bronze and gold plans will be lower than premiums for standard QHP bronze and gold plans, respectively, in proportion to the difference between BBSP silver plans and standard QHP silver plans.

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

B. ACA MARKET DYNAMICS

To inform waiver modeling assumptions, we reviewed historical open enrollment data for the Silver State Health Insurance Exchange (SSHIX) and other states. As shown in Table 13, the distribution of enrollment by metal level in Nevada has remained relatively consistent from 2020 to 2024.

[24] CMS. Download: NHE Projections - Tables (ZIP), Table 1, Line 30, Private Health Insurance Expenditures. National Health Expenditure Data: Projected. Retrieved November 19, 2023, https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/projected

Table 13 State of Nevada NMSP Actuarial and Economic Analysis Historical Nevada Individual Market Exchange Enrollment by Metal					
	2020	2021	2022	2023	2024
Catastrophic	1.0%	0.6%	0.4%	0.3%	0.3%
Bronze	40.0%	38.9%	37.5%	39.2%	36.8%
Silver	55.0%	56.7%	57.4%	55.5%	58.5%
Gold	4.0%	3.8%	4.7%	4.9%	4.5%

In addition, we reviewed the metal level changes on SSHIX between 2020 and 2021 and between 2021 and 2022 based on enrollment data provided by SSHIX, and approximately 6.5% of enrollees changed metal levels in each year. ***Because the historical enrollment distribution by metal level is materially consistent in each year and the percentage of members who switch metals is low, our modeling does not assume any plan switching across metal levels.***

The percentage of returning enrollees who actively enroll in Nevada has fluctuated but has generally remained between 30% and 40%, except in 2020. We show historical active enrollment percentages for returning enrollees in Nevada and other states in Table 14.

Table 14 State of Nevada NMSP Actuarial and Economic Analysis Historical Exchange Enrollment Data					
	2020	2021	2022	2023	2024
% of Re-enrollees who actively enroll					
Nevada	44.7%	33.9%	34.3%	39.0%	31.1%
Colorado	59.5%	45.1%	46.6%	63.2%	58.3%
All SBM	36.3%	28.0%	29.8%	28.2%	28.0%
All FFM	71.2%	73.0%	72.1%	72.3%	70.1%
FFM Only: % of Active re-enrollees who switch plans					
Total FFM			56.2%	57.7%	55.0%
Minimum			23.9%	30.7%	29.6%
Median			37.9%	45.9%	44.8%
Maximum			75.0%	75.7%	66.4%
FFM Only: % of Total enrollees who switch plans					
Total FFM			40.5%	41.7%	38.6%
Minimum			17.0%	18.4%	19.8%
Median			26.7%	31.5%	30.3%
Maximum			54.1%	61.7%	47.9%

Note: Plan switching data was not readily available for years prior to 2022.

We note the following additional observations in Table 14:

- States that use the federally facilitated marketplace[25] (FFM) have notably higher active enrollment percentages from 2020 through 2024 than states with state-based exchanges, such as Nevada and Colorado.

- Active enrollment in Colorado increased significantly in 2023, which was the first year of the Colorado Public Option.

Although some degree of plan switching has occurred historically and is likely to exist in the Baseline scenario, we do not model plan switching in the Baseline scenario (i.e., absent the waiver) because this plan switching would also occur in the Market Stabilization scenario. Therefore, the impact of this plan switching would be normalized and would not impact our projected impact of the waiver. *The incremental plan switching driven by the waiver is modeled in the analysis as the BBSP take-up rate.*

[25] 2024 Marketplace Open Enrollment Period Public Use Files | CMS; https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2024-marketplace-open-enrollment-period-public-use-files

C. DISCUSSION OF BBSP IMPACT ON SECOND LOWEST COST SILVER PLAN

Throughout this analysis, we assume BBSPs will become the SLCS plan in every rating area (and county) within the state of Nevada. In this section we explain why this is a reasonable assumption. However, we also note how the presence of BBSPs is likely to generate additional competition to put downward pressure on standard QHP rates. Note that our modeling does not assume any explicit impact of BBSPs on standard QHP premiums since PTF is not dependent on standard QHP pricing, and assuming no change to standard QHP premiums is a more conservative assumption when evaluating whether the waiver satisfies the affordability guardrail.

It is possible, particularly in the first year of the NMSP when the required premium target is only 3% below the reference premium, that standard QHPs could be aggressively priced to remain competitive with BBSPs. However, this pricing strategy becomes more challenging and less likely after the first year of the NMSP as the required rate reduction for BBSPs is further below the reference premium.

BBSP as SLCS

As noted, the most likely scenario is that a BBSP will become the SLCS upon implementation of the NMSP in 2026. This is primarily due to the robust procurement and contracting process that ties Medicaid procurement to the submission of a good faith bid to offer public option plans (BBSPs) on the SSHIX. The procurement and contracting process will use enforcement mechanisms available to the managed Medicaid program such as financial penalties, corrective action plans, and others, including an actuarial review of underlying assumptions used to develop BBSP plan premiums. This review would include an examination of administrative cost loads built into BBSP and standard QHP premiums, as well as evidence that provider reimbursement rates underlying BBSPs are sufficient to support the required statutory premium targets while producing actuarially sound rates. Moreover, the State's managed Medicaid program will be statewide starting in 2026 with at least two MCOs in each rating area, ensuring that at least two Medicaid MCOs will have established provider networks in every area of the state. Therefore, we expect at least two BBSPs will also be available in every area of the state.

Standard QHP s as SLCS

Although BBSPs will be offered by MCOs or QHPs that may already offer standard QHPs, the BBSP offerings starting in 2026 can be considered as a new competitor. Indeed, increased competition in the market is one of the stated objectives of Nevada SB420 and an acknowledged policy impact of public options generally.[26] Market research also provides empirical evidence that increased individual market competition is associated with lower premium rates and lower annual rate increases.[27, 28, 29, 30, 31] Thus, in the event a BBSP does not become the SLCS, it is reasonable to assume that the NMSP did, in fact, generate downward premium pressure on the plan or plans that becomes the SLCS, even though it is not a BBSP. This assumption is consistent with assumptions cited in approved 1332 public option waivers in other states.[32]

Although the evidence that the change in the SLCS is attributable to the waiver is less direct under this scenario, the State intends to obtain data and other information from the state's issuers, which will be defined through the procurement and contracting process, and from other states to analyze and estimate market trends absent the NMSP and develop a range of potential impacts of the NMSP on standard QHP premiums for purposes of determining PTF in these situations. The State is coordinating with the Division of Insurance to implement requirements for BBSP issuers to submit both BBSP and standard QHP rates accompanied by explanations of how BBSPs impacted standard QHP pricing. For issuers who only offer standard QHPs, we will compare pricing factors to both BBSP and standard QHP offerings from other issuers to assess whether the price drivers are similar to BBSP price drivers. The State will collaborate with other stakeholders and other states with similar experience to develop specific data requests and templates for this purpose.

The Market Stabilization scenario does not model any changes to standard QHP premiums in response to the BBSPs entering the market. The waiver analysis reflects the more direct and likely possibility that a BBSP becomes the SLCS, which produces equivalent outcomes.

BBSP impact on PTF

The State plans to estimate the impact of the BBSP program for purposes of determining PTF through a multi-pronged approach.

[26] https://www.americanprogress.org/article/4-myths-public-option/
[27] https://www.nber.org/papers/w20140
[28] https://www.ajmc.com/view/aca-marketplace-premiums-and-competition-among-hospitals-and-physician-practices
[29] https://pubmed.ncbi.nlm.nih.gov/26643622/
[30] https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2015.0738?journalCode=hlthaff
[31] https://ideonapi.com/resources/blog/increased-competition-individual-aca-market/
[32] Colorado 1332 Waiver Amendment Submission 11-30 Final2 (2).pdf, page 58; https://drive.google.com/file/d/1SUy-iNz3i7IlRTPTqy2OJgNYH1oyN5mX/view

First, the State plans to conduct a Nevada-specific comparative analysis using historical data where the State will monitor the overall market trends before and after the implementation of the NMSP. The State anticipates this analysis will show lower rate increases, all else equal, starting in 2026. Next, the State will conduct a national comparative analysis where annual premium trends in Nevada will be compared against premium trends in other states, adjusting for various factors as appropriate.

Next, Nevada will assess the rate filing information submitted by issuers in Nevada's individual marketplace, paying special attention to network factors and expense loads. We anticipate the network factor for BBSPs will be different than the network factor for standard QHPs, and BBSPs should have lower expense loads than standard QHPs. If an issuer does not offer standard QHP plans, or if an issuer that does offer standard QHPs in the early years does not offer them in the future, no comparison of direct pricing information in the rate filings can be made, and the impact of BBSPs will need to be determined indirectly.
Lastly, the State anticipates collecting industry medical and prescription drug pricing trend information in order to inform the establishment of the reference premium as required by SB420. Collectively, the analyses outlined above will be used by Nevada to estimate what rates would have been absent the waiver to isolate the impact of BBSPs.

D. DISCUSSION OF BBSP TAKE-UP RATE ASSUMPTIONS

Impact of a bronze BBSP offering

Based on the discussion above, a BBSP is assumed to become the SLCS plan across all rating areas in Nevada in all of the NMSP's first four years of operation and throughout the five-year waiver and 10-year deficit neutrality windows. The two driving factors in the calculation of premium tax credit (PTC) savings in this analysis are (1) the percentage by which a BBSP, as the SLCS, is below what would otherwise be the SLCS plan in the Baseline scenario, and (2) the total enrollment of PTC-eligible individuals. However, there is an additional factor that impacts the PTF, which is whether BBSPs are available to consumers at the bronze plan level.

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

Under a waiver scenario where a BBSP becomes the SLCS plan, many existing silver plan consumers under a Baseline scenario may switch to the benchmark plan or something close in price to that plan. Likewise, many bronze purchasers under the Baseline scenario will be expected to purchase a bronze-level BBSP under the Market Stabilization scenario. If the NMSP would not include bronze BBSP offerings, we would expect some amount of previous bronze purchasers to take coverage under a silver BBSP, thereby using up the entire available subsidy. However, our modeling does assume the NMSP will include bronze BBSPs.

One key downstream implication of including bronze BBSPs for this waiver analysis is that the take-up assumption in the BBSPs does impact the overall PTF calculation. A higher assumed take-up rate in the BBSPs increases PTF, as it is assumed more bronze purchasers will also take up BBSP coverage and use only a portion (as opposed to all) of their available subsidy.[33] Said differently, if the BBSPs only offered silver and gold plans, take-up in the BBSPs would have no impact at all on PTF. The actual take-up of the BBSPs will only be impactful on PTF if we assume bronze-level BBSPs are offered.

Overall BBSP take-up rate

In our analysis, we assume a price advantage for BBSPs due to the requirements of SB420 and the State's enforcement mechanisms through the procurement and contracting process. This price advantage implies some consumers will see additional value in the BBSPs and will take up BBSP coverage. It is difficult to predict consumer behavior in the presence of the BBSPs' price advantage, and this difficulty stems from several factors:

[33] Since bronze gross premiums are generally lower than silver and gold plan premiums, subsidies for bronze plans are likewise generally less than subsidies for silver and gold plans. Therefore, if issuers offer a bronze BBSP, we assume a portion of current bronze individual market enrollees and new individual market enrollees will select the bronze BBSP instead of a silver or gold BBSP, thereby reducing subsidies under the waiver and increasing PTF.

- Although price is an important factor, consumers do not always choose a plan based on price.[34]
- Provider networks will be required to align with Medicaid's broad provider networks to a certain extent; however, other product features of BBSPs offered by the various individual exchange insurers are not known at this time.

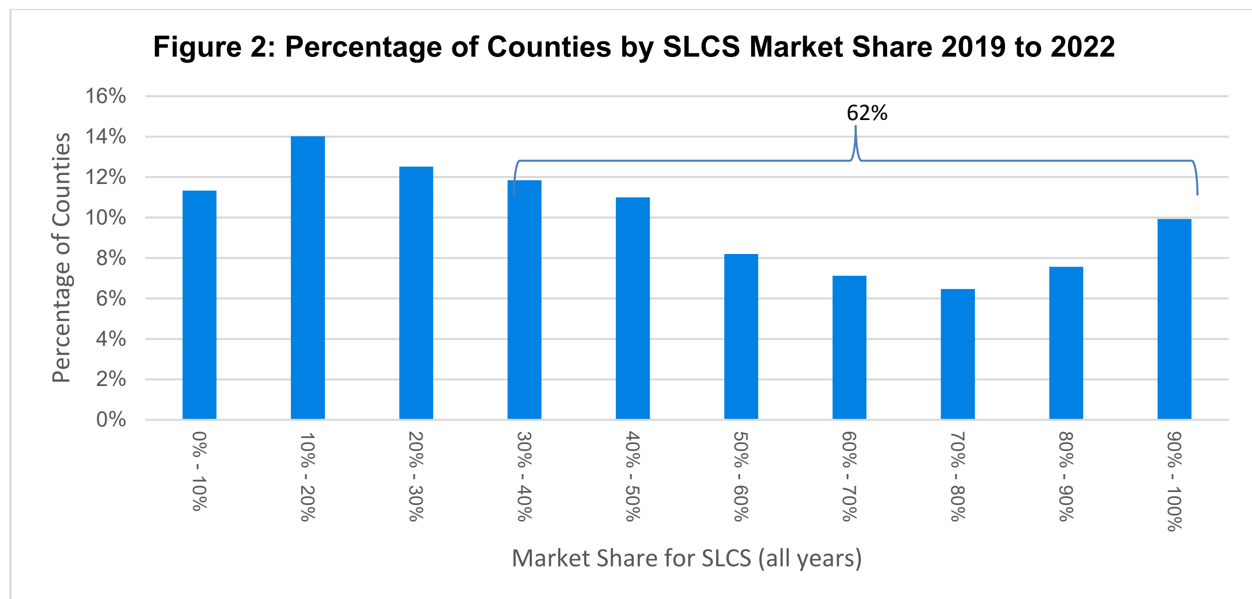
To encourage more active consumer selection, the State of Nevada will undertake several initiatives which are described below. Notwithstanding these initiatives, we assume some material share of the market will voluntarily enroll in standard QHP coverage for various reasons. We use several analyses to support the estimated take-up rate of BBSPs using publicly available data from marketplaces, both state-based and those utilizing the federal platform, HealthCare.gov.

Share of market for SLCS issuer

Since we assume it is highly likely that a BBSP will become the SLCS in all rating areas,[35] historical SLCS market share is a potential indicator of BBSP take-up in the absence of the state initiatives to encourage BBSP enrollment noted above. In other words, these estimates would be a minimum bound for BBSP take-up estimates.

We analyzed public enrollment data for states utilizing HealthCare.gov to determine the market share typically commanded by the SLCS. For the four years from 2019 through 2022, between 30 and 40 percent of enrollees in states utilizing HealthCare.gov who reside in a county with more than two issuers were enrolled in the SLCS plan. The median enrollment in the SLCS by county in counties with at least two issuers was slightly higher, ranging between 35% and 50% over the same four years. Key drivers of the SLCS plan's market share include the number of issuers in the county and the difference between the SLCS premium and the next higher premium.

Figure 2 shows the distribution of county-years (1 county in a year) that have an SLCS issuer that has the market share shown on the X axis. For example, the second bar from the left illustrates that approximately 14% of counties across the five years of 2019-2022 had an SLCS that garnered between 10% and 20% of the total market (all metals). Based on this historical data, there is roughly a 62% chance that the SLCS issuer will garner more than 30% of the market. Again, note that these market shares do not include the impact of any specific initiative to raise awareness of the benefit of active enrollment and shopping for a more affordable plan, such as those the State plans to undertake.



[34] Consumer inertia is discussed in more detail here: https://www.thecgo.org/research/sources-of-consumer-inertia-in-the-individual-health-insurance-market/

[35] See Section III.C for additional explanation.

Auto-enrollment and plan switching

The historical percentage of enrollees who auto-enroll in their health plans is also a potential indicator of BBSP take-up since it is a measure of enrollee engagement in plan selection. As shown in Table 14 in Section III.B of this report, we examined historical open enrollment data to estimate the percentage of enrollees who are active shoppers for health coverage (i.e., not enrolled in their current plan by default) and the percentage of those active shoppers who change plans. The auto-enrollment rate on SBMs averaged more than 70%, implying relatively few active shoppers, while the auto-enrollment in states utilizing the federally facilitated marketplace (FFM) HealthCare.gov averaged less than 30%, implying a much greater rate of active purchasing. Nevada had an auto-enrollment rate of more than 60% each year from 2021 to 2024, so fewer than 40% of enrollees in Nevada made an active choice to either remain in the current plan or switch plans. The median percentage of active enrollees who switch plans in FFM states is approximately 45%. We reviewed historical SSHIX data in Rating Area 1 in Nevada from 2020 through 2022, and approximately 14% of enrollees switched plans each year.

State initiatives

To close the gap between Nevada's historical active enrollment experience and the higher level of engagement for states that use the FFM, Nevada intends to implement a variety of state outreach and enrollment initiatives. The strategies the State will implement to achieve these goals are described below.

- **Issuer marketing and outreach requirements:** The State will require issuers under their BBSP contracts to widely market and promote the new BBSPs to Nevada consumers during open enrollment. For instance, the State is exploring including contractual requirements for issuers to develop their own marketing and outreach campaign meeting certain parameters, to be approved by the State prior to open enrollment. This will include mailers and other communications notifying consumers of the availability of BBSPs and of potential savings by actively shopping rather than remaining in their current plan. Issuers could highlight BBSPs as a way to mitigate any premium increases felt by many consumers due to the expiration of enhanced IRA subsidies.

- **Integrating active shopping promotion into the broader SSHIX marketing campaign:** Promotion of active plan selection will be woven into SSHIX's fall marketing campaign. For instance, SSHIX can include static messaging on the Nevada Health Link website to urge consumers to review the health coverage options available to them on the Nevada Health Link prior to its standard auto-enrollment procedures to remind consumers that premiums may be lower in other plans if they shop online. The State is also exploring including language in the dynamic enrollment and eligibility notices consumers receive from SSHIX immediately prior to open enrollment.

- **Default sorting and plan display:** The Nevada Health Link's default sort option lists plans from lowest to highest premium. Since BBSPs' premiums will be priced lower than other plan options, maintaining that sorting function should ensure that BBSPs will be among the first search results consumers see, thus increasing the visibility of BBSPs and the likelihood consumers enroll in a BBSP.

- **Differentiating BBSPs:** The State plans to create a BBSP logo or some similar differentiating moniker for use on its website and plan preview tool and its application plan selection pages. SSHIX can require plan names to incorporate the BBSP name. SSHIX and issuers can market BBSPs as 'quality assured products' brought to consumers by the State.

These marketing and outreach strategies, when combined with the tendency for consumers to enroll in plans based on price, support that Nevada can achieve active enrollment rates more consistent with FFM states. [36]

Final take-up rate assumption

Taken together and absent the intended state initiatives, both the market share analysis and the auto-enrollment / plan switching analysis suggest a BBSP take-up rate of 30% to 40% would be reasonable under normal conditions. However, we use a higher estimate than these analyses suggest on average for the following reasons:

- There will be more publicity around the BBSP offerings relative to simply being the SLCS in any given year.

- The State will require issuers under their BBSP contracts to widely market and promote the BBSPs during open enrollment.

[36] See: Holahan, Wengle, and O'Brien. How Do People Make Choices among Marketplace Plans? Available at: https://www.urban.org/sites/default/files/2023-09/How%20Do%20People%20Make%20Choices%20among%20Marketplace%20Plans.pdf

- Active plan selection will be woven into the SSHIX Fall open enrollment campaign.
- For the same reasons that a BBSP is likely to be the SLCS, a BBSP will likely also have the lowest cost silver (LCS) status.
- Within the Nevada Health Link application, the default sort option lists plans by net premium from lowest to highest. Since BBSPs are expected to have lower premiums than other plan options, this sorting function will ensure BBSPs are among the first plans visible to consumers on the platform.
- The BBSPs will be offered by well-established issuers in the market who are also Medicaid MCOs. They will not be a "new entrant" to the market from a consumer perspective.
- Active enrollment in Colorado increased by almost 35% in the first year of the Colorado public option, from 47% in 2022 to 63% in 2023.
- BBSPs will have certain notation or a logo in the Nevada Health Link plan selection page that further draws attention to them.

Therefore, under the Market Stabilization scenario, we assume a take-up for enrollees on-exchange of 80% in all years of the NMSP.

Reinsurance

Reinsurance has the same proportionate impact on premiums for both BBSPs and standard QHPs. We assume the premium reductions driven by reinsurance will not have a significant impact on enrollment in the individual market. This is primarily due to the subsidized nature of the individual market. Most enrollees get subsidies and pay no more (or no less) than a fixed percentage of their income and are largely insulated from gross price changes, whether increases or decreases. As gross premiums decline due to reinsurance, many of the uninsured who are eligible for subsidies will see no difference in the net price available to them and will have no additional incentive to purchase coverage. Waivers in other states have not shown large increases in enrollment attributable to the implementation of reinsurance.

However, unsubsidized individuals will receive the full benefit of the price reduction under a reinsurance program. Hence, to the extent premium reductions due to reinsurance may provide additional incentives for some uninsured individuals to enroll in the individual market, we assume enrollment in BBSPs will also increase slightly due to the implementation of reinsurance.

Small employer migration

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

Using publicly available premium rate data for the small group and individual markets, we compared premium rates in 2022 and trended them forward to 2024 using average rate increases that were approved by the Nevada Department of Insurance for benefit years 2023 and 2024. This analysis shows that small group rates are currently lower than individual market rates by 4% to 26% depending on rating area and metal level, and approximately 16% lower on average.[37] We include details on the variance among small group premiums relative to individual in Section VI.

Under a waiver scenario, individual market gross premiums are projected to decrease by approximately 11% to 15% relative to the Baseline starting in Year 2 of the NMSP. This analysis of the current premiums in both the small group and individual markets in Nevada indicates that, with the reduction in individual prices stemming from the NMSP, available premium rates in the individual market will reach some degree of parity with small group premium rates. This implies that, based on price alone, some incremental number of employers could consider offering an ICHRA benefit to some or all of their employees as average prices in these markets converge.[38] However, employers are not inclined to shop purely on the lowest price and will likely also consider their benefit offerings relative to other employers to attract the best talent. Employers still retain some degree of paternalism, as well, wanting to provide their employees with optimal benefit package whenever possible.

[37] This average is not a weighted average but the representative amount that small group silver plans in rating areas 1 and 2 are below individual market. This represents the large majority of the state's enrollment and was deemed a reasonably proxy. Further, Gold plan rate relationships were similar to silver.

[38] Please see Methodology section for further discussion and development of the small group and individual rate relationships.

However, under an ICHRA, an employee waives the federal subsidies they might otherwise have received. Thus, under the Market Stabilization scenario (waiver scenario), we expect that the largest part of any incremental membership growth coming from small group to the individual market in response to an ICHRA offering will be unsubsidized. Consequently, there would be no increase to federal subsidies for these individuals.

There is a limited circumstance under which ICHRAs (or the offer of an ICHRA) might increase federal subsidies in the waiver scenario. If an employee received an ICHRA benefit that is deemed unaffordable, that individual can refuse the ICHRA benefit and claim any subsidy for which they might be eligible. However, an offering of an unaffordable ICHRA does not make sense relative to simply not offering coverage in any form, traditional or ICHRA. Therefore, this circumstance is very unlikely, and its only effect might be to increase an employee's awareness of their subsidy eligibility.

For these reasons, when evaluating the waiver against the deficit neutrality guardrail, we make no assumption of any enrollment increases under a waiver scenario relative to ICHRA offerings in the small group market. Further, we do not assume any small employers will stop offering coverage altogether for similar reasons (e.g., being able to attract and retain talent). This assumption might somewhat understate federal subsidies in the waiver scenario, thereby increasing the estimate of PTF. This would be offset, however, by possible individual market morbidity improvements in the waiver scenario from any incremental membership migration. All told, we consider the net effect of this dynamic to be a very small impact on the calculation of PTF and of little consequence to our overall evaluation of compliance with the deficit neutrality guardrail. Moreover, any upward bias in our calculation of estimated PTF that might occur due to small employer migration would fall well within the 10% margin we apply to the total PTF calculation.

IV. ACTUARIAL ANALYSIS

This section demonstrates how Nevada's Section 1332 waiver application meets the federal requirements for the affordability, scope of coverage, and comprehensiveness guardrails under the modeled scenarios.

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

A. AFFORDABILITY OF PREMIUMS AND COST-SHARING

Changes in gross premiums under the waiver

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.[39] 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."

Table 16 shows the average gross premium under both the Baseline and Market Stabilization scenarios for both on and off-exchange enrollees. The average gross premiums under the Market Stabilization scenario reflect the projected BBSP take-up rate.

Table 16
State of Nevada
Nevada Market Stabilization Actuarial and Economic Analysis
Projected Average Gross Premium Change From Baseline

Year	Baseline Scenario	Market Stabilization Scenario	Average Gross Premium Change Due to Waiver
2026	$593.38	$577.21	-2.7%
2027	$617.51	$547.60	-11.3%
2028	$641.90	$561.11	-12.6%
2029	$667.95	$575.80	-13.8%
2030	$695.02	$597.01	-14.1%
2031	$722.61	$619.01	-14.3%
2032	$751.41	$641.81	-14.6%
2033	$781.38	$664.97	-14.9%
2034	$812.76	$690.18	-15.1%
2035	$845.52	$714.63	-15.5%

Exhibits 1.1 through 1.5, included in the Exhibits section at the end of the report, show the projected average gross premium change each year by income, metal, age band, subsidized status, and Rating Area for individual market enrollees. **These exhibits show that the decrease in gross premiums under the waiver is generally greater for the following vulnerable populations in Nevada:**

- Lower-income individuals, who are disproportionately Hispanic, African American, American Indian, and Asian-Pacific Islander based on data regarding Nevada's earning disparities,[40]
- Older individuals, including individuals 65 and older,
- Residents who live in rural and frontier / remote areas of the State (outside of the Clark and Washoe Counties).

[39] See https://www.gpo.gov/fdsys/pkg/FR-2015-12-16/pdf/2015-31563.pdf for more information.
[40] Earnings Disparities by Race and Ethnicity, U.S. Department of Labor (dol.gov); https://www.dol.gov/agencies/ofccp/about/data/earnings/race-and-ethnicity; Retrieved July 19, 2024

The Market Stabilization scenario ten-year SLCS premium projections and the changes versus the Baseline scenario are shown in Exhibit 2. Exhibits 2.1 through 2.4 show the ten-year SLCS premium projections under the Baseline and waiver scenarios in each of Nevada's four rating areas. The projected SLCS decrease versus the Baseline scenario in 2029 is more than 15% in Rating Areas 1, 2, and 4 but slightly less than 15% in Rating Area 3 due to the varying impact of reinsurance. Therefore, Exhibits 2.1 through 2.4 also demonstrate that the gross premium reduction target required by SB420, which is that "the average premiums for the PO must be at least 15 percent lower than the average reference premium" in Nevada, can be achieved even if this target is not achieved in each Rating Area.

The SLCS premiums shown in all versions of Exhibit 2 are based on a non-smoker for the given age.

Cost-sharing is not expected to be different under the waiver, for either BBSPs or standard qualified health plans (QHPs), than it is without the waiver. Since cost-sharing is based on an actuarial value (i.e., a percentage of plan costs) which is tied to the metal level, aggregate out-of-pocket costs for enrollees will generally decrease if they enroll in a plan with the same or higher metal level. As discussed in Section II.B, our modeling assumes all individuals enroll in a plan of the same metal level.

Therefore, non-premium cost-sharing is projected to be at least as affordable under the waiver as it is without the waiver.

Changes in net premiums under the waiver

Table 17 shows the average enrollee net premium under both the Baseline and Market Stabilization scenarios for both on and off-exchange enrollees. The average enrollee net premium decreases versus the Baseline in all years of the waiver period and the deficit neutrality window.

Table 17
State of Nevada
NMSP Actuarial and Economic Analysis
Projected Average Net Premium Change From Baseline

	No Waiver	Market Stabilization Scenario				
Year	Baseline	BBSP Policy Only	BBSP with Reinsurance	BBSP with Reinsurance and Premium Relief	Average Net Premium Change Due to Waiver Before Premium Relief	Average Net Premium Change Due to Waiver After Premium Relief
2026	$276.03	$275.16	$275.16	$274.75	-0.3%	-0.5%
2027	$286.48	$285.19	$273.24	$271.64	-4.6%	-5.2%
2028	$297.19	$295.26	$282.43	$280.86	-5.0%	-5.5%
2029	$308.26	$305.57	$292.15	$289.82	-5.2%	-6.0%
2030	$319.65	$316.52	$302.16	$300.63	-5.5%	-5.9%
2031	$331.18	$328.13	$312.53	$311.02	-5.6%	-6.1%
2032	$343.17	$340.28	$323.50	$322.01	-5.7%	-6.2%
2033	$355.93	$352.27	$334.35	$332.88	-6.1%	-6.5%
2034	$368.89	$365.32	$346.44	$344.25	-6.1%	-6.7%
2035	$382.38	$378.62	$357.82	$355.67	-6.4%	-7.0%

Exhibits 3.1 through 3.5 show the projected average net premium change (before the impact of the premium relief described below) each year by income, metal, age band, subsidized status, and Rating Area for individual market enrollees.

Because of the success of the BBSP and Reinsurance programs at lowering gross premiums, Exhibits 3.1 through 3.5, show that net premiums for some enrollees are projected to be higher under the waiver than they would have been in the Baseline scenario. While some of the projected net premium increases reflected in these exhibits can be mitigated by plan selection (i.e., higher BBSP take-up), the enrollee net premium for about 24% of consumers will increase regardless of whether they switch to a BBSP plan or not. More than 97% of these consumers are enrolled in bronze plans, and more than 75% have incomes between 200% and 400% FPL. Fewer than 2% of these consumers are over age 65. The net premiums for these consumers under the waiver in 2026 are higher than without the waiver by less than $2, on average. The net premiums for approximately 2% of these consumers will be more than $5 higher under the waiver; however, almost all consumers with increases of more than $5 are in Rating Area 3 where gross premiums are highest, and the others are in Rating Area 4.

In response to stakeholder feedback, the State of Nevada will provide premium relief to consumers whose net premium is higher under the NMSP than it would have been without the NMSP due to PTC reductions driven by the NMSP premium reduction requirements, and who cannot avoid this net premium increase by switching to a lower-priced plan within the same metal level. This premium relief will be available to consumers enrolled in the SSHIX as of December 2025 and who reenroll in 2026 coverage. The amount of premium relief available to consumers will not reflect changes in net premium due to age, household size, household income as a percentage of FPL, ACA affordability limits, or metal selection.

Other specific details of the premium relief program are not yet determined as of the date of this report. The impact of the program on average net premiums shown in Table 17 is based on preliminary estimates. The actual impact of the premium relief program may change once program details are defined, particularly at the individual level; however, we do not anticipate the impact of the final program design on aggregate average premiums to be materially different than the estimates shown in Table 17.

B. COMPARABLE NUMBER OF STATE RESIDENTS COVERED

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

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

The Market Stabilization scenario enrollment projections compared to the Baseline scenario are shown on the following exhibits:

- Exhibit 4.1: Ten-year projected enrollment by income level
- Exhibit 4.2: Ten-year projected enrollment by metallic coverage level
- Exhibit 4.3: Ten-year projected enrollment by age group
- Exhibit 4.4: Ten-year projected enrollment by subsidy eligibility
- Exhibit 4.5: Ten-year projected enrollment by rating area

Exhibit 4.1 demonstrates the waiver provides coverage to at least as many residents as without the waiver, as required by the guardrail. Exhibit 4.5 demonstrates the impact on enrollment by Rating Area, which is greater in underserved rural areas on a percentage basis. We project enrollment in Rating Areas 3 and 4 to increase by more than 3% and 5%, respectively, by 2027 due to the waiver, whereas we project enrollment in Rating Areas 1 and 2 to increase by approximately 1.5% and 2%, respectively.

C. COMPARABLE COVERAGE

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

V. ECONOMIC ANALYSIS

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

a. **Income, payroll, and excise taxes:** The excise tax to fund the Patient-Centered Outcomes Research Initiative (PCORI) for plan years that end on or after October 1, 2023 and before October 1, 2024 is $3.22 per enrolled member per year. Given that the enrollment increase in the individual market expected from the proposed waiver is between approximately 600 and 2,100 for all 10 years of the deficit neutrality window, we do not expect the increase in federal revenue to be more than $10,000 in a year, even with inflation. Relative to the premium tax credit (PTC) reductions, which are in the hundreds of millions, the PCORI fee change is immaterial to the economic analysis and was not modeled explicitly.

b. **User fees:** Nevada's exchange has been a state-based exchange since 2020 and does not utilize the federal platform.[41]

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)[42] and then applying an adjustment to account for the tax reconciliation process. This adjustment is 10%.[43]

d. **Changes in CSRs and Medicaid spending:** Cost-sharing reductions (CSRs) are not a federal obligation and, therefore, are not modeled. It is assumed that the NMSP does not impact Medicaid spending in the Market Stabilization scenario relative to the Baseline scenario.

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

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

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

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

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

At a high level, changes in PTCs related to SB420 and the implementation of the NMSP will be driven by overall enrollment of PTC-eligible individuals and families, the percentage savings the BBSPs will drive relative to standard QHPs as they become the SLCS plan in each of the rating areas in Nevada, and the decrease in all individual market premiums due to reinsurance. In addition, as noted in Section III.C of this report, the effect on PTF will be influenced by the actual enrollment in bronze BBSPs. Therefore, we illustrate the development of PTC savings and PTF for each scenario by using a series of four exhibits:

- Projected enrollment of PTC-eligible enrollees in the individual market. In the Market Stabilization scenario, we also show the change in enrollment from the Baseline scenario.
- Projected gross premiums, split by BBSP and standard QHP enrollment, and then a composite market-wide premium based on the assumed take-up of BBSPs.

[41] 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.

[42] 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.

[43] 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. Please note, the net premiums shown in the economic analysis do not include the impact of premium relief since the premium relief program does not directly impact, nor is it directly impacted by, PTF.

- Calculation of total APTCs and final estimated PTCs after tax reconciliation. Per member per month (PMPM) values are multiplied by membership values for each year to obtain the 10-year deficit neutrality window totals.

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

A. PROJECTED CHANGES IN PTCS

The Baseline and Market Stabilization scenarios assume enhanced subsidies provided by ARP expire at the end of 2025.

Baseline Scenario

Enrollment

Table 18 shows the 10-year enrollment projection under the Baseline scenario for enrollees both on- and off-exchange. The enrollment projection for enrollees on-exchange is further split between members with and without PTC.

Table 18
State of Nevada
NMSP Actuarial and Economic Analysis Baseline Scenario
Individual Market Enrollment by Segment

	On-Exchange			Off-Exchange	
Year	(1) PTC-Eligible	(2) Non-PTC-Eligible	(3) Total	(4) Total	(5) Total Individual Market
2026	76,400	8,800	85,200	16,200	101,400
2027	77,600	8,700	86,300	16,400	102,700
2028	78,700	8,800	87,500	16,700	104,200
2029	79,800	8,800	88,600	16,900	105,500
2030	80,800	8,900	89,700	17,100	106,800
2031	81,900	9,000	90,900	17,300	108,200
2032	83,000	9,100	92,100	17,500	109,600
2033	84,100	9,200	93,300	17,800	111,100
2034	85,200	9,300	94,500	18,000	112,500
2035	86,300	9,400	95,700	18,200	113,900
Average Annual Change	1.36%	0.74%	1.30%	1.30%	1.30%

- The 2026 Total Individual Market enrollment shown in column (5) for the beginning of the 10-year deficit neutrality window is consistent with Table 10, which illustrates the development of the 2026 number from 2022.

- Column (1) values increase due to population growth and for a small amount of movement from column (2).

- The non-PTC-eligible enrollment in column (2) increases, albeit at a slower rate than other segments. This is because federal poverty levels and the income affordability limits are indexed such that they increase slower than overall individual market premium growth; therefore, more people become eligible for at least some federal subsidy amounts and move to column (1). The income affordability limits are assumed to index at about 0.05% of income per year.

- Column (4) includes the individual market catastrophic plan enrollment.

- Columns (3), (4), and (5) values beyond 2026 increase at the annual population growth estimate of 1.3%.

Premiums

The following assumptions apply to projected gross premiums under the Baseline scenario:

- Gross premiums for silver plans on the individual market are projected with a 4% annual increase.
- Gross premiums for bronze and gold plans are projected with a 4.25% increase for 2025, decreasing by 5 basis points each year for 5 years.
- Beginning in 2030, gross premiums for all plans on the individual market are projected with a 4% annual increase. See Section VI below for a detailed description of the development of this factor.

Table 19 shows the statewide 10-year gross premium projection under the Baseline scenario. The PMPMs are averages based on the current mix of plan selections which is based on FPL, age, and metal level. We assume all enrollees remain in their current plan. There is no BBSP offering in the Baseline scenario, so BBSP enrollment and gross premiums are shown as zero to keep the format of exhibits consistent across the Baseline and Market Stabilization scenarios.

Table 19
State of Nevada
NMSP Actuarial and Economic Analysis
Baseline Scenario
Summary of Enrollment and Gross Premium by BBSP and Standard QHP Segments – All Rating Areas

	BBSP				Standard QHP			Total		
			Gross Premium			Gross Premium			Gross Premium	
Year	BBSP Take-Up %	Enrollment	Aggregate (thousands)	PMPM	Enrollment	Aggregate (thousands)	PMPM	Enrollment	Aggregate (thousands)	PMPM
2026	0%	0	0	0	101,400	$722,000	$593	101,400	$722,000	$593
2027	0%	0	0	0	102,700	$761,000	$618	102,700	$761,000	$618
2028	0%	0	0	0	104,200	$803,000	$642	104,200	$803,000	$642
2029	0%	0	0	0	105,500	$846,000	$668	105,500	$846,000	$668
2030	0%	0	0	0	106,800	$891,000	$695	106,800	$891,000	$695
2031	0%	0	0	0	108,200	$938,000	$723	108,200	$938,000	$723
2032	0%	0	0	0	109,600	$988,000	$751	109,600	$988,000	$751
2033	0%	0	0	0	111,100	$1,042,000	$781	111,100	$1,042,000	$781
2034	0%	0	0	0	112,500	$1,097,000	$813	112,500	$1,097,000	$813
2035	0%	0	0	0	113,900	$1,156,000	$846	113,900	$1,156,000	$846

The same statewide 10-year gross premium projection under the Baseline scenario for each of Nevada's four rating areas is shown in Exhibits 5.1 through 5.4. As these exhibits illustrate, the average gross premiums in the more rural regions, Rating Areas 3 and 4, are significantly higher than in the more urban regions, Rating Areas 1 and 2. The average premiums in Rating Area 3, which has the highest premiums, are nearly 60% higher than the average premiums in Rating Area 1, which has the lowest premiums.

Subsidies

The following assumptions apply to projected subsidies under the Baseline scenario:

- *FPL increases:* The 100% federal poverty level (FPL), used to calculate a PTC-eligible person's subsidy, is increased by 2.5% annually after 2023.[44]
- *Income affordability limits*: These limits are indexed over time. We based our indexing on a conservative estimate of past indexing (i.e., generating less PTF) 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.

[44] 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 20 State of Nevada NMSP Actuarial and Economic Analysis Baseline Scenario Average Aggregate Premiums and Member Subsidies Per Member Per Month (PMPM)						
	On-Exchange					
	PTC-Eligible			Non-PTC-Eligible	Off-Exchange	Total Individual Market
Year	(1) Average Aggregate Gross Premium	(2) Average Aggregate APTC	(3) Average Aggregate Enrollee Net Premium	(4) Average Aggregate Enrollee Gross Premium	(5) Average Aggregate Enrollee Gross Premium	(6) Average Aggregate Gross Premium
2026	$615	$421	$194	$568	$504	$593
2027	$639	$438	$201	$598	$524	$618
2028	$665	$456	$208	$620	$545	$642
2029	$691	$476	$216	$649	$567	$668
2030	$719	$496	$223	$676	$590	$695
2031	$748	$517	$231	$703	$614	$723
2032	$778	$539	$238	$731	$638	$751
2033	$808	$562	$246	$762	$664	$781
2034	$841	$586	$255	$793	$690	$813
2035	$875	$611	$263	$826	$718	$846

Note: Total Individual Market Gross Premiums in column (6) are consistent with Table 19 above. Column (5) 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 21 below illustrates the year-over-year changes in each of the PMPM values in Table 20.

We note the following regarding Table 20:

- Average aggregate gross premiums, APTCs, and enrollee net premiums are based on the current mix of plan selections which is based on FPL, age, and metal level. We assume all enrollees remain in their current plan.

Table 21 State of Nevada NMSP Actuarial and Economic Analysis Baseline Scenario Annual Change in Average Aggregate Premiums and Member Subsidies PMPM						
	On-Exchange					
	PTC-Eligible			Non-PTC-Eligible	Off-Exchange	Total Individual Market
Year	(1) Average Aggregate Gross Premium	(2) Average Aggregate APTC	(3) Average Aggregate Enrollee Net Premium	(4) Average Aggregate Enrollee Gross Premium	(5) Average Aggregate Enrollee Gross Premium	(6) Average Aggregate Gross Premium
2026	--	--	--	--	--	--
2027	3.92%	4.02%	3.71%	5.27%	4.06%	4.07%
2028	3.97%	4.17%	3.52%	3.73%	4.05%	3.95%
2029	4.00%	4.19%	3.57%	4.60%	4.02%	4.06%
2030	4.05%	4.34%	3.41%	4.17%	4.00%	4.05%
2031	3.96%	4.23%	3.37%	3.96%	4.00%	3.97%
2032	3.97%	4.24%	3.35%	4.06%	4.00%	3.99%
2033	3.98%	4.26%	3.35%	4.13%	4.01%	3.99%
2034	4.00%	4.28%	3.36%	4.16%	4.00%	4.02%
2035	4.01%	4.29%	3.37%	4.19%	4.00%	4.03%

We note the following regarding the annual changes illustrated in Table 21:

- Average aggregate gross premiums, as noted earlier, are increasing at approximately 4% per year (within tolerance for rounding), for both on-exchange enrollees and off-exchange enrollees.
- Average aggregate 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.
- Average aggregate APTCs, being the balancing item, are increasing more than gross premium annually.
- Non-PTC-eligible exchange enrollee average aggregate gross premiums are more volatile due their small size and a changing mix of enrollees from year to year. Various enrollees will move from non-PTC-eligible to PTC- eligible over time as the income limits increase more slowly than premiums.

Market Stabilization Scenario

This scenario reflects expected premiums, enrollment, and federal subsidies under the Nevada 1332 waiver.

Enrollment

The Market Stabilization scenario reflects the same enrollment assumptions as the Baseline scenario plus the following assumptions:

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

Projected enrollment is based on a simple linear elasticity coefficient[45] 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.[46] Table 22 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 22
State of Nevada
NMSP Actuarial and Economic Analysis
Market Stabilization Scenario
2026 Enrollment Elasticity – Members Above 400% FPL

		Market Stabilization Scenario
(a)	BBSP Appeal Enrollment Increase – Over 400%	330
(b)	Uninsured – Above 400% FPL	19,510
(c) =(a) / (b)	% Increased Assumed	1.7%
(d)	Premium Reduction	(3.2%)
(e) = (c) / (d)	Elasticity	-0.532

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

Table 23 shows the 10-year enrollment projection under the Market Stabilization scenario. Table 24 shows the change in enrollment from the Baseline scenario to the Market Stabilization scenario.

[45] Elasticity is defined as a consumer's sensitivity to price changes in making purchasing decisions. An elasticity of -1.00 indicates that a 1% price decrease will result in 1% more eligible consumers purchasing coverage. Elasticity of 0.00 means price changes do not affect purchasing decisions at all. Elasticity between -1.00 and 0.00 means that consumers have at least some sensitivity to price changes. Moreover, elasticity is very likely different at different income levels. However, we use a simple linear mechanism that ignores the income level aspect of consumer behavior as the additional complexity does not add additional precision of results or change our conclusions. We note that the elasticity implied in our enrollment increase estimates is reasonably within range of a published benchmark.

[46] 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 23 State of Nevada NMSP Actuarial and Economic Analysis Market Stabilization Scenario Individual Market Enrollment by Segment					
	On-Exchange			Off-Exchange	
Year	(1) PTC-Eligible	(2) Non-PTC-Eligible	(3) Total	(4) Total	(5) Total Individual Market
2026	76,500	9,000	85,500	16,500	102,000
2027	77,300	10,200	87,500	17,000	104,500
2028	78,200	10,500	88,700	17,300	106,000
2029	79,100	10,700	89,800	17,600	107,400
2030	80,200	10,800	91,000	17,800	108,800
2031	81,300	10,900	92,200	18,000	110,200
2032	82,400	11,000	93,400	18,300	111,700
2033	83,600	11,100	94,700	18,500	113,200
2034	84,700	11,100	95,800	18,800	114,600
2035	85,900	11,300	97,200	19,000	116,200
Average Annual Increase	**1.30%**	**2.56%**	**1.44%**	**1.58%**	**1.46%**

- 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 10 in Section II.E above, which illustrates the development of the 2026 number from 2022, due to the expected additional enrollment from the BBSP appeal.
- Column (1) enrollment increases over time due to population growth and some movement from column (2), as in the Baseline scenario.
- Column (4) increases relative to the Baseline scenario due to the “BBSP Appeal” as well.

The net total enrollment changes from Baseline are shown in Table 24. The change in PTC eligible enrollment reflects the net effect of enrollment growth due to the BBSP appeal and enrollment decreases due to enrollees who were eligible for PTCs who lose their PTC eligibility.

Table 24 State of Nevada NMSP Actuarial and Economic Analysis Market Stabilization Scenario Impact of NMSP on Individual Enrollment			
Year	Change in PTC Eligible	Change in Non-PTC Eligible	Total Change
2026	100	500	600
2027	(300)	2,100	1,800
2028	(500)	2,300	1,800
2029	(700)	2,600	1,900
2030	(600)	2,600	2,000
2031	(600)	2,600	2,000
2032	(600)	2,700	2,100
2033	(500)	2,600	2,100
2034	(500)	2,600	2,100
2035	(400)	2,700	2,300

Table 24 shows that the NMSP is expected to increase the nonsubsidized enrollment as gross premiums will be cheaper and nonsubsidized consumers will reap the full savings of a BBSP offering (i.e., the “BBSP Appeal”). Subsidized enrollment is projected to decrease slightly as subsidies decrease under the NMSP and current enrollees with small subsidies no longer qualify for subsidies.

Premiums

The Market Stabilization scenario reflects the same premium assumptions as the Baseline scenario plus the following assumptions:

- *BBSP adoption rate:* New and existing individual market enrollment is assumed to shift into BBSPs due to lower gross prices for unsubsidized consumers and lower net premiums (i.e., after subsidy) for subsidized consumers who switch to a BBSP. Adoption of BBSPs is assumed to be 80% for on-exchange enrollees. The shift to BBSPs causes composite market-wide premiums to be lower, all else equal.

  The adoption rate of BBSPs is likely important for various other aspects of program management, provider satisfaction, and overall success of the program. For that reason, we assume adoption will be relatively high but that a material percentage of the market may not choose a BBSP (in this case, 20% for on-exchange enrollees).

- *BBSP premium rate progression:* Table 25 assumes the reference premium increases by 4% annually in the first four years, and the BBSP discount relative to the reference premium before reinsurance is approximately 3.2%, 5.2%, 6.6%, and 8.0% in the first through fourth years of the program, respectively. Note, this has the overall effect of keeping BBSP premium trend lower than overall market trend over this time period (2026 through 2029), and then BBSP premiums increase at the rate of the reference premium increase, which is assumed to be equal to overall individual market premium growth.

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

- *Reinsurance:* A reinsurance program will be introduced in the second year of the NMSP. The reinsurance parameters will target[47] statewide premium reductions of 6.9%, 7.0%, and 7.1% in the second through fourth years of the program, respectively. Reinsurance has the overall effect of reducing premiums across the entire individual market, although the actual premium reduction will vary by plan based on each issuer's evaluation of the impact of the reinsurance program on their specific experience.

Table 25 shows the 10-year gross premium projection under the Market Stabilization scenario for both on-exchange and off-exchange enrollees in the individual market. The PMPMs are averages based on the projected mix of plan selections which is based on FPL, age, and metal level. Note, membership mix differences between the BBSPs and standard QHPs mean the actual gross premium differences will not match the projected discount from the reference premium. The impact of the waiver on total enrollment and gross premiums can be determined by comparing the last 3 columns in Table 25 to the last three columns in Table 19. In addition, Table 5 summarizes how the projected enrollment change is impacted by BBSPs and reinsurance separately.

Table 25
State of Nevada
NMSP Actuarial and Economic Analysis
Market Stabilization Scenario
Summary of Enrollment and Gross Premium by BBSP and Standard QHP Segments – All Rating Areas

	BBSP				Standard QHP			Total		
			Gross Premium			Gross Premium			Gross Premium	
Year	BBSP Take-Up %	Enrollment	Aggregate (thousands)	PMPM	Enrollment	Aggregate (thousands)	PMPM	Enrollment	Aggregate (thousands)	PMPM
2026	77%	78,300	$544,000	$579	23,700	$163,000	$573	102,000	$707,000	$577
2027	77%	80,300	$526,000	$546	24,200	$161,000	$554	104,500	$687,000	$548
2028	77%	81,400	$544,000	$557	24,600	$169,000	$574	106,000	$713,000	$561
2029	77%	82,500	$564,000	$570	24,900	$178,000	$596	107,400	$742,000	$576
2030	77%	83,500	$592,000	$591	25,300	$187,000	$616	108,800	$779,000	$597
2031	77%	84,600	$622,000	$613	25,600	$196,000	$639	110,200	$818,000	$619
2032	77%	85,800	$654,000	$635	25,900	$206,000	$664	111,700	$860,000	$642
2033	77%	86,800	$687,000	$659	26,400	$217,000	$684	113,200	$904,000	$665
2034	77%	88,000	$721,000	$683	26,600	$228,000	$714	114,600	$949,000	$690
2035	77%	89,100	$757,000	$708	27,100	$239,000	$735	116,200	$996,000	$715

[47] Actual parameters may change due to CMS PTF determinations and claims experience throughout the course of the NMSP.

We note the following regarding Table 25:

- The BBSP take-up percentage in Table 25 is slightly less than the 80% projected take-up for SSHIX enrollees because Table 25 includes off-exchange enrollment, and BBSP take-up is expected to be lower among off-exchange enrollees than for on-exchange enrollees.
- The average gross premium PMPM for BBSP enrollees is slightly higher than the average gross premium PMPM for standard QHP enrollees in 2026 because of the difference in the age mix of projected enrollees. After 2026, the decrease in the average PMPM due to BBSP premium reduction targets outweighs the impact of this projected age mix difference.

The same statewide 10-year gross premium projection under the Market Stabilization scenario for each of Nevada's four rating areas is shown in Exhibits 6.1 through 6.4. The differences in BBSP take-up assumptions in Exhibits 6.1 through 6.4 are driven by differences in member mix by on and off-exchange and by FPL and metal. Rating Area 1 has a higher proportion of members for whom we assume higher take-up (e.g., on-exchange silver under 200% FPL) than the other rating areas.

Subsidies

Premiums under the Market Stabilization scenario reflect the same key assumptions as the Baseline scenario plus the following assumption:

- *BBSP becomes the SLCS plan:* We assume a BBSP becomes the SLCS plan in each rating area and achieves the targeted savings relative to the reference premium. Similarly, we assume a BBSP also achieves savings relative to the SLCS premium modeled in the Baseline scenario. See additional discussion in Section II.B above related to why we assume the competitive landscape driven by BBSPs decreases the benchmark silver plan, regardless of whether a BBSP becomes the SLCS.

Table 26
State of Nevada
NMSP Actuarial and Economic Analysis
Market Stabilization Scenario
Average Aggregate Premiums and Member Subsidies Per Member Per Month (PMPM)

	On-Exchange				Off-Exchange	Total Individual Market
	PTC-Eligible			Non-PTC-Eligible		
Year	(1) Average Aggregate Gross Premium	(2) Average Aggregate APTC	(3) Average Aggregate Enrollee Net Premium*	(4) Average Aggregate Enrollee Gross Premium	(5) Average Aggregate Enrollee Gross Premium	(6) Average Aggregate Gross Premium
2026	$599	$403	$196	$557	$489	$577
2027	$570	$371	$199	$516	$464	$548
2028	$585	$378	$207	$528	$475	$561
2029	$600	$385	$215	$545	$487	$576
2030	$622	$400	$222	$564	$505	$597
2031	$645	$415	$229	$586	$523	$619
2032	$668	$431	$237	$609	$542	$642
2033	$692	$448	$245	$630	$562	$665
2034	$718	$465	$253	$659	$582	$690
2035	$744	$483	$261	$679	$603	$715

** Before premium relief. We estimate the premium relief program will reduce the average aggregate enrollee net premium for PTC-eligible enrollees by approximately $0.50 PMPM in 2026 and approximately $2 to $3 PMPM from 2027 through 2035.*

We note the following regarding Table 26:

- Average aggregate gross premiums, APTCs, and enrollee net premiums are based on the projected mix of plan selections under the Market Stabilization scenario which is based on FPL, age, and metal level. We assume 80% of SSHIX members enroll in a BBSP and the other 20% remain in their current plan (i.e., the same plan as in the Baseline scenario).

Table 27
State of Nevada
NMSP Actuarial and Economic Analysis
Market Stabilization Scenario
Change versus Baseline in Average Aggregate Premiums and Member Subsidies PMPM

	On-Exchange				Off-Exchange	Total Individual Market
	PTC-Eligible			Non-PTC-Eligible		
Year	(1) Average Aggregate Gross Premium	(2) Average Aggregate APTC	(3) Average Aggregate Enrollee Net Premium*	(4) Average Aggregate Enrollee Gross Premium	(5) Average Aggregate Enrollee Gross Premium	(6) Average Aggregate Gross Premium
2026	(2.7%)	(4.4%)	0.9%	(2.0%)	(2.9%)	(2.7%)
2027	(10.8%)	(15.3%)	(1.0%)	(13.8%)	(11.5%)	(11.3%)
2028	(12.1%)	(17.2%)	(0.7%)	(15.0%)	(12.9%)	(12.6%)
2029	(13.2%)	(19.0%)	(0.6%)	(16.1%)	(14.1%)	(13.8%)
2030	(13.5%)	(19.4%)	(0.6%)	(16.6%)	(14.4%)	(14.1%)
2031	(13.8%)	(19.7%)	(0.6%)	(16.6%)	(14.7%)	(14.3%)
2032	(14.0%)	(20.0%)	(0.6%)	(16.8%)	(15.0%)	(14.6%)
2033	(14.3%)	(20.3%)	(0.7%)	(17.3%)	(15.4%)	(14.9%)
2034	(14.6%)	(20.6%)	(0.6%)	(17.0%)	(15.7%)	(15.1%)
2035	(14.9%)	(21.0%)	(0.7%)	(17.9%)	(16.0%)	(15.5%)

** Before premium relief. We estimate the premium relief program will reduce the average aggregate enrollee net premium change versus Baseline for PTC-eligible enrollees by approximately 0.3% in 2026 and approximately 0.8% to 1.5% from 2027 through 2035.*

Commentary on Table 27:

- Average Aggregate Gross Premiums in column (1) decline under the Market Stabilization scenario relative to the Baseline scenario. The difference grows over time as BBSP premium discounts relative to the reference premium and BBSP take-up both increase through year 4 of the program.

- The change in Average Aggregate APTCs in column (2) relative to the Baseline scenario is greater than the BBSP premium discounts relative to both the reference premium by year (as noted in Table 8 in Section II.D above) and to the Baseline SLCS premium.

- Average Aggregate Enrollee Net Premiums in column (3) reflect projected plan selections but do not reflect the impact of the premium relief program. The average aggregate enrollee net premiums for PTC-eligible enrollees are slightly higher relative to the Baseline scenario in the first year of the waiver the subsidies for PTC-eligible enrollees decrease by more than gross premiums, on average, prior to reinsurance and prior to the premium relief program. The premium relief program will reduce the average aggregate enrollee net premium. However, we project the average aggregate enrollee net premium in the Market Stabilization scenario for PTC-eligible enrollees will be less than in the Baseline scenario by 2027 regardless of the final premium relief program design.

- Average Aggregate Enrollee Gross Premiums for Non-PTC-Eligible and Off-Exchange enrollees in columns (4) and (5), respectively, are lower than the Baseline scenario in all years of the Market Stabilization scenario.

Additional details regarding changes in enrollee gross and net premiums can be found in Section IV.

Finally, in Table 28, we calculate the savings in PTCs by multiplying APTC PMPMs by membership for the Baseline and Market Stabilization scenarios, calculating the difference in APTCs between the two scenarios, and adjusting for tax reconciliation.[48] The PTC membership under the Market Stabilization scenario reflects the decrease shown in Table 24 above due to some current enrollees with small subsidies who will no longer qualify for subsidies.

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

Table 28 State of Nevada NMSP Actuarial and Economic Analysis Market Stabilization Scenario Impact on Subsidies and Pass-Through Funding								
	Baseline			Market Stabilization			Change	
Year	PTC Membership	APTC PMPM	Annual APTC (thousands)	PTC Membership	APTC PMPM	Annual APTC (thousands)	Change in APTC	PTC Savings
2026	76,400	$421	$387,000	76,500	$403	$370,000	($17,000)	$15,000
2027	77,600	$438	$408,000	77,300	$371	$344,000	($64,000)	$58,000
2028	78,700	$456	$431,000	78,200	$378	$354,000	($77,000)	$69,000
2029	79,800	$476	$456,000	79,100	$385	$366,000	($90,000)	$81,000
2030	80,800	$496	$482,000	80,200	$400	$385,000	($97,000)	$87,000
2031	81,900	$517	$508,000	81,300	$415	$405,000	($103,000)	$93,000
2032	83,000	$539	$537,000	82,400	$431	$427,000	($110,000)	$99,000
2033	84,100	$562	$567,000	83,600	$448	$449,000	($118,000)	$106,000
2034	85,200	$586	$600,000	84,700	$465	$473,000	($127,000)	$114,000
2035	86,300	$611	$633,000	85,900	$483	$498,000	($135,000)	$122,000
5-Year Waiver Window								**$310,000**
10-Year Deficit Neutrality Window								**$844,000**
5-Year Waiver Window – With 10% Margin								**$279,000**
10-Year Deficit Neutrality Window – With 10% Margin								**$760,000**

We estimate the federal PTC savings under the Market Stabilization scenario to be $310 million over the five-year waiver period and $844 million over the 10-year deficit neutrality period. As required by CMS, the federal subsidies under the Market Stabilization scenario do not exceed the federal subsidies in the Baseline scenario over the 10-year deficit neutrality period.

Table 29 shows the aggregate PTC savings in Table 28 separated between the BBSP policy and the reinsurance policy, and between individuals projected to enroll in BBSPs and individuals projected to enroll in standard QHPs.

Table 29 State of Nevada NMSP Actuarial and Economic Analysis Market Stabilization Scenario Impact of NMSP on Aggregate PTC Savings				
	BBSP Policy Only		Reinsurance Policy Incremental Impact	
Year	BBSP Enrollees	Standard QHP Enrollees	BBSP Enrollees	Standard QHP Enrollees
2026	$12,000	$3,000	$0	$0
2027	$21,000	$5,000	$26,000	$6,000
2028	$29,000	$6,000	$27,000	$7,000
2029	$37,000	$7,000	$28,000	$9,000
2030	$39,000	$8,000	$31,000	$9,000
2031	$41,000	$9,000	$34,000	$9,000
2032	$43,000	$9,000	$38,000	$9,000
2033	$45,000	$10,000	$41,000	$10,000
2034	$48,000	$9,000	$45,000	$12,000
2035	$50,000	$11,000	$49,000	$12,000

Exhibit 7.1 shows the allocation of Table 28 split by enrollment (BBSP versus Standard QHP). Exhibit 7.2 shows this same level of detail based on the BBSP program only (i.e., without reinsurance). The values shown in Exhibit 7.2 illustrate the portion of PTC attributable to the BBSP program assuming premium reductions are split between BBSPs and reinsurance as modeled in the Market Stabilization scenario. If the premium reductions are achieved through a different split between the programs, the total PTC in Exhibit 7.1 will change and the proportion of PTC attributable to BBSPs will change.

VI. DATA AND METHODOLOGY

A. DATA SOURCES AND ADJUSTMENTS

Health care coverage and enrollment

The Silver State Health Insurance Exchange (SSHIX) provided enrollment data as of early 2023. The exchange data includes the following elements:

- Exchange individual identifier
- Household case identifier
- Federal poverty level (FPL) percentage
- Age
- ZIP Code
- County
- Plan level
- Net premium
- Advance premium tax credit (APTC) amount
- Health Insurance Oversight System (HIOS) issuer identifier
- CMS plan identifier
- Relationship to subscriber
- Enrollee status
- Status start date
- Status end date
- Last update date

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

We mapped in each member's and contract's total SLCS plan premium amount from the publicly available Public Use Files (PUFs) based on their county. We also excluded a minimal amount of membership with invalid or missing entries for key fields, such as county, age, and premium.

The exchange data represents a snapshot as of early 2023, and thus, will not match the full year 2023 due to new enrollment, terminations, and midyear plan changes, among other reasons. We did account for membership that terminated prior to our snapshot.

SSHIX enrollment and plan selection

To facilitate the analysis of ACA market dynamics, SSHIX provided two additional data sets that show two consecutive years of enrollment data by individual. The first data set reflects enrollment changes between 2020 and 2021 for individuals enrolled in 2020, and the second data set reflects enrollment changes between 2021 and 2022 for individuals enrolled in 2021. The following elements are included in both data sets for both the initial year and the renewal year for all enrollees in the initial year:[49]

- Household case identifier
- Enrollment identifier
- Exchange individual identifier
- Health Insurance Oversight System (HIOS) issuer identifier
- Metal level
- Date of birth
- Tobacco use identifier
- County
- Gross premium
- Applied APTC amount
- Net premium
- Federal poverty level (FPL) percentage
- FPL bucket
- Effective date
- End date

[49] The renewal year data only includes individuals who are included in the initial year data; new enrollees in the renewal year are excluded from these data sets.

In addition, each data set included a renewal status to indicate whether the enrollee actively renewed (i.e., changed plans), passively renewed (i.e., stayed in the same plan), or cancelled enrollment.

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.

Publicly available data

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

Nevada Issuer EDGE Server Data

Six Nevada issuers provided 2022 full year High-Cost Risk Pool reports from the EDGE server. These reports contain member-level pharmacy and medical paid claims for the 2022 benefit year. We used this information to model estimated 2027 reinsurance costs.

Other

- State of Nevada Department of Health and Human Services guidance memo (see Appendix C)

B. METHODOLOGY

We summarized the 2023 exchange enrollment and premium information to create a baseline, grouped by metallic coverage level, rating area, age band, income band as a percentage of FPL, and contract size to produce approximately 3,000 model cohorts. For 2023, we calculated subsidies based on the actual mix of member premiums in 2023 (which reflects the mix of plan selection), the premium for the 2023 SLCS plan, a representative income as a percentage of FPL within each income band (see Table 30 below), and 2023 premium limits (based on the expanded ARP levels). For 2024 through 2035, we projected enrollment and premium increases by cohort for each scenario, and we calculated the corresponding subsidies for each cohort. The age mix, income mix, and plan selection (e.g., issuer) mix within each cohort is assumed to stay constant in future years. Assumptions are assumed to impact each cohort uniformly across the cohort's mix of age, income, and plan selection. The following sections provide further detail on the assumptions for enrollment and premium changes.

Based on each scenario's ACA premium limits, we calculated revised subsidies for each model cell and year. The total subsidies in the Market Stabilization scenario are compared to the Baseline scenario to calculate the estimated PTF.

To model the estimated cost of reinsurance, we summarized 2022 member-level individual market claims by rating area and metal from the EDGE data and project forward through 2035. We adjusted for anticipated medical and pharmacy trend, Medicaid redeterminations, expiration of enhanced subsidies, and the impact of BBSP plans on the market. Reinsurance was calculated based on members' total annual medical and pharmacy claims compared to the program parameters.

Enrollment assumptions

Population-driven enrollment growth

We assumed the overall individual market will grow by the population growth rate, at a minimum, absent other shocks to the market. We use an underlying general population growth rate to project individual market growth absent other shocks. The population of the State of Nevada is assumed to grow 1.3% annually after 2022.[50] We then layer in separate additional enrollment impacts for the expiration of the PHE and the loss of enhanced subsidies, detailed below. Other shocks that have historically impacted the individual market, such as changes in broad economic conditions, pandemics, or policy changes at the state or federal level could occur but are not known at this time.

[50] 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 growth due to expiration of the PHE

We assumed exchange enrollment will increase in each income level between 2023 and 2026 due to the expiration of the PHE, as shown in Table 30. First, we estimated the total membership at each income level that we expect to lose Medicaid coverage upon expiration of the PHE by reviewing growth in Nevada Medicaid enrollment since the PHE started compared to pre-PHE enrollment. Although Medicaid disenrollment due to the expiration of the PHE will impact all income levels and eligibility groups, we expect the impact to be greater for higher-income members and for the Childless Adults eligibility group.

For each cohort, we estimated the percentage that will take up group coverage, individual exchange coverage, or become uninsured upon disenrollment from Medicaid. We expect individuals in the higher income buckets will be more likely to have commercial group insurance available and less likely to enter the individual market. We assume individuals who are disenrolled from Medicaid and subsequently enroll in the SSHIX will have incomes that render them ineligible for Medicaid. Therefore, we assume the enrollment increase due to the expiration of the PHE does not have any impact below 133% FPL.

Table 30
NMSP Actuarial and Economic Analysis
Modeling Assumptions
2024 Individual Market Enrollment Increase Due to Expiration of the PHE

Income (% FPL)	Member Increase %	Member Increase Count
Under 100%	0%	0
100 to 133%	0%	0
133 to 150%	16%	2,224
150 to 200%	18%	3,756
200 to 250%	28%	4,459
250 to 300%	26%	2,661
300 to 400%	12%	1,160
Over 400%	9%	1,440
Total	**16%**	**15,700**

The enrollment growth assumption was applied based on FPL, as noted above. However, Table 31 shows the resulting enrollment growth by age based on the enrollee distribution by FPL within each age band.

Table 31
NMSP Actuarial and Economic Analysis
Modeling Assumptions
2024 Individual Market Enrollment Increase Due to Expiration of the PHE

Age Bucket	Member Increase %	Member Increase Count
0 to 14	16%	103
15-20	17%	132
21-25	16%	405
26-30	17%	1,156
31-35	17%	1,504
36-40	17%	1,738
41-45	17%	1,768
46-50	17%	1,822
51-55	17%	2,019
56-60	17%	2,320
61-65	16%	2,503
Over 65	11%	230
Total	**16%**	**15,700**

Enrollment decrease due to the expiration of enhanced subsidies

We assumed exchange enrollment will decrease in each income level between 2023 and 2026 due to the expiration of enhanced subsidies, as shown in Table 32. To develop these assumptions, we estimated the increase in members due to ARP by measuring the 2021 and 2022 increases in enrollment. We assumed that a relatively comparable number of members will disenroll due to the expiration of enhanced subsidies.

Table 32 NMSP Actuarial and Economic Analysis Modeling Assumptions 2026 Enrollment Decrease Due to Expiration of Enhanced Subsidies		
Income (% FPL)	**Member Decrease %**	**Member Decrease Count**
Under 100%	-35%	-628
100 to 133%	-23%	-1,758
133 to 150%	-23%	-3,737
150 to 200%	-15%	-3,759
200 to 250%	-15%	-3,151
250 to 300%	-20%	-2,645
300 to 400%	-30%	-3,243
Over 400%	-60%	-10,859
Total	**-26%**	**-29,781**

The enrollment decrease assumption was applied based on FPL, as noted above. However, Table 33 shows the resulting enrollment change by age based on the enrollee distribution by FPL within each age band.

Table 33 NMSP Actuarial and Economic Analysis Modeling Assumptions 2026 Enrollment Decrease Due to Expiration of Enhanced Subsidies		
Age Bucket	**Member Decrease %**	**Member Decrease Count**
0 to 14	-29%	-221
15-20	-24%	-219
21-25	-23%	-689
26-30	-26%	-2,164
31-35	-27%	-2,929
36-40	-27%	-3,334
41-45	-26%	-3,359
46-50	-26%	-3,326
51-55	-26%	-3,700
56-60	-26%	-4,406
61-65	-27%	-4,843
Over 65	-24%	-592
Total	**-26%**	**-29,781**

Premium assumptions

Consumer Price Index – Medical

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

Standard QHP gross premium increases (before reinsurance)

From 2018 through 2022, the average annual change in SLCS plan premiums on the individual exchange is -1.58% nationwide (decreasing each year) and -2.0% in Nevada[51] (decreasing in three of the four years). The actual annual percentage changes fluctuated widely in many states during this time due to market circumstances that are not expected to recur. Therefore, we did not assume the recent decreases and fluctuations in exchange premiums will continue in the future.

Premium trends reflected in 2024 modeled gross premiums are based on observed average trends in 2024 rates on the SSHIX by metal. We apply the following trends by metal: 4.8% for bronze plans, 3.6% for silver plans, and 1.0% for gold plans.

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

Based on observed differences in premium changes by metal level over recent years, we assume gold and bronze plans trends in 2025 will be 25 basis points higher than silver plan trends and converge to the same trend as silver plans by 2030. From 2022 to 2024, the average annual trend for the lowest-cost bronze and gold plans and highest-cost bronze and bold plans in Nevada exceeded the average annual trend by silver plans by at least 80 basis points. However, these variances cannot reasonably continue indefinitely because they would result in disparities in the actuarial values of gross premiums by metal. Therefore, we project that a trend variance continues but converges over time.

The projected trends produce the following relationships for average premiums by metal for non-smoker aged 41 to 45 in Rating Area 1 with income between 150% and 200% FPL:

Table 34
NMSP Actuarial and Economic Analysis
Modeling Assumptions
Premium Relativities by Metal

	Baseline	Market Stabilization			
	2026	**2026**	**2027**	**2028**	**2029**
Average Premiums					
Bronze	$409.63	$396.57	$374.89	$383.39	$392.17
Silver	$495.41	$479.61	$452.74	$462.57	$472.92
Gold	$674.89	$653.37	$617.65	$631.66	$646.12
Ratios					
Bronze : Silver	0.83	0.83	0.83	0.83	0.83
Gold : Silver	1.36	1.36	1.36	1.37	1.37
Gold : Bronze	1.65	1.65	1.65	1.65	1.65
Premium differential between Bronze and Gold	$265.26	$256.80	$242.76	$248.27	$253.95

Although the premium amounts differ between the Baseline and Market Stabilization scenarios, the ratios between metals are the same in any given year (i.e., the Baseline ratios in 2029 are the same as the Market Stabilization ratios in 2029).

Morbidity changes due to the expiration of the PHE

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

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

Morbidity changes due to the expiration of enhanced subsidies

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

Claim distribution

Exhibit 8 shows the projected claim distribution by claim size in 2027 used to develop the estimated impact of reinsurance on premiums.

Demographic and distribution assumptions

Overall BBSP take-up rate

We assumed new and existing SSHIX enrollees will enroll in BBSPs. The BBSPs will reduce the SLCS plan premium, which will result in lower federal premium subsidies for all subsidy-eligible enrollees. Any difference between the federal subsidy and the premium must be paid by the enrollee. For a heavily subsidized enrollee to maintain the same level of out-of-pocket cost, they will likely need to shift to a BBSP. We assumed low-subsidy or nonsubsidized enrollees are less sensitive to these out-of-pocket cost increases than heavily subsidized enrollees. Therefore, we assumed heavily subsidized enrollees will enroll in a BBSP at higher rates than low-subsidy or nonsubsidized enrollees. The projected number of enrollees assumed to enroll in a BBSP by income and metallic levels during the 10-year deficit neutrality window are shown in Exhibit 9.

To estimate our take-up of the PO, we assumed BBSPs as a whole could be treated as an exchange issuer. We then analyzed the historical market share for SLCS issuers at the county level as a proxy for what market share the BBSPs might receive, given they are assumed to be both the SLCS and LCS in this analysis. We used public data from the following sources:

- County-level Plan data from QHP Landscape files (Healthcare.gov Data Services Hub)
  https://data.healthcare.gov/datasets?keyword%5B0%5D=QHP

- Rate information from CMS's "Rate PUF"
  https://www.cms.gov/marketplace/resources/data/public-use-files

- Enrollment data from CMS's Issuer-Level Public Use File
  https://www.cms.gov/marketplace/resources/data/issuer-level-enrollment-data

We analyzed data for 2019 through 2022 and excluded counties with two or fewer issuers (approximately 40% of counties across all years) to better simulate the Nevada competitive environment. We calculated the market share in counties where the SLCS and the LCS were offered by the same issuer, calculated the weighted average market share across all counties, and calculated ranges of market share estimates.

Subsidized members under 100% FPL

PTC subsidies typically are not available to enrollees below 100% FPL because those residents are expected to enroll in Medicaid. It is our understanding that some legal immigrants are not eligible for Medicaid in Nevada, but they are eligible for PTC subsidies on the exchange. In addition, some enrollees with incomes below 100% FPL but who are not eligible to enroll in Medicaid due to the asset test may be eligible to enroll in the individual market, but they are not eligible for PTC subsidies.

Income levels

The FPL in 2022 and 2023 is $13,590 and $14,580, respectively, for a one-person household. For modeling purposes, we assumed all enrollees in each income level have the same FPL percentage, based on the approximate distribution of 2023 exchange enrollment within each bucket. The modeled FPL percentages for 2023 in each bucket are shown in Table 35.

Table 35
NMSP Actuarial and Economic Analysis
Modeling Assumptions
Modeled Household Income Levels - One-Person Household

Income (% FPL)	Modeled FPL %	Modeled 2023 Household Income
Under 100%	100%	Less than $14,580
100 to 133%	120%	$17,496
133 to 150%	145%	$21,141
150 to 200%	190%	$27,702
200 to 250%	245%	$35,721
250 to 300%	280%	$40,824
300 to 400%	385%	$56,133
Over 400%	600%	$87,480

FPL increases

We assumed the FPL will increase each year with trend. The FPL is assumed to increase by 2.5% every year, based on CMS projections.

ACA affordability limits

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

Small group rates

In estimating the impact and potential migration from the small group market, we used public premium rate data from issuers in the individual and small group markets in Nevada in 2022 (CMS PUF files for individual and rate files from the SERFF filing system for small group). We reviewed rate increases in each market for 2023 and 2024 and concluded that the overall relationship of rates between markets has not changed materially. Table 36 below shows that small group rates are lower than individual rates across almost all metal levels and geographic areas.

Table 36
State of Nevada
NMSP Actuarial and Economic Analysis
Modeling Assumptions
Small Group to Individual Premium Rate Relationship

	Bronze	Silver	Gold
Rating Area 1	96.1%	96.3%	92.2%
Rating Area 2	89.5%	87.6%	85.3%
Rating Area 3	74.0%	73.0%	68.8%
Rating Area 4	85.1%	86.9%	86.8%

EXHIBITS

Exhibit 1.1
State of Nevada
Nevada Market Stabilization Actuarial and Economic Analysis
Individual Market Average Gross Premium: 2026 through 2035 by Federal Poverty Leve

Average Gross Premium by FPL % - Baseline

Income Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Under 100%	$ 709	$ 737	$ 767	$ 798	$ 830	$ 863	$ 897	$ 933	$ 971	$ 1,009
100 to 133%	$ 621	$ 646	$ 672	$ 699	$ 727	$ 756	$ 786	$ 818	$ 850	$ 884
133 to 150%	$ 631	$ 656	$ 682	$ 710	$ 738	$ 767	$ 798	$ 830	$ 863	$ 898
150 to 200%	$ 638	$ 664	$ 691	$ 718	$ 747	$ 777	$ 808	$ 840	$ 874	$ 909
200 to 250%	$ 571	$ 594	$ 618	$ 643	$ 669	$ 695	$ 723	$ 752	$ 782	$ 814
250 to 300%	$ 580	$ 604	$ 628	$ 654	$ 680	$ 707	$ 735	$ 765	$ 795	$ 827
300 to 400%	$ 614	$ 639	$ 665	$ 692	$ 720	$ 749	$ 779	$ 810	$ 842	$ 876
Over 400%	$ 608	$ 633	$ 658	$ 685	$ 712	$ 741	$ 770	$ 801	$ 833	$ 867
Total - On Exchange	**$ 610**	**$ 635**	**$ 661**	**$ 687**	**$ 715**	**$ 744**	**$ 773**	**$ 804**	**$ 836**	**$ 870**
Total - Off Exchange	$ 504	$ 524	$ 545	$ 567	$ 590	$ 614	$ 638	$ 664	$ 690	$ 718
Total Individuals	**$ 593**	**$ 618**	**$ 642**	**$ 668**	**$ 695**	**$ 723**	**$ 751**	**$ 781**	**$ 813**	**$ 846**

Average Gross Premium by FPL % - With Waiver

Income Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Under 100%	$ 689	$ 652	$ 668	$ 684	$ 709	$ 736	$ 763	$ 791	$ 820	$ 851
100 to 133%	$ 604	$ 571	$ 585	$ 599	$ 622	$ 645	$ 669	$ 693	$ 719	$ 745
133 to 150%	$ 613	$ 580	$ 594	$ 608	$ 631	$ 654	$ 679	$ 704	$ 730	$ 757
150 to 200%	$ 620	$ 587	$ 601	$ 616	$ 639	$ 662	$ 687	$ 712	$ 739	$ 766
200 to 250%	$ 556	$ 527	$ 540	$ 554	$ 574	$ 596	$ 618	$ 640	$ 664	$ 689
250 to 300%	$ 566	$ 537	$ 551	$ 565	$ 586	$ 608	$ 631	$ 654	$ 678	$ 703
300 to 400%	$ 601	$ 571	$ 587	$ 604	$ 626	$ 649	$ 673	$ 698	$ 724	$ 751
Over 400%	$ 596	$ 569	$ 585	$ 603	$ 625	$ 648	$ 672	$ 697	$ 723	$ 750
Total - On Exchange	**$ 595**	**$ 564**	**$ 578**	**$ 593**	**$ 615**	**$ 638**	**$ 661**	**$ 686**	**$ 711**	**$ 737**
Total - Off Exchange	$ 489	$ 464	$ 475	$ 487	$ 505	$ 523	$ 542	$ 562	$ 582	$ 603
Total Individuals	**$ 577**	**$ 548**	**$ 561**	**$ 576**	**$ 597**	**$ 619**	**$ 642**	**$ 665**	**$ 690**	**$ 715**

Change in Average Gross in Premium Due to Waiver

Income Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Under 100%	$ (20)	$ (85)	$ (99)	$ (114)	$ (120)	$ (127)	$ (134)	$ (142)	$ (150)	$ (159)
100 to 133%	$ (18)	$ (75)	$ (87)	$ (100)	$ (105)	$ (111)	$ (118)	$ (124)	$ (131)	$ (139)
133 to 150%	$ (18)	$ (76)	$ (88)	$ (101)	$ (107)	$ (113)	$ (119)	$ (126)	$ (134)	$ (141)
150 to 200%	$ (18)	$ (77)	$ (89)	$ (102)	$ (108)	$ (114)	$ (121)	$ (128)	$ (135)	$ (143)
200 to 250%	$ (15)	$ (67)	$ (78)	$ (89)	$ (94)	$ (100)	$ (106)	$ (112)	$ (118)	$ (125)
250 to 300%	$ (14)	$ (67)	$ (78)	$ (88)	$ (93)	$ (99)	$ (105)	$ (111)	$ (117)	$ (124)
300 to 400%	$ (14)	$ (68)	$ (78)	$ (89)	$ (94)	$ (99)	$ (105)	$ (112)	$ (118)	$ (125)
Over 400%	$ (11)	$ (64)	$ (73)	$ (82)	$ (87)	$ (93)	$ (98)	$ (104)	$ (110)	$ (117)
Total - On Exchange	**$ (16)**	**$ (72)**	**$ (83)**	**$ (95)**	**$ (100)**	**$ (106)**	**$ (112)**	**$ (119)**	**$ (125)**	**$ (133)**
Total - Off Exchange	$ (15)	$ (60)	$ (70)	$ (80)	$ (85)	$ (90)	$ (96)	$ (102)	$ (108)	$ (115)
Total Individuals	**$ (16)**	**$ (70)**	**$ (81)**	**$ (92)**	**$ (98)**	**$ (104)**	**$ (110)**	**$ (116)**	**$ (123)**	**$ (131)**

Exhibit 1.2
State of Nevada
Nevada Market Stabilization Actuarial and Economic Analysis
Individual Market Average Gross Premium: 2026 through 2035 by Metal

Average Gross Premium by Metal - Baseline

Plan Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Bronze	$ 545	$ 568	$ 591	$ 615	$ 640	$ 665	$ 692	$ 719	$ 748	$ 778
Silver	$ 644	$ 670	$ 697	$ 725	$ 754	$ 784	$ 815	$ 848	$ 882	$ 917
Gold	$ 717	$ 747	$ 778	$ 809	$ 842	$ 875	$ 910	$ 947	$ 985	$ 1,024
Total - On Exchange	**$ 610**	**$ 635**	**$ 661**	**$ 687**	**$ 715**	**$ 744**	**$ 773**	**$ 804**	**$ 836**	**$ 870**
Total - Off Exchange	$ 504	$ 524	$ 545	$ 567	$ 590	$ 614	$ 638	$ 664	$ 690	$ 718
Total Individuals	**$ 593**	**$ 618**	**$ 642**	**$ 668**	**$ 695**	**$ 723**	**$ 751**	**$ 781**	**$ 813**	**$ 846**

Average Gross Premium by Metal - With Waiver

Plan Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Bronze	$ 532	$ 505	$ 518	$ 532	$ 552	$ 573	$ 594	$ 616	$ 638	$ 662
Silver	$ 627	$ 593	$ 608	$ 623	$ 646	$ 670	$ 695	$ 721	$ 747	$ 775
Gold	$ 702	$ 669	$ 688	$ 708	$ 734	$ 761	$ 789	$ 819	$ 849	$ 880
Total - On Exchange	**$ 595**	**$ 564**	**$ 578**	**$ 593**	**$ 615**	**$ 638**	**$ 661**	**$ 686**	**$ 711**	**$ 737**
Total - Off Exchange	$ 489	$ 464	$ 475	$ 487	$ 505	$ 523	$ 542	$ 562	$ 582	$ 603
Total Individuals	**$ 577**	**$ 548**	**$ 561**	**$ 576**	**$ 597**	**$ 619**	**$ 642**	**$ 665**	**$ 690**	**$ 715**

Change in Average Gross Premium Due to Waiver

Plan Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Bronze	$ (13)	$ (63)	$ (73)	$ (83)	$ (87)	$ (93)	$ (98)	$ (104)	$ (110)	$ (116)
Silver	$ (17)	$ (76)	$ (89)	$ (102)	$ (107)	$ (113)	$ (120)	$ (127)	$ (134)	$ (142)
Gold	$ (15)	$ (78)	$ (90)	$ (101)	$ (107)	$ (114)	$ (121)	$ (128)	$ (136)	$ (144)
Total - On Exchange	**$ (16)**	**$ (72)**	**$ (83)**	**$ (95)**	**$ (100)**	**$ (106)**	**$ (112)**	**$ (119)**	**$ (125)**	**$ (133)**
Total - Off Exchange	$ (15)	$ (60)	$ (70)	$ (80)	$ (85)	$ (90)	$ (96)	$ (102)	$ (108)	$ (115)
Total Individuals	**$ (16)**	**$ (70)**	**$ (81)**	**$ (92)**	**$ (98)**	**$ (104)**	**$ (110)**	**$ (116)**	**$ (123)**	**$ (131)**

Exhibit 1.3
State of Nevada
Nevada Market Stabilization Actuarial and Economic Analysis
Individual Market Average Gross Premium: 2026 through 2035 by Age Group

Average Gross Premium by Age Group - Baseline

Age Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
0-14	$ 282	$ 294	$ 306	$ 318	$ 331	$ 344	$ 358	$ 372	$ 387	$ 402
14-20	$ 333	$ 346	$ 360	$ 375	$ 390	$ 405	$ 421	$ 438	$ 456	$ 474
21-25	$ 360	$ 375	$ 390	$ 406	$ 422	$ 439	$ 456	$ 474	$ 493	$ 513
26-30	$ 382	$ 398	$ 414	$ 430	$ 447	$ 465	$ 484	$ 503	$ 523	$ 544
31-35	$ 398	$ 414	$ 431	$ 448	$ 466	$ 485	$ 504	$ 524	$ 545	$ 567
36-40	$ 398	$ 414	$ 431	$ 448	$ 466	$ 485	$ 504	$ 524	$ 545	$ 567
41-45	$ 419	$ 436	$ 454	$ 472	$ 491	$ 510	$ 531	$ 552	$ 574	$ 597
46-50	$ 494	$ 514	$ 535	$ 556	$ 579	$ 602	$ 626	$ 651	$ 677	$ 704
51-55	$ 633	$ 659	$ 685	$ 713	$ 741	$ 771	$ 802	$ 834	$ 867	$ 902
56-60	$ 825	$ 859	$ 893	$ 929	$ 966	$ 1,005	$ 1,045	$ 1,087	$ 1,130	$ 1,176
60-65	$ 1,011	$ 1,053	$ 1,095	$ 1,139	$ 1,185	$ 1,232	$ 1,281	$ 1,333	$ 1,386	$ 1,441
Over 65	$ 963	$ 1,001	$ 1,042	$ 1,083	$ 1,127	$ 1,172	$ 1,219	$ 1,267	$ 1,318	$ 1,371
Total - On Excha	**$ 610**	**$ 635**	**$ 661**	**$ 687**	**$ 715**	**$ 744**	**$ 773**	**$ 804**	**$ 836**	**$ 870**
Total - Off Excha	$ 504	$ 524	$ 545	$ 567	$ 590	$ 614	$ 638	$ 664	$ 690	$ 718
Total Individuals	**$ 593**	**$ 618**	**$ 642**	**$ 668**	**$ 695**	**$ 723**	**$ 751**	**$ 781**	**$ 813**	**$ 846**

Average Gross Premium by Age Group - With Waiver

Age Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
0-14	$ 275	$ 261	$ 268	$ 275	$ 285	$ 295	$ 306	$ 318	$ 329	$ 341
14-20	$ 324	$ 307	$ 314	$ 322	$ 334	$ 347	$ 360	$ 373	$ 387	$ 401
21-25	$ 351	$ 332	$ 340	$ 349	$ 362	$ 375	$ 389	$ 403	$ 418	$ 434
26-30	$ 372	$ 353	$ 362	$ 371	$ 385	$ 399	$ 414	$ 429	$ 445	$ 461
31-35	$ 387	$ 367	$ 377	$ 386	$ 401	$ 416	$ 431	$ 447	$ 463	$ 481
36-40	$ 388	$ 367	$ 377	$ 387	$ 401	$ 416	$ 431	$ 447	$ 464	$ 481
41-45	$ 408	$ 387	$ 397	$ 407	$ 422	$ 438	$ 454	$ 470	$ 488	$ 506
46-50	$ 481	$ 456	$ 468	$ 480	$ 497	$ 516	$ 535	$ 555	$ 575	$ 596
51-55	$ 616	$ 584	$ 599	$ 614	$ 637	$ 661	$ 685	$ 711	$ 737	$ 764
56-60	$ 804	$ 762	$ 781	$ 801	$ 831	$ 862	$ 894	$ 927	$ 961	$ 996
60-65	$ 985	$ 934	$ 958	$ 983	$ 1,019	$ 1,057	$ 1,096	$ 1,137	$ 1,179	$ 1,222
Over 65	$ 936	$ 886	$ 908	$ 930	$ 965	$ 1,001	$ 1,038	$ 1,076	$ 1,116	$ 1,157
Total - On Excha	**$ 595**	**$ 564**	**$ 578**	**$ 593**	**$ 615**	**$ 638**	**$ 661**	**$ 686**	**$ 711**	**$ 737**
Total - Off Excha	$ 489	$ 464	$ 475	$ 487	$ 505	$ 523	$ 542	$ 562	$ 582	$ 603
Total Individuals	**$ 577**	**$ 548**	**$ 561**	**$ 576**	**$ 597**	**$ 619**	**$ 642**	**$ 665**	**$ 690**	**$ 715**

Change in Average Gross Premium Due to Waiver

Age Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
0-14	$ (7)	$ (33)	$ (38)	$ (43)	$ (46)	$ (48)	$ (51)	$ (54)	$ (57)	$ (61)
14-20	$ (9)	$ (39)	$ (46)	$ (52)	$ (55)	$ (58)	$ (62)	$ (65)	$ (69)	$ (73)
21-25	$ (10)	$ (43)	$ (50)	$ (57)	$ (60)	$ (63)	$ (67)	$ (71)	$ (75)	$ (79)
26-30	$ (10)	$ (45)	$ (52)	$ (59)	$ (63)	$ (66)	$ (70)	$ (74)	$ (79)	$ (83)
31-35	$ (10)	$ (47)	$ (54)	$ (62)	$ (65)	$ (69)	$ (73)	$ (77)	$ (82)	$ (86)
36-40	$ (10)	$ (47)	$ (54)	$ (62)	$ (65)	$ (69)	$ (73)	$ (77)	$ (82)	$ (86)
41-45	$ (11)	$ (49)	$ (57)	$ (65)	$ (69)	$ (73)	$ (77)	$ (81)	$ (86)	$ (91)
46-50	$ (13)	$ (58)	$ (67)	$ (77)	$ (81)	$ (86)	$ (91)	$ (96)	$ (102)	$ (107)
51-55	$ (17)	$ (74)	$ (86)	$ (98)	$ (104)	$ (110)	$ (116)	$ (123)	$ (130)	$ (138)
56-60	$ (22)	$ (97)	$ (112)	$ (128)	$ (135)	$ (143)	$ (151)	$ (160)	$ (170)	$ (179)
60-65	$ (26)	$ (118)	$ (137)	$ (156)	$ (165)	$ (175)	$ (185)	$ (196)	$ (207)	$ (219)
Over 65	$ (27)	$ (115)	$ (134)	$ (153)	$ (162)	$ (171)	$ (181)	$ (192)	$ (203)	$ (214)
Total - On Excha	**$ (16)**	**$ (72)**	**$ (83)**	**$ (95)**	**$ (100)**	**$ (106)**	**$ (112)**	**$ (119)**	**$ (125)**	**$ (133)**
Total - Off Excha	$ (15)	$ (60)	$ (70)	$ (80)	$ (85)	$ (90)	$ (96)	$ (102)	$ (108)	$ (115)
Total Individuals	**$ (16)**	**$ (70)**	**$ (81)**	**$ (92)**	**$ (98)**	**$ (104)**	**$ (110)**	**$ (116)**	**$ (123)**	**$ (131)**

Exhibit 1.4
State of Nevada
Nevada Market Stabilization Actuarial and Economic Analysis
Individual Market Average Gross Premium: 2026 through 2035 by APTC Eligibility

Average Gross Premium by Subsidy Eligibility - Baseline

Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Subsidized	$ 619	$ 645	$ 671	$ 697	$ 725	$ 754	$ 784	$ 815	$ 847	$ 881
Unsubsidized	$ 415	$ 432	$ 450	$ 468	$ 487	$ 507	$ 527	$ 548	$ 571	$ 593
Total - On Exchange	**$ 610**	**$ 635**	**$ 661**	**$ 687**	**$ 715**	**$ 744**	**$ 773**	**$ 804**	**$ 836**	**$ 870**
Total - Off Exchange	$ 504	$ 524	$ 545	$ 567	$ 590	$ 614	$ 638	$ 664	$ 690	$ 718
Total Individuals	**$ 593**	**$ 618**	**$ 642**	**$ 668**	**$ 695**	**$ 723**	**$ 751**	**$ 781**	**$ 813**	**$ 846**

Average Gross Premium by Subsidy Eligibility - With Waiver

Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Subsidized	$ 604	$ 573	$ 588	$ 604	$ 626	$ 649	$ 673	$ 697	$ 722	$ 749
Unsubsidized	$ 408	$ 387	$ 398	$ 410	$ 425	$ 441	$ 457	$ 475	$ 492	$ 510
Total - On Exchange	**$ 595**	**$ 564**	**$ 578**	**$ 593**	**$ 615**	**$ 638**	**$ 661**	**$ 686**	**$ 711**	**$ 737**
Total - Off Exchange	$ 489	$ 464	$ 475	$ 487	$ 505	$ 523	$ 542	$ 562	$ 582	$ 603
Total Individuals	**$ 577**	**$ 548**	**$ 561**	**$ 576**	**$ 597**	**$ 619**	**$ 642**	**$ 665**	**$ 690**	**$ 715**

Change in Average Gross Premium Due to Waiver

Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Subsidized	$ (16)	$ (71)	$ (82)	$ (94)	$ (99)	$ (105)	$ (111)	$ (118)	$ (125)	$ (132)
Unsubsidized	$ (7)	$ (45)	$ (52)	$ (58)	$ (62)	$ (66)	$ (70)	$ (74)	$ (78)	$ (83)
Total - On Exchange	**$ (16)**	**$ (72)**	**$ (83)**	**$ (95)**	**$ (100)**	**$ (106)**	**$ (112)**	**$ (119)**	**$ (125)**	**$ (133)**
Total - Off Exchange	$ (15)	$ (60)	$ (70)	$ (80)	$ (85)	$ (90)	$ (96)	$ (102)	$ (108)	$ (115)
Total Individuals	**$ (16)**	**$ (70)**	**$ (81)**	**$ (92)**	**$ (98)**	**$ (104)**	**$ (110)**	**$ (116)**	**$ (123)**	**$ (131)**

Exhibit 1.5
State of Nevada
Nevada Market Stabilization Actuarial and Economic Analysis
Individual Market Average Gross Premium: 2026 through 2035 by Rating Area

Average Gross Premium by Rating Area - Baseline

Rating Area	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Rating Area 1	$ 566	$ 589	$ 612	$ 637	$ 663	$ 689	$ 717	$ 745	$ 775	$ 806
Rating Area 2	$ 709	$ 738	$ 768	$ 798	$ 830	$ 864	$ 898	$ 934	$ 971	$ 1,010
Rating Area 3	$ 921	$ 959	$ 997	$ 1,037	$ 1,079	$ 1,122	$ 1,167	$ 1,214	$ 1,262	$ 1,313
Rating Area 4	$ 821	$ 854	$ 889	$ 925	$ 962	$ 1,000	$ 1,040	$ 1,082	$ 1,125	$ 1,170
Total - On Exchange	**$ 610**	**$ 635**	**$ 661**	**$ 687**	**$ 715**	**$ 744**	**$ 773**	**$ 804**	**$ 836**	**$ 870**
Total - Off Exchange	$ 504	$ 524	$ 545	$ 567	$ 590	$ 614	$ 638	$ 664	$ 690	$ 718
Total Individuals	**$ 593**	**$ 618**	**$ 642**	**$ 668**	**$ 695**	**$ 723**	**$ 751**	**$ 781**	**$ 813**	**$ 846**

Average Gross Premium by Rating Area - With Waiver

Rating Area	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Rating Area 1	$ 551	$ 522	$ 535	$ 549	$ 570	$ 591	$ 613	$ 635	$ 659	$ 683
Rating Area 2	$ 691	$ 653	$ 670	$ 688	$ 713	$ 740	$ 767	$ 796	$ 825	$ 856
Rating Area 3	$ 897	$ 861	$ 883	$ 906	$ 940	$ 975	$ 1,012	$ 1,050	$ 1,089	$ 1,129
Rating Area 4	$ 800	$ 724	$ 742	$ 760	$ 788	$ 816	$ 845	$ 875	$ 907	$ 939
Total - On Exchange	**$ 595**	**$ 564**	**$ 578**	**$ 593**	**$ 615**	**$ 638**	**$ 661**	**$ 686**	**$ 711**	**$ 737**
Total - Off Exchange	$ 489	$ 464	$ 475	$ 487	$ 505	$ 523	$ 542	$ 562	$ 582	$ 603
Total Individuals	**$ 577**	**$ 548**	**$ 561**	**$ 576**	**$ 597**	**$ 619**	**$ 642**	**$ 665**	**$ 690**	**$ 715**

Change in Average Gross Premium Due to Waiver

Rating Area	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Rating Area 1	$ (15)	$ (66)	$ (77)	$ (88)	$ (93)	$ (98)	$ (104)	$ (110)	$ (117)	$ (123)
Rating Area 2	$ (18)	$ (84)	$ (97)	$ (111)	$ (117)	$ (124)	$ (131)	$ (138)	$ (146)	$ (154)
Rating Area 3	$ (24)	$ (98)	$ (115)	$ (132)	$ (139)	$ (147)	$ (155)	$ (164)	$ (174)	$ (183)
Rating Area 4	$ (21)	$ (130)	$ (147)	$ (164)	$ (174)	$ (184)	$ (195)	$ (207)	$ (218)	$ (231)
Total - On Exchange	**$ (16)**	**$ (72)**	**$ (83)**	**$ (95)**	**$ (100)**	**$ (106)**	**$ (112)**	**$ (119)**	**$ (125)**	**$ (133)**
Total - Off Exchange	$ (15)	$ (60)	$ (70)	$ (80)	$ (85)	$ (90)	$ (96)	$ (102)	$ (108)	$ (115)
Total Individuals	**$ (16)**	**$ (70)**	**$ (81)**	**$ (92)**	**$ (98)**	**$ (104)**	**$ (110)**	**$ (116)**	**$ (123)**	**$ (131)**

Exhibit 2
State of Nevada
Nevada Market Stabilization Actuarial and Economic Analysis
Individual Market Changes in SLCS Plan Monthly Premium from 1332 Waiver Implementation
All Rating Areas

Year	21-Year Old Monthly Premium				40-Year Old Monthly Premium			
	Baseline	Waiver	Difference	Percent Change	Baseline	Waiver	Difference	Percent Change
2026	$347.61	$336.55	($11.06)	-3.2%	$444.24	$430.11	($14.13)	-3.2%
2027	$361.51	$317.73	($43.78)	-12.1%	$462.01	$406.06	($55.95)	-12.1%
2028	$375.97	$324.61	($51.36)	-13.7%	$480.49	$414.86	($65.64)	-13.7%
2029	$391.01	$331.87	($59.14)	-15.1%	$499.71	$424.13	($75.58)	-15.1%
2030	$406.65	$344.22	($62.43)	-15.4%	$519.70	$439.91	($79.79)	-15.4%
2031	$422.92	$356.99	($65.93)	-15.6%	$540.49	$456.23	($84.26)	-15.6%
2032	$439.84	$370.20	($69.63)	-15.8%	$562.11	$473.12	($88.99)	-15.8%
2033	$457.43	$383.88	($73.55)	-16.1%	$584.59	$490.59	($94.00)	-16.1%
2034	$475.73	$398.04	($77.69)	-16.3%	$607.98	$508.70	($99.28)	-16.3%
2035	$494.75	$412.70	($82.05)	-16.6%	$632.30	$527.44	($104.86)	-16.6%

Exhibit 2.1
State of Nevada
Nevada Market Stabilization Actuarial and Economic Analysis
Individual Market Changes in SLCS Plan Monthly Premium from 1332 Waiver Implementation
Rating Area 1

	21-Year Old Monthly Premium				40-Year Old Monthly Premium			
Year	Baseline	Waiver	Difference	Percent Change	Baseline	Waiver	Difference	Percent Change
2026	$320.11	$309.89	($10.21)	-3.2%	$409.10	$396.04	($13.05)	-3.2%
2027	$332.91	$292.53	($40.39)	-12.1%	$425.46	$373.85	($51.61)	-12.1%
2028	$346.23	$298.87	($47.35)	-13.7%	$442.48	$381.96	($60.52)	-13.7%
2029	$360.08	$305.56	($54.51)	-15.1%	$460.18	$390.51	($69.67)	-15.1%
2030	$374.48	$316.93	($57.55)	-15.4%	$478.58	$405.04	($73.54)	-15.4%
2031	$389.46	$328.68	($60.77)	-15.6%	$497.73	$420.06	($77.67)	-15.6%
2032	$405.04	$340.84	($64.19)	-15.8%	$517.64	$435.60	($82.04)	-15.8%
2033	$421.24	$353.42	($67.82)	-16.1%	$538.34	$451.67	($86.67)	-16.1%
2034	$438.09	$366.44	($71.65)	-16.4%	$559.88	$468.31	($91.57)	-16.4%
2035	$455.61	$379.91	($75.70)	-16.6%	$582.27	$485.52	($96.75)	-16.6%

Exhibit 2.2
State of Nevada
Nevada Market Stabilization Actuarial and Economic Analysis
Individual Market Changes in SLCS Plan Monthly Premium from 1332 Waiver Implementation
Rating Area 2

Year	21-Year Old Monthly Premium				40-Year Old Monthly Premium			
	Baseline	Waiver	Difference	Percent Change	Baseline	Waiver	Difference	Percent Change
2026	$387.74	$375.40	($12.33)	-3.2%	$495.53	$479.77	($15.76)	-3.2%
2027	$403.25	$353.28	($49.97)	-12.4%	$515.35	$451.49	($63.86)	-12.4%
2028	$419.38	$360.93	($58.45)	-13.9%	$535.96	$461.27	($74.69)	-13.9%
2029	$436.15	$369.03	($67.13)	-15.4%	$557.40	$471.62	($85.79)	-15.4%
2030	$453.60	$382.77	($70.83)	-15.6%	$579.70	$489.18	($90.52)	-15.6%
2031	$471.74	$397.00	($74.75)	-15.8%	$602.89	$507.36	($95.53)	-15.8%
2032	$490.61	$411.73	($78.89)	-16.1%	$627.00	$526.18	($100.82)	-16.1%
2033	$510.24	$426.98	($83.26)	-16.3%	$652.08	$545.68	($106.40)	-16.3%
2034	$530.65	$442.80	($87.85)	-16.6%	$678.17	$565.90	($112.27)	-16.6%
2035	$551.87	$459.24	($92.64)	-16.8%	$705.29	$586.91	($118.39)	-16.8%

Exhibit 2.3
State of Nevada
Nevada Market Stabilization Actuarial and Economic Analysis
Individual Market Changes in SLCS Plan Monthly Premium from 1332 Waiver Implementation
Rating Area 3

Year	21-Year Old Monthly Premium				40-Year Old Monthly Premium			
	Baseline	Waiver	Difference	Percent Change	Baseline	Waiver	Difference	Percent Change
2026	$579.20	$560.81	($18.40)	-3.2%	$740.22	$716.71	($23.51)	-3.2%
2027	$602.37	$535.07	($67.30)	-11.2%	$769.83	$683.82	($86.01)	-11.2%
2028	$626.47	$546.69	($79.78)	-12.7%	$800.63	$698.67	($101.96)	-12.7%
2029	$651.53	$558.97	($92.56)	-14.2%	$832.65	$714.36	($118.29)	-14.2%
2030	$677.59	$580.00	($97.59)	-14.4%	$865.96	$741.24	($124.72)	-14.4%
2031	$704.69	$601.79	($102.90)	-14.6%	$900.59	$769.09	($131.50)	-14.6%
2032	$732.88	$624.37	($108.51)	-14.8%	$936.62	$797.95	($138.67)	-14.8%
2033	$762.19	$647.76	($114.44)	-15.0%	$974.08	$827.83	($146.25)	-15.0%
2034	$792.68	$671.99	($120.69)	-15.2%	$1,013.05	$858.80	($154.25)	-15.2%
2035	$824.39	$697.08	($127.30)	-15.4%	$1,053.57	$890.87	($162.69)	-15.4%

Exhibit 2.4
State of Nevada
Nevada Market Stabilization Actuarial and Economic Analysis
Individual Market Changes in SLCS Plan Monthly Premium from 1332 Waiver Implementation
Rating Area 4

	21-Year Old Monthly Premium				40-Year Old Monthly Premium			
Year	Baseline	Waiver	Difference	Percent Change	Baseline	Waiver	Difference	Percent Change
2026	$495.54	$479.81	($15.73)	-3.2%	$633.30	$613.20	($20.10)	-3.2%
2027	$515.36	$432.37	($82.99)	-16.1%	$658.63	$552.57	($106.06)	-16.1%
2028	$535.98	$441.18	($94.80)	-17.7%	$684.98	$563.82	($121.15)	-17.7%
2029	$557.41	$450.46	($106.96)	-19.2%	$712.38	$575.68	($136.69)	-19.2%
2030	$579.71	$466.68	($113.03)	-19.5%	$740.87	$596.42	($144.45)	-19.5%
2031	$602.90	$483.40	($119.49)	-19.8%	$770.51	$617.79	($152.71)	-19.8%
2032	$627.02	$500.67	($126.34)	-20.1%	$801.33	$639.86	($161.47)	-20.1%
2033	$652.10	$518.50	($133.59)	-20.5%	$833.38	$662.65	($170.73)	-20.5%
2034	$678.18	$537.28	($140.90)	-20.8%	$866.71	$686.64	($180.07)	-20.8%
2035	$705.31	$556.64	($148.67)	-21.1%	$901.38	$711.39	($189.99)	-21.1%

Exhibit 3.1
State of Nevada
Nevada Market Stabilization Actuarial and Economic Analysis
Individual Market Average Net Premium: 2026 through 2035 by Federal Poverty Level

Average Net Premium by FPL % - Baseline

Income Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Under 100%	$ 134	$ 139	$ 145	$ 150	$ 156	$ 162	$ 168	$ 174	$ 181	$ 188
100 to 133%	$ 89	$ 93	$ 96	$ 100	$ 104	$ 108	$ 112	$ 117	$ 121	$ 126
133 to 150%	$ 114	$ 118	$ 122	$ 127	$ 131	$ 136	$ 141	$ 146	$ 151	$ 157
150 to 200%	$ 173	$ 180	$ 186	$ 193	$ 200	$ 207	$ 214	$ 221	$ 229	$ 237
200 to 250%	$ 220	$ 227	$ 235	$ 242	$ 250	$ 258	$ 266	$ 275	$ 284	$ 293
250 to 300%	$ 262	$ 271	$ 280	$ 290	$ 299	$ 309	$ 319	$ 329	$ 340	$ 351
300 to 400%	$ 355	$ 368	$ 380	$ 393	$ 406	$ 419	$ 433	$ 447	$ 462	$ 477
Over 400%	$ 608	$ 633	$ 658	$ 685	$ 712	$ 741	$ 770	$ 801	$ 833	$ 867
Total - On Exchange	**$ 233**	**$ 241**	**$ 250**	**$ 259**	**$ 268**	**$ 277**	**$ 287**	**$ 297**	**$ 308**	**$ 319**
Total - Off Exchange	**$ 504**	**$ 524**	**$ 545**	**$ 567**	**$ 590**	**$ 614**	**$ 638**	**$ 664**	**$ 690**	**$ 718**
Total Individuals	**$ 276**	**$ 286**	**$ 297**	**$ 308**	**$ 320**	**$ 331**	**$ 343**	**$ 356**	**$ 369**	**$ 382**

Average Net Premium by FPL % - With Waiver

Income Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Under 100%	$ 133	$ 128	$ 132	$ 137	$ 141	$ 146	$ 152	$ 157	$ 163	$ 168
100 to 133%	$ 89	$ 88	$ 92	$ 95	$ 99	$ 102	$ 106	$ 110	$ 114	$ 119
133 to 150%	$ 114	$ 115	$ 119	$ 124	$ 128	$ 133	$ 137	$ 142	$ 147	$ 152
150 to 200%	$ 174	$ 177	$ 184	$ 190	$ 197	$ 204	$ 211	$ 218	$ 225	$ 233
200 to 250%	$ 222	$ 228	$ 237	$ 246	$ 254	$ 262	$ 270	$ 279	$ 288	$ 297
250 to 300%	$ 265	$ 274	$ 285	$ 296	$ 306	$ 316	$ 327	$ 337	$ 349	$ 360
300 to 400%	$ 360	$ 371	$ 385	$ 400	$ 413	$ 427	$ 441	$ 455	$ 470	$ 486
Over 400%	$ 596	$ 569	$ 585	$ 603	$ 625	$ 648	$ 672	$ 697	$ 723	$ 750
Total - On Exchange	**$ 234**	**$ 236**	**$ 245**	**$ 254**	**$ 262**	**$ 271**	**$ 281**	**$ 290**	**$ 300**	**$ 310**
Total - Off Exchange	**$ 489**	**$ 464**	**$ 475**	**$ 487**	**$ 505**	**$ 523**	**$ 542**	**$ 562**	**$ 582**	**$ 603**
Total Individuals	**$ 275**	**$ 273**	**$ 282**	**$ 292**	**$ 302**	**$ 313**	**$ 323**	**$ 334**	**$ 346**	**$ 358**

Change in Average Net Premium Due to Waiver

Income Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Under 100%	$ (1)	$ (11)	$ (12)	$ (13)	$ (14)	$ (15)	$ (16)	$ (17)	$ (18)	$ (20)
100 to 133%	$ 0	$ (5)	$ (5)	$ (5)	$ (5)	$ (6)	$ (6)	$ (7)	$ (7)	$ (8)
133 to 150%	$ 1	$ (3)	$ (3)	$ (3)	$ (3)	$ (4)	$ (4)	$ (4)	$ (5)	$ (5)
150 to 200%	$ 1	$ (3)	$ (3)	$ (2)	$ (3)	$ (3)	$ (3)	$ (3)	$ (4)	$ (4)
200 to 250%	$ 2	$ 1	$ 3	$ 4	$ 4	$ 4	$ 4	$ 4	$ 4	$ 4
250 to 300%	$ 3	$ 3	$ 5	$ 7	$ 7	$ 7	$ 8	$ 8	$ 8	$ 9
300 to 400%	$ 5	$ 3	$ 5	$ 7	$ 7	$ 8	$ 8	$ 8	$ 9	$ 9
Over 400%	$ (11)	$ (64)	$ (73)	$ (82)	$ (87)	$ (93)	$ (98)	$ (104)	$ (110)	$ (117)
Total - On Exchange	**$ 1**	**$ (5)**	**$ (5)**	**$ (5)**	**$ (6)**	**$ (6)**	**$ (7)**	**$ (7)**	**$ (8)**	**$ (8)**
Total - Off Exchange	**$ (15)**	**$ (60)**	**$ (70)**	**$ (80)**	**$ (85)**	**$ (90)**	**$ (96)**	**$ (102)**	**$ (108)**	**$ (115)**
Total Individuals	**$ (1)**	**$ (13)**	**$ (15)**	**$ (16)**	**$ (17)**	**$ (19)**	**$ (20)**	**$ (22)**	**$ (22)**	**$ (25)**

Exhibit 3.2
State of Nevada
Nevada Market Stabilization Actuarial and Economic Analysis
Individual Market Average Net Premium: 2026 through 2035 by Meta

Average Net Premium by Metal - Baseline

Plan Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Bronze	$ 234	$ 243	$ 251	$ 260	$ 269	$ 278	$ 288	$ 297	$ 307	$ 318
Silver	$ 212	$ 220	$ 228	$ 236	$ 244	$ 253	$ 262	$ 271	$ 281	$ 291
Gold	$ 512	$ 532	$ 553	$ 574	$ 596	$ 618	$ 642	$ 666	$ 691	$ 717
Total - On Exchange	**$ 233**	**$ 241**	**$ 250**	**$ 259**	**$ 268**	**$ 277**	**$ 287**	**$ 297**	**$ 308**	**$ 319**
Total - Off Exchange	**$ 504**	**$ 524**	**$ 545**	**$ 567**	**$ 590**	**$ 614**	**$ 638**	**$ 664**	**$ 690**	**$ 718**
Total Individuals	**$ 276**	**$ 286**	**$ 297**	**$ 308**	**$ 320**	**$ 331**	**$ 343**	**$ 356**	**$ 369**	**$ 382**

Average Net Premium by Metal - With Waiver

Plan Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Bronze	$ 237	$ 242	$ 252	$ 262	$ 270	$ 280	$ 289	$ 298	$ 308	$ 319
Silver	$ 213	$ 213	$ 221	$ 229	$ 237	$ 245	$ 253	$ 262	$ 271	$ 280
Gold	$ 509	$ 499	$ 517	$ 534	$ 553	$ 573	$ 593	$ 614	$ 636	$ 658
Total - On Exchange	**$ 234**	**$ 236**	**$ 245**	**$ 254**	**$ 262**	**$ 271**	**$ 281**	**$ 290**	**$ 300**	**$ 310**
Total - Off Exchange	**$ 489**	**$ 464**	**$ 475**	**$ 487**	**$ 505**	**$ 523**	**$ 542**	**$ 562**	**$ 582**	**$ 603**
Total Individuals	**$ 275**	**$ 273**	**$ 282**	**$ 292**	**$ 302**	**$ 313**	**$ 323**	**$ 334**	**$ 346**	**$ 358**

Change in Average Net Premium Due to Waiver

Plan Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Bronze	$ 3	$ (0)	$ 1	$ 2	$ 1	$ 1	$ 1	$ 1	$ 1	$ 1
Silver	$ 0	$ (6)	$ (7)	$ (7)	$ (8)	$ (8)	$ (9)	$ (10)	$ (10)	$ (11)
Gold	$ (3)	$ (33)	$ (37)	$ (40)	$ (43)	$ (46)	$ (48)	$ (52)	$ (55)	$ (58)
Total - On Exchange	**$ 1**	**$ (5)**	**$ (5)**	**$ (5)**	**$ (6)**	**$ (6)**	**$ (7)**	**$ (7)**	**$ (8)**	**$ (8)**
Total - Off Exchange	**$ (15)**	**$ (60)**	**$ (70)**	**$ (80)**	**$ (85)**	**$ (90)**	**$ (96)**	**$ (102)**	**$ (108)**	**$ (115)**
Total Individuals	**$ (1)**	**$ (13)**	**$ (15)**	**$ (16)**	**$ (17)**	**$ (19)**	**$ (20)**	**$ (22)**	**$ (22)**	**$ (25)**

Exhibit 3.3
State of Nevada
Nevada Market Stabilization Actuarial and Economic Analysis
Individual Market Average Net Premium: 2026 through 2035 by Age Group

Average Net Premium by Age Group - Baseline

Age Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
0-14	$ 200	$ 208	$ 216	$ 224	$ 232	$ 240	$ 249	$ 258	$ 267	$ 277
14-20	$ 182	$ 189	$ 195	$ 202	$ 209	$ 216	$ 224	$ 232	$ 239	$ 248
21-25	$ 183	$ 190	$ 196	$ 203	$ 210	$ 218	$ 225	$ 233	$ 241	$ 250
26-30	$ 214	$ 222	$ 230	$ 238	$ 246	$ 255	$ 264	$ 273	$ 283	$ 292
31-35	$ 205	$ 213	$ 220	$ 228	$ 236	$ 244	$ 253	$ 262	$ 271	$ 280
36-40	$ 195	$ 202	$ 209	$ 217	$ 224	$ 232	$ 240	$ 249	$ 257	$ 266
41-45	$ 195	$ 202	$ 209	$ 217	$ 224	$ 232	$ 240	$ 249	$ 257	$ 266
46-50	$ 208	$ 215	$ 223	$ 231	$ 239	$ 247	$ 256	$ 265	$ 274	$ 283
51-55	$ 236	$ 245	$ 253	$ 262	$ 272	$ 281	$ 291	$ 301	$ 312	$ 323
56-60	$ 272	$ 282	$ 292	$ 303	$ 313	$ 324	$ 336	$ 348	$ 360	$ 373
60-65	$ 311	$ 323	$ 335	$ 347	$ 359	$ 372	$ 385	$ 399	$ 413	$ 428
Over 65	$ 165	$ 172	$ 178	$ 184	$ 191	$ 198	$ 205	$ 212	$ 220	$ 228
Total - On Exchange	**$ 233**	**$ 241**	**$ 250**	**$ 259**	**$ 268**	**$ 277**	**$ 287**	**$ 297**	**$ 308**	**$ 319**
Total - Off Exchange	**$ 504**	**$ 524**	**$ 545**	**$ 567**	**$ 590**	**$ 614**	**$ 638**	**$ 664**	**$ 690**	**$ 718**
Total Individuals	**$ 276**	**$ 286**	**$ 297**	**$ 308**	**$ 320**	**$ 331**	**$ 343**	**$ 356**	**$ 369**	**$ 382**

Average Net Premium by Age Group - With Waiver

Age Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
0-14	$ 199	$ 196	$ 202	$ 208	$ 215	$ 223	$ 231	$ 239	$ 247	$ 256
14-20	$ 182	$ 183	$ 189	$ 195	$ 202	$ 209	$ 217	$ 224	$ 232	$ 240
21-25	$ 183	$ 185	$ 191	$ 197	$ 204	$ 211	$ 218	$ 226	$ 233	$ 241
26-30	$ 214	$ 214	$ 221	$ 229	$ 237	$ 245	$ 253	$ 262	$ 271	$ 280
31-35	$ 206	$ 207	$ 214	$ 221	$ 229	$ 237	$ 245	$ 253	$ 262	$ 271
36-40	$ 196	$ 198	$ 205	$ 212	$ 219	$ 227	$ 234	$ 242	$ 250	$ 259
41-45	$ 196	$ 198	$ 205	$ 212	$ 219	$ 227	$ 234	$ 242	$ 250	$ 259
46-50	$ 209	$ 211	$ 219	$ 227	$ 235	$ 242	$ 251	$ 259	$ 268	$ 277
51-55	$ 237	$ 240	$ 249	$ 258	$ 267	$ 276	$ 285	$ 295	$ 305	$ 315
56-60	$ 274	$ 276	$ 287	$ 298	$ 308	$ 319	$ 329	$ 341	$ 352	$ 364
60-65	$ 314	$ 317	$ 329	$ 342	$ 354	$ 366	$ 378	$ 391	$ 405	$ 418
Over 65	$ 167	$ 168	$ 175	$ 182	$ 188	$ 195	$ 202	$ 208	$ 216	$ 223
Total - On Exchange	**$ 234**	**$ 236**	**$ 245**	**$ 254**	**$ 262**	**$ 271**	**$ 281**	**$ 290**	**$ 300**	**$ 310**
Total - Off Exchange	**$ 489**	**$ 464**	**$ 475**	**$ 487**	**$ 505**	**$ 523**	**$ 542**	**$ 562**	**$ 582**	**$ 603**
Total Individuals	**$ 275**	**$ 273**	**$ 282**	**$ 292**	**$ 302**	**$ 313**	**$ 323**	**$ 334**	**$ 346**	**$ 358**

Change in Average Net Premium Due to Waiver

Age Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
0-14	$ (1)	$ (12)	$ (14)	$ (15)	$ (16)	$ (17)	$ (18)	$ (19)	$ (20)	$ (21)
14-20	$ (0)	$ (5)	$ (6)	$ (7)	$ (7)	$ (7)	$ (7)	$ (7)	$ (8)	$ (8)
21-25	$ 0	$ (5)	$ (5)	$ (6)	$ (6)	$ (7)	$ (7)	$ (8)	$ (8)	$ (8)
26-30	$ (0)	$ (8)	$ (9)	$ (9)	$ (10)	$ (10)	$ (11)	$ (11)	$ (12)	$ (12)
31-35	$ 0	$ (6)	$ (6)	$ (7)	$ (7)	$ (8)	$ (8)	$ (9)	$ (9)	$ (10)
36-40	$ 1	$ (4)	$ (5)	$ (5)	$ (5)	$ (5)	$ (6)	$ (6)	$ (7)	$ (7)
41-45	$ 1	$ (4)	$ (5)	$ (5)	$ (5)	$ (5)	$ (6)	$ (6)	$ (7)	$ (7)
46-50	$ 1	$ (4)	$ (4)	$ (4)	$ (4)	$ (5)	$ (5)	$ (5)	$ (6)	$ (6)
51-55	$ 1	$ (4)	$ (4)	$ (4)	$ (5)	$ (5)	$ (6)	$ (6)	$ (7)	$ (7)
56-60	$ 2	$ (5)	$ (5)	$ (5)	$ (5)	$ (6)	$ (7)	$ (7)	$ (8)	$ (9)
60-65	$ 3	$ (6)	$ (6)	$ (5)	$ (6)	$ (6)	$ (7)	$ (8)	$ (9)	$ (10)
Over 65	$ 2	$ (3)	$ (3)	$ (2)	$ (3)	$ (3)	$ (3)	$ (4)	$ (4)	$ (5)
Total - On Exchange	**$ 1**	**$ (5)**	**$ (5)**	**$ (5)**	**$ (6)**	**$ (6)**	**$ (7)**	**$ (7)**	**$ (8)**	**$ (8)**
Total - Off Exchange	**$ (15)**	**$ (60)**	**$ (70)**	**$ (80)**	**$ (85)**	**$ (90)**	**$ (96)**	**$ (102)**	**$ (108)**	**$ (115)**
Total Individuals	**$ (1)**	**$ (13)**	**$ (15)**	**$ (16)**	**$ (17)**	**$ (19)**	**$ (20)**	**$ (22)**	**$ (22)**	**$ (25)**

Exhibit 3.4
State of Nevada
Nevada Market Stabilization Actuarial and Economic Analysis
Individual Market Average Net Premium: 2026 through 2035 by APTC Eligibility

Average Net Premium by Subsidy Eligibility - Baseline

Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Subsidized	$ 194	$ 201	$ 208	$ 216	$ 223	$ 231	$ 238	$ 247	$ 255	$ 263
Unsubsidized	$ 568	$ 597	$ 622	$ 650	$ 676	$ 704	$ 733	$ 763	$ 793	$ 825
Total - On Exchange	**$ 233**	**$ 241**	**$ 250**	**$ 259**	**$ 268**	**$ 277**	**$ 287**	**$ 297**	**$ 308**	**$ 319**
Total - Off Exchange	**$ 504**	**$ 524**	**$ 545**	**$ 567**	**$ 590**	**$ 614**	**$ 638**	**$ 664**	**$ 690**	**$ 718**
Total Individuals	**$ 276**	**$ 286**	**$ 297**	**$ 308**	**$ 320**	**$ 331**	**$ 343**	**$ 356**	**$ 369**	**$ 382**

Average Net Premium by Subsidy Eligibility - With Waiver

Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Subsidized	$ 196	$ 199	$ 207	$ 215	$ 222	$ 229	$ 237	$ 245	$ 253	$ 261
Unsubsidized	$ 557	$ 515	$ 528	$ 543	$ 563	$ 585	$ 607	$ 632	$ 657	$ 681
Total - On Exchange	**$ 234**	**$ 236**	**$ 245**	**$ 254**	**$ 262**	**$ 271**	**$ 281**	**$ 290**	**$ 300**	**$ 310**
Total - Off Exchange	**$ 489**	**$ 464**	**$ 475**	**$ 487**	**$ 505**	**$ 523**	**$ 542**	**$ 562**	**$ 582**	**$ 603**
Total Individuals	**$ 275**	**$ 273**	**$ 282**	**$ 292**	**$ 302**	**$ 313**	**$ 323**	**$ 334**	**$ 346**	**$ 358**

Change in Average Net Premium Due to Waiver

Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Subsidized	$ 2	$ (2)	$ (2)	$ (1)	$ (1)	$ (1)	$ (2)	$ (2)	$ (2)	$ (2)
Unsubsidized	$ (11)	$ (82)	$ (94)	$ (107)	$ (112)	$ (119)	$ (126)	$ (131)	$ (136)	$ (144)
Total - On Exchange	**$ 1**	**$ (5)**	**$ (5)**	**$ (5)**	**$ (6)**	**$ (6)**	**$ (7)**	**$ (7)**	**$ (8)**	**$ (8)**
Total - Off Exchange	**$ (15)**	**$ (60)**	**$ (70)**	**$ (80)**	**$ (85)**	**$ (90)**	**$ (96)**	**$ (102)**	**$ (108)**	**$ (115)**
Total Individuals	**$ (1)**	**$ (13)**	**$ (15)**	**$ (16)**	**$ (17)**	**$ (19)**	**$ (20)**	**$ (22)**	**$ (22)**	**$ (25)**

Exhibit 3.5
State of Nevada
Nevada Market Stabilization Actuarial and Economic Analysis
Individual Market Average Net Premium: 2026 through 2035 by Rating Area

Average Net Premium by Rating Area - Baseline

Rating Area	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Rating Area 1	$ 218	$ 226	$ 234	$ 242	$ 251	$ 260	$ 269	$ 278	$ 288	$ 298
Rating Area 2	$ 314	$ 326	$ 338	$ 350	$ 363	$ 376	$ 389	$ 403	$ 418	$ 433
Rating Area 3	$ 247	$ 256	$ 266	$ 275	$ 284	$ 294	$ 304	$ 315	$ 326	$ 337
Rating Area 4	$ 246	$ 255	$ 264	$ 274	$ 283	$ 293	$ 303	$ 314	$ 325	$ 336
Total - On Exchange	**$ 233**	**$ 241**	**$ 250**	**$ 259**	**$ 268**	**$ 277**	**$ 287**	**$ 297**	**$ 308**	**$ 319**
Total - Off Exchange	**$ 504**	**$ 524**	**$ 545**	**$ 567**	**$ 590**	**$ 614**	**$ 638**	**$ 664**	**$ 690**	**$ 718**
Total Individuals	**$ 276**	**$ 286**	**$ 297**	**$ 308**	**$ 320**	**$ 331**	**$ 343**	**$ 356**	**$ 369**	**$ 382**

Average Net Premium by Rating Area - With Waiver

Rating Area	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Rating Area 1	$ 219	$ 221	$ 229	$ 237	$ 246	$ 254	$ 263	$ 271	$ 281	$ 290
Rating Area 2	$ 314	$ 314	$ 326	$ 337	$ 349	$ 361	$ 373	$ 386	$ 399	$ 413
Rating Area 3	$ 252	$ 258	$ 269	$ 280	$ 290	$ 300	$ 310	$ 320	$ 331	$ 342
Rating Area 4	$ 250	$ 251	$ 261	$ 271	$ 280	$ 289	$ 299	$ 309	$ 319	$ 330
Total - On Exchange	**$ 234**	**$ 236**	**$ 245**	**$ 254**	**$ 262**	**$ 271**	**$ 281**	**$ 290**	**$ 300**	**$ 310**
Total - Off Exchange	**$ 489**	**$ 464**	**$ 475**	**$ 487**	**$ 505**	**$ 523**	**$ 542**	**$ 562**	**$ 582**	**$ 603**
Total Individuals	**$ 275**	**$ 273**	**$ 282**	**$ 292**	**$ 302**	**$ 313**	**$ 323**	**$ 334**	**$ 346**	**$ 358**

Change in Average Net Premium Due to Waiver

Rating Area	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Rating Area 1	$ 1	$ (5)	$ (5)	$ (5)	$ (5)	$ (6)	$ (6)	$ (7)	$ (7)	$ (8)
Rating Area 2	$ 1	$ (11)	$ (12)	$ (13)	$ (14)	$ (15)	$ (16)	$ (17)	$ (18)	$ (19)
Rating Area 3	$ 4	$ 2	$ 4	$ 5	$ 5	$ 5	$ 5	$ 5	$ 5	$ 5
Rating Area 4	$ 3	$ (5)	$ (4)	$ (3)	$ (4)	$ (4)	$ (5)	$ (5)	$ (6)	$ (6)
Total - On Exchange	**$ 1**	**$ (5)**	**$ (5)**	**$ (5)**	**$ (6)**	**$ (6)**	**$ (7)**	**$ (7)**	**$ (8)**	**$ (8)**
Total - Off Exchange	**$ (15)**	**$ (60)**	**$ (70)**	**$ (80)**	**$ (85)**	**$ (90)**	**$ (96)**	**$ (102)**	**$ (108)**	**$ (115)**
Total Individuals	**$ (1)**	**$ (13)**	**$ (15)**	**$ (16)**	**$ (17)**	**$ (19)**	**$ (20)**	**$ (22)**	**$ (22)**	**$ (25)**

Exhibit 4.1
State of Nevada
Nevada Market Stabilization Actuarial and Economic Analysis
Individual Market Estimated Enrollees: 2026 through 2035 by Federal Poverty Leve

Total Enrollment by FPL % - Baseline

Income Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Under 100%	1,830	1,850	1,880	1,900	1,930	1,950	1,980	2,000	2,030	2,060
100 to 133%	6,120	6,200	6,290	6,370	6,450	6,530	6,620	6,700	6,790	6,880
133 to 150%	13,160	13,330	13,500	13,680	13,860	14,040	14,220	14,400	14,590	14,780
150 to 200%	22,720	23,010	23,310	23,610	23,920	24,230	24,550	24,870	25,190	25,520
200 to 250%	18,900	19,140	19,390	19,650	19,900	20,160	20,420	20,690	20,960	21,230
250 to 300%	11,040	11,190	11,330	11,480	11,630	11,780	11,930	12,090	12,250	12,410
300 to 400%	8,150	8,260	8,370	8,480	8,590	8,700	8,810	8,920	9,040	9,160
Over 400%	19,510	19,760	20,020	20,280	20,540	20,810	21,080	21,360	21,630	21,910
Total Individual*	**101,430**	**102,750**	**104,090**	**105,440**	**106,810**	**108,200**	**109,610**	**111,030**	**112,480**	**113,940**

Total Enrollment by FPL % - With Waiver

Income Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Under 100%	1,840	1,890	1,910	1,940	1,970	1,990	2,020	2,040	2,070	2,100
100 to 133%	6,130	6,260	6,340	6,420	6,510	6,590	6,680	6,770	6,850	6,940
133 to 150%	13,170	13,460	13,630	13,810	13,990	14,170	14,360	14,540	14,730	14,920
150 to 200%	22,760	23,290	23,600	23,910	24,220	24,530	24,850	25,170	25,500	25,830
200 to 250%	18,930	19,380	19,630	19,890	20,150	20,410	20,680	20,950	21,220	21,490
250 to 300%	11,070	11,340	11,490	11,640	11,790	11,940	12,100	12,260	12,420	12,580
300 to 400%	8,240	8,480	8,590	8,700	8,820	8,930	9,050	9,160	9,280	9,400
Over 400%	19,840	20,460	20,820	21,130	21,410	21,690	21,970	22,250	22,540	22,840
Total Individual*	**101,970**	**104,550**	**106,020**	**107,450**	**108,850**	**110,260**	**111,700**	**113,150**	**114,620**	**116,110**

Change in Enrollment Due to Waiver

Income Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Under 100%	10	40	30	40	40	40	40	40	40	40
100 to 133%	10	60	50	50	60	60	60	70	60	60
133 to 150%	10	130	130	130	130	130	140	140	140	140
150 to 200%	40	280	290	300	300	300	300	300	310	310
200 to 250%	30	240	240	240	250	250	260	260	260	260
250 to 300%	30	150	160	160	160	160	170	170	170	170
300 to 400%	90	220	220	220	230	230	240	240	240	240
Over 400%	330	700	800	850	870	880	890	890	910	930
Total Individual*	**540**	**1,800**	**1,930**	**2,010**	**2,040**	**2,060**	**2,090**	**2,120**	**2,140**	**2,170**

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

Exhibit 4.2
State of Nevada
Nevada Market Stabilization Actuarial and Economic Analysis
Individual Market Estimated Enrollees: 2026 through 2035 by Metal

Total Enrollment by Metal - Baseline

Plan Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Catastrophic	810	820	830	840	850	870	880	890	900	910
Bronze	40,550	41,080	41,610	42,150	42,700	43,250	43,820	44,390	44,960	45,550
Silver	56,200	56,930	57,670	58,420	59,180	59,950	60,730	61,520	62,320	63,130
Gold	3,870	3,920	3,970	4,020	4,080	4,130	4,180	4,240	4,290	4,350
Total Individual*	**101,430**	**102,750**	**104,090**	**105,440**	**106,810**	**108,200**	**109,610**	**111,030**	**112,480**	**113,940**

Total Enrollment by Metal - With Waiver

Plan Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Catastrophic	830	850	870	880	890	900	910	930	940	950
Bronze	40,860	41,970	42,580	43,170	43,730	44,300	44,870	45,460	46,050	46,650
Silver	56,380	57,730	58,510	59,290	60,060	60,840	61,630	62,430	63,240	64,070
Gold	3,900	4,000	4,060	4,120	4,170	4,220	4,280	4,330	4,390	4,450
Total Individual*	**101,970**	**104,550**	**106,020**	**107,450**	**108,850**	**110,260**	**111,700**	**113,150**	**114,620**	**116,110**

Change in Enrollment Due to Waiver

Plan Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Catastrophic	20	30	40	40	40	30	30	40	40	40
Bronze	310	890	970	1,020	1,030	1,050	1,050	1,070	1,090	1,100
Silver	180	800	840	870	880	890	900	910	920	940
Gold	30	80	90	100	90	90	100	90	100	100
Total Individual*	**540**	**1,800**	**1,930**	**2,010**	**2,040**	**2,060**	**2,090**	**2,120**	**2,140**	**2,170**

**Changes at the metal level may not sum to the total due to rounding.*

Exhibit 4.3
State of Nevada
Nevada Market Stabilization Actuarial and Economic Analysis
Individual Market Estimated Enrollees: 2026 through 2035 by Age Group

Total Enrollment by Age Group - Baseline

Age Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
0-14	12,550	12,710	12,870	13,040	13,210	13,380	13,560	13,730	13,910	14,090
14-20	5,530	5,600	5,670	5,740	5,820	5,890	5,970	6,050	6,130	6,210
21-25	4,690	4,750	4,810	4,870	4,940	5,000	5,070	5,130	5,200	5,270
26-30	7,510	7,610	7,710	7,810	7,910	8,010	8,120	8,220	8,330	8,440
31-35	8,420	8,530	8,640	8,750	8,870	8,980	9,100	9,220	9,340	9,460
36-40	8,320	8,430	8,540	8,650	8,760	8,880	8,990	9,110	9,230	9,350
41-45	7,800	7,900	8,000	8,100	8,210	8,320	8,420	8,530	8,640	8,760
46-50	8,370	8,480	8,590	8,700	8,820	8,930	9,050	9,170	9,280	9,410
51-55	10,420	10,550	10,690	10,830	10,970	11,110	11,260	11,400	11,550	11,700
56-60	12,950	13,120	13,290	13,460	13,640	13,810	13,990	14,170	14,360	14,550
60-65	13,180	13,360	13,530	13,700	13,880	14,060	14,250	14,430	14,620	14,810
Over 65	1,700	1,720	1,750	1,770	1,790	1,820	1,840	1,860	1,890	1,910
Total Individual*	**101,430**	**102,750**	**104,090**	**105,440**	**106,810**	**108,200**	**109,610**	**111,030**	**112,480**	**113,940**

Total Enrollment by Age Group - With Waiver

Age Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
0-14	12,610	12,930	13,110	13,290	13,460	13,640	13,820	14,000	14,180	14,360
14-20	5,560	5,700	5,780	5,850	5,930	6,010	6,080	6,160	6,240	6,330
21-25	4,710	4,830	4,900	4,970	5,030	5,100	5,160	5,230	5,300	5,370
26-30	7,550	7,740	7,850	7,960	8,060	8,160	8,270	8,380	8,490	8,600
31-35	8,460	8,680	8,800	8,920	9,030	9,150	9,270	9,390	9,510	9,640
36-40	8,370	8,580	8,700	8,820	8,930	9,050	9,160	9,280	9,400	9,530
41-45	7,840	8,040	8,150	8,260	8,370	8,470	8,580	8,700	8,810	8,920
46-50	8,420	8,630	8,750	8,870	8,990	9,100	9,220	9,340	9,460	9,580
51-55	10,470	10,740	10,890	11,040	11,180	11,320	11,470	11,620	11,770	11,930
56-60	13,020	13,350	13,530	13,720	13,900	14,080	14,260	14,440	14,630	14,820
60-65	13,250	13,590	13,780	13,970	14,150	14,330	14,520	14,710	14,900	15,090
Over 65	1,710	1,760	1,780	1,800	1,830	1,850	1,870	1,900	1,920	1,950
Total Individual*	**101,970**	**104,550**	**106,020**	**107,450**	**108,850**	**110,260**	**111,700**	**113,150**	**114,620**	**116,110**

Change in Enrollment Due to Waiver

Age Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
0-14	60	220	240	250	250	260	260	270	270	270
14-20	30	100	110	110	110	120	110	110	110	120
21-25	20	80	90	100	90	100	90	100	100	100
26-30	40	130	140	150	150	150	150	160	160	160
31-35	40	150	160	170	160	170	170	170	170	180
36-40	50	150	160	170	170	170	170	170	170	180
41-45	40	140	150	160	160	150	160	170	170	160
46-50	50	150	160	170	170	170	170	170	180	170
51-55	50	190	200	210	210	210	210	220	220	230
56-60	70	230	240	260	260	270	270	270	270	270
60-65	70	230	250	270	270	270	270	280	280	280
Over 65	10	40	30	30	40	30	30	40	30	40
Total Individual*	**540**	**1,800**	**1,930**	**2,010**	**2,040**	**2,060**	**2,090**	**2,120**	**2,140**	**2,170**

**Changes at the age group level may not sum to the total due to rounding.*

Exhibit 4.4
State of Nevada
Nevada Market Stabilization Actuarial and Economic Analysis
Individual Market Estimated Enrollees: 2026 through 2035 by APTC Eligibility

Total Enrollment by Subsidy Eligibility - Baseline

Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Subsidized	76,390	77,600	78,660	79,780	80,810	81,900	82,990	84,070	85,180	86,290
Unsubsidized	25,040	25,160	25,430	25,670	26,000	26,300	26,620	26,960	27,300	27,650
Total Individual*	**101,430**	**102,750**	**104,090**	**105,440**	**106,810**	**108,200**	**109,610**	**111,030**	**112,480**	**113,940**

Total Enrollment by Subsidy Eligibility - With Waiver

Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Subsidized	76,460	77,310	78,210	79,120	80,220	81,300	82,390	83,560	84,740	85,850
Unsubsidized	25,510	27,240	27,810	28,330	28,620	28,970	29,310	29,580	29,880	30,260
Total Individual*	**101,970**	**104,550**	**106,020**	**107,450**	**108,850**	**110,260**	**111,700**	**113,150**	**114,620**	**116,110**

Change in Enrollment Due to Waiver

Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Subsidized	70	(290)	(450)	(660)	(590)	(600)	(600)	(510)	(440)	(440)
Unsubsidized	470	2,080	2,380	2,660	2,620	2,670	2,690	2,620	2,580	2,610
Total Individual*	**540**	**1,800**	**1,930**	**2,010**	**2,040**	**2,060**	**2,090**	**2,120**	**2,140**	**2,170**

**Changes at the subsidized level may not sum to the total due to rounding.*

Exhibit 4.5
State of Nevada
Nevada Market Stabilization Actuarial and Economic Analysis
Individual Market Estimated Enrollees: 2026 through 2035 by Rating Area

Total Enrollment by Rating Area - Baseline

Rating Area	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Rating Area 1	79,950	80,980	82,040	83,100	84,180	85,280	86,390	87,510	88,650	89,800
Rating Area 2	14,030	14,210	14,400	14,590	14,780	14,970	15,160	15,360	15,560	15,760
Rating Area 3	5,240	5,310	5,370	5,440	5,520	5,590	5,660	5,730	5,810	5,880
Rating Area 4	2,220	2,250	2,280	2,310	2,340	2,370	2,400	2,430	2,460	2,490
Total Individual*	**101,430**	**102,750**	**104,090**	**105,440**	**106,810**	**108,200**	**109,610**	**111,030**	**112,480**	**113,940**

Total Enrollment by Rating Area - With Waiver

Rating Area	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Rating Area 1	80,350	82,210	83,360	84,480	85,580	86,690	87,820	88,960	90,120	91,290
Rating Area 2	14,130	14,500	14,710	14,910	15,100	15,300	15,500	15,700	15,900	16,110
Rating Area 3	5,260	5,470	5,550	5,620	5,700	5,770	5,850	5,920	6,000	6,080
Rating Area 4	2,230	2,370	2,400	2,440	2,470	2,500	2,530	2,560	2,600	2,630
Total Individual*	**101,970**	**104,550**	**106,020**	**107,450**	**108,850**	**110,260**	**111,700**	**113,150**	**114,620**	**116,110**

Change in Enrollment Due to Waiver

Rating Area	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Rating Area 1	400	1,230	1,320	1,380	1,400	1,410	1,430	1,450	1,470	1,490
Rating Area 2	100	290	310	320	320	330	340	340	340	350
Rating Area 3	20	160	180	180	180	180	190	190	190	200
Rating Area 4	10	120	120	130	130	130	130	130	140	140
Total Individual*	**540**	**1,800**	**1,930**	**2,010**	**2,040**	**2,060**	**2,090**	**2,120**	**2,140**	**2,170**

**Changes at the rating area level may not sum to the total due to rounding.*

Exhibit 5.1
State of Nevada
NMSP Actuarial and Economic Analysis
Baseline Scenario
Summary of Enrollment and Gross Premium by BBSP and Standard QHP Segments - Rating Area 1

	BBSP				Standard QHP			Total		
			Gross Premium			Gross Premium			Gross Premium	
Year	BBSP Take-Up %	Enrollment	Aggregate (thousands)	PMPM	Enrollment	Aggregate (thousands)	PMPM	Enrollment	Aggregate (thousands)	PMPM
2026	0%	0	$0	$0	80,000	$528,000	$550	80,000	$528,000	$550
2027	0%	0	$0	$0	81,000	$557,000	$573	81,000	$557,000	$573
2028	0%	0	$0	$0	82,100	$587,000	$596	82,100	$587,000	$596
2029	0%	0	$0	$0	83,200	$619,000	$620	83,200	$619,000	$620
2030	0%	0	$0	$0	84,100	$652,000	$646	84,100	$652,000	$646
2031	0%	0	$0	$0	85,300	$686,000	$671	85,300	$686,000	$671
2032	0%	0	$0	$0	86,300	$723,000	$698	86,300	$723,000	$698
2033	0%	0	$0	$0	87,500	$762,000	$726	87,500	$762,000	$726
2034	0%	0	$0	$0	88,600	$803,000	$755	88,600	$803,000	$755
2035	0%	0	$0	$0	89,800	$845,000	$785	89,800	$845,000	$785

Exhibit 5.2
State of Nevada
NMSP Actuarial and Economic Analysis
Baseline Scenario
Summary of Enrollment and Gross Premium by BBSP and Standard QHP Segments - Rating Area 2

	BBSP				Standard QHP			Total		
			Gross Premium			Gross Premium			Gross Premium	
Year	BBSP Take-Up %	Enrollment	Aggregate (thousands)	PMPM	Enrollment	Aggregate (thousands)	PMPM	Enrollment	Aggregate (thousands)	PMPM
2026	0%	0	$0	$0	14,000	$115,000	$685	14,000	$115,000	$685
2027	0%	0	$0	$0	14,200	$121,000	$712	14,200	$121,000	$712
2028	0%	0	$0	$0	14,400	$128,000	$741	14,400	$128,000	$741
2029	0%	0	$0	$0	14,600	$135,000	$770	14,600	$135,000	$770
2030	0%	0	$0	$0	14,800	$142,000	$800	14,800	$142,000	$800
2031	0%	0	$0	$0	14,900	$150,000	$837	14,900	$150,000	$837
2032	0%	0	$0	$0	15,200	$158,000	$864	15,200	$158,000	$864
2033	0%	0	$0	$0	15,400	$166,000	$899	15,400	$166,000	$899
2034	0%	0	$0	$0	15,600	$175,000	$935	15,600	$175,000	$935
2035	0%	0	$0	$0	15,800	$184,000	$972	15,800	$184,000	$972

Exhibit 5.3
State of Nevada
NMSP Actuarial and Economic Analysis
Baseline Scenario
Summary of Enrollment and Gross Premium by BBSP and Standard QHP Segments - Rating Area 3

	BBSP				Standard QHP			Total		
			Gross Premium			Gross Premium			Gross Premium	
Year	BBSP Take-Up %	Enrollment	Aggregate (thousands)	PMPM	Enrollment	Aggregate (thousands)	PMPM	Enrollment	Aggregate (thousands)	PMPM
2026	0%	0	$0	$0	5,100	$57,000	$931	5,100	$57,000	$931
2027	0%	0	$0	$0	5,300	$60,000	$944	5,300	$60,000	$944
2028	0%	0	$0	$0	5,400	$63,000	$977	5,400	$63,000	$977
2029	0%	0	$0	$0	5,400	$67,000	$1,030	5,400	$67,000	$1,030
2030	0%	0	$0	$0	5,500	$70,000	$1,065	5,500	$70,000	$1,065
2031	0%	0	$0	$0	5,600	$74,000	$1,102	5,600	$74,000	$1,102
2032	0%	0	$0	$0	5,700	$78,000	$1,141	5,700	$78,000	$1,141
2033	0%	0	$0	$0	5,700	$82,000	$1,202	5,700	$82,000	$1,202
2034	0%	0	$0	$0	5,800	$87,000	$1,244	5,800	$87,000	$1,244
2035	0%	0	$0	$0	5,800	$91,000	$1,311	5,800	$91,000	$1,311

Exhibit 5.4
State of Nevada
NMSP Actuarial and Economic Analysis
Baseline Scenario
Summary of Enrollment and Gross Premium by BBSP and Standard QHP Segments - Rating Area 4

	BBSP				Standard QHP			Total		
			Gross Premium			Gross Premium			Gross Premium	
Year	BSP Take-Up	Enrollment	Aggregate (thousands)	PMPM	Enrollment	Aggregate (thousands)	PMPM	Enrollment	Aggregate (thousands)	PMPM
2026	0%	0	$0	$0	2,300	$22,000	$783	2,300	$22,000	$783
2027	0%	0	$0	$0	2,200	$23,000	$862	2,200	$23,000	$862
2028	0%	0	$0	$0	2,300	$24,000	$870	2,300	$24,000	$870
2029	0%	0	$0	$0	2,300	$25,000	$917	2,300	$25,000	$917
2030	0%	0	$0	$0	2,400	$27,000	$925	2,400	$27,000	$925
2031	0%	0	$0	$0	2,400	$28,000	$975	2,400	$28,000	$975
2032	0%	0	$0	$0	2,400	$30,000	$1,027	2,400	$30,000	$1,027
2033	0%	0	$0	$0	2,500	$31,000	$1,039	2,500	$31,000	$1,039
2034	0%	0	$0	$0	2,500	$33,000	$1,094	2,500	$33,000	$1,094
2035	0%	0	$0	$0	2,500	$35,000	$1,153	2,500	$35,000	$1,153

Exhibit 6.1
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Market Stabilization Scenario
Summary of Enrollment and Gross Premium by BBSP and Standard QHP Segments - Rating Area 1

	BBSP				Standard QHP			Total		
			Gross Premium			Gross Premium			Gross Premium	
Year	BBSP Take-Up %	Enrollment	Aggregate (thousands)	PMPM	Enrollment	Aggregate (thousands)	PMPM	Enrollment	Aggregate (thousands)	PMPM
2026	77%	62,000	$401,000	$539	18,300	$116,000	$527	80,300	$517,000	$536
2027	77%	63,500	$387,000	$508	18,600	$114,000	$512	82,100	$501,000	$509
2028	77%	64,400	$401,000	$518	19,000	$120,000	$527	83,400	$521,000	$520
2029	77%	65,300	$415,000	$530	19,100	$126,000	$552	84,400	$541,000	$535
2030	77%	66,100	$436,000	$550	19,500	$133,000	$567	85,600	$569,000	$554
2031	77%	66,900	$458,000	$570	19,800	$139,000	$587	86,700	$597,000	$574
2032	77%	67,900	$481,000	$590	20,000	$147,000	$611	87,900	$628,000	$595
2033	77%	68,600	$505,000	$614	20,600	$154,000	$622	89,200	$659,000	$616
2034	77%	69,600	$531,000	$635	20,400	$162,000	$660	90,000	$693,000	$641
2035	77%	70,500	$557,000	$659	20,900	$170,000	$676	91,400	$727,000	$663

Exhibit 6.2
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Market Stabilization Scenario
Summary of Enrollment and Gross Premium by BBSP and Standard QHP Segments - Rating Area 2

	BBSP				Standard QHP			Total		
			Gross Premium			Gross Premium			Gross Premium	
Year	BBSP Take-Up %	Enrollment	Aggregate (thousands)	PMPM	Enrollment	Aggregate (thousands)	PMPM	Enrollment	Aggregate (thousands)	PMPM
2026	74%	10,500	$84,000	$664	3,700	$29,000	$658	14,200	$113,000	$663
2027	74%	10,700	$81,000	$629	3,800	$29,000	$632	14,500	$110,000	$630
2028	74%	10,900	$84,000	$640	3,800	$30,000	$665	14,700	$114,000	$646
2029	74%	11,000	$87,000	$657	4,000	$32,000	$665	15,000	$119,000	$659
2030	74%	11,200	$91,000	$678	3,900	$33,000	$716	15,100	$124,000	$688
2031	74%	11,300	$96,000	$706	4,000	$35,000	$733	15,300	$131,000	$713
2032	74%	11,500	$101,000	$729	4,000	$37,000	$770	15,500	$138,000	$739
2033	74%	11,600	$106,000	$759	4,000	$39,000	$808	15,600	$145,000	$771
2034	74%	11,800	$111,000	$784	4,200	$41,000	$810	16,000	$152,000	$790
2035	74%	11,900	$117,000	$816	4,200	$43,000	$850	16,100	$160,000	$825

Exhibit 6.3
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Market Stabilization Scenario
Summary of Enrollment and Gross Premium by BBSP and Standard QHP Segments - Rating Area 3

	BBSP				Standard QHP			Total		
			Gross Premium			Gross Premium			Gross Premium	
Year	BBSP Take-Up %	Enrollment	Aggregate (thousands)	PMPM	Enrollment	Aggregate (thousands)	PMPM	Enrollment	Aggregate (thousands)	PMPM
2026	77%	4,000	$43,000	$891	1,200	$13,000	$905	5,200	$56,000	$894
2027	77%	4,200	$42,000	$842	1,300	$13,000	$846	5,500	$55,000	$843
2028	77%	4,200	$44,000	$872	1,300	$14,000	$890	5,500	$58,000	$876
2029	77%	4,300	$46,000	$882	1,300	$15,000	$937	5,600	$61,000	$895
2030	77%	4,300	$48,000	$927	1,400	$15,000	$914	5,700	$63,000	$924
2031	77%	4,400	$50,000	$952	1,300	$16,000	$1,034	5,700	$66,000	$971
2032	77%	4,400	$53,000	$1,001	1,400	$17,000	$1,009	5,800	$70,000	$1,003
2033	77%	4,600	$56,000	$1,006	1,300	$18,000	$1,142	5,900	$74,000	$1,036
2034	77%	4,600	$58,000	$1,058	1,400	$19,000	$1,115	6,000	$77,000	$1,071
2035	77%	4,700	$61,000	$1,087	1,400	$20,000	$1,171	6,100	$81,000	$1,107

Exhibit 6.4
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Market Stabilization Scenario
Summary of Enrollment and Gross Premium by BBSP and Standard QHP Segments - Rating Area 4

	BBSP				Standard QHP			Total		
			Gross Premium			Gross Premium			Gross Premium	
Year	BBSP Take-Up %	Enrollment	Aggregate (thousands)	PMPM	Enrollment	Aggregate (thousands)	PMPM	Enrollment	Aggregate (thousands)	PMPM
2026	78%	1,800	$16,000	$757	500	$5,000	$799	2,300	$21,000	$766
2027	78%	1,900	$16,000	$687	500	$5,000	$781	2,400	$21,000	$707
2028	78%	1,900	$16,000	$711	500	$5,000	$821	2,400	$21,000	$734
2029	78%	1,900	$17,000	$736	500	$5,000	$863	2,400	$22,000	$762
2030	78%	1,900	$18,000	$772	500	$5,000	$905	2,400	$23,000	$800
2031	78%	2,000	$18,000	$770	500	$6,000	$949	2,500	$24,000	$805
2032	78%	2,000	$19,000	$807	500	$6,000	$996	2,500	$25,000	$845
2033	78%	2,000	$20,000	$847	500	$6,000	$1,045	2,500	$26,000	$887
2034	78%	2,000	$21,000	$889	600	$7,000	$914	2,600	$28,000	$895
2035	78%	2,000	$22,000	$933	600	$7,000	$959	2,600	$29,000	$939

Exhibit 7.1
State of Nevada
NMSP Actuarial and Economic Analysis
Market Stabilization Scenario
Impact of NMSP on Premium and Subsidies Split by BBSPs and Standard QHP

	Baseline						Market Stablization						PTC Savings Allocation	
	BBSP Enrollees			Standard QHP Enrollees			BBSP Enrollees			Standard QHP Enrollees				
Year	PTC Membership	APTC PMPM	Annual APTC (thousands)	PTC Membership	APTC PMPM	Annual APTC (thousands)	PTC Membership	APTC PMPM	Annual APTC (thousands)	PTC Membership	APTC PMPM	Annual APTC (thousands)	BBSPs	Standard QHP
2026	63,500	$427	$325,000	12,900	$394	$61,000	63,500	$409	$311,000	13,000	$378	$59,000	$12,000	$3,000
2027	64,500	$444	$343,000	13,100	$411	$65,000	64,300	$376	$290,000	12,800	$352	$54,000	$47,000	$11,000
2028	65,300	$463	$363,000	13,300	$428	$68,000	65,100	$383	$299,000	12,900	$355	$55,000	$56,000	$13,000
2029	66,300	$482	$383,000	13,500	$445	$72,000	65,900	$390	$309,000	12,800	$371	$57,000	$65,000	$16,000
2030	67,100	$503	$405,000	13,700	$464	$76,000	66,800	$405	$325,000	13,100	$382	$60,000	$70,000	$17,000
2031	68,000	$524	$428,000	13,900	$484	$81,000	67,700	$421	$342,000	13,300	$395	$63,000	$75,000	$18,000
2032	68,900	$546	$452,000	14,100	$504	$85,000	68,600	$437	$360,000	13,500	$414	$67,000	$81,000	$18,000
2033	69,800	$570	$477,000	14,200	$529	$90,000	69,500	$454	$379,000	13,800	$423	$70,000	$86,000	$20,000
2034	70,700	$594	$504,000	14,400	$552	$95,000	70,500	$471	$399,000	14,000	$440	$74,000	$93,000	$21,000
2035	71,700	$619	$532,000	14,600	$575	$101,000	71,400	$490	$420,000	14,200	$458	$78,000	$99,000	$23,000
5-Year Waiver Window													**$250,000**	**$60,000**
10-Year Deficit Neutrality Window													**$684,000**	**$160,000**
5-Year Waiver Window – With 10% Margin													**$225,000**	**$54,000**
10-Year Deficit Neutrality Window – With 10% Margin													**$616,000**	**$144,000**

Exhibit 7.2
State of Nevada
NMSP Actuarial and Economic Analysis
Market Stabilization Scenario - Impact of BBSP Program Only
Impact of NMSP on Premium and Subsidies Split by BBSPs and Standard QHP

	Baseline						Market Stablization: BBSPs Only						PTC Savings Allocation	
	BBSPs			Standard QHP			BBSPs			Standard QHP				
Year	PTC Membership	APTC PMPM	Annual APTC (thousands)	PTC Membership	APTC PMPM	Annual APTC (thousands)	PTC Membership	APTC PMPM	Annual APTC (thousands)	PTC Membership	APTC PMPM	Annual APTC (thousands)	BBSPs	Standard QHP
2026	63,500	$427	$325,000	12,900	$394	$61,000	63,500	$409	$311,000	12,900	$377	$58,000	$12,000	$3,000
2027	64,500	$444	$343,000	13,100	$411	$65,000	64,300	$414	$320,000	13,100	$380	$60,000	$21,000	$5,000
2028	65,300	$463	$363,000	13,300	$428	$68,000	65,100	$424	$331,000	13,200	$390	$62,000	$29,000	$6,000
2029	66,300	$482	$383,000	13,500	$445	$72,000	65,900	$433	$342,000	13,300	$400	$64,000	$37,000	$7,000
2030	67,100	$503	$405,000	13,700	$464	$76,000	66,800	$451	$362,000	13,500	$417	$68,000	$39,000	$8,000
2031	68,000	$524	$428,000	13,900	$484	$81,000	67,700	$470	$382,000	13,800	$432	$71,000	$41,000	$9,000
2032	68,900	$546	$452,000	14,100	$504	$85,000	68,700	$490	$404,000	14,000	$450	$76,000	$43,000	$9,000
2033	69,800	$570	$477,000	14,200	$529	$90,000	69,600	$511	$427,000	14,200	$469	$80,000	$45,000	$10,000
2034	70,700	$594	$504,000	14,400	$552	$95,000	70,500	$533	$451,000	14,400	$489	$85,000	$48,000	$9,000
2035	71,700	$619	$532,000	14,600	$575	$101,000	71,400	$556	$476,000	14,500	$514	$89,000	$50,000	$11,000
5-Year Waiver Window													**$138,000**	**$29,000**
10-Year Deficit Neutrality Window													**$365,000**	**$77,000**
5-Year Waiver Window – With 10% Margin													**$124,000**	**$26,000**
10-Year Deficit Neutrality Window – With 10% Margin													**$329,000**	**$69,000**

Exhibit 8
State of Nevada
Nevada Market Stabilization Actuarial and Economic Analysis
Individual Market Claim Distribution - 2027

Claim Size Band	Frequency		Cumulative Frequency	
	Member Count	Claim Amount	Member Count	Claim Amount
$0	3.29%	0.00%	3.29%	0.00%
$0-$2,500	72.03%	0.01%	75.33%	0.01%
$2,500-$5,000	8.70%	0.02%	84.03%	0.03%
$5,000-$7,500	3.96%	2.31%	87.99%	2.34%
$7,500-$10,000	1.99%	3.12%	89.97%	5.46%
$10,000-$15,000	2.45%	5.48%	92.42%	10.94%
$15,000-$20,000	1.61%	5.10%	94.04%	16.03%
$20,000-$25,000	0.99%	4.11%	95.03%	20.14%
$25,000-$30,000	0.68%	3.46%	95.71%	23.60%
$30,000-$35,000	0.51%	3.07%	96.22%	26.68%
$35,000-$40,000	0.41%	2.97%	96.64%	29.65%
$40,000-$45,000	0.37%	3.09%	97.01%	32.74%
$45,000-$50,000	0.32%	2.98%	97.33%	35.72%
$50,000-$55,000	0.28%	3.06%	97.60%	38.78%
$55,000-$60,000	0.27%	3.28%	97.88%	42.06%
$60,000-$65,000	0.22%	2.83%	98.10%	44.89%
$65,000-$70,000	0.18%	2.34%	98.27%	47.22%
$70,000-$75,000	0.13%	1.80%	98.41%	49.02%
$75,000-$80,000	0.12%	1.81%	98.53%	50.84%
$80,000-$85,000	0.11%	1.71%	98.65%	52.55%
$85,000-$90,000	0.11%	1.86%	98.76%	54.40%
$90,000-$95,000	0.09%	1.57%	98.86%	55.98%
$95,000-$100,000	0.10%	1.69%	98.95%	57.67%
$100,000-$110,000	0.14%	2.70%	99.09%	60.37%
$110,000-$120,000	0.09%	2.04%	99.18%	62.40%
$120,000-$130,000	0.09%	2.05%	99.27%	64.46%
$130,000-$140,000	0.08%	2.06%	99.35%	66.51%
$140,000-$150,000	0.07%	1.82%	99.42%	68.34%
$150,000-$160,000	0.05%	1.29%	99.47%	69.63%
$160,000-$175,000	0.07%	2.27%	99.54%	71.89%
$175,000-$200,000	0.10%	3.17%	99.64%	75.06%
$200,000-$225,000	0.06%	2.39%	99.70%	77.45%
$225,000-$250,000	0.06%	2.39%	99.76%	79.84%
$250,000-$275,000	0.03%	1.25%	99.78%	81.09%
$275,000-$300,000	0.03%	1.74%	99.82%	82.82%
$300,000-$325,000	0.03%	1.77%	99.85%	84.59%
$325,000-$350,000	0.02%	1.02%	99.86%	85.61%
$350,000-$400,000	0.03%	2.20%	99.89%	87.81%
$400,000-$425,000	0.01%	0.73%	99.90%	88.54%
$425,000-$450,000	0.01%	1.17%	99.92%	89.70%
$450,000-$475,000	0.01%	0.90%	99.93%	90.60%
$475,000-$500,000	0.01%	0.95%	99.94%	91.55%
$500,000-$550,000	0.01%	1.20%	99.95%	92.76%
$550,000-$600,000	0.01%	1.01%	99.96%	93.76%
$600,000-$650,000	0.01%	1.09%	99.97%	94.86%
$650,000-$700,000	0.00%	0.12%	99.97%	94.98%
$700,000-$750,000	0.00%	0.64%	99.98%	95.62%
$750,000-$800,000	0.01%	0.82%	99.98%	96.44%
$800,000-$850,000	0.00%	0.15%	99.99%	96.59%
$850,000-$900,000	0.00%	0.62%	99.99%	97.21%
$900,000-$950,000	0.00%	0.17%	99.99%	97.37%
$950,000-$1,000,000	0.00%	0.00%	99.99%	97.37%
$1,000,000-$1,100,000	0.00%	0.55%	99.99%	97.93%
$1,100,000-$1,200,000	0.00%	0.00%	99.99%	97.93%
$1,200,000-$1,300,000	0.00%	0.44%	100.00%	98.36%
$1,300,000-$1,400,000	0.00%	0.25%	100.00%	98.61%
$1,400,000-$1,500,000	0.00%	0.26%	100.00%	98.87%
$1,500,000-$1,600,000	0.00%	0.28%	100.00%	99.15%
$1,600,000-$1,700,000	0.00%	0.00%	100.00%	99.15%
$1,700,000-$1,800,000	0.00%	0.00%	100.00%	99.15%
$1,800,000-$1,900,000	0.00%	0.00%	100.00%	99.15%
$1,900,000-$2,000,000	0.00%	0.00%	100.00%	99.15%
$2,000,000-$2,250,000	0.00%	0.38%	100.00%	99.53%
$2,250,000-$2,500,000	0.00%	0.00%	100.00%	99.53%
$2,500,000-$2,750,000	0.00%	0.47%	100.00%	100.00%
$2,750,000-$3,000,000	0.00%	0.00%	100.00%	100.00%
$3,000,000+	0.00%	0.00%	100.00%	100.00%

Exhibit 9
State of Nevada
Nevada Market Stabilization Actuarial and Economic Analysis
Impact on 2029 Net Member Premium
Projected BBSP Take-up by Metal and Income

Individual Market Enrolled Members		
Metal	**Income (% FPL)**	**BBSP Take-up**
BRONZE	Under 100%	88%
BRONZE	100 to 133%	88%
BRONZE	133 to 150%	89%
BRONZE	150 to 200%	89%
BRONZE	200 to 250%	84%
BRONZE	250 to 300%	79%
BRONZE	300 to 400%	69%
BRONZE	Over 400%	60%
SILVER	Under 100%	88%
SILVER	100 to 133%	88%
SILVER	133 to 150%	88%
SILVER	150 to 200%	89%
SILVER	200 to 250%	84%
SILVER	250 to 300%	79%
SILVER	300 to 400%	69%
SILVER	Over 400%	60%
GOLD	Under 100%	78%
GOLD	100 to 133%	78%
GOLD	133 to 150%	78%
GOLD	150 to 200%	78%
GOLD	200 to 250%	74%
GOLD	250 to 300%	69%
GOLD	300 to 400%	59%
GOLD	Over 400%	50%
Off- Exchange		58%

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

August 19, 2024
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.

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CHAPTER 695K - PUBLIC OPTION

GENERAL PROVISIONS

NRS 695K.010 Purpose and policy of Legislature in enacting chapter. [Effective January 1, 2026.]
NRS 695K.020 Definitions. [Effective January 1, 2026.]
NRS 695K.030 "Certified community behavioral health clinic" defined. [Effective January 1, 2026.]
NRS 695K.040 "Commissioner" defined. [Effective January 1, 2026.]
NRS 695K.050 "Director" defined. [Effective January 1, 2026.]
NRS 695K.060 "Exchange" defined. [Effective January 1, 2026.]
NRS 695K.070 "Federally qualified health center" defined. [Effective January 1, 2026.]
NRS 695K.080 "Provider of health care" defined. [Effective January 1, 2026.]
NRS 695K.090 "Public Option" defined. [Effective January 1, 2026.]
NRS 695K.100 "Rural health clinic" defined. [Effective January 1, 2026.]
NRS 695K.110 "Trust Fund" defined. [Effective January 1, 2026.]

ADMINISTRATION; OPERATION

NRS 695K.200 Design, establishment and operation; availability; requirements; premiums. [Effective January 1, 2026, through December 31, 2029.]
NRS 695K.200 Design, establishment and operation; availability; requirements. [Effective January 1, 2030.]
NRS 695K.210 Application for federal waivers and approvals; acceptance of gifts, grants and donations; deposit of money; contracts for services. [Effective January 1, 2026.]
NRS 695K.220 Administration: Contract with health carrier or other qualified person or entity or performance by Director; duties of administrator; deposit of money. [Effective January 1, 2026.]
NRS 695K.230 Duties of certain providers of health care; exception. [Effective January 1, 2026.]
NRS 695K.240 Establishment of networks and reimbursement of providers of health care: Requirements. [Effective January 1, 2026.]

PUBLIC OPTION TRUST FUND

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

GENERAL PROVISIONS

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

1. Leverage the combined purchasing power of the State to lower premiums and costs relating to health insurance for residents of this State;
2. Improve access to high-quality, affordable health care for residents of this State, including residents of this State who are employed by small businesses;
3. Reduce disparities in access to health care and health outcomes and increase access to health care for historically marginalized communities; and
4. Increase competition in the market for individual health insurance in this State to improve the availability of coverage for residents of rural areas of this State.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ADMINISTRATION; OPERATION

NRS 695K.200 Design, establishment and operation; availability; requirements; premiums. [Effective January 1, 2026, through December 31, 2029.]

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

2. The Director:

(a) Shall make the Public Option available:

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

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

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

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

3. The Public Option must:

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

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

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

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

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

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

6. As used in this section:

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

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

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

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

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

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

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

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

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

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

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

2. The Director:

(a) Shall make the Public Option available:

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

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

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

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

3. The Public Option must:

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

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

4. As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5. The Director may:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8. As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PUBLIC OPTION TRUST FUND

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

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

2. The Trust Fund consists of:

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

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

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

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

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

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

(Added to NRS by 2021, 3621)

Excerpt: Nevada SB 482 (2019)

Sec. 45.

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

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

Excerpt: Nevada Revised Statute Chapter 679B.120

The Commissioner shall:

1. Organize and manage the Division, and direct and supervise all its activities;
2. Execute the duties imposed upon him or her by this Code;
3. Enforce the provisions of this Code;
4. Have the powers and authority expressly conferred upon him or her by or reasonably implied from the provisions of this Code"

Excerpt: Nevada Revised Statute Chapter 679B.400

1. The Legislature finds and declares that:

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

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

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

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

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

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

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

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

APPENDIX C

State of Nevada Guidance Memorandum

Joe Lombardo
Governor

Richard Whitley, MS
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF HEALTH CARE FINANCING AND POLICY

Helping people. It's who we are and what we do.

Stacie Weeks, JD
MPH
Administrator

GENERAL GUIDANCE LETTER 23-003

Date: November 20, 2023

From: Richard Whitley, DHHS Director
Stacie Weeks, DHCFP Administrator

Subject: Notice of Revised Carrier Premium Reduction Targets for Plans Established in NRS 695K

PURPOSE: This letter serves as updated state guidance on the premium reduction targets as revised by the Director pursuant to NRS 695K.200, which were previously outlined in the Department's General Guidance Letter 22-001, published on October 4, 2022.

AUTHORITIES:

NRS 695K.200: […]
5. The Director, in consultation with the Commissioner and the Executive Director of the Exchange, may revise the requirements of subsection 4, provided that the average premiums for the Public Option must be at least 15 percent lower than the average reference premium in this State over the first 4 years in which the Public Option is in operation.

APPLICATION:
As provided in state law, the new premium reduction requirements will be effective for the Plan Year that is effective on January 1, 2026. It will apply to all carriers that contract with the Department to offer the new health insurance options, established under Chapter NRS 695K, referred to as Battle Born State Plans (BBSPs). The updates to the premium reduction target, as described in this guidance, is reflective of the updated actuarial analysis and the findings from Milliman, Inc. about the addition of a reinsurance program as part of the State's updated Section 1332 Innovation Waiver proposal.[1] These findings are available in the State's Section 1332 Innovation Waiver and the Milliman Actuarial Analysis, 2023, and available at: https://dhcfp.nv.gov/marketstabilization/.

This guidance shall apply, unless otherwise revised by the Director, to the Department's 5-year contract period with carriers for the BBSP program, starting Calendar Year 2026. For future contract periods, the Director will issue additional guidance regarding any premium reduction targets deemed necessary for the success of the waiver programs.

Updated Premium Reduction Target for Plan Years 2026-2030 for Participating Carriers

Pursuant to the Director's broad and express authority in subsection 5 of NRS 695K.200, the Director establishes a premium reduction target for the new BBSPs for Plan Years 2026-2030 as follows:

[1] State law requires the Director to submit a 1332 Waiver

The annual premium cost of a carrier's BBSP (silver plan) in the Silver State Health Insurance Exchange (SSHIX) must be lower than the average reference premium ("the benchmark") in each county by a percentage that increases each Plan Year through Plan Year 2030, as outlined below and cannot increase more than the increase in Consumer Price Index for Medical Care plus any adjustments necessary to reflect local changes in utilization and morbidity:

- For Plan Year 2026, this percentage must be at least three percent lower than the benchmark.
- For Plan Year 2027 to Plan Year 2029, BBSP carriers must achieve a cumulative premium reduction of at least 15 percent as compared to the benchmark. For Plan Years 2027 and 2028, the premium reduction amounts will be negotiated by the Director as part of the procurement and contracting process with carriers with the goal of ensuring that the 15 percent overall reduction target is achieved by participating carriers by Plan Year 2029.
- For Plan Year 2030, carriers must maintain a 15 percent premium reduction as compared to the benchmark.

For the purposes of the premium reduction targets for Plan Years 2026-2030, the benchmark (average reference premium) shall mean "the second-lowest cost silver level plan available through the SSHIX during the 2024 plan year by county trended forward for inflation according to the Consumer Price Index for Medical Care and any adjustments to reflect local changes in utilization and morbidity."

Impact of State-Based Reinsurance Program

For Plan Years 2027, 2028, 2029, and 2030—the percentage of the premium reduction target will be inclusive of the impact of a state reinsurance program on premium costs. The reinsurance program is intended to account for a substantial portion of the required premium reductions beginning Plan Year 2027. For Plan Years 2027 and 2028, the premium reduction amounts will be negotiated by the Director as part of the procurement and contracting process with carriers with the goal of ensuring that the 15 percent overall reduction target is achieved by participating carriers.

APPENDIX D

CCIIO Checklist for Section 1332 State Relief and Empowerment Waivers

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)[47] 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.
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.

[47] CMS (July 2019). Checklist for Section 1332 State Relief and Empowerment Waivers (also called Section 1332 waivers or State Innovation Waivers) Applications. Retrieved November 9, 2022, from https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Checklist-for-Section-1332-State-Relief-and_Empowerment-Waivers.pdf.

<table>
<tr><th></th><th>HHS Citation and Description</th><th>Actuary Response</th></tr>
<tr><td>5.</td><td>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.</td><td>1. See Appendix A for the actuarial certification.

i. See Sections I.A and IV.B for a demonstration that the Nevada Section 1332 waiver complies with the coverage requirement.
a. See the Exhibits section
ii. See Sections I.A, IV.A, and IV.C for a demonstration that the Nevada Section 1332 waiver complies with the comprehensiveness and affordability requirements.
a. See the Exhibits section
b. See the Exhibits section

2. See Section V

3. See Section VI

The Nevada 1332 waiver impacts the individual market. The baseline projection and a comparison to the projection under the waiver are included in Sections IV and V.

The required analyses are included as noted below:

▪ Exhibits 4.1 through 4.5: Non-group market enrollees by income as a share of FPL.

▪ Table 3: Overall average non-group market premium rate.

▪ Exhibits 2 through 2.4: SLCS plan rate for a representative consumer.

▪ The State of Nevada uses the federal default age rating curve.

▪ Section V: Aggregate premiums and PTC.

▪ The State of Nevada uses a state-based platform. Costs are assumed to be the same both with and without the waiver.

▪ Sections IV through VI: Documentation of all assumptions and methodologies used to develop the projections and growth of healthcare spending.

Risk Stabilization Waiver Concept requirements:

▪ Table 12: Comprehensive description of parameters.

▪ Section V: Projected funding levels.

▪ Table 1: Projected reimbursements.

▪ Exhibit 8: Expected distribution of claims by claim size.</td></tr>
</table>

	HHS Citation and Description	Actuary Response
6.	**45 CFR 155.1308(f)(4)(iv)** Draft timeline for implementation of the proposed waiver.	See Section 1D of waiver application.
7.	**45 CFR 155.1308(f)(4)(v)(A)-(E)** Additional Information.	See Section 5 of waiver application.
8.	**45 CFR 155.1308(f)(4)(vi)** Reporting targets.	See Section 5E of waiver application.
9.	**83 FR 53575** Administration's Principles.	Need from Manatt / Nevada.

Public Comment and Tribal Consultation Materials

Medicaid Seeks Public Comment for New State Innovation Waiver

Carson City, NV November 20, 2023

The Nevada Division of Health Care Financing and Policy (Nevada Medicaid) today announced the beginning of a 30-day public comment period for a State Section 1332 State Innovation Waiver application. The public comment period is open from November 20 through December 20, 2023. Stakeholders, the public, patients, insurers, and providers are encouraged to provide feedback. This is the first formal step in submitting a proposal to the Centers for Medicare and Medicaid Services for the implementation of new state health insurance options as required by Nevada Revised Statutes 695K.

As part of the waiver application, Nevada Governor Joe Lombardo is proposing to establish a new Market Stabilization Program to help mitigate the potential risks posed to the state's health care system by the implementation of the new health insurance options.

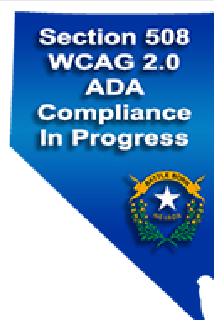
The proposal includes seeking federal approval for implementing:
• A state-based reinsurance program at no cost to the state.
• An annual bonus payment program to reward health insurance carriers that make strides in improving health outcomes and quality of care.
• A loan repayment program designed to support health care providers who commit to living and practicing in Nevada for at least four years.

"The new initiatives outlined in this waiver application aim to improve access to health care for Nevadans, while strengthening the marketplace for those who purchase their own health insurance," Nevada Medicaid Administrator Stacie Weeks said.

Public notices, meetings, public comment methods, 1332 Actuarial Analysis/Economic Analysis, and the draft of the 1332 State Waiver Application are available here: https://dhcfp.nv.gov/MarketStabilization/.

Contact

Ky Plaskon
Public Information Officer, Division of Health Care Financing and Policy
KyPlaskon@dhcfp.nv.gov



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DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF HEALTH CARE FINANCING AND POLICY

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REVISED NOTICE OF PUBLIC WORKSHOP

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

Date of Publication: November 9, 2023
Date of Revision: **November 13, 2023**

Date and Time of Meeting: November 27, 2023, at 1:00 PM to 3:00 PM

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

Place of Meeting: Division of Public and Behavioral Health (DPBH)
4150 Technology Way
Third Floor Conference Room #303
Carson City, Nevada 89706

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

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

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

Please be cautious and do not click on links in the chat area of the meeting unless you have verified they are safe. If you ever have questions about a link in a document purporting to be from Nevada Medicaid, please do not hesitate to contact michael.gorden@dhcfp.nv.gov for verification.

Webinar:	https://tinyurl.com/PW112723
	Select "Join," enter your name and email and then select "Join." The meeting should not require a password.
Audio Only:	(775) 321-6111
Conference ID:	816 527 440#

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

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

This meeting may be recorded to facilitate note-taking or other uses. By participating you consent to recording of your participation in this meeting.

Agenda

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

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

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

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

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

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

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

b. Public comment regarding subject matter.

2. Public comment regarding any other issue

3. Adjournment

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

Nevada Medicaid is unaware of any financial impact to other entities or local government due to this public hearing, other than as stated above.
PLEASE NOTE: Items may be taken out of order. Items may be pulled or removed from the agenda at any time. All public comment may be limited to three minutes.

The DHCFP is exempt from Chapter 233B according to NRS 233B.039 and is not required to comply with the Nevada Administrative Procedure Act in this process. This meeting is conducted by and with state agency staff which is not a public body for purposes of NRS 241 related to Nevada Open Meeting Law but every effort is made to be transparent in notice and information provided to encourage public awareness and participation.

This notice and agenda have been posted online at http://dhcfp.nv.gov and http://notice.nv.gov, as well as Carson City, Las Vegas, Elko, and Reno central offices for DHCFP. E-mail notice has been made to such individuals as have requested notice of meetings (to request notifications please contact michael.gorden@dhcfp.nv.gov , or at 1100 East William Street, Suite 101, Carson City, Nevada 89701.

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

If you require a physical copy of supporting material for the public meeting, please contact michael.gorden@dhcfp.nv.gov , or at 1100 East William Street, Suite 101, Carson City, Nevada 89701. Supporting material will also be posted online as referenced above.

Note: We are pleased to make reasonable accommodations for members of the public with a disability and wish to participate. If accommodated arrangements are necessary, notify DHCFP as soon as possible in advance of the meeting, by e-mail at michael.gorden@dhcfp.nv.gov in writing, at 1100 East William Street, Suite 101, Carson City, Nevada 89701.

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

NOTICE OF PUBLIC WORKSHOP

1332 Waiver Application Presentation and Public Comment Meeting

Date of Publication: November 15, 2023

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

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

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

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

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

*General Public Comments (No action may be taken upon a matter raised under public comment period unless the matter itself has been specifically included on an agenda as an action item. To provide public comment telephonically, you may join the meeting by dialing (775) 321-6111 and when prompted to provide the Meeting ID, enter 676 196 451#. You may then press *5 to raise your hand during the public comment periods to provide your comment. Comments will be limited to three minutes per person. Persons making comment will be asked to begin by stating their name for the record and to spell their last name. Those who wish to provide a written comment may submit their comment via mail to 1100 E. William Street, Ste. 101, Carson City, Nevada 89701 or via email to 1332WaiverProgram@dhcfp.nv.gov). Written comments will be accepted between November 20, 2023, and December 20, 2023.*

Please be cautious and do not click on links in the chat area of the meeting unless you have verified they are safe. If you ever have questions about a link in a document purporting to be from Nevada Medicaid, please do not hesitate to contact michael.gorden@dhcfp.nv.gov for verification.

Webinar: https://tinyurl.com/PW12052023

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

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

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

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

This meeting may be recorded to facilitate note-taking or other uses. By participating you consent to recording of your participation in this meeting.

Agenda

1. Presentation and public comment on the State’s Section 1332 Innovation Waiver

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

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

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

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

    The waiver text, notice of public comment and Tribal consultation, and public comments received will be posted at the Division’s Market Stabilization Program webpage located here: https://dhcfp.nv.gov/marketstabilization/.

    b. Public comment regarding subject matter.

2. Public comment regarding any other issue

3. Adjournment

NOTE: To use the long link to the meeting in the event there are issues with the URL shortener, please use the following complete link:
https://teams.microsoft.com/l/meetup-join/19%3ameeting_M2VlNzZhZWQtMDFlZC00MzdjLWFlYjYtZmFhZDNmYWIxYWFj%40thread.v2/0?context=%7b%22Tid%22%3a%22e4a340e6-b89e-4e68-8eaa-1544d2703980%22%2c%22Oid%22%3a%22cc4c7a00-e2be-4dda-a27b-3405a8271b9c%22%7d

Nevada Medicaid is unaware of any financial impact to other entities or local government due to this public hearing, other than as stated above.
PLEASE NOTE: Items may be taken out of order. Items may be pulled or removed from the agenda at any time. All public comment may be limited to three minutes.

The DHCFP is exempt from Chapter 233B according to NRS 233B.039 and is not required to comply with the Nevada Administrative Procedure Act in this process. This meeting is conducted by and with state agency staff which is not a public body for purposes of NRS 241 related to Nevada Open Meeting Law but every effort is made to be transparent in notice and information provided to encourage public awareness and participation.

This notice and agenda have been posted online at http://dhcfp.nv.gov and http://notice.nv.gov, as well as Carson City, Las Vegas, Elko, and Reno central offices for DHCFP. E-mail notice has been made to such individuals as have requested notice of meetings (to request notifications please contact michael.gorden@dhcfp.nv.gov , or at 1100 East William Street, Suite 101, Carson City, Nevada 89701.

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

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Joe Lombardo
Governor

Richard Whitley, MS
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF HEALTH CARE FINANCING AND POLICY

Helping people. It's who we are and what we do.

Stacie Weeks, JD
MPH
Administrator

November 6, 2023

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

Dear Tribal Members:

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

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

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

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

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

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

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

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

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

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

There is no anticipated fiscal impact to Tribal Governments.

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

Sincerely,

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

Casey Angres
Division Compliance Chief, DHCFP

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

Joe Lombardo
Governor

Richard Whitley
Director

Nevada Battle Born State Plans and Market Stabilization Program Tribal Consultation

Division of Health Care Financing and Policy

November 29 and December 7, 2023

Department of Health and Human Services

Helping people. It's who we are and what we do.

Purpose and 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.

Agenda

- Waiver Overview: Battle Born State Plans & Nevada Market Stabilization Program
- Impact to Tribal Communities
- Questions & Public Comment

Overview: Battle Born State Plans

- State law requires the Nevada Director of Health and Human Services to contract with health carriers to offer new health insurance options – referred to in the waiver as Battle Born State Plans (BBSPs).
- These new options must be available to consumers who shop for health insurance in the State's health exchange (Nevada Health Link), starting January 1, 2026.
- These new options will, for the most part, mirror other plans in the Nevada Health Link except that they must meet an annual premium reduction target and pay their provider networks rates that at or better than Medicare.

1. See Nevada Revised Statutes (NRS) Chap. 695K.

Overview: Market Stabilization Program

- The second key initiative is a Market Stabilization Program.
- The waiver proposes to use federal savings from the BBSPs to finance this program.
- The key goals of the program are to:
  - **Mitigate the potential risk** of the new premium reduction targets on health carriers and their provider networks;
  - Reward health carriers and their provider networks if they **improve health outcomes and quality of care**; and
  - **Ensure market stability** in Nevada's individual health insurance market with the introduction of the new health insurance options and reforms.

Overview: Market Stabilization Program (cont.)

To achieve these goals, the Governor has outlined three new initiatives:

1. **A state-based reinsurance program** at no cost to the state that is aimed at alleviating any unexpected financial risk to participating carriers and their provider networks with the introduction of the BBSPs;
2. **A quality incentive payment program** to reward high-performing health carriers and their provider networks; and
3. **A "Practice in Nevada" program** to provide incentive more providers to live and practice in Nevada, especially in rural regions of the State.

These programs, if approved, would begin in Plan Year 2027 after the State receives its first year of federal savings under the waiver from Plan Year 2026.

BBSP Statutory Requirements

State law requires the Director to contract with health carriers to offer the new Battle Born State Plans and use the Director's **Medicaid contracting authority** to enforce certain state requirements.

Participating carriers must:

- Offer these new plans through the Nevada Health Link and **meet all federal and state standards for qualified health plans** under the Affordable Care Act.
- Offer at least **one Silver and one Gold** Battle Born State Plan.
- Offer plans that will **meet certain premium reduction targets** which will increase gradually to at least 15% percent over the first four years.
- Pay **providers rates that are no lower than Medicare rates.**

New State Procurement Process

- Under State law, the Director must implement **a new procurement process** to establish the new contracts with health carriers, creating a State-private model for operating the new health plans.
- This procurement must take place at the same time as the State's next **Medicaid managed care procurement** (slated for January 1, 2025 or earlier).
- 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 the new Battle Born State Plans.
- The Division will use the new **contract as its tool to enforce** the statutory requirements for the Battle Born State Plans, including the premium reduction target.
- Currently, the Division contracts with four health carriers for its Medicaid managed care program (Anthem, Health Plan of Nevada, Silver Summit, Molina).

BBSP Design

- The Battle Born State Plans will need to comply with existing nongroup and qualified health plan rules, as well as an **additional layer** of new requirements set forth in a contract with the State.

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

Nongroup Plan Requirements	QHPs	BBSPs
State Network Adequacy	ACA Standards	Premium Reduction Target
State Solvency Standards	Essential Benefits	Minimum Provider Rate Floor
State Rate Review	Consumer Protections	Other Contract Requirements
No Metal Tiers	QHP Certification	Silver/Gold Tiers
Direct Purchase from Carrier	Carrier Fee	Purchase from Carrier on SSHIX
	Metal Tiers	Direct Purchase from Carrier
	Purchase from Carrier on SSHIX	

Other New BBSP Requirements

- A provider under contract with the State as a network provider in other state-contracted health insurance programs must participate **as an in-network provider in at least one network** with one carriers offering the BBSPs.
- These providers must also apply policies to **accept new patients** enrolled in BBSPs to the same extent as the provider accepts new patients enrolled in other private health insurance plans
- State law requires the Director to **promote in its contracting process** strategies with health carriers that will:
  - Better align networks between Medicaid and the 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

1332 Waiver & Actuarial Study

- The 1332 Waiver is expected to lower premiums and generate savings for the federal government due to lower premium tax credits.
- Nevada can bring home these savings to fund other State-based programs that strengthen the health insurance market and access to care.
- The 1332 Waiver is expected to achieve an estimated **$279 million in federal savings** in the first five years, and **$760 million** at the end of the first ten years.
- The new reinsurance program is anticipated to relieve pressure on health carriers and their provider networks by nearly half once it's up and running.

The Process

1. Actuarial study & waiver development
2. Post for state public comment period
3. Public workshops / hearings and Tribal consultation
4. Federal submission
5. Completeness review
6. Federal public comment period
7. Negotiations/ Federal Decision

Impact to Tribal Communities

Impact to Tribal Communities

- Mandated premium reductions will reduce premiums for consumers purchasing Battle Born State Plans, which includes consumers who are **American Indian/Alaskan Natives (AI/AN).**
  - According to the 2023 Open Enrollment Public Use File, there were **516 AI/AN members** enrolled in coverage through the Nevada Health Link in 2023.[1]
- The Battle Born State Plan program ***does not impact existing protections*** available to American Indian/Alaskan Natives through the Nevada Health Link:
  - American Indian/Alaskan Natives who earn less than 300% of the Federal Poverty Level (FPL) remain exempt from cost sharing and qualify for premium tax credits.
  - The Modified Adjusted Gross Income calculation for American Indian/Alaskan Natives will continue to exclude some revenue earned on reservations from Federal Trust payments.
  - American Indian/Alaskan Natives may still change QHPs once a month, without worrying about enrollment dates.[2]

1. See 2023 Marketplace Open Enrollment Public Use Files. 2. See Nevada Health Link.

Impact to Tribal Communities (cont.)

- The Battle Born State Plan will not impact existing financial assistance provided under the Division of Health Care Financing and Policy (Medicaid) in which American Indian/ Alaskan Natives eligible for Medicaid do not pay premiums and do not have any other cost sharing.
- The BBSPs will not impact health care services provided through IHS, Tribal or urban Indian health programs.
- The BBSPs do require more robust and aligned networks with Medicaid, including essential community providers.
- As a reminder, Qualified Health Plans, which will include BBSPs, must include at least 35% of available essential community providers 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 are also required to pay tribal providers participating in BBSP networks no lower than what they pay in Medicare.

Public Comment

Questions & Comments

The Division will now collect questions and comments from the tribal representatives regarding the waiver application and new Battle Born State 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 December 20, 2023.*** *The 1332 waiver application will be submitted to the federal government* ***by January 1, 2024.***

Waiver Materials can be found online at:

Nevada Market Stabilization Program (nv.gov)

Contact Information

Michael Gorden – Waiver & Stakeholder Director, Division of Health Care Financing and Policy; michael.gorden@dhcfp.nv.gov

Monica Schiffer - DHCFP Tribal Liaison, Division of Health Care Financing and Policy; mschiffer@dhcfp.nv.gov

Acronyms

ACA – Affordable Care Act

AI/AN – American Indian/Alaskan Natives

BBSP – Battle Born State Plan

DHCFP – Division of Health Care Financing and Policy (NV Medicaid Program)

MSP – Market Stabilization Program

QHP – Qualified Health Plan

Joe Lombardo
Governor

Richard Whitley
Director

Nevada Battle Born State Plans and Market Stabilization Program Public Hearing

Division of Health Care Financing and Policy

November 27, 2023, and December 5, 2023

Department of Health and Human Services

Helping people. It's who we are and what we do.

Purpose and Agenda

The Division is hosting two public meetings to engage stakeholders on the State's 1332 Waiver application, which must be submitted for federal approval no later January 1, 2024, per state law.

This waiver seeks federal approval for the State to receive the federal savings from its implementation of new state-contracted health insurance options and a reinsurance program to establish and finance a Market Stabilization Program.

Agenda

- Waiver Overview: Battle Born State Plans & Market Stabilization Program
- Questions & Public Comment
- Next Steps

Overview: Battle Born State Plans

- State law requires the Nevada Director of Health and Human Services to contract with health carriers to offer new health insurance options – referred to in the waiver as Battle Born State Plans (BBSPs).
- These new options must be available to consumers who shop for health insurance in the State's health exchange (Nevada Health Link), starting January 1, 2026.
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Overview: Market Stabilization Program (cont.)

To achieve these goals, the Governor has outlined three new initiatives:

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1332 Waiver & Actuarial Study

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4. Federal submission
5. Completeness review
6. Federal public comment period
7. Negotiations/ Federal Decision

Public Comment

Next Steps

- Public comments will be accepted through December 20, 2023.
- The 1332 waiver application will be submitted to the federal government by January 1, 2024.

Contact Information

Stacie Weeks – Administrator, Division of Health Care Financing and Policy; sweeks@dhcfp.nv.gov

Malinda Southard – Deputy Administrator, Community Supports & Engagement, Division of Health Care Financing and Policy; msouthard@dhcfp.nv.gov

Michael Gorden – Waiver & Stakeholder Director, Division of Health Care Financing and Policy; michael.gorden@dhcfp.nv.gov

Acronyms

ACA – Affordable Care Act

BBSP – Battle Born State Plan

DHCFP – Division of Health Care Financing and Policy (NV Medicaid Program)

MSP – Market Stabilization Program

The Nevada Coverage and Market Stabilization Program Section 1332 Waiver

State Responses to Public Comments

The Nevada Department of Health and Human Services (DHHS) held a public comment period on its draft waiver application beginning on November 20, 2023 and ending on December 20, 2023. During this comment period, two public hearings were held in person and via webinar on November 27 and December 5 and two tribal consultations were held in person and via webinar on November 29 and December 7. The State received a total of 52 comments from consumer advocates, hospitals and providers, carriers, and other stakeholders. The State received 32 comments in strong support of the waiver while multiple comments included concerns that are addressed below. The below represents a summary of comments Nevada received through the public hearings and written comments and the State's responses to those comments. All written comments submitted are available on the Nevada Coverage and Stabilization Program landing page.

1. Public Comment: The State received more than 30 comments in support of the Nevada Coverage and Market Stabilization Program under the Section 1332 waiver. Commenters expressed support for provisions of the waiver that could help lower the costs of health care coverage, invest in provider workforce development, and seek value-based payment reforms. Supporters also pointed to the promise of the Public Option (i.e., Battle Born State Plans, or BBSPs) in providing consumers enhanced job mobility, guarding against medical debt, and narrowing health disparities.
    a. State Response: DHHS appreciates commenters' support for the waiver application and the shared goals to expand access to affordable coverage, improve quality, and invest in health practitioners in the State. DHHS also appreciates commenters' urging to improve health coverage affordability in the individual insurance market.
2. Public Comment: Several commenters underscored the importance of improving affordability in the individual market. A few commenters urged the State to use pass-through funding for a premium subsidy rather than a state-based reinsurance program, while another commenter expressed opposition to using taxpayer funds (e.g., federal pass-through funding) to subsidize carriers in meeting their required premium reductions.
    a. State Response: DHHS has undertaken careful consideration of this policy design, and earlier drafts of the actuarial report modeled for a state-based premium subsidy using federal pass-through funds. The nature of the deficit neutrality guardrail for Section 1332 waivers limits the impact of any premium subsidies to substantially improve health coverage affordability. The State would receive reduced pass-through funds if it were to implement a state-based premium subsidy, as new enrollment would increase federal spending and that increased federal spending would reduce available pass-through funding. In other words, states are unable to make premium subsidies (or similarly cost-sharing subsidies) "too attractive" since doing so erodes the pass-through funding. The State has determined that investing in reinsurance, quality incentive payments, and the provider workforce are effective tools to ensure a healthy and stable individual marketplace that improves long-term affordability of care for Nevadans, while still maintaining the pass-through funding needed to maintain the program.
3. Public Comment: One commenter expressed concern that the Nevada Division of Insurance (DOI) would administer the BBSP, referencing existing auto insurance policies that have increased car insurance premiums in the State.
    a. State Response: DHHS will be responsible for administering the BBSPs, not DOI. DHHS will oversee the procurement and contracting process and will provide ongoing monitoring of compliance of requirements established in the contract between the State and BBSP carriers. While the DOI will not administer the BBSPs, it will continue to lead the rate review process, license the carriers, and

oversee plan solvency for plans offered in the individual health insurance market, which includes BBSPs, like all other nongroup products.

4. Public Comment: One commenter suggested the State create funding benchmarks to ensure sufficient funds are available to invest in the Quality Incentive Payment Program and the Practice in Nevada Program.
    a. State Response: The State agrees that investments in quality improvement and the provider workforce are vitally important in Nevada. Based on the actuarial analysis by Milliman, it is anticipated that starting in Year 2 of the program, as a result of the entry of the BBSPs into the market, the federal savings generated each year would cover the cost of financing a reinsurance program across the individual market while garnering millions of dollars in additional remaining funds each year for the Quality Incentive Payment Program and Practice in Nevada Program.
5. Public Comment: A few commenters expressed concern that the premium reduction requirements will result in a cost shift from carriers to providers through reduced reimbursement rates. Commenters stated the cost shift could incentivize providers to leave the State or reduce the scope of services provided, exacerbating provider shortage challenges. Other commenters expressed concern that providers would recoup their reduced reimbursement by seeking higher reimbursement rates from other health care purchasers, putting upward pressure on premiums across payers.
    a. State Response: The BBSPs' provider reimbursement rates will likely have a minimal impact on provider behavior due to the fact that the BBSP is being targeted at the individual market in Nevada, representing a very small proportion of a provider's revenue. In December 2022 the actuarial firm Milliman conducted an assessment (see Appendix D in 2022 waiver draft) to determine the impact of the BBSPs on providers and concluded that the law's provider participation requirement would likely have little effect on provider participation in BBSP offerings and providers would be likely to contract with the BBSP at the required rates to achieve premium targets. Additionally, the state-based reinsurance program to be implemented under the Section 1332 waiver is anticipated to help subsidize the reduction in premiums under the new BBSPs, which will count towards achieving the required premium reduction targets. The State projects that starting in Year 2, the reinsurance program will account for roughly half of required premium reductions. Furthermore, the State plans to require carriers to meet an administrative cost constraint that is stricter than prevailing individual market Qualified Health Plan (QHP) administrative expense loads to ensure carriers and providers share the weight of achieving premium savings, equally. In other words, BBSP carriers cannot cost shift all of the savings needed to achieve the premium reduction target onto their providers, or they risk a breach of contract and associated penalties.
6. Public Comment: Commenters expressed concern that the law's provider reimbursement design using Medicare rates as a floor (or establishing rates for services not covered in Medicare) does not adequately compensate providers and could in practice become a reimbursement ceiling. One commenter urged the State to permit physicians to negotiate rates not covered within Medicare.
    a. State Response: The Medicare rates, and comparable rates identified by DHHS for services not covered by Medicare, will serve only as a floor for reimbursement. Providers and BBSPs are expected to negotiate rates for participation, just as they do today for private health insurance. Depending on the provider and BBSP negotiations, provider rates may be higher than Medicare in some instances. The reference to Medicare rates (and comparable rates for non-Medicare services) is intended to protect providers from receiving rates below Medicare. Providers who feel like rates, in the aggregate, are not at least as high as Medicare rates can appeal for DHHS review. If a carrier is deemed out of compliance, they will face certain penalties under their contract and be required to correct the improper reimbursement scheme.

7. Public Comment: One commenter noted that the waiver application's actuarial analysis does not adequately explore the impact of provider reimbursement rate reductions on provider participation in the BBSPs, which the commenter stated could result in BBSPs having fewer participating providers and in turn the perception of BBSPs as a lower quality insurance product.
    a. State Response: BBSP provider networks will be robust due to several factors. First, there is a requirement for providers who participate in Medicaid, the Public Employees' Benefit Plan, or the workers' compensation program to also be in-network with at least one BBSP. Second, the State has existing network adequacy requirements for QHPs. Also, BBSPs' provider reimbursement rates will most likely have a marginal impact on provider behavior because the BBSP is being targeted at the individual market in Nevada, representing a small proportion of a provider's revenue. Further, while the State is implementing a reimbursement floor for provider payments under the BBSPs tied to Medicare rates, it anticipates providers and health carriers offering BBSPs to continue to negotiate their rates for all services as they do today.
8. Public Comment: A few commenters urged the State to encourage carriers offering BBSPs to reimburse providers at rates above Medicare, including by developing incentive payments for instituting commercial reimbursement rates or by conditioning participating in value-based payment arrangements on carriers reimbursing providers at commercial rates.
    a. State Response: The State appreciates commenters' feedback and intends to solicit additional input in a future RFI on how it can reward plans for quality and other state priorities. This could include offering rates that are above Medicare rates in the BBSPs, among other design considerations.
9. Public Comment: A few commenters expressed concern with the requirement that providers who participate in the Public Employees' Benefits Program, Medicaid, or the State's workers' compensation program must agree to participate in at least one provider network for a BBSP, stating that this requirement could disrupt providers' payer mix and drive providers out of the market, in turn reducing the number of participating providers in the Medicaid program.
    a. State Response: A Milliman analysis conducted in December 2022 (see Appendix D in 2022 waiver draft) found that the BBSPs' provider participation requirements will likely have a marginal impact on provider revenue and participation given the small proportion of revenue impacted. Additionally, under current law DHHS retains authority to waive the BBSP provider participation requirements when necessary to ensure that those who receive coverage under Medicaid and the Public Employees' Benefits Program have sufficient access to covered services. DHHS is considering establishing a process for offering a waiver for those providers who can show that the BBSP will have a substantial negative impact on their provider revenues based on their patient mix.
10. Public Comment: A few commenters highlighted strong support for the Practice in Nevada Program. Commenters requested additional information about eligibility for the program, urged the State to consider expanding eligibility for the Practice in Nevada program to all providers statewide, and requested the State prioritize pass-through funding for the Practice in Nevada program.
    a. State Response: The State appreciates commenters' feedback and will work with stakeholders and policymakers to finalize the details of program design – including Practice in Nevada Program eligibility – throughout 2024. At a minimum, the State will require providers to commit to living and practicing in the State for at least four consecutive years and making such commitment through a contract with the State which will require providers to return the funds if such commitment is not met.
11. Public Comment: One commenter suggested DHHS limit who can enroll in the BBSPs to minimize disruption to the commercial insurance market.

a. State Response: The State does not have authority to limit who can enroll in the BBSPs. The BBSPs must be available as QHPs as required by Nevada Revised Statute 695K. The Affordable Care Act (ACA) requires guaranteed issue for all QHPs, meaning insurance companies are required to issue a health plan to any applicant regardless of health status or other factors. This federal requirement is one of the few that cannot be waived under a Section 1332 waiver. Moreover, it is very unlikely that BBSPs will disrupt the commercial insurance market. Few consumers currently enrolled in the commercial market would have a financial incentive to leave their current coverage and enroll in a BBSP. Any consumer with an offer of affordable minimum essential coverage (MEC) from their employer does not qualify for an advance premium tax credit (APTC) for purchase of a plan within the Nevada Health Link, including a BBSP. In addition, the ACA's employer shared responsibility provision, which requires large employers to offer affordable coverage or pay a fee, keeps large employers engaged in offering health benefits and means that most consumers employed by large businesses do currently have an offer of affordable MEC and therefore will likely not be driven to enroll in the BBSP. Note that this same argument was made with the implementation of the new federal premium tax credits and exchanges after the Affordable Care Act passed and no major disruption occurred to the commercial insurance market at that time.

12. Public Comment: A few commenters expressed concern that insurers will be unable to meet the BBSP premium reduction requirements, noting there is little room to make administrative or in many cases provider cuts, particularly with the providers serving rural regions of the state.
    a. State Response: If the waiver is approved, the State would subsidize a portion of carriers' premium reductions through the state-based reinsurance program, which is anticipated to reduce premiums and help insurers achieve the required premium reductions. The State estimates that the reinsurance program in 2027 can help to offset the burden of premium reductions on carriers and their provider networks by subsidizing the reduction in rates by about half. The State is also exploring how it will calibrate the trend factor to consider multiple factors influencing premiums and costs in Nevada's market.
13. Public Comment: A few commenters expressed concern with the State's proposal to implement an administrative cost constraint that is stricter than the prevailing QHP administrative expense load in the Medical Loss Ratio (MLR), stating carriers will struggle to reduce administrative expenses and that this could undermine services benefiting consumers.
    a. State Response: This policy is intended to mitigate the risk of carriers cost-shifting the entire burden of meeting an annual premium reduction target onto their provider networks. Further, the State is already subsidizing a portion of carriers' premium reductions through the State's reinsurance program, which is anticipated to reduce premiums and will count towards the required premium reductions. The State estimates that the reinsurance program in 2027 can help to offset the burden of premium reductions on carriers and their provider networks by subsidizing the reduction in rates by about half.
14. Public Comment: A few commenters urged for transparency in how the State calculates pass-through funding and determines available funds for the reinsurance program. Commenters also expressed concern with the tiered structure of the reinsurance program in which reinsurance will have a lesser impact on reducing premiums in Rating Areas 1 and 2.
    a. State Response: The Centers for Medicare and Medicaid Services (CMS) and the Department of the Treasury are responsible for calculating the amount of pass-through funding. The federal government then communicates federal pass-through funding amounts to the state prior to the payment of the pass-through funding. While the State acknowledges carriers' concerns with the tiered reinsurance design, it is supportive of this design in order to address longstanding affordability disparities by geographic region in the State. In implementing a geographic tiered

structure, DHHS can reduce premiums more in the highest-cost, more rural geographic areas (i.e., Rating Areas 3 and 4). However, DHHS is open to modeling other scenarios for reinsurance if such models align with goals of improving access to lower premiums for more consumers, statewide.

15. Public Comment: One commenter expressed concern that the State is relying on federal pass-through funds rather than a pre-determined set of funding to finance the State's reinsurance program.
    a. State Response: The State does not anticipate seeking additional funding for this program if not obtained through the waiver in the form of federal pass-through funding. Further, the waiver application's actuarial report projects that starting in Year 2, there will be sufficient funding from federal pass-through funds to finance the first year of the reinsurance program. Based on the actuarial analysis by Milliman, it is anticipated that starting in Year 2 of the program, the entry of the BBSPs into the market will generate enough federal savings each year to cover the cost of financing a reinsurance program across the individual market, while garnering millions of dollars in additional remaining funds each year for the Quality Incentive Payment Program and Practice in Nevada Program. Depending on the amount of federal pass-through funds received each year, the State retains the authority to adjust the attachment point and limits on the reinsurance program to ensure the funds available cover the cost of the program.
16. Public Comment: A few commenters expressed concern with conditioning eligibility to offer a bid in the Medicaid Managed Care Program on submitting a good faith bid to offer a BBSP, stating that this could result in less competition in the bid process since plans may not have the ability to propose a BBSP which will not enter the Exchange market until 2026. Commenters are also concerned that tying the BBSPs to the Managed Care program could risk destabilizing the Medicaid program as a whole if carriers cannot meet BBSP requirements.
    a. State Response: Nevada's Medicaid Managed Care procurement is competitive, with seven carriers submitting bids to participate in the program during the last procurement in 2021. Further, carriers in Nevada offering Managed Care Plans already participate in the individual insurance market due to an existing contractual requirement that Managed Care Plans also offer an Exchange product. This requirement has not destabilized the Medicaid program. Additionally, the alignment of the BBSP procurement process with the Medicaid Managed Care procurement is intended to leverage the State's purchasing authority in the Medicaid program to ensure that good faith bids for BBPS are provided and achieved. The State will evaluate bids for the Managed Care plans and BBSPs separately, and each procurement will result in separate contracts with DHHS – one for Medicaid managed care and one for the new BBSP program. If a carrier does not offer a good faith bid for the BBSP, they will be deemed ineligible to participate (through the procurement) in Medicaid Managed Care program.
17. Public Comment: A few commenters questioned if the State can effectively reduce costs and improve affordability with the implementation of the BBSPs given the challenges encountered by other states implementing premium reductions under their public option programs.
    a. State Response: Unique to the Market Coverage and Stabilization Program in Nevada, DHHS will enforce statutory requirements for the BBSPs – including the premium reduction targets – by using the legal tools under its new contracts with carriers, similar to the ways in which the State's Medicaid program enforces its existing contracts with Managed Care Plan carriers. These tools include corrective action plans, financial penalties, and/or sanctions that can be imposed by the Director if carriers do not meet contractual obligations. In leveraging its robust contracting oversight authority, the State can more effectively ensure that carriers will meet the premium reduction targets and other requirements of state law for the BBSP program.

November 20, 2023

DHHS
400 West King Street, Suite 300
Carson City, Nevada 89703

RE: Nevada Draft Section 1332 State Innovation Waiver Application Public Notice

Thank you for the opportunity to provide comments on Nevada's section 1332 State Innovation Waiver application.

My name is Pauline Lavoie and me and my daughter have struggled for years to secure affordable insurance. A few years ago, I had to quit my job to find work that gave me the flexibility I needed for my daughter. I am fortunate to be able to work and still have time to take and pick my daughter up from school and her extracurricular activities, help her with homework, and have dinner together. Unfortunately, choosing this flexibility has meant giving up the health coverage available through my previous job. Since then, finding affordable and adequate coverage for her and myself has been challenging. Being a working mom is difficult enough, and I know a lot of moms in this exact situation.

Thankfully, Nevada passed the Public Option and not only will this provide affordable coverage - with the approval of this waiver Nevada can finally invest in the critical healthcare infrastructure like a provider pipeline and stabilization so that Nevada can finally address our decade long provider shortage.

I am particularly supportive of Public Option plans being offered because, unlike the junk plans that I so often see presented as an affordable option, these plans will be qualified health plans that cover basic necessities like preventative care.

And, Nevada's ability to leverage Medicaid insurance contracts means that families like mine will be able to actually see 15% reduction in premiums because we all know those insurance companies will do anything to keep those billion dollar contracts.

For the first time in a very long time, the Public Option and the millions of dollars we can get from this waiver will provide hope to families like mine that have, for so long, struggled with securing healthcare coverage and actually accessing healthcare.

Thank you for the opportunity to provide comments on the section 1332 waiver application in support of Nevada's Public Option.

Please approve this waiver and deliver hope to families like mine.

Sincerely,

Pauline Lavoie
Lunabears@yahoo.com

Support Letter for Nevada's Public Option
Cullen McGinnis

My name is Cullen McGinnis, and I have lived in Nevada my whole life and am from an immigrant family. I have watched my family struggle with high healthcare costs and I have experienced this myself as someone who has lived with asthma since I was a child. In 2018 my grandfather had heart surgery and afterwards he had to live in an assisted living facility. He did not recover from this surgery and he would go on to pass away in that center shortly afterwards. The cost for that surgery and his rehabilitation afterwards was a significant burden to my family and it added to the stress and suffering of my family during that time. A public option would have allowed my family to have access to affordable health insurance. I know that many Asian Pacific Islanders have experienced something similar, as many of us live in multigenerational homes and struggle with the high cost of caring for our aging family.

In my personal experience as someone living with asthma I have had to pay high prices for my inhaler that I need to function. Even with insurance my inhalers cost me hundreds of dollars. In the past this has led me to ration my medication or to even go without until I could afford it, often to the detriment of my health. 32% of API and Native Nevadans have reported rationing medication due to high cost as well, so we can see that high medication costs are a huge burden to our community.

I know that once I turn 26 the high cost of health insurance will become a huge burden to me, especially as someone with a pre existing condition. High costs in Nevada have led me to consider that my future may be brighter in other states where there is more public investment in healthcare and where costs are lower and outcomes are better. Many young Nevadans grapple with this reality as well, and it would be a shame for Nevada to lose talented people to states that have created a more competitive health insurance market.

76% of API and Native Nevadans reported that they worry about health insurance becoming unaffordable. High healthcare costs are becoming untenable for many in my community, and we should not have to go into debt to receive necessary medical attention or preventative care. By creating a public option and introducing a more competitive market, health insurance costs will go down for us.

I hope that the public option will be properly implemented so that healthcare costs can go down and I can continue to afford to live in this state that I have called home for my whole life.

As someone who struggles with chronic illness, I need access to medical care often that I can't afford without health insurance. High health insurance prices are a burden and barrier to accessing the care I need as a recent college graduate. I support the public option to create more reasonably priced health insurance plans so people like me can access the care they need.

Navigating Healthcare as Filipino American Immigrants

I am Lorenzita Santos, the daughter of Filipino immigrants, writing to shed light on the profound impact of healthcare costs on my family. My father, grappling with diabetes for most of his life, bore the weight of healthcare expenses, particularly during the 2008 recession when he juggled three jobs to cover groceries, our home, and insulin.

Affordability Struggles

Healthcare costs have always been a concern, affecting not only my family but also the broader Filipino community. Shockingly, the AAPI community, to which we belong, is twice as likely to be diagnosed with diabetes than other communities. Affordable healthcare is crucial for the well-being of hardworking immigrant families.

The Public Option: A Solution

In the midst of these challenges, the Public Option emerges as a vital step forward. By offering reasonably priced plans with sufficient coverage, it signifies a positive shift toward protecting families and immigrant communities like ours. Keeping insurance costs low becomes a lifeline for those navigating the complexities of healthcare affordability.

Urgent Need for Change

Nevada's high uninsured rate, particularly within the AAPI community, underscores the urgency for solutions like the Public Option. Over 340,000 Nevadans, including a significant AAPI population, grapple with being uninsured. The Public Option is more than a policy shift; it's a promise to safeguard the health and well-being of families like mine.

Sincerely,

Lorenzita Santos

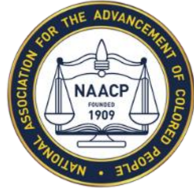
As the Community Engagement Director at One APIA Nevada, my commitment to advocating for a public health option in Nevada stems from the urgent need to enhance healthcare affordability and accessibility.

High healthcare costs have been a significant barrier, preventing Nevadans from seeking necessary medical care or obtaining comprehensive insurance coverage. I have encountered many cases where community members face financial strain due to exorbitant medical bills, forcing them to forgo essential treatments or preventive care.

A public health option is a critical step towards mitigating these challenges, as it promotes affordability by leveraging tax dollars to benefit Nevada consumers. The approval of the waiver and the consequent funding for healthcare workforce development are paramount. The scarcity of healthcare providers in Nevada not only limits access to care but also contributes to escalating costs. By investing in workforce development, we not only address the shortage of healthcare professionals but also pave the way for a more competitive healthcare landscape in Nevada.

We must take steps to make quality healthcare accessible, affordable, and equitable for all Nevadans.

Shelby Parkes
One APIA Nevada



NAACP
Las Vegas Branch

November 25, 2023

State of Nevada
Department of Health & Human Services
Mr. Richard Whitley, Director
400 W. King St., Suite 300
Carson City, Nev. 89703

Director Whitley,

The Las Vegas Branch of the NAACP stands in unwavering support for the implementation of Nevada's state-based health exchange. Implementing a public option will improve access to quality healthcare for all residents and play a crucial role in mitigating the health inequities faced by Black people and communities of color.

Communities of color, specifically Black people face higher rates of chronic illnesses, limited access to care, and poorer health outcomes compared to their white counterparts. A public option will provide affordable and comprehensive coverage, addressing financial constraints and systemic barriers that hinder access to quality healthcare.

Creating a state-based health exchange will reduce health disparities by ensuring that marginalized communities can access the care they need. By focusing on proactive measures like regular check-ups and screenings, we can identify health issues sooner and prevent them from escalating. **This approach improves health outcomes and reduces the financial burden on individuals *and the state***.

States with public health exchanges experience significant cost savings. Studies from the Center for American Progress or the National Partnership for Women and Families have shown that states operating their own healthcare exchanges can save millions of dollars annually through administrative efficiencies and reduced costs associated with uncompensated care. These savings are essential in a state like Nevada that lack diverse income streams.

In conclusion, Nevada's public option healthcare system is a vital step towards achieving health equity and justice for all residents. It ensures affordable and comprehensive coverage, empowering Black people and communities of color to access the care they deserve. The cost savings associated with a public state health exchange benefit both the state's economy and the well-being of its residents. It’s truly a win-win.

Sincerely yours,

Quentin-Michael Savwoir
President, NAACP Las Vegas

Fax: (702) 369-1342
Phone: (702) 638-1300

3065 N. Rancho Dr., Ste. #154
Las Vegas, NV 89130

www.naacplasvegas.org

December 5, 2023

Good afternoon.

I am Adam Zarrin (Z-A-R-R-I-N), the Director of State Government Affairs for the Leukemia & Lymphoma Society (LLS). Our mission is to cure blood cancers and improve the quality of life of patients and their families.

Last week, we shared how Americans nationwide feel trapped by medical debt. Others bravely shared their stories from across Nevada about their struggle to afford their medical bills.

This is not surprising when nearly 7 in 10 adults in the U.S. say they are concerned about affording healthcare.

We also encouraged the Department to focus on individuals and their experiences with the healthcare system. Our comments today are focused on how the state's policy can improve the quality of life for patients.

Affordable, high-quality insurance is necessary to prevent medical debt.

The public option plans will continue efforts to improve health plan options for Nevadans.

We are glad that the proposed waiver is projected to increase marketplace enrollment.

It would also reduce individual premiums, starting at 3 percent in 2026 and almost 14 percent in 2028. And it would do so without jeopardizing provider networks and quality of care for patients.

The Department can further improve these outcomes by funding the subsidies it contemplated in the first draft of the waiver. These subsidies immediately help patients in a meaningful way.

Patients still have out-of-pocket costs besides their premiums. Co-pays, co-insurances, and travel cause patients to consider delaying treatment. Or lead to the medical debt that traps patients.

Using pass-through funds for a premium subsidy will benefit patients more directly than reinsurance. So again, the state should consider including it as they did in their first draft of the waiver.

The public option will bring needed investments to improve Nevada's healthcare system.

Overall, the public option does what it set out to do -- reduce premiums, improve coverage, and save the state money.

Thank you to the Department and the Legislature for their leadership in improving patients' quality of life.

We hope that the waiver will continue through its process toward approval so that patients can enjoy the benefits of the public option.

We appreciate your consideration. Thank you.

We want to thank Sen. Cannizzaro for passing and Governor Lombardo for implementing SB 420.

This innovative policy and implementation plan takes a new approach to delivering affordable, quality healthcare to Nevadans and offers the opportunity to dramatically reduce the cost of healthcare in this state.

By leveraging the state's purchasing power through Medicaid, the state is able to drive down costs for consumers on the individual market and enact critical reforms in the Medicaid market. While all Nevadans will be able to benefit from this policy, one of the biggest beneficiaries will be Nevada families that make too much money for federal premium support but are still priced out of health insurance.

These are not rich families. These are middle-income and in some cases low income families that have not been at the center of the healthcare affordability conversation.

For a family of four with two working parents, they would not qualify for any premium support if each parent makes just $60,000 a year. That is just slightly higher than the average annual salary in Nevada of about $59,000 a year or $28 an hour, according to Ziprecruiter.

These families need help and support and this policy delivers exactly that.

For the first time, these families have a policy, a Public Option, which will allow them to see reduced premiums so they are able to secure more affordable, quality insurance.

For the first time, we have a state policy focused on consumers left in the gap between income levels that allow a family to ***actually*** afford insurance and government coverage and subsidies for low-income families.

In addition to the real benefits, the state's 1332 waiver application also has important provisions dedicated to addressing Nevada's decades-long provider shortage problem.

Nevada was ranked 48th in the nation with regard to the availability of primary care physicians and a report by UNR's School of Medicine found that Nevada needs more than 2,500 additional providers just to meet the national average. Some of the main ways that we can address this is funding workforce development initiatives like state based residency training slots, expanding

pay parity and scope for APRNs and tearing down barriers that prevent healthcare providers from moving to and practicing in Nevada.

These are important reforms and we encourage the state and CMS to look at comprehensive reforms and best practices that Nevada can engage in, along with the funding that will be provided through approval of the 1332 waiver, to truly rebuild and expand Nevada's network of healthcare providers. We need a healthcare infrastructure that can actually meet the needs of Nevada families and the 1332 waiver application provisions focused on workforce development are essential - we are strongly in support of them and thankful for their inclusion.

Finally, we wanted to point out and applaud the outcome based payment reforms included in SB420 and the 1332 waiver application. For far too long, Nevadans have been suffering under a healthcare system that is among the most expensive in the country with some of the worst healthcare outcomes. It is indeed the inverse of the type of healthcare system you actually want; instead of low cost, high quality we suffer from high cost, low quality.

By modernizing Nevada's payment system so that we incentivize healthcare providers to focus on patients outcomes, Nevada can drastically and practically address this issue. We can deliver in the individual market some of the same reforms that we are seeing in the Medicare and Medicaid market. Over the long-term, these incentive based payment solutions can finally change our healthcare system that has been focused on maximizing profits for insurers while demonstrating indifference to patient care and patient outcomes.

We want to remind everyone, including current providers that all MCOs offer exchange plans already and have been required to for years. We encourage DHHS and Medicaid to continue to explore additional administrative actions and reforms that can realign Nevada's healthcare system to the benefit of consumers and Nevada families and not simply deliver an additional point or two in profit margins to some of the largest healthcare corporations in the world.

Maite Guerra
Latino Anti-Disinformation Manager for BBP/IPN

Public Option Comment

My name is Maite Guerra and I am the Anti-Disinformation manager at Battle Born Progress/Institute for a Progressive Nevada.

I am here to discuss how for decades wealthy insurance companies have raised health insurance rates and profited at the expense of hard-working Nevadans. We see many hardworking Nevadans unable to afford quality insurance that effectively covers their medical needs. For that reason, I am here on behalf of the organization to show support for the public option because it will increase insurance options for Nevadans who continue to struggle with affordable healthcare despite medical concerns for themselves and their families.

Currently, 11.6 percent of Nevada residents lack coverage from either public or private insurance, placing the state among the bottom ten in terms of health insurance inclusion. Public option aims to offer a cost-effective alternative for individuals ineligible for public insurance such as Medicare or Medicare, for those without employer-provided insurance, or those who are self-employed.

The effectiveness of Nevada's Public Option Insurance lies in its exemplary governance, as it places the needs of community members at the forefront. By offering a choice for Nevadans to obtain affordable healthcare, it grants them greater autonomy to make decisions that enhance the quality of Nevadans lives.

NSEA
NEVADA STATE EDUCATION ASSOCIATION

December 5, 2023

Nevada Department of Health and Human Services
Division of Health Care Financing and Policy
1210 S. Valley View Boulevard
Las Vegas, NV 89102

Dear Sirs,

The Nevada State Education Association has been the voice of Nevada educators for over 120 years.

NSEA supports the creation of Battle Born Health Plans to ensure high-quality, affordable healthcare options for Nevadans.

Like public education and other vital services, Nevada ranks near the bottom of states in investment in healthcare. In addition to underinvestment, health disparities continue to run deep in our healthcare system. Nevada's low-income communities face fewer options and higher prices, and there is a significant health disparity in Nevada's communities of color.

In Nevada's rural communities, there are even fewer health insurance options and higher prices. Outside of Clark and Washoe there is typically just one plan on the health exchange, or none at all. This has left rural Nevadans with less choice and higher costs. In order to access basic healthcare in rural areas, many Nevadans have to travel for hours. In some emergency situations, air transport is required at a very high cost.

Due to WEP/GPO, many retired Nevada teachers may not qualify for Medicare and rely on private insurance plans. Some insurance carriers have been known to push older people into sub-standard insurance programs, with high deductible and high co-pay programs.

This new healthcare option will ensure that Nevadans always have equal access to affordable, quality coverage -- especially if they lose their job and insurance or do not have Medicare eligibility. Moreover, it will cut health care costs for everyone in the state by driving competition into the market and forcing insurance companies to compete with the new option for Nevadans' business.

In Solidarity,

Dawn Etcheverry, President

Thank you for the opportunity to testify on this important subject, for the record my name is Steven J Horner I am the President of Nevada State Education Association-Retired and I live in SD 11 and AD8.

So many public employees have worked 30 years or more but because we are a Windfall Elimination Provision/Government Pension Offset (WEP/GPO) state they have discovered that they are not eligible for Medicare. This public option is a way for our dedicated teachers, support professionals, and administrators to have affordable health insurance.

Drug prices and health costs are skyrocketing. Without affordable health insurance many of the teachers and support professionals I work with cannot afford to retire with dignity. That is a blight on our state. Working until a person is eighty or eighty-five simply because they cannot afford to go onto the open market for health insurance should end with this fully funded affordable public option.

This doesn't affect just public-school employees but all public employees that have dedicated their lives to serving the people of Nevada. Full funding is so important to those that sacrificed to serve. Please make sure this is properly and fully funded.

Support Letter for Nevada's Public Option

Fiorina Chau

My name is Fiorina and I am a first generation Asian American. Last year marked a profound loss in our family as my grandmother experienced a stroke. Hearing the news was devastating, especially since every sporadic movement gave us hope that she would recover from her coma. A decision awaited us – the agonizing choice between clinging to the possibility of her recovery through continued hospitalization, surgeries, and medications, all of which incurred substantial costs, or making the painful decision to let her go. Gratefully, our family, along with our extended relatives, unanimously pooled our resources, allowing my grandmother to persist in her fight. It's a decision that, I believe, resonates with countless families facing similar heart-wrenching choices.

Nevertheless, I can't help but wonder: What if we hadn't had that support? Unfortunately, many are forced to abandon the fight due to the unattainability of affordable health insurance. The prospect that the well-being of our loved ones, and even ourselves, hinges on financial resources is a stark reality. A public option could redefine this narrative, offering families a genuine choice.

Even when it doesn't come down to life or death, lack of affordable healthcare affects many Nevadans in their everyday lives. For instance, due to financial constraints, my friend had to opt for a less effective medication than the one prescribed. They rely on this medication everyday to complete daily tasks. Having access to more affordable high quality healthcare would improve his quality of life. This struggle is shared by 76% of API and Native Nevadans grappling with escalating health insurance concerns.

The implementation of a public option policy in Nevada could be transformative for its residents. It has the potential to instigate a more competitive healthcare market, thereby driving down costs for alternative insurance options. Moreover, affordable healthcare could be a game-changer, granting Nevadans access to necessary medications and procedures without the suffocating weight of financial burdens. For many, it could mean the difference between life and death.

November 30, 2023

DHHS
400 West King Street, Suite 300
Carson City, Nevada 89703

RE: Nevada Draft Section 1332 State Innovation Waiver Application Public Notice

Thank you to the Nevada Department of Health and Human Services (DHHS) and the Nevada Division of Health Care Financing and Policy for the opportunity to provide comments on Nevada's section 1332 State Innovation Waiver application.

My name is Brenda Rodriguez and in 2020 I was pregnant with my first child and uninsured. During this time like most, I was struggling and wasn't sure how I would be paying for doctor appointments and the hospital bill once I delivered my son. Due to the fact that I was on DACA, I was able to only qualify to receive emergency Medicaid which helped only pay for the delivery of my son. Although I would not qualify for the Public Option due to my immigration status many others will have the opportunity to access affordable coverage in Nevada.

Despite being one the most expensive states in the nation for healthcare costs we have some of the worst healthcare outcomes. Two-thirds of Nevadans have struggled to afford healthcare and "65% of respondents who reported health care affordability burdens in the prior 12 months included people foregoing health insurance because it was too expensive, delaying visits for medical needs including dental care, mental health care or addiction treatment, and struggling to pay medical bills." Despite the high costs, even Nevadans that have coverage struggle to get care - with Nevada ranked as the worst state to get primary care providers.

Now, with the Public Option, Nevada is leveraging taxpayer dollars to bring affordability and competition into Nevada. Because of the Public Option, 90,000 Nevadans will see more affordable health insurance options,cutting the uninsured rate amongst those eligible for individual health coverage by 12% and saving Nevadans more than $500 million. For those without access to coverage, this new affordable coverage option will be a lifeline that will save people money and allow them to more easily plan and budget for their family's needs.

On top of this, because of the $500 million in savings, Nevada will be able to recapture these dollars with this 1332 waiver to invest in marketplace stability, workforce development and payment optimization. Three things Nevada's broken healthcare market desperately needs.

With the approval of this waiver, Nevada will have the resources to deploy to address these problems.

Thank you for the opportunity to provide my insight and experience with Nevada's healthcare market and how the Nevada Public Option and the 1332 waiver will help fix our broken healthcare system.

Please approve this waiver and give Nevadans some hope.

Sincerely,

Brenda Rodriguez
brendarodriguez17@gmail.com

From: z har
To: DHCFP 1332waiverprogram
Subject: Health Insurance Public Option
Date: Tuesday, November 28, 2023 6:48:51 PM

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I am in favor of Nevada exploring the option of a public health insurance.

Thank you,
Kelly Larson

From: Michelle Krieg
To: DHCFP 1332waiverprogram
Subject: Public Comment
Date: Monday, November 27, 2023 4:43:15 PM

WARNING - This email originated from outside the State of Nevada. Exercise caution when opening attachments or clicking links, especially from unknown senders.

Hello,

My name is Michelle Krieg and I'm a Reno, Nevada resident. In January of this year I was diagnosed with an early stage of cervical cancer, and had to undergo a number of procedures and tests before needing a hysterectomy. At the time I was on a high deductible plan through my husband's work, but a month before the hysterectomy the company he worked for for over 10 years, laid him off and closed their business. We then had to go through cobra for our insurance. On one hand, we are grateful for the cobra option, but on the other, it meant that our premium now doubled in cost at a time when we were already mentally and financially stressed because of the health condition I was dealing with, and my husband being laid off. We managed to get through the next few months, I had the surgery and my husband got a new job, but we are still paying medical bills from my surgery.

My husband's new job hires workers as independent contractors and since I'm already a sole proprietor, we had to go to healthlink for insurance. Yet again we were faced with an array of high deductible plans. Currently, our so-called affordable plan costs us $9,000 in annual premiums, and is followed by a $17,000 family deductible, for a total of $26,000 a year of out of pocket costs before any healthcare services are covered by our insurance. This means, we do not go to the doctor or seek medical care unless absolutely necessary. These high deductible plans do not actually provide healthcare, they provide catastrophic insurance. $26,000 every year! This is not affordable healthcare, this is not quality and this is not sustainable for working class families. There must be another way.

- Kindly,
Michelle Krieg

From: Megan Lewis
To: DHCFP 1332waiverprogram
Subject: Public Option LTE: Carlos Perez Campbell 12/05
Date: Wednesday, December 6, 2023 2:21:53 PM

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Nevada Department of Health and Human Services
400 West King Street, Suite 300
Carson City, Nevada 89703

RE: Reno Family Healthcare Costs

Nevadans have long deserved affordable options for healthcare. As a head of household, insuring my family of three cost me $448 a month. My employer contributes a large potion on top of the amount that I put in. Yet, we typically only have maintenance healthcare and dental work done. While the monthly amount of healthcare is a cost that we are used to being taken out of our paychecks, the question must be asked if there is a better path forward. In Nevada, the democratic controlled legislature has crafted a better path forward through a Public Option.

The public option would allow people to opt into a state operated insurance program that will compete with other health insurance providers in the state. This is significant for a few reasons, mainly that through the public option, prices to insure yourself and your family goes down and it will create an insurance plan that will be vastly more affordable for people to obtain. The public option is not only sound policy, but it is a tool which will insure 90,000 Nevadans within 5 years of its implementation thanks to its more affordable price. In addition, it will give the government the greater ability to negotiate prescription drug prices downward which in our time of major inflation would provide real economic relief for families, especially sectors of our state that are most vulnerable.

Many in our community rightfully may see this and misunderstand it as a government grab into healthcare choice and lament the thought of the government forcing people to get healthcare through their scheme. Our Governor, Joe lambardo, appears to be on that side of the issue. However, I strongly urge Nevadans to see the facts and the benefits of having a public option.

Firstly, competition has always proven to improve the quality of services in all industries. With the entry of a state backed insurance plan, the traditional insurance companies will be forced to compete for Nevadans. They will have to lower costs and improve their services in order to entice us for our business! A public option to you would above all else give you an OPTION. In addition, uninsured individuals will have a health care plan that is in reach. This opportunity will provide Nevadans with an alternative to our current system which is overwhelming Nevadans. It is important that we strengthen the Public option, expand it and preserve it.

I support Nevada's creation of a Public Option that meets the same standards and offers the same essential benefits as private plans offered in the individual market. For those without access to coverage, this new affordable coverage option will be a lifeline that will save people money and allow them to more easily plan and budget for their family's needs.

Thank you for the opportunity to provide comments on the section 1332 waiver application in support of Nevada's Public Option.

Sincerely,

Carlos Perez Campbell
(775) 750-0232

Megan Lewis
For Our Future Nevada
NNV Organizing Manager
She/Hers
(775) 685-0544

From: Madisen McGrath
To: DHCFP 1332waiverprogram
Subject: RE: Nevada Draft Section 1332 State Innovation Waiver Application Public Notice
Date: Wednesday, December 6, 2023 2:22:27 PM

WARNING - This email originated from outside the State of Nevada. Exercise caution when opening attachments or clicking links, especially from unknown senders.

December 5, 2023

Nevada Department of Health and Human Services
400 West King Street, Suite 300
Carson City, Nevada 89703

RE: Nevada Draft Section 1332 State Innovation Waiver Application Public Notice

Thank you to the Nevada Department of Health and Human Services (DHHS) and the Nevada Division of Health Care Financing and Policy for the opportunity to provide comments on Nevada's section 1332 State Innovation Waiver application.

Even with expanded access to public and private health insurance coverage during the pandemic, Nevada suffers the highest uninsured rate of any state that has expanded Medicaid. Nearly half of uninsured Nevadans report the major reason they are uninsured is due to coverage being "too expensive". For those who are able to access health insurance, individual marketplace premiums have continued to rise. As a result, many Nevadans, like myself, go without care or are forced to make difficult choices between necessities like food, rent and getting the care we need.

I am Ms. McGrath, an educator who has proudly served our school district for over two decades. I've always seen teaching as my calling and my students as my second family. I enjoyed the work, but eventually realized it was time to retire. I had been on the district's health insurance plan for decades, and now I was alone in the individual markets before I qualify for Medicare in 6 months. However, after researching the marketplace I realized that my health insurance would be $800/month. I was shocked. In order to pay for this new, expensive bill, I had to return to substitute teaching to pay for my health insurance.

My story is not unique, and it speaks to a larger issue: the sky-high cost of healthcare in our country. It's a problem that calls for immediate reform. Educators like me, who have devoted their lives to shaping young minds, shouldn't have to make such painful choices between health and livelihood.

Nevadans, and all Americans, deserve an affordable and accessible healthcare system. It's time for our leaders to consider a public option that provides lower health costs for all. Let's ensure that educators and countless others can retire without the weight of financial stress, and that healthcare becomes a right, not a privilege.

I support Nevada's creation of a Public Option that meets the same standards and offers the same essential benefits as private plans offered in the individual market. For those without access to coverage, this new affordable coverage option will be a lifeline that will save people money and allow them to more easily plan and budget for their family's needs.

Thank you for the opportunity to provide comments on the section 1332 waiver application in support of Nevada's Public Option.

Sincerely,

Julie McGrath
(775) 815-9187
jmcgrath@washoeschools.net

December 8, 2023

Stacie Weeks, JD, MPH, Administrator
Nevada Division of Health Care Financing and Policy
1100 E. William Street, Suite 101
Carson City, NV 89701

Dear Ms. Weeks:

The Nevada Association of Health Plans (NvAHP) appreciates the opportunity to provide comments on the recently released 1332 Waiver Application and Actuarial Analysis of the Nevada Market Stabilization Program (NMSP) that includes the operation of a Public Option (PO) health insurance offering on the Silver State Exchange, as required by statute.

The NvAHP is a statewide trade association representing ten member companies who provide commercial health insurance and government programs to Nevadans. Our mission is to ensure the growth and development of a high-quality and affordable health care delivery system throughout the state.

The NvAHP has collaborated with the State of Nevada (State) throughout the multi-year process since the passage of SB420 in 2021. We have submitted eight letters beginning with the public design phase through stakeholder engagement and waiver design. We appreciate Governor Lombardo's efforts to collaborate with us and we support him in the effort to focus on market stabilization with the waiver application and understand there are limitations because of the language in SB420. However, our coalition continues to have serious concerns and questions about portions of the program structure. We respectfully provide key suggestions for the state's consideration as it moves forward with the 1332 Waiver Application and implementation of the PO that we believe will improve the market stabilization proposal while not risking instability in the Medicaid procurement process.

1332 Waiver Application

Medicaid Managed Care RFP Process

- Section 12(1) of SB420 outlines that the competitive bidding process for the PO must coincide with the statewide procurement process for the Medicaid managed care program. However, the State's waiver application dictates that it will issue a joint statewide Public Option and Medicaid procurement process, where bidding carriers will be scored based on whether they offer good faith bids for both: (1) a Medicaid Managed Care contract and (2) a Public Option contract.

- We are concerned with tying the scoring process of the MCO Request for Proposal (RFP) submission for Medicaid to the approval of a PO plan. Bidders know the statute requires a good

faith offer of a PO plan by any insurer who may win the contract but beyond that, the statute does not tie the two programs together to the extent proposed in the waiver application. Tying submission of a PO plan to the bidding process for management of Medicaid, in August of 2024 when the RFP is issued, is likely to result in less competition in the bid process since plans may not have the ability to propose a PO plan that will not hit the Exchange market until 2026.

- Since the PO process is new and untested in Nevada, and as we have seen in other states, tying these two elements so closely together creates a serious risk of destabilizing the Medicaid program as a whole if the PO is not successful. If for any myriad of reasons, the PO does not perform as expected and benchmarks are not able to be met, it could put the Medicaid MCO contracts in jeopardy if those benchmarks are part of the RFP.

Our members are concerned with the adverse impact these requirements may have on the Medicaid program and the Nevadans that managed care organizations serve. The concept that Medicaid bid proposals may be rejected based solely on the bid proposals for what is a distinct and entirely separate program that will not serve Medicaid members seems unduly punitive.

We strongly urge the State to reconsider the actuarial certification requirement and the automatic ineligibility for participation in the Medicaid program to ensure that the Medicaid managed care program does not falter - especially as managed care expands statewide for the first time.

Administrative Cost Constraints to Meet Premium Reduction Targets

We do not believe there is a need to implement an administrative cost constraint that is stricter than the prevailing individual market Qualified Health Plan (QHP) administrative expense load Medical Loss Ratio (MLR). And our members do not see any lever in the PO that would reduce administrative expenses for insurers or address the rise in health care costs.

- The Affordable Care Act (ACA) MLR provision already requires commercial health insurance providers to spend a certain percentage of premiums on medical care and limits the portion of premium dollars that can be spent on administration, marketing, and risk margin. As a result, administrative costs are already capped as a percentage of premium with or without the PO. Any additional constraints would be duplicative of the existing ACA requirements.

- As the individual ACA market matured and stabilized over the past nine years, carriers have aggressively priced their offerings to compete, almost eliminating required MLR rebates. Carriers have streamlined their administrative expenses to lower overall pricing and capture more membership, ensuring a sustainable risk pool.

- The framework presumes that issuers have excessive administrative costs that can be cut. Nevada is a competitive insurance market and the costs to administer and offer a PO plan would be no different than a non-public option plan. It is possible that administrative costs for the PO could increase depending on the requirements associated with the plan offering if there are unique network requirements or unique benefit design requirements that are not provided in non-PO plans.

- We are concerned that the PO has no mechanism to reduce administrative costs and that any reductions in insurer's required risk margins pose a significant threat to issuer competition and consumer choice in the Nevada market.

- Insurer administrative costs are spent on programs that benefit consumers vis-à-vis cost containment and quality improvement. This includes:
    - **Cost Containment:** Prevention of fraud, waste, and abuse by doctors and patients. Answering questions from doctors and hospitals, helping providers with best practices, and ensuring proper credentialing for quality care. Programs to better manage chronic conditions and coordinate care between doctors to ensure that the right treatment is provided to the right patient at the right time.
    - **Quality Improvement:** Preventive care programs to keep consumers healthy, like weight management plans or helping people to quit smoking. Patient education and follow-up calls by health plan staff to members discharged from a hospital and services to improve health in communities, like sponsoring local health fairs and providing free disease screenings and other educational events.
    - **Administrative:** General and administrative costs to run the business, including salaries, outsourced services, equipment, accreditation and certification fees, rent, legal fees and expenses, advertising, postage, utilities, to name a few.
    - **Premium Tax:** Nevada's highest premium tax.

We suggest not setting reduction targets of administrative costs beyond what current Silver State Exchange (Exchange) plans have. The intention of the State to require reductions in administrative costs beyond what has been found appropriate by the Division of Insurance (DOI) for Exchange plans is also not directed by the statute and will create yet another factor which could reduce the ability of insurers to meet the goals of the statute.

Premium Reductions

The NvAHP does not see a path for premium reductions, and we would like more details from the State on where cuts can be made in order to reach the premium reductions. We understand that they are dictated by statute, but a premium is still required to be actuarily sound.

Outside of Nevada's two most populus counties, Critical Access Hospitals ensure that Nevadans can receive medical care when needed. These hospitals are reimbursed at much higher rates than the 100% of Medicare hospitals in Clark and Washoe counties receive. CMS has designated these locations to receive higher reimbursement rates so that they may continue to operate on lower patient counts than their counterparts. The public option premium reductions may cause reimbursement reductions that could negatively impact our rural care sites and the members that utilize them for care.

- Premium reductions through lower physician or hospital rates are unrealistic.
    - Physicians on average are already at least 100 percent of Medicare.
    - Prescription drug affordability is not addressed.

<u>Market Stabilization Reinsurance Program</u>

A successful reinsurance program cannot rely on an unproven public option to generate federal pass-through funding for its portion which places significant risks and unknowns on carriers. If the State wants a reinsurance program, we strongly recommend an alternative financing mechanism for the State portion outside of an unproven and unrealistic public option.

- Presents significant risks and unknowns to the market.
    - "If a carrier cannot meet the target set forth in its contractual agreement with DHHS, the Director may utilize a corrective action plan (if deemed a viable option for the carrier, in order to allow the carrier to make up some of the reduction in future years) and any other penalties set forth in such agreement, including a financial penalty that is worth all or some of the value of the federal pass-through funding that the State would have otherwise received if the carrier had met their agreed-upon premium reduction target(s)." (pg. 18 of waiver application)
    - If federal funding is insufficient for the reinsurance program in any given year, the state will adjust the reinsurance program attachment point and coinsurance. "In turn, this also shifts more of the burden back on carriers in meeting the statutorily required premium reduction target of 15 percent over the first four years of the waiver period. The State's contracts with carriers for the BBSPs would therefore include two sets of agreed-upon certified rates for achieving the premium reduction target– with and without reinsurance—to ensure the mandatory four-year statutory target can be achieved." (pg. 14 of waiver application). Are we including this as is or is this meant to be a starting point?
- Transparency is vital in how pass-through funding will be calculated.

The tiered structure of the reinsurance program will make the premium reduction targets in rating area 1 that much harder to meet.

- Per the state's actuarial report, reinsurance will reduce premiums by 7.2% on average across the entire state.
- Individual market state-based reinsurance program parameters. $60K attachment point with $1M cap per member. Coinsurance b/w attachment point and cap varies by rating area. Coinsurance:
    - Rating area 1: 20%
    - Rating area 2: 35%
    - Rating areas 3 & 4: 70%
- By the state's design, reinsurance will have a much lower impact on premiums than 7.2%. in rating areas 1 and 2. Will the state look to the public option to have an even greater impact on premiums than 7.8% in rating areas 1 and 2?
- A recent study indicates providers in rating area 1 are already at 100% of Medicare. Hospitals are very close. There is almost no way to hit the premium reduction target and even less so with the least generous reinsurance parameters in rating area 1.

Implementation of SB420

As noted in our previous public comment letters, we continue to believe that the PO as outlined in SB420 is problematic and will not result in any meaningful increase in insurance coverage to Nevadans. There is also concern that the PO may not generate the projected savings and is likely to realize negative results including a reduction in provider participation of government-sponsored plans.

We are also concerned with the points below.

- ***Public Option Experiences in other States –*** Plans in other states have not been able to meet the premium reduction goals and/or provider reimbursement reduction goals. These states have

focused on attempting to reduce hospital/facility and provider costs without addressing the overall cost of health care, such as the cost of pharmaceuticals.

- ***Unlimited enrollment eligibility*** – Without eligibility being defined, enrollment could hurt the existing individual and small group market if businesses are discouraged from providing coverage through the small group market. We are concerned that the state may unintentionally destabilize the existing individual and small group health insurance markets in Nevada.

Our coalition members will continue to review the 1332 Waiver Application and may provide additional comments prior to December 20, 2023.

We look forward to working with the State as it continues to move forward with the implementation of the Market Stabilization Program and Public Option.

Thank you.

Helen Foley
Legislative Advocate
Nevada Association of Health Plans
702-234-6500

December 13, 2023

Nevada Department of Health and Human Services
Division of Health Care Financing and Policy
1100 East William Street, Suite 101
Carson City, NV 89701

RE: Nevada Draft Section 1332 State Innovation Waiver Application Public Notice

Thank you to the Nevada Division of Health Care Financing and Policy for the opportunity to provide comments on Nevada's 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 the Division of Health Care Financing and Policy ("the Division") to create a public health insurance option in Nevada.** We believe this proposal is a strong foundation to increase health coverage options for Nevadans while building upon existing state efforts to promote health care affordability. We are excited to see the continued efforts to ensure access to affordable health insurance coverage through the creation of Battle Born State Plans and appreciate the opportunity to share our perspective on the design of the state's federal 1332 waiver.

Current Coverage and Affordability Landscape in Nevada

Even with expanded access to public and private health insurance coverage during the pandemic, Nevada suffers the highest uninsured rate of any state that has expanded Medicaid. More than 340,000 (11%) Nevadans are uninsured, with Hispanic (20%) and American Indian/Alaskan Native (21%) populations being disproportionately impacted. Nearly half of uninsured Nevadans report the major reason they are uninsured is due to coverage being "too expensive." For those who are able to access health insurance, individual marketplace premiums have continued to rise. Many insured Nevadans report experiencing health care affordability burdens, while even more worry about affording health care costs both now and in the future. Due to this, more than half of Nevadans reported delaying or going without health care due to cost in 2022.

Increasing Affordability for Nevadans

We are supportive of the state taking a unique approach to strengthen the long term sustainability of the market in Nevada by leveraging the savings created by the Public Option for three new initiatives – a state-based reinsurance program, quality incentive payment program tied to improved outcomes for participating carriers and providers and the "Practice in Nevada" provider incentive program. Nevada's Coverage and Market Stabilization Program aims 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.

One of the overarching goals of the Public Option was to reduce the cost of health coverage and the number of Nevada residents forced to go without health insurance because they can't afford it. With the Public Option and reinsurance working together, individual marketplace premiums will fall 15% over four years. For those without access to coverage, this premium reduction will be a lifeline that will save people money and allow them to more easily plan and budget for their family's needs.

To further lower out-of-pocket costs for Nevada residents, the state should consider leveraging any additional funding available to provide direct subsidies and financial support to people eligible for premium tax credits to offset premium and out-of-pocket costs, which can be targeted by income, age, geography or other factors the state decides. Several other states have implemented a state-based Marketplace subsidy, with New Jersey and Colorado successfully combining premium subsidies with their reinsurance programs. Direct to consumer subsidies are known to expand coverage, support the market risk pool and reduce premiums for enrollees.

Maintaining Access to Care for People
Reimbursement for providers who participate in one of Nevada's public option plans are expected to meet or exceed Medicare rates, with special attention paid to critical safety net providers, including critical access hospitals, federally qualified health centers, and rural health clinics, to ensure access to these essential providers. Furthermore, the quality incentive payment targets through the Marketplace Stabilization Program's "waterfall" approach will incentivize better care delivery that prioritizes positive health care outcomes and shifts away from costly fee-for-service. Carriers will have the option to leverage several incentive models, such as offering providers valued-based payment bonuses tied to quality metrics, setting primary care spending targets or engaging in efforts to increase health care workforce capacity. These programs are proven to improve health outcomes for people, all while providing financial certainty for providers and ensuring Nevadans maintain access to robust provider networks and health plan choices.

Addressing the Provider Shortage in Nevada
Nevadan's health coverage issues are exacerbated by the state not having enough physicians to meet Nevadan's growing health needs. Every county in Nevada is experiencing a shortage of medical professionals, and in 2021, Nevada was ranked 48th in the nation with regard to the availability of primary care physicians per 100,000 residents, leading to long wait times for primary and specialty care. Drawing doctors to complete their graduate medical education in Nevada has become more difficult as the state's population has increased but graduate residency spots have not. Thus, many of Nevada's 300 medical school graduates complete their residency elsewhere, never returning to practice in Nevada.

To ensure that the quality incentive payment and "Practice in Nevada" programs are effective in addressing the state's unique health care challenges, **the state should create funding benchmarks for these programs that define "sufficient funding"**. This can be done by allocating percentages of how much federal pass through funding will be dedicated to the carrier and provider quality incentive programs once reinsurance is "fully funded" to ensure they

receive the necessary funding to be impactful for patients. For example, the affordability programs funded, in part, through the Colorado 1332 waiver, limits funding for reinsurance at 73% of pass through funds or approximately $90 million, ensuring $18 million of the leftover passthrough funding is allocated for state subsidies and 10% is allocated for payments to carriers. Applying these funding requirements not only ensures that patients will receive the maximum benefits of this program – instead of carriers themselves – but because of the percentage allocations tied to the dollar amounts (i.e. "73% of remaining funds"), allows the program to ebb and flow as the total waiver funds change from year to year.

Program Improvement
In addition to the policy recommendations made above, it is critical that the Division has the tools and data to successfully implement the waiver and oversee Battle Born State Plans as intended. The Division should use regulatory authority where needed to create mechanisms to measure the success of the proposed programs in stabilizing Nevada's market and reducing costs and provide data informed recommendations as needed to improve program effectiveness.

Thank you for the opportunity to provide comments on the section 1332 waiver application in support of Nevada's Coverage and Market Stabilization Program. If you have any questions or are interested in further discussion of our comments on the proposed 1332 waiver application, please do not hesitate to reach out to Jodi Helsel at jodi@committeetoprotect.org.

Sincerely,

Dr. Rob Davidson
Executive Director
Committee to Protect Health Care

Dr. Harpreet Tsui
Nevada Lead
Committee to Protect Health Care

[EXTERNAL] Please do not reply, click links, or open attachments unless you recognize the source of this message and know the content is safe.

From: Jonkey, Ashley <ashley.jonkey@elevancehealth.com>
Sent: Wednesday, December 13, 2023 10:12 AM
To: Stacie Weeks <sweeks@dhcfp.nv.gov>
Subject: Feedback - Reinsurance

WARNING - This email originated from outside the State of Nevada. Exercise caution when opening attachments or clicking links, especially from unknown senders.

Administrator Weeks – Elevance Health (Anthem BCBS) provides the below feedback regarding reinsurance parameters. Additionally, we provided additional comments through our trade association on the 1332 waiver via a letter that was submitted on 12/8/23 to the Division.

Should you have any questions, please let me know.

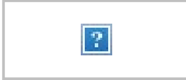
Reinsurance Issues/Questions/Comments:

- The tiered structure of the reinsurance program will make the premium reduction targets in rating area 1 that much harder to meet.
- Per the state's actuarial report, reinsurance will reduce premium by 7.2% on average across the entire state.
- Individual market state-based reinsurance program parameters. $60K attachment point with $1M cap per member. Coinsurance b/w attachment point and cap varies by rating area. Coinsurance:
  - Rating area 1: 20%
  - Rating area 2: 35%
  - Rating areas 3 & 4: 70%
- By the state's design, reinsurance will have a much lower impact on premiums than 7.2%. in rating areas 1 and 2. Will the state look to the public option to have an even greater impact on premiums than 7.8% in rating areas 1 and 2?

As you know, we do not believe the public option premium reduction requirements are realistic with or

without reinsurance. This is even more acute in ratings area 1 and 2 where the less generous reinsurance parameters will have a lesser impact on premiums and providers are at or generally near the 100% of Medicare aggregate reimbursement levels already, per the floor in the statute.

Thank you! Ashley



Ashley Jonkey
Government Affairs Director, Nevada
M: 775.842.2367
Ashley.Jonkey@elevancehealth.com

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From:	Jodi Helsel
To:	DHCFP 1332waiverprogram
Cc:	Jerry Zebrack
Subject:	1332 Waiver Comments from Jerry Zebrack, MD
Date:	Wednesday, December 13, 2023 3:42:35 PM

WARNING - This email originated from outside the State of Nevada. Exercise caution when opening attachments or clicking links, especially from unknown senders.

The below comments are from Dr. Jerry Zebrack (cc'd):

To the Nevada Division of Health Care Financing and Policy,

As a cardiologist, I'm supportive of the framework the Division has proposed to create a public health insurance option in Nevada. It will build a strong foundation to increase health coverage options for Nevadans while promoting health care affordability.

Doctors hear all the time from our patients how the high cost of health care prevents them from seeking care. Some patients come in after suffering for months, even years, from a problem that could have been treated earlier. Others stop coming because they lose their insurance. Too many patients fall in a gap, not qualifying for federal premium support but also not able to afford coverage.

That's why the public option is so important, and why doctors like me support the design of the federal 1332 waiver. The public option will increase health care affordability and access for patients like mine. With a public option and reinsurance, individual marketplace premiums will decrease 15 percent over four years. Nevada's Coverage and Market Stabilization Program can lower the cost of health insurance for up to, or even more than, 100,000 Nevadans on the individual market.

The state can, and should, help patients even further by leveraging additional available funding to directly subsidize premium tax credits to offset premium and out-of-pocket costs.

When patients are better able to afford and access care, they're better able to live, work, learn, and care for their families. That makes our communities and our whole state healthier and stronger. Thank you for your work to help my patients.

Jerry Zebrack M.D.
Reno, NV

--

Jodi Helsel
she/her
Organizing Director | Committee to Protect Health Care
619-433-9258
www.committeetoprotect.org

From:	Randi Lampert
To:	DHCFP 1332waiverprogram
Subject:	public option comments
Date:	Thursday, December 14, 2023 6:06:20 PM

WARNING - This email originated from outside the State of Nevada. Exercise caution when opening attachments or clicking links, especially from unknown senders.

To the Nevada Division of Health Care Financing and Policy,

Thank you for the opportunity to share comments on Nevada's section 1332 State Innovation Waiver application to create the Nevada Coverage and Market Stabilization Program. As a pediatrician in Las Vegas, I support the framework proposed to create a public health insurance option in Nevada. I believe it will help increase health coverage options for Nevadans, including my patients.

Furthermore, I support the state leveraging the savings created by the public option for the "Practice in Nevada" provider incentive program. This program can help address the dire shortage of health care providers in our state — a shortage being felt by providers like me and our patients every day.

This shortage is especially acute for developmental and behavioral health in our state. My patients have often waited over a year to receive a diagnosis of autism. While they are waiting they are missing out on critical services; these services are most effective when started at as early an age as possible. I saw one patient recently that had been expelled from kindergarten for behavioral issues while waiting to see a child psychiatrist. When he finally saw us 9 months later, he was diagnosed with ADHD which is easily treatable with medication. But in that time period he has fallen over a year behind academically. Stories like these are all too common for pediatricians in our state.

My patients and all Nevadans deserve to be able to access care affordably and when they need it. Your division can help ensure greater access to affordable care across the state. Thank you for your work to do so.

Sincerely,

Dr. Randi Lampert
Pediatrics
Las Vegas

From: Amy Brenner
To: DHCFP 1332waiverprogram
Subject: Sign Up for Market Stabilization ListServ
Date: Saturday, December 16, 2023 9:57:32 PM

WARNING - This email originated from outside the State of Nevada. Exercise caution when opening attachments or clicking links, especially from unknown senders.

Hello,

I am not in favor of a state run health insurance program., if it is administrated by The Nevada Department of Insurance (NDI). The NDI's stipulations for auto insurers have caused auto insurance premiums to become some of the highest in the nation. I do not want to see this happened to public health insurance offerings in the state of Nevada.

Amy K. Hebel-Brenner, M.Ed.
775-357-6734
amykbrenner@gmail.com

From:	Jamie Urtiaga
To:	DHCFP 1332waiverprogram
Subject:	Practice in Nevada program
Date:	Sunday, December 17, 2023 4:57:23 PM

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Practice in Nevada program

I am interested in finding out more about this program for MD loan repayment- who is eligible, when and how to apply, any pertinent details. Please provide a website or brochure with details if available.

Thanks

Grassroots NV Public Option Written Comment

12/16/23

Nevada Department of Health and Human Services
400 West King Street, Suite 300
Carson City, Nevada 89703

RE: Nevada Draft Section 1332 State Innovation Waiver Application Public Notice

Thank you to the Nevada Department of Health and Human Services (DHHS) and the Nevada Division of Health Care Financing and Policy for the opportunity to provide comments on Nevada's section 1332 State Innovation Waiver application.

Even with expanded access to public and private health insurance coverage during the pandemic, Nevada suffers the highest uninsured rate of any state that has expanded Medicaid. Nearly half of uninsured Nevadans report the major reason they are uninsured is due to coverage being "too expensive". For those who can access health insurance, individual marketplace premiums have continued to rise. As a result, many Nevadans, like myself, go without care or are forced to make difficult choices between necessities like food, rent, and getting the care we need.

My husband found cancer in his liver and had to have a doctor for every organ of his body. He was put on the transplant list and given extensive medication. It cost around 500 to 600 dollars a month. In a short period we almost lost our house; while my family lived in and out of california in hotels. Fortunately a friend of mine had loaned me an RV to make living in california possible during his treatment. Having a public health insurance option would have saved us the time and efforts to find adequate coverage instead of bouncing around health insurances to cover my husband's medical expenses.

I support Nevada's creation of a Public Option that meets the same standards and offers the same essential benefits as private plans offered in the individual market. For those without access to coverage, this new affordable coverage option will be a lifeline that will save people money and allow them to more easily plan and budget for their family's needs.

Thank you for the opportunity to provide comments on the section 1332 waiver application in support of Nevada's Public Option.

Sincerely,
Ethelinda Fincher
7024618281

From: Keiara Katz
To: DHCFP 1332waiverprogram
Cc: jclark@forourfuturefund.org
Subject: RE: Nevada Draft Section 1332 State Innovation Waiver Application Public Notice
Date: Tuesday, December 19, 2023 11:08:08 AM

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12/19/2023

Nevada Department of Health and Human Services
400 West King Street, Suite 300
Carson City, Nevada 89703

RE: Nevada Draft Section 1332 State Innovation Waiver Application Public Notice

Thank you to the Nevada Department of Health and Human Services (DHHS) and the Nevada Division of Health Care Financing and Policy for the opportunity to provide comments on Nevada's section 1332 State Innovation Waiver application.

Even with expanded access to public and private health insurance coverage during the pandemic, Nevada suffers the highest uninsured rate of any state that has expanded Medicaid. Nearly half of uninsured Nevadans report the major reason they are uninsured is due to coverage being "too expensive". For those who are able to access health insurance, individual marketplace premiums have continued to rise. As a result, many Nevadans, like myself, go without care or are forced to make difficult choices between necessities like food, rent and getting the care we need.

As a Nevadan diagnosed with Relapsing-Remitting MS in 2017 and serving as a District Activist Leader with the National MS Society, I strongly endorse the passage of the bill to implement the Public Option in our state. Having personally grappled with the challenges of insurance pre-authorizations and witnessed the struggles of countless individuals facing high healthcare costs, I believe the Public Option is a vital step towards addressing the gaps in our current system. The bill's enactment would signify a significant stride towards accessible and affordable healthcare for all Nevadans. By sharing my story and advocating for this crucial change, I hope to contribute to a progressing healthcare system that prioritizes the well-being of individuals over financial barriers. I urge policymakers to consider the transformative impact the Public Option can have on the lives of people like me and to actively support its passage to benefit our community's health and prosperity.

I support Nevada's creation of a Public Option that meets the same standards and offers the same essential benefits as private plans offered in the individual market. For those without access to coverage, this new affordable coverage option will be a lifeline that will save people money and allow them to more easily plan and budget for their family's needs.

Thank you for the opportunity to provide comments on the section 1332 waiver application in support of Nevada's Public Option.

Sincerely,

Keiara Katz
NV District Activist Leader
National MS Society

702-528-1734
www.linkedin.com/in/keiarakatz
nationalmssociety.org

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"The journey of a thousand miles begins with a single step."

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From: Kevin Clarke
To: DHCFP 1332waiverprogram
Subject: 1332WaiverProgram@dhcfp.nv.gov
Date: Tuesday, December 19, 2023 2:58:42 PM

WARNING - This email originated from outside the State of Nevada. Exercise caution when opening attachments or clicking links, especially from unknown senders.

Thank you to the Nevada Department of Health and Human Services (DHHS) and the Nevada Division of Health Care Financing and Policy for the opportunity to provide comments on Nevada's section 1332 State Innovation Waiver application.

I have spent the majority of my life being the sole provider of my household of 7. In 2017 I found myself out of the job I held my entire adult life which had given the entirety of my family insurance. Searching in the job market found me relocating myself, my wife, and 5 children to the Las Vegas Valley in pursuit of a more affordable life. The new job didn't have health insurance provided as my previous job did, so for my first 3 years in the Valley we bit the bullet and went without Health Insurance as a family. That meant no check ups or doctor's appointments, my youngest son accrued 6 cavities in this time.

My eldest son passed out due to heat exhaustion in this time period, after his visit to the emergency room we found a medical bill towering over the cost of $8,000 which we couldn't afford. I wouldn't wish this uncertainty and economic anxiety on any Nevadan. Having a Public Option would mean that families like mine would have never had to look down the barrel of a world without access to Health Care. The well being of myself and my children wouldn't be left at the hands of the job I am employed by and provide a lifeline to those of us who can't afford it. I support Nevada's creation of a Public Option that'll make sure no one will have to go through what I went through.

Thank you for the opportunity to provide comments on the section 1332 waiver application in support of Nevada's Public Option.

Sincerely,

Kevin Clarke Sr
nivek177@yahoo.com

Sowjanya Reganti, MD, President
Joseph Adashek, MD, President-Elect
Andy Eisen, MD, Immediate Past President
Jeffrey Roth, MD, Secretary
Jay Morgan, MD, Treasurer
Steve Lore, MD, Rural Representative
Florence Jameson, MD, Chief AMA Delegate
Andy Pasternak, MD, AMA Delegate
Joseph Adashek, MD, AMA Alternate Delegate
Peter Fenwick, MD, AMA Alternate Delegate
Sarah Watkins, Executive Director
Jacqueline L. Nguyen, JD, Policy Director

December 18, 2023

Nevada Department of Health
and Human Services
Richard Whitley, Director

Via Email: 1332WaiverProgram@dhcfp.nv.gov

Division of Health Care Finance and
Policy Department of Health and Human Services
Stacie Weeks, Administrator

Re: 1332 Waiver Program

Dear Director Whitley and Administrator Weeks:

On behalf of the Nevada State Medical Association (NSMA), the state's largest and oldest organization representing physicians and physician assistants, we are writing to express concerns regarding Nevada's proposed public option 1332 waiver and its potential implications for patients, physicians, and the healthcare landscape within our state.

NSMA and our physicians are dedicated to providing quality care to our community. We are deeply invested in the welfare of our patients and the viability of healthcare delivery systems. While the intention behind the proposed public option policy is commendable in aiming to increase accessibility and affordability of healthcare, there are several key concerns that need to be addressed to ensure its successful implementation without compromising the quality of care provided.

NSMA is committed to the goal of improving access to, and affordability of, health insurance for all in Nevada. We believe that public options should have the goals of maximizing patient choice of health plans and that there should be health plan marketplace competition. However, this must be done with guardrails in place to protect physicians and their patients. Especially in Nevada, which has a dire physician shortage, any efforts to implement the public option without prioritizing quality access to care and physician workforce expansion will have the ultimate effect of harming patients in our state.

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www.nvdoctors.org

Since the inception of this policy, NSMA has stood with its healthcare allies in thoughtful opposition, but we understand the Administration is required by law to move forward and would ask the Division to consider the following concerns we continue to underscore when submitting the final waiver.

First, the reimbursement rates outlined in the proposed policy are alarming. As a crucial component of sustaining medical practices, fair and sustainable reimbursement rates are essential to support the comprehensive care we offer to patients. In the public option, provider rates are tied to Medicare, which is set to receive a 3.36% cut in 2024, after having just received a 2% cut in 2023. In fact, since 2001, Medicare physician payments have been cut 26% once you calculate in inflation. This is not a feasible benchmark. Additionally, for any services not covered by Medicare, the policy states that reasonable rates will be calculated against the Public Employees Benefits Program rates or Medicaid. Mandating a proposed rate, as they stand, negates any negotiating position for physicians and poses a significant threat to the financial viability of medical practices, potentially leading to reduced access to care and jeopardizing the sustainability of healthcare services across the state. Therefore, while we understand Medicare rates are required by NRS 695k, we would ask that in the waiver, physicians have the ability to negotiate rates NOT covered within Medicare.

Additionally, the administrative burdens associated with the implementation of the public option policy are a cause for concern. Additional bureaucratic complexities and regulatory requirements may impose substantial burdens on physicians and healthcare facilities, diverting valuable resources away from patient care and contributing to physician burnout. Requiring physicians who currently care for Nevadans who need to access their worker's compensation or Public Employee Benefits Program benefits to join a network without the ability to negotiate their own contracts will likely hurt all state programs and drive physicians from the market.

The reality is this- physicians who take Medicaid currently are already doing so to provide a service to our community. In most instances, the Medicaid portion of their practice is a loss for the provider. This loss can only be supported by a carefully considered payor mix. To increase their Medicaid patient population by mandating participation in the public option disrupts their practices' payor mix that allows them to keep their practices open. By mandating any physician that already does a service to the community by taking Medicaid to participate in the public option may have the unintended consequence of driving many providers from the Medicaid system as a whole. We would ask for a waiver, beyond the rural populations, for physicians to opt out of mandated service in the public option.

Finally, the lack of clear mechanisms for addressing these concerns and actively involving healthcare stakeholders, particularly physicians, in the policymaking process is discouraging. Collaborative dialogue and input from frontline healthcare providers are essential to develop policies that effectively address the needs of both patients and healthcare professionals.

We urge the Division to consider these concerns seriously and engage in open dialogue with healthcare stakeholders to collaboratively devise solutions that ensure the success of the public option policy while safeguarding the quality of healthcare delivery. Preserving a sustainable and thriving healthcare environment in Nevada requires thoughtful consideration of these issues and a concerted effort to address them in the policy framework.

Regarding the specific waiver proposals:

State-Based Reinsurance Program:
NSMA acknowledges that a reinsurance program may help alleviate any disruptions to the insurance market. However, since the plan is tied to the public option, which mandates the new Battle Born State Plans to meet annual premium reduction targets, NSMA is concerned that there will be cost shifting to the contracted physicians. As stated in our public comments during the hearings for Senate Bill 420, NSMA urges for safeguards for providers that ensure that the premium reduction targets are mandated to be sourced from efficiencies in carrier management.

Quality Incentive Program (QIP) for Issuers:
NSMA agrees that a QIP program will work to incentivize carriers to use value-based measures to improve health outcomes. However, these measures cannot be made on the backs of an already stretched provider population. NSMA recommends that any quality incentive payment made to carriers also incorporates the criteria that such carriers demonstrate that they pay providers at a rate comparable to commercial rates. This will then be a dual incentive to carriers to accomplish the goals of improved health outcomes for patients while also recognizing the important goal of maintaining and then increasing the provider workforce.

"Practice in Nevada" Incentive Program for Health Care Providers:
NSMA applauds the state's plan to finance a new "Practice in Nevada" program. In the Waiver Application, the state asserts that "increasing the number of providers is essential to addressing poor health outcomes and health disparities. It is also important for controlling the rise in the cost of health care and ensuring the stability of the State's insurance market." NSMA wholeheartedly agrees.

Therefore, we would assert that the creation of the Practice in Nevada program should receive higher priority to receive money from the pass-through funding. Additionally, it would be critical to have the NSMA take a significant stakeholder position in the creation, maintenance, and oversight of the program as our physician members are on the front lines of recruitment of physicians into the state.

We also urge that the Practice in Nevada program be expanded to not only areas that are designated federal Health Professional Shortage Areas but opened to all of Nevada as our provider shortages are statewide.

We understand submission of a waiver is required by law, but we strongly urge thorough consideration and thoughtful revision of the proposed 1332 waiver to safeguard the interests of our residents and preserve the integrity of our healthcare system. It is imperative that any changes made prioritize maintaining and enhancing the accessibility, affordability, and quality of healthcare for all Nevadans.
Thank you for your consideration of these critical matters. The Nevada State Medical Association and our physicians are available and eager to contribute to constructive discussions aimed at improving our healthcare system for the benefit of all Nevadans.

Sincerely,

Jacqueline L. Nguyen

Jacqueline L. Nguyen, JD
Policy Director
Nevada State Medical Association

December 19, 2023

Stacie Weeks, Administrator
Division of Health Care Financing and Policy (DHCFP, Nevada Medicaid)
1100 East William Street, Suite 101
Carson City, NV 89701

Dear Administrator Weeks,

As the largest and broadest-based business organization in Nevada, the Vegas Chamber is focused on helping Nevada businesses succeed and grow. It has been part of the core mission of the Vegas Chamber to support employers, their employees, and the Southern Nevada community since its founding in 1911.

Overwhelmingly, our members identify healthcare as one of their biggest challenges regarding employee retention and recruitment in our community. That is why the Chamber has been a longtime proponent that every Nevadan should have access to affordable healthcare coverage.

However, the Chamber believes that Senate Bill 420, since its introduction and adoption by the State Legislature in 2021, does not support that objective. Instead, it will hinder and impede Nevadans' access to quality, affordable healthcare and have many unintended consequences. The reality is that expanding access to affordable healthcare needs to be a market-driven process with sustainable solutions and should not be reliant on government mandates and directives.

The Chamber maintains that Nevada's Public Option program will not reduce health care costs, but rather, it will shift costs onto other Nevadans, which is not equitable can be devasting to Nevadans. It is a program that will not help Nevada's families but has the potential to harm access to health providers and services. Furthermore, mandating a state insurance plan to offer a rate five percent lower than commercial rates is another cost-shift. As you know, evidence from other states that have implemented similar Public Option programs indicates that insurance costs go up, which is very concerning to employers and employees and their families. Our priority is to support Nevadans and their families, and that is why the Chamber continues to be opposed to the program.

While the State is trying to mitigate many of the above-mentioned concerns with its 1332 Waiver Application, the need for the waiver application highlights the challenges and problems associated with the Public Option program and the negative impact it will have on Nevadans' access to healthcare. Please note that the Chamber does appreciate the efforts by Governor Lombardo and the agency to mitigate the negative effects on SB 420. But unfortunately, this does not go far enough in addressing the fundamental flaws of the legislation and the program.

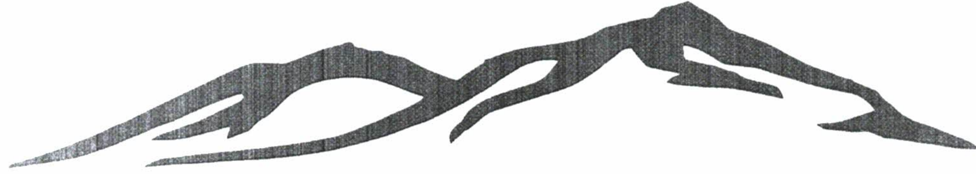
If we can provide any further assistance or information, please contact us at 702.641.5822 Thank you for your time and consideration on this important policy matter.

Sincerely,

Mary Beth Sewald
President & CEO

Hugh Anderson
Government Affairs Committee, Chairman

575 Symphony Park Ave., Ste. 100
Las Vegas, NV 89106
702.641.5822 • VegasChamber.com



PHILIP MALINAS, M.D. & ASSOCIATES

Child, Adolescent and Adult Psychiatry

Dear Nevada Division of Health Care Financing and Policy,

I'm a psychiatrist from Reno in support of the framework proposed to create a public health insurance option in Nevada.

Health care in Nevada has become more expensive and difficult to access for too many. Eleven percent of Nevadans are uninsured, and even insured Nevadans report experiencing health care affordability burdens. At the same time, patients seeking care are experiencing long wait times for both primary and specialty visits. In 2021, Nevada was ranked 48th in the United States with regard to primary care physician availability per 100,000 residents. To get an appointment with a psychiatrist can take many months, if you can get in to see one.

Thankfully, the public option and its proposed initiatives can help alleviate these issues, which are impacting patients like mine on a daily basis. By making health care coverage more affordable and encouraging more physicians to "Practice in Nevada" this framework will make it easier for patients to get care when they need it, not just when they can afford it or months down the line when a doctor is finally available. The public option will also encourage competition, incentivizing better care delivery that prioritizes positive health outcomes.

I look forward to the implementation of this framework and the health benefits it will bring to my patients and community. I encourage the Nevada Department of Health and Human Services to continue looking at ways to bring health care providers into Nevada, make healthcare more affordable, and increase access.

Thank you for the opportunity to provide these comments.

Sincerely,

Philip Malinas, MD
Child, Adolescent and Adult Psychiatrist
Reno

639 Isbell Road, Suite 380, Reno, NV 89509
(775)440-1520 ♦ Fax:(775)451-1870

Nevada Hospital Association

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December 19, 2023

Department of Health and Human Services
Division of Health Care Financing and Policy (DHCFP)
1100 East William Street, Suite 101
Carson City, NV 89701

Submitted electronically to: 1332WaiverProgram@dhcfp.nv.gov

RE: Nevada Coverage and Market Stabilization Program

Dear DHCFP:

The Nevada Hospital Association (NHA) is grateful for the work of Governor Lombardo's Office and DHCFP in developing the new Nevada Market Stabilization Program. This new and innovative program addresses many of the concerns the NHA has raised since the passage of SB420. However, we still have a few concerns stemming from the original legislation.

Working together, we hope to overcome the significant challenges posed by the original legislation in introducing a new health insurance product to the market.

1. Premium Reductions

SB420 required health insurance premium reductions of 15% in the first four years of the Public Option. This is a significant reduction in a short period of time. In trying to meet this requirement, insurance companies will likely lower reimbursement to healthcare providers who currently experience extremely low reimbursement rates from Medicaid and Medicare and have significant costs related to uninsured and underinsured patients.

These lower rates will exacerbate an already severe physician shortage. Nevada needs 1,589 physicians to meet the national average[1], and ranks 45th for active physicians among U.S. states[2]. Nearly 70% of the state's population resides in a Primary Medical Health Professional Shortage Area (HPSA)[3]. Moving patients from commercial rates to lower

[1] *Nevada Health Workforce Research Center, "Physician Workforce in Nevada: A Chartbook," 2022 edition*
[2] *Nevada Health Workforce Research Center, "Physician Workforce in Nevada: A Chartbook," 2022 edition*
[3] *UNR School of Medicine, Office of Statewide Initiatives, Nevada Rural and Frontier Health Data Book, 11th Edition*

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reimbursement rates will incentivize physicians to leave the state, reduce the scope of services they provide, or stop practicing all together. This dramatic premium cut may have the opposite effect of what the program is intended to do, which is to increase access.

Patients will be harmed by this as well. In addition to decreased access to physicians, patients will likely experience coverage denials as insurance companies work to control expenses. A forced reduction in premiums may have unintended consequences.

2. Reimbursement Rates

SB420 set a baseline for reimbursement. It required providers to be paid at least Medicare rates. This requirement is often referred to as a "floor" for rates. We are concerned that Medicare rates will also become the "ceiling" for rates paid to providers.

The State recognized that Medicare rates may be the maximum reimbursement that providers will receive under SB420. Medicaid Administrator Bierman wrote in her guidance issued on October 4, 2022, when revising the "reference premium" from a 5% reduction to 4%:

> "[…] 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***." (Emphasis added)[4]

The Public Option of SB420 may not be actuarially sound if providers are actually paid above Medicare rates.

Currently, Medicare does not reimburse healthcare providers for the full cost of care. It only covers approximately 87% of a hospital's cost[5] to provide services to a Medicare Beneficiary. This contributes to the cost shifting problem plaguing Nevada and many other states. Cost shifting occurs when healthcare costs are shifted from governmental payors and the low and uninsured patient populations to those who have commercial insurance.

The Market Stabilization Program can help alleviate this significant issue through an incentive encouraging insurance providers to offer healthcare providers reimbursement rates that are

[4] General Guidance Letter 22-001

[5] *Medicare Information, 2019, Fortune Magazine, Spring 2021*

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comparable to the self-insured and commercial markets. Those incentives can be optimized by reinsurance metrics that reward their use.

3. Limiting Enrollment

Limiting enrollment in the program is imperative. It is essential to preserve our commercial health insurance markets. The more Nevadans who enroll in the Public Option, the greater the cost shift to Nevadans who maintain commercial health insurance. Eventually, commercial insurance will be unaffordable. People will move to the Public Option because it is cheaper. This will cause commercial insurance to disappear, and providers will leave the state due to poor reimbursement rates for their services. Again, this adversely affects patient access.

The program should focus on providing health insurance to those who are ineligible for other programs or who pay extraordinary premiums and deductibles.

While there are many challenges that lie ahead, we look forward to collaborating with the Administration and legislators to address them while maintaining and enhancing access to healthcare for all Nevada communities.

Very truly yours,

Patrick D. Kelly
President and CEO
Nevada Hospital Association

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

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ahip.org

December 20, 2023

Stacie Weeks, Administrator
Nevada Department of Health and Human Services
Division of Health Care Financing and Policy
1100 East William Street, Suite 101
Carson City, NV 89701

Re: Comments on 1332 Waiver Application

Dear Administrator Weeks:

AHIP and its member plans appreciate the opportunity to provide comments on the Nevada Coverage and Market Stabilization Program Section 1332 waiver application. Every Nevadan deserves affordable coverage and access to high-quality care -regardless of income, health status or preexisting conditions. We agree that hardworking Nevadans who purchase their coverage in the individual market increasingly find health care costs and as a result premium costs out of reach if they do not qualify for premium subsidies. We believe that the foundation of the Section 1332 waiver application – implementation of the public option - will not address these concerns or the underlying factors driving health care costs. Instead, it would eliminate competition and choice and ultimately undermine health care affordability for Nevadans.

As noted during the December 5th public workshop, AHIP appreciates the Administration's efforts towards "reformulating" the public option through a unique market stabilization plan. However, the proposed waiver at its core remains an attempt to implement SB 420's public option, and it therefore continues to suffer from many of the same shortcomings and fundamental flaws that AHIP and other stakeholders previously identified when SB 420 was under debate. We remain very concerned on key problematic items, discussed below, and would request the Division address these concerns prior to submitting the 1332 waiver application.

Public Option

AHIP has repeatedly expressed concerns about the implementation of a government-controlled health insurance plan with unrealistic targets for premium reduction. We have historically supported state actions that reduce premiums and out-of-pocket costs, including Section 1332 reinsurance waivers across the country and state programs that reduce cost-sharing. However, as designed, the Nevada public option program would not achieve this goal.

The Public Option program intends to lower premiums by at least 15% through reductions in provider reimbursement, reductions in administrative costs by health insurance providers, and improved cost efficiencies through value-based purchasing. We have significant concerns about the proposed administrative cost constraints and provider reimbursement reductions:

Administrative Cost Constraints

Under the administrative cost constraint, health insurance providers would be required to reduce a portion of their administrative expenses for public option plans, referred to as Battle Born State Plans (BBSPs), in a manner that is stricter than prevailing individual market QHP administrative expense loads. However, there are no provisions of the public option that lower administrative costs, in fact, additional requirements for health insurance providers may increase costs. Administrative costs are not just profit. Administrative costs include spending that is important to patient care and include programmatic patient services that help lower the cost of care, increase access, and improve outcomes. Such programs include 24/7 nurse lines, medical interpreters and translation services, fraud/waste/abuse programs, and interactive technology and transparency tools. Health insurance providers are already subject to strict medical-loss

ratio (MLR) requirements under the Affordable Care Act (ACA) and those requirements are successfully working to place guardrails around administrative costs. As a result, the number of MLR rebates issued to Nevadans has substantially decreased over recent years. Reducing administrative costs beyond the current ACA MLR requirements will limit the ability of health insurance providers to design and offer programs that directly benefit patients.

A recent actuarial analysis conducted by Wakely Consulting Group found that a 3% increase in loss ratio could reduce a low-cost health insurance provider's risk margins to 0%. Such a risk margin does not allow for an actuarially appropriate margin of error in estimating claims and risk adjustment expenses. This could have negative implications for competition, deterring new entrants to the market, and potentially causing health insurance providers to exit the market.

Provider Reimbursement Reductions

Setting reimbursement rates for doctors and hospitals at below-commercial market rates is unsustainable and will result in cost-shifting to other purchasers of health insurance coverage, including employers. Federal price-cap proposals have repeatedly been dismissed because they posed too many risks to the health care delivery system. To recoup the burden of these under-compensated costs, providers will shift to other purchasers of health insurance coverage in the form of higher reimbursement rates. These higher rates will, in turn, put upward pressure on premiums paid by small and large employer groups, self-insured plans, and Taft-Hartley trust plans, such as the state of Nevada Public Employees' Benefits Program (PEBP) and those covered under the Culinary Union and School District self-funded plans.

The impact of provider reimbursement reductions as a significant source of the premium reduction is not adequately explored in the waiver application actuarial analysis conducted by Milliman. It is unclear the amount of the reimbursement reductions, and how they will be distributed among different geographies and specialties. The Wakely analysis notes that physician rates, on average, are likely already at or near 100% of Medicare Fee-for-Service. With the public option floor for average physician reimbursement at 100% Medicare FFS, little to no premium savings can be expected via physician reimbursement cuts. Significant reductions would disincentivize providers from participating in BBSPs, and present real potential for a formation of two tiers of individual insurance products—more expensive individual market plans with greater provider participation and BBSPs with less provider participation and the perception of having "lower quality doctors". The Milliman analysis enrollment projections assume similar levels of the perceived provider quality and access in the BBSPs and other types of individual market products. If consumers perceive differences in provider quality, breadth, and access, we anticipate some consumers would prefer to remain in individual market plans with better provider access rather than switching to lower-cost BBSPs. Consumers who enroll in BBSPs may experience dissatisfaction with provider quality, breadth, and access. If so, this would affect both the growth projection in the BBSPs and the savings.

Additionally, reducing reimbursements to these providers would exacerbate the state's already significant access issues. The recent Nevada State Health Assessment from the Division of Public and Behavioral Health reported that access to care continues to be a major problem due to physicians shortages in all areas of the state. Nevada ranks 45th in the nation for active physicians per 100,000 population, 49th for primary care physicians, and 49th for general surgeons. The question of how BBSPs will ensure adequate provider networks, especially in rural areas of the state, when there is an existing provider shortage is not answered in the actuarial analysis.

Experience in Other States

We do not believe the public option will produce the desired results, and we can look to examples from other states that have implemented similar programs, such as Washington and Colorado, where the public option has yet to show it has been successful in driving down costs, increasing competition and choice, making healthcare more affordable. As an example, Colorado only had one small health insurer, Denver Health, that could meet the 5% premium reduction requirements for its public option plans in 2023 in the Denver metro area and those plans were priced at a loss. For 2024, no carrier, including Denver Health, is able to meet the state's public option premium reduction requirements.

Rather than creating a government-controlled health insurance plan, Nevada should continue to focus on strategies to enroll Nevadans in coverage options that are available today, including Medicaid and federally subsidized plans offered on Nevada Health Link. Our members stand ready to work with you and other stakeholders to make coverage more affordable, but we must do it in ways that do not destabilize or jeopardize the state's health insurance market for all Nevadans and provide real, immediate assistance to improve health insurance coverage options for all Nevadans.

Medicaid Managed Care

AHIP has concerns with deeply problematic language connecting the state's Medicaid managed care plans with public option plans. The waiver requires health insurance providers bidding to participate in Nevada's Medicaid Managed Care program to also submit bids to offer individual market BBSPs in a concurrent statewide procurement. We are especially concerned that *scoring* for Medicaid managed care procurement would be based on the issuer's public option bid, which goes above and beyond existing requirements for managed care issuers to offer a silver and gold QHP.

This requirement could potentially deter new entrants into the market and jeopardizes competition and patient choice. The Medicaid market in Nevada is relatively small compared to other states. While some health insurance providers may excel at providing a great Medicaid managed care product, they may not be positioned to do as well on the individual market. Medicaid and individual coverage are distinct products and markets, tailored for specific populations, with their own unique regulatory structures and risk pools. Health insurance providers with experience offering Medicaid managed care products may struggle to meet the required premium targets and benefit designs in the individual market. No other state that has pursued a public option that ties the public option contracts with Medicaid managed care.

The Medicaid market in Nevada is relatively small compared to other states. The currently proposed regulations could disincentivize health insurance providers from participating in Medicaid bidding-- potentially leading to a chilling effect of insurers choosing not to participate in the Medicaid program, which means less competition and choice for Nevadans.

Additionally, health insurance providers that remain in the Medicaid market will have to attract providers in their BBSP network despite the lower reimbursement rate. To do so, they will have to leverage their Medicaid provider network by requiring providers to be in-network for both programs. Medicaid providers may be reluctant to join networks accepting the lower-reimbursed public option patients and drop out of networks, leading to access and appointment wait time issues. Although SB 420 gives the state authority to waive these provisions, this is likely to add undue burden on DHCFP and PEBP. In short, the tying of the participation in the Nevada Medicaid and the BBSP creates a potentially significant impact on Medicaid, and the magnitude and consequences of this impact are not explored in the Milliman report. Doing so could potentially increase provider shortages and destabilize the Nevada Medicaid program.

Marketplace Stabilization

AHIP supports state reinsurance programs that lower premiums for individuals and families. Successful state reinsurance programs with broad-based funding mechanisms allow health insurance providers to offer more affordable coverage in the individual market and increase competition and the number of plan options for residents. We want to partner with the Department as they design the reinsurance program to ensure maximum premium relief while also maximizing the state's investment and securing adequate funding.

While we are generally supportive of the proposal to establish a state reinsurance program, we are concerned that the waiver application does not meet federal requirements. Federally-approved reinsurance programs require funds for the first year of operation. As noted in the waiver application, the operation of the reinsurance program would be reliant on the amount of federal pass-through funds available starting in year two. Relying on public option premium reductions is not a viable model for financing the state's portion of reinsurance. If assumed premium reductions do not materialize, funding for

the reinsurance program will not be available. Corrections to the reinsurance funding are necessary to demonstrate that the program doesn't lead to unforeseen adverse impacts on affordability or access.

AHIP has concerns with the tiered structure of the reinsurance program and differing coinsurance levels in specified rating areas. As specified in the Milliman analysis, the proposed tiering has significantly lower coinsurance for rating areas 1 and 2, than for rating area 3. This would result in the reinsurance program having a much lower impact on premiums in those rating areas, making it challenging for health insurance providers to meet the 15% premium reduction targets in those locations.

We are also concerned that utilizing a state reinsurance program does not overcome the numerous and fundamental flaws of a public option. While we appreciate the Executive Branch's attempt to mitigate the harmful impacts the public option would have on the state's health care sector, we believe the proposed waiver application cannot avoid the fundamental defects AHIP and other stakeholders previously identified with the public option itself.

Our members are eager to work with the Department to pursue policies that will work. However, we do not believe the public option is a sustainable, long-term solution for Nevada's health care affordability issues. Please do not hesitate to contact me with any questions at lrich@ahip.org.

Sincerely,

Laura Rich
Regional Director

AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone. Visit www.ahip.org to learn how working together, we are Guiding Greater Health.

From: Ellen Eversole
To: DHCFP 1332waiverprogram
Subject: 1332 Waiver Application Public Comment Submission
Date: Wednesday, December 20, 2023 1:41:34 PM

WARNING - This email originated from outside the State of Nevada. Exercise caution when opening attachments or clicking links, especially from unknown senders.

To the Nevada Department of Health and Human Services,

My name is Ellen Eversole and I have been working as a registered nurse in Clark County since 1985. I now volunteer as an Advance Practice Registered Nurse in Clark County. Additionally, I am an assistant professor of nursing at a university in Henderson.

In the 38 years that I have been delivering healthcare to Nevadans, I have witnessed patient delays in receiving care or patients going without care due to them not being able to afford to pay the bill. Furthermore, these patients were unable to get access to quality insurance or could not find much needed specialty care. How did these patients eventually get treated? The answer is emergency rooms. I cannot state enough how emergency rooms have become the defacto source of primary care for thousands of Nevadans, simply because coverage or affordable care is out of reach.

Instead of having a chance at treating and preventing serious illnesses, Nevadans have been forced o seek medical care at the most dire times of their lives, because without quality insurance, they did not have access to primary care providers and routine wellness checks

I am now speaking up and sharing my voice because these individuals are my neighbors and are a part of my community. They are NEVADANS and need help and support. Finally, we have a policy solution that can assist them with the Nevada Public Option!

I am very supportive of the Public Option and the 1332 Waiver application as it will deliver real results that support the patients. The reduction in premiums of 16% over five years will make healthcare more affordable for Nevadans, who are currently being priced out of the market, and it will keep insurance for them affordable. The end result will be access to affordable healthcare; hence, the prevention of chronic diseases that could cost thousands of dollars to them and to the state.

Additionally, I am excited to see the savings our state will see through Public Option's investment in healthcare workforce development. We have seen Nevadans suffer from a shortage of healthcare professionals including nurses, primary care providers and specialty providers. This we have seen for decades. Now, with the hundreds of millions of dollars that we will see from Public Option, we can invest in workforce development that will that will result in optimal training and gainful pay for a healthcare industry that has been sorely underfunded. While the largest insurance

corporations in the world extract millions and millions of dollars from Nevadan families, we do not see those dollars being reinvested in the state to improve care, attract healthcare providers or modernize treatment protocols. We can change this with 1332 Waiver. This is something that Nevadan desperately needs. I am absolutely thrilled to see the state work with the federal government to deliver real results that will help Nevadans.

Thank you so much for allowing me to share my voice and for submitting this 1332 Waiver Application to help my patients and families in communities across Nevada. This will enable everyday people get the healthcare they need, save lives and will provide hope that healthcare can get better in this state.

Sincerely,

Ellen Eversole, APRN, FNP-C
Phone: 702-371-5566
2680 Parisian Ct.
Henderson, NV 89044
ellen.eversole@yahoo.com

From: Nita Schwartz
To: DHCFP 1332waiverprogram; Jodi Helsel; Nita Schwartz
Subject: Public Option Comments
Date: Wednesday, December 20, 2023 2:07:01 PM

WARNING - This email originated from outside the State of Nevada. Exercise caution when opening attachments or clicking links, especially from unknown senders.

Dear Division of Health Care Financing and Policy,

I'm writing to support the state's section 1332 State Innovation Waiver application to create the Nevada Coverage and Market Stabilization Program. As a doctor in Douglas County, I support the framework proposed to create a public health insurance option in our state.

In my 33 years of practice, I've seen countless patients harmed by Nevada's high health care costs and lack of insurance coverage. I have seen many times where people had to choose between prescription medications and other essentials like food or utilities. I have seen bad outcomes because of delays in diagnostic or therapeutic care. These problems are vastly magnified in sparsely populated and underserved areas.

The public option will prevent Nevadans from having to suffer in these ways. With the state taking this unique approach, it will:

- Make health care coverage more affordable and accessible for tens of thousands of Nevadans
- Reduce premiums and lower out-of-pocket costs for patients
- Increase access to essential providers, including in rural areas Winnemucca, where I have provided emergency department care, rural Douglas county where I live, as well as Lyon and Story counties where I still provide medical services.
- Incentivize better care delivery that shifts away from costly fee-for-service toward better health outcomes
- Encourage more health care providers to practice in Nevada, reducing our shortage and increasing access

All these benefits will mean healthier patients and a state that leads on health care and improving health outcomes. Doctors thank you for your work toward these goals and for the opportunity to comment on the section 1332 waiver application.

Sincerely,

Dr. Nita Schwartz
Hospice Medical Director
Carson City

December 20, 2023

Richard Whitley
Director
Nevada Department of Health and Human Services
1100 E William St, Ste 101
Carson City, NV 89701

Re: Nevada Section 1332 Waiver Application

Dear Director Whitley:

Thank you for the opportunity to provide feedback on the Nevada Section 1332 Waiver Application.

The undersigned organizations represent millions of individuals facing serious, acute and chronic health conditions in Nevada. 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 healthcare programs and the people that they serve. We urge the state to make the best use of the recommendations, knowledge and experience our organizations offer here.

Our organizations are committed to ensuring that Nevada's healthcare programs provide quality and affordable healthcare coverage. We appreciate that this waiver is moving forward and support the state's commitment, as codified by Senate Bill 420, to implement a new coverage program for improving access to affordable coverage. However, we urge the state to use pass-through funds generated by the waiver to support a premium subsidy program for Nevadans with low-incomes. We believe a subsidy program best aligns with the purposes of the state statute and will be far more effective at improving coverage access and affordability than the state's current proposal.

Senate Bill 420 declares that the state's new coverage program is intended to lower premiums and other healthcare costs by leveraging the state's purchasing power, improve access to high-quality and affordable healthcare, reduce disparities in access to health care, and increase competition in the individual health insurance market.[1] To support the program, state law also requires the submission of a Section 1332 waiver. The statute also identifies, as a purpose for such a waiver, securing federal financial support to subsidize health coverage for low-income residents.

Consistent with the statute, Nevada originally planned to use a Section 1332 waiver to fund a state premium subsidy program directed towards low-income enrollees.[2] We support this approach. Nevada ranks in the top ten states with the highest uninsured rate. Among individuals with incomes from 200-399% of the federal poverty level, Nevada's uninsured rate is nearly 15%; for those with incomes from 100-199% FPL, the rate is nearly 19%; for people under 100% FPL, it is about 20%.[3] Research consistently shows that higher cost-sharing, including premiums, is associated with decreased use of preventive services and medical care among low-income populations.[4] Nevadans, particularly those at low incomes, would better be able to afford quality coverage and to access care with the assistance of premium subsidies.

The new waiver draft proposes to use most pass-through funds to support a reinsurance program. Though we agree that reinsurance can play a role in addressing affordability, the benefits of such a program flow primarily to individuals at higher incomes who are not eligible for federal premium tax credits. It does not make coverage cheaper for people — generally at lower incomes — who already qualify for federal subsidies.[5]

As the state's own analyses demonstrate, a premium subsidy program would do far more to increase access and affordability — particularly for low-income residents — than reinsurance would. According to the state, a waiver with a premium subsidy program could be expected to increase individual market enrollment by 5,900 in 2027, rising to 12,200 by 2030. These benefits greatly exceed the predicted effects of the new reinsurance-focused waiver, which may raise enrollment by about 1,800-2,100 annually (with much of these gains concentrated among residents at higher incomes).

Once again, our organizations thank you for releasing this draft application for public comment and moving forward with the waiver process outlined in state law. We encourage you to use pass-through funds to support a premium subsidy that would maximize the number of patients and consumers who gain coverage under the waiver. Thank you for the opportunity to provide comments.

Sincerely,

American Heart Association
American Lung Association
Child Neurology Foundation
Cystic Fibrosis Foundation

Epilepsy Foundation of America
Hemophilia Federation of America
National Bleeding Disorders Foundation
National Multiple Sclerosis Society
National Patient Advocate Foundation
The Leukemia & Lymphoma Society

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[1] Nevada State Legislature. Chapter 695K-Public Option. Available at: https://www.leg.state.nv.us/nrs/NRS-695K.html

[2] Section 1332 Waiver Application Nevada Public Option. Nevada Department of Health and Human Services. December 27, 2022. Available at: https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/MarketStabilization/Archive_1332_Application_Consolidated_Remediated.pdf

[3] KFF, Uninsured Rates for the Nonelderly by Federal Poverty Level (FPL), 2022. Available at: https://www.kff.org/uninsured/state-indicator/nonelderly-uninsured-rate-federal-poverty-level-fpl.

[4] Artiga, Samantha, Ubri, Petry, and Zur, Julia. The Effects of Premiums and Cost-Sharing on Low-Income Populations: Updated Review of Research Findings. KFF. June 1, 2027. Available at: https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/

[5] 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.

Our Mission
The Health Services Coalition is dedicated to improving the quality, affordability and accessibility of health care in Southern Nevada for its members and the community at large.

Better:

December 18, 2023

Mr. Richard Whitley, Director
Nevada Department of Health and Human Services
400 West King Street, Suite 300
Carson City, Nevada 89703

Via email (1332WaiverProgram@dhcfp.nv.gov)

RE: 1332 Waiver Application and Actuarial Analysis (Public Option/Market Stabilization Program)

We have been tracking the Nevada Public Option since it was created by a group called "New Day," and then proposed by Senate Majority Leader Nicole Cannizarro as SB420 in 2021. It has now been rebranded and restructured by the Governor Lombardo Administration as the "Nevada Coverage and Market Stabilization Program." The Health Services Coalition, representing 280,000 lives in Nevada, remained neutral but shared ongoing concerns about the impact of the enacted SB420 on the overall healthcare market and provider shortages. We now oppose this first-in-nation federal waiver request for an additional commercial insurance subsidy program in Nevada.

First and foremost, the proposed Coverage and Market Stabilization Program completely reverses the potential positive impact of creating accountability within the commercial insurance industry for their high prices and profits. Instead, it becomes a costly taxpayer commitment to the already highly profitable commercial insurance industry. The revised proposal overwhelmingly uses the federal pass-through savings generated by the public option to fund a state-based reinsurance program. This basically means the insurance industry will now have the taxpayer pay for their claims, for which they still receive premiums, enriching rather than reforming their profit margins. It also appears to create a new taxpayer paid bonus, all without legislative approval.

2975 S. Rainbow Blvd.
Suite E7
Las Vegas, NV 89146
702-474-4418 office

www.lvhsc.org

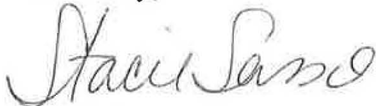
Boyd Gaming Corporation
Bricklayers
Caesars Entertainment
Cement Masons and Plasterers Health and Welfare Trust
City of Henderson
Clark County Self-funded
Clark County Firefighters
Construction Industry and Laborers Health and Welfare Trust
Culinary Health Fund
Employee Painters Trust
Golden Nugget Hotel and Casino
IBEW 357 Electricians
Las Vegas Firefighters
Las Vegas Metropolitan Police Dept Health and Welfare Trust
MGM Resorts International
Mirage Hotel
Nevada HAND
NV Energy
N. Las Vegas Firefighters
Operating Engineers Local 501
Plumbers and Pipefitters Health and Welfare Fund
Switch
Teamsters Local 14 – Security Fund for Southern Nevada
Teamsters Local 631 – Security Fund for Southern Nevada
Teamsters Security Fund for So. NV - Hotel & Casino Workers (Formerly Teamsters 995)
UFCW Local 711 and Retail Food Employers Benefit Fund Plumbers and Pipef

Nevada's individual market exchange insurers include UnitedHealthcare, Centene, Aetna BCBS, and Elevance. These are some of the companies that, per the legislation, must submit a good faith bid to offer a public option plan on the state exchange. The new proposed waiver to create a reinsurance program will now divert the lion's share of the federal savings pass through monies, estimated to range from $760 to $844 million over ten years, to pay high-cost claims in the individual insurance market, further padding the insurance company profits, moving risk to the taxpayer rather than the commercial insurers. These insurers are already receiving significant federal taxpayer subsidies on the exchange through the existing structure of the ACA.

This proposed reinsurance model will now significantly reduce (or eliminate) the premium reduction targets built into the enacted Public Option program, while diverting federal savings from other uses to improve access and affordability. The commercial insurers are already heavily subsidized and profitable. UnitedHealthcare generated $210.5 billion in revenues during the first three quarters of 2023 and $13.2 billion in earnings from operations with a 6.3% operating margin.[i] The insurer's parent has returned over $11.5 billion to its shareholders during this period through dividends and share repurchases.[ii] Centene had $114.5 billion in revenues and $3.1 billion in operating revenues[iii] and spent $1.6 billion to repurchase it shares.[iv]

Unfortunately, the waiver application's inclusion of a reinsurance program – as well as a second taxpayer bite at the taxpayer apple through a new payment for quality of some kind, provides for clear favorites in Nevada's healthcare market, and they are the highly profitable insurance industry. Rather than putting the brakes on the profits of these companies in order to help contain rising prices, it steps on the gas. The Health Services Coalition opposes this use of public funding.

Sincerely,



Stacie Sasso
Executive Director

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[i] https://www.unitedhealthgroup.com/content/dam/UHG/PDF/investors/2023/UNH-Q3-2023-Release.pdf

[ii] https://www.unitedhealthgroup.com/content/dam/UHG/PDF/investors/2023/UNH-Q3-2023-Release.pdf

[iii] https://filecache.investorroom.com/mr5ir_centene/433/CNC%20%28Centene%20Corporation%29%20%20%2810-Q%29%202023-10-24.pdf_.pdf

[iv] https://investors.centene.com/2023-10-24-CENTENE-CORPORATION-REPORTS-THIRD-QUARTER-2023-RESULTS

NEVADA'S
HEALTH CARE FUTURE

December 20, 2023

VIA ELECTRONIC MAIL

Stacie Weeks, Administrator
Nevada Department of Health and Human Services
Division of Health Care Financing and Policy
1100 East William Street, Suite 101
Carson City, NV 89701

Dear Administrator Weeks:

Thank you for the opportunity to offer comments on the implementation of the Nevada Public Option and the state's revised 1332 waiver application. Nevada's Health Care Future (NVHCF) is committed to working together to ensure every Nevadan has access to the affordable, high-quality health coverage and care they need and deserve.

The evidence continues to show that Nevada Senate Bill 420, which established the Nevada Public Option, will harm Nevadans' access to affordable, high-quality health coverage and care. Unfortunately, the state's proposed market stabilization program does nothing to remedy SB 420's fundamental structural flaws, nor will it shield Nevadans from the negative consequences of implementing SB 420.

When it comes to the underlying policy of SB 420, research clearly demonstrates that the consequences of creating the Public Option, an unaffordable new state government-controlled health insurance system, will be harmful to Nevadans.

Before the state's revised 1332 waiver application, NVHCF engaged Wakely Actuarial Consulting to perform an actuarial analysis of SB 420. The analysis finds that the 2021 law risks worsening Nevada's already significant health care provider shortage. Nevada has been suffering from a physician shortage, ranking 48th in the nation in primary care physicians per capita.

Among other key findings, the report warns that the law could also reduce health care competition in Nevada, cause some insurers to exit the market, deter new entrants, put increased financial hardship on hospitals, and ultimately threaten access to care for Nevada patients.

Not only does the state's revised waiver application do nothing to change the underlying flaws of SB 420, but the revisions themselves – including an attempt to mitigate the burden on providers and carriers through reinsurance, and the softening of premium reduction targets – demonstrate the harmful and burdensome consequences that SB 420 will cause.

Further, the revised waiver application relies on many misguided assumptions, the results of which could prove harmful to Nevadans. Key concerns include:

- With many providers and hospitals already at or close to 100% of Medicare fee-for-service (FFS) reimbursement rates, and without any meaningful drivers contained in this policy to lower the cost of care, there is very little chance of carriers meeting the state's premium reduction targets.
- The many new requirements and mandates for payers that SB 420 imposes could increase, rather than decrease, administrative costs, depending on factors such as unique network requirements or unique benefit design requirements. Even worse, any reduction in carriers' required risk margins could pose a significant threat to competition and consumer choice in the state, the complete opposite of the purported objectives of SB 420.
- Particularly in light of the above concerns, the assumption that the creation of Public Option plans will help lower non-public option premiums is deeply misguided.
- The degree to which the waiver ties the procurement process for Medicaid contracts directly to carriers' submission of Public Option plans for Nevada's individual market could destabilize the Medicaid program.
- With its revised application the state proposes putting into place a market stabilization program that implements and relies upon the Public Option. Tying the state's proposed reinsurance program to the creation of the Public Option is a risky strategy, and the facts suggest this is not a viable model for financing the reinsurance program.

Simply put, the revised waiver application does not fix the problems inherent in SB 420's Public Option provisions. And, given its substantial risk to Nevadans' health care access and affordability, it is notable that by the state's own calculations, this proposal would decrease the number of uninsured Nevadans by a mere 2,200 – a result which could be better achieved by private coverage and existing public programs working together.

Since our inception, we have been focused on building on what's working in health care to improve access rather than starting over. We stand ready to support policy proposals that accomplish these goals. Thank you again for this opportunity to express our serious concerns related to these policy proposals.

Sincerely,

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