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FIRST JUDICIAL DISTRICT COURT OF NEVADA
IN AND FOR CARSON CITY

NATIONAL TAXPAYERS UNION, a non-profit organization, and ROBIN L. TITUS, MD,

Plaintiffs,

v.

THE STATE OF NEVADA, ex, rel., JOSEPH LOMBARDO, in his official capacity as Governor of the State of Nevada; ZACH CONINE, in his official capacity as Nevada State Treasurer; RICHARD WHITLEY, in his official capacity as Director of the Nevada Department of Health and Human Services; SCOTT J. KIPPER, in his official capacity as the Nevada Commissioner of Insurance; and RUSSELL COOK, in his official capacity as Executive Director of the Silver State Health Insurance Exchange,

Defendants.

Case No. 25OC00089 1B

Dept. No. I

PLAINTIFFS' APPENDIX TO MOTION FOR PRELIMINARY INJUNCTION

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(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.

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.

	HHS Citation and Description	Actuary Response
5.	**45 CFR 155.1308(f)(4)(i)-(iii)** Actuarial analyses and actuarial certifications. Economic analyses. Data and assumptions. **Note a state can combine the elements of an actuarial analysis and economic analysis into one report or submit separate actuarial and economic reports.*	1. See Appendix A for the actuarial certification. i. See 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.

	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

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

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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.

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

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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

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.

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.**

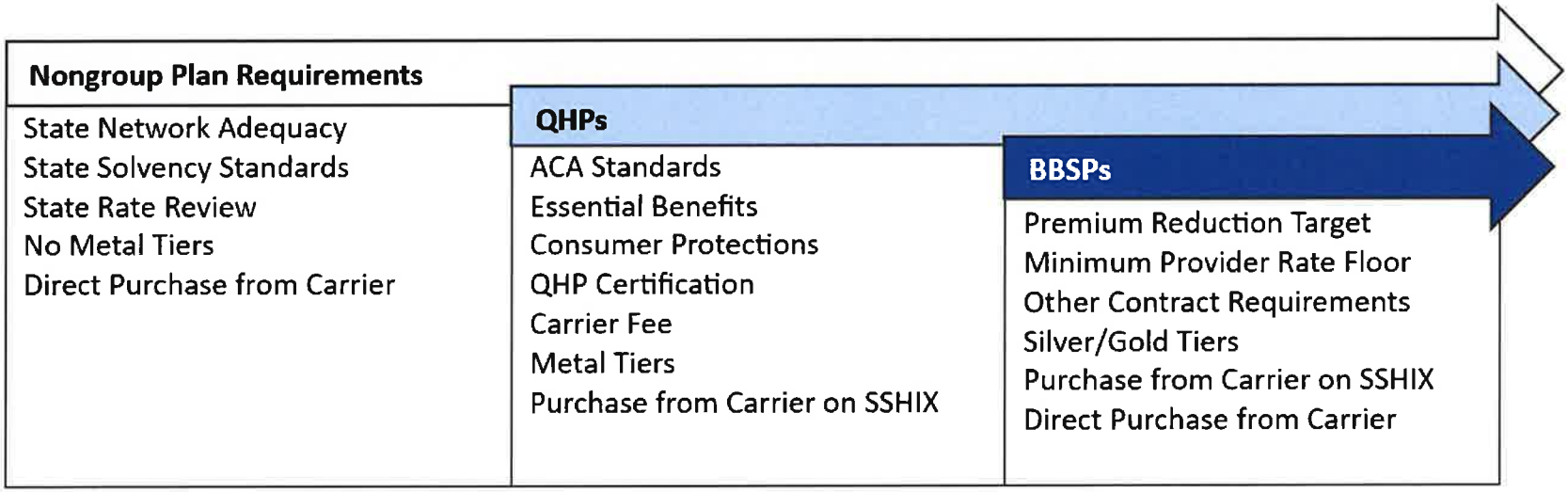
New State Procurement Process

- 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



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

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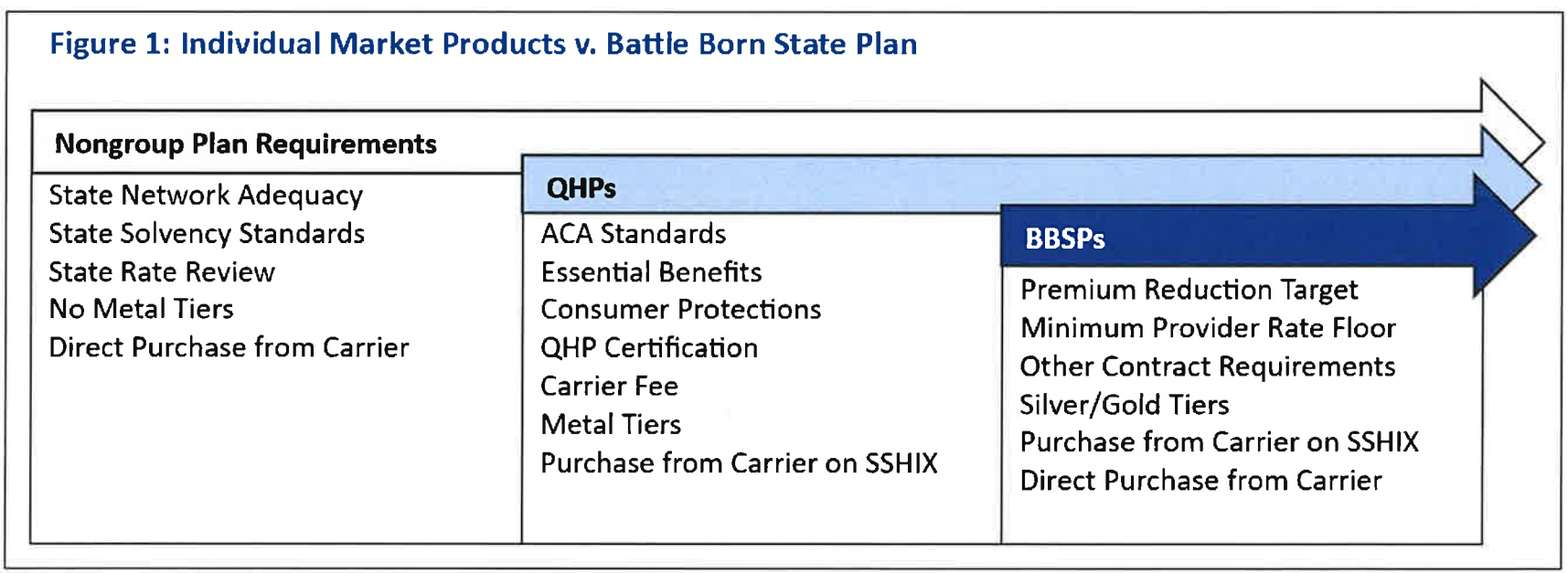

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