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Attorneys for Plaintiffs

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. 25OC00109 1B

Dept. No. I

PLAINTIFFS' APPENDIX TO MOTION FOR PRELIMINARY INJUNCTION

Volume 13 of 18

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT

January 10, 2025

VIA ELECTRONIC MAIL: michael.conway@state.co.us;
Michael Conway
Commissioner of Insurance
Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202

VIA ELECTRONIC MAIL: rwhitley@dhhs.nv.gov
Richard Whitley
Director
Nevada Department of Health and Human Services
400 West King Street, Suite 300
Carson City, NV 89703

Dear Commissioner Conway and Director Whitley,

I want to thank you for the strong partnership between the U.S. Department of Health and Human Services (HHS) and the U.S. Department of the Treasury (collectively, "the Departments") and your states, and share an update on the Departments' expectations for pass-through reporting (as described in Specific Term and Condition (STC) 15.[1]) for your respective approved State Innovation Waivers under section 1332 of the Affordable Care Act (also referred to as section 1332 waivers).[2] I am pleased to send this letter on behalf of the Departments.

The STCs governing your respective section 1332 waivers define each state's responsibilities with respect to implementation of the waiver and use of pass-through funding during the waiver period as well as the nature, character, and extent of anticipated federal oversight of the waiver. Colorado and Nevada are the first states to use section 1332 waivers to implement premium-reduction targets for qualified health plans to increase the affordability of individual market health insurance for their state residents. As part of complying with STC 15, it is the Departments' expectation that Colorado and Nevada will require all issuers[3] to annually submit without-waiver (i.e., without-reinsurance and without-Colorado Option/Battle-Born State Plan (BBSP)) rates to their respective state, and that Colorado and Nevada will include these without-waiver rates as part of each state's pass-through funding premium submission. Specifically, issuers should provide without-waiver rates to the state separately for their non-Colorado

[1] The STCs governing each state's approved section 1332 waiver can be found at: https://www.cms.gov/marketplace/states/section-1332-state-innovation-waivers.
[2] Colorado's currently approved waiver amendment was approved on June 23, 2022, and Nevada's currently approved waiver was approved on January 10, 2025.
[3] In Nevada, issuers that do not offer BBSPs should provide without-waiver rates or explicitly state that they are equal to their without-reinsurance, with-BBSP rates.

Option plans/non-BBSPs and for their Colorado Option plans/BBSPs. The Departments encourage Colorado and Nevada to work with issuers in their respective states to ensure that issuers provide sufficient detail in their without-waiver rate analysis to explain which aspects of each waiver affect premiums and by how much so that this information can be included in the states' pass-through funding reports.[4]

In the event that an issuer does not provide without-waiver rates, the Departments may, as appropriate, zero out any impact(s) of the Colorado Option (for a Colorado issuer) or the BBSP (for a Nevada issuer) identified by the relevant state. In the event that an issuer does not provide the state the requested without-waiver rates, but the state does estimate a premium impact due to Colorado Option/BBSP-specific policies implemented under the waiver (e.g., a cap on Colorado Option plan/BBSP administrative costs or profits), then the Departments anticipate that they would estimate the premium impact associated with a given policy to be equal to the difference between the issuer's relevant unified rate review template (URRT) factor for Colorado Option plans/BBSPs and for non-Colorado Option plans/non-BBSPs in the pass-through funding year.

While the Departments recognize that submitting additional sets of rates may increase obligations for states and issuers, we believe not only that this approach will result in a more efficient and timely process for determining pass-through funding, but also that this approach is consistent with that generally used by other states with approved section 1332 waivers.

Through section 1332 waivers, the Departments aim to assist states with developing health insurance markets that expand coverage, lower costs, and ensure that affordable health coverage is available for their residents.

The Departments remain committed to working with you and other state partners to advance health coverage policies and implement section 1332 waivers that improve affordability and coverage. Please do not hesitate to contact us if you have any questions.

Sincerely,

Ellen Montz

CC: Aviva Aron-Dine, Deputy Assistant Secretary, Tax Policy, U.S. Department of the Treasury
The Honorable Jared Polis, Governor, State of Colorado
The Honorable Joe Lombardo, Governor, State of Nevada
Stacie Weeks, Administrator, Division of Health Care Financing Policy, Nevada Department of Health and Human Services
Kate Harris, Chief Deputy Commissioner, Colorado Division of Insurance
Kyla Hoskins, Deputy Commissioner, Colorado Division of Insurance
Laura Mortimer, Reinsurance and Health Insurance Affordability Enterprise Director, Colorado Division of Insurance

[4] Note: If an issuer refuses to submit without-waiver rates, this will not be considered a breach of the STCs by the state.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

January 10, 2025

Richard Whitley
Director
Nevada Department of Health and Human Services
400 West King Street, Suite 300
Carson City, NV 89703

Dear Director Whitley:

Thank you for your December 29, 2023, submission, August 23, 2024, addendum, and January 1, 2025, addendum to Nevada's application for a State Innovation Waiver under section 1332 of the Patient Protection and Affordable Care Act (ACA) (also referred to as a "section 1332 waiver"). Nevada (also referred to as "the State") has requested a waiver for calendar years 2026 through 2030 to implement plan-level rating variation(s) for state-contracted qualified health plans (QHPs) known as Battle Born State Plans (BBSPs) and a Market Stabilization Program[1] for the individual health insurance market. I am pleased to send this letter from the Department of Health and Human Services (HHS), as well as on behalf of the Department of the Treasury (collectively, "the Departments").

This letter is to inform you that the Departments, having completed their review of the waiver application, approve Nevada's section 1332 waiver application. The State's final approved waiver application refers to the December 29, 2023, application, the August 23, 2024, addendum, and the January 1, 2025, addendum.[2] Described below are the specific terms and conditions (STCs) of this waiver. The Departments' approval of the waiver is conditioned upon the State's acceptance of these STCs by February 8, 2025. This approval is effective for a waiver period of January 1, 2026, through December 31, 2030.

The Departments are granting Nevada's request to waive the single risk pool requirement in the individual market under ACA section 1312(c)(1) as implemented at 45 C.F.R. § 156.80(d)(2) to the extent it would otherwise prohibit plan-level rating variation(s) for the BBSP in the individual market, as well as to waive ACA section 1312(c)(1) to the extent it would otherwise require excluding total expected state reinsurance payments when establishing the market-wide

[1] The Market Stabilization Program will include a state reinsurance program, targeted premium relief for some enrollees in the Silver State Health Insurance Exchange (Nevada's state-based exchange, "the Exchange"), a quality incentive payment program, and the Practice in Nevada provider retention program to encourage health care providers to remain in the State.

[2] The August 23, 2024, addendum (also referred to as the "August addendum"), in part, updated details related to reinsurance program parameters, the premium reduction target methodology, processes for safeguarding provider rate floors and network adequacy, and some of the State's assumptions (including those related to BBSP take-up rates), and added state premium subsidies for certain Exchange enrollees. The January 1, 2025, addendum, which was updated on January 6, 2025, (collectively referred to as the "January addendum"), updated the BBSP take-up rates and adjusted the reinsurance program to begin in the first year of the waiver plan.

index rate for the purpose of operating a state reinsurance program, as described in the State's waiver application. The waiver plan also includes state premium subsidies for certain Exchange enrollees, a quality incentive payment program, and the Practice in Nevada provider retention program.

The Departments remain committed to working with state partners to advance health coverage policies. Through section 1332 waivers, the Departments aim to assist states with developing health insurance markets that expand coverage, lower costs, and ensure that affordable health coverage is available for their residents. The Departments have determined that this waiver plan satisfies the statutory guardrails (as set forth in sections 1332(b)(1)(A)-(D) of the ACA).

The Departments note that the State's waiver application and the Departments' approval of the waiver application reflect state and federal law at the time of approval. Moving forward, in accordance with STC 2, the State must inform the Departments of any change in state law or regulation that could impact the waiver, including any changes to the requirements of the State's waiver plan, or any proposed technical changes to the waiver occurring after the date of this approval letter, at least thirty (30) calendar days prior to the intended implementation of the change. Additionally, if there is a change in state or federal law, the Departments may, consistent with the federal regulations and the STCs, request additional information from the State as part of their responsibility to conduct oversight and monitoring to ensure that approved section 1332 waivers continue to meet the statutory guardrails.

The enclosed STCs further define the State's responsibilities with respect to implementation of the waiver; use of pass-through funding during the waiver period; and the nature, character, and extent of anticipated federal oversight of the waiver. STCs 11 and 15 both contemplate that the Departments may require periodic reporting of information in addition to the items specifically enumerated therein. Given the novel nature of Nevada's waiver, it is likely that periodic reporting of additional information will be required. The State is encouraged to engage with the Departments early in the process if it is interested in amending or extending its waiver plan. The required information and process may vary based on the complexity of the proposed change or extension. A breach of any of the STCs may lead to termination of Nevada's section 1332 waiver.

Departments' Determination

Based on consideration of the analysis and information submitted by the State as part of its waiver application, along with the State's responses to questions from the Departments during the review period and consideration of the Departments' experience with existing section 1332 waivers and other health programs, and public comments, the Departments have determined that Nevada's waiver plan meets the statutory guardrail requirements in sections 1332(b)(1)(A)-(D) of the ACA.

First, the Departments have determined that the State's section 1332 waiver is projected to provide coverage that is at least as comprehensive as coverage provided without the waiver. More specifically, the waiver plan will not alter the essential health benefits provided in individual health insurance coverage offered through the Exchange, as BBSPs will be offered as QHPs and will provide essential health benefits for those enrolled.

The Departments have determined that the State's waiver is also projected to, in each year of the waiver, provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable as would be provided without the waiver. Under state law[3], and under the approved waiver, BBSPs are required to reduce premiums by certain targets including by at least 3% in the first year of the waiver (2026) and 15% by the fourth year of the waiver (2029) relative to the 2024 second-lowest cost silver plan for the relevant county. In addition, the Nevada Department of Health and Human Services and Division of Insurance have new and existing programmatic and regulatory authorities to support the premium reduction targets through BBSP contracting and rate review proceedings.[4] The State's waiver plan also includes implementation of a premium relief program, which will provide a premium subsidy for reenrolling enrollees whose net premium is projected to increase regardless of whether they enroll in a BBSP or non-BBSP, as well as additional premium relief, as needed, as discussed further below.

The State projects that net premiums will decrease in each year of the waiver, improving affordability for unsubsidized enrollees and certain subsidized enrollees. Under the waiver, the State has projected average net premium rates in the individual market will be lower than without the waiver by 0.2% in plan year (PY) 2026, 3.1% in PY 2027, 4.1% in PY 2028, 5.7% in PY 2029, and 5.9% in PY 2030 due to the State's reinsurance program and BBSP premium reduction targets. There are no projected changes in affordability for the small group market. The Departments have reviewed the actuarial assumptions underlying Nevada's estimated premium reductions and conducted an internal analysis and also found that the proposed premium reductions are feasible. For example, 2021-2022 Medical Loss Ratio data suggest that there is excess premium (on average approximately 4%) in the individual market plans in Nevada which could allow for issuers to reduce premiums. The State's estimate of the premium reductions attributable to reinsurance is consistent with other approved waivers implementing state reinsurance programs.[5]

The Departments greatly appreciate Nevada's engagement during the waiver review process. Nevada's original, December 2023 submission projected increases in average net premiums in the first year of the waiver. The Departments would not have been able to approve that proposal as it would have violated the statutory affordability guardrail. The State subsequently modified the waiver plan to provide a premium relief program and a reinsurance program beginning in the first year of the waiver. The State's updated projections provided in the January addendum estimate no increase in average net premiums in each year of the waiver compared to without the waiver.

Because the BBSP take-up rate is both uncertain and a key determinant of average net premiums, in accordance with STC 11, the State will monitor BBSP take-up rates; if take-up at the close of Open Enrollment is less than 35%, the State will provide additional premium relief as part of the premium relief program to ensure there is no increase in average net premiums relative to the without-waiver baseline. The State beginning the reinsurance program in 2026 and the State's premium relief program (including the additional premium relief requirement in STC 11) would

[3] NRS 695K.210, available at: https://www.leg.state.nv.us/nrs/NRS-695K.html#NRS695KSec210.
[4] *ibid.*
[5] See Table 5, https://www.cms.gov/files/document/cciio-data-brief-042024-508-final.pdf

insulate certain subsidized enrollees from increases in premium contributions, and result in savings experienced by unsubsidized individuals and some subsidized enrollees due to the BBSP premium reduction targets[6] and the State's reinsurance program; the combination of these policies result in the waiver meeting the affordability guardrail for plan year 2026. The Departments have therefore determined that the waiver meets the affordability guardrail.

The Departments have determined that the State's waiver satisfies the coverage guardrail, meeting the statutory requirement that the waiver is projected to provide coverage to at least a comparable number of state residents as would be provided without the waiver. Under the waiver and compared to the without-waiver baseline, Nevada projects that individual market enrollment will increase slightly in each year of the waiver: by 600 enrollees in PY 2026, 1,800 enrollees in PY 2027, 1,800 enrollees in PY 2028, 1,900 enrollees in PY 2029, and 2,000 enrollees in PY 2030. We note that Nevada can still meet the coverage guardrail even if the actual enrollment impact is somewhat lower than the State estimates, since a section 1332 waiver is not required to increase enrollment, but rather, must provide coverage to a comparable number of people as would be provided absent the waiver, in order to meet the statutory coverage guardrail.

Finally, the Departments have determined that the waiver is not projected to increase the federal deficit. Compared to without the waiver, the Departments project lower individual market premiums in the State and thus a net decrease in federal spending on premium tax credits (PTC) in the individual market in PY 2026 and over the five-year waiver period due to market-wide premium reductions resulting from implementation of a reinsurance program and the introduction of BBSPs. These PTC savings will be passed through to the State to be used for implementation of the waiver plan. Nevada projects net federal savings of $31 million in PY 2026, and a total of $322 million in net federal savings over the five-year waiver period due to premium reductions for BBSPs and the implementation of a reinsurance program.

Consideration of Public Comments

To increase transparency, section 1332(a)(4)(B) of the ACA requires the establishment of a process for public notice and comment on a state's section 1332 waiver application that is sufficient to ensure a meaningful level of public input. This includes a state-level public comment period (generally occurring prior to application submission), as well as a federal public comment period after the state's application is received and deemed complete by the Secretary of Health and Human Services and the Secretary of the Treasury (collectively, "the Secretaries").[7]

Prior to submitting its waiver application to the Departments on December 29, 2023, the Nevada Department of Health and Human Services hosted six public comment sessions to gather feedback on its proposed waiver application.

The Departments conducted two federal comment periods, during which they received a total of 44 comments, the majority of which generally supported the waiver proposal. The first 30-day

[6] Even if the premium reductions achieved are less than the targets set by the State, the Departments still project that coverage will be at least as affordable as it would be without the waiver.

[7] Requirements for the State comment period are codified at 31 C.F.R. § 33.112(a)(1) and 45 C.F.R. § 155.1312(a)(1), while federal public comment period requirements are codified at 31 C.F.R. § 33.116 and 45 C.F.R. § 155.1316.

federal comment period on the initial waiver application submitted on December 29, 2023, was held from February 12, 2024, through March 14, 2024. During this period, the Departments received a total of 35 comments. The second 30-day federal comment period on the addendum to the waiver application submitted on August 23, 2024, was conducted from August 26, 2024, through September 25, 2024. The Departments received nine public comments during this second federal comment period.

The Departments shared all comments received during the federal comment periods with the State for its review and consideration and have also posted them on the CMS section 1332 waiver website.[8] The Departments also sent Nevada a series of questions throughout the review period of the waiver application. These questions, and the responses from Nevada, are also posted on the CMS section 1332 waiver website.[9] A summary of major themes raised in the public comments and the Departments' responses are provided in Appendix A.

Next Steps

Please send your written acceptance and any communications and questions regarding program matters or official correspondence concerning the waiver to lina.rashid@cms.hhs.gov or stateinnovationwaivers@cms.hhs.gov.

Congratulations. We look forward to working with you and your staff. Please do not hesitate to contact us if you have any questions.

Sincerely,

Chiquita Brooks-LaSure

Enclosure

CC: Aviva Aron-Dine, Deputy Assistant Secretary, Tax Policy, U.S. Department of the Treasury
The Honorable Joe Lombardo, Governor, State of Nevada
Stacie Weeks, Administrator, Division of Health Care Financing Policy, Nevada Department of Health and Human Services

[8] https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers
[9] *Ibid.*

Appendix A: Summary and Responses to Major Themes
Raised in Public Comments Submitted During the Federal Comment Periods

The Department of Health and Human Services (HHS), as well as on behalf of the Department of the Treasury (collectively, "the Departments"), received a total of 44 comments during two federal public comment periods; of these, 23 were from organizations and 21 were from individuals. The majority of comments received during both federal public comment periods supported Nevada's waiver plan.

The Departments received 35 comments during the federal public comment period held from February 12, 2024, through March 14, 2024, on Nevada's initial waiver application, which was submitted on December 29, 2023.

On March 20, 2024, Nevada requested the Departments pause their review of the waiver application as the State planned to submit an addendum to update the waiver plan and actuarial assumptions. On August 23, 2024, Nevada submitted an addendum (the "August addendum") to its waiver application detailing an updated reinsurance program, adjustments to premium reduction targets, a targeted premium relief program for certain enrollees in the State Exchange, outreach strategies, and a requirement for Battle Born State Plan (BBSP) issuers to offer at least one bronze BBSP and one silver non-BBSP.

On August 23, 2024, the Departments resumed review of the waiver application, including the August 23, 2024, addendum submitted by Nevada. In response to this August addendum, the Departments conducted a second federal public comment period from August 26, 2024, through September 25, 2024, during which the Departments received nine comments.

On January 1, 2025, Nevada submitted an addendum in response to feedback from the Departments and public comments. The State also submitted updates to this addendum on January 6, 2025 (collectively, the "January addendum").

Guardrails and Premium Reduction Targets

Public Comments:

Many commenters who submitted comments in support of Nevada's proposed waiver expressed that the Departments should approve the waiver application as it satisfies the statutory guardrails and would improve affordability and coverage. Many of the comments from individuals included personal stories centered on affordability as a barrier to coverage and access; for example, one commenter stated: "Many Nevadans, like myself go without care or are forced to make difficult choices between necessities like food, rent and getting the care we need."

Some commenters noted that public option programs, generally, and the State's waiver plan, specifically, would result in significant savings on federal premium tax credit (PTC) spending due to lower premiums. Two comments in response to the August addendum noted that the addition of a premium relief program for certain Exchange enrollees would further improve affordability. A few commenters appreciated the August addendum's additional focus on consumer outreach and enrollment assistance, stating that these activities would increase coverage and help consumers make more informed decisions about their health insurance needs.

Some commenters expressed concern that Nevada's premium reduction targets are unrealistic, and that the waiver application did not sufficiently demonstrate that the waiver would result in the projected federal savings. A few commenters stated that public option programs reduce competition and do not improve affordability. In response to Nevada's initial waiver application, one commenter asserted that market forces would have driven premiums down if it were feasible to decrease premiums without resulting in issuer insolvency. A few commenters also noted that meeting premium reduction targets could necessitate constraining administrative costs, and felt this would result in reduced services for enrollees and be particularly challenging in light of the administrative requirements for BBSPs. In response to the August addendum, one commenter expressed concern that issuers would be unable to achieve the premium reduction targets because providers would be required to join only one BBSP network and issuers would be unable to negotiate provider reimbursement rates effectively. Two commenters who were opposed to the waiver application supported the adjusted premium target methodology described in the August addendum while maintaining their opposition to the waiver overall.

Departments' Response:
The Departments appreciate commenters' support for the waiver application and agree that Nevada's waiver plan will improve affordability and coverage for Nevadans and that the outreach and enrollment efforts will support Nevadans in making informed health insurance choices. Based on consideration of the analysis and information submitted by the State as part of its waiver application, along with the State's responses to questions from the Departments during the review period and consideration of the Departments' experience with existing section 1332 waivers and other health programs, and public comments, the Departments have determined that Nevada's waiver plan meets the statutory guardrail requirements in sections 1332(b)(1)(A)-(D) of the ACA. In evaluating the statutory guardrails, the Departments considered the impact of the entire waiver on each guardrail compared to the without-waiver baseline. An explanation of the Departments' determination that the Nevada waiver plan meets the guardrails is included in the letter to the State.

The Departments have considered the possibility that issuers will not achieve the premium reduction targets required by the State and have determined that, even with premium reductions that are less than the targets set by the State, the waiver is still projected to result in with-waiver premiums that are lower than without-waiver premiums, and the waiver would still be projected to meet the guardrails.[1] Even if the premiums under the waiver are the same as premiums absent the waiver, the waiver would still provide coverage that is as affordable as without the waiver. However, the Departments appreciate commenters' concerns regarding the required premium reductions and their potential impact on issuers and the individual market in Nevada. Based on public comments and the Departments' review of Nevada's initial waiver application, the Departments asked the State to provide more information.[2] In the August addendum, the State adjusted its methodology for calculating the premium reduction targets for BBSPs and revised its approach to the reinsurance program to include statewide reinsurance parameters to address

[1]The comprehensiveness guardrail would also still be met if issuers do not meet the premium reduction targets because the coverage provided under the waiver would be as comprehensive as the coverage defined in section 1302(b) of the ACA and offered through Exchanges.
[2] The Departments' questions and the State's responses are available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers

concerns about varying levels of difficulty for different issuers to meet the premium reduction targets and geographic variation in reinsurance rates. Further, after submitting the August addendum the State adjusted its waiver plan in the January addendum to include implementation of the reinsurance program in the first year of the waiver to improve affordability in response to public comments. Moreover, per the Specific Terms and Conditions (STCs), the State will agree to provide additional premium relief as described in STC 11, if the BBSP take-up rate is less than 35% to ensure there is no increase in average net premiums in any year of the waiver. The Departments' review of the State's analysis confirmed that it accounts for current pricing and that the State's assumptions regarding issuer participation and the potential for provider rate reductions under the waiver are reasonable, and the Departments will continue to monitor issuer participation. Further, the Departments have reviewed the actuarial assumptions underlying Nevada's estimated premium reductions and conducted an internal analysis and also found that the proposed premium reductions are feasible.

Regarding the comments expressing concern that meeting premium reduction targets could lead to issuer insolvency, monitoring to ensure actuarially sound rates and issuer solvency are components of the State's proposed bidding and contracting processes. Further, the State responded to public comments received during the first federal public comment period by revising the premium reduction targets to allow issuers with less competitive rates to meet the premium reduction targets more gradually than issuers with more competitive rates, as described in the August addendum.

BBSP Contracting and Issuer Participation in Medicaid and the Exchange

Public Comments:

A few commenters expressed that requiring issuers bidding to become Medicaid managed care organizations (MCOs) in the State to submit a good faith bid to offer BBSPs could discourage issuers from participating in Nevada's Exchange and Medicaid program and could risk issuer insolvency. One commenter noted that Medicaid and the individual market differ in terms of populations served, provider contracting practices, and regulatory requirements, such that this requirement would harm competition and choice in Nevada's Medicaid program. Another commenter noted that there was insufficient time for MCOs to submit competitive bids.

A few commenters in support of the waiver noted that linking Medicaid and BBSP contracting would allow the State to leverage existing Medicaid tools for improving care delivery and controlling costs and could ease coverage transitions and improve continuity of care. One commenter noted that Medicaid MCOs are already required to offer QHPs in Nevada.

Departments' Response:

The Departments appreciate the comments noting that leveraging the Medicaid contracting process may facilitate cost control and quality improvements through BBSPs. The Departments acknowledge commenters' concerns about issuer participation in Nevada's Exchange and Medicaid program. Although the State does not anticipate any issuer would leave the individual market in response to the waiver, the State does have authority to require all issuers bidding for MCO contracts to submit "good faith bids." All current MCOs in Nevada offer QHPs on the state Exchange and are familiar with the population, costs, regulatory requirements, and structure of QHPs in Nevada. In addition, the provider reimbursement rate floor included in the BBSP

statute[3] and the State's analysis of current provider rates suggest that there is room for negotiation with providers.

In addition to market conditions and trends in issuer participation in Nevada since the state law requiring establishment of a public option program[4] was signed into law on June 9, 2021, and step 1 of the 2026 request for proposals for BBSP issuers was issued on August 23, 2024, Nevada has reported no decrease in issuer participation. The waiver plan also includes a reinsurance program, which has expanded issuer participation in some states with approved section 1332 waivers implementing state reinsurance programs. The State received responses to its request for proposals to offer BBSPs from 7 issuers, some of which are not currently serving as Medicaid MCOs. Further, Nevada extended the deadline for good faith BBSP bid submissions from October 16, 2024, to October 23, 2024, and the deadline for full proposals from October 23, 2024, to October 31, 2024, to ensure interested issuers had adequate time to respond.

Network Adequacy and Provider Rates

Public Comments:

Several commenters supported Nevada's efforts to address provider shortages through the Practice in Nevada provider retention program. A few commenters expressed concern that negotiating lower provider rates and requiring providers participating in certain public health insurance programs to participate in one BBSP could lead to physicians leaving the State and/or to inadequate networks for BBSPs should providers contract with only one BBSP. A few commenters also stated that many providers are already accepting rates at or below the provider rate floor of 100% of Medicare rates set in state statute, limiting issuers' ability to negotiate lower rates.

Departments' Response:

The Departments appreciate commenters' support for the Practice in Nevada provider retention program. Regarding concerns that the provider participation requirements could cause hardship for providers or impact network adequacy, in the August addendum the State clarified processes for providers to seek exemption from the participation requirement and noted that it will require BBSP issuers to monitor and ensure providers accept BBSP enrollees at the same rate as patients enrolled in plans that are not BBSPs. The State's analysis of current provider rates suggests that, in the aggregate, provider rates are well above 100% of Medicare rates, suggesting that negotiating lower rates without violating this floor is feasible. Further, BBSP issuers will be required to comply with all QHP standards, including those related to network adequacy.

Reinsurance

Public Comments:

Several commenters supported the proposed reinsurance program or reinsurance programs generally, noting that reinsurance can improve affordability for enrollees. A few commenters expressed concern about the State's plan to fully fund the reinsurance program with pass-through funding because they were skeptical that the waiver would result in adequate pass-through funding and objected to the State's plan to potentially fine issuers who fail to comply with BBSP contracting requirements and use this funding to support the reinsurance program. In response to

[3] NRS Chapter 695K; See https://www.leg.state.nv.us/nrs/NRS-695K.html

[4] *Ibid.*

Nevada's initial waiver application, one commenter expressed concern that varying coinsurance rates by rating area would make it more challenging for issuers in rating areas with lower coinsurance rates to meet premium reduction targets. This same commenter submitted a comment during the second federal comment period and noted that they appreciated the updated parameters Nevada included in the August addendum, which addressed their prior concern.

A few commenters expressed that they would prefer the State invest pass-through funding in premium subsidies or other affordability policies for lower-income enrollees rather than reinsurance because they asserted that reinsurance does not improve affordability and could potentially result in less PTC for lower-income enrollees and has a smaller impact on coverage.

Departments' Response:
The Departments appreciate the support for Nevada's proposed reinsurance program and agree reinsurance will improve the affordability of coverage. The Departments also appreciate the comments on the importance of stable funding for reinsurance programs. The STCs for the waiver require in STC 3 that the State must ensure sufficient funds are available on an annual basis for the waiver to operate as described in the State's waiver plan. The Departments found the State's projections reasonable and determined that in the event premium reduction targets are not achieved by some issuers, the statutory guardrails would still be met.

Regarding comments urging the State to replace the reinsurance program with premium subsidies, the State included a targeted premium relief program for certain Exchange enrollees as part of its waiver addenda. Further, the State as specified in STC 11 will agree to provide additional premium relief as part of the premium relief program should take up of BBSPs fall short of projections so that there will be no increase in average net premiums in any year of the waiver. In responses to both comments urging that reinsurance funding be redirected to premium subsidies and those expressing concern that the State might fine issuers that do not comply with BBSP contract requirements, the Departments defer to states to develop the scope of their waiver plans and remain committed to working with state partners to advance health care coverage and affordability policies. The updates to the State's waiver plan in the January addendum adjusted the reinsurance program to begin in the first year of the waiver plan and added the premium relief requirement in STC 11 to further improve affordability for enrollees. These changes are consistent with public comments and the Departments' feedback.

DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS)
U.S. DEPARTMENT OF THE TREASURY
PATIENT PROTECTION AND AFFORDABLE CARE ACT SECTION 1332 STATE INNOVATION WAIVER
SPECIFIC TERMS AND CONDITIONS
TITLE: State of Nevada-Patient Protection and Affordable Care Act Section 1332 Waiver Approval
AWARDEE: The State of Nevada Department of Health and Human Services

I. PREFACE

The following are the specific terms and conditions (STCs) for the State of Nevada Department of Health and Human Services' (hereafter referred to as "the State") Patient Protection and Affordable Care Act (ACA)[1] section 1332 State Innovation Waiver to implement state-contracted qualified health plans (QHPs) known as Battle Born State Plans (BBSPs) and a Market Stabilization Program for the individual health insurance market (hereafter referred to as "the waiver" or "the waiver plan"), which has been approved by the U.S. Department of Health and Human Services (HHS) and the U.S. Department of the Treasury (collectively, "the Departments"). These STCs govern the operation of the waiver by the State. The STCs set forth, in detail, the State's responsibilities to the Departments related to the waiver. These STCs are effective beginning January 1, 2026, through December 31, 2030, unless the waiver is extended, otherwise amended, suspended, or terminated by the parties in accordance with the applicable processes set forth in and provided by these STCs; however, the Departments reserve the right to amend these STCs when the Departments make the annual determination of the pass-through amount for plan years 2026 through 2030. The State's final waiver application[2] to waive certain provisions of the ACA is specifically incorporated by reference into these STCs, except with regard to any proposal or text in the waiver plan that is inconsistent with the Departments' approval of the waiver or these STCs.

1. ACA Provision Waived under Section 1332 State Innovation Waiver (Section 1332 waiver). Section 1312(c)(1) of the ACA as implemented at 45 C.F.R. § 156.80(d)(2) to the extent it would otherwise prohibit plan-level rating variation(s) for BBSPs in the individual market. Additionally, section 1312(c)(1) of the ACA is waived for the purposes of operating a state reinsurance program to the extent it would otherwise require excluding total expected State reinsurance payments when establishing the market-wide index rate.

2. Changes in State Law and Technical Changes to the Waiver. The State must inform the Departments of any change in state law or regulations that could impact the waiver, including any changes to the requirements of the State's waiver plan, or any

[1] The Patient Protection and Affordable Care Act (Pub. L. 111-148) was enacted on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), which amended and revised several provisions of the Patient Protection and Affordable Care Act, was enacted on March 30, 2010. In these STCs, the two statutes are referred to collectively as the "Patient Protection and Affordable Care Act" or "ACA."
[2] The State's "final waiver application" or "waiver plan" refer to the December 29, 2023, application, the August 23, 2024, addendum, and the January addendum.

proposed technical changes to the waiver occurring after the date of this approval letter, at least thirty (30) calendar days prior to the intended implementation date of the change. Changes might be considered technical changes if they are routine changes of an operational nature that do not impact whether the statutory guardrails (as set forth in sections 1332(b)(1)(A)-(D) of the ACA) are met, and which do not materially impact, such as by establishing or eliminating, any obligations of the State or the Departments with respect to the waiver.[3] The State must consult with the Departments well in advance of implementing any change and must receive confirmation from the Departments that the change is a technical change prior to implementation of the change. The Departments will consider the facts and circumstances of each proposed change and reserve discretion to request additional information from a state when determining whether a proposed change is a technical change or requires submission of a waiver amendment request.[4] If the Departments determine that the change to the State's waiver plan is not a technical change but instead would be an amendment, the State must submit a waiver amendment request as set forth in STC 9 and receive approval from the Departments prior to implementing the change described in the waiver amendment request.

Consistent with the State's waiver, the State is responsible for any reconciliation of reinsurance payments that it wishes to make to account for any duplicative reimbursement through the State's reinsurance program for the same high-cost claims reimbursed through the HHS-operated risk adjustment program. This is also considered a technical change to the State reinsurance program.

3. Funds to Operate the Waiver. The State's waiver plan will be funded through a combination of federal pass-through funding and funding from state appropriations, if necessary. The State must ensure sufficient funds are available on an annual basis for the waiver to operate as described in the State's waiver plan.[5]

4. Compliance with Federal Non-Discrimination Statutes. The State must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, title I and II of the Genetic Information Nondiscrimination Act of 2008 and section 1557 of the ACA.

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[3] Generally, changes that are operational in nature that comply with standard requirements in statute and regulations established for minimum essential coverage or the operation of state-based exchanges might be considered technical changes unless the change could impact whether the waiver can continue to meet the statutory guardrails or could materially impact, such as by establishing or eliminating, the obligations of the State or the Departments with respect to the waiver. While the Departments ultimately determine if a change is considered a technical change, some examples of routine changes of an operational nature that, implemented alone or in combination, may constitute technical changes are: changes to premium reduction targets, changes in the parameters (e.g. the program size, coinsurance rate, attachment point, or cap) of the state reinsurance program, certain changes in state subsidies for certain Exchange enrollees, or changes to the parameters of the quality incentive pool or Practice in Nevada provider retention program.

[4] Failure to provide requested information in a timely manner may result in delays in the Departments' determination as to whether the change is a technical change or requires submission of a waiver amendment request.

[5] The Departments emphasize that the State must ensure sufficient funding for the components of the waiver that have a direct impact on the statutory guardrails. These components include supporting the state premium subsidies for certain Exchange enrollees, any administrative costs associated with the waiver plan (such as BBSP contracting and monitoring), and the state reinsurance program. To the extent funds are available, as described in the State's waiver plan, the State's waiver will also include a quality incentive pool and the Practice in Nevada provider retention program. Pass-through funding may not be used as matching funds for the federal loan forgiveness program.

5. Compliance with Applicable Federal Laws. Per 31 C.F.R. § 33.120(a) and 45 C.F.R.§ 155.1320(a), the State must comply with all applicable federal laws and regulations, unless a law or regulation has been specifically waived. The Departments' State Innovation Waiver authority is limited to requirements described in section 1332(a)(2) of the ACA. Further, section 1332(c) of the ACA states that while the Secretaries of the Departments have broad discretion to determine the scope of a waiver, no federal laws or requirements may be waived that are not within the Secretaries' authority. *See* 77 Fed. Reg. 11700, 11711 (February 27, 2012). Therefore, for example, section 1332 of the ACA does not grant the Departments authority to waive any provision of the Employee Retirement Income Security Act of 1974. The State must also comply with requirements of the Cash Management Improvement Act.

6. Changes to Applicable Federal Laws. The Departments reserve the right to amend, suspend, or terminate the waiver, these STCs, or the pass-through funding amount as needed to reflect changes to applicable federal laws or changes of an operational nature without requiring the State to submit a new waiver proposal. In the event that any aspect, term, or provision of this waiver or these STCs is held invalid, illegal, or unenforceable by a court in any jurisdiction, such invalidity, illegality, or unenforceability shall not affect any other aspect, term, or provision of this waiver or these STCs provided that the remaining aspects, terms, and provisions of the waiver continue to comply with the statutory guardrails. The Departments will notify the State at least thirty (30) calendar days in advance of the expected implementation date of the amended STCs, if applicable, to allow the State to discuss the changes necessary to ensure compliance with law, regulation, and policy, to allow the State adequate time to come into compliance with state and federal requirements (including rate review and consumer noticing requirements), and to provide comment, if applicable. Changes will be considered in force upon the Departments' issuance of amended STCs. The State must accept the changes in writing within thirty (30) calendar days of the Departments' notification for the waiver to continue to be in effect. The State must, within the applicable timeframes, come into compliance with any changes in federal law or regulations affecting section 1332 waivers, unless the provision being changed has been expressly waived for the waiver period. If any of the waived provision(s) identified in STC 1 are eliminated under federal law, the Departments would re-evaluate the waiver to see if it still meets all of the section 1332 waiver requirements. If the Departments determine that the waiver needs to be suspended or terminated as a result of a change to federal law, the Departments will provide further guidance to the State as to that process.

7. Finding of Non-Compliance. The Departments will review and, when appropriate, investigate documented complaints that the State is failing to materially comply with requirements specified in the State's waiver and these STCs. In addition, the Departments will promptly share with the State any complaint that they may receive and will notify the State of any applicable monitoring and compliance issues.

8. State Request for Suspension, Withdrawal, or Termination of a Waiver. The

State may only request to suspend, withdraw, or terminate all or portions of its waiver plan consistent with the following requirements:

(a) Request for suspension, withdrawal, or termination: If the State wishes to suspend, withdraw, or terminate all or any portion(s) of the waiver, the State must submit a request to the Departments in writing specifying: the reasons for the requested suspension, withdrawal, or termination; the effective date of the requested suspension, withdrawal or termination; and the proposed phase-out plan (with the summary of comments received, as described below). The State must submit its request and draft phase-out plan to the Departments no less than nine (9) months[6] before the proposed effective date of the waiver's suspension, withdrawal, or termination. Prior to submitting the request and draft phase-out plan to the Departments, the State must publish on its website the draft phase-out plan for a thirty (30) calendar day public comment period and conduct Federal tribal consultation as applicable. The State must include with its request and proposed phase-out plan a summary of each public comment received, the State's response to the comment and whether or how the State incorporated measures into a revised phase-out plan to address the comment.

(b) Departments' approval: The State must obtain the Departments' approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must begin no sooner than fourteen (14) calendar days after the Departments' approval of the phase-out plan, unless otherwise directed by the Departments.

(c) Recovery of unused funding: Any unused pass-through funding will be recovered. The State will comply with all necessary steps to facilitate the recovery within a prompt timeframe.

9. State Request for Amendment.

(a) Definition: For purposes of these STCs and per 31 C.F.R. § 33.130(a) and 45 C.F.R. § 155.1330(a), an amendment is a change to a waiver plan that is not otherwise allowable under these STCs, a change that could impact any of the statutory guardrails, or a change to the program design for an approved waiver.[7] Such potential changes could include, but are not limited to, changes to eligibility, coverage, benefits, premiums, out-of-pocket spending, and cost sharing. See STC 2 for information on changes that could be considered technical changes instead of a change that would require a waiver amendment.

(b) Amendment Request Submission Process: Consistent with 31 C.F.R. § 33.130 and 45

[6] This timeframe reflects the complexity and novel nature of Nevada's section 1332 waiver and the need for additional time for coordination and review of any waiver suspension, withdrawal, or termination requests submitted by the State.
[7] Modifications to waivers that are determined by the Departments to be technical changes are not considered waiver amendments and are not subject to the requirements outlined in STC 9 or 31 C.F.R. § 33.130 and 45 C.F.R. § 155.1330.

C.F.R. § 155.1330, to amend a waiver the State must comply with the following requirements:

(1) The State must submit a letter to the Departments notifying them in writing of its intent to request an amendment to its waiver plan(s). The State must include a detailed description of all of the intended change(s), including the proposed implementation date(s), in its letter of intent. The Departments encourage the State to submit its letter of intent at least fifteen (15) months prior to the waiver amendment's proposed implementation date and to engage with the Departments early in its development of a potential waiver amendment. The State may wish to submit this letter of intent more than fifteen (15) months prior to the waiver amendment's proposed implementation date, depending on the complexity of the amendment request and the timeline for implementation, among other factors.

(2) The Departments will review the State's letter of intent requesting changes to its waiver plan. Within approximately thirty (30) calendar days of the Departments' receipt of the State's letter of intent, the Departments will respond to the State and confirm whether the change requested is a waiver amendment, as well as identify the information the State needs to submit in its waiver amendment request. This written response will also include whether the proposed waiver amendment(s) would be subject to any additional or different requirements consistent with STC 9(c)(7).

    For example, depending on the complexity of the amendment request, scope of changes from the waiver plan, operational/technical changes, or implementation considerations, the Departments may impose requirements similar to those specified in 31 C.F.R. § 33.108(f) and 45 C.F.R. § 155.1308(f) for new section 1332 waiver applications.

(3) The State should generally plan to submit its waiver amendment request in writing in electronic format, as outlined in STC 9(c), no later than nine (9) months prior to the waiver amendment's proposed implementation date in order to allow for sufficient time for review of the waiver amendment request. Similar to the regulations at 31 C.F.R. § 33.108(b) and 45 C.F.R. § 155.1308(b) for new waiver applications, the State must submit the waiver amendment request sufficiently in advance of the requested waiver amendment implementation date, particularly when the waiver plan or requested amendment could impact premium rates, to allow for an appropriate review and implementation timeframe. Depending on the complexity of the amendment request, the State may want to submit the amendment request earlier than nine (9) months prior to implementation. In developing the implementation timeframe for its waiver amendment request, the State must maintain uninterrupted operations of the Exchange in the State and provide adequate notice to affected

stakeholders and issuers of health insurance plans that would be (or may be) affected by the amendment to take necessary action based on approval of the waiver amendment request.

(4) The Departments reserve the right to deny or withhold approval of a state waiver amendment request based on non-compliance with these STCs or any additional direction and information requests from the Departments, including a failure by the State to submit required reports and other deliverables in a timely fashion.

(5) The State is not authorized to implement any aspect of the proposed amendment without prior approval from the Secretaries.

(c) Content of Amendment Application: All amendment applications are subject to approval at the discretion of the Secretaries in accordance with section 1332 of the ACA. The State must furnish such information and analysis regarding the proposed waiver amendment that is necessary to permit the Departments to evaluate the request. A waiver amendment request must include the following:

(l) A detailed description of the requested amendment, including the time period for the proposed amended waiver, impact on the statutory guardrails, the scope of the proposed amendment to the waiver plan—including whether the State seeks to waive any new provisions and the rationale for the waiver—and related changes to the waiver plan elements as applicable, including sufficient supporting documentation;

(2) An explanation and evidence of the process used by the State to ensure meaningful public input on the proposed waiver amendment request. The State must conduct the State public notice process that is specified for new applications at 31 C.F.R. § 33.112 and 45 C.F.R. § 155.1312. It may be permissible for a state to use its annual public forum required under 31 C.F.R. § 33.120(c) and 45 C.F.R. § 155.1320(c) for the dual purpose of soliciting public input on a proposed waiver amendment request and on the progress of its waiver plan;

(3) Evidence of sufficient authority under state law(s) in order to meet the requirement in section 1332(b)(2)(A) of the ACA for purposes of pursuing the waiver amendment request;

(4) An implementation plan with operational details (if appropriate) to demonstrate that the waiver would maintain uninterrupted operations of the Exchange in the State, and provision of adequate notice for stakeholders and issuers of health insurance plans that would be (or may be) affected by the proposed amendment to take necessary action based on approval of the waiver amendment request;

(5) An updated actuarial and/or economic analysis demonstrating how the

waiver, as amended, will meet the statutory guardrails. Such analysis must identify the "with waiver" impact of the requested amendment on the statutory guardrails. Such analysis must include a "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using data from recent experience, as well as a summary of and detailed projections of the change in the "with waiver" scenario;

(6) An explanation of the estimated impact, if any, of the waiver amendment on pass-through funding, as well as any new proposed uses for pass-through funding if applicable; and

(7) Any further requested information and/or analysis that is determined necessary by the Departments to evaluate the waiver amendment request.

10. State Request for Waiver Extension.

(a) Definition: For purposes of these STCs and per 31 C.F.R. § 33.132 and 45 C.F.R. § 155.1332, an extension is an extension of an approved waiver under the existing waiver terms.

The waiver extension request and approval process is separate from the waiver amendment request and approval process described in STC 9, with separate timelines and requirements. An extension request can only include an extension of the existing waiver terms, not other changes to the existing waiver plan. If a state also seeks to make substantive changes to its waiver plan along with seeking an extension, the Departments will treat those changes as amendments and the requirements of STC 9 will also apply.

(b) Extension Request Submission Process: Consistent with 31 C.F.R. § 33.132 and 45 C.F.R. § 155.1332, to extend the waiver the State must comply with the following requirements:

(l) The State must inform the Departments if the State will apply for an extension of its waiver at least one (1) year prior to the waiver's end date. The State must submit a letter of intent in electronic format to the Departments to notify them in writing of its intent to request an extension of its waiver plan. The State must include a detailed description of the requested extension period in the letter of intent. The Departments will then review the State's letter of intent request. Within approximately thirty (30) calendar days of the Departments' receipt of the letter of intent, the Departments will respond to the State and confirm whether the extension request will be considered an extension request and, if applicable, whether the request includes changes that would be considered an amendment request subject to the separate process and requirements set forth in STC 9. The Departments' response will also identify the information the State needs to submit in its waiver extension request.

(2) The State must submit its waiver extension request in writing in electronic format, consistent with the format and manner requirements applicable to initial waiver applications under 31 C.F.R. § 33.108(a) and 45 C.F.R. § 155.1308(a).

(3) An extension request shall be deemed granted unless the Secretaries, within ninety (90) calendar days after the date of the State's submission of a complete waiver extension request, either deny such request in writing or inform the State in writing with respect to any additional information needed to make a final determination with respect to the request.

(4) The Departments reserve the right to deny a state's waiver extension request based on non-compliance with these STCs or any additional direction and information requests from the Departments, including a failure by the State to submit required reports and other deliverables in a timely fashion.

(c) Content of Extension Application: All extension applications are subject to approval at the discretion of the Secretaries in accordance with section 1332 of the ACA. The State must furnish information and analysis regarding the proposed waiver extension that is necessary to permit the Departments to evaluate the request. In addition to the periodic reports required by 31 C.F.R. § 33.124 and 45 C.F.R. § 155.1324, the Departments may require additional data and information to be submitted to review the extension request in accordance with 31 C.F.R. § 33.120(f)(2) and 45 C.F.R. § 155.1320(f)(2). A waiver extension request may be required to include the following information:

(l) Updated economic or actuarial analyses for the requested extension period in a format and manner specified by the Departments;

(2) Preliminary evaluation data and analysis from the existing waiver;

(3) Evidence of sufficient authority under state law(s) to meet the requirement in section 1332(b)(2)(A) of the ACA for purposes of pursuing the waiver extension request;

(4) An explanation of the process followed by the State to ensure meaningful public input on the proposed waiver extension request at the state level. It may be permissible for the State to use its annual public forum under 31 C.F.R. § 33.120(c) and 45 C.F.R. § 155.1320(c) for the dual purpose of soliciting public input on a proposed waiver extension request and on the progress of its waiver plan;[8] and

(5) Other information as requested by the Departments that is necessary

[8] *Ibid.*

to reach a decision on the waiver extension request.

The Departments will identify the information the State needs to submit as part of its waiver extension request in its response to the State's letter of intent.

(d) Temporary Extension of Waivers: The Departments may extend an existing waiver program on a temporary basis for an additional year while a waiver extension request is under review, without regard to the date when the extension application was submitted.

(e) End of Waiver Period: If the State does not submit an extension request before the end of the waiver period consistent with STC 10(b)(1), the Departments will provide guidance on wind-down of the State's waiver.

11. Reporting and Additional Premium Relief. The State must submit quarterly and annual reports as specified in 31 C.F.R. § 33.124 and 45 C.F.R. § 155.1324, and other reports as specified below.

Annual Reports: The State must submit a draft annual report to the Departments within ninety (90) calendar days after the end of the first waiver year and each subsequent year that the waiver is in effect. The State will publish the draft annual report on the State's public website within thirty (30) calendar days of submission to the Departments. Within sixty (60) calendar days of receipt of comments from the Departments on the report, the State must submit to the Departments the final annual report for the waiver year, summary of the comments, and all public comments received as part of the post-award forum process. The State must publish the final annual report on the State's public website within thirty (30) calendar days of approval by the Departments.

Report Contents: Each such annual report must include:

(a) The progress of the waiver;

(b) Data and metrics sufficient to show compliance and assist evaluation of the waiver's compliance with sections 1332(b)(l)(A) through (D) of the ACA:

(1) Projected and actual individual market enrollment in the State, both through the Exchange and off-Exchange.

(2) Projected and actual average individual market premium rate (i.e., total individual market premiums divided by total member months of all enrollees).

(3) The actual Second Lowest Cost Silver Plan (SLCSP) premium under the waiver, and an estimate of the SLCSP premium as it would have been without the waiver and with the BBSPs alone, for a representative consumer (e.g., a 21-year-old non-smoker) in each rating area.

(4) The State's network adequacy requirements, including but not limited to: the number of BBSPs that meet the network adequacy requirements for ACA plans, data collected by the State and issuers related to enrollee and provider complaints, and qualitative data from stakeholders shared during the annual post-award forum;

(c) A summary of the annual post-award public forum, held in accordance with 31 C.F.R. § 33.120(c) and 45 C.F.R. § 155.1320(c), including all public comments received at such forum regarding the progress of the waiver and action taken in response to such concerns or comments;

(d) Technical changes to the State's waiver plan, including the funding level the program will be operating at for the next plan year, or other waiver plan changes as specified in STC 2;

(e) Notification of changes to state law or regulations that may impact the waiver as specified in STC 2;

(f) Reporting of:

(1) Federal pass-through funding spent on reinsurance claim payments to issuers from the State reinsurance program and/or operation of the reinsurance program;

(2) Federal pass-through funding spent on State subsidies for certain Exchange enrollees;

(3) Federal pass-through funding spent on the quality improvement and Practice in Nevada provider retention programs; and

(4) The unspent balance of federal pass-through funding for the reporting year, if applicable;

(g) The amount of State funding from State appropriations (if any), or other funding to support the waiver, specifically: 1) any funds designated by the State to provide reinsurance to issuers that offer individual health benefit plans in the State or any other money from any other source accepted to fully fund the State's reinsurance program for the reporting year, and 2) any State funds allocated to other aspects of the waiver;

(h) A description of any incentives for providers, enrollees, and issuers to continue managing health care cost and claims for individuals eligible for reinsurance;

(i) Reporting specific to the premium relief program:

(1) The number of enrollees who received State subsidies as part of the premium relief program stratified by income (≤ 100% of FPL, >100-133% of FPL, >133 150% of FPL, >150 200% of

FPL, >200 250% of FPL, >250 300% of FPL, >300 400% of FPL, and >400% of FPL), metal level (bronze, silver, and gold), and plan type (BBSP or non-BBSP).

(2) The with- and without-waiver market-wide average net premium, and the accompanying data and methodology the State used for these calculations. Subsidy schedule parameters and the State's detailed methodology for calculating the premium relief subsidies for enrollees (if different parameters and methodologies were used for different subpopulations, the State should detail these differences as well).

(j) *If applicable:* A report on the reconciliation (if any) of reinsurance payments that are duplicative of reimbursement through the HHS-operated risk adjustment program high-cost risk pooling mechanism. The report should include the State's reinsurance program reinsurance payment (before reconciliation) for high-cost claims to issuers who also receive payment through the HHS-operated risk adjustment program under the high-cost risk pooling mechanism, the high-cost risk pool payment amount made by HHS for those claims, and the reinsurance true-up amount applied; and

(k) Other information the Departments determine is necessary to calculate pass-through amounts or to evaluate the waiver.

Quarterly and Other Reports: Under 31 C.F.R. § 33.120(b), 31 C.F.R. § 33.124(a), 45 C.F.R. § 155.1320(b), and 45 C.F.R. § 155.1324(a), the State must conduct periodic reviews related to the implementation of the waiver. The State must report on the operation of the waiver quarterly, including, but not limited to reports of any ongoing operational challenges and plans for and results of associated corrective actions, no later than sixty (60) calendar days following the end of each calendar quarter. The State can submit its annual report in lieu of their fourth quarter report.

Rate Filing Schedule: The State will inform the Departments of the number and names of issuers participating in each rating area for the upcoming plan year at initial and final rate filings within seven (7) calendar days of posting the initial and final rate filings, and in the first year of the waiver the number of issuers participating in each rating area in the previous plan year, to allow the Departments to monitor market stability, issuer participation, and the breadth of plan offerings.

BBSP Implementation Report: The State must submit an annual BBSP implementation report to the Departments including the data and methodology used to calculate: 1) the BBSP take-up rate, 2) the with- and without-waiver market-wide average net premium (i.e., the average net premium for the individual market), and 3) the eligibility criteria and subsidy schedules for state subsidies for certain enrollees in the Exchange, including any adjustments to the subsidy schedules in response to the BBSP take-up rate as specified in the Additional Premium Relief Implementation section. In order for the Departments to effectively monitor guardrail compliance, the State must submit this information as early

in the applicable plan year as possible; if the BBSP take-up rate is less than the 35% threshold described in the additional premium relief implementation section, the State must submit this information at least thirty (30) calendar days in advance of the intended implementation date of the additional premium relief program required below, and in no event later than 120 calendar days prior to the end of the plan year.

Additional Premium Relief Implementation: In the first waiver year, and, as applicable, in subsequent years that the waiver is in effect, if take up of the BBSPs is under 35% (i.e., more than 5 percentage points below the level assumed in the State's waiver analysis) as of the close of Open Enrollment, the State will provide additional premium relief as part of the premium relief program beginning at the first feasible date, but no later than the end of the plan year, to ensure the market-wide average net premium for the plan year is no higher than without the waiver.

12. Post Award Forum. Per 31 C.F.R. § 33.120(c) and 45 C.F.R. § 155. 1320(c), within six (6) months of the waiver's effective date and annually thereafter, the State will afford the public an opportunity to provide meaningful comment on the progress of the waiver.[9] The State is required to publish the date, time, and location of the public forum in a prominent location on the State's public web site at least thirty (30) calendar days prior to the date of the planned public forum. Per 31 C.F.R. § 33.120(c) and 45 C.F.R. § 155.1320(c), the State must also include a summary of this forum as part of the quarterly report for the quarter in which the forum was held and the annual report as required under 31 C.F.R. § 33.124 and 45 C.F.R. § 155.1324 and as specified in STC 11.

13. Monitoring Calls. The State must participate in monitoring calls with the Departments that are deemed necessary by the Departments. The purpose of these monitoring calls is to discuss any significant actual or anticipated developments affecting the waiver. Areas to be addressed include the impact on the statutory guardrails set forth in sections 1332(b)(1)(A)-(D) of the ACA and state legislative or policy changes. The Departments will update the State on any federal policies and issues that may affect any aspect of the waiver. The State and the Departments will jointly develop the agenda for the calls. It is anticipated that these calls will occur at least semi-annually.

14. Federal Evaluation. The Departments will evaluate the waiver using federal data, state reporting, and the application itself to ensure that the Secretaries can exercise appropriate oversight of the approved waiver. Per 31 C.F.R. § 33.120(f) and 45 C.F.R. § 155.1320(f), if requested by the Departments, the State must fully cooperate with the Departments or an independent evaluator selected by the Departments to undertake an independent evaluation of any component of the waiver. As part of this required cooperation, the State must submit all requested data and information to the Departments or the independent evaluator. The Departments may charge the State for evaluation costs to the federal government.

15. Pass-through Funding. Under section 1332(a)(3) of the ACA, pass-through

[9] *Ibid.*

funding is based on the amount of premium tax credits (PTC) that would have been provided to individuals in the State under section 36B of the Internal Revenue Code absent the waiver, but that will not be provided under the State's waiver, reduced, if necessary, to ensure deficit neutrality as required by section 1332(b)(1)(D) of the ACA. The State will receive pass-through funding for the purpose of implementing the waiver, including administration of the waiver, when the requirements described below are met.

For the 2026 plan year and each plan year thereafter, by September 15 of the preceding year or once the State has finalized rates for the applicable plan year, whichever is later, the State will provide the following information to the Departments:

(a) The final SLCSP rates and plan IDs for individual health insurance coverage for a representative individual (e.g., a 21-year-old non-smoker) in each rating area or service area (if premiums vary by geographies smaller than rating areas) for the applicable plan year that are actuarially certified. Also include the actuarial memorandums;

(b) The estimates of what the final silver plan rates and plan IDs for individual health insurance coverage for a representative individual in each rating area or service area (if premiums vary by geographies smaller than rating areas) would have been absent approval of this waiver, and (1) separately with the introduction of BBSPs alone and (2) separately with reinsurance alone for the applicable plan year, that are actuarially certified. The State must include with this information the detailed methods and assumptions the State used to estimate the final silver plan rates and State's estimate of what the final silver plan rates would have been for each rating area or service area absent approval of this waiver. The State's methods and assumptions should specify, in particular, any assumptions relating to issuer participation or plan offerings absent the waiver. Also include the actuarial memorandums;

(c) The total amount of all premiums expected to be paid for individual health insurance coverage for the applicable plan year;

(d) What total premiums for individual health insurance coverage would have been for the applicable plan year without the waiver;

(e) The amount of APTC paid by month and rating area for the current plan year to date;

(f) The number of APTC recipients by month and rating area for the current plan year to date;

(g) The State specific age curve premium variation for the current and upcoming plan year for the individual markets;

(h) Reports of the estimated total reinsurance reimbursements for the upcoming plan year;

(i) Reports of the total enrollment estimates for individual health insurance coverage, both with and without the waiver for the upcoming plan year;

(j) An explanation of why the experience for the upcoming plan year may vary from previous estimates and how assumptions used to estimate the impact have changed. This includes an explanation of changes in the estimated impact of the waiver on aggregate premiums, the estimated impact to the SLCSP rates, and the estimated impact on enrollment. The State should also explain changes to the total estimated reinsurance funding and estimated Battle Born State Plan premium reductions relative to prior estimates;

(k) The subsidy schedules and eligibility criteria for any state-provided subsidies; and

(l) Any other information or data requested by the Departments.

The estimated amount of pass-through funding for calendar years 2026 through 2030 will be communicated to the State as soon as practicable, conditional on receipt of items (a) through (l) in the paragraph above by the date specified above. Pass-through amounts are subject to a final administrative determination by the Department of the Treasury prior to payment, and will be made available no later than April of the applicable calendar year. The pass-through amount for calendar years 2026 through 2030 will be calculated by the Departments annually (per section 1332(a)(3) of the ACA) and reported to the State on the earliest date practicable, conditional on receipt of items (a) through (l) in the paragraph above by the applicable deadline.

The pass-through funds cannot be obligated prior to the effective date for the waiver. The State agrees to use the full amount of pass-through funding for purposes of implementing the State's waiver. This includes administrative support for the waiver, State premium subsidies for certain enrollees, the State reinsurance program, a quality incentive program, and the Practice in Nevada provider retention program. Moreover, to the extent pass-through funding exceeds the amount necessary for the State to implement the waiver in a given plan year, the remaining funds must be carried forward and used for purposes of implementing the State's waiver in a subsequent year.

If the waiver is not extended, the Departments will promptly recover unused pass-through funds following the end of the waiver period, December 31, 2030. The State must comply with all necessary steps to facilitate the recovery of such amounts by the Departments within a prompt timeframe.

16. The Departments' Right to Amend, Suspend, or Terminate. Consistent with 31 C.F.R. § 33.120(d) and 45 C.F.R. § 155.1320(d), the Departments reserve the right to amend, suspend, or terminate the waiver (in whole or in part) at any time before

the date of expiration if the Departments determine that the State has materially failed to comply with these STCs, or if the State fails to meet the statutory guardrails.

(a) The Departments will promptly notify the State in writing of the determination and the reasons for the amendment, suspension, or termination, together with the effective date.

(b) In the event that all of or a portion of the waiver is suspended or terminated by the Departments, federal funding available after the effective date of the suspension or termination will be limited to normal closeout costs associated with an orderly suspension or termination including service costs during any approved transition period and administrative costs of transitioning participants, as described in 31 C.F.R. § 33.120(e) and 45 C.F.R. § 155.1320(e).

(c) The Departments will recover unused pass-through funding. The State must comply with all necessary steps to facilitate the recovery of such amounts by the Departments within a prompt timeframe.

Richard Whitley
Director
Nevada Department of Health and Human Services
State of Nevada

Date: _____

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services

Date: January 10, 2025

Aviva Aron-Dine
Deputy Assistant Secretary, Tax Policy
U.S. Department of the Treasury

Date: _____

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

January 10, 2025

Richard Whitley
Director
Nevada Department of Health and Human Services
400 West King Street, Suite 300
Carson City, NV 89703

Dear Director Whitley:

Thank you for your December 29, 2023, submission, August 23, 2024, addendum, and January 1, 2025, addendum to Nevada's application for a State Innovation Waiver under section 1332 of the Patient Protection and Affordable Care Act (ACA) (also referred to as a "section 1332 waiver"). Nevada (also referred to as "the State") has requested a waiver for calendar years 2026 through 2030 to implement plan-level rating variation(s) for state-contracted qualified health plans (QHPs) known as Battle Born State Plans (BBSPs) and a Market Stabilization Program[1] for the individual health insurance market. I am pleased to send this letter from the Department of Health and Human Services (HHS), as well as on behalf of the Department of the Treasury (collectively, "the Departments").

This letter is to inform you that the Departments, having completed their review of the waiver application, approve Nevada's section 1332 waiver application. The State's final approved waiver application refers to the December 29, 2023, application, the August 23, 2024, addendum, and the January 1, 2025, addendum.[2] Described below are the specific terms and conditions (STCs) of this waiver. The Departments' approval of the waiver is conditioned upon the State's acceptance of these STCs by February 8, 2025. This approval is effective for a waiver period of January 1, 2026, through December 31, 2030.

The Departments are granting Nevada's request to waive the single risk pool requirement in the individual market under ACA section 1312(c)(1) as implemented at 45 C.F.R. § 156.80(d)(2) to the extent it would otherwise prohibit plan-level rating variation(s) for the BBSP in the individual market, as well as to waive ACA section 1312(c)(1) to the extent it would otherwise require excluding total expected state reinsurance payments when establishing the market-wide

[1] The Market Stabilization Program will include a state reinsurance program, targeted premium relief for some enrollees in the Silver State Health Insurance Exchange (Nevada's state-based exchange, "the Exchange"), a quality incentive payment program, and the Practice in Nevada provider retention program to encourage health care providers to remain in the State.

[2] The August 23, 2024, addendum (also referred to as the "August addendum"), in part, updated details related to reinsurance program parameters, the premium reduction target methodology, processes for safeguarding provider rate floors and network adequacy, and some of the State's assumptions (including those related to BBSP take-up rates), and added state premium subsidies for certain Exchange enrollees. The January 1, 2025, addendum, which was updated on January 6, 2025, (collectively referred to as the "January addendum"), updated the BBSP take-up rates and adjusted the reinsurance program to begin in the first year of the waiver plan.

index rate for the purpose of operating a state reinsurance program, as described in the State's waiver application. The waiver plan also includes state premium subsidies for certain Exchange enrollees, a quality incentive payment program, and the Practice in Nevada provider retention program.

The Departments remain committed to working with state partners to advance health coverage policies. Through section 1332 waivers, the Departments aim to assist states with developing health insurance markets that expand coverage, lower costs, and ensure that affordable health coverage is available for their residents. The Departments have determined that this waiver plan satisfies the statutory guardrails (as set forth in sections 1332(b)(1)(A)-(D) of the ACA).

The Departments note that the State's waiver application and the Departments' approval of the waiver application reflect state and federal law at the time of approval. Moving forward, in accordance with STC 2, the State must inform the Departments of any change in state law or regulation that could impact the waiver, including any changes to the requirements of the State's waiver plan, or any proposed technical changes to the waiver occurring after the date of this approval letter, at least thirty (30) calendar days prior to the intended implementation of the change. Additionally, if there is a change in state or federal law, the Departments may, consistent with the federal regulations and the STCs, request additional information from the State as part of their responsibility to conduct oversight and monitoring to ensure that approved section 1332 waivers continue to meet the statutory guardrails.

The enclosed STCs further define the State's responsibilities with respect to implementation of the waiver; use of pass-through funding during the waiver period; and the nature, character, and extent of anticipated federal oversight of the waiver. STCs 11 and 15 both contemplate that the Departments may require periodic reporting of information in addition to the items specifically enumerated therein. Given the novel nature of Nevada's waiver, it is likely that periodic reporting of additional information will be required. The State is encouraged to engage with the Departments early in the process if it is interested in amending or extending its waiver plan. The required information and process may vary based on the complexity of the proposed change or extension. A breach of any of the STCs may lead to termination of Nevada's section 1332 waiver.

Departments' Determination

Based on consideration of the analysis and information submitted by the State as part of its waiver application, along with the State's responses to questions from the Departments during the review period and consideration of the Departments' experience with existing section 1332 waivers and other health programs, and public comments, the Departments have determined that Nevada's waiver plan meets the statutory guardrail requirements in sections 1332(b)(1)(A)-(D) of the ACA.

First, the Departments have determined that the State's section 1332 waiver is projected to provide coverage that is at least as comprehensive as coverage provided without the waiver. More specifically, the waiver plan will not alter the essential health benefits provided in individual health insurance coverage offered through the Exchange, as BBSPs will be offered as QHPs and will provide essential health benefits for those enrolled.

The Departments have determined that the State's waiver is also projected to, in each year of the waiver, provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable as would be provided without the waiver. Under state law[3], and under the approved waiver, BBSPs are required to reduce premiums by certain targets including by at least 3% in the first year of the waiver (2026) and 15% by the fourth year of the waiver (2029) relative to the 2024 second-lowest cost silver plan for the relevant county. In addition, the Nevada Department of Health and Human Services and Division of Insurance have new and existing programmatic and regulatory authorities to support the premium reduction targets through BBSP contracting and rate review proceedings.[4] The State's waiver plan also includes implementation of a premium relief program, which will provide a premium subsidy for reenrolling enrollees whose net premium is projected to increase regardless of whether they enroll in a BBSP or non-BBSP, as well as additional premium relief, as needed, as discussed further below.

The State projects that net premiums will decrease in each year of the waiver, improving affordability for unsubsidized enrollees and certain subsidized enrollees. Under the waiver, the State has projected average net premium rates in the individual market will be lower than without the waiver by 0.2% in plan year (PY) 2026, 3.1% in PY 2027, 4.1% in PY 2028, 5.7% in PY 2029, and 5.9% in PY 2030 due to the State's reinsurance program and BBSP premium reduction targets. There are no projected changes in affordability for the small group market. The Departments have reviewed the actuarial assumptions underlying Nevada's estimated premium reductions and conducted an internal analysis and also found that the proposed premium reductions are feasible. For example, 2021-2022 Medical Loss Ratio data suggest that there is excess premium (on average approximately 4%) in the individual market plans in Nevada which could allow for issuers to reduce premiums. The State's estimate of the premium reductions attributable to reinsurance is consistent with other approved waivers implementing state reinsurance programs.[5]

The Departments greatly appreciate Nevada's engagement during the waiver review process. Nevada's original, December 2023 submission projected increases in average net premiums in the first year of the waiver. The Departments would not have been able to approve that proposal as it would have violated the statutory affordability guardrail. The State subsequently modified the waiver plan to provide a premium relief program and a reinsurance program beginning in the first year of the waiver. The State's updated projections provided in the January addendum estimate no increase in average net premiums in each year of the waiver compared to without the waiver.

Because the BBSP take-up rate is both uncertain and a key determinant of average net premiums, in accordance with STC 11, the State will monitor BBSP take-up rates; if take-up at the close of Open Enrollment is less than 35%, the State will provide additional premium relief as part of the premium relief program to ensure there is no increase in average net premiums relative to the without-waiver baseline. The State beginning the reinsurance program in 2026 and the State's premium relief program (including the additional premium relief requirement in STC 11) would

[3] NRS 695K.210, available at: https://www.leg.state.nv.us/nrs/NRS-695K.html#NRS695KSec210.
[4] *ibid.*
[5] See Table 5, https://www.cms.gov/files/document/cciio-data-brief-042024-508-final.pdf

insulate certain subsidized enrollees from increases in premium contributions, and result in savings experienced by unsubsidized individuals and some subsidized enrollees due to the BBSP premium reduction targets[6] and the State's reinsurance program; the combination of these policies result in the waiver meeting the affordability guardrail for plan year 2026. The Departments have therefore determined that the waiver meets the affordability guardrail.

The Departments have determined that the State's waiver satisfies the coverage guardrail, meeting the statutory requirement that the waiver is projected to provide coverage to at least a comparable number of state residents as would be provided without the waiver. Under the waiver and compared to the without-waiver baseline, Nevada projects that individual market enrollment will increase slightly in each year of the waiver: by 600 enrollees in PY 2026, 1,800 enrollees in PY 2027, 1,800 enrollees in PY 2028, 1,900 enrollees in PY 2029, and 2,000 enrollees in PY 2030. We note that Nevada can still meet the coverage guardrail even if the actual enrollment impact is somewhat lower than the State estimates, since a section 1332 waiver is not required to increase enrollment, but rather, must provide coverage to a comparable number of people as would be provided absent the waiver, in order to meet the statutory coverage guardrail.

Finally, the Departments have determined that the waiver is not projected to increase the federal deficit. Compared to without the waiver, the Departments project lower individual market premiums in the State and thus a net decrease in federal spending on premium tax credits (PTC) in the individual market in PY 2026 and over the five-year waiver period due to market-wide premium reductions resulting from implementation of a reinsurance program and the introduction of BBSPs. These PTC savings will be passed through to the State to be used for implementation of the waiver plan. Nevada projects net federal savings of $31 million in PY 2026, and a total of $322 million in net federal savings over the five-year waiver period due to premium reductions for BBSPs and the implementation of a reinsurance program.

Consideration of Public Comments

To increase transparency, section 1332(a)(4)(B) of the ACA requires the establishment of a process for public notice and comment on a state's section 1332 waiver application that is sufficient to ensure a meaningful level of public input. This includes a state-level public comment period (generally occurring prior to application submission), as well as a federal public comment period after the state's application is received and deemed complete by the Secretary of Health and Human Services and the Secretary of the Treasury (collectively, "the Secretaries").[7]

Prior to submitting its waiver application to the Departments on December 29, 2023, the Nevada Department of Health and Human Services hosted six public comment sessions to gather feedback on its proposed waiver application.

The Departments conducted two federal comment periods, during which they received a total of 44 comments, the majority of which generally supported the waiver proposal. The first 30-day

[6] Even if the premium reductions achieved are less than the targets set by the State, the Departments still project that coverage will be at least as affordable as it would be without the waiver.

[7] Requirements for the State comment period are codified at 31 C.F.R. § 33.112(a)(1) and 45 C.F.R. § 155.1312(a)(1), while federal public comment period requirements are codified at 31 C.F.R. § 33.116 and 45 C.F.R. § 155.1316.

federal comment period on the initial waiver application submitted on December 29, 2023, was held from February 12, 2024, through March 14, 2024. During this period, the Departments received a total of 35 comments. The second 30-day federal comment period on the addendum to the waiver application submitted on August 23, 2024, was conducted from August 26, 2024, through September 25, 2024. The Departments received nine public comments during this second federal comment period.

The Departments shared all comments received during the federal comment periods with the State for its review and consideration and have also posted them on the CMS section 1332 waiver website.[8] The Departments also sent Nevada a series of questions throughout the review period of the waiver application. These questions, and the responses from Nevada, are also posted on the CMS section 1332 waiver website.[9] A summary of major themes raised in the public comments and the Departments' responses are provided in Appendix A.

Next Steps

Please send your written acceptance and any communications and questions regarding program matters or official correspondence concerning the waiver to lina.rashid@cms.hhs.gov or stateinnovationwaivers@cms.hhs.gov.

Congratulations. We look forward to working with you and your staff. Please do not hesitate to contact us if you have any questions.

Sincerely,

Chiquita Brooks-LaSure

Enclosure

CC: Aviva Aron-Dine, Deputy Assistant Secretary, Tax Policy, U.S. Department of the Treasury
The Honorable Joe Lombardo, Governor, State of Nevada
Stacie Weeks, Administrator, Division of Health Care Financing Policy, Nevada Department of Health and Human Services

[8] https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers
[9] *Ibid.*

Appendix A: Summary and Responses to Major Themes
Raised in Public Comments Submitted During the Federal Comment Periods

The Department of Health and Human Services (HHS), as well as on behalf of the Department of the Treasury (collectively, "the Departments"), received a total of 44 comments during two federal public comment periods; of these, 23 were from organizations and 21 were from individuals. The majority of comments received during both federal public comment periods supported Nevada's waiver plan.

The Departments received 35 comments during the federal public comment period held from February 12, 2024, through March 14, 2024, on Nevada's initial waiver application, which was submitted on December 29, 2023.

On March 20, 2024, Nevada requested the Departments pause their review of the waiver application as the State planned to submit an addendum to update the waiver plan and actuarial assumptions. On August 23, 2024, Nevada submitted an addendum (the "August addendum") to its waiver application detailing an updated reinsurance program, adjustments to premium reduction targets, a targeted premium relief program for certain enrollees in the State Exchange, outreach strategies, and a requirement for Battle Born State Plan (BBSP) issuers to offer at least one bronze BBSP and one silver non-BBSP.

On August 23, 2024, the Departments resumed review of the waiver application, including the August 23, 2024, addendum submitted by Nevada. In response to this August addendum, the Departments conducted a second federal public comment period from August 26, 2024, through September 25, 2024, during which the Departments received nine comments.

On January 1, 2025, Nevada submitted an addendum in response to feedback from the Departments and public comments. The State also submitted updates to this addendum on January 6, 2025 (collectively, the "January addendum").

Guardrails and Premium Reduction Targets

Public Comments:

Many commenters who submitted comments in support of Nevada's proposed waiver expressed that the Departments should approve the waiver application as it satisfies the statutory guardrails and would improve affordability and coverage. Many of the comments from individuals included personal stories centered on affordability as a barrier to coverage and access; for example, one commenter stated: "Many Nevadans, like myself go without care or are forced to make difficult choices between necessities like food, rent and getting the care we need."

Some commenters noted that public option programs, generally, and the State's waiver plan, specifically, would result in significant savings on federal premium tax credit (PTC) spending due to lower premiums. Two comments in response to the August addendum noted that the addition of a premium relief program for certain Exchange enrollees would further improve affordability. A few commenters appreciated the August addendum's additional focus on consumer outreach and enrollment assistance, stating that these activities would increase coverage and help consumers make more informed decisions about their health insurance needs.

Some commenters expressed concern that Nevada's premium reduction targets are unrealistic, and that the waiver application did not sufficiently demonstrate that the waiver would result in the projected federal savings. A few commenters stated that public option programs reduce competition and do not improve affordability. In response to Nevada's initial waiver application, one commenter asserted that market forces would have driven premiums down if it were feasible to decrease premiums without resulting in issuer insolvency. A few commenters also noted that meeting premium reduction targets could necessitate constraining administrative costs, and felt this would result in reduced services for enrollees and be particularly challenging in light of the administrative requirements for BBSPs. In response to the August addendum, one commenter expressed concern that issuers would be unable to achieve the premium reduction targets because providers would be required to join only one BBSP network and issuers would be unable to negotiate provider reimbursement rates effectively. Two commenters who were opposed to the waiver application supported the adjusted premium target methodology described in the August addendum while maintaining their opposition to the waiver overall.

Departments' Response:
The Departments appreciate commenters' support for the waiver application and agree that Nevada's waiver plan will improve affordability and coverage for Nevadans and that the outreach and enrollment efforts will support Nevadans in making informed health insurance choices. Based on consideration of the analysis and information submitted by the State as part of its waiver application, along with the State's responses to questions from the Departments during the review period and consideration of the Departments' experience with existing section 1332 waivers and other health programs, and public comments, the Departments have determined that Nevada's waiver plan meets the statutory guardrail requirements in sections 1332(b)(1)(A)-(D) of the ACA. In evaluating the statutory guardrails, the Departments considered the impact of the entire waiver on each guardrail compared to the without-waiver baseline. An explanation of the Departments' determination that the Nevada waiver plan meets the guardrails is included in the letter to the State.

The Departments have considered the possibility that issuers will not achieve the premium reduction targets required by the State and have determined that, even with premium reductions that are less than the targets set by the State, the waiver is still projected to result in with-waiver premiums that are lower than without-waiver premiums, and the waiver would still be projected to meet the guardrails.[1] Even if the premiums under the waiver are the same as premiums absent the waiver, the waiver would still provide coverage that is as affordable as without the waiver. However, the Departments appreciate commenters' concerns regarding the required premium reductions and their potential impact on issuers and the individual market in Nevada. Based on public comments and the Departments' review of Nevada's initial waiver application, the Departments asked the State to provide more information.[2] In the August addendum, the State adjusted its methodology for calculating the premium reduction targets for BBSPs and revised its approach to the reinsurance program to include statewide reinsurance parameters to address

[1]The comprehensiveness guardrail would also still be met if issuers do not meet the premium reduction targets because the coverage provided under the waiver would be as comprehensive as the coverage defined in section 1302(b) of the ACA and offered through Exchanges.
[2] The Departments' questions and the State's responses are available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers

concerns about varying levels of difficulty for different issuers to meet the premium reduction targets and geographic variation in reinsurance rates. Further, after submitting the August addendum the State adjusted its waiver plan in the January addendum to include implementation of the reinsurance program in the first year of the waiver to improve affordability in response to public comments. Moreover, per the Specific Terms and Conditions (STCs), the State will agree to provide additional premium relief as described in STC 11, if the BBSP take-up rate is less than 35% to ensure there is no increase in average net premiums in any year of the waiver. The Departments' review of the State's analysis confirmed that it accounts for current pricing and that the State's assumptions regarding issuer participation and the potential for provider rate reductions under the waiver are reasonable, and the Departments will continue to monitor issuer participation. Further, the Departments have reviewed the actuarial assumptions underlying Nevada's estimated premium reductions and conducted an internal analysis and also found that the proposed premium reductions are feasible.

Regarding the comments expressing concern that meeting premium reduction targets could lead to issuer insolvency, monitoring to ensure actuarially sound rates and issuer solvency are components of the State's proposed bidding and contracting processes. Further, the State responded to public comments received during the first federal public comment period by revising the premium reduction targets to allow issuers with less competitive rates to meet the premium reduction targets more gradually than issuers with more competitive rates, as described in the August addendum.

BBSP Contracting and Issuer Participation in Medicaid and the Exchange

Public Comments:

A few commenters expressed that requiring issuers bidding to become Medicaid managed care organizations (MCOs) in the State to submit a good faith bid to offer BBSPs could discourage issuers from participating in Nevada's Exchange and Medicaid program and could risk issuer insolvency. One commenter noted that Medicaid and the individual market differ in terms of populations served, provider contracting practices, and regulatory requirements, such that this requirement would harm competition and choice in Nevada's Medicaid program. Another commenter noted that there was insufficient time for MCOs to submit competitive bids.

A few commenters in support of the waiver noted that linking Medicaid and BBSP contracting would allow the State to leverage existing Medicaid tools for improving care delivery and controlling costs and could ease coverage transitions and improve continuity of care. One commenter noted that Medicaid MCOs are already required to offer QHPs in Nevada.

Departments' Response:

The Departments appreciate the comments noting that leveraging the Medicaid contracting process may facilitate cost control and quality improvements through BBSPs. The Departments acknowledge commenters' concerns about issuer participation in Nevada's Exchange and Medicaid program. Although the State does not anticipate any issuer would leave the individual market in response to the waiver, the State does have authority to require all issuers bidding for MCO contracts to submit "good faith bids." All current MCOs in Nevada offer QHPs on the state Exchange and are familiar with the population, costs, regulatory requirements, and structure of QHPs in Nevada. In addition, the provider reimbursement rate floor included in the BBSP

statute[3] and the State's analysis of current provider rates suggest that there is room for negotiation with providers.

In addition to market conditions and trends in issuer participation in Nevada since the state law requiring establishment of a public option program[4] was signed into law on June 9, 2021, and step 1 of the 2026 request for proposals for BBSP issuers was issued on August 23, 2024, Nevada has reported no decrease in issuer participation. The waiver plan also includes a reinsurance program, which has expanded issuer participation in some states with approved section 1332 waivers implementing state reinsurance programs. The State received responses to its request for proposals to offer BBSPs from 7 issuers, some of which are not currently serving as Medicaid MCOs. Further, Nevada extended the deadline for good faith BBSP bid submissions from October 16, 2024, to October 23, 2024, and the deadline for full proposals from October 23, 2024, to October 31, 2024, to ensure interested issuers had adequate time to respond.

Network Adequacy and Provider Rates

Public Comments:

Several commenters supported Nevada's efforts to address provider shortages through the Practice in Nevada provider retention program. A few commenters expressed concern that negotiating lower provider rates and requiring providers participating in certain public health insurance programs to participate in one BBSP could lead to physicians leaving the State and/or to inadequate networks for BBSPs should providers contract with only one BBSP. A few commenters also stated that many providers are already accepting rates at or below the provider rate floor of 100% of Medicare rates set in state statute, limiting issuers' ability to negotiate lower rates.

Departments' Response:

The Departments appreciate commenters' support for the Practice in Nevada provider retention program. Regarding concerns that the provider participation requirements could cause hardship for providers or impact network adequacy, in the August addendum the State clarified processes for providers to seek exemption from the participation requirement and noted that it will require BBSP issuers to monitor and ensure providers accept BBSP enrollees at the same rate as patients enrolled in plans that are not BBSPs. The State's analysis of current provider rates suggests that, in the aggregate, provider rates are well above 100% of Medicare rates, suggesting that negotiating lower rates without violating this floor is feasible. Further, BBSP issuers will be required to comply with all QHP standards, including those related to network adequacy.

Reinsurance

Public Comments:

Several commenters supported the proposed reinsurance program or reinsurance programs generally, noting that reinsurance can improve affordability for enrollees. A few commenters expressed concern about the State's plan to fully fund the reinsurance program with pass-through funding because they were skeptical that the waiver would result in adequate pass-through funding and objected to the State's plan to potentially fine issuers who fail to comply with BBSP contracting requirements and use this funding to support the reinsurance program. In response to

[3] NRS Chapter 695K; See https://www.leg.state.nv.us/nrs/NRS-695K.html

[4] *Ibid.*

Nevada's initial waiver application, one commenter expressed concern that varying coinsurance rates by rating area would make it more challenging for issuers in rating areas with lower coinsurance rates to meet premium reduction targets. This same commenter submitted a comment during the second federal comment period and noted that they appreciated the updated parameters Nevada included in the August addendum, which addressed their prior concern.

A few commenters expressed that they would prefer the State invest pass-through funding in premium subsidies or other affordability policies for lower-income enrollees rather than reinsurance because they asserted that reinsurance does not improve affordability and could potentially result in less PTC for lower-income enrollees and has a smaller impact on coverage.

Departments' Response:
The Departments appreciate the support for Nevada's proposed reinsurance program and agree reinsurance will improve the affordability of coverage. The Departments also appreciate the comments on the importance of stable funding for reinsurance programs. The STCs for the waiver require in STC 3 that the State must ensure sufficient funds are available on an annual basis for the waiver to operate as described in the State's waiver plan. The Departments found the State's projections reasonable and determined that in the event premium reduction targets are not achieved by some issuers, the statutory guardrails would still be met.

Regarding comments urging the State to replace the reinsurance program with premium subsidies, the State included a targeted premium relief program for certain Exchange enrollees as part of its waiver addenda. Further, the State as specified in STC 11 will agree to provide additional premium relief as part of the premium relief program should take up of BBSPs fall short of projections so that there will be no increase in average net premiums in any year of the waiver. In responses to both comments urging that reinsurance funding be redirected to premium subsidies and those expressing concern that the State might fine issuers that do not comply with BBSP contract requirements, the Departments defer to states to develop the scope of their waiver plans and remain committed to working with state partners to advance health care coverage and affordability policies. The updates to the State's waiver plan in the January addendum adjusted the reinsurance program to begin in the first year of the waiver plan and added the premium relief requirement in STC 11 to further improve affordability for enrollees. These changes are consistent with public comments and the Departments' feedback.

DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS)
U.S. DEPARTMENT OF THE TREASURY
PATIENT PROTECTION AND AFFORDABLE CARE ACT SECTION 1332 STATE INNOVATION WAIVER
SPECIFIC TERMS AND CONDITIONS
TITLE: State of Nevada-Patient Protection and Affordable Care Act Section 1332 Waiver Approval
AWARDEE: The State of Nevada Department of Health and Human Services

I. PREFACE

The following are the specific terms and conditions (STCs) for the State of Nevada Department of Health and Human Services' (hereafter referred to as "the State") Patient Protection and Affordable Care Act (ACA)[1] section 1332 State Innovation Waiver to implement state-contracted qualified health plans (QHPs) known as Battle Born State Plans (BBSPs) and a Market Stabilization Program for the individual health insurance market (hereafter referred to as "the waiver" or "the waiver plan"), which has been approved by the U.S. Department of Health and Human Services (HHS) and the U.S. Department of the Treasury (collectively, "the Departments"). These STCs govern the operation of the waiver by the State. The STCs set forth, in detail, the State's responsibilities to the Departments related to the waiver. These STCs are effective beginning January 1, 2026, through December 31, 2030, unless the waiver is extended, otherwise amended, suspended, or terminated by the parties in accordance with the applicable processes set forth in and provided by these STCs; however, the Departments reserve the right to amend these STCs when the Departments make the annual determination of the pass-through amount for plan years 2026 through 2030. The State's final waiver application[2] to waive certain provisions of the ACA is specifically incorporated by reference into these STCs, except with regard to any proposal or text in the waiver plan that is inconsistent with the Departments' approval of the waiver or these STCs.

1. ACA Provision Waived under Section 1332 State Innovation Waiver (Section 1332 waiver). Section 1312(c)(1) of the ACA as implemented at 45 C.F.R. § 156.80(d)(2) to the extent it would otherwise prohibit plan-level rating variation(s) for BBSPs in the individual market. Additionally, section 1312(c)(1) of the ACA is waived for the purposes of operating a state reinsurance program to the extent it would otherwise require excluding total expected State reinsurance payments when establishing the market-wide index rate.

2. Changes in State Law and Technical Changes to the Waiver. The State must inform the Departments of any change in state law or regulations that could impact the waiver, including any changes to the requirements of the State's waiver plan, or any

[1] The Patient Protection and Affordable Care Act (Pub. L. 111-148) was enacted on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), which amended and revised several provisions of the Patient Protection and Affordable Care Act, was enacted on March 30, 2010. In these STCs, the two statutes are referred to collectively as the "Patient Protection and Affordable Care Act" or "ACA."
[2] The State's "final waiver application" or "waiver plan" refer to the December 29, 2023, application, the August 23, 2024, addendum, and the January addendum.

proposed technical changes to the waiver occurring after the date of this approval letter, at least thirty (30) calendar days prior to the intended implementation date of the change. Changes might be considered technical changes if they are routine changes of an operational nature that do not impact whether the statutory guardrails (as set forth in sections 1332(b)(1)(A)-(D) of the ACA) are met, and which do not materially impact, such as by establishing or eliminating, any obligations of the State or the Departments with respect to the waiver.[3] The State must consult with the Departments well in advance of implementing any change and must receive confirmation from the Departments that the change is a technical change prior to implementation of the change. The Departments will consider the facts and circumstances of each proposed change and reserve discretion to request additional information from a state when determining whether a proposed change is a technical change or requires submission of a waiver amendment request.[4] If the Departments determine that the change to the State's waiver plan is not a technical change but instead would be an amendment, the State must submit a waiver amendment request as set forth in STC 9 and receive approval from the Departments prior to implementing the change described in the waiver amendment request.

Consistent with the State's waiver, the State is responsible for any reconciliation of reinsurance payments that it wishes to make to account for any duplicative reimbursement through the State's reinsurance program for the same high-cost claims reimbursed through the HHS-operated risk adjustment program. This is also considered a technical change to the State reinsurance program.

3. Funds to Operate the Waiver. The State's waiver plan will be funded through a combination of federal pass-through funding and funding from state appropriations, if necessary. The State must ensure sufficient funds are available on an annual basis for the waiver to operate as described in the State's waiver plan.[5]

4. Compliance with Federal Non-Discrimination Statutes. The State must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, title I and II of the Genetic Information Nondiscrimination Act of 2008 and section 1557 of the ACA.

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[3] Generally, changes that are operational in nature that comply with standard requirements in statute and regulations established for minimum essential coverage or the operation of state-based exchanges might be considered technical changes unless the change could impact whether the waiver can continue to meet the statutory guardrails or could materially impact, such as by establishing or eliminating, the obligations of the State or the Departments with respect to the waiver. While the Departments ultimately determine if a change is considered a technical change, some examples of routine changes of an operational nature that, implemented alone or in combination, may constitute technical changes are: changes to premium reduction targets, changes in the parameters (e.g. the program size, coinsurance rate, attachment point, or cap) of the state reinsurance program, certain changes in state subsidies for certain Exchange enrollees, or changes to the parameters of the quality incentive pool or Practice in Nevada provider retention program.

[4] Failure to provide requested information in a timely manner may result in delays in the Departments' determination as to whether the change is a technical change or requires submission of a waiver amendment request.

[5] The Departments emphasize that the State must ensure sufficient funding for the components of the waiver that have a direct impact on the statutory guardrails. These components include supporting the state premium subsidies for certain Exchange enrollees, any administrative costs associated with the waiver plan (such as BBSP contracting and monitoring), and the state reinsurance program. To the extent funds are available, as described in the State's waiver plan, the State's waiver will also include a quality incentive pool and the Practice in Nevada provider retention program. Pass-through funding may not be used as matching funds for the federal loan forgiveness program.

5. Compliance with Applicable Federal Laws. Per 31 C.F.R. § 33.120(a) and 45 C.F.R.§ 155.1320(a), the State must comply with all applicable federal laws and regulations, unless a law or regulation has been specifically waived. The Departments' State Innovation Waiver authority is limited to requirements described in section 1332(a)(2) of the ACA. Further, section 1332(c) of the ACA states that while the Secretaries of the Departments have broad discretion to determine the scope of a waiver, no federal laws or requirements may be waived that are not within the Secretaries' authority. *See* 77 Fed. Reg. 11700, 11711 (February 27, 2012). Therefore, for example, section 1332 of the ACA does not grant the Departments authority to waive any provision of the Employee Retirement Income Security Act of 1974. The State must also comply with requirements of the Cash Management Improvement Act.

6. Changes to Applicable Federal Laws. The Departments reserve the right to amend, suspend, or terminate the waiver, these STCs, or the pass-through funding amount as needed to reflect changes to applicable federal laws or changes of an operational nature without requiring the State to submit a new waiver proposal. In the event that any aspect, term, or provision of this waiver or these STCs is held invalid, illegal, or unenforceable by a court in any jurisdiction, such invalidity, illegality, or unenforceability shall not affect any other aspect, term, or provision of this waiver or these STCs provided that the remaining aspects, terms, and provisions of the waiver continue to comply with the statutory guardrails. The Departments will notify the State at least thirty (30) calendar days in advance of the expected implementation date of the amended STCs, if applicable, to allow the State to discuss the changes necessary to ensure compliance with law, regulation, and policy, to allow the State adequate time to come into compliance with state and federal requirements (including rate review and consumer noticing requirements), and to provide comment, if applicable. Changes will be considered in force upon the Departments' issuance of amended STCs. The State must accept the changes in writing within thirty (30) calendar days of the Departments' notification for the waiver to continue to be in effect. The State must, within the applicable timeframes, come into compliance with any changes in federal law or regulations affecting section 1332 waivers, unless the provision being changed has been expressly waived for the waiver period. If any of the waived provision(s) identified in STC 1 are eliminated under federal law, the Departments would re-evaluate the waiver to see if it still meets all of the section 1332 waiver requirements. If the Departments determine that the waiver needs to be suspended or terminated as a result of a change to federal law, the Departments will provide further guidance to the State as to that process.

7. Finding of Non-Compliance. The Departments will review and, when appropriate, investigate documented complaints that the State is failing to materially comply with requirements specified in the State's waiver and these STCs. In addition, the Departments will promptly share with the State any complaint that they may receive and will notify the State of any applicable monitoring and compliance issues.

8. State Request for Suspension, Withdrawal, or Termination of a Waiver. The

State may only request to suspend, withdraw, or terminate all or portions of its waiver plan consistent with the following requirements:

(a) Request for suspension, withdrawal, or termination: If the State wishes to suspend, withdraw, or terminate all or any portion(s) of the waiver, the State must submit a request to the Departments in writing specifying: the reasons for the requested suspension, withdrawal, or termination; the effective date of the requested suspension, withdrawal or termination; and the proposed phase-out plan (with the summary of comments received, as described below). The State must submit its request and draft phase-out plan to the Departments no less than nine (9) months[6] before the proposed effective date of the waiver's suspension, withdrawal, or termination. Prior to submitting the request and draft phase-out plan to the Departments, the State must publish on its website the draft phase-out plan for a thirty (30) calendar day public comment period and conduct Federal tribal consultation as applicable. The State must include with its request and proposed phase-out plan a summary of each public comment received, the State's response to the comment and whether or how the State incorporated measures into a revised phase-out plan to address the comment.

(b) Departments' approval: The State must obtain the Departments' approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must begin no sooner than fourteen (14) calendar days after the Departments' approval of the phase-out plan, unless otherwise directed by the Departments.

(c) Recovery of unused funding: Any unused pass-through funding will be recovered. The State will comply with all necessary steps to facilitate the recovery within a prompt timeframe.

9. State Request for Amendment.

(a) Definition: For purposes of these STCs and per 31 C.F.R. § 33.130(a) and 45 C.F.R. § 155.1330(a), an amendment is a change to a waiver plan that is not otherwise allowable under these STCs, a change that could impact any of the statutory guardrails, or a change to the program design for an approved waiver.[7] Such potential changes could include, but are not limited to, changes to eligibility, coverage, benefits, premiums, out-of-pocket spending, and cost sharing. See STC 2 for information on changes that could be considered technical changes instead of a change that would require a waiver amendment.

(b) Amendment Request Submission Process: Consistent with 31 C.F.R. § 33.130 and 45

[6] This timeframe reflects the complexity and novel nature of Nevada's section 1332 waiver and the need for additional time for coordination and review of any waiver suspension, withdrawal, or termination requests submitted by the State.
[7] Modifications to waivers that are determined by the Departments to be technical changes are not considered waiver amendments and are not subject to the requirements outlined in STC 9 or 31 C.F.R. § 33.130 and 45 C.F.R. § 155.1330.

C.F.R. § 155.1330, to amend a waiver the State must comply with the following requirements:

(1) The State must submit a letter to the Departments notifying them in writing of its intent to request an amendment to its waiver plan(s). The State must include a detailed description of all of the intended change(s), including the proposed implementation date(s), in its letter of intent. The Departments encourage the State to submit its letter of intent at least fifteen (15) months prior to the waiver amendment's proposed implementation date and to engage with the Departments early in its development of a potential waiver amendment. The State may wish to submit this letter of intent more than fifteen (15) months prior to the waiver amendment's proposed implementation date, depending on the complexity of the amendment request and the timeline for implementation, among other factors.

(2) The Departments will review the State's letter of intent requesting changes to its waiver plan. Within approximately thirty (30) calendar days of the Departments' receipt of the State's letter of intent, the Departments will respond to the State and confirm whether the change requested is a waiver amendment, as well as identify the information the State needs to submit in its waiver amendment request. This written response will also include whether the proposed waiver amendment(s) would be subject to any additional or different requirements consistent with STC 9(c)(7).

For example, depending on the complexity of the amendment request, scope of changes from the waiver plan, operational/technical changes, or implementation considerations, the Departments may impose requirements similar to those specified in 31 C.F.R. § 33.108(f) and 45 C.F.R. § 155.1308(f) for new section 1332 waiver applications.

(3) The State should generally plan to submit its waiver amendment request in writing in electronic format, as outlined in STC 9(c), no later than nine (9) months prior to the waiver amendment's proposed implementation date in order to allow for sufficient time for review of the waiver amendment request. Similar to the regulations at 31 C.F.R. § 33.108(b) and 45 C.F.R. § 155.1308(b) for new waiver applications, the State must submit the waiver amendment request sufficiently in advance of the requested waiver amendment implementation date, particularly when the waiver plan or requested amendment could impact premium rates, to allow for an appropriate review and implementation timeframe. Depending on the complexity of the amendment request, the State may want to submit the amendment request earlier than nine (9) months prior to implementation. In developing the implementation timeframe for its waiver amendment request, the State must maintain uninterrupted operations of the Exchange in the State and provide adequate notice to affected

stakeholders and issuers of health insurance plans that would be (or may be) affected by the amendment to take necessary action based on approval of the waiver amendment request.

(4) The Departments reserve the right to deny or withhold approval of a state waiver amendment request based on non-compliance with these STCs or any additional direction and information requests from the Departments, including a failure by the State to submit required reports and other deliverables in a timely fashion.

(5) The State is not authorized to implement any aspect of the proposed amendment without prior approval from the Secretaries.

(c) Content of Amendment Application: All amendment applications are subject to approval at the discretion of the Secretaries in accordance with section 1332 of the ACA. The State must furnish such information and analysis regarding the proposed waiver amendment that is necessary to permit the Departments to evaluate the request. A waiver amendment request must include the following:

(l) A detailed description of the requested amendment, including the time period for the proposed amended waiver, impact on the statutory guardrails, the scope of the proposed amendment to the waiver plan—including whether the State seeks to waive any new provisions and the rationale for the waiver—and related changes to the waiver plan elements as applicable, including sufficient supporting documentation;

(2) An explanation and evidence of the process used by the State to ensure meaningful public input on the proposed waiver amendment request. The State must conduct the State public notice process that is specified for new applications at 31 C.F.R. § 33.112 and 45 C.F.R. § 155.1312. It may be permissible for a state to use its annual public forum required under 31 C.F.R. § 33.120(c) and 45 C.F.R. § 155.1320(c) for the dual purpose of soliciting public input on a proposed waiver amendment request and on the progress of its waiver plan;

(3) Evidence of sufficient authority under state law(s) in order to meet the requirement in section 1332(b)(2)(A) of the ACA for purposes of pursuing the waiver amendment request;

(4) An implementation plan with operational details (if appropriate) to demonstrate that the waiver would maintain uninterrupted operations of the Exchange in the State, and provision of adequate notice for stakeholders and issuers of health insurance plans that would be (or may be) affected by the proposed amendment to take necessary action based on approval of the waiver amendment request;

(5) An updated actuarial and/or economic analysis demonstrating how the

waiver, as amended, will meet the statutory guardrails. Such analysis must identify the "with waiver" impact of the requested amendment on the statutory guardrails. Such analysis must include a "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using data from recent experience, as well as a summary of and detailed projections of the change in the "with waiver" scenario;

(6) An explanation of the estimated impact, if any, of the waiver amendment on pass-through funding, as well as any new proposed uses for pass-through funding if applicable; and

(7) Any further requested information and/or analysis that is determined necessary by the Departments to evaluate the waiver amendment request.

10. State Request for Waiver Extension.

(a) Definition: For purposes of these STCs and per 31 C.F.R. § 33.132 and 45 C.F.R. § 155.1332, an extension is an extension of an approved waiver under the existing waiver terms.

The waiver extension request and approval process is separate from the waiver amendment request and approval process described in STC 9, with separate timelines and requirements. An extension request can only include an extension of the existing waiver terms, not other changes to the existing waiver plan. If a state also seeks to make substantive changes to its waiver plan along with seeking an extension, the Departments will treat those changes as amendments and the requirements of STC 9 will also apply.

(b) Extension Request Submission Process: Consistent with 31 C.F.R. § 33.132 and 45 C.F.R. § 155.1332, to extend the waiver the State must comply with the following requirements:

(l) The State must inform the Departments if the State will apply for an extension of its waiver at least one (1) year prior to the waiver's end date. The State must submit a letter of intent in electronic format to the Departments to notify them in writing of its intent to request an extension of its waiver plan. The State must include a detailed description of the requested extension period in the letter of intent. The Departments will then review the State's letter of intent request. Within approximately thirty (30) calendar days of the Departments' receipt of the letter of intent, the Departments will respond to the State and confirm whether the extension request will be considered an extension request and, if applicable, whether the request includes changes that would be considered an amendment request subject to the separate process and requirements set forth in STC 9. The Departments' response will also identify the information the State needs to submit in its waiver extension request.

(2) The State must submit its waiver extension request in writing in electronic format, consistent with the format and manner requirements applicable to initial waiver applications under 31 C.F.R. § 33.108(a) and 45 C.F.R. § 155.1308(a).

(3) An extension request shall be deemed granted unless the Secretaries, within ninety (90) calendar days after the date of the State's submission of a complete waiver extension request, either deny such request in writing or inform the State in writing with respect to any additional information needed to make a final determination with respect to the request.

(4) The Departments reserve the right to deny a state's waiver extension request based on non-compliance with these STCs or any additional direction and information requests from the Departments, including a failure by the State to submit required reports and other deliverables in a timely fashion.

(c) Content of Extension Application: All extension applications are subject to approval at the discretion of the Secretaries in accordance with section 1332 of the ACA. The State must furnish information and analysis regarding the proposed waiver extension that is necessary to permit the Departments to evaluate the request. In addition to the periodic reports required by 31 C.F.R. § 33.124 and 45 C.F.R. § 155.1324, the Departments may require additional data and information to be submitted to review the extension request in accordance with 31 C.F.R. § 33.120(f)(2) and 45 C.F.R. § 155.1320(f)(2). A waiver extension request may be required to include the following information:

(l) Updated economic or actuarial analyses for the requested extension period in a format and manner specified by the Departments;

(2) Preliminary evaluation data and analysis from the existing waiver;

(3) Evidence of sufficient authority under state law(s) to meet the requirement in section 1332(b)(2)(A) of the ACA for purposes of pursuing the waiver extension request;

(4) An explanation of the process followed by the State to ensure meaningful public input on the proposed waiver extension request at the state level. It may be permissible for the State to use its annual public forum under 31 C.F.R. § 33.120(c) and 45 C.F.R. § 155.1320(c) for the dual purpose of soliciting public input on a proposed waiver extension request and on the progress of its waiver plan;[8] and

(5) Other information as requested by the Departments that is necessary

[8] *Ibid.*

to reach a decision on the waiver extension request.

The Departments will identify the information the State needs to submit as part of its waiver extension request in its response to the State's letter of intent.

(d) Temporary Extension of Waivers: The Departments may extend an existing waiver program on a temporary basis for an additional year while a waiver extension request is under review, without regard to the date when the extension application was submitted.

(e) End of Waiver Period: If the State does not submit an extension request before the end of the waiver period consistent with STC 10(b)(1), the Departments will provide guidance on wind-down of the State's waiver.

11. Reporting and Additional Premium Relief. The State must submit quarterly and annual reports as specified in 31 C.F.R. § 33.124 and 45 C.F.R. § 155.1324, and other reports as specified below.

Annual Reports: The State must submit a draft annual report to the Departments within ninety (90) calendar days after the end of the first waiver year and each subsequent year that the waiver is in effect. The State will publish the draft annual report on the State's public website within thirty (30) calendar days of submission to the Departments. Within sixty (60) calendar days of receipt of comments from the Departments on the report, the State must submit to the Departments the final annual report for the waiver year, summary of the comments, and all public comments received as part of the post-award forum process. The State must publish the final annual report on the State's public website within thirty (30) calendar days of approval by the Departments.

Report Contents: Each such annual report must include:

(a) The progress of the waiver;

(b) Data and metrics sufficient to show compliance and assist evaluation of the waiver's compliance with sections 1332(b)(l)(A) through (D) of the ACA:

(1) Projected and actual individual market enrollment in the State, both through the Exchange and off-Exchange.

(2) Projected and actual average individual market premium rate (i.e., total individual market premiums divided by total member months of all enrollees).

(3) The actual Second Lowest Cost Silver Plan (SLCSP) premium under the waiver, and an estimate of the SLCSP premium as it would have been without the waiver and with the BBSPs alone, for a representative consumer (e.g., a 21-year-old non-smoker) in each rating area.

(4) The State's network adequacy requirements, including but not limited to: the number of BBSPs that meet the network adequacy requirements for ACA plans, data collected by the State and issuers related to enrollee and provider complaints, and qualitative data from stakeholders shared during the annual post-award forum;

(c) A summary of the annual post-award public forum, held in accordance with 31 C.F.R. § 33.120(c) and 45 C.F.R. § 155.1320(c), including all public comments received at such forum regarding the progress of the waiver and action taken in response to such concerns or comments;

(d) Technical changes to the State's waiver plan, including the funding level the program will be operating at for the next plan year, or other waiver plan changes as specified in STC 2;

(e) Notification of changes to state law or regulations that may impact the waiver as specified in STC 2;

(f) Reporting of:

(1) Federal pass-through funding spent on reinsurance claim payments to issuers from the State reinsurance program and/or operation of the reinsurance program;

(2) Federal pass-through funding spent on State subsidies for certain Exchange enrollees;

(3) Federal pass-through funding spent on the quality improvement and Practice in Nevada provider retention programs; and

(4) The unspent balance of federal pass-through funding for the reporting year, if applicable;

(g) The amount of State funding from State appropriations (if any), or other funding to support the waiver, specifically: 1) any funds designated by the State to provide reinsurance to issuers that offer individual health benefit plans in the State or any other money from any other source accepted to fully fund the State's reinsurance program for the reporting year, and 2) any State funds allocated to other aspects of the waiver;

(h) A description of any incentives for providers, enrollees, and issuers to continue managing health care cost and claims for individuals eligible for reinsurance;

(i) Reporting specific to the premium relief program:

(1) The number of enrollees who received State subsidies as part of the premium relief program stratified by income (≤ 100% of FPL, >100-133% of FPL, >133 150% of FPL, >150 200% of

FPL, >200 250% of FPL, >250 300% of FPL, >300 400% of FPL, and >400% of FPL), metal level (bronze, silver, and gold), and plan type (BBSP or non-BBSP).

(2) The with- and without-waiver market-wide average net premium, and the accompanying data and methodology the State used for these calculations. Subsidy schedule parameters and the State's detailed methodology for calculating the premium relief subsidies for enrollees (if different parameters and methodologies were used for different subpopulations, the State should detail these differences as well).

(j) *If applicable:* A report on the reconciliation (if any) of reinsurance payments that are duplicative of reimbursement through the HHS-operated risk adjustment program high-cost risk pooling mechanism. The report should include the State's reinsurance program reinsurance payment (before reconciliation) for high-cost claims to issuers who also receive payment through the HHS-operated risk adjustment program under the high-cost risk pooling mechanism, the high-cost risk pool payment amount made by HHS for those claims, and the reinsurance true-up amount applied; and

(k) Other information the Departments determine is necessary to calculate pass-through amounts or to evaluate the waiver.

Quarterly and Other Reports: Under 31 C.F.R. § 33.120(b), 31 C.F.R. § 33.124(a), 45 C.F.R. § 155.1320(b), and 45 C.F.R. § 155.1324(a), the State must conduct periodic reviews related to the implementation of the waiver. The State must report on the operation of the waiver quarterly, including, but not limited to reports of any ongoing operational challenges and plans for and results of associated corrective actions, no later than sixty (60) calendar days following the end of each calendar quarter. The State can submit its annual report in lieu of their fourth quarter report.

Rate Filing Schedule: The State will inform the Departments of the number and names of issuers participating in each rating area for the upcoming plan year at initial and final rate filings within seven (7) calendar days of posting the initial and final rate filings, and in the first year of the waiver the number of issuers participating in each rating area in the previous plan year, to allow the Departments to monitor market stability, issuer participation, and the breadth of plan offerings.

BBSP Implementation Report: The State must submit an annual BBSP implementation report to the Departments including the data and methodology used to calculate: 1) the BBSP take-up rate, 2) the with- and without-waiver market-wide average net premium (i.e., the average net premium for the individual market), and 3) the eligibility criteria and subsidy schedules for state subsidies for certain enrollees in the Exchange, including any adjustments to the subsidy schedules in response to the BBSP take-up rate as specified in the Additional Premium Relief Implementation section. In order for the Departments to effectively monitor guardrail compliance, the State must submit this information as early

in the applicable plan year as possible; if the BBSP take-up rate is less than the 35% threshold described in the additional premium relief implementation section, the State must submit this information at least thirty (30) calendar days in advance of the intended implementation date of the additional premium relief program required below, and in no event later than 120 calendar days prior to the end of the plan year.

Additional Premium Relief Implementation: In the first waiver year, and, as applicable, in subsequent years that the waiver is in effect, if take up of the BBSPs is under 35% (i.e., more than 5 percentage points below the level assumed in the State's waiver analysis) as of the close of Open Enrollment, the State will provide additional premium relief as part of the premium relief program beginning at the first feasible date, but no later than the end of the plan year, to ensure the market-wide average net premium for the plan year is no higher than without the waiver.

12. Post Award Forum. Per 31 C.F.R. § 33.120(c) and 45 C.F.R. § 155. 1320(c), within six (6) months of the waiver's effective date and annually thereafter, the State will afford the public an opportunity to provide meaningful comment on the progress of the waiver.[9] The State is required to publish the date, time, and location of the public forum in a prominent location on the State's public web site at least thirty (30) calendar days prior to the date of the planned public forum. Per 31 C.F.R. § 33.120(c) and 45 C.F.R. § 155.1320(c), the State must also include a summary of this forum as part of the quarterly report for the quarter in which the forum was held and the annual report as required under 31 C.F.R. § 33.124 and 45 C.F.R. § 155.1324 and as specified in STC 11.

13. Monitoring Calls. The State must participate in monitoring calls with the Departments that are deemed necessary by the Departments. The purpose of these monitoring calls is to discuss any significant actual or anticipated developments affecting the waiver. Areas to be addressed include the impact on the statutory guardrails set forth in sections 1332(b)(1)(A)-(D) of the ACA and state legislative or policy changes. The Departments will update the State on any federal policies and issues that may affect any aspect of the waiver. The State and the Departments will jointly develop the agenda for the calls. It is anticipated that these calls will occur at least semi-annually.

14. Federal Evaluation. The Departments will evaluate the waiver using federal data, state reporting, and the application itself to ensure that the Secretaries can exercise appropriate oversight of the approved waiver. Per 31 C.F.R. § 33.120(f) and 45 C.F.R. § 155.1320(f), if requested by the Departments, the State must fully cooperate with the Departments or an independent evaluator selected by the Departments to undertake an independent evaluation of any component of the waiver. As part of this required cooperation, the State must submit all requested data and information to the Departments or the independent evaluator. The Departments may charge the State for evaluation costs to the federal government.

15. Pass-through Funding. Under section 1332(a)(3) of the ACA, pass-through

[9] *Ibid.*

funding is based on the amount of premium tax credits (PTC) that would have been provided to individuals in the State under section 36B of the Internal Revenue Code absent the waiver, but that will not be provided under the State's waiver, reduced, if necessary, to ensure deficit neutrality as required by section 1332(b)(1)(D) of the ACA. The State will receive pass-through funding for the purpose of implementing the waiver, including administration of the waiver, when the requirements described below are met.

For the 2026 plan year and each plan year thereafter, by September 15 of the preceding year or once the State has finalized rates for the applicable plan year, whichever is later, the State will provide the following information to the Departments:

(a) The final SLCSP rates and plan IDs for individual health insurance coverage for a representative individual (e.g., a 21-year-old non-smoker) in each rating area or service area (if premiums vary by geographies smaller than rating areas) for the applicable plan year that are actuarially certified. Also include the actuarial memorandums;

(b) The estimates of what the final silver plan rates and plan IDs for individual health insurance coverage for a representative individual in each rating area or service area (if premiums vary by geographies smaller than rating areas) would have been absent approval of this waiver, and (1) separately with the introduction of BBSPs alone and (2) separately with reinsurance alone for the applicable plan year, that are actuarially certified. The State must include with this information the detailed methods and assumptions the State used to estimate the final silver plan rates and State's estimate of what the final silver plan rates would have been for each rating area or service area absent approval of this waiver. The State's methods and assumptions should specify, in particular, any assumptions relating to issuer participation or plan offerings absent the waiver. Also include the actuarial memorandums;

(c) The total amount of all premiums expected to be paid for individual health insurance coverage for the applicable plan year;

(d) What total premiums for individual health insurance coverage would have been for the applicable plan year without the waiver;

(e) The amount of APTC paid by month and rating area for the current plan year to date;

(f) The number of APTC recipients by month and rating area for the current plan year to date;

(g) The State specific age curve premium variation for the current and upcoming plan year for the individual markets;

(h) Reports of the estimated total reinsurance reimbursements for the upcoming plan year;

(i) Reports of the total enrollment estimates for individual health insurance coverage, both with and without the waiver for the upcoming plan year;

(j) An explanation of why the experience for the upcoming plan year may vary from previous estimates and how assumptions used to estimate the impact have changed. This includes an explanation of changes in the estimated impact of the waiver on aggregate premiums, the estimated impact to the SLCSP rates, and the estimated impact on enrollment. The State should also explain changes to the total estimated reinsurance funding and estimated Battle Born State Plan premium reductions relative to prior estimates;

(k) The subsidy schedules and eligibility criteria for any state-provided subsidies; and

(l) Any other information or data requested by the Departments.

The estimated amount of pass-through funding for calendar years 2026 through 2030 will be communicated to the State as soon as practicable, conditional on receipt of items (a) through (l) in the paragraph above by the date specified above. Pass-through amounts are subject to a final administrative determination by the Department of the Treasury prior to payment, and will be made available no later than April of the applicable calendar year. The pass-through amount for calendar years 2026 through 2030 will be calculated by the Departments annually (per section 1332(a)(3) of the ACA) and reported to the State on the earliest date practicable, conditional on receipt of items (a) through (l) in the paragraph above by the applicable deadline.

The pass-through funds cannot be obligated prior to the effective date for the waiver. The State agrees to use the full amount of pass-through funding for purposes of implementing the State's waiver. This includes administrative support for the waiver, State premium subsidies for certain enrollees, the State reinsurance program, a quality incentive program, and the Practice in Nevada provider retention program. Moreover, to the extent pass-through funding exceeds the amount necessary for the State to implement the waiver in a given plan year, the remaining funds must be carried forward and used for purposes of implementing the State's waiver in a subsequent year.

If the waiver is not extended, the Departments will promptly recover unused pass-through funds following the end of the waiver period, December 31, 2030. The State must comply with all necessary steps to facilitate the recovery of such amounts by the Departments within a prompt timeframe.

16. The Departments' Right to Amend, Suspend, or Terminate. Consistent with 31 C.F.R. § 33.120(d) and 45 C.F.R. § 155.1320(d), the Departments reserve the right to amend, suspend, or terminate the waiver (in whole or in part) at any time before

the date of expiration if the Departments determine that the State has materially failed to comply with these STCs, or if the State fails to meet the statutory guardrails.

(a) The Departments will promptly notify the State in writing of the determination and the reasons for the amendment, suspension, or termination, together with the effective date.

(b) In the event that all of or a portion of the waiver is suspended or terminated by the Departments, federal funding available after the effective date of the suspension or termination will be limited to normal closeout costs associated with an orderly suspension or termination including service costs during any approved transition period and administrative costs of transitioning participants, as described in 31 C.F.R. § 33.120(e) and 45 C.F.R. § 155.1320(e).

(c) The Departments will recover unused pass-through funding. The State must comply with all necessary steps to facilitate the recovery of such amounts by the Departments within a prompt timeframe.

Richard Whitley
Director
Nevada Department of Health and Human Services
State of Nevada

Date: January 10, 2025

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services

Date: January 10, 2025

Aviva Aron-Dine
Deputy Assistant Secretary, Tax Policy
U.S. Department of the Treasury

Date: January 13, 2025

Steve Sisolak
Governor

Richard Whitley, MS
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF HEALTH CARE FINANCING AND POLICY

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Suzanne Bierman, JD MPH
Administrator

GENERAL GUIDANCE LETTER 22-001

Date: October 4, 2022

From: Richard Whitley, DHHS Director
Suzanne Bierman, Administrator

Subject: Requirements for the Public Option Premiums

PURPOSE: This letter is intended to clarify the premium requirements of NRS 695K.200 for the Public Option products. As provided in state law, these requirements will be effective as of January 1, 2026 and expire on December 31, 2029. Pursuant to the Director's express authority in subsection 5 of NRS 695K.200, the Director revises the premium requirements in subsection 4 to mean that premiums for the Public Option:

- Must be lower than the average reference premium in each county by a percentage that increases each year, starting with 4% in year 1 and growing by at least 4% each year until it reaches at least 16% in year 4; and
- Must not increase in any given year by a percentage greater than the increase in the Consumer Price Index for Medical Care plus any adjustments necessary to reflect local changes in utilization and morbidity.

Also, for the purposes of these revisions and as further explained in this guidance, the average reference premium shall mean "the average second-lowest cost silver level plan available through the Exchange during the 2024 plan year by county trended forward for inflation according to the Consumer Price Index for Medical Care and any adjustments to reflect local changes in utilization and morbidity."

AUTHORITIES:

NRS 695K.200: [...]
4. Except as otherwise provided in this section, the premiums for the Public Option:
(a) Must be at least 5 percent lower than the reference premium for that zip code; and
(b) Must not increase in any year by a percentage greater than the increase in the Medicare Economic Index for that year.
5. The Director, in consultation with the Commissioner and the Executive Director of the Exchange, may revise the requirements of subsection 4, provided that the average premiums for the Public Option must be at least 15 percent lower than the average reference premium in this State over the first 4 years in which the Public Option is in operation.
6. As used in this section: [...]
(d) "Reference premium" means, for any zip code, the lower of:
(1) The premium for the second-lowest cost silver level plan available through the Exchange in the zip code during the 2024 plan year, adjusted by the percentage change in the Medicare Economic Index between January 1, 2024, and January 1 of the year to which a premium applies; or

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

NRS 695K.240: [...]

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

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

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

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

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

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

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

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

APPLICATION

As provided in state statute, the premium-reduction requirements for the Public Option products are time-limited and will begin on January 1, 2026 and end on December 31, 2029. The plain language of subsection 5 under NRS 695K.200 provides that the Director may revise these requirements as long as the average premiums for the Public Option are at least 15 percent lower than the average reference premium in the State over the first four years of the program. For the reasons listed below, the Director revises the premium-reduction requirements in subsection 4 as follows:

> 4. Except as otherwise provided in this section, the premiums for the Public Option:
>
> (a) Must be ~~at least 5 percent~~ lower than the average reference premium in each county by a percentage that increases each year, starting with 4% in year 1 and growing by at least 4% each year until it reaches at least 16% in year 4 ~~for that zip code~~; and
>
> (b) Must not increase in any year by a percentage greater than the increase in the ~~Medicare Economic Index~~ Consumer Price Index for Medical Care for that year plus any adjustments necessary to reflect local changes in utilization and morbidity.

The purpose of these revisions is to ensure that the Public Option premiums will be actuarially sound, meaning that they can reasonably cover the projected cost of health care claims and growth of medical inflation in the state's individual health insurance market. For example, subsection 4 of NRS 695K.200, as originally written, applies the Medicare Economic Index (MEI) as a trend factor for controlling the cost of inflation in the Public Option products. Upon review and in consultation with the Department of Insurance, Exchange, and independent actuarial experts—the Department has determined that MEI does not adequately reflect the high rate of growth in medical inflation in the State's individual

health insurance market, where the Public Option products must be offered. Therefore, pursuant to the Director's authority under subsection 5 of NRS 695K.200, the Director revises subsection 4 of NRS 695K.200 to replace MEI with Consumer Price Index for Medical Care (CPI-M) to better reflect the cost of inflation in this market. The revision also allows the Department to make any adjustments deemed necessary to reflect local changes in utilization and morbidity.

The Director also defines "average reference premium" for purposes of implementing these revisions to subsection 4 and meeting the 15 percent premium-reduction target in the first four years in subsection 5 as follows:

> The average reference premium means the second-lowest cost silver level plan available through the Exchange during the 2024 plan year by county trended forward for inflation according to the Consumer Price Index for Medical Care and any adjustments to reflect local changes in utilization and morbidity.

Such an interpretation is consistent with Nevada rules of statutory construction, which provide that "provisions within a common statutory scheme [must be interpreted] harmoniously with one another in accordance with the general purpose of those statutes and to avoid unreasonable or absurd results, thereby giving effect to the Legislature's intent." Dezzani v. Kern & Assocs., Ltd., 134 Nev. 61, 64 (2018) (quoting Torrealba v. Kesmetis, 124 Nev. 95, 101 (2008)). Construing the "reference premium" definition in subsection 6 to apply to the revised premium-reduction requirements for subsection 4 and the 15 percent target in subsection 5 would create a direct conflict with the Director's duty to meet the express mandate in NRS 695K.240, which is to ensure provider reimbursement rates in the Public Option are no lower than Medicare rates (i.e., the express provider-reimbursement mandate). This is because the definition of "reference premium" in subsection 6 creates an unintended and unreasonable result with respect to premium reductions in the Public Option, where health carriers would be required to lower premiums to levels that risk actuarial soundness and full compliance with the express provider-reimbursement mandate under NRS 695K.240.

For example, applying the definition of reference premium in subsection 6, as written, would result in a target that relies either on: (1) MEI, which as previously stated is unworkable and therefore has been replaced by CPI-M in accordance with the Director's revision authority; or (2) a target based on the preceding year, each year, which has a compounding effect and would drive down premiums exponentially (i.e., at a rapid, additive rate). This creates an absurd and unintended result, where the Director must use a definition that relies on the elements deemed revisable under subsection 5 and applies a target based on a reference point that can only be reasonably achieved by risking compliance with the express provider-reimbursement mandate under NRS 695K.240. Unlike the premium-reduction requirements in NRS 695K.200 and other key statutory provisions related to the operation of the Public Option, the express provider-reimbursement mandate in NRS 695K.200 can neither be revised nor waived by the Director.

For all these reasons, the Director interprets "average reference premium" in a separate and distinct manner from "reference premium," as permitted by Nevada rules of statutory construction, to balance and give effect to the legislature's intent, which was to allow the Director to revise the premium-reduction requirements and meet a 15 percent reduction target in the first four years, all while ensuring such reductions do not result in provider reimbursement rates in the Public Option that are below those paid by Medicare.

Signature: Suzanne Bierman
Suzanne Bierman (Oct 31, 2022 11:21 PDT)

Email: suzanne.bierman@dhcfp.nv.gov

Signature:

Email: rwhitley@dhhs.nv.gov

Joe Lombardo
Governor

Richard Whitley, MS
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF HEALTH CARE FINANCING AND POLICY

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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.

Holland & Hart

Christopher M. Jackson
Partner
Phone 303.295.8305
CMJackson@hollandhart.com

January 2, 2024

Via Certified Mail
Nevada Department of Health & Human Services
Division of Health Care Financing & Policy
1100 E. William Street, Ste. 101
Carson City, NV 89701

Attn: Director Richard Whitley, MS
Administrator Stacie Weeks, JD, MPH

Re: NRS 233B.110 Request
Guidance Letter 23-003 (Nov. 20, 2023) and Guidance Letter 22-001 (Oct. 4, 2022) (collectively, "Guidance Letters")

Dear Director Whitley and Administrator Weeks:

Our firm represents the National Taxpayers Union ("NTU") and Hon. Robin Titus, MD. We are writing pursuant to NRS 233B.0617 to request that the Department of Health and Human Services and its Division of Health Care Financing and Policy (collectively, "the agency") pass upon the validity of the Guidance Letters referenced above.

In our view, the Guidance Letters are invalid and interfere with or impair, or threaten to interfere with or impair, NTU's and Dr. Titus's legal rights and privileges for at least two reasons. *First*, they were promulgated in violation of the Nevada Administrative Procedure Act ("NAPA"). The Guidance Letters are "regulations" within the meaning of NAPA. *See* NRS 233B.038 (defining "regulation" as any "agency rule, standard, directive or statement of general applicability which effectuates or interprets law or policy"). And while SB 420 (Nev. 2021) purported to exempt the adoption of regulations like these from NAPA, that exemption is not effective until January 1, 2026. SB 420, §§ 20(5)(i), 41(2)(b). As a result, before the agency promulgated the Guidance Letters, it was required to comply with NAPA's provisions on administrative regulations, which among other things require public notice and an opportunity to comment before review and approval by the Legislative Commission. *See* NRS 233B.095–233B.120. The agency failed to meet NAPA's requirements.

Second, the Guidance Letters were promulgated pursuant to SB 420, and SB 420 violates at least three provisions of the Nevada Constitution: Article III, Section 1; Article IV, Section 18(2); and Article IV, Section 19.

Pursuant to NRS 233B.110(1), we hereby request that you "pass upon the validity of the regulation[s] in question." We further request that your review consider whether the Guidance Letters are consistent not only with the Nevada Constitution and NAPA, but with all other applicable state laws and regulations as well.

Thank you for your prompt attention to this request.

Sincerely,

Christopher M. Jackson
Holland & Hart LLP

CMJ:kjo

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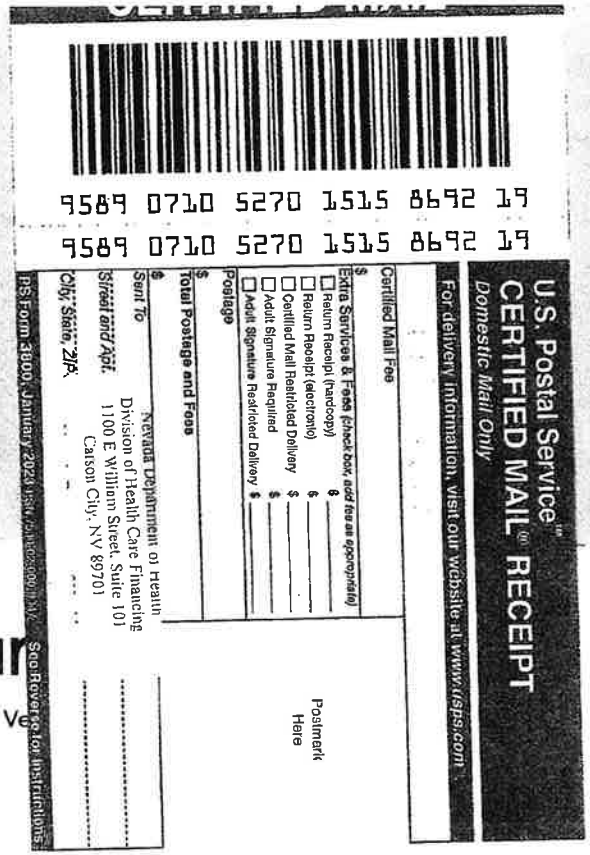

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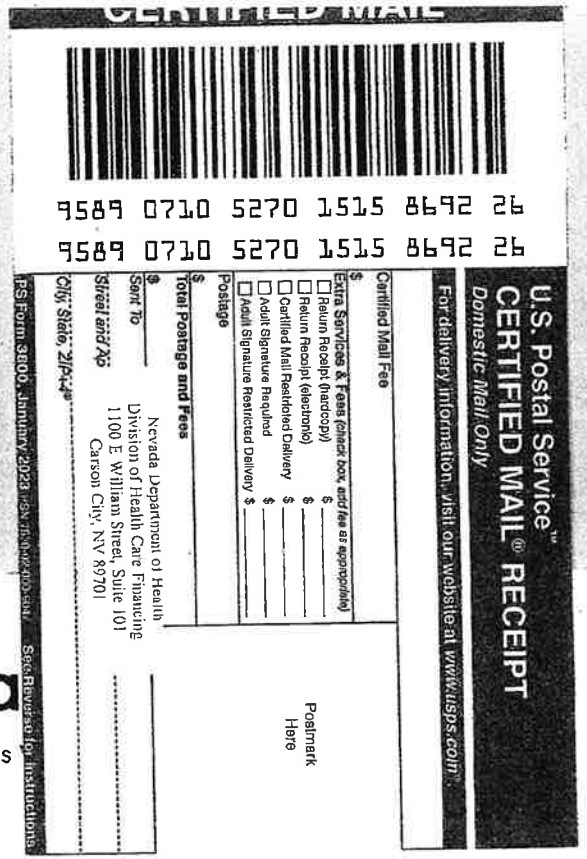
Division of Health Care Financing & Policy
ATTN: Richard Whitley, MS
1100 E. William Street, Suite 101
Carson City, NV 89701



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