Joshua M. Halen (NSBN 13885)
HOLLAND & HART LLP
5470 Kietzke Lane, Suite 100
Reno, NV 89511
Tel: (775) 327-3000
Fax: (775) 786-6179
jmhalen@hollandhart.com

Christopher M. Jackson (*pro hac vice* forthcoming)
HOLLAND & HART LLP
555 17th Street, Suite 3200
Denver, CO 80202
Tel: (303) 295-8000
cmjackson@hollandhart.com

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. 25OC00108 1B

Dept. No. 1

PLAINTIFFS' APPENDIX TO MOTION FOR PRELIMINARY INJUNCTION

Volume 18 of 18

HOLLAND & HART LLP
5470 KIETZKE LANE, SUITE 100
RENO, NV 89511

INDEX

EXHIBIT #	DESCRIPTION	PAGES
N	July 30 2024 Order Granting Motions to Dismiss First Amended Complaint in case # 24 OC 00001 1B	1184-1198
O	January 19, 2022 Nevada Department of Health and Human Services Questions & Answers for the Nevada Public Option (Senate Bill 420)	1199-1214
P	October 2022 Nevada Department of Health and Human Services Fact Sheet - Nevada Public Option	1215-1216
Q	Nevada Department of Health and Human Services Request for Information for the Nevada Battle Born State Plans and Market Stabilization Program	1217-1221
R	Silver State Health Insurance Exchange Notice of Hearing of Fees to be Charged to Insurers	1222-1223
S	Declaration of Joshua M. Halen	

HOLLAND & HART LLP
5470 KIETZKE LANE, SUITE 100
RENO, NV 89511

35340515_v1

FIRST JUDICIAL DISTRICT COURT OF NEVADA
CARSON CITY

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

Plaintiffs,

vs.

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, and

LEGISLATURE OF THE STATE OF NEVADA,

Intervenor-Defendant.

Case No. 24 OC 00001 1B

Dept. No. 2

ORDER GRANTING MOTIONS TO DISMISS FIRST AMENDED COMPLAINT

This matter came before the Court on motions to dismiss filed by Defendants. Plaintiffs filed their First Amended Complaint for Declaratory and Injunctive Relief on January 29, 2024. The named defendants, all members of the State executive branch ("Executive Defendants"), filed their motion to dismiss on February 23, 2024. The Nevada Legislature intervened in this action by way of a stipulated order entered on February 26.

The Executive Defendants and the Legislature filed, and joined in each other's, motions to dismiss, the Plaintiffs filed their responses in March, and the Executive Defendants and the Legislature filed replies by the end of that month. After reviewing the pleadings and papers on file and considering the parties' arguments at the hearing on June 26, 2024, the Court enters the following order.

FACTUAL BACKGROUND

In their First Amended Complaint ("FAC"), Plaintiffs raise several state constitutional claims challenging the validity of specific provisions of Senate Bill No. 420 of the 2021 regular legislative session ("SB 420"). SB 420, 2021 Nev. Stat., Ch. 537, at 3614. SB 420 was passed and approved on June 9, 2021, although the many different sections of the bill became, or will become, effective at the various times stated in section 41 of the bill. Plaintiffs also raise a state statutory claim under the Administrative Procedure Act ("APA") in NRS Chapter 233B. In that claim, Plaintiffs allege that the Executive Defendants violated the APA by adopting guidance letters concerning the state's administration of the challenged provisions of SB 420 without complying with the administrative rulemaking requirements under the APA. Each of Plaintiffs' four causes of action articulated in the First Amended Complaint seeks declaratory relief under NRS Chapter 30.

The Interest of the Plaintiffs in the Legislation

Plaintiff National Taxpayers Union ("NTU") alleges it is a public interest, nonprofit, nonpartisan corporation organized under the laws of Delaware and authorized to do business in Nevada. *See* FAC ¶ 6. It also alleges that its purpose is "to advocate for public policies that promote transparency, accountability, and efficiency in government" and that its leadership advocated for passage of the two-thirds supermajority provision for adopting legislation which increases revenue. FAC ¶17. Even though it lists many of its purposes, NTU does not allege that SB 420 will cause the organization any direct harm. NTU does allege that its "forty-five Nevada members and supporters will be harmed by SB 420" but

has not stated who those members are and how they will be harmed and has not provided any means for this Court to identify those members.

Plaintiff Dr. Titus is a state resident, a licensed and practicing physician, and a member of the Nevada Legislature. She alleges she "will be personally harmed by the Defendants' continued implementation of the Public Option, a government-run health insurance program that requires Nevada health care providers to participate and accept lower reimbursement rates." FAC ¶ 18. Dr. Titus does not allege that she has yet suffered any injury, but only speculates that she will be harmed by the public option if it is allowed to go into effect on January 1, 2026.

Plaintiffs assert in their first three causes of action a key identical allegation: "Without this Court's intervention, Defendants will proceed to implement SB 420 resulting in irrevocable and irreparable harm to the rights of Nevada citizens protected under Nevada's Constitution." FAC ¶ 87, 94, 101 (emphasis added).

The Challenged Legislation

The challenged provisions of SB 420 provide for the design, establishment, and operation of "a health benefit plan known as the Public Option." SB 420, 2021 Nev. Stat., Ch. 537, § 10(1), at 3617 (codified in NRS 695K.200(1)). Even though the challenged provisions were enacted during the 2021 regular session, they do not become effective and operative until January 1, 2026, with certain limited exceptions. SB 420, 2021 Nev. Stat., Ch. 537, §§ 2-15, at 3616-22 (codified in NRS Chapter 695K), and § 41(2), at 3648 (setting forth the effective dates for the specific provisions of SB 420).

Under Section 11 of SB 420 (codified in NRS 695K.210), the Executive Defendants must work collaboratively to apply to the United States Secretary of Health and Human Services for a waiver under federal law and regulations to obtain pass-through federal funding to carry out the challenged provisions of SB 420. Defendant Director Whitley submitted the State's waiver application to the federal government on December 29, 2023. FAC ¶¶ 55, 56. *See* 42 U.S.C. § 18052; The Patient Protection and Affordable Care Act, H.R. 3590, Pub. L. 111-148, § 1332, 124 Stat. 119, 203 (Mar. 23, 2010). Plaintiffs do not

allege that the State's waiver application has been granted, and they do not allege that the program can go forward without resolution of the waiver application.

Section 14 of SB 420 (codified in NRS 695K.240) states that Nevada public option health care provider reimbursements "must be comparable to or better than" the reimbursement rates under existing federal programs. Section 13 of SB 420 (codified in NRS 695K.230) only requires providers to participate in the public option if they also participate in "the Public Employees' Benefits Program established pursuant to subsection 1 of NRS 287.043 or the Medicaid program, or [provide] care to an injured employee pursuant to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS," which are more commonly known as the Workers' Compensation Laws. Under this section, these health care providers must enroll as a provider in at least one Public Option provider network but are not required to accept new patients; they are only required to "accept new patients who are enrolled in the Public Option to the same extent as the provider accepts new patients who are not enrolled in the Public Option." (emphasis added).

Section 41(2) of SB 420 provides that the APA exemption for the Public Option in Section 20 of SB 420 became effective upon "passage and approval" for the "purposes of procurement and any other preparatory administrative tasks necessary to carry out" the public health insurance option, which includes the adoption, amendment, or repeal of any rule or policy governing the public health insurance option. *See* 2021 Nev. Stat., Ch. 537, § 20, at 3631-32 (amending the Nevada Administrative Procedure Act in NRS 233B.039), and § 41(2), at 3648 (setting forth the effective dates for the specific provisions of SB 420). The bill does not define what is meant by "purposes of procurement and any other preparatory administrative tasks necessary to carry out the provisions of those sections . . . ."

The Constitutional and Legal Challenges

Plaintiffs assert three constitutional challenges to SB 420. First, they claim that the legislation generates public revenue, but that the bill was not passed by a two-thirds vote in both chambers of the Legislature. As such, Plaintiffs argue that the bill violates article

4, section 18 (2) of the Nevada Constitution which requires an affirmative vote of two-thirds of each House for a bill "which creates, generates, or increases any public revenue in any form . . . ." Nev. Const. art. 4, § 18 (2). Plaintiffs assert that the bill will require the State to create a health benefit plan, or "Public Option," available to consumers which will raise revenues from the purchase of the health plan or from carrier premium fees or premium taxes. FAC ¶¶ 2, 28-31, 39-61, 84-86.

Second, Plaintiffs allege that SB 420 authorizes defendants in section 15 of the bill "nearly unlimited discretion to use unspecified amounts of funds from the state treasury for unspecified purposes that the legislature did not approve in passing SB 420." FAC ¶¶ 3, 62-69, 92-93. Plaintiffs claim this violates the Appropriations Clause of the constitution. *See id.*, art. 4, §19 ("No money shall be drawn from the treasury but in consequence of appropriations made by law.").

Third, it is asserted that the legislation violates the separation of powers doctrine in article 3, section 1 of the constitution as executive branch officials are authorized by the bill to revise statutory language (a power of the Legislature) which establishes health insurance premium level reduction targets. Plaintiffs claim this revision was done by defendants who issued guidance letters as authorized by the legislation. FAC ¶¶ 4, 73-80, 98-104. Similarly, in their fourth cause of action, Plaintiffs also claim that the issuance of the guidance letters were effectively "regulations" which were not adopted and filed in accordance with Nevada's Administrative Procedure Act ("APA") in Chapter 233B of the Nevada Revised Statutes. FAC ¶¶ 105-114.

LEGAL ANALYSIS

A complaint may be dismissed at any time for lack of subject matter jurisdiction. NRCP 12(b)(1) & (h)(3). Upon a motion to dismiss for failure to state a claim under NRCP 12(b)(5), this Court typically must take all factual allegations in the complaint as true and draw all inferences in favor of Plaintiffs. The complaint should only be dismissed if it appears beyond doubt that plaintiffs could prove no set of facts which entitle them to the relief they seek. *Buzz Stew v. City of N. Las Vegas*, 124 Nev. 224, 228, 181 P.3d 670, 672

(2008). Nevertheless, this Court is not limited to the content of the complaint when it refers in this case to, and relies upon, the legislation which is central to the claims and no party questions the authenticity of the legislation. *See Baxter v. Dignity Health*, 131 Nev. 759, 764, 357 P.3d 927, 930 (2015) (citing cases). Here, no one questions the authenticity of SB 420.

It is also the case that, when plaintiffs assert constitutional questions, proof of standing is a jurisdictional requirement. *Stockmeier v. Nev. Dep't of Corrections*, 122 Nev. 385, 393, 135 P.3d 220, 225-26 (2006), *overruled in part on other grounds by State ex rel. Bd. of Parole Comm'rs v. Morrow*, 127 Nev. 265, 255 P.3 224 (2011). Thus, if these Plaintiffs do not show standing to sue, or an exception to standing, the Court is without jurisdiction to hear the case. The same is true when the allegations of a complaint are not ripe for adjudication. The lack of ripeness also affects the court's jurisdiction to hear a case. *See Allstate Ins. Co. v. Thorpe*, 123 Nev. 565, 571, 170 P.3d 989, 993 (2007) (failure to exhaust administrative remedies rendered the matter unripe and nonjusticiable); *Herbst Gaming, Inc. v. Heller*, 122 Nev. 877, 887, 141 P.3d 1224, 1230-31 (2006) (the focus is the degree to which alleged harm is sufficiently concrete to yield a justiciable controversy).

Naming the State as a Defendant

The First Amended Complaint names state officers and employees as defendants but does not name the State of Nevada as a defendant. Nevada law provides: "In any action against the State of Nevada, the action must be brought in the name of the State of Nevada on relation of the particular department, commission, board or other agency of the State whose actions are the basis for the suit." NRS 41.031(2). This statute was adopted by the Legislature which has authority to waive what is otherwise the State's immunity to suit. Nev. Const. art. 4, § 22. The Nevada Supreme Court has held that section 41.031 does not apply only to torts. *Echeverria v. State*, 137 Nev. 486, 490-92, 495 P.3d 471, 475-77 (2021). A failure to comply with this statute deprives this Court of subject matter jurisdiction. *See, e.g., Craig v. Donnelly*, 135 Nev. 37, 39-40, 439 P.3d 413, 415 (Nev. Ct. App. 2019). Defendants acknowledge that the error can be addressed by granting Plaintiffs leave to

amend. Generally, leave to amend should be "freely given when justice so requires." *Harlow, Inc. v. Dist. Ct.*, 129 Nev. 394, 398, 302 P.3d 1148, 1152 (2013). Accordingly, this Court will address the additional reasons for dismissal of the action.

Standing

Our rules state that "[e]very action shall be prosecuted in the name of the real party in interest." NRCP 17(a). A real party in interest "is one who possesses the right to enforce the claim and has a significant interest in the litigation." *Arguello v. Sunset Station, Inc.*, 127 Nev. 365, 368, 252 P.3d 206, 208 (2011). A plaintiff must demonstrate "standing" to bring an action. This is to say that there must be a "showing of injury-in-fact, redressability, and causation that federal cases require for [federal constitutional] Article III standing." *Nat'l Ass'n of Mut. Ins. Cos. v. State Dep't of Bus. & Indus.*, 139 Nev. ___, ___, 524 P.3d 470, 476 (Adv. Op. 3, 2023)["*NAMIC*"](*citing cases*). Standing presents a question of law. *Id.*, *citing Arguello v. Sunset Station, Inc.*, 127 Nev. 365, 368, 252 P.3d 206, 208 (2011). A speculative injury is insufficient to establish standing and it is up to the plaintiffs to demonstrate that they suffered actual personal injury. *Doe v. Bryan*, 102 Nev. 523, 525-26, 728 P.2d 443, 444-45 (1986), *cited by Morency v. State, Dep't of Educ.*, 137 Nev. 622, 626 n.5, 496 P.3d 584, 588 n. 5 (2021). In sum, standing requires either a showing of injury-in-fact, statutory standing, or a constitutional expenditure challenge or separation-of-powers dispute that will evade review if strict standing requirements are imposed. *NAMIC*, 139 Nev. at ___, 524 P.3d at 476.

> The question of standing concerns whether the party seeking relief has a sufficient interest in the litigation. The primary purpose of this standing inquiry is to ensure the litigant will vigorously and effectively present his or her case against an adverse party." [*Schwartz*] Thus, "a requirement of standing is that the litigant personally suffer injury that can be fairly traced to the allegedly unconstitutional statute and which would be redressed by invalidating the statute." [*Ellie*] A general interest in the matter is normally insufficient: "a party must show a personal injury." [*Schwartz*]

Morency v. Dep't of Educ., 137 Nev. at 625, 496 P.3d at 588 (2021), *quoting Schwartz v. Lopez*, 132 Nev. 732, 743, 382 P.3d 886, 894 (2016) ("*Schwartz*"); *Elley v. Stephens*, 104 Nev.

413, 416, 760 P.2d 768, 770 (1988) ("*Elley*"). "[A] party generally has standing to assert only its own rights and cannot raise the claims of a third party not before the court." *Beazer Homes, Beazer Homes Holding Corp. v. Dist. Ct.*, 128 Nev. 723, 730, 291 P.3d 128, 133 (2012). In Nevada, a person cannot show standing simply because he or she is a taxpayer. *Blanding v. City of Las Vegas*, 52 Nev. 52, 74, 280 P. 644, 650 (1929).

Nevada does recognize a special exception to direct or personal standing known as the public importance exception. *Schwartz*, 132 Nev. at 743, 382 P.3d at 894. *See also Nevada Policy Research Inst. v. Cannizzaro*, 138 Nev. 259, 507 P.3d 1203 (2022) ("*Cannizzaro*"). The general test for applying the public importance exception requires the plaintiff to show that (1) the case "involve[s] an issue of significant public importance"; and (2) the case "involve[s] a challenge to a legislative expenditure or appropriation on the basis that it violates a specific provision of the Nevada Constitution" or when a "plaintiff seeks vindication of the Nevada Constitution's separation-of-powers clause"; and (3) "the plaintiff must be an 'appropriate' party, meaning that there is no one else in a better position who will likely bring an action and that the plaintiff is capable of fully advocating his or her position in court." *Cannizzaro*, 138 Nev. at 263, 507 P.3d at 1208; *Schwartz*, 132 Nev. at 743, 382 P.3d at 894-95. The public importance exception is a narrow exception intended to apply only when a claim is likely to evade review. *NAMIC*, 139 Nev. at __; 524 P.3d at 476. Additionally, only "extraordinary cases" that fall within the separation-of-powers class of cases will meet the exception. *Cannizzaro*, 138 Nev. at 263, 507 P.3d at 1208.

In this case, Plaintiff NTU does not have individualized standing under Nevada law, and NTU does not meet the requirements for representational standing. This plaintiff has neither alleged nor shown how SB 420 has any effect on the entity itself. It has also not shown that there is no one else in a better position who will likely bring an action against the legislation. NTU also neither identifies any of its purported Nevada members nor provides any means to sufficiently ascertain who those individuals are for this Court to analyze the limited exception of representational standing.

Plaintiff Titus also has not shown that she has individual standing under Nevada law because any allegations of harm to her are purely speculative. Dr. Titus does not allege she is currently harmed by SB 420. She asserts harm by the implementation of the public option, "a government-run health insurance program that requires Nevada health care providers to participate and accept lower reimbursement rates." FAC ¶ 18. The plain language of Section 14 of SB 420 (codified in NRS 695K.240), however, belies Dr. Titus' allegations of any current harm, as it may prohibit in the future Nevada public option provider reimbursements from being less than those under existing federal programs. Plaintiff Titus also does not assert representational standing and cannot do so as she has not demonstrated that no one else is in a better position to bring and advocate a position against the legislation.

This Court said during the arguments on the motions to dismiss that it believed the public importance exception to standing applied. Upon further reflection, the Court believes that it does not apply. The case law on this exception has stated that it is a "narrow" exception (*Schwartz*) when a claim is likely to evade review and is allowed in "extraordinary cases" involving the separation of powers issue which will evade review and be "rare" (*Cannizzaro*). The cases in Nevada have involved many citizens and parents of children in school alleging a diversion of millions of dollars of public education funds to private schools (*Schwartz*); "legislation affecting the financial concerns of a significant number of businesses, organizations, and individuals throughout the state" (*Morency*); and the protection of public funds in a separation of powers issue likely to recur (*Cannizzaro*).

In this case, there is a claimed legislative appropriation without a two-thirds vote because the Public Option, if it ever takes effect, will generate or increase public revenues in the future from the consumer purchases of the health plan or from carrier premium fees or premium taxes. The asserted appropriation of money by the State Treasurer without certainty and specificity from the Legislature is a vague and uncertain allegation which does not appear to be sufficient to meet the "narrow" exception or "extraordinary" case requirement. Similarly, the alleged separation of powers violations which stem from

Plaintiff Titus also has not shown that she has individual standing under Nevada law because any allegations of harm to her are purely speculative. Dr. Titus does not allege she is currently harmed by SB 420. She asserts harm by the implementation of the public option, "a government-run health insurance program that requires Nevada health care providers to participate and accept lower reimbursement rates." FAC ¶ 18. The plain language of Section 14 of SB 420 (codified in NRS 695K.240), however, belies Dr. Titus' allegations of any current harm, as it may prohibit in the future Nevada public option provider reimbursements from being less than those under existing federal programs. Plaintiff Titus also does not assert representational standing and cannot do so as she has not demonstrated that no one else is in a better position to bring and advocate a position against the legislation.

This Court said during the arguments on the motions to dismiss that it believed the public importance exception to standing applied. Upon further reflection, the Court believes that it does not apply. The case law on this exception has stated that it is a "narrow" exception (*Schwartz*) when a claim is likely to evade review and is allowed in "extraordinary cases" involving the separation of powers issue which will evade review and be "rare" (*Cannizzaro*). The cases in Nevada have involved many citizens and parents of children in school alleging a diversion of millions of dollars of public education funds to private schools (*Schwartz*); "legislation affecting the financial concerns of a significant number of businesses, organizations, and individuals throughout the state" (*Morency*); and the protection of public funds in a separation of powers issue likely to recur (*Cannizzaro*).

In this case, there is a claimed legislative appropriation without a two-thirds vote because the Public Option, if it ever takes effect, will generate or increase public revenues in the future from the consumer purchases of the health plan or from carrier premium fees or premium taxes. The asserted appropriation of money by the State Treasurer without certainty and specificity from the Legislature is a vague and uncertain allegation which does not appear to be sufficient to meet the "narrow" exception or "extraordinary" case requirement. Similarly, the alleged separation of powers violations which stem from

actions taken (or to be taken) by the Executive Defendants submitting a waiver application and guidance letters without administrative rulemaking and does not appear to meet the public importance exception for standing. Additionally, Plaintiffs have not met their burden (beyond simply stating) that there is "no one else in a better position who will likely bring an action and that [Plaintiffs are] capable of fully advocating [their] position in Court. If and when the law is fully implemented and facts are known as to the impact of the legislation, perhaps a more appropriate plaintiff or plaintiffs will bring the claims. Plaintiffs have not met their burden in this case.

Both Plaintiffs also lack standing to assert the fourth cause of action because they have not articulated a redressable injury resulting from the alleged violation of the APA. This cause of action also clearly does not meet the public importance exception which is limited to constitutional claims.

Ripeness

Most importantly, Plaintiffs must show that their claims are ripe for determination. "This court is confined to controversies in the true sense. The parties must be adverse and the issues ripe for determination. *Kress v. Corey*, 65 Nev. 1, 189 P.2d 352 (1948). We do not have constitutional permission to render advisory opinions. Nev. Const. art. 6, § 4." *City of North Las Vegas v. Cluff*, 85 Nev. 200, 201, 452 P.2d 461, 462 (1969). Two factors control the ripeness inquiry: "(1) the hardship to the parties of withholding judicial review, and (2) the suitability of the issues for review." *Herbst Gaming, Inc. v. Heller*, 122 Nev. 877, 887, 141 P.3d 1224, 1231 (2006).

"Of course, the duty of every judicial tribunal is to decide actual controversies by a judgment which can be carried into effect, and not to give opinions upon moot questions or abstract propositions, or to declare principles of law which cannot affect the matter in issue before it." *NCAA v. Univ. of Nevada, Reno*, 97 Nev. 56, 57, 624 P.2d 10, 10 (1981).

The Supreme Court of Nevada has articulated the standards for obtaining declaratory relief, which Plaintiffs seek in this case:

> The requisite precedent facts or conditions which the courts generally hold must exist in order that declaratory relief may be obtained may be summarized as follows: (1) there must exist a justiciable controversy; that is to say, a controversy in which a claim of right is asserted against one who has an interest in contesting it; (2) the controversy must be between persons whose interests are adverse; (3) the party seeking declaratory relief must have a legal interest in the controversy, that is to say, a legally protectible interest; and (4) the issue involved in the controversy must be ripe for judicial determination. Declaratory Judgments, Borchard, pp. 26–57.

Kress v. Corey, 65 Nev. 1, 26, 189 P.2d 352, 364 (1948). The allegations of Plaintiffs' First Amended Complaint do not specifically state that they have currently suffered any harm. The language chosen by Plaintiffs suggesting that "the State's waiver application projects that the State will directly receive hundreds of millions of dollars in pass-through federal funding" [FAC ¶ 31 (emphasis added)] are both tacit admissions that these are elements that are yet to happen or be definitively determined. As such, the alleged generation of public revenue authorized by SB 420 without a two-thirds vote of the Legislature is something that may or may not occur in the future, depending on whether the waiver application is granted. Similarly, the alleged unlawful appropriations depend on money being available in the Public Option trust fund, which has yet to happen. Plaintiffs will suffer no hardship regarding these two issues by having to wait to adjudicate their challenges to SB 420 until there is a more concrete dispute on the parameters of the public option.

Plaintiffs assert that the ripeness requirement does not apply to the public importance exception to standing. This Court disagrees. Standing and ripeness serve different purposes—standing addresses who can bring a claim, while ripeness is a matter of timing. *Herbst Gaming, Inc.*, 122 Nev. at 887, 141 P.3d at 1230-31, *quoting Matter of T.R.*, 119 Nev. 646, 651, 80 P.3d 1276, 1279-80 (2003). For that reason, satisfaction of the public importance exception to standing does not satisfy the standards for ripeness, and Plaintiffs' first three causes of action are not ripe for judicial determination. *See Jowers v. S.C. Dep't of Health & Envtl. Control*, 815 S.E.2d 446, 458-59 (S.C. 2018) ("The public importance exception does not apply to a lack of ripeness."); *Walker v. Munro*, 879 P.2d 920,

927-28 (Wash. 1994) (declining to apply the public-importance exception because plaintiffs' constitutional challenge to statutory provisions was not ripe for review given that the challenged statutes were not effective and not operative yet); *DiNino v. State ex rel. Gorton*, 684 P.2d 1297, 1300-01 (Wash. 1984) (declining to apply the public-importance exception because plaintiffs' constitutional challenge to statutory provisions was not ripe for review given that "[t]his case presents a hypothetical, speculative controversy."). So, even if Plaintiffs could meet the public importance exception for the first three causes of action, those causes of action remain subject to dismissal because they are not ripe.

CONCLUSIONS OF LAW

In this case, Plaintiff NTU lacks individualized and representational standing to address the claimed violations of SB 420 under Nevada law. Similarly, Plaintiff Titus has also failed to demonstrate individual standing under Nevada law because the harm she asserts is too speculative. Plaintiff's also lack standing under the narrow public importance exception because the appropriation of money by the State Treasurer is uncertain at this time and, similarly, the alleged separation of powers claim is based upon actions which have yet to be finalized. Nor is it clear that Dr. Titus is an appropriate party to pursue the claims raised in this case. If SB 420 becomes fully implemented, it appears likely that the claimed violations will be raised by someone who is in a better position to identify the specific harm and that the issues will not evade review.

Plaintiffs NTU and Titus are unable to establish that the first three causes of action are ripe for judicial determination because SB 420 is not fully implemented, and it is currently unclear whether it will be fully implemented. Application of the public importance exception, if this Court were to apply it to the standing issue, would not change the requirement of ripeness in this case.

Finally, Plaintiffs lack standing to assert the fourth cause of action because they have not articulated a redressable injury resulting from the alleged violation the Administrative Procedure Act.

The issues of standing, ripeness and failure to state a claim addressed above could only be corrected if Plaintiffs were to satisfy the legal standards and demonstrate a current harm from the targeted legislation and could show that they meet the public importance exception for standing. Any amended complaint would have to satisfy each of these issues. Additionally, Plaintiff's would also be required to properly name the State of Nevada in addition to the state officers and employees for this Court to properly have subject matter jurisdiction under NRS 41.031(2). Accordingly,

IT IS HEREBY ORDERED that Plaintiffs' First Amended Complaint is dismissed without prejudice.

IT IS FURTHER ORDERED that counsel for the Executive Defendants shall serve written notice of entry of this order to all other parties and file proof of such service within seven days after the Court sends this Order to counsel.

IT IS SO ORDERED.

July 30th, 2024.

Kristin Luis
Kristin Luis
District Judge

CERTIFICATE OF SERVICE

I certify that I am an employee of the First Judicial District Court of Nevada; that on July 30, 2024, I served a copy of this document by placing a true copy in an envelope addressed to:

Joshua M. Halen, Esq. HOLLAND & HART LLP 5441 Kietzke Lane, 2nd Floor Reno, NV 89511 Constance L. Akridge, Esq. HOLLAND & HART LLP 9555 Hillwood Dr., 2nd Floor Las Vegas, NV 89134 Christopher M. Jackson, Esq. HOLLAND & HART LLP 555 17th St., Ste. 3200 Denver, CO 80202	Office of the Attorney General of Nevada Marni K. Watkins, Esq. Casey J. Quinn, Esq. 1 State of Nevada Way Suite 100 Las Vegas, NV 89119 Kevin C. Powers, Esq. Legislative Counsel Bureau, Legal Division 401 S. Carson St. Carson City NV 89701

the envelope sealed and then deposited in the Court's central mailing basket in the court clerk's office for delivery to the USPS at 1111 South Roop Street, Carson City, Nevada, for mailing.

Billie Shadron
Judicial Assistant

Nevada Department of Health and Human Services
DIVISION OF HEALTH CARE FINANCING AND POLICY

Questions & Answers (Q&A) for the Nevada Public Option (Senate Bill 420)

Last updated: 1/19/2022

Version	Date	Description of Updates
1.0	1/19/2022	Release of version 1.0

Disclaimer: This Q&A is intended to serve as a helpful reference and resource for the public and key stakeholders regarding the Nevada Public Option as defined by Senate Bill (SB) 420. SB 420 was passed by the Nevada Legislature and signed into State law by Governor Steve Sisolak in 2021. This Q&A is intended to address many of the questions raised by stakeholders during the State's public design sessions regarding the implementation and operations of the Nevada Public Option. It also intended to provide general background on the requirements of SB 420 with respect to the design and operation of the Nevada Public Option. DHHS will continue to update this Q&A as needed to provide the most current information to the public and stakeholders.

Contents

A. Overview of the Nevada Public Option

1. What is the Nevada Public Option?

Beginning in 2026, all Nevadans who shop for health insurance in the State's individual health insurance market (which includes Nevada Health Link) will have access to a new health insurance option known as the Public Option. The Public Option is being established pursuant to Senate Bill (SB) 420 of the 2021 Legislative Session, authored by Senator Nicole Cannizaro and signed into State law by Governor Steve Sisolak on June 9, 2021.

2. What are the goals of the Public Option?

Per the stated purpose of the policy of the Legislature in section 2 of SB 420, the key goals for establishing the Nevada Public Option are to:

- Leverage the State's purchasing (contracting) power to lower premiums and costs for health care for all Nevadans;
- Improve access and reduce disparities related to quality of care and outcomes for historically marginalized communities;
- Increase competition in individual health insurance rating areas to improve availability of coverage for rural Nevadans; and
- Promote value-based health care financing.

3. Who is responsible for implementing the Public Option?

The Director of the Nevada Department of Health and Human Services (DHHS), in consultation with the Executive Director of the Silver State Health Insurance Exchange (the Exchange) and the Insurance Commissioner, is responsible for designing, establishing, and operating the Nevada Public Option in accordance with the requirements of SB 420.

4. What is the timeline for the Nevada Public Option?

The Nevada Public Option is anticipated to be available in the marketplace (https://www.nevadahealthlink.com/sshix/) for consumers to purchase beginning in January 2026 as required by SB 420. In the period leading up to this date, the State will engage in

various implementation activities including, at a minimum, engaging stakeholders on product and waiver design, developing a 1332 waiver application, negotiating the waiver application with federal officials, and conducting a new statewide public procurement for the Nevada Public Option to identify qualified carriers to offer the new Nevada Public Option plans to consumers.

Below is an estimated timeline that outlines the phases, key milestones, and implementation activities over the next five years, with the expectation that some of these timelines may need to be adjusted to address various changes or issues that may arise either at the State or federal level.

B. Key Elements of the Nevada Public Option

1. Who will be able to purchase a Nevada Public Option plan?

All Nevada residents will be able to purchase a Nevada Public Option plan. The State may also make the Public Option available to small employers or their employees to the extent permitted by federal law.

2. Where will consumers shop for and purchase Nevada Public Option plans?

Nevada consumers will be able to shop for and purchase Nevada Public Option plans through the Nevada Health Link or directly from a health carrier selling health insurance in the State's individual market.

3. Will consumers who buy the Nevada Public Option be eligible for federal subsidies under the Affordable Care Act (ACA)?

Consumers with certain income levels may receive federal ACA subsidies to help offset the cost of a Nevada Public Option plan if they purchase the plan through the Nevada Health Link. However, if a consumer purchases a Nevada Public Option plan directly from the health carrier in the private individual market (i.e., outside of the Nevada Health Link), they will not be eligible for federal ACA subsidies.

4. Who will offer the new Nevada Public Option plans?

SB 420 provides the Director with new State authority to contract with health insurance carriers to offer the new Nevada Public Option plans to consumers. This concept is similar to the approach used in Medicaid Managed Care, where the State contracts with health plans to provide coverage and services through a network of providers to Medicaid beneficiaries.

Health carriers will be selected by the Director through a statewide competitive procurement process. This process will take place at the same time as the next Medicaid Managed Care procurement, and all carriers that wish to participate in the State's Medicaid Managed Care program will be required to submit a good faith bid to contract with the State to offer and administer Nevada Public Option plans. The State may also invite non-Medicaid insurers to submit bids for the new Nevada Public Option plans.

5. Is the Director of DHHS required to administer the Nevada Public Option plans directly to consumers?

Under the requirements of SB 420, the Director of DHHS is required to design, establish, and operate the Nevada Public Option. However, it does not require that the Director of DHHS operate the Nevada Public Option directly. Instead, section 12 of SB 420 specifies that the Director of DHHS must operate the Nevada Public Option by contracting with a health carrier or other qualified entity to administer the new Nevada Public Option plans. The only exception to this requirement is if direct administration by the Director of DHHS is **necessary for the operation** of the Nevada Public Option.

Furthermore, if the Director of DHHS were to directly administer the new Nevada Public Option plans, the Director would be unable to fulfill his responsibilities in section 12 to contract with

health carriers or other qualified entities to offer the new Nevada Public Option plans in addition to the other criteria and procedures for a new statewide procurement prescribed by the new law for selecting such an administrator or administrators. It also renders the other provisions in SB 420 moot that require health carriers seeking to participate (or to continue to participate) in the State's Medicaid Managed Care program to offer good faith bids to the Director of DHHS to administer the Nevada Public Option.

6. What type of health insurance policy will the Nevada Public Option qualify as under State law?

SB 420 requires that the Nevada Public Option plans be qualified health plans (as defined in the Affordable Care Act) and sold on and off the Exchange as individual policies of health insurance on the individual market. All State and federal requirements and procedures for qualified health plans and nongroup plans would apply to the new Nevada Public Option plans.

SB 420 further provides that the Director **may** choose to offer the new Nevada Public Option plans to small businesses, or their employees, as permitted by, and in accordance with, federal and State law for small group health insurance policies.

7. How will the State select the health carriers to administer Nevada Public Option plans?

The Director of DHHS will oversee the selection of health carriers through a statewide competitive procurement process. When selecting health carriers, the Director will prioritize applicants whose proposals:

- Demonstrate alignment of networks of providers between the Nevada Public Option and Medicaid Managed Care, where applicable;
- Provide for the inclusion of critical access hospitals, rural health clinics, certified community behavioral health clinics and federally-qualified health centers in the networks of providers for the Nevada Public Option and Medicaid Managed Care, where applicable;
- Strengthen the State health care workforce, particularly in rural areas for providers of primary care, mental health care, and treatment for substance use disorders;
- Use payment models for providers included in the networks of providers for the Nevada Public Option that increase value for persons enrolled in the new plans and the State; and

- Contract with providers of health care in a manner that decreases disparities among different populations in this State with regard to access to health care and health outcomes and supports culturally competent care.

8. How will the State help to ensure that the Nevada Public Option plans are affordable?

SB 420 provides for a temporary target on consumer premiums for Nevada Public Option plans for the first four years of operation. Specifically, Nevada Public Option premiums must be at least 5 percent lower than the cost of premiums for plans used by the federal government to calculate federal ACA subsidies (i.e., the cost of the second-lowest cost silver level plan). In addition, the premium for a Nevada Public Option plan may not increase in any year by a percentage greater than the increase in the Medicare Economic Index for that year.

The Director of DHHS may revise these requirements, provided that, over the first four years in which the Public Option is in operation, the average premiums for the Nevada Public Option are at least 15 percent lower.

These targets expire on January 1, 2030.

9. How will the State use the Nevada Public Option to promote value-based health care financing, improve outcomes, lower cost, and achieve other State objectives?

Under SB 420, the Director of DHHS is directed to use the Nevada Public Option (via the procurement and contracting process with health carriers) to:

- Ensure that care for persons who were previously covered by Medicaid or the Children's Health Insurance Program and enroll in the Nevada Public Option is minimally disrupted;
- Encourage the use of payment models that increase value for persons enrolled in the Public Option and the State;
- Improve health outcomes for persons enrolled in the Nevada Public Option;
- Reward providers of health care and medical facilities for delivering high-quality services; and
- Lower the cost of care in both urban and rural areas of this State.

SB 420 also seeks to increase the leverage of the Director to achieve these objectives by requiring that the procurement process for Medicaid Managed Care and the Nevada Public

Option take place concurrently, and by requiring that health insurance carriers seeking to provide Medicaid Managed Care plans also submit good faith bids to provide Nevada Public Option plans.

10. Will the State set reimbursement rates for health care providers who participate in the new Nevada Public Option plans?

SB 420 provides that, subject to the limited exceptions discussed below, reimbursement rates under the Nevada Public Option must be, in the aggregate, comparable to or better than reimbursement rates available under Medicare. This **does not** establish Medicare rates as a cap or ceiling on provider reimbursement for Nevada Public Option plans. Instead, the intent of this requirement is to establish a floor for provider reimbursement that can act as a level-playing field for providers who negotiate their rates with health carriers for the Nevada Public Option plans.

Health carriers seeking to participate in the Nevada Public Option may find it advantageous for the procurement process to offer a bid that provides for higher provider reimbursement rates than those paid in Medicare in order to attract a more robust provider network. For example, SB 420 directs the Director of DHHS to give greater consideration (or preference) to bids by health carriers that would provide consumers with improved access to providers. This includes more robust provider networks that consist of rural and safety-net providers, provider arrangements that seek to address workforce challenges, and networks that provide for greater alignment of providers between Medicaid and private markets.

For purposes of this requirement, the aggregate reimbursement rate under Medicare includes any add-on payments or other subsidies that a provider receives under Medicare.

There are exceptions to this requirement, including:

- Providers that receive cost-based reimbursement from Medicare must receive reimbursement under the Nevada Public Option that is comparable to or better than the cost-based reimbursement rates provided for that provider by Medicare;
- The reimbursement rates for a federally qualified health center or a rural health clinic under the Nevada 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; and

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

C. Provider Participation and Consumer Access to Care

1. **In implementing the Nevada Public Option, how will the State seek to ensure adequate access to providers, particularly in rural areas, and address shortages in the health care workforce?**

To ensure that consumers covered under the Nevada Public Option have adequate access to providers, SB 420 requires health care providers who participate in the State's Medicaid program, Public Employees' Benefits Program (PEBP), or who provide care to injured employees under the State's workers' compensation program to enroll as a participating provider in at least one network of providers established for the Nevada Public Option.

These providers under contract to participate in these other insurance programs must also accept new patients who are enrolled in the Nevada Public Option to the same extent as they accept new patients not enrolled in the Nevada Public Option. The Director of DHHS and the Executive Officer of the PEBP do have authority to waive these requirements when necessary to ensure that Medicaid enrollees and individuals who receive benefits under the PEBP have sufficient access to covered services.

In addition, SB 420 directs the Director of DHHS to prioritize health carrier proposals in the Nevada Public Option procurement process that include critical access hospitals, rural health clinics, certified community behavioral health clinics, and federally-qualified health centers in their Nevada Public Option and Medicaid Managed Care networks (where applicable) in addition to proposals that would strengthen the health care workforce in Nevada, particularly in rural areas of the State for providers of primary care, mental health care, and treatment for substance use disorders.

2. **Is Nevada the only state using a "provider participation" requirement for a public insurance program?**

At least three states have similar requirements on the books that leverage existing contractual arrangements with providers to ensure adequate access to providers under certain public

programs. For example, Washington recently updated its State law for its Public Option to provide that, if there is not a Public Option plan in each county by 2022, all hospitals in the State that accept Medicaid or public employee health benefits will be required to participate in the provider network of at least one of the State's Public Option plans. [1]

Under Colorado's Public Option (which will take effect in 2023), if a health insurance carrier contracted to provide a Public Option plan cannot meet the premium or network adequacy requirements that apply to Public Option plans, the Commissioner of Insurance may require a hospital to participate in the carrier's Public Option plan.[2]

In Minnesota, providers who participate in the State employees' health insurance plans, workers' compensation insurance, public employees' insurance program, or health insurance plans offered to city, county, or school district employees must also participate in the State's Medicaid program.[3]

3. Will the Nevada Public Option help to lower prescription drug costs for consumers?

SB 420 does not directly address prescription drug costs. But it does provide opportunities for the State to seek new alignment and coordination in the procurement processes for Medicaid Managed Care and the Nevada Public Option to increase the purchasing power of the State and allow it to leverage this power to achieve a number of State aims, including but not limited to, lowering prescription drug costs.

---

[1] Washington Session Law, Chapter 246: Increasing Affordability of Standardized Plans (April 19, 2021). Available at https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/Senate/5377-S2.SL.pdf?q=20210625082437

[2] Colo. Rev. Stat. § 25-1.5-117. Available at: https://casetext.com/statute/colorado-revised-statutes/title-25-public-health-and-environment/administration/article-15-powers-and-duties-of-the-department-of-public-health-and-environment/part-1-general-powers-and-duties/section-25-15-117-hospitals-standardized-health-benefit-plan-participation-penalties; Colo. Rev. Stat. § 10-16-1306. Available at: https://casetext.com/statute/colorado-revised-statutes/title-10-insurance/health-care-coverage/article-16-health-care-coverage/part-13-colorado-standardized-health-benefit-plan/section-10-16-1306-rate-filings-failure-to-meet-premium-requirements-notice-public-hearing-rules

[3] Minn. Admin Rules 9505.5220. Available at: https://www.revisor.mn.gov/rules/9505.5220/; Minnesota Department of Human Services, , Provider Manual: Provider Participation Requirements – Rule 101. Available at: https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16_152332;

D. Section 1332 Waivers and the Actuarial Analysis

1. What is a Section 1332 waiver?

Section 1332 waivers permit States to implement innovative strategies for providing high-quality, affordable health coverage to State residents and receive waivers from certain requirements of the ACA as needed to implement these strategies. Section 1332 waivers must be approved by the Centers for Medicare and Medicaid Services (CMS) and comply with certain guardrails designed to preserve the number of individuals covered in the State, and the comprehensiveness and affordability of coverage offered. These are known as the comprehensive coverage requirement, the affordability requirement, and the scope of coverage requirement. In addition, the waiver must not increase the federal deficit.

Using Section 1332 waivers, states may implement policies that will reduce premium rates for plans offered on the State's health insurance exchange, which in turn reduces the amount the federal government must pay for premium tax credits under the ACA. Importantly, Section 1332 waivers permit states to capture these savings, which would otherwise accrue to the federal government, through what is known as "pass-through" federal funding.

2. When must the State submit its Section 1332 waiver?

Under SB 420, the State must submit its Section 1332 waiver to CMS no later than January 1, 2024.

3. What are the benefits of requesting a 1332 waiver for the Nevada Public Option?

The benefits of requesting a Section 1332 waiver include the opportunity to receive federal pass-through funding, which can be used to further increase the affordability of the Nevada Public Option for Nevadans, and to waive certain provisions of the ACA as needed.

According to the new State law, this funding will be deposited in a Nevada Public Option Trust Fund, to be administered by the State Treasurer and used to implement the Nevada Public Option. If the State Treasurer determines there are sufficient funds, monies in the Nevada Public Option Trust Fund may also be used to increase the affordability of the State's Public Option plans. For example, one way this new funding could be used by the State is to reduce premiums and out-of-pocket costs for Nevadans who purchase Nevada Public Option plans,

including those who are low-income but not eligible for Medicaid or premium tax credits under the ACA.

4. Is the State required to conduct an actuarial analysis for the Section 1332 waiver? If so, what must it include?

Yes, under federal rules, all Section 1332 waiver applications must include an actuarial analysis and actuarial certifications to support State assertions that the waiver will comply with the comprehensive coverage requirement, the affordability requirement, and the scope of coverage requirement.

SB 420 further directs the Director of DHHS, the Commissioner of Insurance, and the Director of the Exchange to utilize an "independent actuary," when contracting for actuarial services in developing its 1332 waiver application. It also provides that the actuarial analysis pursuant to the development of its 1332 waiver application must be completed before the waiver application is submitted and must include an analysis of the effect on premiums for health insurance in the State with respect to the "provider participation" requirement set forth in SB420.

To assist in the preparation of a 1332 waiver application, the State has secured the actuarial services of Milliman—an actuarial vendor that meets the qualifications outlined in section 11 of SB 420 for an independent contractor—through a subcontract with Manatt. Pursuant to section 39 of SB 420, this actuarial analysis will be completed and available for public review before the waiver application is submitted and will also address the likely effect on premiums in the health insurance market with and without the "provider participation requirement" in section 13 of SB 420. Milliman will be evaluating this requirement and other requirements in SB 420 that are likely to impact premiums when determining the actuarial assumptions and corresponding values necessary to complete the actuarial analysis.

5. What happens if the State's 1332 waiver application is denied?

Per SB 420, a federal denial of the 1332 waiver application does not mean that the Nevada Public Option will not be implemented. It only means that the State will not receive pass-through funding under Section 1332 or waiver of provisions of the ACA. This is because SB 420 does not condition the implementation of the Nevada Public Option on approval of a Section 1332 waiver. All core provisions of the Nevada Public Option, and its goals of increased

affordability, improved access and reduction in disparities, increased competition in individual health insurance, and the promotion of value-based health care financing can be achieved absent approval of the State's Section 1332 waiver. If the waiver is denied, the State may need to reconsider whether future State resources will be needed to support DHHS operations or to subsidize premium costs for the Nevada Public Option plans.

E. Public Waiver Input and Stakeholder Engagement

1. **What are the mechanisms for public input at the State and federal levels with respect to the 1332 waiver application?**

The public will have many opportunities to provide input into the design and implementation of the Nevada Public Option, beginning with six public design sessions. Information regarding all upcoming public meetings regarding the Nevada Public Option, including dates and times, links to join meetings, agendas, minutes, and video recordings, are posted at DHHS.nv.gov/PublicOption

The State has also established an email address, NVpublicoption@dhhs.nv.gov, for questions or comments regarding the Nevada Public Option. There will be future opportunities to provide public feedback regarding the waiver application. The State is accepting ongoing public written comments at the email listed above and will review all feedback in support of its efforts to implement the Nevada Public Option.

2. **What are the federal requirements for engaging the public regarding the State's 1332 waiver application?**

Prior to submitting a Section 1332 waiver for review and consideration, a State must provide public notice and a comment period sufficient to ensure a meaningful level of public input on the application. During the public comment period, the State must conduct public hearings regarding the State's application. In addition, a State with one or more federally recognized Tribes within its borders must conduct a separate process for meaningful consultation with the Tribes as part of the notice and comment process. There is also a federal notice and comment period for the public once the State's waiver application has been formally submitted.

3. **How can the public stay informed and receive updates about the State's design and implementation of the Nevada Public Option?**

Nevada DHHS has established a website that will provide regular updates on the design and implementation of the Nevada Public Option: http://dhhs.nv.gov/PublicOption/. The website also includes a link where you can sign up for email notifications regarding implementation of the Nevada Public Option.

4. **Will the Legislature have an opportunity to adjust for any issues identified from the State's 1332 waiver, actuarial analysis, and/or implementation process?**

Yes, because the Nevada Public Option is not scheduled to launch until January 1, 2026, there will be adequate time for the Legislature to revise SB 420 as needed to address any issues that arise from the waiver development and actuarial analysis, or otherwise. Furthermore, the waiver application and actuarial analysis are slated to be completed in February 2023 which is aligned with the State's next legislative session.

F. Other Topics or Questions

1. **How does the design of the Nevada Public Option attempt to avoid some of the early pitfalls of Washington's Public Option rollout?**

In its first year, premiums in Washington for the Public Option were reportedly higher than existing products in the individual market. To avoid this issue for Nevada's first year, SB 420 requires that Nevada Public Option premiums meet certain premium reduction targets and caps their growth over time (see Question B8).

It was also reported that participation by health carriers and providers was problematic for the State. Therefore, to help ensure carrier participation statewide, SB 420 requires carriers that wish to participate in the State's Medicaid Managed Care program to submit a good faith bid to contract with the State to offer and administer products for the Nevada Public Option. It also requires that providers participating in current public insurance programs to also participate in the new Nevada Public Option networks.

2. **Is the State considering the longer-term savings to the market from lowering the uninsured rate in Nevada as part of the actuarial analysis?**

The State will be working with its independent actuary to determine whether the potential for savings from the uninsured can be considered in the actuarial analysis in a manner that meets actuarial standards.

3. Is there a second actuarial analysis in SB 420? What is it for?

Pursuant to subsection 1 in section 16.5 of SB 420, a second actuarial analysis is required as part of a 1332 waiver application that is separate from the efforts underway for the Nevada Public Option. Specifically, this section requests that Nevada Health Link seek federal approval to waive the federal rules necessary to permit certain labor and agricultural organizations to offer a product for direct purchase as a policy of individual health insurance in Nevada. Efforts to engage stakeholders regarding the design and analysis for this effort will be led by the Nevada Health Link and are separate from the process and activities underway for the Nevada Public Option.

Nevada Department of Health and Human Services
DIVISION OF HEALTH CARE FINANCING AND POLICY

FACT SHEET - Nevada Public Option

Nevada Medicaid - October 2022
Contact: NVPublicOption@dhhs.nv.gov
Website: https://DHHS.nv.gov/PublicOption

Overview

In 2021, the Nevada Legislature passed Senate Bill 420, becoming the second state to approve a Public Option. Starting on January 1, 2026, Nevadans can purchase one of the new Public Option plans through the Silver State Health Insurance Exchange or directly from participating health carriers.

How it Works

The Nevada Public Option works by leveraging the State's purchasing power with health carriers to negotiate a better deal for Nevadans. This purchasing power comes from the State's Medicaid managed care contracts with health carriers, which are worth more than $2 billion. The new state law requires health carriers that want to continue to participate as a Medicaid managed care organization in Nevada to also submit a good faith bid to offer a new, low-cost Public Option plan through the Silver State Health Insurance Exchange.

Although the State's purchasing of the new Public Option plans will be tied to the State's future procurements for Medicaid managed care organizations, the new Public Option plans will not look like Medicaid products. Instead, the new Public Options plans must meet all state and federal private health insurance standards for individual market plans offered through the Silver State Health Insurance Exchange. The real difference between the new Public Option plans and other private plans offered through the Silver State Health Insurance Exchange will be the additional state statutory and contractual requirements that will apply to the new Public Option plans.

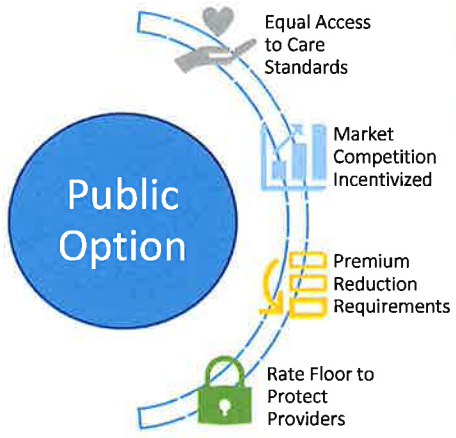
Through these new state contracts, the State can drive reforms and improve statewide access and affordability for consumers. For example, the state law requires state officials to enter contracts with health carriers that will:

- Promote new value-based provider payments to help drive down costs and improve quality of care.
- Utilize new strategies to reduce health disparities and increase access to culturally competent care.
- Strengthen Nevada's health care workforce.
- Increase access to safety-net providers by improving alignment of provider networks between Medicaid and the private insurance market.

Guardrails & Targeted Efforts to Reduce Costs

The new state law creates guardrails for the Nevada Public Option to lower premiums, ensure access to care, prevent large provider rate cuts, and increase market competition.

Figure 1: Statutory Guardrails



- **Guarantees Lower Premiums** – Health carriers offering new Public Option plans must meet certain premium reduction targets. State officials may revise these targets as long as premiums are reduced by 15 percent in the first four years.
- **Ensures Equitable Access to Care** – Providers participating in Medicaid and the State's public employee benefit plan must participate in at least one provider network in the Public Option. They must also apply the same practices for accepting new patients enrolled in Public Option plans as they apply to new patients enrolled in other private health plans.
- **Prevents Large Provider Rate Cuts**– Health carriers offering new Public Option plans must agree to pay providers in their networks at rates that are no lower than Medicare. Health carriers can pay providers rates that are higher

than Medicare. Medicare is intended to serve as a floor to protect providers when negotiating with health carriers for rates in the Public Option.

- **Increases Market Competition** – Health carriers seeking to participate in Nevada's Medicaid managed care program must also bid on a contract for the Public Option. This new requirement is designed to leverage the State's purchasing authority with health carriers and increase competition in both markets.

Implementation and Projected Gains

State law requires Nevada Medicaid to submit a 1332 State Innovation Waiver application to the federal government. As part of that application, the State hired an actuarial consulting firm to conduct the required analysis for the waiver and describe the impact on Nevada providers. Results of the analysis can be found on the Public Option website. Preliminary findings indicate that the Public Option will result in the following gains:

Significant Health Care Savings

The Nevada Public Option is anticipated to generate $341 to $464 million in health care savings for taxpayers over the first five years, most of which can be reinvested in Nevada's health care system.

New Critical Federal Funds for Nevada

Nevada is expected to receive hundreds of millions in new federal dollars in 2026 because of the savings produced by the Public Option. The new funds can be used to lower health care costs for Nevadans and help address other barriers faced by the remaining uninsured, including new investments in navigators.

Minimal Impact on Provider Revenue

Minimal changes in provider revenue are expected due to the small size of Nevada's individual health insurance market. Reductions in reimbursement to providers are expected to be offset by more Nevadans being able to access affordable health care and less unpaid bad medical debt.

Thousands with More Affordable Coverage

About 50,000 Nevadans are expected to enroll in Public Option plans in 2026. This number is expected to nearly double by 2030.

The State's Projected Timeline

2021	2022	2023	2024	2025	2026
•SB 420 signed into law (June) and public design sessions (Nov-Dec)	•Develop 1332 waiver and conduct actuarial analysis/provider impact study •Share early findings (Sept.) and host weekly public Q&A sessions (Oct.) •Post for public comment period (Nov.)	•Submit waiver to federal government (March) •Negotiations with federal government •Issue Request for Information (RFI) to collect feedback on procurement (Summer)	•Develop Request For Proposals (RFP) •Issue Public Option RFP in conjunction with Managed Care RFP (Nov/Dec)	•Procurement period and plan awards for Public Option •Public Option carriers submit for qualified health plan certification with exchange and submit rates for approval by Nevada Department of Insurance	•Public Option plans available on exchange for open enrollment •DHCFP provides oversight of new Public Option contracts to ensure terms are met

Additional Resources

https://DHHS.nv.gov/PublicOption

Request for Information for the Nevada Battle Born State Plans and Market Stabilization Program

Response Deadline: June 16, 2024, at 5:00 PM PST

Introduction:

The Nevada Division of Health Care Financing and Policy (the Division) is soliciting informational responses from interested qualified carriers, health care providers, recipients, and other interested parties to inform the State's upcoming procurement of Battle Born State Plans (BBSPs), which will be new State-contracted health plans for individuals who purchase their own insurance. These new health plans will be available for consumers who purchase through the State's individual health insurance marketplace beginning in Plan Year 2026. The rollout of the BBSPs will coincide with the implementation of the Governor's Market Stabilization Program, which is intended to mitigate any financial risk to carriers and limit the impact of the new program on provider networks, while strengthening the long-term sustainability of Nevada's individual health insurance market.

Background:

Pursuant to Nevada Revised Statute (NRS) Chapter 695K, the Nevada Director of Health and Human Services (the Director) must establish and design a Public Option program in the individual health insurance market in order to lower premiums and health care costs for consumers, improve access to high-quality, affordable health care, reduce disparities in access and health outcomes, and increase competition in the State's individual market. To fulfill this new duty, the Director must contract with carriers to offer new health insurance options, known as Battle Born State Plans (BBSPs), through Nevada's state-based health insurance exchange, the Silver State Health Insurance Exchange (SSHIX).

BBSPs will resemble currently available health plans sold on SSHIX. All BBSPs must meet all State and federal requirements as standard qualified health plans (QHPs), including QHP certification. BBSPs will differ from traditional QHPs in that carriers offering BBSPs will be required to contract with the State to meet specific priorities and requirements outlined by the State, including an annual premium reduction target that will be defined pursuant to guidance issued from the Division. The current guidance regarding this target can be found here. To initiate these new contracts with carriers, the Director must conduct a State procurement process that coincides with the statewide procurement for Nevada's Medicaid Managed Care plans. To comply with State law, the Director must offer the new BBSPs to consumers for purchase on SSHIX no later than January 1, 2026.

Along with offering BBSPs, Nevada is seeking a Section 1332 Innovation Waiver from the federal government to create a Market Stabilization Program (MSP)[1] The MSP is intended to mitigate unexpected financial risks to carriers and impacts on provider networks as a result of the BBSPs. In the long term, the MSP will work to ensure the sustainability of the individual market. The MSP would accomplish these goals through three measures:

[1] Nevada's Section 1332 Waiver application can be found here: https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/MarketStabilization/FinalNV1332Application_vF2024v2.pdf

1. A State-Based Reinsurance Program
2. Implementation of a Quality Incentive Payment Program
3. A "Practice in Nevada" Incentive Program for Health Care Providers

This RFI will be used to inform the development of the final Request for Proposal (RFP) and BBSP-carrier contracts for particular programmatic features of these programs. For more information about the Division's activities, including other details about the BBSP and Market Stabilization programs, please visit: https://dhcfp.nv.gov/marketstabilization/.

To sign up for updates about this effort, click here.

Request for Information:

The Division is soliciting public input on certain innovations that will be part of the State's MSP and BBSPs, including the types of requirements or expectations the State may set through its procurement for, and future contractual arrangements with, qualified BBSP carriers.

This is only a Request for Information (RFI); no award will be made because of this solicitation. The Division invites comments, suggestions, and recommendations from potential vendors and other interested parties on any questions or issues raised in this RFI. Other interested parties include, but are not limited, to purchasers of individual market health insurance plans, consumer advocacy entities, community-based organizations, county governments and service providers, hospital systems, medical providers, and associations representing providers.

This RFI is solely for information and planning purposes and does not constitute a request for proposal or an invitation to bid. All information received in response to this solicitation is considered confidential business information by the Administrator of the Purchasing Division. This solicitation will not lead to evaluation or award pursuant to NRS 333.335(7), so responses remain confidential. Any information marked by a Respondent as trademark and proprietary will not be disclosed if the Respondent submits a redacted version of its Response to the Division when submitting its original Response to the RFI.

Response Instructions:

Carriers and other interested parties should answer the questions listed below for their RFI Response. Alternative approaches and methodologies for accomplishing the desired or intended results of this RFI are also solicited. Below is a template for RFI Responses. Respondents should identify the Section and the questions which they are responding to, restating the RFI question above their response. If a Respondent chooses to not answer a question under one of the RFI categories, the Respondent should state "no response" to that specific question. Submissions that do not follow the Response Instructions may be excluded by the Division for review and consideration.

Response Template
[Logo, as appropriate]
[Responder's Name]
[Organization or Company Name, as appropriate]

Re: RFI for Nevada Battle Born State Plans and Market Stabilization Program
Section 1: Opportunities to Advance Health Equity

1.A. [Restate Question]

Response: [Include response]

Respondents may submit questions about this RFI to the Division no later than **June 3, 2024** at 1332waiverprogram@dhcfp.nv.gov. Answers to questions received will be posted on the Division's website as an addendum to the RFI no later than **August 1, 2024.**

Response Submission:

Responders must submit their responses to the Division at 1332waiverprogram@dhcfp.nv.gov no later than **June 16, 2024 at 5:00 PM PST.**

RFI Questions:

I. Opportunities to Advance Health Equity & Address Disparities for Rural Communities

NRS Chapter 695K states that one of the purposes of the Public Option is to reduce disparities related to health care access and health outcomes, as well as increase access to care for historically marginalized communities. As required by State law, the Director must prioritize BBSP awards that effectively implement strategies that decrease disparities in health access and outcomes and support culturally competent care. The Director must also prioritize bids that align provider networks among BBSP and Managed Care Organization (MCO) programs to support continuity of care as consumers' earnings increase and they transition to purchasing health insurance in the individual market. The State is currently assessing various opportunities and strategies to improve health equity through the new BBSPs and the MSP.

A. Which types of requirements should the Division consider for its contracts for BBSPs to advance health equity by mitigating disparities in health care access and outcomes? For instance, the Division is considering inclusion of the following requirements for BBSP carriers:
    a. Submission of a report on the carrier's efforts to expand access to care and improve outcomes for under-represented or hard-to-reach populations (including people of color, people for whom English is not their first language, and rural populations)
    b. Collection of race, ethnicity, and language data
    c. Submission of workforce development plans to increase access to providers in rural communities and improve cultural competency among the State's health care workforce
    d. Reporting on enrollees' out-of-pocket spending annually to better track and address medical debt which disproportionately impacts low-income communities and communities of color[2]

B. The Division is considering requiring BBSP carriers to collect and report on enrollees' demographic data (e.g., race, ethnicity, language, etc.), as these data are valuable for identifying, understanding, and eliminating health disparities.
    a. Do carriers currently collect such data? If so, how is this data currently used?
    b. Are there other demographic metrics the State should consider requiring?
    c. Are there any special considerations related to these potential requirements?
    d. Should the Division align these requirements with those that it includes in its managed care program for Medicaid plans?

C. Are there best practices or strategies in developing health equity and rural health care program requirements and/or benchmarks that have been effective in other states? If so, what are these strategies, and how effective do you think they would be if implemented in Nevada?

II. Quality Incentive Payment Program

[2] Shameek Rakshit and others. The Burden of Medical Debt in the United States. Available here.

Currently, Nevada's Medicaid Managed Care program utilizes a quality incentive bonus payment program to reward carriers that achieve specific quality targets and goals. The Division intends to implement a similar program – the Quality Incentive Payment Program – for the BBSP program. The BBSP Quality Incentive Payment Program will function like the Medicaid Managed Care incentive program in which carriers are rewarded at the end of each year if quality metrics are met.

A. The Division is considering a variety of value-based payment incentives, including bonuses for primary care spending targets, rewards for carriers that meet their premium targets in a manner that avoids lowering provider rates to the Medicare average rate, efforts to address public health crises (e.g., opioid crisis, maternal and child health outcomes), investments to narrow health disparities, and investments in provider workforce capacity in Nevada.
    a. Which quality targets or goals should the State measure in value-based payment design in the commercial market?
    b. Which incentives should the State prioritize in its value-based payment design?
    c. What considerations should the State keep in mind in incorporating these quality goals and incentives in the Quality Incentive Payment Program?
    d. If the State offers a bonus payment to BBSPs that meet their premium targets without reducing provider reimbursement to the Medicare average rate, are there strategies for how the Division should measure and enforce such bonus payments?

B. The State aims to align value-based initiatives across Medicaid and the individual market to directly influence and improve how care is delivered and financed in Nevada.
    a. How should measures and incentives in Medicaid and the commercial market align? How should they differ?
    b. What considerations should the Division keep in mind to advance this objective?

III. Practice in Nevada Incentive Program for Providers

To combat the provider workforce shortage in Nevada, the Division intends to implement the Practice in Nevada Incentive Program as part of the MSP. The Practice in Nevada Incentive Program will be a loan repayment program for medical providers that links repayment to a commitment to live and work in Nevada. At a minimum, the program will require providers to practice in the community in which they live for four years and enter into a contract with the State to meet specific program requirements. Those found in violation of the program requirements will be required under contract to repay the State for any financial assistance received.

A. What program design elements should the Division consider for the Practice in Nevada Incentive Program? For instance, should the Division consider mechanisms to encourage providers to practice in the most rural communities in the State or to encourage participation of certain provider types (i.e., primary care providers)?

B. Are there provider loan repayment program models the Division should consider that have shown promise in Nevada or other states with respect to strengthening provider workforce, improving health outcomes, and controlling health care costs?

C. What strategies and/or incentives should the Division consider to ensure the retention of providers in the State once the four-year commitment to practice in the State is satisfied?

IV. Reinsurance Program Parameters

The State intends to finance a new state reinsurance program for all carriers operating in the State's individual market with federal pass-through funds made available under the Section 1332 waiver. Through this new reinsurance program, the State seeks to share some of the financial risk with carriers for the cost of covering the individual market in a manner that would help lower costs for consumers ineligible for premium assistance. This, in turn, helps limit the potential risk and losses for carriers operating in the individual market.

A. The State is considering either designing the reinsurance program with (A) a geographic tiered structure designed to reduce premiums more in the highest-cost geographic areas (i.e., Rating Areas 3 and 4), or (B) with an even distribution across regions. Are there considerations the Division should keep in mind when making this determination?
B. What additional feedback would you offer the State regarding the proposed reinsurance program in the waiver?

V. Other Information

The State is looking for feedback from carriers seeking to bid that should be considered in building out the timeline for the Request for Proposals and the new contracts. This includes considerations for QHP Certification, Network Adequacy, and Rate Review procedures, including considerations that are specific to new market entrants versus existing market entrants.

Joe Lombardo
Governor

Florence Jameson, MD
Chairwoman

Ryan High
Executive Director

Silver State Health Insurance Exchange

2310 South Carson Street, Suite 2 Carson City, NV 89701 T: 775-687-9939 F: 775-687-9932

www.nevadahealthlink.com/sshix

NOTICE OF HEARING OF FEES TO BE CHARGED TO INSURERS

FOR

CALENDAR YEAR 2024

IN THE

SILVER STATE HEALTH INSURANCE EXCHANGE

FOR ADOPTION BY THE BOARD ON

FEBRUARY 16, 2023

The Silver State Health Insurance Exchange will hold a public hearing at 1:30 p.m. on February 16, 2023, via Zoom Webinar. The purpose of the hearing is to receive comments from all interested persons regarding the adoption of regulations that pertain to the Silver State Health Insurance Exchange and Chapter 695I of the Nevada Administrative Code. The hearing will be held in conjunction with the Board meeting scheduled for the same time and will be included as Agenda Item VIII of the Board meeting. This agenda item will be heard no earlier than 1:30 p.m. or as soon thereafter upon the conclusion of the preceding agenda items.

Date and Time of Hearing:	Thursday, February 16, 2023 at 1:30 p.m.
Place of Hearing:	Zoom and Teleconference: In order to participate via Zoom, you will need to download this application onto your device or **join from your computer browser**. If you are unable to complete this action, you may dial into the teleconference phone number provided below.
Videoconference Location:	Zoom Meeting When: February 16, 2023 1:30 PM Pacific Time (US and Canada) Topic: SSHIX Board Meeting Please click the link below to join the webinar: https://nevadahealthlink.zoom.us/j/84997675335?pwd=SXFIV2M2M01ZSHRvS2ViUWpxZXVoUT09 Or Telephone: Dial: +1 408 961 3927 US Toll +1 855 758 1310 US Toll-free Meeting ID: 849 9767 5335 (Enter after dialing phone number)
Physical Location:	2310 South Carson St., Suite 3A, Carson City, NV 89701

Silver State Health Insurance Exchange
Notice of Hearing on fees to be Charged to Insurers for Calendar Year 2024

Approved text may be made available at:	2310 S. Carson St., Suite 2 Carson City, NV 89701 775-687-9939
Or located online at:	https://www.nevadahealthlink.com/meeting-types/silver-state-health-insurance-exchange-board-meeting/

Hearing on Fees to be Charged to Insurers:

1. Pursuant to Regulation Ex-04-A adopt the 2024 fees to be charged to insurers. Adopt a 3.05% of pre-subsidized premium fee for Qualified Health Plans and Standalone Dental Plans offered on the Exchange.

Plan Type	Percent of Premium
Qualified Health Plan	3.05%
Standalone Dental Plan	3.05%

Authority:

42 USC § 18031(d)(5)(A), NRS 695I.210, Section 4 of Regulation Ex-04A.

Effective Dates of Fees:

January 1, 2024 through December 31, 2024

Posted: January 13, 2023

3. This Declaration is submitted in support of Plaintiffs' Motion for Preliminary Injunction.

4. Attached as **Exhibit A** to Plaintiffs' Motion is a true and correct copy of S.B. 420 (81st Leg., Nev. 2021).

5. Attached as **Exhibit B** to Plaintiffs' Motion is a true and correct copy of the public record of S.B. 420 that is maintained by the Nevada State Legislature.

6. Attached as **Exhibit C** to Plaintiffs' Motion is a true and correct copy of the public record of the votes on S.B. 420 that is maintained by the Nevada State Legislature.

7. I have reviewed the public records maintained by the Nevada State legislature, which are available online at https://www.leg.state.nv.us/, and after a reasonable search, I did not find any material changes that the legislature made to S.B. 420 in the 2021, 2023, or 2025 legislative sessions.

8. Attached as **Exhibit D** to Plaintiffs' Motion is a true and correct copy of the State of Nevada's December 7, 2022, Section 1332 Waiver Application.

9. Attached as **Exhibit E** to Plaintiffs' Motion is a true and correct copy of the January 1, 2024, letter from the Director of the Nevada Department of Health & Human Services to the U.S. Secretary of the Treasury and the U.S. Secretary of Health and Human Services.

10. Attached as **Exhibit F** to Plaintiffs' Motion is a true and correct copy of the August 23, 2024 letter from the Director of the Nevada Department of Health & Human Services to the U.S. Secretary of the Treasury and the U.S. Secretary of Health and Human Services, which was attached to the State of Nevada's addendum to its Waiver Application.

11. Attached as **Exhibit G** to Plaintiffs' Motion is a true and correct copy of the January 10, 2025, letter from Ellen Montz, U.S. Department of Health and Human Services, to Richard Whitley, Director of the Nevada Department of Health and Human Services.

12. Attached as **Exhibit H** to Plaintiffs' Motion is a true and correct copy of the January 10, 2025, letter from Chiquita Brooks-LaSure, U.S. Department of Health and Human Services, to Richard Whitley, Director of the Nevada Department of Health and Human Services.

HOLLAND & HART LLP
5441 KIETZKE LANE
SECOND FLOOR
RENO, NV 89511

13. Attached as **Exhibit I** to Plaintiffs' Motion is a true and correct copy of the January 10, 2025, letter from Chiquita Brooks-LaSure, U.S. Department of Health and Human Services, to Richard Whitley, Director of the Nevada Department of Health and Human Services, fully executed by the parties.

14. Attached as **Exhibit J** to Plaintiffs' Motion is a true and correct copy of the October 4, 2022, "Guidance Letter" issued by Richard Whitley and Suzanne Bierman of the Nevada Department of Health and Human Services.

15. Attached as **Exhibit K** to Plaintiffs' Motion is a true and correct copy of the November 20, 2023, "Guidance Letter" issued by Richard Whitley and Suzanne Bierman of the Nevada Department of Health and Human Services.

16. Attached as **Exhibit L** to Plaintiffs' Motion is a true and correct copy of the January 2, 2024, letter sent from Holland & Hart LLP to the Nevada Department of Health & Human Services.

17. Attached as **Exhibit M-1** to Plaintiffs' Motion is a true and correct copy of *Health Workforce Nevada: A Chartbook - 2023 Edition* from the Nevada Health Workforce Research Center. Exhibit M-1 details that as of 2023, 10.2% of Nevada's workforce was employed in the healthcare industry. Attached as **Exhibit M-2** to Plaintiff's Motion is a true and correct copy of *Gross Domestic Product: Health Care and Social Assistance (62) In Nevada*, retrieved from the Federal Reserve Bank of St. Louis's website on June 17, 2025. Exhibit M-2 details that the healthcare industry in Nevada is a $15 billion industry.

18. Attached as **Exhibit N** to Plaintiffs' Motion is a true and correct copy of the July 30, 2024, Order Granting Motions to Dismiss First Amendment Complaint in *National Taxpayers Union v. Lombardo*, No. 24 OC 00001 1B.

19. My office has periodically reviewed various sources searching for other lawsuits that make a constitutional challenge to S.B. 420. It has never located any such filing. Likewise, my office has periodically reviewed various sources to see if any individuals or organizations have indicated any interest in filing such a lawsuit. It has never located any such individual or organization.

HOLLAND & HART LLP
5441 KIETZKE LANE
SECOND FLOOR
RENO, NV 89511

20. Attached as **Exhibit O** to Plaintiffs' Motion is a true and correct copy of the January 19, 2022, Questions & Answers (Q&A) for the Nevada Public Option (Senate Bill 420) created by the Nevada Department of Health and Human Services.

21. Attached as **Exhibit P** to Plaintiffs' Motion is a true and correct copy of the October 2022 FACT SHEET – Nevada Public Option created by the Nevada Department of Health and Human Services.

22. Attached as **Exhibit Q** to Plaintiffs' Motion is a true and correct copy of the Request for Information for the Nevada Battle Born State Plans and Market Stabilization Program issued by the Nevada Department of Health and Human Services.

23. Attached as **Exhibit R** to Plaintiffs' Motion is a trust and correct copy of the Silver State Health Insurance February 16, 2023, Agent Item detailing the Revenue/Carrier Premium Fees ("CPFs" or "QHP fees") at a rate of 3.05% of total premiums collected on the sale of health insurance plans sold through the Exchange.

Pursuant to NRS 53.045, I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

DATED: July 2, 2025

Joshua M. Halen

35141305_v1

HOLLAND & HART LLP
5441 KIETZKE LANE
SECOND FLOOR
RENO, NV 89511