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. 25OC00151 1

Dept. No. I

PLAINTIFFS' APPENDIX TO MOTION FOR PRELIMINARY INJUNCTION

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35340515_v1

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

(a) Inform the person, in writing or by electronic communication, of his or her duty as a mandatory reporter pursuant to this section;

(b) Obtain a written acknowledgment or electronic record from the person that he or she has been informed of his or her duty pursuant to this section; and

(c) Maintain a copy of the written acknowledgment or electronic record for as long as the person is licensed, certified or endorsed in this State.

8. The employer of a person who is described in subsection 4 and who is not required in his or her professional or occupational capacity to be licensed, certified or endorsed in this State must, upon initial employment of the person:

(a) Inform the person, in writing or by electronic communication, of his or her duty as a mandatory reporter pursuant to this section;

(b) Obtain a written acknowledgment or electronic record from the person that he or she has been informed of his or her duty pursuant to this section; and

(c) Maintain a copy of the written acknowledgment or electronic record for as long as the person is employed by the employer.

9. Before a person may serve as a volunteer at a public school or private school, the school must:

(a) Inform the person, in writing or by electronic communication, of his or her duty as a mandatory reporter pursuant to this section and NRS 392.303;

(b) Obtain a written acknowledgment or electronic record from the person that he or she has been informed of his or her duty pursuant to this section and NRS 392.303; and

(c) Maintain a copy of the written acknowledgment or electronic record for as long as the person serves as a volunteer at the school.

10. As used in this section:

(a) "Private school" has the meaning ascribed to it in NRS 394.103.

(b) "Public school" has the meaning ascribed to it in NRS 385.007.

Sec. 34. NRS 439B.260 is hereby amended to read as follows:

439B.260 1. A major hospital shall reduce or discount the total billed charge by at least 30 percent for hospital services provided to an inpatient who:

(a) Has no policy of health insurance or other contractual agreement with a third party that provides health coverage for the charge;

(b) Is not eligible for coverage by a state or federal program of public assistance that would provide for the payment of the charge; and

(c) Makes reasonable arrangements within 30 days after the date that notice was sent pursuant to subsection 2 to pay the hospital bill.

2. A major hospital shall include on or with the first statement of the hospital bill provided to the patient after his or her discharge a notice of the reduction or discount available pursuant to this section, including, without limitation, notice of the criteria a patient must satisfy to qualify for a reduction or discount.

3. A major hospital or patient who disputes the reasonableness of arrangements made pursuant to paragraph (c) of subsection 1 may submit the dispute to the Bureau for Hospital Patients for resolution as provided in NRS 232.462.

4. A major hospital shall reduce or discount the total billed charge of its outpatient pharmacy by at least 30 percent to a patient who is eligible for Medicare.

5. As used in this section, "third party" means:

(a) An insurer, as that term is defined in NRS 679B.540;

(b) A health benefit plan, as that term is defined in NRS 687B.470, for employees which provides coverage for services and care at a hospital;

(c) A participating public agency, as that term is defined in NRS 287.04052, and any other local governmental agency of the State of Nevada which provides a system of health insurance for the benefit of its officers and employees, and the dependents of officers and employees, pursuant to chapter 287 of NRS; ~~[or]~~

(d) ***The Public Option established pursuant to section 10 of this act; or***

(e) Any other insurer or organization providing health coverage or benefits in accordance with state or federal law.

➥ The term does not include an insurer that provides coverage under a policy of casualty or property insurance.

Sec. 35. NRS 439B.665 is hereby amended to read as follows:

439B.665 1. On or before February 1 of each year, a nonprofit organization that advocates on behalf of patients or funds medical research in this State and has received a payment, donation, subsidy or anything else of value from a manufacturer, third party or pharmacy benefit manager or a trade or advocacy group for manufacturers, third parties or pharmacy benefit managers during the immediately preceding calendar year shall:

(a) Compile a report which includes:

(1) For each such contribution, the amount of the contribution and the manufacturer, third party or pharmacy benefit manager or group that provided the payment, donation, subsidy or other contribution; and

(2) The percentage of the total gross income of the organization during the immediately preceding calendar year attributable to payments, donations, subsidies or other contributions from each manufacturer, third party, pharmacy benefit manager or group; and

(b) Except as otherwise provided in this paragraph, post the report on an Internet website that is maintained by the nonprofit organization and accessible to the public. If the nonprofit organization does not maintain an Internet website that is accessible to the public, the nonprofit organization shall submit the report compiled pursuant to paragraph (a) to the Department.

2. As used in this section, "third party" means:

(a) An insurer, as that term is defined in NRS 679B.540;

(b) A health benefit plan, as that term is defined in NRS 687B.470, for employees which provides coverage for prescription drugs;

(c) A participating public agency, as that term is defined in NRS 287.04052, and any other local governmental agency of the State of Nevada which provides a system of health insurance for the benefit of its officers and employees, and the dependents of officers and employees, pursuant to chapter 287 of NRS; ~~[or]~~

(d) ***The Public Option established pursuant to section 10 of this act; or***

(e) Any other insurer or organization that provides health coverage or benefits in accordance with state or federal law.

➥ The term does not include an insurer that provides coverage under a policy of casualty or property insurance.

Sec. 36. NRS 439B.736 is hereby amended to read as follows:

439B.736 1. "Third party" includes, without limitation:

(a) The issuer of a health benefit plan, as defined in NRS 695G.019, which provides coverage for medically necessary emergency services;

(b) The Public Employees' Benefits Program established pursuant to subsection 1 of NRS 287.043; ~~[and]~~

(c) ***The Public Option established pursuant to section 10 of this act; and***

(d) Any other entity or organization that elects pursuant to NRS 439B.757 for the provisions of NRS 439B.700 to 439B.760,

inclusive, to apply to the provision of medically necessary emergency services by out-of-network providers to covered persons.

2. The term does not include the State Plan for Medicaid, the Children's Health Insurance Program or a health maintenance organization, as defined in NRS 695C.030, or managed care organization, as defined in NRS 695G.050, when providing health care services through managed care to recipients of Medicaid under the State Plan for Medicaid or insurance pursuant to the Children's Health Insurance Program pursuant to a contract with the Division of Health Care Financing and Policy of the Department.

Sec. 37. NRS 449A.162 is hereby amended to read as follows:

449A.162 1. Except as otherwise provided in subsection 3, if a hospital provides hospital care to a person who has a policy of health insurance issued by a third party that provides health coverage for care provided at that hospital and the hospital has a contractual agreement with the third party, the hospital:

(a) Shall proceed with any efforts to collect on any amount owed to the hospital for the hospital care in accordance with the provisions of NRS 449A.159.

(b) Shall not collect or attempt to collect from the patient or other responsible party more than the sum of the amounts of any deductible, copayment or coinsurance payable by or on behalf of the patient under the policy of health insurance.

(c) Shall not collect or attempt to collect that amount from:

(1) Any proceeds or potential proceeds of a civil action brought by or on behalf of the patient, including, without limitation, any amount awarded for medical expenses; or

(2) An insurer other than an insurer that provides coverage under a policy of health insurance or an insurer that provides coverage for medical payments under a policy of casualty insurance.

2. If the hospital collects or receives any payments from an insurer that provides coverage for medical payments under a policy of casualty insurance, the hospital shall, not later than 30 days after a determination is made concerning coverage, return to the patient any amount collected or received that is in excess of the deductible, copayment or coinsurance payable by or on behalf of the patient under the policy of health insurance.

3. This section does not apply to:

(a) Amounts owed to the hospital which are not covered under the policy of health insurance; or

(b) Medicaid, Medicare, the Children's Health Insurance Program or any other public program which may pay all or part of the bill.

4. This section does not limit any rights of a patient to contest an attempt to collect an amount owed to a hospital, including, without limitation, contesting a lien obtained by a hospital.

5. As used in this section, "third party" means:

(a) An insurer, as defined in NRS 679B.540;

(b) A health benefit plan, as defined in NRS 687B.470, for employees which provides coverage for services and care at a hospital;

(c) A participating public agency, as defined in NRS 287.04052, and any other local governmental agency of the State of Nevada which provides a system of health insurance for the benefit of its officers and employees, and the dependents of officers and employees, pursuant to chapter 287 of NRS; ~~[or]~~

(d) ***The Public Option established pursuant to section 10 of this act; or***

(e) Any other insurer or organization providing health coverage or benefits in accordance with state or federal law.

Sec. 38. Section 10 of this act is hereby amended to read as follows:

Sec. 10. 1. The Director, in consultation with the Commissioner and the Executive Director of the Exchange, shall design, establish and operate a health benefit plan known as the Public Option.

2. The Director:

(a) Shall make the Public Option available:

(1) As a qualified health plan through the Exchange to natural persons who reside in this State and are eligible to enroll in such a plan through the Exchange under the provisions of 45 C.F.R. § 155.305; and

(2) For direct purchase as a policy of individual health insurance by any natural person who resides in this State. The provisions of chapter 689A of NRS and other applicable provisions of this title apply to the Public Option when offered as a policy of individual health insurance.

(b) May make the Public Option available to small employers in this State or their employees to the extent authorized by federal law. The provisions of chapter 689C of NRS and other applicable provisions of this title apply to the Public Option when it is offered as a policy of health insurance for small employers.

(c) Shall comply with all state and federal laws and regulations applicable to insurers when carrying out the

provisions of sections 2 to 15, inclusive, of this act, to the extent that such laws and regulations are not waived.

3. The Public Option must:

(a) Be a qualified health plan, as defined in 42 U.S.C. § 18021; and

(b) Provide at least levels of coverage consistent with the actuarial value of one silver plan and one gold plan.

4. ~~[Except as otherwise provided in this section, the premiums for the Public Option:~~

~~(a) Must be at least 5 percent lower than the reference premium for that zip code; and~~

~~(b) Must not increase in any year by a percentage greater than the increase in the Medicare Economic Index for that year.~~

~~5. The Director, in consultation with the Commissioner and the Executive Director of the Exchange, may revise the requirements of subsection 4, provided that the average premiums for the Public Option must be at least 15 percent lower than the average reference premium in this State over the first 4 years in which the Public Option is in operation.~~

~~6.]~~ As used in this section:

(a) "Gold plan" means a qualified health plan that meets the requirements established by 42 U.S.C. § 18022 for a gold level plan.

(b) "Health benefit plan" means a policy, contract, certificate or agreement to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

(c) "Medicare Economic Index" means the Medicare Economic Index, as designated by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services pursuant to 42 C.F.R. § 405.504.

(d) "Reference premium" means, for any zip code, the lower of:

(1) The premium for the second-lowest cost silver level plan available through the Exchange in the zip code during the 2024 plan year, adjusted by the percentage change in the Medicare Economic Index between January 1, 2024, and January 1 of the year to which a premium applies; or

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

(e) "Silver plan" means a qualified health plan that meets the requirements established by 42 U.S.C. § 18022 for a silver level plan.

(f) "Small employer" has the meaning ascribed to it in 42 U.S.C. § 18024(b)(2).

Sec. 38.3. 1. There is hereby appropriated from the State General Fund to the Division of Welfare and Supportive Services of the Department of Health and Human Services the sum of $167,850 to pay the costs for enhancements to the information technology system of the Division that are necessary to carry out the provisions of sections 24 to 28, inclusive, of this act.

2. Any remaining balance of the appropriation made by subsection 1 must not be committed for expenditure after June 30, 2023, by the entity to which the appropriation is made or any entity to which money from the appropriation is granted or otherwise transferred in any manner, and any portion of the appropriated money remaining must not be spent for any purpose after September 15, 2023, by either the entity to which the money was appropriated or the entity to which the money was subsequently granted or transferred, and must be reverted to the State General Fund on or before September 15, 2023.

Sec. 38.6. 1. There is hereby appropriated from the State General Fund to the Public Option Trust Fund created by section 15 of this act the sum of $1,639,366 to pay the costs of carrying out the provisions of sections 2 to 15, inclusive, and 39 of this act.

2. Any remaining balance of the appropriation made by subsection 1 must not be committed for expenditure after June 30, 2023, by the entity to which the appropriation is made or any entity to which money from the appropriation is granted or otherwise transferred in any manner, and any portion of the appropriated money remaining must not be spent for any purpose after September 15, 2023, by either the entity to which the money was appropriated or the entity to which the money was subsequently granted or transferred, and must be reverted to the State General Fund on or before September 15, 2023.

Sec. 38.8. 1. There is hereby appropriated from the State General Fund to the Silver State Health Insurance Exchange the sum of $600,000 to pay the costs of carrying out the provisions of sections 2 to 15, inclusive, and 39 of this act.

2. Any remaining balance of the appropriation made by subsection 1 must not be committed for expenditure after June 30, 2023, by the entity to which the appropriation is made or any entity to which money from the appropriation is granted or otherwise

transferred in any manner, and any portion of the appropriated money remaining must not be spent for any purpose after September 15, 2023, by either the entity to which the money was appropriated or the entity to which the money was subsequently granted or transferred, and must be reverted to the State General Fund on or before September 15, 2023.

Sec. 39. 1. The Director of the Department of Health and Human Services, the Commissioner of Insurance and the Executive Director of the Silver State Health Insurance Exchange shall apply for the waiver described in paragraph (a) of subsection 1 of section 11 of this act not later than January 1, 2024.

2. In preparing the initial application for the waiver described in paragraph (a) of subsection 1 of section 11 of this act, the Director of the Department of Health and Human Services, the Commissioner of Insurance and the Executive Director of the Silver State Health Insurance Exchange shall contract with an independent actuary to conduct an actuarial assessment pursuant to subsection 2 of section 11 of this act. The actuarial assessment:

(a) Must be completed before the application for the waiver is submitted; and

(b) Must include, without limitation, an analysis of the likely effect on premiums for health insurance in this State of:

(1) The provisions of subsection 1 of section 13 of this act, as those provisions apply to providers of health care, as defined in NRS 695G.070, who participate in the Public Employees' Benefits Program established pursuant to subsection 1 of NRS 287.043 or provide care to an injured employee pursuant to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS, and the amendatory provisions of section 21 of this act; and

(2) Repealing the provisions described in subparagraph (1).

3. The Director of the Department of Health and Human Services shall make the Public Option available to natural persons who reside in this State in accordance with the provisions of section 10 of this act for the coverage year that begins on January 1, 2026.

4. As used in this section, "Public Option" has the meaning ascribed to it in section 8 of this act.

Sec. 39.5. On or before January 1, 2025, the Executive Director of the Silver State Health Insurance Exchange, in collaboration with the Department of Health and Human Services, shall:

1. Apply for the waiver described in subsection 1 of section 16.5 of this act; and

2. Submit to the Director of the Legislative Counsel Bureau for transmittal to the 83rd Session of the Legislature a report of recommendations concerning any revisions to Nevada law necessary to:

(a) Authorize an organization described in section 501(c)(5) of the Internal Revenue Code to offer a policy of insurance described in subsection 1 of section 16.5 of this act for direct purchase outside the Exchange as a policy of individual health insurance;

(b) Align state law concerning individual health insurance with the requirements in the request for the waiver described in subsection 1 of section 16.5 of this act; and

(c) Ensure that any state subsidies available to reduce the cost of premiums for individual health insurance are available for a policy of insurance described in subsection 1 of section 16.5 of this act.

Sec. 40. Notwithstanding the provisions of NRS 218D.430 and 218D.435, a committee, other than the Assembly Standing Committee on Ways and Means and the Senate Standing Committee on Finance, may vote on this act before the expiration of the period prescribed for the return of a fiscal note in NRS 218D.475. This section applies retroactively from and after March 22, 2021.

Sec. 40.5. The provisions of NRS 354.599 do not apply to any additional expenses of a local government that are related to the provisions of this act.

Sec. 41. 1. This section and sections 16.3, 16.5, 16.8 and 39 to 40.5, inclusive, of this act become effective upon passage and approval.

2. Sections 1 to 14, inclusive, 16, 19, 20, 21, 22, 29 to 32, inclusive, and 34 to 37, inclusive, of this act become effective:

(a) Upon passage and approval for the purposes of procurement and any other preparatory administrative tasks necessary to carry out the provisions of those sections; and

(b) On January 1, 2026, for all other purposes.

3. Sections 15, 16.35 to 16.47, inclusive, 20.5, 38.3 and 38.6 of this act become effective on July 1, 2021.

4. Sections 17, 18, 23 to 28, inclusive, 33 and 38.8 of this act become effective on January 1, 2022.

5. Section 38 of this act becomes effective on January 1, 2030.

APPENDIX C
State of Nevada Guidance Memorandum

Steve Sisolak
Governor

Richard Whitley, MS
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF HEALTH CARE FINANCING AND POLICY

Helping people. It's who we are and what we do.

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

APPENDIX D
Provider Participation Analysis

Summary of the Provider Participation Requirement in SB420 (Nevada Public Option) and its Impact on Provider Reimbursement

Milliman

Executive Summary

Nevada Senate Bill 420 (SB420 and subsequent guidance as issued by the state on December 27, 2023 require premiums in the new Nevada Public Option (PO) plans to be at least 16% lower than the average reference premium by year four of the Public Option program (2029). Given that the structure of a typical premium rate in the individual market consists predominantly of payments to providers for facility and professional services, and prescription drugs, PO offerings on Nevada's exchange will need to have provider reimbursement that is lower than the current average reimbursement for Qualified Health Plans (QHPs) on Nevada's exchange to meet the premium reduction targets in the bill and related guidance.[1]

The prospect of lower reimbursement might influence a provider's decision to contract with any or all PO issuers. Therefore, to reduce the possibility of inadequate networks under PO offerings, SB420 included a provision (referred to interchangeably as the "provider participation requirement" or the "provider tying provision") that requires providers to participate in at least one PO offering if they are participating in either Medicaid, the public employees benefit program, or the state's workers' compensation program. Moreover, the bill requires that an evaluation be done to assess the impact on premiums[2] if the provider participation requirement (PPR) were waived by the Director of DHHS, as permitted by SB420.

Our approach to conducting the evaluation required by SB420 is to assess the overall impact of the PO on provider revenue and then determine the likelihood that the impact would lead providers to elect not to participate in the program. *If the impact to provider revenue is small, then the PPR may be less impactful on provider engagement with the PO and network adequacy as providers might be willing to contract with issuers offering PO plans at the provider reimbursement levels required to meet the premium targets.* To assess the impact of the PPR on provider revenue, we simulate the estimated provider reimbursement in Year 4 of the PO and compare this to current provider reimbursement, applied to a 2022 health insurance market environment and expressed as a percentage of Medicare reimbursement. Year 4 of the PO represents the greatest premium savings requirement under the SB420 and thus the greatest potential impact to provider revenue.

Based on discussions with the State, we understand that the state's intent is to utilize the contracting process with issuers to shift some of the burden of the required premium reduction targets under SB420 from the providers to issuers. Therefore, in addition to reduced provider reimbursement, we assume lower issuer premium expense loads on PO offerings relative to non-PO offerings on the exchange. Lower expense loads in PO premiums, by themselves, decrease premium rates for PO offerings, and thereby reduce the amount of provider reimbursement reductions otherwise needed to meet the premium targets under SB420.

In our best estimate modeling, we assume about 60% of individual market members in Nevada will switch to a Public Option offering. We assume that individuals who switch from a non-PO exchange offering to a PO offering will decrease provider revenue from 169% of Medicare reimbursement to 139% of Medicare reimbursement, or about 17.3% across facility and professional services combined. Consistent with estimates used in our 1332 waiver analysis, we further assume that 16% of the uninsured who are eligible for premium tax credits will take up coverage under the PO because of additional state-based premium subsidies. Coverage for these individuals will lead to increased provider revenue for several reasons that we outline in detail in our analysis, but that are attributable to anticipated changes in consumer behavior and realized provider reimbursement levels for individuals who transition from no coverage to having coverage.

The combined impact of these member migrations to the Public Option is an estimated provider revenue reduction of approximately $25 million in aggregate or approximately 0.11% of total provider revenue (facility and professional services combined). The providers' average payment rate (excluding volume changes) expressed as a percentage of Medicare reimbursement is estimated to decline by 0.94%. These results are summarized in the table below:

[1] The bill and subsequent guidance are included as Appendices B and C, respectively, in Milliman's 1332 Waiver Actuarial / Economic Analysis and Certification for Nevada's Public Option report

[2] The text of the bill does not specify which premiums in which market. We interpret it to mean individual market and public option premiums.

Table 1
Provider Participation Requirement in SB420
Summary of PPR Impact on Facility and Professional Provider Revenue
CY 2022 Basis (for Illustrative Purposes Only)

Public Option Take-Up %		Public Option Take-Up #			Key Financial Metrics			
From Individual Market	From APTC Uninsured	From Individual Market	From APTC Uninsured	Total PO	% Total Uninsured Take Up	Change in Provider Revenue	Change in Provider Revenue % of Total	Change in Average Payment Rate
60%	16%	68,700	9,742	78,442	3.3%	-25 M	-0.11%	-0.94%

All results in this memo are based on a CY 2022 market environment, unless otherwise noted, for illustrative purposes only. Using a CY 2022 basis isolates the impact of the provider participation requirement on provider revenue from other projection assumptions that would otherwise be required to model the Public Option in future years.

We conducted sensitivity analysis on provider revenue projections, producing a range of financial impacts that vary based on the assumed PO take-up rates from the individual market (which has a negative impact on provider revenue) and PO take-up from the uninsured (which has a positive effect). The impact on total provider revenue ranges from a maximum impact of -0.29% of revenue to minimum of 0.0%.

Overall, the introduction of the PO has a small negative impact on provider revenue under our best estimate assumptions. This minor impact to overall provider revenue is driven in large part by the fact that the PO is being targeted at the individual market in Nevada and a sub-segment of the uninsured (those that are eligible for ACA coverage but are not enrolled) that combined are only about 3% to 4% of the total Nevada population and thus represent a very small proportion of a provider's revenue.

Given the small target markets, *we conclude that the impact of a provider participation requirement, whether implemented or repealed, would likely have little effect on provider participation in PO offerings, that providers would be likely to contract with the PO at the required rates to achieve premium targets, and that as a result PO premium rates in the individual market would not be materially affected by the repeal of the requirement.*

Providers may have other reasons for not participating in a PO offering aside from revenue concerns. Our analysis does not reflect any other potential provider considerations beyond the revenue impacts described in this report. In addition, while this analysis is done on a market-wide basis, effects of the public option will vary by region, by provider type (professional or facilities), and by individual provider.

Introduction

The legislation establishing Nevada's Public Option (PO) includes a provision that requires providers who participate in the state's Medicaid program or the Public Employees' Benefits Program (PEBP) to also participate in at least one PO offering.

Section 13.1 of the legislation reads as follows:

"Except as otherwise provided in subsection 2, each provider of health care who participates in the Public Employees' Benefits Program established pursuant to subsection 1 of NRS 287.043 or the Medicaid program, or who provides care to an injured employee pursuant to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS, shall:

(a) Enroll as a participating provider in at least one network of providers established for the Public Option; and

(b) Accept new patients who are enrolled in the Public Option to the same extent as the provider or facility accepts new patients who are not enrolled in the Public Option."

Further, Section 39.2 reads as follows related to the actuarial analysis to be submitted for the purposes for getting an approved 1332 Waiver from the federal government:

"The actuarial assessment:

(a) Must be completed before the application for the waiver is submitted; and

(b) Must include, without limitation, an analysis of the likely effect on premiums for health insurance in this State of:

(1) The provisions of subsection 1 of section 13 of this act, as those provisions apply to providers of health care, as defined in NRS 695G.070, who participate in the Public Employees' Benefits Program established pursuant to subsection 1 of NRS 287.043 or provide care to an injured employee pursuant to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS, and the amendatory provisions of section 21 of this act; and

(2) Repealing the provisions described in subparagraph (1).

In short, the bill requires an actuarial analysis evaluate the impact of the provider participation requirement on premiums for health insurance in the state and the impact of repealing such a provision.

General Assumptions on the Effect of the Provider Participation Requirement

All else being equal, SB420's provider participation requirement (PPR) is intended to maintain provider participation across all PO offerings at levels at least equal to current participation levels in either the Medicaid or PEBP. If the PPR remains in effect, providers who choose not to participate in the PO may see reduced revenue from the loss of their Medicaid and / or PEBP patients.

The PPR would only be needed if participating in the PO had effects on providers that were perceived to be materially negative, in particular, negative effects on their revenue which may lead providers to opt out of participation. If providers were disinclined to participate due to negative provider revenue impacts and the PPR were not in place, there could be upward pressure on provider reimbursement under the PO to provide a greater incentive for providers to join the PO networks to ensure network adequacy. This upward pressure on provider reimbursement would make it more challenging for PO issuers to meet the premium targets under the bill. With the PPR in place, providers may be more likely to participate even at lower reimbursement levels to avoid the negative impact of lost Medicaid / PEBP patients.

However, if the PO has a neutral or only a modest negative effect on provider revenue, then providers would be inclined to participate with or without the PPR. In other words, the PPR or its repeal would have little or no impact as there would be incentives, or at least the lack of disincentives, associated with participating in PO networks.

Therefore, the key question for determining the need for the PPR is: what are the effects of participating in the PO on provider revenue, including both average reimbursement rates and overall provider revenue volume?

Estimated Impacts on Public Option Unit Costs

To understand the impact of the PO on provider revenue, we first model the unit cost or fee schedule changes, measured as a percentage of what reimbursement would be under Medicare fee-for-service (FFS), that would be required to reach the premium target of a 16% reduction in Year 4 of the PO. Medicare FFS reimbursement is often used as a basis for standardized comparisons of reimbursement under various scenarios. We use Year 4 because under SB420, the Year 4 price requirement for PO offerings is 16% below the reference

premium.[3] Beyond Year 4, there are no additional price reductions required relative to the reference premium. Thus, Year 4 represents the maximum potential effect on provider revenue that the bill requires from the PO.

In addition to reductions in provider reimbursement for services rendered to PO enrollees, the Nevada Department of Health and Human Services (DHHS) intends to require PO issuers to reduce administrative expenses attributable to PO plan offerings relative to non-public option plan offerings, although the final required expense reduction from DHHS is to be determined.

Required reductions in provider reimbursement and issuer expenses are modeled by first using an estimated average market premium of approximately $500, taken from the 2021 CMS Risk Adjustment Report,[4] and trended for the average rate 2022 rate increase of 4.1%[5] to $520.50. We assume the PO will not drive savings on pharmacy claims through provider contracts. Information from Nevada's 2022 Unified Rate Review Templates[6] was used to estimate average issuer administrative expense loads. Medical and prescription drug claims relationships were inferred from Milliman's *Health Cost Guidelines*™. From these data and assumptions, the structure of an average premium in the Nevada individual ACA for the 2022 market is simulated.

Next, based on guidance from DHHS, we model the expense reductions by PO issuers to affect a 3% difference in medical loss ratio (row 6 of Table 2 below), which translates to a 4.5% rate decrease on premiums (row 3 in Table 2 below) when combined with reductions in medical costs. The required reduction in provider reimbursement to reach a premium reduction target of 16% is calculated as the balancing item, specifically 17.6% shown in Row 1 of Table 2 below:

Table 2
Provided Participation Requirement in SB420
ACA Premium Structure and Estimated
Rate Impacts of Claims and Admin Reductions

		Pre-PO	Year 4 of PO Program	Change	Effect on Premium
(1)	Medical Claims	$314.64	$259.22	**-17.6%**	-10.6%
(2)	Rx Claims	$103.43	$103.43	0.0%	0.0%
(3)	Fixed Issuer Administration	$73.16	$49.93	-31.8%	**-4.5%**
(4)	Variable Issuer Administration & Profit	$29.27	$24.58	-16.0%	-0.9%
(5)	Total Premium	$520.50	$437.15	-16.0%	
(6)	Pricing Loss ratio	80%	83%		

Although not illustrated here, these assumptions provide for a reasonable sharing of the cost of the public option program on a dollar basis (not a percentage basis). Said differently, based on a 60% PO take-up rate, the dollar cost of the PO program is shared roughly evenly between providers and issuers. The ultimate impact of the PO on provider reimbursement levels may vary by issuer and will depend on the impact of other value-based purchasing initiatives required by DHHS on PO offerings, including those that might affect prescription drug costs (which are not captured here), as well as any incremental medical management or administrative efficiency practices the PO might have versus non-PO plans.

Estimated Impacts on Overall Provider Revenue Volume

The overall change in provider revenue volume, assuming unit cost or fee schedule reductions shown above will depend on actual enrollment in the PO. This enrollment is expected to come from two segments: the current ACA individual market and the uninsured who are eligible for ACA coverage but are currently forgoing that coverage. We discuss the impact to overall provider revenue of each of these below.

Enrollment from other ACA-Compliant Plans

Unless a non-PO plan's cost structure is modified, we assume a PO plan will be the second lowest cost silver plan on the Nevada exchange in all regions by Year 4 due to the premium reduction requirements of SB420 and related guidance. This also assumes that there will be more than one PO offering in each region.[7] Therefore, most of the PO enrollment is expected to come from current enrollees in ACA plans that become more expensive on a net (after federal premium subsidy) basis because federal premium subsidies have decreased due to the introduction of the PO. Smaller enrollment in the PO will also come from those currently enrolled in an ACA plan but are unsubsidized. For purposes of this demonstration, we assume the premiums for the new PO benchmark plans are 16% lower

[3] For additional analysis of the reference premiums, please see Milliman's full report "1332 Waiver Actuarial / Economic Analysis and Certification for Nevada's Public Option .

[4] https://www.cms.gov/files/document/appendix-2021-benefit-year-risk-adjustment-summary-report-hhs-risk-adjustment-program-state-specific.xlsx

[5] https://acasignups.net/21/10/01/nevada-avg-2022-aca-premium-rate-changes-41-indy-market-53-sm-group-market#:~:text=Overall%2C%20for%20Plan%20Year%202022%20consumers%20can%20choose,off%20the%20Exchange%2C%20is%204.4%20percent.%20On-%20Exchange%3A

[6] https://www.cms.gov/files/zip/2022-urr-puf2.zip

[7] See Section 2 of our full report

than the reference premium by the fourth year of the PO, consistent with the requirements of SB420 Section 2 and related guidance, although the actual differential could be greater.[8]

Due to the lower premiums of the PO and the increase in out-of-pocket net premium for non-PO plans among the population receiving federal premium tax credits, we assume that approximately 60% of the existing ACA market will migrate to PO plans for purposes of this demonstration. Because Nevada's PO is only one of three in the nation (Washington and Colorado being the other two), is structurally different than either of these, and has certain program and product offering parameters that are as of yet undefined, there is material uncertainty at this time around PO take-up levels. For example, the migration to PO plans may be lower if underlying provider reimbursement for non-PO plans is modified and, correspondingly, non-PO premiums are lowered in response to the introduction of the PO to the market. Conversely, take-up in the PO offerings could be higher if, for example, the State of Nevada uses pass-through funding to provide premium subsidy wraps only for lower income enrollees in the PO. We have sensitivity tested different take up scenarios in Tables 4 and 5 further below.

Enrollment in Public Option Plans from the Uninsured

We also assume a certain percentage of the uninsured who are eligible for tax credits will enroll in the PO. Using population data from various public sources, we estimate the total uninsured population in 2022 in Nevada at nearly 300,000 individuals.[9] Using data from the Guinn Center, we estimate approximately 61,000 of the total uninsured are eligible for tax credits under the ACA.[10] This is the population that would most likely respond to a PO offering, particularly if additional state-sponsored premium or cost sharing subsidies are offered.

Three factors cause the *total volume of revenue* paid to providers from uninsured persons to be materially lower than for the population enrolled in ACA plans currently. If these uninsured persons obtain coverage under the PO, these factors are mitigated or eliminated.

1. Uninsured persons generally use fewer healthcare services overall as they face financial barriers to care relative to insureds. According to Kaiser Health Foundation research, uninsured individuals use 50% fewer services overall relative to insured individuals.[11] We assume healthcare utilization for the previously uninsured will increase by a factor of 2.00 (1 / 0.5) under the PO, thereby increasing revenue to providers.

2. About 70% of uninsured costs are uncompensated care to providers.[12] Once insured, most costs for these previously uninsured individuals will be compensated by insurer payments, which will increase provider revenue. However, as uncompensated care decreases, payments intended to offset these costs, such as Uncompensated Care (UCC) payments under Medicare, will decrease as well. Our analysis includes an adjustment to account for UCC payments of 20.7%. The net effect of increasing collectability and decreased UCC payments is 1.971 (1 / (0.30+0.207).

3. Net provider reimbursement for self-pay patients, after provider discounts, is lower than typical individual market or employer group market provider reimbursement, estimated to be around 100% of Medicare FFS reimbursement.[13] In the ACA, we estimate the reimbursement to be 169% of Medicare FFS reimbursement.[14]

Finally, reimbursement under the PO is expected to be lower than the non-Public Option ACA market. We estimate average reimbursement will decrease by approximately 17.6% under the Public Option relative to the individual ACA market, from 169% of Medicare FFS reimbursement to 139% of Medicare FFS reimbursement in Year 4 of the PO (1.39/1.69 = 0.821).

We summarize the factors (a) through (c) plus the impact of reimbursement under the PO on a PMPM basis in Table 3.

Table 3
Provider Participation Requirement in SB420
Uninsured to Public Option Enrollee
Average Incremental Change in Provider Revenue

	PMPM*	Increase Factor**
Estimated Uninsured Revenue at 100% of Medicare	$55.73	
(a) Full insured utilization	$111.46	2.000
(b) Net impact of improved collectability and decreased UCC	$219.68	1.971
(c) Impact of higher ACA reimbursement	$371.26	1.690
(d) Change to PO Reimbursement	$304.92	0.821
Total PMPM Change in Revenue	$249.19	

[8] SB420 does not put constraints on how much lower PO premiums could be, only how low they must be. It is possible that PO plans could achieve greater savings than the minimums prescribed in the bill.
[9] Milliman research using American Community Survey (ACS) data and Current Population Survey data, calibrated using 2021 information where appropriate.
[10] Guinn-Center-NV-Uninsured-Population-abridged.pdf (guinncenter.org)
[11] Uncompensated Care for the Uninsured in 2013: A Detailed Examination | KFF
[12] Uncompensated Care for the Uninsured in 2013: A Detailed Examination | KFF
[13] Hospital Pricing And The Uninsured: Do The Uninsured Pay Higher Prices? | Health Affairs
[14] Milliman proprietary research.

For modeling purposes, Table 3 shows providers, on average, are estimated to see an additional $249 PMPM in revenue ($304.92 - $55.13) when an uninsured person obtains insurance under the PO due to higher overall reimbursement, less uncompensated care, and higher utilization.

We combine the impacts of migrating ACA members to the PO and the associated decrease in revenue for providers with the migration of uninsured to the PO and the associated increase in revenue in Table 4. Please note, this is an illustration using reasonable assumptions across the entire market. Individual providers will have different results.

Table 4
Provider Participation Requirement in SB420
Estimated Provider Revenue Impacts in Year 4 of the Public Option applied to CY 0222 (In Millions)

	From ACA	From Uninsured	Total
Members Transferring to PO	68,700	9,700	78,400
Pre-PO Allowed Costs (Provider Revenue)	$305 M	$7 M	$312 M
		Incremental $'s	
Increase in Utilization	$0 M	$7 M	$7 M
Improved Collectability (Net of UCC decrease)	$0 M	$13 M	$13 M
Subtotal before Reimbursement Change	$0 M	$19 M	
Pre-PO Reimbursement			
PO Reimbursement			
Change in Reimbursement	-$54 M	$10 M	-$44 M
Total	-$54 M	$29 M	-$25 M

**Numbers may not foot due to rounding.*

Table 4 shows that total provider revenue will decrease as ACA enrollees migrate to the PO and increase as uninsured obtain coverage under the PO. In total, under our best estimate modeling, provider revenue is expected to decrease when considering the combined impact of these two population segments. The results of various stress tests involving different migration assumptions can be seen in Table 5:

Table 5
Provider Participation Requirement in SB420
Estimated Provider Revenue Impacts in Year 4 of the Public Option Applied to CY 2022 (In Millions)
Sensitivity to ACA and Uninsured Migration

			APTC Eligible Uninsured Take-Up Rate		
			Low	**Medium**	**High**
			5%	**16%**	**29%**
ACA Migration	**High**	**85%**	-$67 M	-$47 M	-$23 M
	Medium	**60%**	-$45 M	-$25 M	$-1 M
	Low	**50%**	-$37 M	-$16 M	$8 M

Based on this range of results, it is likely that overall provider revenue volume will decline under the Public Option in absolute dollars. Table 6 shows these results as a percentage of total provider revenue, indicating a relatively immaterial estimated provider revenue change on a percentage basis.

Table 6
Provider Participation Requirement in SB420
Estimated Provider Revenue Impacts in Year 4 of the Public Option
(% of Total Provider Revenue)
Sensitivity to ACA and Uninsured Migration

			APTC Eligible Uninsured Take-Up Rate		
			Low	**Medium**	**High**
			5%	**16%**	**29%**
ACA Migration	**High**	**85%**	-0.30%	-0.21%	-0.11%
	Medium	**60%**	-0.20%	-0.11%	0.0%
	Low	**50%**	-0.16%	-0.07%	0.04%

Impacts on Average Provider Payment Rate Across Entire Nevada Market

In addition to overall revenue volume, providers may also be concerned that the average payment rate across their entire population may be adversely affected.

To understand this, we model the overall market-wide *average payment rate* (measured as a percentage of Medicare) before and after the introduction of the PO. We estimated non-pharmacy claims volumes across all Nevada insurance markets and the uninsured populations in 2022 and assigned a payment index for each of these markets, taken from various public and private / proprietary sources. The index is relative to Medicare (1.00) and the composite for the entire state is calculated by taking a provider revenue weighted average across all markets. Detailed methodology and sourcing of data and assumptions can be found in the Data Sources and Methodology section.

We then shift enrollment from the ACA and the uninsured into the PO, and recalculate the payment index. Note, we do not shift or increase any enrollment in the Medicaid, Medicare, Employer, or Other categories in order to isolate the impact of the introduction of the PO which, as currently written, will not involve these market segments.

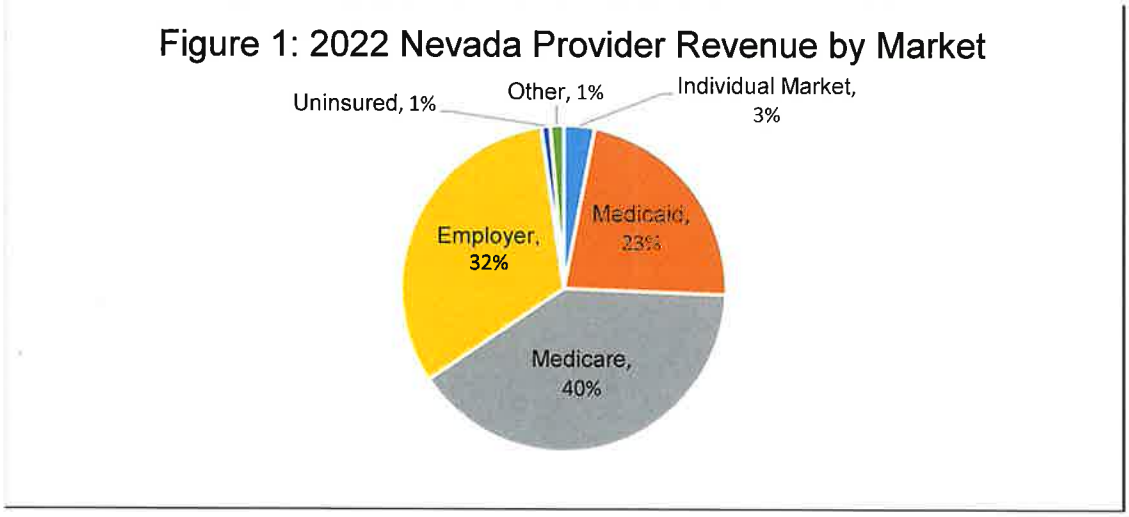
Table 7 below summarizes the calculation of the payment index in 2022 without a PO and the corresponding payment index in the presence of a Public Option.

Table 7
Provider Participation Requirement in SB420
Estimated Average Provider Payment Rate After Introduction of a Public Option
Using CY 2022 Enrollment and Medical Expenses

		Individual Market	Medicaid	Medicare	Employer	Uninsured	Other	Public Option	Total**
No PO	Enrollees	115 K	788 K	644 K	1,368 K	298 K	57 K	0 K	3,269 K
	Medical Expense*	676 M	4,981 M	8,822 M	7,114 M	199 M	295 M	0 M	22,087 M
	% State Provider Revenue	3%	23%	40%	32%	1%	1%	0%	100%
	(a) Payment Index	169%	90%	100%	183%	100%	183%	0%	127.9%
PO Year 4	Enrollees	46 K	788 K	644 K	1,368 K	288 K	57 K	78 K	3,269 K
	Medical Expense*	270 M	4,981 M	8,822 M	7,114 M	193 M	295 M	402 M	22,077 M
	% State Provider Revenue	1%	25%	38%	32%	1%	1%	2%	100%
	(b) Payment Index	169%	90%	100%	183%	100%	183%	139%	126.7%
	Change in Payment Index = (b) / (a) -1								***-0.94%***

**Excludes pharmacy spend for all markets.*
*** Medical expense weighted average.*

Figure 1 below shows the estimated distribution of 2022 Nevada provider revenue by insurance market. The Medicaid, Medicare, and employer markets combine for approximately 95% of current revenue, with the individual market comprising only 3%. The size of the individual market relative to other markets limits the impact of any reimbursement changes specific to the individual market on the total payment index.



Note, the payment rate assumed for the Public Option in Year 4 is 139% of Medicare FFS reimbursement, which is 30 points lower (169% - 139%) than the individual market. However, offsetting this is an increase in payment rate for the uninsured who enroll in the PO. This is an increase in payment rate of 39 points (139%-100%). The net effect of this population movement to the PO is to decrease the average payment rate across all markets in Nevada by 0.94%.

SB420 requires that provider reimbursement rates for the PO be, in the aggregate, comparable to or better than Medicare rates, with some exceptions for certain types of providers. Table 7 illustrates that the PO can satisfy this state requirement and still achieve the premium reduction targets.

Conclusions

Overall, the introduction of the PO has a small negative impact on provider revenue under our best estimate assumptions. This minor impact to overall provider revenue is driven in large part by the fact that the PO is being targeted at the individual market in Nevada and a sub-segment of the uninsured (those that are eligible for ACA coverage but are not enrolled) that, when combined, comprise only about 3% to 4% of the total Nevada population and thus represent a very small proportion of providers' revenue.

Given the small target markets, *we conclude that the impact of a provider participation requirement, whether implemented or repealed, would likely have little effect on provider participation in PO offerings, that providers would be likely to contract with the PO at the required rates to achieve premium targets, and that as a result PO premium rates in the individual market would not be materially affected by the repeal of the requirement.*

Providers may have other reasons for not participating in a PO offering aside from revenue concerns. Our analysis does not reflect any other potential provider considerations beyond the revenue impacts described in this report. In addition, while this analysis is done on a market-wide basis, effects of the public option will vary by region, by provider type (professional or facilities), and by individual provider.

Data Sources and Methodology

Data Sources

The following is a list of data sources used to construct modeling to calculate Nevada's overall provider reimbursement in total dollars and average reimbursement as a percentage of Medicare in Tables 7.

Enrollment by Market Segment

- Individual Market – on exchange enrollment relied on data requested from the Silver State Exchange, March 2022. Off exchange data was estimated based on NAIC MLR reports and CMS Risk Adjustment files (see web sources below).
- Medicaid – Nevada Department of Health and Human Services Chart Pack, accessed November 8th, 2022. https://app.powerbigov.us/view?r=eyJrIjoiZGQ0NTE5ZmUtYjAxNi00NjQzLTliNzktOGM4YjgxYjgwODY2IiwidCI6ImU0YTM0MGU2LWI4OWUtNGU2OC04ZWFhLTE1NDRkMjcwMzk4MCJ9 "Medicaid by Category" for January of 2022. We assume this contains dual eligible of 86,000, received from DHHS on November 8th, 2022, and netted these from the Chart Pack numbers.
- Medicare – Kaiser Health Foundation https://www.kff.org/medicare/state-indicator/total-medicare-beneficiaries/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D plus dual eligible of 86,000.
- Employer – Estimated from American Community Survey data indicating employer-sponsored coverage as well as total population estimates, backing out estimates for other markets and uninsured.
- Uninsured – Guinn Center "Nevada's Uninsured Population," page 24, with adjustments to 2022 shifts due to the population changes and the American Rescue Plan (ARP).
- Other (Tricare etc.) – American Community Survey data, derived from coverage not falling into other market categories

Allowed Costs PMPM

- Individual Market – Estimated by applying 80.3% loss ratio to 2021 Risk Adjustment Revenue PMPM found at https://www.cms.gov/files/document/appendix-2021-benefit-year-risk-adjustment-summary-report-hhs-risk-adjustment-program-state-specific.xlsx. 2021 values were trended at 0% for one year. Estimated pricing loss ratio of 80.3% taken from 2022 URRT data found here: https://www.cms.gov/files/zip/2022-urr-puf2.zip.
- Medicaid – https://www.medicaid.gov/state-overviews/scorecard/how-much-states-spend-per-medicaid-enrollee/index.html 2019 values were trend at NHE per capita increases for 2020-2022. NHE data can be found here: https://www.cms.gov/files/zip/nhe-projections-tables.zip Table 1
- Medicare – Per capita expenditures from National Health Expenditures tables found at https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountsstatehealthaccountsresidence; specifically, the "Health expenditures by state of residence.zip" and the "Medicare_per_enrollee20.xls" files. 2020 values are trended at historical average of 4.7% annually, also taken from this source.
- Employer – Premium PMPM calculated from NAIC MLR data found at https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr for the small group and large group markets in Nevada and by applying an estimated loss ratio of 85%. Values for both small group and large group markets for 2020 were trended at NHE trend rates from 2020 to 2022.
- Uninsured – Based on individual market allowed costs adjusted for lower utilization, lower percentage of Medicare, patient pay collectability, and uncompensated care payments. See Table 2 and corresponding footnotes.
- Other (Tricare etc.) – Assumed to be similar to employer group costs.

Provider Reimbursement by Market Segment

- Individual Market – We use Milliman proprietary discount analysis for commercial markets to estimate individual market reimbursement levels. An adjustment is made to account for the general practice of contracting at lower rates in the individual market than in the employer market to account for the prevalence of narrow networks.
- Medicaid – Physician reimbursement rate as a percentage of Medicare is estimated from Kaiser Family Foundation data found here: https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Hospital reimbursement as a percentage of Medicare is estimated from MACPAC report found here: https://www.macpac.gov/wp-content/uploads/2017/04/Medicaid-Hospital-Payment-A-Comparison-across-States-and-to-Medicare.pdf

- Medicare – We assume 100% of Medicare for all Medicare revenue.
- Employer – Based on Milliman's proprietary discount analysis.
- Uninsured – Collected uninsured payments (cash) were assumed to be 100% of Medicare based on data found here: https://www.healthaffairs.org/doi/10.1377/hlthaff.27.2.w116
- Other (Tricare etc.) - As this is a very small population for which no data exists to analyze attributable reimbursement and any assumption is immaterial to the result, reimbursement for these programs was assumed to be similar to the employer market.

Table 2 Methodology

We use enrollment estimates multiplied by estimated allowed costs by market segment to calculate estimated total provider revenue. Allowed costs are calculated by taking premium values by market multiplied by an expected long term loss ratio (ignoring year by year fluctuations) by market and then dividing by an average-paid-to-allowed ratio by market. Total allowed costs for the state of Nevada in 2022 were reviewed for reasonableness using National Health Expenditure data by state found here: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/res-tables.zip

The composite payment index is calculated as the allowed-cost-weighted average of the market specific payment indexes.

Caveats and Limitations

Milliman developed certain models to estimate the values included in this paper. The intent of the models was to estimate the impact of the provider participation requirement and its potential repeal or nonenforcement on the Nevada PO premiums. We reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

The models rely on data and information as input to the models. We relied upon certain data and information provided by, the Nevada Exchange, and publicly available data published by State and federal agencies to develop the analyses shown in this paper. We did not audit this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. We performed a limited review of the data used directly in our analysis for reasonableness and consistency, and we did not find material defects in the data. If there are material defects in the data, it is possible they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable, or for relationships that are materially inconsistent. Such a review was beyond the scope of our engagement.

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

There is heightened uncertainty concerning future insurance market enrollment due to the current COVID-19 public health emergency and its associated policies that may change materially in the future.

Milliman prepared this report for the specific purpose of evaluating the financial impact of the Nevada PO provider participation requirement. This paper should not be used for any other purpose. This paper has been prepared solely for the internal business use of, and is only to be relied upon by, the management of the Nevada Department of Health and Human Services. We understand this report may be shared with other interested parties. Milliman does not intend to benefit or create a legal duty to any third-party recipient of its work. This paper should only be reviewed in its entirety. The results of this analysis may not be appropriate for every stakeholder.

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

The authors of this paper are actuaries for Milliman, members of the American Academy of Actuaries, and meet the Qualification Standards of the Academy to render the actuarial opinion contained herein. To the best of their knowledge and belief, this report is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices. The terms of Milliman's subcontract with Manatt, signed January 26, 2022, to provide services to the Nevada Department of Health and Human Services Division of Health Care Financing and Policy apply to this paper and its use.

Appendix F
Sensitivity Test of 80% PO Take-up

Exhibit 3
State of Nevada Public Option
Scenario 1B: ARP Public Option - Premium Wrap
Premiums and Member Subsidies Assuming 80% PO Take-up

		On-Exchange				
		PTC Eligible		Non-PTC Eligible		Total Individual Market
Year	Gross Premiums	APTC	Enrollee Net Premiums	Enrollee Gross Premiums	Off-Exchange Enrollee Gross Premiums	Gross Premiums
2026	$599	$471	$128	$357	$502	$579
2027	$604	$466	$139	$337	$505	$584
2028	$601	$460	$141	$324	$502	$580
2029	$599	$457	$142	$289	$498	$575
2030	$621	$475	$146	$323	$518	$598
2031	$644	$495	$150	$354	$539	$622
2032	$670	$516	$154	$380	$560	$647
2033	$696	$538	$159	$401	$583	$673
2034	$723	$560	$163	$441	$606	$700
2035	$752	$584	$168	$464	$630	$728

Exhibit 4
State of Nevada Public Option
Scenario 1B: ARP Public Option - Premium Wrap
Impact of Public Option on Premium and Subsidies Assuming 80% PO Take-up

		On-Exchange				
		PTC Eligible		Non-PTC Eligible		Total Individual Market
Year	Gross Premiums	APTC	Enrollee Net Premiums	Enrollee Gross Premiums	Off-Exchange Enrollee Gross Premiums	Gross Premiums
2026	(2.1%)	(4.7%)	8.7%	0.3%	(2.1%)	(2.1%)
2027	(4.9%)	(9.4%)	14.3%	(9.5%)	(5.1%)	(5.1%)
2028	(8.9%)	(13.9%)	12.6%	(16.0%)	(9.3%)	(9.2%)
2029	(12.7%)	(17.9%)	9.4%	(25.2%)	(13.6%)	(13.5%)
2030	(12.9%)	(18.0%)	9.1%	(21.2%)	(13.6%)	(13.5%)
2031	(13.1%)	(18.1%)	8.6%	(15.3%)	(13.6%)	(13.5%)
2032	(13.1%)	(17.9%)	8.4%	(12.6%)	(13.6%)	(13.5%)
2033	(13.1%)	(17.9%)	8.4%	(12.0%)	(13.6%)	(13.4%)
2034	(13.2%)	(17.9%)	8.0%	(6.4%)	(13.6%)	(13.4%)
2035	(13.2%)	(17.8%)	7.8%	(5.4%)	(13.6%)	(13.4%)

Exhibit 5
State of Nevada Public Option
Scenario 2A: No ARP Public Option - PTF Accumulation
Premiums and Member Subsidies Assuming 80% PO Take-up

	On-Exchange					
		PTC Eligible		Non-PTC Eligible		Total Individual Market
Year	Gross Premiums	APTC	Enrollee Net Premiums	Enrollee Gross Premiums	Off-Exchange Enrollee Gross Premiums	Gross Premiums
2026	$608	$418	$190	$549	$513	$588
2027	$619	$413	$206	$510	$517	$592
2028	$617	$406	$211	$508	$515	$590
2029	$612	$398	$214	$506	$511	$585
2030	$636	$415	$221	$527	$531	$608
2031	$661	$433	$229	$550	$552	$633
2032	$687	$451	$236	$574	$574	$658
2033	$715	$471	$244	$593	$597	$684
2034	$744	$491	$252	$619	$621	$712
2035	$773	$512	$261	$652	$646	$740

Exhibit 6
State of Nevada Public Option
Scenario 2A: No ARP Public Option - PTF Accumulation
Impact of Public Option on Premium and Subsidies Assuming 80% PO Take-up

	On-Exchange					
		PTC Eligible		Non-PTC Eligible		Total Individual Market
Year	Gross Premiums	APTC	Enrollee Net Premiums	Enrollee Gross Premiums	Off-Exchange Enrollee Gross Premiums	Gross Premiums
2026	(2.1%)	(5.3%)	5.8%	(2.5%)	(2.1%)	(2.1%)
2027	(4.2%)	(10.2%)	10.7%	(12.9%)	(5.0%)	(5.1%)
2028	(8.1%)	(15.2%)	9.6%	(17.0%)	(9.0%)	(9.1%)
2029	(12.3%)	(20.3%)	7.6%	(20.6%)	(13.3%)	(13.4%)
2030	(12.4%)	(20.2%)	7.5%	(20.3%)	(13.3%)	(13.4%)
2031	(12.4%)	(20.2%)	7.5%	(20.0%)	(13.3%)	(13.4%)
2032	(12.5%)	(20.2%)	7.3%	(20.1%)	(13.3%)	(13.4%)
2033	(12.4%)	(20.0%)	7.4%	(20.6%)	(13.3%)	(13.4%)
2034	(12.4%)	(20.0%)	7.5%	(20.4%)	(13.3%)	(13.4%)
2035	(12.5%)	(20.1%)	7.4%	(19.3%)	(13.3%)	(13.4%)

Exhibit 7
State of Nevada Public Option
Scenario 2B: No ARP Public Option - Premium Wrap
Premiums and Member Subsidies Assuming 80% PO Take-up

		On-Exchange				
		PTC Eligible		Non-PTC Eligible		Total Individual Market
Year	Gross Premiums	APTC	Enrollee Net Premiums	Enrollee Gross Premiums	Off-Exchange Enrollee Gross Premiums	Gross Premiums
2026	$608	$418	$190	$549	$513	$588
2027	$617	$413	$204	$509	$516	$592
2028	$613	$407	$206	$507	$512	$588
2029	$612	$402	$210	$464	$507	$582
2030	$631	$416	$215	$521	$527	$605
2031	$656	$434	$222	$549	$548	$630
2032	$682	$452	$230	$568	$570	$655
2033	$709	$472	$238	$593	$593	$681
2034	$738	$492	$246	$619	$616	$708
2035	$766	$513	$254	$646	$641	$737

Exhibit 8
State of Nevada Public Option
Scenario 2B: No ARP Public Option - Premium Wrap
Impact of Public Option on Premium and Subsidies Assuming 80% PO Take-up

		On-Exchange				
		PTC Eligible		Non-PTC Eligible		Total Individual Market
Year	Gross Premiums	APTC	Enrollee Net Premiums	Enrollee Gross Premiums	Off-Exchange Enrollee Gross Premiums	Gross Premiums
2026	(2.1%)	(5.3%)	5.8%	(2.5%)	(2.1%)	(2.1%)
2027	(4.4%)	(10.1%)	9.7%	(13.1%)	(5.2%)	(5.2%)
2028	(8.7%)	(15.0%)	7.2%	(17.1%)	(9.6%)	(9.4%)
2029	(12.3%)	(19.4%)	5.5%	(27.1%)	(14.0%)	(13.8%)
2030	(13.0%)	(20.0%)	4.6%	(21.2%)	(14.0%)	(13.8%)
2031	(13.1%)	(20.1%)	4.6%	(20.2%)	(14.0%)	(13.8%)
2032	(13.2%)	(20.0%)	4.4%	(21.0%)	(14.0%)	(13.9%)
2033	(13.2%)	(20.0%)	4.5%	(20.6%)	(14.0%)	(13.8%)
2034	(13.1%)	(19.9%)	4.6%	(20.4%)	(14.0%)	(13.8%)
2035	(13.2%)	(19.9%)	4.5%	(20.1%)	(14.0%)	(13.8%)

Section 7: Attached Materials

- Appendix A: 1332 Waiver Checklist
- Appendix B: State Operations Budget for the Public Option
- Appendix C: Public Session Materials
- Appendix D: Additional Public Engagement Materials

APPENDIX A:

CCIIO Checklist for Section 1332 State Relief and Empowerment Waivers

CCIIO Checklist for Section 1332 State Relief and Empowerment Waivers

The table below lists each item in the CCIIO Checklist for Section 1332 State Relief and Empowerment Waivers Applications (Updated July 2019) and discusses how Nevada addresses each issue and/or directs the reader to other parts of this report.

	HHS Citation and Description	Actuary Response
1.	**45 CFR 155. 1308(a), (b), (c), (d)** Application format, application timing, preliminary review, notification of preliminary determination.	This report is intended to be an attachment to Nevada's 1332 waiver application. The actual application submission date is not known as of the date of this report.
2.	**45 CFR 155.1308(f)(2)** Written evidence of the state's compliance with the public notice and comment requirements, set forth in 45 CFR 155.1312.	See Section 4 of waiver application
	Written evidence of the state's compliance with the public hearing's requirements, set forth in 45 CFR 155.1312.	See Section 4 of waiver application
	Written evidence of state's compliance with the meaningful Tribal consultation requirements (if the state has one or more Federally-recognized Indian tribes), set forth in 45 CFR 155.1312.	See Section 4 of waiver application
3.	**45 CFR 155.1308(f)(3)(i), (ii)** Comprehensive description of state's enacted legislation and program to implement a plan meeting the requirements for a section 1332 waiver and a copy of the state's enacted legislation	See Appendices B and C
4.	**45 CFR 155.1308(f)(3)(iii)** List of provision(s) of the law that the state seeks to waive and reason for the specific request(s).	See Section 1B of waiver application

	HHS Citation and Description	Actuary Response
5.	**45 CFR 155.1308(f)(4)(i)-(iii)** Actuarial analyses and actuarial certifications Economic analyses Data and assumptions **Note a state can combine the elements of an actuarial analysis and economic analysis into one report or submit separate actuarial and economic reports*	1. See Appendix A for the actuarial certification. i. See Section 4B for a demonstration that the Nevada Section 1332 waiver complies with the coverage requirement. a. See the Exhibits section ii. See Sections 4A and 4C for a demonstration that the Nevada Section 1332 waiver complies with the comprehensiveness and affordability requirements. a. See the Exhibits section b. See the Exhibits section 2. See Section 5 3. See Section 6 The Nevada 1332 waiver impacts the individual market. The baseline projection and a comparison to the projection under the waiver are included in Sections 4 and 5. The required analyses are included as noted below: ▪ Exhibits 1A.3, 1B.3, 2A.3, and 2B.3: Non-group market enrollees by income as a share of FPL. ▪ Exhibits 1A.1, 1B.1, 2A.1, and 2B.1: Overall average non-group market premium rate. ▪ Exhibits 1A.2, 1B.2, 2A.2, and 2B.2: SLCS plan rate. ▪ The State of Nevada uses the federal default age rating curve. ▪ Section 5: Aggregate premiums and PTC. ▪ The State of Nevada uses a state-based platform. Costs are assumed to be the same both with and without the waiver. ▪ Sections 4 through 6: Documentation of all assumptions and methodologies used to develop the projections and growth of healthcare spending. Nevada is not considering establishing a Risk Stabilization Waiver Concept as part of this 1332 waiver application.
6.	**45 CFR 155.1308(f)(4)(iv)** Draft timeline for implementation of the proposed waiver.	See Section 1D of waiver application
7.	**45 CFR 155.1308(f)(4)(v)(A)-(E)** Additional Information.	See Section 5 of waiver application
8.	**45 CFR 155.1308(f)(4)(vi)** Reporting targets.	See Section 5.E of waiver application
9.	**83 FR 53575** Administration's Principles.	See waiver narrative

APPENDIX B:

State Operations Budget for the Public Option

Estimated Annual SFY Budget Costs for State Operations, Starting SFY2026

NRS 695K.300 provides that pass through funds shall be used to pay for the costs associated with carrying out the statutes pertaining to the administration of the public option at the state level. Below are estimated state administrative costs associated with operating the new public option as outlined under state law in NRS 695K.

Silver State Health Insurance Exchange Operation Costs for Public Option	
Increased Navigator Program Costs	$500,000.00 per SFY
Additional Staffing Costs for Certification/Policy	$250,000.00 per SFY
Increase Technology Vendor Costs (GetInsured)	$1,000,000.00 per SFY
Estimated subtotal	**$1,750,000.00 per SFY**
Nevada Medicaid Operation Costs for Public Option	
New Staffing Costs for Contracts/Waiver	$400,000.00 per SFY
New Legal Fees for Deputy Attorney General	$100,000.00 per SFY
New Public Option Actuary Fees	$1,500,000.00 per SFY
Estimated subtotal	**$2,000,000.00 per SFY**
Estimated Total Operational Costs	**$3,750,000.00 per SFY**

Furthermore, NRS 695K.200 also provides that any additional federal dollars received as pass-through funds pursuant to a 1332 waiver may be used by the Director of Nevada Medicaid to increase consumer affordability. At this time, the State is requesting use of remaining funds to be used to finance new state premium subsidies to improve affordability of qualified health plans in the Exchange.

APPENDIX C:

Public Comment Materials

Public comment materials include:

1. The materials from the six public design sessions DHHS hosted in December 2021 and January 2022
2. Tribal consultation and public comment materials, to be added to the application following the state public comment period

APPENDIX D:

Additional Public Engagement Materials

- Public comment letters submitted by stakeholders during the six design sessions held in December 2021 and January 2022: Link
- September 2021 Actuarial Study Informational Webinar: Slides and Recording
- Questions and Answers for the Nevada Public Option: Link
- Fact Sheet – Nevada Public Option: Link

DRAFT

Joe Lombardo
Governor

Richard Whitley
Director

State of Nevada

Department of Health and Human Services

Nevada Public Option

Public Hearing

January 24, 2023 and February 3, 2023

Helping people. It's who we are and what we do.

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Agenda

- Nevada Public Option Overview
- Public Comment
- Next Steps

DRAFT

Meeting Participation Overview

Written Comments:
Participants may submit comments and questions through the **Zoom Q&A box**; all comments will be recorded and reviewed by the State. To submit questions or comments outside of today's session, write to: **NVpublicoption@dhhs.nv.gov**

Spoken Comments:
Participants must "raise their hand" for Zoom facilitators to unmute them to share comments; the facilitators will notify participants of the appropriate time to volunteer feedback.

If you logged on via phone-only

Press "*9" on your phone to "raise your hand"

Listen for your phone number to be called by moderator

If selected to share your comment, please ensure you are "unmuted' on your phone by pressing "*6"

If you logged on via Zoom interface

Press "Raise Hand" in the "Reactions" button on the screen

If selected to share your comment, you will receive a request to "unmute;" please ensure you accept before speaking

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Purpose & Agenda

In its effort to implement state law, Division is holding two public hearings to engage stakeholders on the state's 1332 waiver application for the Public Option.

Agenda

- Nevada Public Option & Waiver Overview
- Collect Questions & Public Comment

See Nevada Revised Statutes (NRS) Chap. 695K.

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Background

- In 2021, Nevada State Legislature passed into law a Public Option.
- State law charges the Director of the Department of Health and Human Services (DHHS) with overseeing the implementation of the Public Option.
- Public Option plans must be available to consumers for purchase in Nevada Health Link on January 1, 2026.

Statutory goals include:

- Leverage State purchasing 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
- Promote **value-based health care financing**

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Overview of State Statutory Requirements

State law requires the Director contract with health carriers to offer the new Public Option plans and use the Medicaid contracting authority to enforce certain state requirements, such as:

- Participating carriers must offer the Public Option plans through the Nevada Health Link and **meet all federal and state standards for qualified health plans** under the Affordable Care Act.
- Participating carriers must offer **one Silver and one Gold Public Option plan**, which means these products cover at least 70 and 80 percent of consumer health care costs, annually, respectively.
- Participating carriers must offer public options plans that meet certain premium reduction targets which are set at 16% percent over the first four years.
- Participating carriers must pay providers rates that are no lower than Medicare rates.

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New State Procurement Process

- Under state law, the Director must establish **a new procurement process** to establish the new contracts with health carriers creating a state-private model for operating the new Public Option plans.
- This procurement must take place at same time as the state's next Medicaid managed care procurement (2025).
- Any health carriers seeking to participate in the State's Medicaid managed care program must submit **a good faith bid** to also contract with the state to offer and administer Public Option plans.
- Currently, the Division contracts with **four health carriers** for its Medicaid managed care program (Anthem, Health Plan of Nevada, Silver Summit, Molina).
- The Division will use the **contract as its enforcement tool** for the statutory requirements for the Public Option plans.

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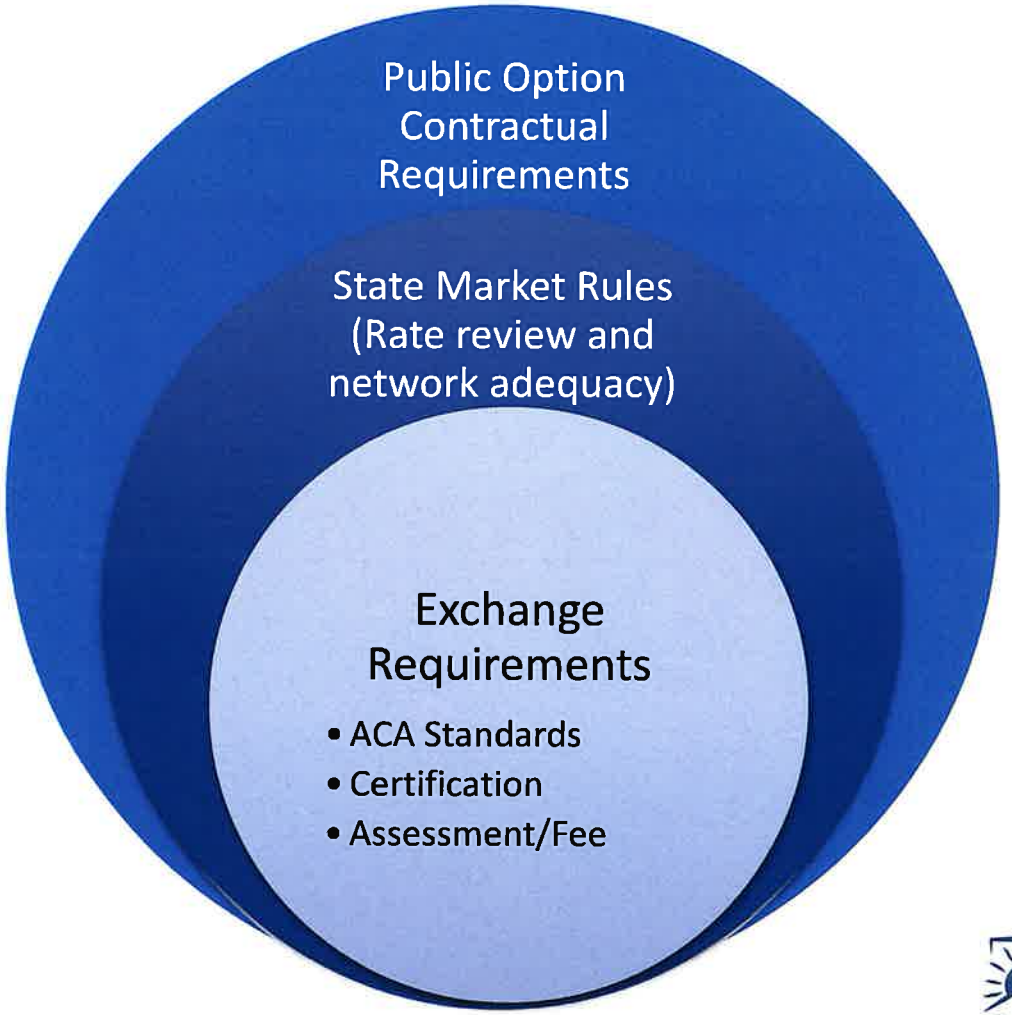
Nevada Public Option Design

This slides provides a visual for what the new public option plans will look like as compared to other qualified health plans offered in the exchange.

The two inner rings reflect today's current plans and the rules they must meet; the public option plans will include need to comply with these rules and an **additional layer** of new requirements set forth in a contract with the state.



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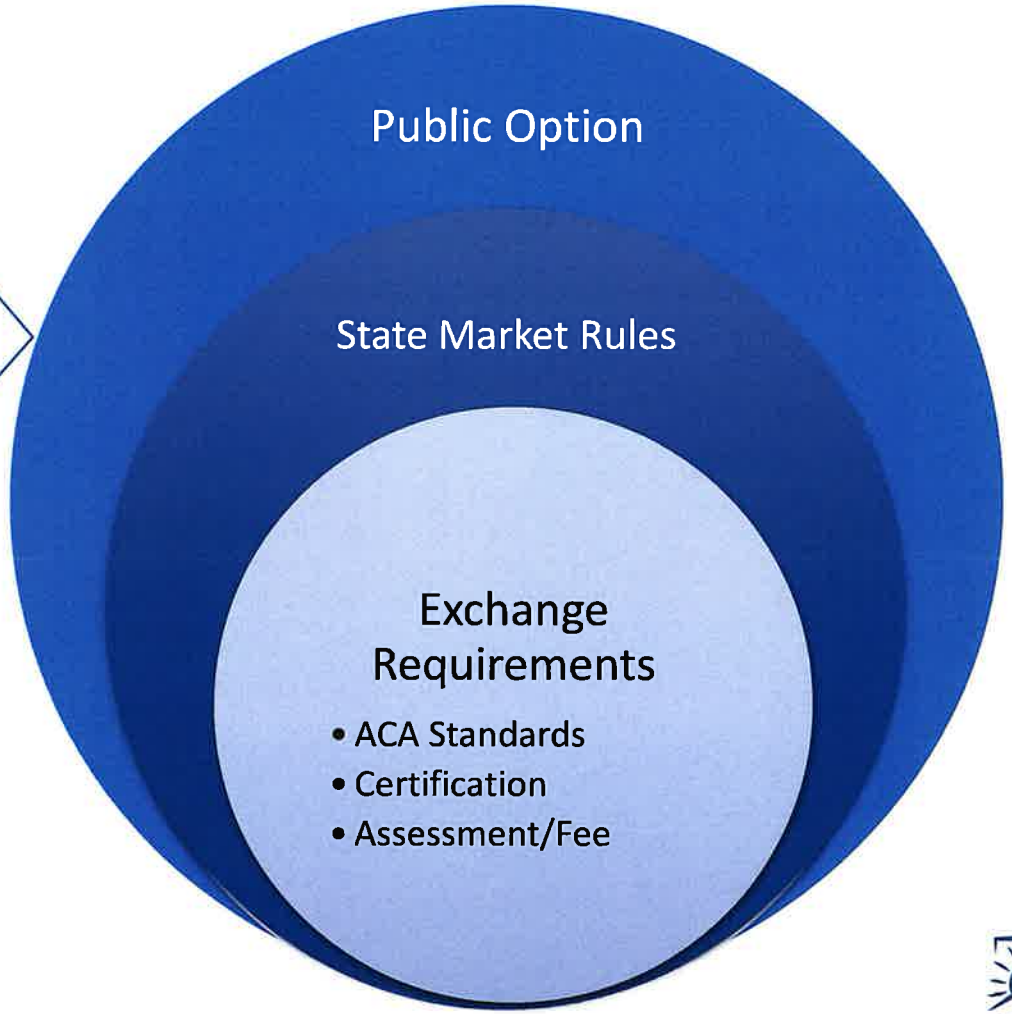
Nevada Public Option Design

Statutory mandates:

- Premium reduction targets
- Minimum plan offerings (silver/gold)
- Provider network alignment with Medicaid networks
- Value-based payment design
- Cultural workforce plans

Contract requirements:

- Administrative spend caps
- Quality metrics
- Penalties for not meeting targets, etc.



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Other New State Requirements

- Providers under contract with the State as network providers in other state-contracted health insurance programs must participate **as an in-network provider within at least one network** with one of the State's contracted PO carriers.
- These providers must also apply policies to **accept new patients** enrolled in public option plans like they apply to other patients enrolled in other forms of health insurance.
- State law requires Director to **promote in its contracting process** with strategies with health carriers that:
  - Better align networks between Medicaid and individual market
  - Address health disparities in the individual market
  - Improve cultural competency in the provider workforce
  - Increase the use of value-based payment models with providers
  - Address the gaps in Nevada's health care workforce

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1332 Waiver & Actuarial Study

- 1332 waiver allows states to capture federal savings in advanced premium tax credits (APTCs) (i.e., pass-through funds (PTF)).[1]
- Final actuarial report will provide estimate of resulting federal PTF plus analysis of effect of the provider participation requirement.
- Actuarial Findings
  - **$341-$464 million** estimated savings in first five years
  - **Minimal impact to providers** – higher volume of service use and less uncompensated care costs
  - **55,300** estimated to enroll in year 1
  - **92,500** estimated to enroll by year 5

The Process

1. Stakeholder input
2. Actuarial study & waiver development
3. Tribal notice
4. Post for state public comment period
5. Federal submission
6. Federal public comment period
7. Completeness review
8. Negotiations/ Federal Decision

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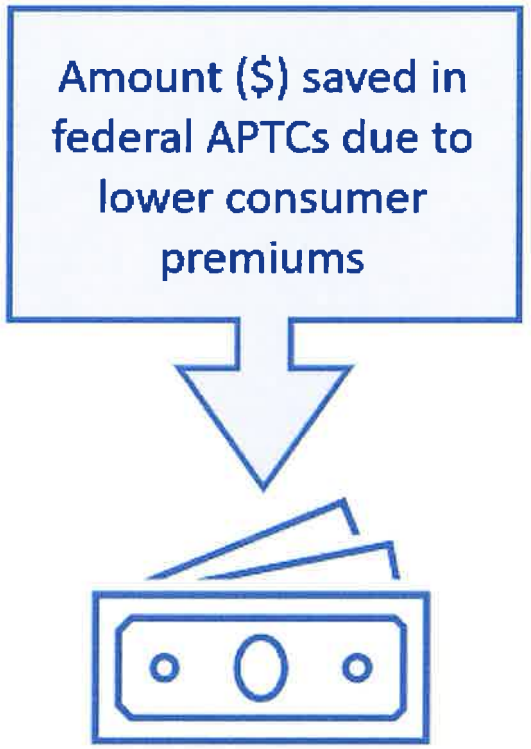
New Funds for Affordability Policies

- State law requires federal PTF to be deposited into state trust fund to support state operations and to improve affordability.
- After Year 1, state operations for Public Option will be self-funded by federal PTF
  - Division costs for staff for contract oversight and waiver compliance; actuarial support
  - Nevada Health Link costs for technology vendor, staff, and navigator program
- Leftover PTF can be used by Director of DHHS to establish new affordability policies:
  - New state premium wraps for consumers in Nevada Health Link to further reduce premium costs
  - Bonus incentive payment program for carriers and network providers who meet certain quality metrics or state goals in market



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Public Comment

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Public Comment

- Public comment will be limited to the total amount of time allocated for public comment on particular issues.
- Individuals will be recognized for up to two minutes and are asked to state their name and organizational affiliation at the top of their statements.
- Participants are encouraged to use the comment box to ensure all feedback is captured or email their comments to **NVpublicoption@dhhs.nv.gov**

Spoken Comments:

- Participants must "raise their hand" for Zoom facilitators to unmute them to share comments; the facilitators will notify participants of the appropriate time to volunteer feedback.

If you logged on via phone-only

Press "*9" on your phone to "raise your hand"

Listen for your phone number to be called by moderator

If selected to share your comment, please ensure you are "unmuted' on your phone by pressing "*6"

If you logged on via Zoom interface

Press "Raise Hand" in the "Reactions" button on the screen

If selected to share your comment, you will receive a request to "unmute;" please ensure you accept before speaking

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Next Steps

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Next Steps

- Public comments will be accepted through February 27, 2023.
- The 1332 waiver application will be submitted to the federal government in March 2023.

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Contact Information

Stacie Weeks – Deputy Administrator, Division of Health Care Financing and Policy; sweeks@dhcfp.nv.gov

Ky Plaskon – DHCFP Public Information Officer; kyplaskon@dhcfp.nv.gov

State of Nevada

Department of Health and Human Services

Section 1332 Waiver Application for Public Option: Tribal Consultation

January 11, 2023

Helping people. It's who we are and what we do.

Purpose & Agenda

In its effort to implement state law, the Division is soliciting feedback and comments from Nevada tribal communities on the state's 1332 waiver application for the public option.

Agenda

- Nevada Public Option & Waiver Overview
- Impact to Tribal Communities
- Collect Questions & Public Comment

See Nevada Revised Statutes (NRS) Chap. 695K.

Background

- In 2021, Nevada State Legislature passed into law a public option.
- State law charges the Director of the Department of Health and Human Services (DHHS) with overseeing the implementation of the public option.
- Public option plans must be available to consumers for purchase in Nevada Health Link on January 1, 2026.

Statutory goals include:

- Leverage State purchasing 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
- Promote **value-based health care financing**

Overview of State Statutory Requirements

State law requires the Director contract with health carriers to offer the new public option plans and use the contracting authority to enforce certain state requirements, such as:

- Participating carriers must offer the public option plans through the Nevada Health Link and **meet all federal and state standards for qualified health plans** under the Affordable Care Act.
- Participating carriers must offer **one Silver and one Gold public option plan**, which means these products cover at least 70 and 80 percent of consumer health care costs, annually, respectively.
- Participating carriers must offer public options plans that meet certain premium reduction targets which are set at 16% percent over the first four years.
- Participating carriers must pay providers rates that are no lower than Medicare rates.

New State Procurement Process

- Under state law, the Director must establish **a new procurement process** to establish the new contracts with health carriers creating a state-private model for operating the new public option plans.
- This procurement must take place at same time as the state's next Medicaid managed care procurement (2025)
- Any health carriers seeking to participate in the State's Medicaid managed care program must submit **a good faith bid** to also contract with the state to offer and administer public option plans.
- Currently, the Division contracts with **four health carriers** for its Medicaid managed care program (Anthem, Health Plan of Nevada, Silver Summit, Molina)
- The Division will use the **contract as its enforcement tool** for the statutory requirements for the public option plans.

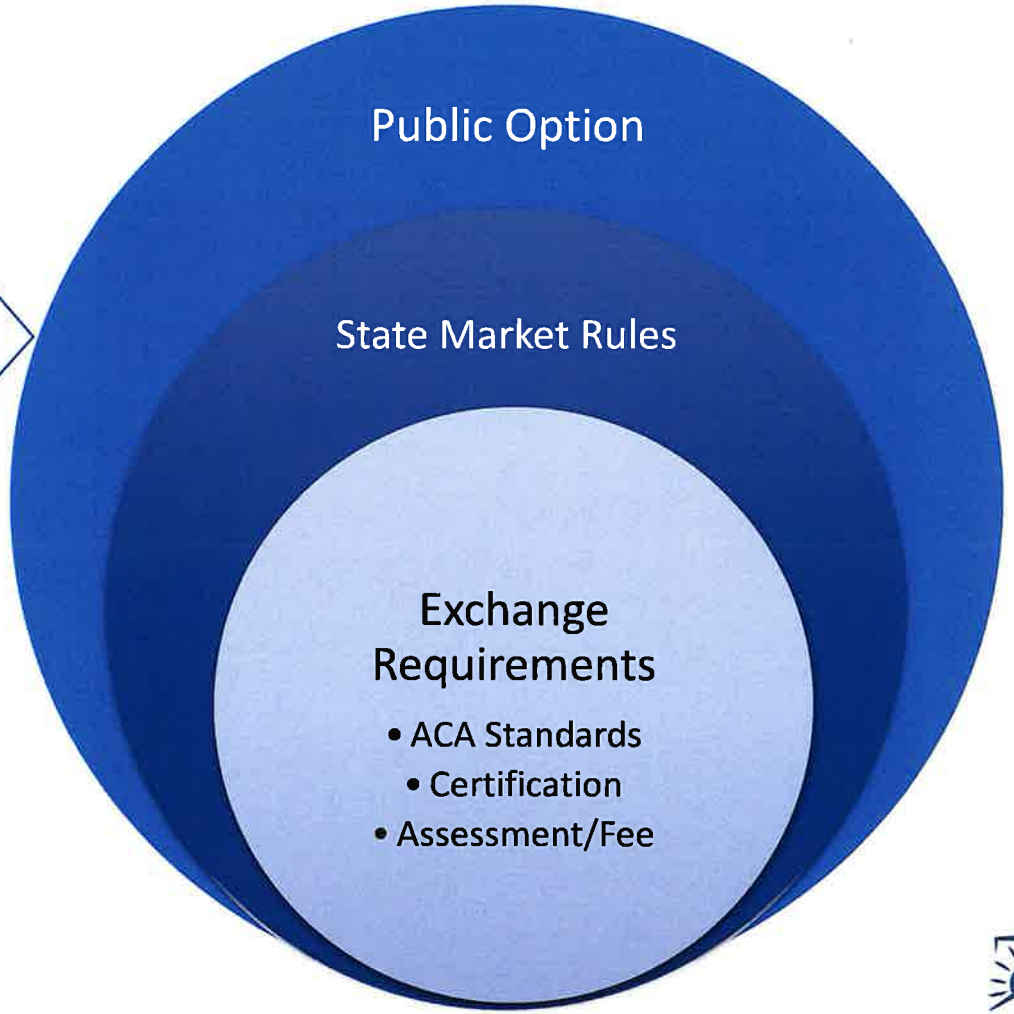
Nevada Public Option Design

Statutory mandates:

- Premium reduction targets
- Minimum plan offerings (silver/gold)
- Provider network alignment with Medicaid networks
- Value-based payment design
- Cultural workforce plans

Contract requirements:

- Administrative spend caps or MLR
- Quality metrics
- Penalties for not meeting targets, etc
- TBD



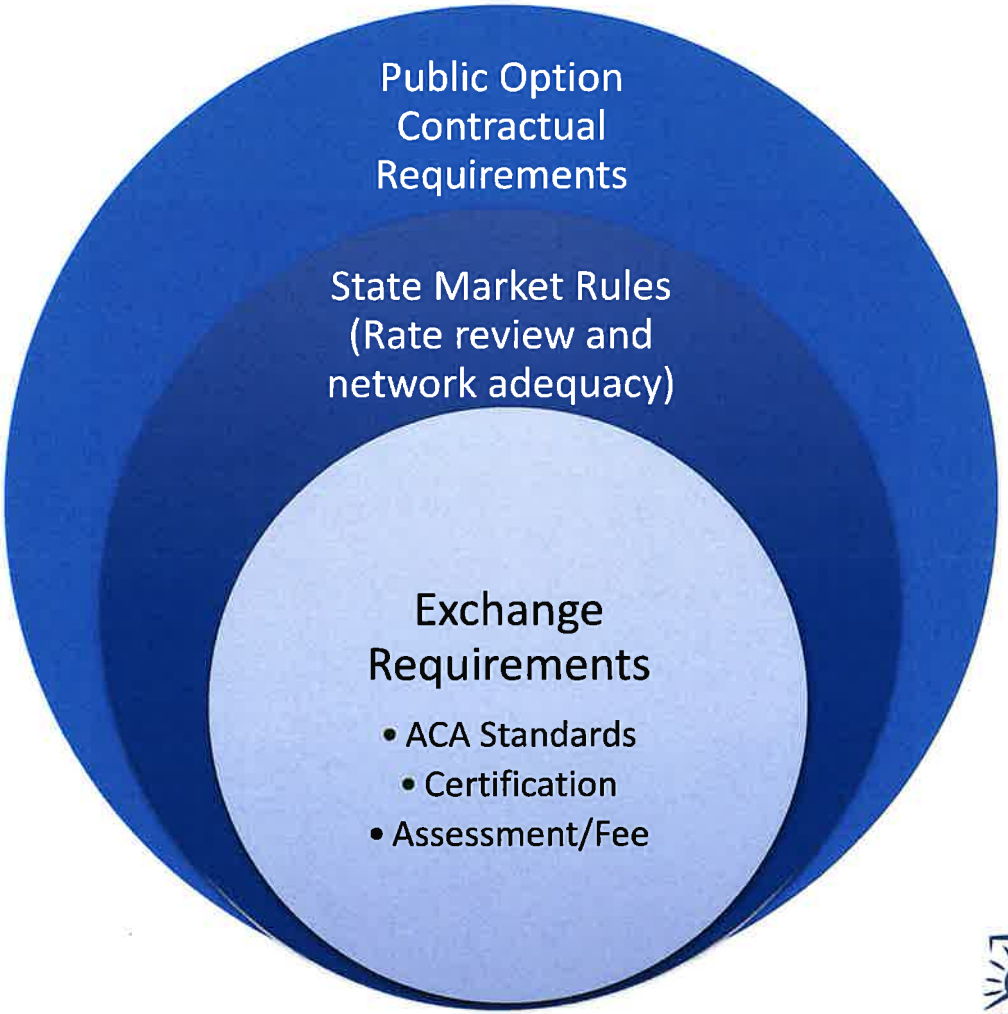
Other New State Requirements

- Providers under contract with the State as network providers in other state-contracted health insurance programs must participate **as an in-network provider within at least one network** with one of the State's contracted PO carriers.
- These providers must also apply policies to **accept new patients** enrolled in public option plans like they apply to other patients enrolled in other forms of health insurance.
- State law requires Director to **promote in its contracting process** with strategies with health carriers that:
  - Better align networks between Medicaid and individual market
  - Address health disparities in the individual market
  - Improve cultural competency in the provider workforce
  - Increase the use of value-based payment models with providers
  - Address the gaps in Nevada's health care workforce

Nevada Public Option Design

This slides provides a visual for what the new public option plans will look like as compared to other qualified health plans offered in the exchange.

The two inner rings reflect today's current plans and the rules they must meet; the public option plans will include need to comply with these rules and an **additional layer** of new requirements set forth in a contract with the state.



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1332 Waiver & Actuarial Study

- State law requires a 1332 waiver to be submitted to U.S. Department of Treasury and HHS/CCIIO to implement the program.
- 1332 waiver allows states to capture federal savings in advanced premium tax credits (APTCs) (i.e., pass-through funds (PTF)).[1]
- States applying for 1332 waiver must include an actuarial analysis and certification.[2]
- Nevada contracted with independent actuarial firm—Milliman—which has experience in evaluating proposals for public option.[3]
- Final actuarial report will provide estimate of resulting federal PTF plus analysis of effect of the provider participation requirement.

The Process

1. Stakeholder input
2. Actuarial study & waiver development
3. Tribal notice
4. Post for state public comment period
5. Federal submission
6. Federal public comment period
7. Completeness review
8. Negotiations/ Federal Decision

Sources

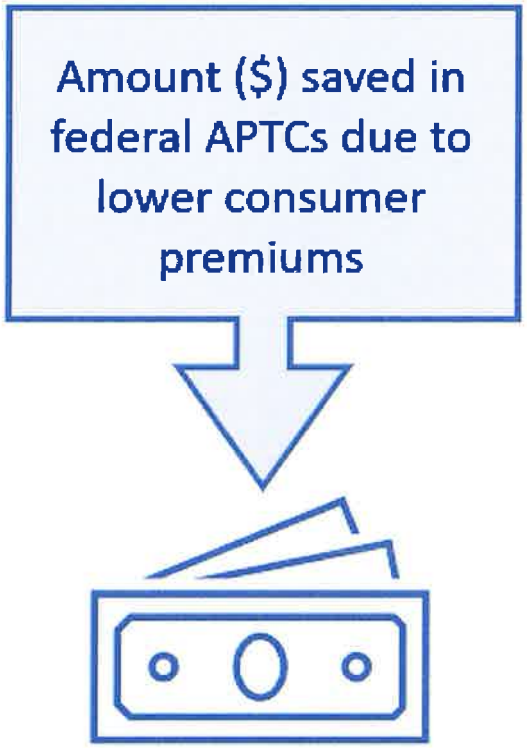
1: NRS 695K.210.

2: 45 CFR § 155.1308.

3. See Fritz Busch & Paul Houchens, *Milliman Report: Evaluation of a Colorado Public Option,* prepared for the Kaiser Permanente, 2019.

New Funds for Affordability Policies

- State law requires federal PTF to be deposited into state trust fund to support state operations and to improve affordability.
- After Year 1, state operations for Public Option will be self-funded by federal PTF
  - Division costs for staff for contract oversight and waiver compliance; actuarial support
  - Nevada Health Link costs for technology vendor, staff, and navigator program
- Leftover PTF can be used by Director of DHHS to establish new affordability policies:
  - New state premium wraps for consumers in Nevada Health Link to further reduce premium costs
  - Bonus incentive payment program for carriers and network providers who meet certain quality metrics or state goals in market



New State Revenue
(Federal Pass-Through Funds)

Impact to Tribal Communities

Impact to Tribal Communities

- The public option's mandated premium reductions will reduce premiums for consumers purchasing public option plans, which includes **American Indians and Alaskan Natives (AI/AN)**
  - According to the 2022 Open Enrollment Public Use File, **there are 765 AI/AN Non-Hispanic members** enrolled in coverage through Nevada Health Link in Nevada 2022.
- The public option program does not impact existing protections available to American Indians through the Nevada Health Link:
  - AI/AN who earn less than 300% of the Federal Poverty Level (FPL) remain exempt from cost sharing and qualify for premium tax credits
  - The calculation of Modified Adjusted Gross Income for AI/AN will still exempt some revenue earned on reservations and from Federal Trust payments
  - AI/AN may still change Qualified Health Plans (QHP) once a month without worrying about enrollment dates

Impact to Tribal Communities (continued)

- The public option will not impact existing financial assistance provided under the Division of Health Care Financing and Policy (Medicaid) in which AI/ANs eligible for Medicaid do not pay premiums and do not have any other cost sharing.
- The public option will not impact health care services provided through IHS, Tribal or urban Indian health programs.
- The public option plans do require more robust and aligned networks with Medicaid, including essential community providers.
- As a reminder, qualified health plans (which will include public option plans) must include at least 30% of available essential community providers in in each plan's service area in the provider network and must offer contracts in "good faith" to all Indian Health Service providers.
- Participating health carriers will also not be able to pay tribal providers participating in public option networks any lower than what they pay in Medicare.

Questions & Comments

The Division will now collect questions and comments from the tribal represent regarding the waiver application and new public option plans.

Any questions will be answered in writing in the next two weeks. The Division will be accepting written public comment on the state's 1332 waiver application until February 27, 2023.

Waiver materials can be found online at:
https://dhhs.nv.gov/PublicOption/

Contact Information

Kyril Plaskin – DHCFP Public Information Officer at kyplaskon@dhcfp.nv.gov

Briza Virgen – DHHS Tribal Liaisons, Division of Health Care Financing and Policy; bvirgen@dhcfp.nv.gov

Monica Schiffer -DHHS Tribal Liaisons, Division of Health Care Financing and Policy; mschiffer@dhcfp.nv.gov