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Attorneys for Plaintiffs

FIRST JUDICIAL DISTRICT COURT OF NEVADA
IN AND FOR CARSON CITY

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

Plaintiffs,

v.

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

Defendants.

Case No. 25OC00161 1B

Dept. No. I

PLAINTIFFS' APPENDIX TO MOTION FOR PRELIMINARY INJUNCTION

Volume 5 of 18

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INDEX

EXHIBIT #	DESCRIPTION	PAGES
E	January 1, 2024 Nevada Department of Health and Human Services submission of application for Section 1332 State Innovation Waiver	273-347

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Joe Lombardo
Governor

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

Richard Whitley, MS
Director

January 1, 2024

The Honorable Janet Yellen
Secretary of the Treasury
Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, D.C. 20220

The Honorable Xavier Becerra
Secretary of Health and Human Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

RE: Nevada Section 1332 Innovation Waiver Request – Battle Born State Plans (BBSPs) and Market Stabilization Program (MSP)

Dear Secretary Yellen and Secretary Becerra:

The State of Nevada submits this application for a Section 1332 State Innovation Waiver as required by state law as part of the Nevada Department of Health and Human Service's implementation of a Public Option and the establishment and financing of a Market Stabilization Program. Both the Public Option health plans, called "Battle Born State Plans" (BBSPs), and the Market Stabilization Program will be implemented upon the approval of this waiver application, and represent new initiatives aimed at improving access to and affordability of health care while ensuring a healthy and stable marketplace for those who purchase insurance through the individual health insurance market.

Nevada seeks to waive Section 1312(c)(1) of the Affordable Care Act and its implementing regulations for a five-year period to establish the BBSP and Market Stabilization Programs detailed in this application. The BBSP and Market Stabilization Programs are intrinsically tied together by design; therefore, the State seeks federal waiver authority for these initiatives in one waiver request. Presently, Section 1312(c)(1) and its implementing regulations limit issuers' ability to vary premium rates for particular health plans from the index rate. Nevada wishes to waive this requirement for the BBSPs, which will ultimately control health care costs by reducing premiums in the health insurance marketplace and generating federal savings on premium tax credits. A waiver of Section 1312(c)(1) will also allow implementation of the State's new reinsurance program in year two of this waiver (CY 2027) and, with remaining funds, support two other programs designed to improve quality, increase the number of health providers, and lower health care costs in Nevada.

This request lies within the authority of the Director of the Nevada Department of Health and Human

Services (the Director), as stated in NRS 695K.210, to request a Section 1332 waiver and "to subsidize the cost of health insurance" and "improve affordability" for Nevadans. It is also consistent with the broad authority of the Nevada Division of Insurance Commissioner to seek a Section 1332 waiver.

Thank you for considering our application and supporting Nevada's health care affordability and market stabilization goals.

Sincerely,

Richard Whitley, MS
Director
Nevada Department of Health and Human Services

SECTION 1332 WAIVER APPLICATION:

NEVADA COVERAGE AND MARKET STABILIZATION PROGRAM

DEPARTMENT OF

HEALTH AND HUMAN SERVICES

DIVISION OF HEALTH CARE FINANCING & POLICY

WAIVER APPLICATION

Federal Submission Date: February 8, 2024

Contents

Section 1: Nevada Program Overview and Waiver Request

A. Overview

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

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

The first initiative for addressing these issues is a new Public Option program. As established under State law, this program must be designed and established by the Nevada Director of Health and Human Services (the Director).[6] To fulfill this new duty, the Director must contract with carriers to offer new health insurance options to consumers through Nevada's State-based health insurance exchange—the Silver State Health Insurance Exchange (SSHIX). These new options must be available to Nevadans and certified as Qualified Health Plans (QHPs). This means these new options must provide the same minimum benefits and cost sharing and meet all the same State and federal requirements as standard QHPs. These new coverage options will be referred to as the "Battle Born State Plans" (BBSPs).

The major difference between BBSPs and other QHPs offered on the SSHIX is that carriers offering BBSPs must contract with the State to meet certain State priorities and requirements, including an annual premium reduction target. To initiate these new contracts with carriers, the Director must conduct a State procurement process that coincides with the statewide procurement for Nevada's Medicaid Managed Care plans. State law requires carriers bidding to participate in Nevada's Medicaid Managed Care program as a Managed Care Organization (MCO) to also submit a "good faith bid" to offer BBSPs in the SSHIX. A good faith bid must, at a

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

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

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

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

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

[6] Nevada Div. of Behavioral and Public Health, Health Professional Shortage Areas, available at: [6] Nev. Rev. Stat. § 695K.200.

minimum, meet the annual premium reduction target for the BBSPs and include a formal certification from the carrier's actuary that the proposed premium rates will meet actuarial soundness principles, as further outlined in this waiver request. The carrier must also commit to submitting their rate filings for BBSPs to the Division of Insurance (DOI) for review and approval. This customary State process will verify actuarial soundness and confirm that solvency standards and all other requirements of standard QHPs have been met. As with every other carrier offering a QHP on the SSHIX, carriers must also commit to filing network adequacy information with the DOI for review and approval and must seek formal QHP certification of their BBSPs each year from SSHIX. However, carriers that offer BBSPs in the SSHIX must meet the annual premium reduction target. The DOI will evaluate the rate filings for the BBSPs in the same manner as other rate filings to determine whether rates are excessive or inadequate and whether carrier solvency and all other requirements of QHPs have been met.

While the introduction of the BBSPs and achieving the premium reduction targets are not expected to disrupt the insurance market, the second initiative—the Market Stabilization Program—is intended to mitigate any unexpected financial risk to carriers and limit the impact on provider networks, while strengthening the long-term sustainability of this market. The Market Stabilization Program accomplishes these goals through three new measures:

- **State-Based Reinsurance Program:** This program is aimed at alleviating any unexpected financial risk to participating carriers and their provider networks with the introduction of the BBSPs that meet premium reduction targets. Under reinsurance, the State will subsidize (or "reinsure") certain high-cost claims for all carriers in the individual market. The State intends to adjust the size of the reinsurance parameters as needed to ensure that it can be fully funded by the pass-through funding generated in the prior year.
- **Quality Incentive Payment Program:** If there is remaining pass-through funding in any year of the waiver period after financing reinsurance, the State intends to use this funding to establish a Quality Incentive Payment Program for carriers offering BBSPs. This program would be designed to reward carriers and their providers for utilizing value-based efforts to improve health outcomes and quality of care. Through this new program, the State will be able to, for the first-time ever, drive changes in how health care is delivered and paid for in the individual market. Over time, these efforts should lead to a healthier population and therefore reduced risk to carriers. It should also lead to shared savings and financial rewards for network providers that are successful in these efforts with carriers.
- **"Practice in Nevada" Incentive Program for Health Care Providers:** If there is sufficient pass-through funding to finance reinsurance and the Quality Incentive Payment Program, the State intends to use such funding to finance a new "Practice in Nevada" program. Nevada faces critical challenges in attracting many types of health care providers, including primary care physicians, obstetricians, behavioral health practitioners, and other allied health professionals, to practice in the State. For example, Nevada ranks last in the number of primary care providers per 100,000 individuals.[7] Increasing the number of providers is essential to addressing poor health outcomes and health disparities. It is also important for controlling the rise in the cost of health care and ensuring the stability of the State's insurance market. Because of the steep demand and supply gap for health care professionals in Nevada, having more medical professionals could help insurers avoid facing unreasonable price hikes from network providers that are in low supply in the State. For example, carriers with smaller market shares (i.e., covered lives) are likely to struggle to negotiate reasonable rates for certain services where only one provider entity is available in a region to provide such services to its members. Most recently, this challenge was notable in the State's Medicaid Managed Care program, where a carrier with a smaller portion of enrollment in the program faced unreasonable prices as compared to other carriers from a certain specialty provider type that is in low supply in the State.

Nevada seeks to waive Section 1312(c)(1) of the ACA and its implementing regulations for the purpose of

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

establishing the reforms described herein. If approved, the Section 1332 waiver is targeted to be effective January 1, 2026, for five years. The reforms will not affect any other provision of the ACA but are expected to result in a lower-than-projected second-lowest cost Silver plan (SLCSP) and a reduced market-wide index rate, thereby lowering premiums and reducing the federal cost of premium tax credits (PTCs).

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

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

B. Federal Provisions to Be Waived

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

Section 1312(c)(1) and its implementing regulations limit the factors by which issuers can vary premium rates for a particular plan from the index rate. The goal of the premium reduction targets for the BBSPs in SSHIX is to control health care costs and support coverage by reducing insurance premiums. Through NRS 695K and this waiver, the Director would condition eligibility to bid as an MCO carrier on submitting a good faith bid to offer a Silver plan and a Gold plan on the SSHIX that meets certain premium reduction targets each year, among other QHP requirements. These premium reductions are expected to be achieved through a combination of lower provider rates, administrative efficiencies, and the implementation of reinsurance. To allow these reductions, Nevada is requesting a waiver of the Single Risk Pool provision of the ACA, Section 1312(c)(1). Under the implementing regulations at 45 CFR 156.80(d)(2), an "issuer may vary premium rates for a particular plan from its market-wide index rate for a relevant state market based only on the following actuarially justified plan-specific factors." These regulations enumerate specific factors, including: (1) actuarial value and cost-sharing; (2) provider network; (3) delivery system; (4) utilization management practices; (5) benefits provided in addition to the EHB; (6) administrative costs; and (7) any expected impact of eligibility for catastrophic plans. A federal waiver of Section 1312(c)(1) will ensure carriers can make plan-level adjustments to the market-wide adjusted index rate for BBSP offerings that correspond to the new premium reduction targets.

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

The State intends, at this time, to establish a reinsurance program that will have a geographic tiered structure that is designed to reduce premiums more in the highest-cost geographic areas (i.e., Rating Areas 3 and 4). The reinsurance program is expected to reduce premiums market-wide by 7.2% by 2030, contributing to plans' ability to meet the premium reduction targets in the years 2027 through 2030 and generating further federal savings.

Section 2: Nevada Section 1332 Waiver Proposal

A. Enabling Statutory Authority

Enabling legislation requires the Director to apply for a Section 1332 waiver no later than January 1, 2024, to implement the reforms and requirements of NRS 695K to establish a new Public Option program and to capture all pass-through funds made available to the State with such reforms.[8]

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

NRS 695K.300(5) also provides the Director with broad express authority to spend federal pass-through funding made available to pay for the costs associated with administering the reforms of Chapter 695K and any associated waivers. It provides the Director with the authority to spend the remaining federal pass-through funding to improve the affordability of the new coverage options established under the Public Option program. The State has determined that this includes the initiatives within the Nevada Market Stabilization Program, including a State-based reinsurance program, a Quality Incentive Payment Program for participating BBSP carriers, and the Practice in Nevada Incentive Program. Each of these initiatives under the Market Stabilization Program can help the State control the rise in the cost of health care in the individual insurance market and increase long-term affordability by improving the quality of health care among enrollees and bolstering the provider base in the State.

In addition to the Director's authority, the Commissioner of Insurance has specific authority in SB 482 (2019), Section 45, to apply for a Section 1332 waiver and implement a State plan that meets the waiver requirements as approved by the Departments.[9] Further, the Commissioner has broad authority in NRS 679B.400 to "develop measures to stabilize prices" and to "establish a mechanism to ensure the provision of adequate insurance at reasonable rates to the residents of this state."[10] This highlights an additional source of State authority to establish a reinsurance program, the Quality Incentive Payment Program, and the Practice in Nevada Incentive Program under the State's Market Stabilization Program.

B. The New Battle Born State Plans

Nevada Senate Bill (SB) 420 (2021) was signed into law on June 9, 2021, and later codified in NRS Chapter 695K. Under this new law, the Director is required to design and establish a Public Option program in the individual market.[11] The statutory design of this new program relies heavily on a State purchasing and contracting strategy of the State's Medicaid Managed Care program. The State will undertake a statewide Medicaid Managed

[8] NRS 695K.210, available at: https://www.leg.state.nv.us/nrs/NRS-695K.html#NRS695KSec210

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

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

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

Care procurement for a five-year contract that begins on January 1, 2026.

The State must require that carriers submitting a bid through the Medicaid Managed Care procurement also produce a good faith bid to offer at least a Silver and Gold BBSP annually in each rating area on the SSHIX. (Through procurement bid scoring and the Quality Incentive Program, the State will also incentivize these carriers to offer Bronze plan products.[12]) Currently, under existing MCO contracts, the MCO carriers must offer at least one silver and gold QHP on the SSHIX by the 2024 coverage year.[13] The difference between current contracting practices with MCO carriers and the new BBSP program is that the State will be asking MCO carriers to offer a Silver and Gold QHP that meets the new BBSP requirements. Carriers will not be prohibited from offering other SSHIX products. The State anticipates that MCO carriers will continue or supplement their current offerings in addition to BBSP offerings given their existing experience offering QHP products due to the Managed Care contractual requirement mentioned above, except in a situation where the plan is a new entrant into the marketplace in Nevada. In that case, the procurement will lead to additional offerings, similar to the State's last procurement where there was a new health plan entrant.

The State intends to define a good faith bid as any bid by a carrier that is deemed complete under State purchasing guidelines and complies with all State requirements for the Public Option Program (the BBSPs). This includes submitting a bid that, at a minimum, satisfies the premium reduction targets and provides a formal attestation and rate certification by the actuary that derived the premium rates, attesting that the rates for the BBSPs are actuarially sound, meaning they are adequate and reasonable in relationship to the benefits covered. The bid must also include sufficient detail documented in the rate certification to understand the specific data, assumptions, and methodologies behind the rate development and projections, like the requirements for the and projections rates proposed by carriers seeking to offer an MCO plan.

If a carrier bids on Medicaid and does not offer a good faith bid for a BBSP contract, the carrier would be ineligible to receive an award for participation in the State's Medicaid Managed Care program for that upcoming contract period. Currently, the Director contracts with four carriers for the State's Medicaid Managed Care program—Anthem, Health Plan of Nevada (United Health Group), Molina, and Silver Summit Health Plan (Centene). The State anticipates that all four will apply to seek to continue participating in Medicaid Managed Care program in the upcoming procurement in 2025, when the State will require statewide bids for the first time. Therefore, the State expects at least four carriers, at a minimum, to submit bids to offer the new BBSPs for coverage year 2026. The upcoming MCO contracts will be for a five-year period, beginning on January 1, 2026, and terminating on December 31, 2030. This timeline for the contract period aligns with this waiver request.

1. Product Design Overview

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

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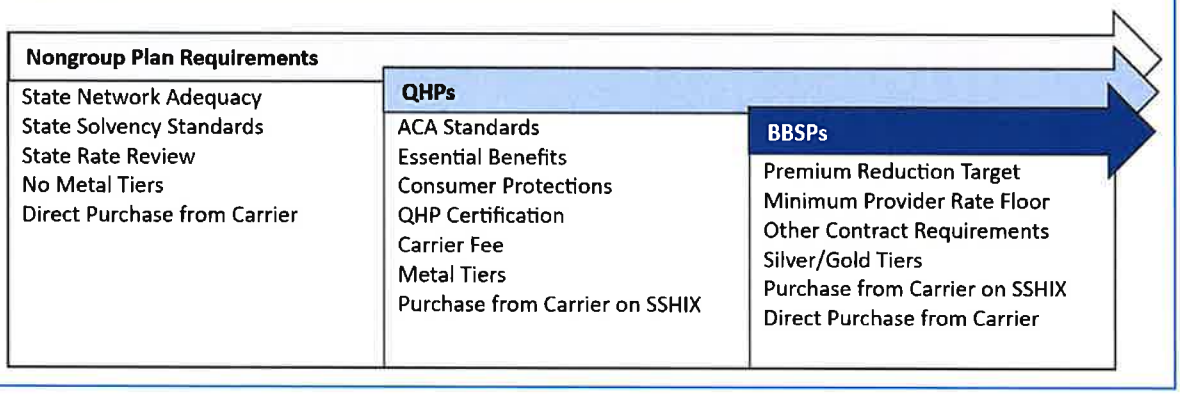
[12] All four current Medicaid Managed Care plans participate in SSHIX and offer Bronze plans, and we anticipate that their existing products would continue.

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

Figure 1: Individual Market Products v. Battle Born State Plan



The BBSP will include the same benefits as other QHPs.[14] In addition, BBSPs must meet certain statutory requirements for premium reductions and a reimbursement floor for network providers, ensuring rates, in the aggregate, are no lower than those paid by Medicare.

The two major differences between BBSPs and standard QHPs include:

- **New Premium Reduction Targets**: Under NRS 695K, carriers offering the new BBSPs must satisfy a new premium reduction target on their Silver plan rates that is at least 15 percent lower than the average reference premium by the fourth plan year. The average reference premium will be based on the SLCSP QHP available in the SSHIX during the 2024 plan year by county, trended forward for inflation according to the Consumer Price Index for Medical Care (CPI-M) and any adjustments necessary to reflect local changes in utilization and morbidity. See Nevada DHCFP Guidance and Bulletin Update 23-003.[15]

  To ensure annual premium rates for the BBSPs will be actuarially sound and meet provider reimbursement floor requirements, the Director has determined the premium reduction target should be no more than 15 percent by the end of the first four years as permitted by State law.[16] In the event that carriers cannot meet premium targets in any given year while meeting actuarial soundness or solvency requirements, the Director may revise the premium reduction targets to ensure BBSPs are offered at a rate that is actuarially sound. As further described in the milestones section, the Director will also require carriers to attest to the actuarial soundness of their proposed rates in their bids for the BBSP contracts similar to how the State verifies bids for the State's Medicaid Managed Care program. Unlike other public option programs to date, this waiver program is based on statutorily defined premium reduction targets that are established at the program level. These targets will be known to the State and to issuers before rates are required to be submitted to the

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

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

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

State each year. Nevada will leverage the procurement and contracting process to ensure compliance with the statutorily defined premium requirements.

In the fifth and final year of the five-year MCO and BBSP contracts with carriers and the 1332 waiver period, the Director intends to include a continuation of the premium reduction targets for BBSP premium rates to ensure the projected reduced trend achieved in the first four years is sustained over time. The Director will use the State's contract authority with carriers offering the BBSPs to enforce these new targets with associated penalties and sanctions as outlined further in Subsection 3.

- **Provider Reimbursement Floor**: State law requires carriers offering the new BBSPs to ensure that their negotiated rates with network providers are the same or better, in the aggregate, than the rates paid by Medicare.[17] The Director intends to establish reasonable rates for services not covered in Medicare (e.g., pregnancy-related coverage). These rates will be calculated annually as a percentage of Public Employees' Benefits Program (PEBP) or Medicaid rates for the same or similar service, where a Medicare rate is unavailable. Carriers must attest in their bids on the BBSP contract that they are in compliance with this requirement with respect to the rates they negotiate with their provider networks.

  To protect providers, the Director will develop an appeal process for network providers who believe a carrier offering a BBSP has not complied with the requirement of Medicare rates or better. These design features will be outlined in the State's BBSP contracts. The contract will also include a corrective action process and associated penalties for noncompliance with the reimbursement floor for providers.

2. New Protections for Consumers and Providers

In addition to the provider reimbursement floor described above, State law provides for certain protections to ensure that the premium reduction targets for the BBSPs do not undermine provider networks or access to care for consumers. These include:

- **Provider Participation Requirement** – Any provider who participates in the PEBP, Medicaid, or the State's workers' compensation program must agree to participate in at least one provider network for a BBSP or risk participation as a network provider in these other public programs. This requirement will be enforced through the State's contractual or enrollment agreements with providers to participate in-network in these programs.[18]
- **Consumer Access Requirement** – Participating providers or facilities must accept new patients enrolled in a BBSP to the same extent as the provider or facility accepts new patients enrolled in a standard QHP. The Director intends to require carriers in the BBSP contract to monitor providers for compliance and to notify

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

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

consumers of this protection and a way to report any violations. Noncompliant providers may risk their provider enrollment in Medicaid if they are not compliant with state law which would include this requirement.

The Nevada Division of Health Care Financing and Policy (Nevada Medicaid), which sits under the Director, oversees the State's contracts with these carriers today and will provide the same oversight of compliance with respect to these new requirements for the BBSP contracts. The Director may waive the provider participation and consumer access requirements if needed to ensure individuals who receive benefits through the State's PEBP, Medicaid, or the workers' compensation program have sufficient access to covered services from network providers. Although the actuarial analysis by Milliman found that the introduction of the BBSPs will not meaningfully impact provider revenue on an aggregate level, the Director intends to develop a process for providers to seek a waiver of the network participation requirements for the BBSP offerings. Providers seeking such a waiver from participation as a BBSP-network provider must show a significant monetary loss in their total patient revenues from serving patients who enroll in a BBSP. Such a loss must also pose a substantial risk to their financial stability due to the new BBSP revenue displacing a sizable portion of their payor mix and associated commercial revenue.

3. New State-Carrier Contracts

To enforce the statutory requirements for the BBSPs (including the premium reduction targets), the Director will utilize the legal tools under its new BBSP contracts with carriers, similar to the ways in which Nevada Medicaid enforces its existing contracts with carriers for its Medicaid Managed Care program, including the existing contract requirement that MCOs offer a QHP in the SSHIX. For example, MCO contracts include corrective action plans, financial penalties, and/or sanctions that can be imposed by the Director when carriers do not meet their contractual obligations.[19]

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

The State will also require carriers to meet an administrative cost constraint through the new contracts with carriers offering BBSPs that are stricter than prevailing individual market and QHP administrative expense loads (based on most recent publicly available rate filing data). Under the administrative cost constraint, carriers offering BBSPs would be required to reduce a portion of their administrative expenses (such as salary, profits, and other administrative expenses or overhead) for the BBSP offerings, which will help reduce prices relative to non-BBSP offerings, all else being equal. The State is considering excluding from what qualifies as administrative expenses, for purposes of this new requirement, any activities or efforts that relate to quality improvement, recipient outreach, care management, call centers or nurse lines, etc.

These new required administrative expense targets will be set by the Director in the new BBSP contracts and may ramp up each year, over the first four years of the program. These administrative efficiencies at the carrier level would count toward the required premium reduction target, reducing the share of premium reductions that must

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

be achieved through provider reimbursement reductions in BBSPs. This will also help mitigate the risk of carriers cost shifting the entire burden of meeting an annual premium reduction target onto their provider networks. For BBSP carriers that do comply with this new requirement (i.e., shift more than half of the cost of the premium reduction target onto their provider networks), the Director may use all financial penalties and sanctions set forth in the contract to enforce compliance.

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

- Advance quality and value-based payment design with providers,
- Improve continuity of care through better alignment of provider networks in the individual market and Medicaid Managed Care program, and
- Help address the State's growing health care workforce shortages and health disparities.[20]

C. Use of Federal Pass-Through Funds

The State understands that, if this waiver application is approved, an initial estimate of the federal pass- through funding amount will be made available to the State the first quarter of the corresponding plan year or coverage year. The final federal pass-through funding amount or final administrative determination by the Centers for Medicare & Medicaid Services (CMS) will be shared in a letter prior to the payment of the federal pass-through funding amount as provided in the specific terms and conditions of the approval letter (typically before the end of April of the corresponding plan or coverage year).

State law requires that any federal pass-through funds received by the State as a result of the approval of this waiver must be reserved to first cover the State administrative costs to implement and operate the program and waiver.[21] These funds would replace the State's initial investment of State general funds to cover the "start-up" costs associated with implementation. As shown in the proposed budget (see Section 4.F.) these costs include staffing and vendor-related costs for both the Nevada Department of Health and Human Services (DHHS) and the DOI.

Once the State administrative costs have been paid for with the new federal pass-through funds, State law permits the Director to use a portion of the funding as determined by the State Treasurer to increase consumer affordability. For this waiver's purposes, the State has determined that the remaining funds should be used by the Director to support a Market Stabilization Program in order to improve affordability in the BBSPs, along with other nongroup plans, as further described in Section 2.E. below. The reinsurance program cannot be fully implemented and financed by the State without an approved Section 1332 waiver. There are no dedicated State funding sources to finance a full reinsurance program; it will be wholly financed with federal pass-through funds. Without the implementation of the waiver and State receipt of federal pass-through funds achieved by premium reductions, the State would not be able to move forward in funding and implementing the reinsurance program.

D. DHHS Consideration of Initial Public Feedback

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

[20] See NRS 695K.220, available at: https://www.leg.state.nv.us/nrs/NRS-695K.html#NRS695KSec210
[21] See NRS 695K.300

of the BBSPs and Market Stabilization Program and will continue to inform design as the State plans for the procurement of the BBSPs.

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

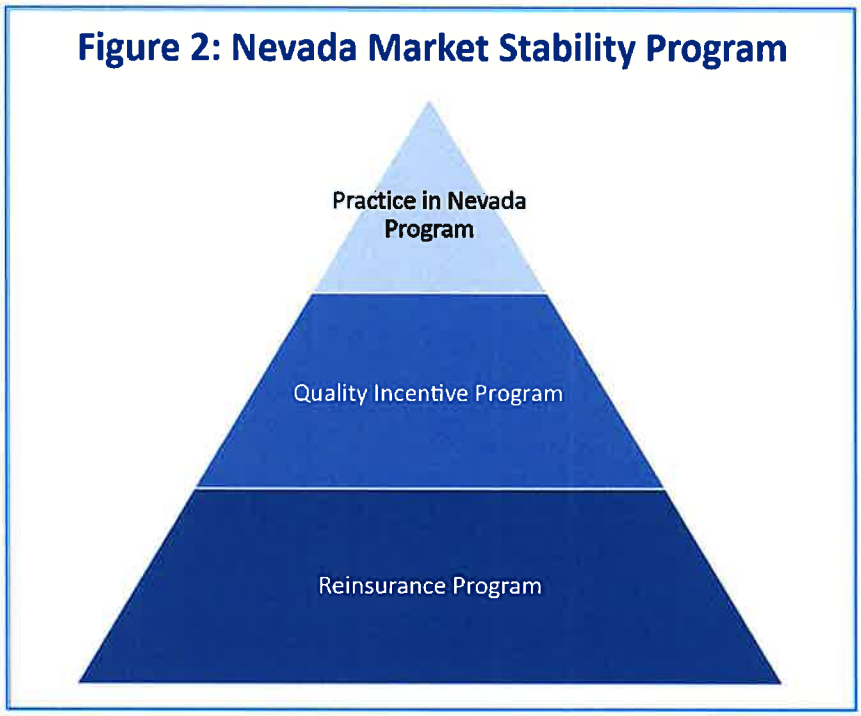
- Commenters underscored the importance of improving affordability, including through reduced premiums, for Nevadans enrolled in health plans in the individual insurance market.
- Commenters urged the State to invest in the provider workforce to improve Nevadans' access to timely preventative care and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

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

E. Nevada Market Stabilization Program

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

As summarized in Figure 2, the new Market Stabilization Program includes three core State market-focused investments. The first investment consists of the establishment of a new State-based reinsurance program for all carriers operating in the State's individual market (i.e., offering nongroup plans). The second, if there is sufficient funding each year after fully financing a reinsurance program, includes a new Quality Incentive Payment Program to reward high-performing insurers that offer BBSPs and meet certain quality metrics or indicators tied to state priorities for the market. And third, if there is sufficient funding to fully finance a reinsurance and Quality Incentive Payment Program, the State intends to finance the Practice in Nevada Incentive Program, which provides for loan repayment to certain health care providers willing to live and work for at least four years in a region of Nevada that qualifies as a federal Health Professional Shortage Area.



The operation and scale of these new programs would be reliant on the amount of federal pass-through funds available to the State each year under an approved Section 1332 waiver, starting in year two. After funding all State operational costs for the Section 1332 waiver program, the State intends to prioritize the remaining funds to first finance in full a State-based reinsurance program. Any remaining funds would be used next to pay for a Quality Incentive Payment Program with the rest being used to support a new workforce development initiative as described below. There are no dedicated State funding sources to finance the waiver program; it will be wholly financed with federal pass-through funds.

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

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

Based on an actuarial analysis by Milliman, it is anticipated that, as a result of the entry of the BBSPs into the market, the federal savings generated in CY 2026 would fully finance the State-based reinsurance program in CY 2027 with over $2 million remaining to spend on the other two programs. Each year that the State receives pass-through funding, the State intends to prioritize the financing of the reinsurance program. This means, after covering state administrative costs for the waiver, the Director would first cover the costs of the reinsurance program before using any of the funds to finance the additional efforts outlined below for the Market Stabilization Program.

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

waiver/plan year, the State intends to reduce the amount it projects to spend on the two other programs that make up the Market Stabilization Program. If such a reduction is still not enough to cover the cost of a reinsurance program, the State would adjust the attachment point and coinsurance to equal the exact amount of pass-through funding available from the previous calendar year. In turn, this also shifts more of the burden back on carriers in meeting the statutorily required premium reduction target of 15 percent over the first four years of the waiver period. In effect, the financing model of this reinsurance program is intended to have the effect of incentivizing carriers to meet the BBSP premium reduction targets so that sufficient funding is available each year to finance a robust reinsurance program. The State's contracts with carriers for the BBSPs would therefore include two sets of agreed-upon certified rates for achieving the premium reduction target– with and without reinsurance—to ensure the mandatory four-year statutory target can be achieved.

Based on an actuarial analysis by Milliman, it is anticipated that, as a result of the entry of the BBSPs into the market, the federal savings generated in CY 2026 would cover the cost of financing a reinsurance program across the individual market, including premium reductions for BBSP carriers that would help offset the impact of the premium reduction target.

Table 1: Projected Pass-Through Funding (PTF) and Cost of Reinsurance

Year	**Pass-Through Funding** (thousands)	**Cost of Reinsurance** (thousands)	**Net Funding Remaining** (thousands)
2026	$15,000	$0	$15,000
2027	$58,000	($56,000)	$2,000
2028	$69,000	($60,000)	$9,000
2029	$81,000	($64,000)	$17,000
2030	$87,000	($70,000)	$17,000
2031	$93,000	($76,000)	$17,000
2032	$99,000	($83,000)	$16,000
2033	$106,000	($90,000)	$16,000
2034	$114,000	($98,000)	$16,000
2035	$122,000	($106,000)	$16,000
Five-Year Waiver Window	**$311,000**	**($250,000)**	**NA***
Ten-Year Deficit Neutrality Window	**$846,000**	**($703,000)**	**NA***
Five-Year Waiver Window – 10% Margin on PTF	**$279,000**	**($250,000)**	**NA***
Ten-Year Deficit Neutrality Window – with 10% Margin on PTF	**$760,000**	**($703,000)**	**NA***

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

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

Currently, the State uses a quality incentive or "bonus" payment program in its Medicaid Managed Care program to reward carriers for achieving certain quality targets or goals. For example, for Plan Year 2023, the State tied a bonus payment (equivalent to a three percent rate increase) for MCOs to a primary care spending target to incentivize MCOs to increase investment in the State's primary care provider system. The State is still analyzing

MCO performance for this bonus payment, but early results show each of the four MCOs made significant progress in achieving this important goal for the State's Medicaid program. Additionally, for Plan Year 2023, the State tied a second bonus payment (equivalent to a one percent rate increase) for MCOs that achieved certain enhancements with provider networks to accelerate the use of value-based payment design across the recommended LAN Framework for alternative payment models. Early results of MCO performance indicate each MCO made significant progress in meeting the goals outlined for this bonus payment.

Similarly, for the BBSP program, carriers will be required, at a minimum, under their contracts to partner with providers around value-based initiatives focused on improving care delivery, promoting better quality, increasing efficiencies, and improving health outcomes. Through the Quality Incentive Payment Program for BBSPs, the State intends to require or incentivize carriers to align these value-based initiatives across the Medicaid and individual markets and, if feasible and practical, with the value-based initiatives used in the Medicare market to achieve a best practice, "all-payor model" for these efforts in the State. An all-payor model is consistent with the best practices and models promoted by CMS' Center for Medicare and Medicaid Innovation. See its recently released AHEAD model initiative. With this new initiative, the State can directly influence and improve how care is delivered and financed, aiming to stabilize Nevada's individual market by improving population health, which in turn reduces costs and risks to carriers.

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

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

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

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

3. Practice in Nevada Incentive Program for Providers

One of the significant drivers of high health care costs and poor health outcomes in Nevada is the alarming provider workforce shortage in the State. The State proposes to utilize federal pass-through funds to finance a new workforce initiative—a loan repayment program that ties payment to a four-year commitment to live and work in Nevada. Anyone violating the loan repayment agreement would be required under the contract to pay back the financial assistance received from the State. As with the Quality Incentive Payment Program, the design features of the Practice in Nevada Incentive Program will be finalized via the development and finalization of the BBSP contracts, which will enforce such relevant provisions. At a minimum the State will require that providers live in the community in which they practice for at least four years and be willing to enter into a contract with the State to meet specific program requirements.

This initiative advances several key goals of the waiver program. By dedicating resources to attract and retain providers – including primary care providers – the State can help expand access to health care services, especially among communities that have the most difficulty accessing providers, and drive improvements in health care outcomes for those and other communities.[22] Two key policy objectives of NRS 695K include improving access to high-quality, affordable health care for residents of the State and reducing health care disparities for historically marginalized communities. Additionally, pursuant to NRS 695K.220.4(c), the State must prioritize insurer applicants whose proposals strengthen the health care workforce in Nevada – particularly in rural areas. This incentive program for providers can serve as an effective strategy for accomplishing these goals outlined in statute. Further, by investing in providers and expanding access to primary care services, the State can help lower spending on unnecessary costs in the health care system, including spending on nonurgent emergency department utilization.[23]

F. Implementation Milestones

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

The second step is for the Director to conduct a statewide procurement for the new BBSPs alongside its next statewide Medicaid Managed Care procurement, which is anticipated to begin no later than January 1,2025. The alignment of this procurement process with the Medicaid Managed Care procurement is intended to leverage the State's purchasing authority and its multi-billion-dollar contracts with carriers.[24] Specifically, State law requires any carrier seeking to be eligible to do business with Nevada Medicaid as an MCO to also submit a good faith bid to offer at least two BBSPs per rating region (i.e., one Silver-level plan and one Gold- level plan). Other carriers not

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

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

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

seeking an award as an MCO in the State's Medicaid Managed Care program may also submit a bid to offer a BBSP. The State does not anticipate any carriers opting to offer a bid for a BBSP contract unless they are also offering a bid for the MCO contract with the State.

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

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

Besides the milestones set forth in State law for the BBSPs, implementation of the Market Stability Program will also take place in 2026, with a rollout date of 2027 upon receipt of federal pass-through funds, pending federal approval.

Table 2 below lists these milestones and key dates for the State's implementation of NRS 695K and the Market Stabilization Program, pursuant to this 1332 waiver approval.

Table 2: Nevada Battle Born State Plan Implementation Timeline and Milestones	
Quarter 4, 2021	• Public workshops on product design held by the State.
Quarters 1-3, 2022	• Actuarial analysis and waiver development.
Quarter 4, 2022	• Nevada Medicaid hosts weekly "office hours" for the Public Option.
Quarter 3, 2023	• Development of a new Market Stabilization Program for waiver.

Table 2: Nevada Battle Born State Plan Implementation Timeline and Milestones	
Quarter 4, 2023	• Finalize actuarial analysis and waiver draft. • Draft waiver application released November 20, 2023. • DHHS hosts two hybrid (in-person and virtual) public workshops/hearings on draft waiver (November 27 and December 5). • DHHS hosts two tribal consultations (November 29 and December 7). • DHHS issues new bulletin to carriers on BBSP revised target and reinsurance program (November 20). • DHHS submits waiver application (by January 1, 2024).
Quarter 1-2, 2024	• CMS/Treasury determine completeness within 45 days and hold 30-day federal public comment period. • DHHS begins development of procurement materials and contracts for BBSPs. • DHHS hosts stakeholder meetings to gather input on procurement for BBSPs.
Quarter 2, 2024	• CMS/Treasury continues a 180-day review/determination period. • DHHS develops Request for Information to gather stakeholder feedback on design elements for the BBSP contracts. • DHHS releases Request for Information to gather stakeholder feedback on BBSP contracts. • DHHS continues development of procurement materials and contracts for BBSPs.
Quarter 3, 2024	• CMS/Treasury make final determination on waiver application. • DHHS finalizes procurement materials and contract for BBSPs
Quarter 4, 2024	• MCO/BBSP statewide procurement begins.
Quarter 1, 2025	• State evaluators for procurement review bids for MCOs and BBSPs.
Quarter 2, 2025	• Continued procurement process.
Quarter 3, 2025	• DHHS sends Letter of Intent to Award MCO and BBSP contracts. • Negotiation and awards final for BBSP contracts. • BBSP carriers submit rate filings to DOI for review/approval. • DOI completes rate analyses and approval processes. • DOI submits final rate filings to the Center for Consumer Information and Insurance Oversight (CCIIO). • BBSP carriers submit for SSHIX certification.
Quarter 4, 2025	• BBSPs are offered for enrollment during Open Enrollment.

Table 2: Nevada Battle Born State Plan Implementation Timeline and Milestones	
Quarter 1, 2026	• BBSPs available on SSHIX for Plan Year 2026.
Quarter 2, 2026	• DHHS/DOI guidance to carriers on reinsurance and Quality Incentive Payment Program. • BBSP carriers submit rate filings to DOI for Plan Year 2027 for review/approval.
Quarter 3, 2026	• DOI completes rate analyses and approval processes. • DOI submits final rate filings to CCIIO. • BBSP carriers submit for SSHIX certification.
Quarter 4, 2026	• BBSP are offered for enrollment during Open Enrollment
Quarter 1, 2027	• BBSP available on SSHIX for Plan Year 2027. • Reinsurance program begins for Plan Year 2027.

G. Inter-agency Coordination

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

1. Nevada DOI

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

2. SSHIX

The SSHIX will continue to annually certify QHPs for participation in its online platform with premium subsidies for consumer shopping as it does today. For Coverage Year 2026 and beyond, QHP offerings will include BBSPs.

3. Nevada DHHS

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

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

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

H. Expected Federal Savings and Enrollment Changes

The actuarial analysis conducted by Milliman, Inc. estimates that the introduction of new BBSPs into the SSHIX with the support of a reinsurance program for the State's individual market could achieve nearly $279 –$310

million in federal savings in the first five years and $760–$844 million at the end of the first ten years.[25]

The actuarial analysis assumes BBSPs are very likely to become the SLCSP in every rating area (and county) within the state of Nevada. Currently there are four MCOs in the Managed Care Program. During the last state legislative session, the Governor's budget included funding and authority for statewide expansion. Therefore, health carriers are informed of that requirement for the next contracting period and are reportedly expanding their provider networks to accomplish this and bid on the next RFP. These carriers are already required to offer a silver and gold plan in the SSHIX and that requirement will continue. With MCOs' existing participation and further interest in SSHIX offerings, alongside the requirement to submit a bid to offer a silver and gold BBSP under the waiver, the State projects that among the carriers awarded MCO contracts, multiple (and possibly all) bids will be chosen to be offered as a BBSP in each rating area. Therefore, we anticipate having more than one BBSP in each rating region. Moreover, multiple carriers offering BBSPs, combined with new premium reduction requirements and the State's contractual enforcement mechanisms in place indicate that the BBSPs are also very likely to be the SLCSP in each rating region.

It is possible, particularly in the first year of the waiver program when the required premium target is only 3% below the reference premium, that non-BBSP plans could be aggressively priced to remain competitive with BBSPs. However, this pricing strategy becomes more challenging and less likely after the first year of the program as the required rate reduction for BBSPs is further below the reference premium. If the SLCSP is not a BBSP, the State intends to obtain data and other information from the States' carriers, which will be defined through the procurement and contracting process, and from other states to analyze and estimate market trends absent the introduction of the BBSPs and develop a range of potential impacts of the BBSPs on non-BBSP premiums for purposes of determining pass-through funding in these situations. The State will collaborate with other stakeholders and other states with similar experience to develop specific data requests and templates for this purpose.

For purposes of the actuarial review conducted by Milliman, it is assumed that the Inflation Reduction Act's enhanced federal marketplace subsidies will expire on January 1, 2026, at the time the new BBSPs enter the Nevada market and SSHIX.[26] Table 3 below shows the projected federal pass-through funding from the BBSPs (i.e., specifically from the new premium reduction target for waiver years 2026–2030) and the new reinsurance program (for waiver years 2027–2030).

Table 3: Summary of Projected Pass-Through Funding by Scenario

	Total Pass-Through Funding (PTF), (in Thousands)		
Time Period	**BBSPs Only**	**Reinsurance**	**Total**
Five-Year Waiver Window	$ 168,000	$142,000	$310,000
Five-Year Waiver Window (With 10% Margin)*	$151,000	$128,000	$279,000
Ten-Year Deficit Neutrality Window	$445,000	$399,000	$844,000
Ten-Year Deficit Neutrality Window (With 10% Margin)*	$401,000	$359,000	$760,000

[25] See Nevada 1332 Waiver Actuarial Report by Milliman, Inc., 2023.

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

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

Table 4 shows the projected federal savings as a result of the approval of this waiver and the implementation of the BBSPs and, subsequently, a reinsurance program. This table assumes the BBSP carriers meet the premium reduction targets for all five years of the waiver (at least 15 percent in the first four years), and that starting in plan year two, the State implements a State-based reinsurance program using federal pass-through from waiver year one to fully finance the program. The premium reduction targets are inclusive of the impact of reinsurance. This analysis also assumes that, with their premium reduction target and the introduction of reinsurance, the BBSPs will be the SLCSP in the SSHIX each year of the waiver period.

Table 4: Impact of Waiver Compared to Baseline

Year	Premiums	Total Change Individual Market Enrollment	Federal Savings (Thousands)
2026	(3.2%)	600	$15,000
2027	(12.0%)	1,800	$58,000
2028	(13.5%)	2,000	$69,000
2029	(15.0%)	2,100	$81,000
2030	(15.2%)	1,900	$87,000

As a result of the new BBSPs in SSHIX and the State-based reinsurance program, Milliman, Inc. also estimates the following changes in enrollment in the SSHIX as described in Table 5, with a BBSP being the SLCSP.

Table 5: Projected SSHIX Enrollment Change from Baseline

Year	BBSPs Only	Reinsurance	Total
2026	600	0	600
2027	700	1,100	1,800
2028	900	1,100	2,000
2029	1,000	1,100	2,100
2030	800	1,100	1,900
2031	900	1,100	2,000
2032	900	1,100	2,000
2033	900	1,200	2,100
2034	900	1,200	2,100
2035	800	1,200	2,000

If the amount of federal savings, and therefore pass-through funds, is lower than estimated, the State intends to adjust its reinsurance attachment point and coinsurance to ensure that there are adequate funds to support the program for the upcoming calendar year. If the amount of federal savings is greater than needed to fully fund the reinsurance program, the State intends to utilize the passthrough to fund the State's new Quality Incentive Payment Program and its Practice in Nevada Program.

The analysis of federal savings shows the impact of the new premium reduction targets and reinsurance in the individual health insurance market in Nevada. It does not assume an impact on federal pass-through funding for the other two programs that make up the Market Stabilization Program (e.g., Quality Incentive Payment Program and Practice in Nevada Program). Although both are expected to reduce costs to carriers over time with improvements in quality of care and population health, the potential short-term effects of these efforts on

premiums are not quantifiable.

Section 3: Actuarial Analysis of Proposed Waiver

A: Impact on Section 1332 Guardrails

This section discusses the impact of the waiver's individual market elements on the four Section 1332 waiver statutory guardrails. Nevada's actuarial analysis conducted by Milliman, Inc., indicates that Nevada's waiver meets the federal requirements for a Section 1332 waiver under the scenarios modeled.

1. Affordability (1332(b)(1)(B))

The Section 1332 waiver must provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable as would be projected without the waiver.

The waiver satisfies the affordability requirement as follows:

- Table 6 shows the percentage by which BBSPs are expected to lower the cost of the benchmark plan in each year of the five- and ten-year windows.
- Average net premiums (after subsidies) for subsidized Silver enrollees are expected to be no higher than Baseline scenarios. Enrollees who switch to the SLCSP, which is assumed to be a BBSP in waiver scenarios, will realize no (zero) change in net premium relative to the Baseline scenario.

Subsidized enrollees who currently receive no-cost Bronze plans could continue to pay no net premium (after subsidies), if they remain in or switch to a Bronze plan with a premium lower than the value of their premium tax credit. The State is exploring ways to support consumers in switching plans when necessary to avoid net premium increases, including policies investing in marketing and navigator resources. Further, Bronze plan enrollees who receive smaller subsidies (e.g., lower-cost areas, younger ages, higher incomes) may see premium decreases (similar to Silver plans described above). The introduction of reinsurance will further lower out-of-pocket premium costs for enrollees. Cost sharing for BBSPs and standard QHPs are not expected to change under the waiver. Therefore, non-premium cost sharing will be at least as affordable under waiver as without the waiver.

As shown below in Table 6, the reinsurance program in 2027 helps to offset the burden on carriers and their provider networks of the premium reduction target by subsidizing the reduction in rates by about half. For example, in waiver year two (2027), carrier rate filings with reinsurance account for 6.8% of that year's reduction, and, by 2030, reinsurance accounts for a cumulative total of 7.2% of the premium reduction target as compared to the average benchmark year. These premium reductions will make coverage more affordable for unsubsidized people.

Table 6: Projected Second-Lowest-Cost Silver Premium Change from Baseline			
Year	**BBSPs Only**	**Reinsurance**	**Total**
2026	-3.2%	0.0%	-3.2%
2027	-5.2%	-6.8%	-12.0%
2028	-6.6%	-6.9%	-13.5%
2029	-8.0%	-7.0%	-15.0%
2030	-8.0%	-7.2%	-15.2%
2031	-8.0%	-7.4%	-15.4%
2032	-8.0%	-7.6%	-15.7%
2033	-8.0%	-7.9%	-15.9%
2034	-8.0%	-8.1%	-16.1%
2035	-8.0%	-8.3%	-16.3%

2. Coverage (1332(b)(1)(C))

The waiver plan must provide coverage to at least a comparable number of its residents as would otherwise be covered without the waiver. Table 7 shows how the waiver plan satisfies the scope of coverage standard for all waiver and deficit neutrality window years. The actuarial report expects modest increases in enrollment due to the introduction of the BBSPs and slightly larger incremental increases in enrollment in the SSHIX due to the implementation of reinsurance, as shown in Table 7. These increases mainly result from individuals who were uninsured but find unsubsidized premiums under the waiver more affordable due to the gross premium reductions related to the reinsurance program.

Table 7: Projected Individual Market Enrollment Change from Baseline			
Year	**BBSPs Only**	**Reinsurance**	**Total**
2026	600	0	600
2027	700	1,100	1,800
2028	900	1,100	2,000
2029	1,000	1,100	2,100
2030	800	1,100	1,900
2031	900	1,100	2,000
2032	900	1,100	2,000
2033	900	1,200	2,100
2034	900	1,200	2,100
2035	800	1,200	2,000

3. Comprehensiveness (1332(b)(1)(A))

The Section 1332 waiver must provide coverage at least as comprehensive as it would be without the waiver. The Nevada Section 1332 waiver complies with this standard because SB420 requires the new BBSPs to meet all QHP standards under the ACA, which includes providing the full set of essential health benefits. It does not make any changes to these benefits, nor does it alter any other coverage requirements for QHPs, for either BBSPs or standard QHPs. Reinsurance does not have any impact on the comprehensiveness of coverage.

4. Deficit Neutrality (1332(b)(1)(D))

The Section 1332 waiver must be deficit neutral to the federal government compared to projections without the waiver. Table 8 shows the total projected pass-through funding by scenario, demonstrating that the reinsurance program and premium reduction target satisfy the deficit neutrality standard.

These reforms reduce federal outlays for premium subsidies relative to the Baseline scenario and these savings are paid to the State in the form of pass-through funding such that total outlays under a waiver (subsidies paid to enrollees plus pass-through funding to the State) are no greater than subsidies paid to enrollees without the waiver. The Milliman report reduces the projected pass-through funding over the five-year waiver and ten-year deficit neutrality windows by a 10% margin to account for unknown contingencies.

Table 8: Projected Pass-Through Funding by Scenario

Total Pass-Through Funding (Thousands)			
Year	**BBSPs Only**	**Reinsurance**	**Total**
2026	$15,000	$0	$15,000
2027	$26,000	$32,000	$58,000
2028	$35,000	$34,000	$69,000
2029	$45,000	$36,000	$81,000
2030	$47,000	$40,000	$87,000
2031	$50,000	$43,000	$93,000
2032	$52,000	$47,000	$99,000
2033	$56,000	$50,000	$106,000
2034	$58,000	$56,000	$114,000
2035	$61,000	$61,000	$122,000
Five-Year Waiver Window	$168,000	$142,000	$310,000
Ten-Year Deficit Neutrality Window	$445,000	$399,000	$844,000
Five-Year Waiver Window – 10% Margin	**$151,000**	**$128,000**	**$279,000**
Ten-Year Deficit Neutrality Window – with 10% Margin	**$401,000**	**$359,000**	**$760,000**

B. Impact on Health Equity

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

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

and lead to worse health outcomes and increased financial risk.[27]

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

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

These rewards would be financed through the Quality Incentive Payment Program. Further, the above contractual requirements will empower the State to measure, track, and act on health care disparities, furthering the authorizing legislation's goal of improved access to health care and better health outcomes for historically marginalized communities.

Finally, DHHS plans to use the State-based reinsurance program as a lever to address geographic disparities in market stability and affordability in the individual market. Those living in Rating Areas 3 and 4 – comprised of more rural counties – have historically been exposed to higher gross premiums.[28] The State plans to implement a tiered reinsurance program that will have a more pronounced impact on lowering premiums in Rating Areas 3 and 4. In doing so, the State is investing more resources to bring market stability to more rural regions in the State where there have been longstanding affordability challenges.

Section 4: Additional Information

A. Administrative Burden

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

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

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

[28] 2023 Nevada Division of Insurance Market Report, available at: https://doi.nv.gov/uploadedFiles/doi.nv.gov/Content/News_and_Notices/2023_InsuranceMarketReport_FINAL_ADA.pdf

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

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

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

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

Nevada believes that the above administrative tasks are similar to other administrative functions currently performed by the federal government so that their impact is minimal. The waiver of Section 1312(c)(1) does not necessitate any changes to the Federally Facilitated Exchange or to IRS operations and will not impact how advanced premium tax credits and premium tax credit payments are calculated or paid.

B. Implementation of Non-waived ACA Provisions

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

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

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

D. Compliance, Waste, Fraud, and Abuse

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

federal requirements for QHPs and all State health insurance laws and regulations.

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

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

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

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

DHHS and DOI are audited as part of the Annual Comprehensive Financial Report (ACFR) and are included in the State Audit. The Legislature's Audit Subcommittee contracts with an external firm to conduct the audits, and the audits are presented to the Legislature. The Nevada BBSP program and federal pass-through funding will be subject to audit under the State's ACFR and Single Audit. The reinsurance program will also be subject to those audits and will be part of the annual report. The federal government is responsible for calculating the federal savings resulting from this waiver and for ensuring that this waiver does not increase federal spending.

E. State Reporting Requirements and Targets

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

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

Each quarterly report will include the following:

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

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

The annual report prepared by DHHS will include the following metrics to assist evaluation of the waiver's compliance with the requirements found in Section 1332(b)(l):

- Actual individual market enrollment in the State.
- Actual average individual market premium rate (i.e., total individual market premiums divided by total member months of all enrollees).
- The actual SLCSP premium under the waiver and an estimate of the SLCSP premium as it would have been without the waiver for a representative consumer (e.g., a 21-year-old nonsmoker) in each rating area.
- The actual amount of Advance Premium Tax Credit (APTC) paid, by rating area, for the plan year.
- The actual number of APTC recipients for the plan year. The number should be the number summed over all 12 months and divided by 12 to provide an annualized measure.
- Changes to the waiver programs, including the funding level the program will be operating at for the next plan year, or other program changes.
- Notification of changes to state law that may impact the waiver.
- Reporting of:
    - Federal pass-through funding spent on subsidy programs adopted by DHHS. The unspent balance of federal pass-through funding for the reporting year, if applicable.

F. Proposed State Operations Budget for Waiver Program

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

Table 9: Estimated Annual SFY Budget Costs for State Operations, Starting SFY 2026	
Nevada Division of Insurance Operation Costs for Public Option	
Data Process Setup Assistance	One-Time Set-Up Cost of $60,000.00
Software License	$10,000.00 per SFY
Reinsurance Program Manager	$80,000.00 per SFY
Increased Rate Review Costs	$20,000.00 per SFY
Outside Auditing Services	$20,000.00 per SFY
Estimated subtotal	**$60,000.00 One Time Cost** **$130,000.00 per SFY**
Nevada Medicaid Operation Costs for Public Option	
New Staffing Costs for Contracts Oversight /Waiver Management	$400,000.00 per SFY
New Actuary and Transaction Fees[29]	$1,600,000.00 per SFY
Estimated subtotal	**$2,000,000.00 per SFY**
Estimated Total Operational Costs per SFY	**$2,130,000.00 per SFY**

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

G. Evidence of Public Notice and Tribal Consultation Requirements

The State of Nevada held a public comment period beginning on November 20, 2023 and ending on December 20, 2023. The public comment period was announced through a posting on the Nevada Department of Health and Human Services Division of Health Care Financing and Policy (DHCFP/the Division)'s website. The State also sent a press release to local media outlets and a similar notice through the Nevada Market Stabilization Program ListServ, announcing the beginning of the 30-day public comment period (see Appendix for this press release). The public hearings were also announced on DHCFP's website as public notices (see Appendix materials). During the public comment period, the Division of Health Care Financing and Policy held two tribal consultations (November 29 and December 7), and two public hearings (November 27 and December 5). The presentations for the consultations and hearings are available in the Appendix.

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

The tribal consultations for the 1332 Waiver Application were held on November 29 and December 7, 2023, from 9:00 – 10:00am PST and 1:30 – 2:30pm PST, respectively, both in-person and via Teams. The meetings were hosted by the Division and all Tribal Chairs and Tribal Health Clinic Directors from the Nevada Tribes were

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

invited to the consultations.[30] During the consultations, staff members from the Division presented an overview of the 1332 Waiver Application and the anticipated impact of the Waiver on tribal communities. After the presentation, Division staff addressed questions from the meeting attendees. Commenters raised questions about the BBSPs, including network provider requirements, whether tribes would be able to sponsor premiums for BBSPs offered on the Exchange with federal funding, and if BBSPs would include an Indian Addendum to coordinate health coverage for tribes with providers in multiple states. The State confirmed that all requirements that apply to Qualified Health Plans also apply to the BBSPs.

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

The Division also accepted written comments during the 30-day comment period. 37 written comments were submitted during this time period. Those submitting written comments expressed similar themes as outlined above during the public hearings. The State received several comments in support of the 1332 Waiver Application, highlighting the potential for the BBSPs to improve affordability and narrow health care disparities. Other commenters expressed concerns related to mandated premium reductions, anticipated provider reimbursement reductions, and certain provider participation requirements. The Appendix also includes responses to themes raised from written comments.

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

Attached Materials

MILLIMAN REPORT

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

Prepared for Nevada Department of Health and Human Services

February 6, 2024

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Table of Contents

EXHIBITS

I. EXECUTIVE SUMMARY

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

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

Based on Section 2 of SB420, which can be found in Appendix B, the stated purpose of the PO is to lower individual market health insurance premiums and consumer out-of-pocket premium costs, improve access to health care, reduce disparities in health care access and outcomes, and improve the availability of coverage for residents of rural areas. Furthermore, the PO plan offerings, hereafter referred to as Battle Born State Plans (BBSPs), are expected to provide the opportunity for some Nevadans to obtain a lower-priced product through reduced provider reimbursement, reduced issuer administrative expenses, and value-based purchasing initiatives designed to drive efficiency in utilization. With lower gross premiums, it is likely that a BBSP will become the benchmark plan in all rating areas in Nevada, thereby lowering federal outlays for premium subsidies, which then become available to the State of Nevada as PTF under the Section 1332 waiver. Where a BBSP does not become the SLCS,[1] it is expected that the introduction of these lower cost plans will increase competition such that standard QHPs, or individual market plans that are not BBSPs, are lower than they otherwise would be, thereby reducing federal subsidies and generating PTF. Therefore, the PTF under the Section 1332 waiver is not expected to rely on having at least two BBSPs in each rating area or on a BBSP being the SLCS.

In addition to the introduction of BBSPs, the State of Nevada intends to implement a reinsurance program in the individual market beginning in 2027. The stated intent of the reinsurance program is to transform the PO into a market stabilization program by reinvesting 1332 waiver pass-through funding back into Nevada's individual health insurance market.[2] The reinsurance program implementation will occur after the implementation of BBSPs to allow for the accumulation of sufficient PTF to cover the State of Nevada's portion of the reinsurance program costs.

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

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

[1] For modeling purposes, whether a BBSP or a standard QHP becomes the second lowest cost silver is not material and we assume the same effect on subsidies. See Section III.B for additional discussion of the effect of increased competition on premium rates on the individual market.
[2] State of Nevada. "Governor Joe Lombardo Announces Plan to Transform the Nevada Public Option into NMSP," State of Nevada press release, October 11, 2023. https://gov.nv.gov/uploadedFiles/gov2022nvgov/content/Newsroom/PRs/2023/2023-10-11_DHHS_NVPublicOption-Memo.pdf. Accessed October 31, 2023.

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

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

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

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

For simplicity and no loss of accuracy, we assume the second lowest cost silver (SLCS) plan in the Market Stabilization scenario will be a BBSP.[3] We assume minimal change in total individual market enrollment, as PTC-eligible individuals' net premiums will be largely the same[4] as in the Baseline scenarios assuming they are enrolled in the SLCS BBSP.

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

A. SUMMARY OF RESULTS

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

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

[3] For modeling purposes, whether a BBSP or standard QHP becomes the second lowest cost silver is not material and we assume the same effect on subsidies.

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

Table 1 State of Nevada NMSP Actuarial and Economic Analysis Projected Pass-Through Funding and Cost of Reinsurance			
Year	Pass-Through Funding (thousands)	Cost of Reinsurance (thousands)	Net Funding Remaining (thousands)
2026	$15,000	$0	$15,000
2027	$58,000	($56,000)	$2,000
2028	$69,000	($60,000)	$9,000
2029	$81,000	($64,000)	$17,000
2030	$87,000	($70,000)	$17,000
2031	$93,000	($76,000)	$17,000
2032	$99,000	($83,000)	$16,000
2033	$106,000	($90,000)	$16,000
2034	$114,000	($98,000)	$16,000
2035	$122,000	($106,000)	$16,000
5-Year Waiver Window	**$310,000**	**($250,000)**	**NA***
10-Year Deficit Neutrality Window	**$844,000**	**($703,000)**	**NA***
5-Year Waiver Window – With 10% Margin on PTF	**$279,000**	**($250,000)**	**NA***
10-Year Deficit Neutrality Window – With 10% Margin on PTF	**$760,000**	**($703,000)**	**NA***

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

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

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

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

Affordability: The 1332 waiver must provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable as would be projected without the waiver. The Nevada NMSP satisfies the affordability requirement as follows:

- Table 2 illustrates that the NMSP is expected to offer gross premium rates in all years of the five-year waiver window and the 10-year deficit neutrality window that are lower than premiums under the Baseline scenario. As described in Appendix C, the BBSPs are expected to be at least 3% lower than the average reference premium (see Appendix C) in 2026 and 15% lower by 2029. Table 2 shows how the BBSPs independently satisfy this guardrail prior to reinsurance, and reinsurance further improves affordability under the NMSP.

- *Available* net premiums (after federal subsidies) for subsidized silver plan enrollees are expected to be no higher than in the Baseline scenario. Enrollees who *actually* switch to the SLCS option, which is assumed to be a BBSP in the Market Stabilization scenario, will realize no (zero) change in net premium relative to the Baseline scenario. Moreover, for younger or higher-income silver plan enrollees who typically have smaller subsidies, BBSP premiums may be below their current net premiums, providing an opportunity for lightly subsidized individuals to realize premium savings if they switch to a BBSP.

Subsidized enrollees who currently receive no-cost bronze plans could continue to have zero net premium (after subsidies) if they switch to a bronze plan (whether a BBSP or not) that is priced below their subsidy in the NMSP. Further, bronze plan enrollees who receive smaller subsidies (e.g., lower-cost areas, younger ages, higher incomes) may see premium decreases (similar to silver plans described above) if they switch to a bronze BBSP.

- The reinsurance program will further reduce gross premiums. Fully subsidized enrollees are not expected to be impacted by reinsurance. Rather, the gross premium reductions stemming from the reinsurance program will result in savings to the federal government by reducing PTCs. However, the additional premium reductions due to reinsurance for lightly or non-subsidized enrollees will be realized, in part or in whole, by enrollees.

- Cost-sharing is not expected to be different under the waiver, for either BBSPs or standard qualified health plans (QHPs), than it is without the waiver. SB420 requires BBSPs to include both silver and gold plans, and DHS intends to incentivize plans to include bronze BBSP offerings. Since cost sharing is based on an actuarial value (i.e., a percentage of plan costs) which is tied to the metal level, aggregate out-of-pocket costs for enrollees will decrease if they enroll in a plan with the same or higher metal level. Our modeling assumes all individuals enroll in a plan with the same or higher metal due to the lower premiums available for the same (or better) coverage under the waiver. Therefore, non-premium cost-sharing will be at least as affordable under the waiver as it is without the waiver.

- Due to the ACA's permissible 3:1 age rating factor, some older adults are eligible for a $0 bronze plan at income levels above 250% FPL. As the NMSP is estimated to reduce premiums, it is likely the number of marketplace enrollees qualifying for a $0 bronze plan will decrease by a very small degree relative to without the waiver.

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

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

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

Year	BBSPs Only	Reinsurance	Total*
2026	-3.2%	0.0%	-3.2%
2027	-5.2%	-6.8%	-12.0%
2028	-6.6%	-6.9%	-13.5%
2029	-8.0%	-7.0%	-15.0%
2030	-8.0%	-7.2%	-15.2%
2031	-8.0%	-7.4%	-15.4%
2032	-8.0%	-7.6%	-15.7%
2033	-8.0%	-7.9%	-15.9%
2034	-8.0%	-8.1%	-16.1%
2035	-8.0%	-8.3%	-16.3%

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

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

We expect modest increases in enrollment due to the introduction of the BBSPs and slightly larger incremental increases in enrollment due to the implementation of reinsurance, as shown in Table 3. These increases mainly result from individuals who were uninsured (including those with higher health care cost burdens) but who would find unsubsidized premiums under the waiver more affordable due to the gross premium reductions related to the NMSP, noted in Table 2 above. We assume the use of PTF for provider quality incentives and workforce initiatives do not impact the scope of coverage.

Table 3
State of Nevada
NMSP Actuarial and Economic Analysis
Projected Individual Market Enrollment Change From Baseline

	No Waiver	Enrollment Increase Due to Waiver		
Year	Baseline	BBSPs Only	Reinsurance	Total
2026	101,400	600	0	102,000
2027	102,700	700	1,100	104,500
2028	104,000	900	1,100	106,000
2029	105,300	1,000	1,100	107,400
2030	106,800	800	1,100	108,700
2031	108,200	900	1,100	110,200
2032	109,600	900	1,100	111,600
2033	111,000	900	1,200	113,100
2034	112,400	900	1,200	114,500
2035	113,900	800	1,200	115,900

** Values are rounded to the nearest hundred*

Comprehensiveness: The 1332 waiver must provide coverage at least as comprehensive, as defined by the ACA's essential health benefits (EHBs), as would be projected without the waiver. The Nevada 1332 waiver complies with this standard because SB420 requires the new BBSPs to meet all QHP standards under the Affordable Care Act, which includes providing the full set of essential health benefits. It does not make any changes to these benefits, nor does it alter any other coverage requirements for QHPs, for either BBSPs or standard QHPs. Reinsurance does not have any impact on the comprehensiveness of coverage. Since the waiver is not expected to impact comprehensiveness of coverage; therefore, by extension, there are no impacts to any specific populations of individuals or households, including those with higher health care cost burdens. Similarly, the use of PTF for provider quality incentives and workforce initiatives do not impact the comprehensiveness of coverage.

Deficit neutrality: The 1332 waiver must be deficit neutral to the federal government compared to projections without the waiver. Table 4 shows the Market Stabilization scenario, demonstrating that the NMSP satisfies the deficit neutrality standard. The Market Stabilization scenario reduces federal outlays for premium subsidies relative to the Baseline scenario and these savings are paid to the state in the form of PTF such that total outlays under a waiver (subsidies paid to enrollees plus pass-through funding to the state) are no greater than subsidies paid to enrollees without the waiver. The annual projected PTF amounts represent our best estimates of the savings in each year. Additionally, we provide the projected PTF over the five-year waiver and 10-year deficit neutrality windows, and we apply a 10% margin to account for unknown contingencies.

The use of PTF for provider quality initiatives could reduce premiums in the waiver scenario further, including the SLCS, to the extent they improve patient outcomes and reduce overall costs. Likewise, workforce initiatives may also eventually reduce premiums due to increased availability of providers and resulting improved patient outcomes. We conservatively do not make any assumptions to reflect the potential impact of these programs during the 10-year deficit neutrality window (i.e., PTF could be understated).

Table 4 State of Nevada NMSP Actuarial and Economic Analysis Projected Pass-Through Funding (in Thousands)*					
	Advanced PTCs		Total Pass-Through Funding		
Year	No Waiver	With Waiver	BBSPs Only	Reinsurance	Total
2026	$396,000	$379,000	$15,000	$0	$15,000
2027	$418,000	$354,000	$26,000	$32,000	$58,000
2028	$442,000	$365,000	$35,000	$34,000	$69,000
2029	$466,000	$376,000	$45,000	$36,000	$81,000
2030	$493,000	$396,000	$47,000	$40,000	$87,000
2031	$520,000	$417,000	$50,000	$43,000	$93,000
2032	$550,000	$440,000	$52,000	$47,000	$99,000
2033	$581,000	$463,000	$56,000	$50,000	$106,000
2034	$614,000	$487,000	$58,000	$56,000	$114,000
2035	$648,000	$513,000	$61,000	$61,000	$122,000
5-Year Waiver Window			**$168,000**	**$142,000**	**$310,000**
10-Year Deficit Neutrality Window			**$445,000**	**$399,000**	**$844,000**
5-Year Waiver Window – With 10% Margin			**$151,000**	**$128,000**	**$279,000**
10-Year Deficit Neutrality Window – With 10% Margin			**$401,000**	**$359,000**	**$760,000**

** Values are rounded to the nearest million*

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

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

B. DATA RELIANCE AND IMPORTANT CAVEATS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Levels of Coverage

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

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

As further explained in Section III.C (see discussion of auto-enrollment and plan switching), the majority of enrollees in the Silver State Health Insurance Exchange have historically remained in the same plan from year to year, and we expect a portion of those who changed plans likely remained in the same metal level. In other words, the number of individuals who have changed metal levels is historically low. We expect most individuals who enroll in a BBSP will do so to realize a lower enrollee net premium. Given the relatively low level of active plan selection in prior years, we do not see strong data to suggest many individuals will be motivated to switch metal levels in response to pricing changes. The high percentage of enrollees who remain in the current plan, even among those who actively enroll, suggests factors such provider network preferences or coverage level likely have an impact on plan selection for some enrollees. If some enrollees choose a lower level of coverage or choose to disenroll in response to the NMSP, PTF would

[5] See https://www.leg.state.nv.us/App/NELIS/REL/81st2021/Bill/8151/Overview.
[6] State of Nevada. "Governor Joe Lombardo Announces Plan to Transform the Nevada Public Option into NMSP." State of Nevada press release, October 11, 2023. https://gov.nv.gov/uploadedFiles/gov2022nvgov/content/Newsroom/PRs/2023/2023-10-11_DHHS_NVPublicOption-Memo.pdf. Accessed October 31, 2023.
[7] Standard QHPs could, in response to the BBSPs, reduce prices or curtail rate increases to remain competitive against BBSPs. We do not attempt to model various issuers' reactions or behaviors in our analysis.

decrease. However, the levels of coverage available to enrollees would satisfy the guardrail, even if they choose a lower level of coverage or no coverage. We conservatively assume enrollees would switch to a PO at their current metal level rather than reduce their coverage level or become uninsured.

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

- Lower-income enrollees with larger subsidies who currently have zero net premium bronze plans could maintain zero net premium either by keeping their plan or by switching to a bronze BBSP, depending on market pricing of bronze plans and changes in subsidies.
- Lightly subsidized enrollees (generally higher-income and / or younger ages) are more likely to see increases in net premiums while maintaining bronze coverage, particularly if they do not switch to a bronze BBSP, because there may be fewer zero premium bronze plans available, depending on how subsidies and market pricing of bronze plans are affected by the NMSP.
- Higher-income enrollees who are unsubsidized will likely see decreases in premium by switching to a bronze BBSP.

A bronze BBSP offering increases pass-through funding (see Section III.B for additional discussion), all else equal.

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

Access

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

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

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

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

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

Premium amounts

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

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

1. The 2024 premium for the SLCS available through the Silver State Health Insurance Exchange, trended to the premium year at the Medicare Economic Index (MEI).

2. The SLCS premium in the prior year.

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

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

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

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

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

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

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

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

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

Provider reimbursement

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

B. GENERATING PASS-THROUGH FUNDING UNDER A 1332 WAIVER

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

Competitive landscape driven by BBSPs decreases the benchmark silver plan

Our modeling assumes more than one BBSP will be offered in each rating area. Therefore, a BBSP is expected to become the SLCS plan in all rating areas[9] in Nevada in 2026. While a BBSP is highly likely to be the SLCS plan in all years of the program, it becomes even more likely in the second through fourth years of the NMSP, as the discounts relative to the reference premium and standard QHP premiums increase. It is possible that a benchmark (i.e., SLCS) plan would not be a BBSP under the following circumstances:

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

- In the first year of the NMSP, when required discounts to the reference premium are only 3% per the State of Nevada's guidance in Appendix C, issuers could choose to price standard QHPs very competitively or recontract provider agreements underlying the standard QHPs to reduce underlying cost structure, or both. If this happens, the premiums for one or more standard QHPs could be lower than the premiums for some BBSPs, and a standard QHP could become the SLCS. However, in such a situation, the impact to PTF would be the same as if a BBSP were the SLCS since this behavior would not appear in the Baseline (no waiver) scenario, assuming the waiver is given credit by CMS for the change in standard QHP pricing and provider contracting.[10]

The competitive situation as of 2024, shown in Table 5 below, shows that, with the exception of Rating Area 2, there are at least two issuers offering plans with premiums within 5% of the second-lowest-cost silver (SLCS) plan. Assuming these issuers also offer BBSP plans that are compliant with the required premium reductions in SB420 and Appendix C, it is highly likely and a reasonable modeling assumption that the benchmark plan will be a BBSP plan and at least 3% lower than in a Baseline (no waiver) scenario. Although SB420 requires issuers of Medicaid managed care plans to offer BBSPs, it does not preclude non-managed care plans from offering BBSPs.

[9] Benchmark silver plans are determined at the county level under the ACA. However, in Nevada in 2023, the benchmark plan is the same across all counties in any one of the four rating areas. For simplicity and brevity, we refer to the SLCS or benchmark plan in a rating area.

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

Table 5 State of Nevada NMSP Actuarial and Economic Analysis Nevada 2024 Individual Exchange Market Top 10 Lowest-Cost Silver Plans by Rating Area							
Rating Area 1		**Rating Area 2**		**Rating Area 3**		**Rating Area 4**	
Issuer Name	**% Difference to SLCS**	**Issuer Name**	**% Difference to SLCS**	**Issuer Name**	**% Difference to SLCS**	**Issuer Name**	**% Difference to SLCS**
Health Plan of Nevada	-0.2%	SilverSummit*	-2.9%	Hometown Health	-0.6%	SilverSummit*	-2.9%
Health Plan of Nevada	0.0%	SilverSummit*	0.0%	HMO Nevada*	0.0%	SilverSummit*	0.0%
HMO Nevada*	2.0%	SilverSummit*	1.9%	Hometown Health	0.1%	SilverSummit*	0.4%
HMO Nevada*	4.6%	SilverSummit*	3.7%	HMO Nevada*	0.2%	SilverSummit*	1.9%
HMO Nevada*	5.4%	SilverSummit*	6.8%	HMO Nevada*	0.5%	SilverSummit*	2.1%
Health Plan of Nevada	5.7%	SilverSummit*	7.2%	Hometown Health	0.9%	HMO Nevada*	4.7%
SilverSummit*	6.7%	SilverSummit*	8.8%	Hometown Health	0.9%	HMO Nevada*	4.8%
Aetna	8.7%	Aetna	9.0%	Hometown Health	1.0%	HMO Nevada*	5.2%
SilverSummit*	9.9%	SilverSummit*	9.1%	Hometown Health	1.1%	SilverSummit*	5.2%
SilverSummit*	10.0%	Hometown Health	9.8%	HMO Nevada*	1.2%	SilverSummit*	5.6%

** Current Nevada Medicaid MCO*

Reference premium tracks closely to individual market before reinsurance

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

Table 6 shows a simple illustration of the mechanics behind how the NMSP generates PTF under a 1332 waiver, given the requirements of SB420 and the State of Nevada's methodology outlined in Appendix C.

Table 6 State of Nevada NMSP Actuarial and Economic Analysis Illustration of Reference Premium Trended at Market Rate						
		2024	**2026**	**2027**	**2028**	**2029**
(1)	Second Lowest Cost Silver Plan* (Baseline)	$ 541.47	$598.26	$622.19	$647.07	$672.96
(2)	*Assumed Annualized Trend*		5.1%	4.0%	4.0%	4.0%
(3)	Reference Premium	$ 541.47	$598.26	$622.19	$647.07	$672.96
(4)	*Assumed Annualized Trend*		5.1%	4.0%	4.0%	4.0%
(5)	BBSP Premium		$579.23	$547.61	$559.45	$571.99
(6)	*Cumulative Difference From Reference Premium*		(3.2%)	(12.0%)	(13.5%)	(15.0%)
(7)	*Cumulative Difference From Baseline*		(3.2%)	(12.0%)	(13.5%)	(15.0%)

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

We note the following in Table 6:

- Line 1 shows the projection for the SLCS in 2024, trended at 5.1% annually through 2026 and 4% annually thereafter.[11] The 4% trend is based on projections of per capita spending in the private insurance markets from CMH National Health Care Expenditure data, reduced by approximately 1% for value-based care initiatives in the Nevada market. We assume the expiration of ARP subsidies to increase morbidity by approximately 2.5% in 2026; however, we simplified this adjustment in Table 6 by increasing the annualized trend from 2024 to 2026 by 1.2%. Additional references and information on this can be found in Section VI of this report. This represents a forecast of the individual market premiums in the absence of the NMSP.

- Line 3 is the calculated reference premium as defined by SB420 and reflecting the State of Nevada's methodology and guidance outlined in Appendix C. It is assumed that medical unit costs will trend at the CPI-M index, which we estimate in this modeling at 3.7%.[12] We also assume that an appropriate utilization and morbidity adjustment will be chosen that will be consistent with overall individual market dynamics in Nevada. In this illustration, that adjustment is assumed to be approximately 1.4% annually between 2024 and 2026 and 0.3% thereafter *such that the reference premium trend equals the overall market change in premiums in the absence of the NMSP.* Additional information and references on this can be found in Section VI of this report.

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

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

Table 6 illustrates how BBSPs can achieve the required 15% savings relative to the reference premium. Because the reference premium tracks to the market, the BBSP premiums will also be 15% below the Baseline SLCS (i.e., the SLCS absent the waiver).

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

For example, if the reference premium were to be trended at a rate lower than the overall individual market, BBSP premiums would be less than 15% below the Baseline SLCS premium by 2029. In Table 7 below, we assume a reference premium trend of 3%, which is below the overall individual market trend and is not adjusted for changes in morbidity, for illustrative purposes.

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

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

Table 7 State of Nevada NMSP Actuarial and Economic Analysis Illustration of Reference Premium Trended Below Market Rate						
		2024	2026	2027	2028	2029
(1)	Second Lowest Cost Silver* (Baseline)	$ 541.47	$ 598.26	$ 622.19	$ 647.07	$ 672.96
(2)	*Assumed Annualized Trend*		5.1%	4.0%	4.0%	4.0%
(3)	Reference Premium	$541.47	$574.44	$591.67	$609.42	$627.71
(4)	*Assumed Annualized Trend*		3.0%	3.0%	3.0%	3.0%
(5)	BBSP Premium		$556.17	$520.75	$526.90	$533.53
(6)	*Cumulative Difference From Reference Premium*		(3.2%)	(12.0%)	(13.5%)	(15.0%)
(7)	*Cumulative Difference From Baseline*		(7.0%)	(16.3%)	(18.6%)	(20.7%)

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

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

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

In summary, SB420 generates PTF primarily through a) the requirement that BBSP premiums are a certain percentage below the reference premium over the course of the first four years of the NMSP, and b) the likelihood that this requirement results in the SLCS or benchmark premium in all areas being no greater than the BBSP target premium. We assume no additional savings from the BBSPs related to annually indexing the reference premium to an artificially low measure of health care inflation (illustrated in Table 7) that is not reflective of the overall individual market absent the waiver. Nor do we assume that BBSPs will contain materially greater advantages in provider reimbursement cost structure, medical management, or value-based purchasing (VBP) to support lower premiums beyond the required 15% reduction versus the reference premium. Under the assumption that the reference premium is properly indexed to the overall individual market without the waiver, as is the intent of the DHHS Guidance in Appendix C, the NMSP will continue to generate PTF under the waiver beyond the first four years of the program due to the availability of BBSPs.

Sources of BBSP premium savings

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

- *Reductions in provider reimbursement unit costs*: It is expected that unit costs paid to facilities and professional providers in Nevada will be reduced to support the lower BBSP premium targets.
- *Reductions in administrative costs*: Issuers will be required to price BBSPs with a smaller expense load relative to standard QHPs to reduce the portion of BBSP premium reductions placed on providers. The required administrative expense targets will be set by the Director and will grade in over the first four years of the program.
- *Improved cost structures and efficiencies due to value-based purchasing initiatives*: Based on discussions with DHHS and the provisions in SB420 related to value-based purchasing, it is expected that the state will see an increased use of these initiatives with providers across both Medicaid MCOs and BBSPs. When these initiatives are aligned across markets in this manner, it increases the likelihood that providers will experience success with respect to their patient populations and outcomes, in addition to reduced administrative burden. The actual scope and impact of these initiatives will likely vary by issuers offering BBSPs, and specific estimates of the impact of these initiatives are outside the scope of this analysis.

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

Reinsurance program structure

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

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

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

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

C. FEDERAL 1332 WAIVER REQUIREMENTS

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

Waivable Provision

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

Section 1332 waiver guardrails

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

1. Affordability of premiums and cost-sharing

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

   The State of Nevada will not force enrollees to select a BBSP; however, **the premiums and cost-sharing *available* under the waiver will be at least as affordable as premiums and cost-sharing absent the waiver for all enrollees**. In short, the affordability guardrail is fulfilled because all enrollees will have *access* to a BBSP offering in 2026. The addition of reinsurance in 2027 ensures all premiums on the individual market will be more affordable with the waiver than without the waiver in the second year of the NMSP.

Although the affordability guardrail is met, the actual premium savings *realized* by individuals may vary based on the enrollee's level of subsidy and plan selection.

- ***Unsubsidized:*** Current enrollees who are not eligible for any subsidies will realize the entire premium savings driven by the NMSP if they switch to the SLCS, which is assumed to be a BBSP. If they elect a standard QHP (assuming it is not the SLCS), they will only realize the direct impact due to the reinsurance portion of the NMSP, unless market dynamics cause the BBSPs to influence premium rates for standard QHPs. Unsubsidized enrollees will realize the full savings attributable to reinsurance, regardless of plan selection.

- ***Lightly subsidized:*** Current enrollees who receive smaller subsidies may realize some net premium savings (after subsidy) if the BBSP gross premium falls below the enrollee's current net premium and they elect a BBSP. Any savings driven by the NMSP for these enrollees will be shared with the federal government, which is then passed through to the State of Nevada under the waiver. If they elect a standard QHP, these enrollees may pay higher net premiums because they will be paying the difference between the pre-NMSP subsidies (based on a higher benchmark silver plan) and the lower post-NMSP subsidies (based on a lower BBSP benchmark plan).

- ***Heavily or fully subsidized:*** The impact of the NMSP on net premiums for current enrollees who receive substantial subsidies will depend on whether they elect a BBSP or a standard QHP. If they switch to a BBSP, which is assumed to be the SLCS, their net premium will remain the same as without the NMSP. If they do not elect a BBSP, their net premium will likely increase to offset the decrease in federal subsidies.

The federal premium subsidy structure will remain unchanged with the introduction of the BBSPs. The out-of-pocket premium cost for the SLCS for a member will continue to be limited to a percentage of household income prescribed under the ACA. *Therefore, the consumer premiums or cost-sharing requirements under the waiver will be no greater than, and possibly lower than, the cost-sharing required absent the waiver.*

The mechanics of a PO offering and corresponding 1332 waiver are different from a standalone reinsurance waiver in at least one important way. Under the latter, premiums for *all plans* offered in the market will be reduced by the effects of the reinsurance program, as the index rate[13] is lowered by the expected reinsurance program receipts. Therefore, all premiums are reduced, regardless of QHP issuer, although in practice issuers can and often do price somewhat different impacts into their premiums to account for their anticipated issuer-specific receipts under the program. The savings from these lower gross premiums accrue to either the consumer (in the case of an unsubsidized enrollee) or the federal government (in the case of a subsidized enrollee) or a mix of both.[14]

This contrasts with a PO program where BBSPs are brought into the market and one of these offerings is assumed to become the second lowest-cost silver plan in the county. All other standard QHPs are assumed to be largely unaffected in terms of price.[15] In this case, both the unsubsidized and the subsidized enrollee may not see any reductions in their premiums *unless they switch to a BBSP that has become the lowest-cost or second lowest cost silver plan.*

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

2. Comparable number of state residents covered

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

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

[13] Under the ACA, the index rate is the allowed claims cost experience for the entire market and serves as the starting point for rate development. If the index rate is lowered for the effect of reinsurance, all rates in the market will be lower, all else equal.
[14] An additional difference between reinsurance waivers and a public option waiver is that the PTF under reinsurance is used to pay for the program costs. The state will also have to contribute to cover program costs. Under a PO waiver, the costs of the program are entirely covered by the PTF.
[15] As noted earlier, the entrance and / or presence of BBSPs could affect pricing of standard QHPs depending on issuer responses.

3. Comparable coverage

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

4. No increase to federal deficit

   Section 31 CFR 33.108(f)(3)(iv)(D) states that the waiver will not increase the federal deficit, either over the five-year waiver period or the 10-year federal deficit neutrality window. CMS requires the total of various costs to be considered when determining the impact on the federal deficit. Section V of this report details those costs and the treatment of them in this waiver modeling. It also shows the projected federal subsidies during the 10-year federal deficit neutrality window under both the Market Stabilization scenario and the Baseline scenario. The Market Stabilization scenario presented in this report illustrates that the Nevada 1332 waiver is not expected to increase the federal deficit when compared to the Baseline scenario without the waiver. The analysis shows that federal costs are expected to decline due to the lowering of the SLCS benchmark premium, which lowers the aggregate federal subsidies.

Other federal requirements

A 1332 waiver must meet several other federal requirements related to modeling parameters, program operations, and reporting. The following requirements are considered in the actuarial analysis and described in this report, as applicable:

1. Current law requirement

   Guidance from CMS, including 86 FR 53459, states that the analysis must only reflect law and legislation that has currently been enacted. The analysis must also ignore the effects of any accompanying 1115 waiver, if applicable. As of the date of this document, the enhanced subsidies are intended to sunset at the end of 2025. We cannot predict whether the enhanced subsidies will be further extended beyond 2025. Therefore, the actuarial and economic analysis is prepared based on current law under which enhanced subsidies expire after 2025. As previously mentioned, the waiver must assume current law (state and federal). This includes applying the State of Nevada's interpretation of statute regarding the premium reduction target; see Appendix C for state-specific guidance regarding the methodology to be utilized by the State of Nevada. And thus, this modification to the requirements of a 1332 waiver has been discussed with the Center for Consumer Information and Insurance Oversight (CCIIO).

2. Health coverage analysis

   Section 31 CFR 33.108(f)(4)(ii)(B) requires that the 1332 waiver include a detailed analysis of the impact of the waiver on health insurance coverage in the State of Nevada. Based on the provisions of the SB 420 legislation, we reasonably assume the Nevada NMSP will not have a material impact on enrollment in other markets. Specifically, the populations eligible to enroll in BBSPs are the individual market and the uninsured. Employer groups, including small employers, are not eligible to enroll in the BBSPs.[16] The enrollment changes in the markets other than the individual and uninsured that are modeled in the actuarial analysis are attributable to forces unrelated to the NMSP, including population growth and shifts, the expiration of ARP subsidies, and the end of the PHE.

3. Demographic information

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

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

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

- An explanation of data sources and quality.

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

4. Explanation of assumptions

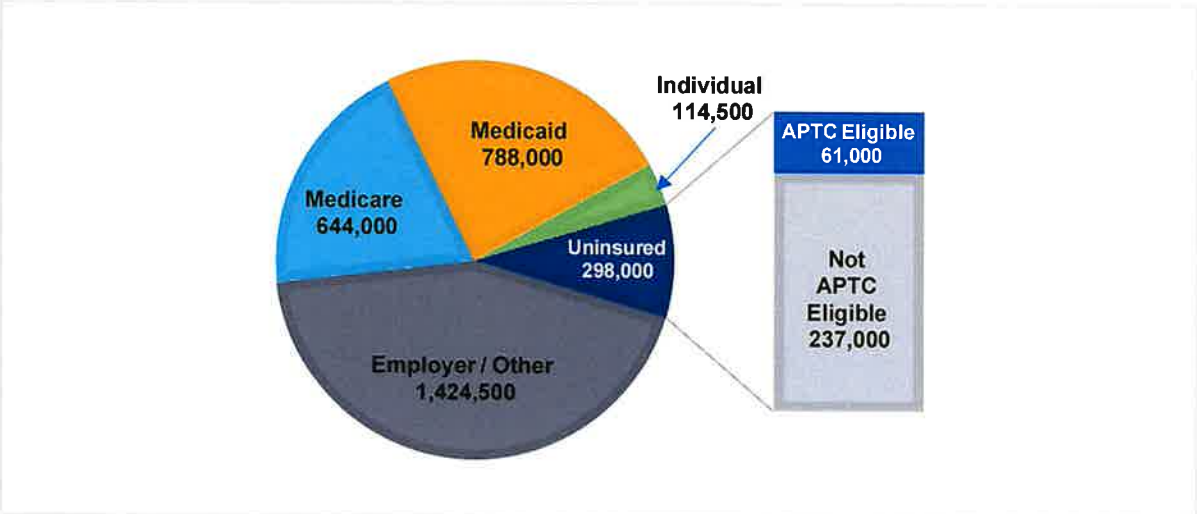
   Section 31 CFR 33.108(f)(4)(iii)(B) requires that the 1332 waiver include an explanation of the key assumptions used to develop the estimates of the effect of the waiver on coverage and the federal budget, such as individual and employer participation rates, behavioral changes, premium and price effects,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

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

D. CURRENT NEVADA COVERAGE LANDSCAPE

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

Figure 1: Sources of Coverage for Nevada Residents in 2022



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

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

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

Medicare

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

Employer-sponsored

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

Medicaid

The Nevada Medicaid program provides health care coverage for beneficiaries who qualify on the basis of income, disability, or other factors, such as being in foster care or receiving adoption assistance. In general, beneficiaries who qualify for Medicaid are not eligible to acquire health care coverage or receive premium tax credits on the Silver State Health Insurance Exchange. However, enrollment application increases on the exchange have sometimes led to increased Medicaid enrollment because some of the uninsured who apply for coverage on the exchange are redirected to the Medicaid program.

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

Individual coverage

Since the inception of the ACA, health care coverage on the Silver State Health Insurance Exchange has been available on a guaranteed issue basis to Nevadans who are not eligible for other coverage (employer, Medicare, Medicaid) and have qualifying immigration status. This includes people with household incomes greater than 138% of the FPL and some specific populations with incomes less than 138% of the FPL, such as legal immigrants, who are not eligible for Medicaid.

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

The expiration of the PHE and potential end to enhanced subsidies under ARP will both have significant impacts on the individual market in Nevada. In particular, material changes in enrollment and morbidity could occur that will affect PTF

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

estimates modeled in this report. As with Medicaid, we do not expect the exact timing of these events to have a material impact on the results of the waiver analysis, and we assume these changes will occur between 2022 and the beginning of the NMSP in 2026.

In 2021, the Biden administration announced administrative changes that affected certain individuals previously unable to enroll in exchange coverage due to the so called "family glitch." Proposed rules for these changes were released in October 2022. These changes made it easier for these individuals and their families to enroll, in many cases. This may result in a potential increase in enrollment in Nevada's individual market, coming primarily from the uninsured.[19] However, the increase would be small and would appear in both the Baseline and Market Stabilization scenarios, with an immaterial impact overall on pass-through funding. Therefore, we do not make any specific assumptions for the impact of this change in our modeling, with the estimated effect being similar with or without the waiver.

Uninsured

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

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

E. PROJECTED 2026 NEVADA COVERAGE LANDSCAPE

The NMSP will begin in 2026; however, as described above, we anticipate changes in the Nevada coverage landscape between 2022 and 2026 due to the expiration of the PHE and the impending expiration of ARP subsidies. To advance the enrollment and population estimates from 2022 to 2026 for purposes of establishing a baseline scenario for modeling pass-through funding, the impacts from the PHE, ARP, and general population growth are shown in Table 8. These values are rounded to emphasize that they are estimates of enrollment four years out with material known changes to the coverage landscape taking place by then, as well as potential unknown changes. There is a high degree of uncertainty related to these projections, but they represent reasonable expectations given current information and for purposes of this modeling.

Table 8
State of Nevada
NMSP Actuarial and Economic Analysis
Estimated Nevada Market Enrollment Shifts 2022-2026

	Individual	Uninsured PTC-Eligible*	Uninsured Non-PTC-Eligible**	Medicaid / CHIP	Employer-Sponsored / Medicare / Other	Total
2022 Enrollment	114,500	61,000	237,000	788,000	2,068,500	3,269,000
PHE Ends	15,700	33,000	0	(191,000)	142,300	0
ARP Ends	(29,800)	18,800	11,000	0	0	0
Population Growth	1,000	3,200	12,600	41,800	109,700	168,300
2026 Enrollment	101,400	116,000	260,600	638,800	2,320,500	3,437,300

**Includes members who may not qualify for subsidies based on income and gross SLCS premium.*
***Includes members eligible for employer-sponsored insurance or Medicaid, or who do not qualify for the individual market due to immigration status.*

We note the following regarding Table 8:

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

[19] CMS has estimated an increase of 1 million individual market enrollees nationwide due to this change. https://www.federalregister.gov/documents/2022/10/13/2022-22184/affordability-of-employer-coverage-for-family-members-of-employees#p-215

- We assume beneficiaries disenrolled from Medicaid will enroll in employer-sponsored and individual coverage or become uninsured approximately in proportion to current market sizes (i.e., proportional allocation).
- We assume the expiration of ARP subsidies at the end of 2025 will result in some current individual market enrollees transitioning to uninsured PTC-eligible status because required out-of-pocket premiums will increase for many enrollees.
- Moreover, given the structure of ARP subsidies, specifically that those with incomes over 400% FPL are eligible for subsidies, the ending of ARP subsidies will make these enrollees ineligible for subsidies. Hence, a material portion of the uninsured over 400% FPL move into the uninsured non-PTC-eligible segment.
- We estimate the total number of enrollees transitioning out of individual coverage due to the expiration of ARP subsidies (29,800) by reviewing the change in historical enrollment from 2019 to the open enrollment of 2022 in the State of Nevada. The detailed assumptions used to develop these projected enrollment impacts are described in more detail in Section VI below.
- We assume population growth at 1.3% annually,[20] except that we adjust population growth in the individual market to reflect an observed enrollment decline of approximately 3,800 from 2022 to 2023.

[20] The sources used to inform the population growth assumption are described in Section 6 below.

III. DESCRIPTION OF SCENARIOS

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

A. DESCRIPTION OF SCENARIOS

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

PTF is the difference between the net federal spending (outlays minus revenues) that would have been generated without the waiver (the Baseline scenario) and the net federal spending after the waiver. To the extent the Section 1332 waiver reduces net[21] federal outlays for premium tax credits, these savings can be passed through to the State of Nevada (i.e., PTF) to be used for various purposes, such as reducing enrollee out-of-pocket premium costs (either subsidized or unsubsidized) or providing further incentives to either enroll in coverage (if uninsured) or stay enrolled (if currently enrolled). Under any 1332 waiver scenario, PTF could also be used for outreach or other initiatives that do not solely or directly impact the individual market. SB420 does require that the state's PTF first be used to fund administrative costs to operate the BBSPs before it is used to fund other initiatives.

Table 9 lists the key assumptions that impact each scenario. A brief description of each is provided below. Detailed methodology and sourcing can be found in Section VI of this report.

Table 9
State of Nevada
NMSP Actuarial and Economic Analysis
Scenario assumptions

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

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

Table 10 State of Nevada NMSP Actuarial and Economic Analysis Scenario Assumption Descriptions		
	Assumption	**Brief Description**
Enrollment	General population growth	Individual market enrollment after 2023 is assumed to grow at the statewide population growth rate, or 1.3%, at a minimum. This growth is assumed to apply uniformly (e.g., across income levels, age groups, metallic levels).
	Expiration of the PHE	We assume the Medicaid disenrollment process due to the expiration of the PHE is completed prior to the effective date of the NMSP in 2026, most likely during 2024. Individual market enrollment is assumed to increase due to the expiration of the PHE as Medicaid disenrollment occurs. The impact varies by income level to account for Medicaid eligibility categories.
	Expiration of ARP subsidies	If ARP subsidies expire in 2025, as currently scheduled, a portion of current Silver State Individual Health Exchange enrollees are assumed to disenroll from individual coverage at the beginning of 2026, driven by increases in net (post-subsidy) premiums. This decreases enrollment in the individual market and increases the uninsured pool.
	BBSP appeal	Some previously uninsured Nevadans who are not subsidy-eligible (mainly near or above 400% FPL) are assumed to enroll in the ACA coverage, either on or off the exchange, due to the lower premiums available through the BBSPs and heightened awareness of the exchange due to NMSP marketing and communications.
	BBSP bronze offering	The BBSPs, by legislation, are only required to have silver and gold level offerings. We assume the BBSPs also offer bronze plans. See Section III.B for a detailed discussion.
	Reinsurance	We assume some previously uninsured Nevadans who are not subsidy-eligible will enroll in ACA coverage due to lower premiums available after the implementation of reinsurance. We assume a higher enrollment growth percentage due to reinsurance in Rating Areas 3 and 4 than in Rating Areas 1 and 2 because the higher coinsurance in Rating Areas 3 and 4 results in a larger premium decrease.
Premiums	Standard QHP premium trend	Gross premiums (before reinsurance) for standard QHPs and off-exchange offerings are assumed to increase 4%[22] per year both with and without the waiver. This assumption is based on CMS projections of per capita national health expenditures and the impact of additional value-based purchasing initiatives that will be part of Nevada's broader efforts to move a larger share of Medicaid and BBSP payments to a value-based purchasing framework.
	Individual market morbidity	Morbidity is the overall illness burden of a population, independent of the population's average age. Higher morbidity increases prices in a risk pool such as Nevada's Individual market, all else equal. End of PHE: We assume premiums for existing standard QHPs on the Silver State Individual Health Exchange decrease by 0.4% in 2023 due to improved morbidity from the additional enrollment transitioning from Medicaid after the expiration of the PHE. End of ARP: The exit of enrollees who leave the individual market due to the expiration of ARP subsidies is assumed to increase morbidity by 2.5%. Increased enrollment due to BBSP appeal: Morbidity is projected to improve 0.2% in 2026 and 0.1% in 2027 relative to the baseline due to additional enrollment from the lower-priced BBSPs. No additional morbidity changes are assumed to happen beyond 2027.
	Premium reduction target	We assume the NMSP will achieve the premium reduction targets described in the agency's memorandum of guidance in Appendix C.

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

	Assumption	Brief Description
	Reinsurance	We assume reinsurance will reflect the following parameters: ▪ Attachment point: $60,000 ▪ Cap: $1,000,000 ▪ Coinsurance: 20% in Rating Area 1, 35% in Rating Area 2, and 70% in Rating Areas 3 and 4 Based on these reinsurance parameters, we estimate reinsurance will decrease premiums by approximately the following percentages: ▪ Rating Area 1: 5% ▪ Rating Area 2: 9% ▪ Rating Area 3: 15% ▪ Rating Area 4: 28%
Subsidies	Indexed FPL	The federal poverty level (FPL) is assumed to increase by 2.5% every year after 2023.[23]
	ACA affordability limits	The maximum amount of premium for which an ACA enrollee is responsible as a percentage of their income is indexed based on National Health Expenditure data and projections published by CMS. We analyzed the changes in these values year over year prior to ARP subsidies becoming available in 2021. Based on the historical change, we projected income limits through the duration of the 10-year deficit neutrality window.
	BBSP adoption rate	Fully subsidized enrollees are assumed to enroll in a BBSP at a higher rate than lower or nonsubsidized enrollees.

Each of the assumptions in Table 10 is developed independently based on our best estimates; however, actual experience relative to each assumption will most likely differ to varying degrees. Furthermore, the amount of time between this analysis and the beginning of the NMSP introduces additional potential for variability to the projected impact of the NMSP on enrollment and costs because it extends the duration of the projection and the opportunity for unforeseen events. We apply an additional 10% discount to the five-year waiver and 10-year deficit estimates to reflect cumulative conservatism across all assumptions. The potential variances include, but are not limited to, enrollment volume and distribution, plan selection, regulatory changes, utilization and cost trend, and member agency.

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

B. DISCUSSION OF BBSP IMPACT ON SECOND LOWEST COST SILVER

Throughout this analysis, we assume BBSPs are very likely to become the SLCS in every rating area (and county) within the state of Nevada. In this section we explain why this is a reasonable assumption and how the presence of BBSPs may generate additional competition to put downward pressure on non-BBSP rates, thereby lowering the price of the plan that did become the SLCS if it is not a BBSP.

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

BBSPs as SLCS

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

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

Non-BBSPs as SLCS

Although BBSPs will be offered by MCOs or QHPs that may already offer non-BBSPs, the BBSP offerings starting in 2026 can be considered as a new competitor. Indeed, increased competition in the market is one of the stated objectives of Nevada SB420 and an acknowledged policy impact of public options generally.[24] Market research also provides empirical evidence that increased individual market competition is associated with lower premium rates and lower annual rate increases.[25, 26, 27, 28, 29] Thus, in the case where a BBSP does not become the SLCS, it is reasonable to assume that the NMSP did, in fact, generate downward premium pressure on the plan or plans that becomes the SLCS, even though it is not a BBSP. The State intends to obtain data and other information from the states' carriers, which will be defined through the procurement and contracting process, and from other states to analyze and estimate market trends absent the NMSP and develop a range of potential impacts of the NMSP on non-BBSP premiums for purposes of determining PTF in these situations. The State will collaborate with other stakeholders and other states with similar experience to develop specific data requests and templates for this purpose.

C. DISCUSSION OF BBSP TAKE-UP RATE ASSUMPTIONS

Impact of a bronze BBSP offering

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

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

Under a waiver scenario where a BBSP becomes the SLCS plan, many existing silver plan consumers under a Baseline scenario may switch to the benchmark plan or something close in price to that plan. Likewise, many bronze purchasers under the Baseline scenario will be expected to purchase a bronze-level BBSP under the Market Stabilization scenario. If BBSP issuers do not have a bronze offering available, some amount of previous bronze purchasers will be assumed to take coverage under a silver BBSP, thereby using up the entire available subsidy.

The primary downstream implication of including bronze BBSPs for this waiver analysis is that the take-up assumption in the BBSPs does impact the overall PTF calculation. A higher assumed take-up rate in the BBSPs increases PTF, as it is assumed more bronze purchasers will also take up BBSP coverage and use only a portion (as opposed to all) of their available subsidy.[30] Said differently, if the BBSPs only offered silver and gold plans, take-up in the BBSPs would have no impact at all on PTF. The actual take-up of the BBSPs will only be impactful on PTF if we assume bronze-level BBSPs are offered.

Overall BBSP take-up rate

In our analysis, we assume a price advantage for BBSPs due to the requirements of SB420 and the State's enforcement mechanisms through the procurement and contracting process. This price advantage implies some consumers will see

[24] https://www.americanprogress.org/article/4-myths-public-option/
[25] https://www.nber.org/papers/w20140
[26] https://www.ajmc.com/view/aca-marketplace-premiums-and-competition-among-hospitals-and-physician-practices
[27] https://pubmed.ncbi.nlm.nih.gov/26643622/
[28] https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2015.0738?journalCode=hlthaff
[29] https://ideonapi.com/resources/blog/increased-competition-individual-aca-market/
[30] Since bronze gross premiums are generally lower than silver and gold plan premiums, subsidies for bronze plans are likewise generally less than subsidies for silver and gold plans. Therefore, if issuers offer a bronze BBSP, we assume a portion of current bronze individual market enrollees and new individual market enrollees will select the bronze BBSP instead of a silver or gold BBSP, thereby reducing subsidies under the waiver and increasing the pass-through funding.

additional value in the BBSPs and will take up BBSP coverage. It is difficult to predict consumer behavior in the presence of the BBSPs' price advantage, and this difficulty stems from several factors:

- Although price is an important factor, consumers do not always choose a plan based on price.[31]
- Provider networks will be required to align with Medicaid's broad provider networks to a certain extent; however, other product features of BBSPs offered by the various individual exchange insurers are not known at this time.

Notwithstanding, we assume that some material share of the market will respond to the lower prices of BBSPs in the individual market, both on and off the exchange. However, a separate material share of the market may not take up BBSP coverage for various reasons, based on exchange experience across the country. We use two analyses to support the estimated take-up rate of BBSPs using publicly available data from marketplaces, both state-based and those utilizing the federal platform, HealthCare.gov.

Share of market for SLCS carrier

Since we assume it is highly likely that a BBSP will become the SLCS in all rating areas,[32] historical SLCS market share is a potential indicator of BBSP take-up. We analyzed public enrollment data for states utilizing Healthcare.gov (which does not include Nevada due to data limitations) to determine the market share typically commanded by the SLCS. For the four years from 2019 through 2022, between 30 and 40 percent of enrollees who reside in a county with at least two carriers were enrolled in the SLCS plan. The median enrollment by county in a SLCS in counties with at least two carriers was slightly higher, ranging between 35% and 50% over the same four years. Key drivers of the SLCS plan's market share include the number of carriers in the county and the difference between the SLCS premium and the next higher premium.

Auto-enrollment and plan switching

The historical percentage of enrollees who auto-enroll in their health plans is also a potential indicator of BBSP take-up since it is a measure of enrollee engagement in plan selection. We examined the 2022 and 2023 open enrollment data[33] to estimate the percentage of enrollees who are active shoppers for health coverage (i.e., not enrolled in their current plan by default) and the percentage of those active shoppers who change plans. For this analysis, we used a combination of states with state-based marketplaces (SBMs) and states utilizing HealthCare.gov, as appropriate. The auto-enrollment rate was approximately 70% on SBMs, implying relatively few active shoppers, while the auto-enrollment in states utilizing HealthCare.gov is approximately 28%, implying a much greater rate of active purchasing. Nevada had an auto-enrollment rate of approximately 60%, implying about 40% of enrollees in Nevada made an active choice to either remain in the current plan or switch plans.

Active shoppers will also switch plans at various rates and for various reasons. Public data[33] shows that plan switching for active purchasers ranges between 31 and 76%. By combining the active enrollment percentage with the percentage who switch plans, we estimate between 12% (40% x 31%) and 29% (40% x 76%) of enrollees might switch plans.

Final take-up rate assumption

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

- There will be more publicity around the BBSP offerings relative to simply being the SLCS in any given year,
- BBSP plans are likely to have certain notation on the exchange enrollment page that further draws attention to them,
- For the same reasons that a BBSP is likely to be the SLCS, a BBSP will likely also have the lowest cost silver (LCS) status, and

[31] Consumer inertia is discussed in more detail here: https://www.thecgo.org/research/sources-of-consumer-inertia-in-the-individual-health-insurance-market/
[32] See Section III.B for additional explanation.
[33] https://www.cms.gov/files/zip/2023-oep-state-level-public-use-file.zip

- The BBSPs will be offered by well-established carriers in the market who are also MCO's. They will not be a "new entrant" to the market in the typical sense.

Therefore, under the Market Stabilization scenario, we assume a 40% take-up in 2026 and an ultimate take-up rate for enrollees on-exchange of 50% realized by the fourth year of the NMSP.

Take-up impact on PTF

To understand the relative impact of BBSP take-up on the 10-year PTF, the estimated impact of a 50% versus a 60% take-up assumption is shown in Table 11.

Table 11
State of Nevada
NMSP Actuarial and Economic Analysis
BBSP Take-Up Sensitivity on Pass-Through Funding Through 10-Year Deficit Neutrality Window

Scenario	BBSP Take-Up 50%	BBSP Take-Up 60%	Change in PTF (thousands)	Change in PTF %	Change in BBSP Take-Up (50% to 60%)	PTF Impact of 1% Increase in Take-Up
Market Stabilization	$844,000	$844,000	($897)	-0.11%	20%	-0.01%

Note: All dollar values in thousands.

As can be seen in Table 11, the change from a 50% to a 60% assumed take-up in the BBSPs has only a small impact on PTF. This small impact reflects two offsetting components as take-up increases:

1. Bronze enrollees who enroll in a BBSP, which increases PTF if the BBSP has $0 net premium when their Standard QHP had a non-zero net premium, as discussed above.

2. More total members enrolling in a BBSP, which decreases premiums and leads to a lower impact of reinsurance and thus lower PTF.

The assumption of a 50% ultimate BBSP take-up rate is based on actuarial judgement given that no PO program exists that is similar to Nevada's program and has enrollment experience. Colorado's program is approved but just began in 2023, and Washington's program does not have key features that will distinguish Nevada's program, such as enforceable premium targets and procurement ties to the Medicaid program. Therefore, the 50% assumption is based on balancing considerations already noted above but, for clarity, we repeat here:

- The BBSPs will offer a meaningful price advantage over standard QHPs.
- However, not all consumers shop on price.
- Some features of the BBSPs are not known at this time.

In short, given the price advantage, it is reasonable to assume some material share of the individual market will shift to BBSPs. However, based on historical SLCS market share, active enrollment versus auto-enrollment experience across ACA individual markets, and the uncertainty in both consumer behavior and final BBSP product features, it is also reasonable to assume that some material share of the market does NOT switch to a BBSP.

In summary, the take-up rate for BBSPs is not a material consideration when estimating PTF.

Reinsurance

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

However, unsubsidized individuals will receive the full benefit of the price reduction under a reinsurance program.

Hence, to the extent premium reductions due to reinsurance may provide additional incentives for some uninsured individuals to enroll in the individual market, we assume enrollment in BBSPs will also increase slightly due to the implementation of reinsurance.

Small employer migration

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

Using publicly available premium rate data for the small group and individual markets, we compared premium rates in 2022 and trended them forward to 2024 using average rate increases that were approved by the Nevada Department of Insurance for benefit years 2023 and 2024. This analysis shows that small group rates are currently lower than individual market rates by 4% to 26% depending on rating area and metal level, and approximately 16% lower on average.[34] We include details on the variance among small group premiums relative to individual in Section VI.

Under a waiver scenario, individual market gross premiums are projected to decrease by approximately 12 to 15% relative to the Baseline starting in Year 2 of the NMSP. This analysis of the current premiums in both the small group and individual markets in Nevada indicates that, with the reduction in individual prices stemming from the NMSP, available premium rates in the individual market will reach some degree of parity with small group premium rates. This implies that, based on price alone, some incremental number of employers could consider offering an ICHRA benefit to some or all of their employees as average prices in these markets converge.[35] However, employers are not inclined to shop purely on the lowest price and will likely also consider their benefit offerings relative to other employers to attract the best talent. Employers still retain some degree of paternalism, as well, wanting to provide their employees with optimal benefit package whenever possible.

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

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

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

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

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

IV. ACTUARIAL ANALYSIS

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

A. AFFORDABILITY OF PREMIUMS AND COST-SHARING

As required under 45 CFR 155.1308(f)(3)(iv)(B), a state's proposed 1332 waiver must provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable under Title I of the ACA. As described in CMS-9936-N, increasing the number of state residents with large health care spending burdens relative to their incomes would result in a waiver proposal failing to meet the affordability requirement of the 1332 waiver application.[36] Additionally, regulations state an evaluation of the affordability requirement will take into account the impact of the waiver proposal to "vulnerable residents, including low-income individuals, elderly individuals, and those with serious health issues or who have a greater risk of developing serious health issues." The exhibits referenced in this section are shown in the Exhibits section at the end of the report.

The Market Stabilization scenario premium projections are shown on the following exhibits:

- Exhibit 1: Statewide 10-year premium projection and change from Baseline scenario
- Exhibit 2: Ten-year SLCS projection and change from Baseline scenario

Exhibit 2 demonstrates the waiver provides coverage that is at least as affordable as the coverage available without the waiver, as required by the guardrail. Exhibits 2.1 through 2.4 further demonstrate that this guardrail is satisfied for each of Nevada's four rating areas. The SLCS in in Rating Areas 3 and 4, which are rural areas with underserved populations, decreases by 23% and 35%, respectively, by the end of the five-year waiver period. The SLCS in Rating Areas 1 and 2 decreases by less than 20% during the same time period.

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

We conservatively assume some enrollees will not choose to enroll in BBSPs. The projected decrease in member premiums under the waiver shown in Exhibit 1 is attributable to the BBSP adoption rate assumption. Table 12 illustrates how these projected member premiums change based on different aggregate BBSP adoption rate assumptions. If all eligible enrollees choose a BBSP, member premiums will decrease by the same amount as the SLCS plan premium decreases in Exhibit 1.

Note, Table 12 assumes the BBSP take-up rate applies in all years, whereas the scenarios modeled in this report assume BBSP take-up rates increase over the first four years of the NMSP. Furthermore, the BBSP take-up percentage off-exchange take up is expected to be lower than on-exchange. We assume 50% take-up on-exchange in our analysis; however, the effective take-up rate across the entire individual market reflected in our analysis is slightly lower than 50%. Therefore, the premiums shown in Table 12 will not match any of the scenario results.

[36] See https://www.gpo.gov/fdsys/pkg/FR-2015-12-16/pdf/2015-31563.pdf for more information.

Table 12 State of Nevada NMSP Actuarial and Economic Analysis Sensitivity Illustration Individual Market Composite Monthly Premium by BBSP Take-Up Rate					
	BBSP Take-Up Rate				
Year	30%	40%	50%	60%	70%
2026	$603.22	$602.05	$600.53	$598.14	$595.74
2027	$579.06	$576.94	$574.47	$571.12	$567.77
2028	$596.39	$592.91	$589.31	$585.39	$581.47
2029	$614.51	$609.50	$604.65	$600.20	$595.76
2030	$638.01	$632.80	$627.75	$623.13	$618.51
2031	$661.24	$655.82	$650.57	$645.78	$640.98
2032	$686.55	$680.90	$675.44	$670.44	$665.45
2033	$711.69	$705.82	$700.14	$694.95	$689.75
2034	$738.48	$732.38	$726.47	$721.06	$715.66
2035	$766.36	$760.01	$753.86	$748.23	$742.61

B. COMPARABLE NUMBER OF STATE RESIDENTS COVERED

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

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

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

- Exhibit 3: Ten-year projected enrollment by income level
- Exhibit 4: Ten-year projected enrollment by metallic coverage level
- Exhibit 5: Ten-year projected enrollment by age group
- Exhibit 6: Ten-year projected enrollment by subsidy eligibility
- Exhibit 7: Ten-year projected enrollment by rating area

Exhibit 6 demonstrates the waiver provides coverage to at least as many residents as without the waiver, as required by the guardrail. Exhibit 7 demonstrates how the waiver is expected to have a greater impact on enrollment in underserved rural areas. We project enrollment in Rating Areas 3 and 4 to increase by more than 7% by 2027 due to the waiver, whereas we project enrollment in Rating Areas 1 and 2 to increase by slightly more than 1% and 2%, respectively.

C. COMPARABLE COVERAGE

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

V. ECONOMIC ANALYSIS

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

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

b. **User fees:** Nevada's exchange has been a state-based exchange since 2020 and does not utilize the federal platform.[37]

c. **Changes in PTCs and other tax credits:** Our modeling includes the changes to the premium tax credits for those exchange enrollees qualifying for subsidies. We estimate premium tax credits by modeling advanced premium tax credits (APTCs)[38] and then applying an adjustment to account for the tax reconciliation process. This adjustment is 10%.[39]

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

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

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

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

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

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

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

- Projected enrollment of PTC-eligible enrollees in the individual market. In the Market Stabilization scenario, we also show the change in enrollment from the Baseline scenario.

[37] Governor Brian Sandoval (May 11, 2018). Letter to CMS CCIIO. Retrieved November 9, 2022, from https://www.cms.gov/CCIIO/Resources/Technical-Implementation-Letters/Downloads/nv-declaration-letter.pdf.
[38] ATPCs are based on estimated household income and household size, as opposed to PTCs that are determined after the end of the year based on actual income and household size.
[39] IRS. Table 2: Individual Income and Tax Data, by State and Size of Adjusted Gross Income, Tax Year 2019. Retrieved November 9, 2022, from https://www.irs.gov/pub/irs-soi/19in29nv.xlsx (Excel download).

- Projected gross premiums, split by BBSP and standard QHP enrollment, and then a composite market-wide premium based on the assumed take-up of BBSPs.
- Composite gross premiums split by PTC eligibility, with the APTC and net premium portions of an PTC-eligible enrollee's premium shown separately.
- Calculation of total APTCs and final estimated PTCs after tax reconciliation. Per member per month (PMPM) values are multiplied by membership values for each year to obtain the 10-year deficit neutrality window totals.

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

A. PROJECTED CHANGES IN PTCS

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

Baseline Scenario

Enrollment

Table 13 shows the 10-year enrollment projection under the Baseline scenario for enrollees both on- and off-exchange. The enrollment projection for enrollees on-exchange is further split between members with and without PTC.

Table 13
State of Nevada
NMSP Actuarial and Economic Analysis
Baseline Scenario
Individual Market Enrollment by Segment

	On-Exchange			Off-Exchange	
Year	(1) PTC-Eligible	(2) Non-PTC-Eligible	(3) Total	(4) Total	(5) Total Individual Market
2026	75,400	10,600	86,000	15,400	101,400
2027	76,400	10,700	87,100	15,600	102,700
2028	77,400	10,800	88,200	15,800	104,000
2029	78,400	10,900	89,300	16,000	105,300
2030	79,500	11,100	90,600	16,200	106,800
2031	80,500	11,200	91,700	16,500	108,200
2032	81,600	11,300	92,900	16,700	109,600
2033	82,800	11,300	94,100	16,900	111,000
2034	83,900	11,400	95,300	17,100	112,400
2035	85,000	11,600	96,600	17,300	113,900
Average Annual Change	**1.34%**	**1.01%**	**1.30%**	**1.30%**	**1.30%**

- The 2026 Total Individual Market enrollment shown in column (5) for the beginning of the 10-year deficit neutrality window is consistent with Table 8, which illustrates the development of the 2026 number from 2022.
- Column (1) values increase due to population growth and for a small amount of movement from column (2).
- The non-PTC-eligible enrollment in column (2) increases, albeit at a slower rate than other segments. This is because federal poverty levels and the income affordability limits are indexed such that they increase slower than overall individual market premium growth; therefore, more people become eligible for at least some federal subsidy amounts and move to column (1). The income affordability limits are assumed to index at about 0.05% of income per year.

- Column (4) includes the individual market catastrophic plan enrollment.
- Columns (4) and (5) values beyond 2026 increase at the annual population growth estimate of 1.3%.

Premiums

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

- *Standard QHP premium trend:* Gross premiums for the individual market are projected with a 4% annual increase. See Section VI below for a detailed description of the development of this factor.

Table 14 shows the statewide 10-year premium projection under the Baseline scenario. The PMPMs are averages based on the current mix of plan selections which is based on FPL, age, and metal level. We assume all enrollees remain in their current plan. There is no BBSP offering in the Baseline scenario, so BBSP enrollment and premiums are shown as zero to keep the format of exhibits consistent across the Baseline and Market Stabilization scenarios.

Table 14
State of Nevada
NMSP Actuarial and Economic Analysis Baseline Scenario
Summary of Enrollment and Premium by BBSP and Standard QHP Segments – All Rating Areas

	BBSP				Standard QHP			Total		
			Premium			Premium			Premium	
Year	BBSP Take-Up %	Enrollment	Aggregate (thousands)	PMPM	Enrollment	Aggregate (thousands)	PMPM	Enrollment	Aggregate (thousands)	PMPM
2026	0%	0	0	0	101,400	$740,000	$608	101,400	$740,000	$608
2027	0%	0	0	0	102,700	$780,000	$633	102,700	$780,000	$633
2028	0%	0	0	0	104,000	$822,000	$658	104,000	$822,000	$658
2029	0%	0	0	0	105,300	$866,000	$685	105,300	$866,000	$685
2030	0%	0	0	0	106,800	$912,000	$711	106,800	$912,000	$711
2031	0%	0	0	0	108,200	$961,000	$740	108,200	$961,000	$740
2032	0%	0	0	0	109,600	$1,013,000	$770	109,600	$1,013,000	$770
2033	0%	0	0	0	111,000	$1,067,000	$801	111,000	$1,067,000	$801
2034	0%	0	0	0	112,400	$1,124,000	$833	112,400	$1,124,000	$833
2035	0%	0	0	0	113,900	$1,184,000	$866	113,900	$1,184,000	$866

Tables 14.1 through 14.4 show the same statewide 10-year premium projection under the Baseline scenario for each of Nevada's four rating areas. As these tables illustrate, the average premiums in the more rural regions, Rating Areas 3 and 4, are significantly higher than in the more urban regions, Rating Areas 1 and 2. The average premiums in Rating Area 3, which has the highest premiums, are nearly 60% higher than the average premiums in Rating Area 1, which has the lowest premiums.

Table 14.1
State of Nevada
NMSP Actuarial and Economic Analysis Baseline Scenario
Summary of Enrollment and Premium by BBSP and Standard QHP Segments - Rating Area 1

	BBSP				Standard QHP			Total		
			Premium			Premium			Premium	
Year	BBSP Take-Up %	Enrollment	Aggregate (thousands)	PMPM	Enrollment	Aggregate (thousands)	PMPM	Enrollment	Aggregate (thousands)	PMPM
2026	0%	0	0	0	80,100	$548,000	$570	80,100	$548,000	$570
2027	0%	0	0	0	81,100	$578,000	$594	81,100	$578,000	$594
2028	0%	0	0	0	82,100	$609,000	$618	82,100	$609,000	$618
2029	0%	0	0	0	83,200	$641,000	$642	83,200	$641,000	$642
2030	0%	0	0	0	84,300	$675,000	$668	84,300	$675,000	$668
2031	0%	0	0	0	85,400	$712,000	$695	85,400	$712,000	$695
2032	0%	0	0	0	86,500	$750,000	$723	86,500	$750,000	$723
2033	0%	0	0	0	87,600	$790,000	$752	87,600	$790,000	$752
2034	0%	0	0	0	88,800	$832,000	$781	88,800	$832,000	$781
2035	0%	0	0	0	89,900	$877,000	$813	89,900	$877,000	$813

Table 14.2
State of Nevada
NMSP Actuarial and Economic Analysis Baseline Scenario
Summary of Enrollment and Premium by BBSP and Standard QHP Segments - Rating Area 2

	BBSP				Standard QHP			Total		
			Premium			Premium			Premium	
Year	BBSP Take-Up %	Enrollment	Aggregate (thousands)	PMPM	Enrollment	Aggregate (thousands)	PMPM	Enrollment	Aggregate (thousands)	PMPM
2026	0%	0	0	0	13,900	$114,000	$683	13,900	$114,000	$683
2027	0%	0	0	0	14,100	$120,000	$710	14,100	$120,000	$710
2028	0%	0	0	0	14,300	$126,000	$737	14,300	$126,000	$737
2029	0%	0	0	0	14,400	$133,000	$771	14,400	$133,000	$771
2030	0%	0	0	0	14,700	$140,000	$796	14,700	$140,000	$796
2031	0%	0	0	0	14,900	$148,000	$828	14,900	$148,000	$828
2032	0%	0	0	0	15,100	$156,000	$860	15,100	$156,000	$860
2033	0%	0	0	0	15,300	$164,000	$894	15,300	$164,000	$894
2034	0%	0	0	0	15,500	$173,000	$930	15,500	$173,000	$930
2035	0%	0	0	0	15,700	$182,000	$967	15,700	$182,000	$967

Table 14.3
State of Nevada
NMSP Actuarial and Economic Analysis Baseline Scenario
Summary of Enrollment and Premium by BBSP and Standard QHP Segments - Rating Area 3

	BBSP				Standard QHP			Total		
			Premium			Premium			Premium	
Year	BBSP Take-Up %	Enrollment	Aggregate (thousands)	PMPM	Enrollment	Aggregate (thousands)	PMPM	Enrollment	Aggregate (thousands)	PMPM
2026	0%	0	0	0	5,200	$56,000	$904	5,200	$56,000	$904
2027	0%	0	0	0	5,300	$59,000	$934	5,300	$59,000	$934
2028	0%	0	0	0	5,300	$63,000	$984	5,300	$63,000	$984
2029	0%	0	0	0	5,400	$66,000	$1,018	5,400	$66,000	$1,018
2030	0%	0	0	0	5,500	$69,000	$1,053	5,500	$69,000	$1,053
2031	0%	0	0	0	5,500	$73,000	$1,109	5,500	$73,000	$1,109
2032	0%	0	0	0	5,600	$77,000	$1,148	5,600	$77,000	$1,148
2033	0%	0	0	0	5,700	$81,000	$1,188	5,700	$81,000	$1,188
2034	0%	0	0	0	5,700	$86,000	$1,251	5,700	$86,000	$1,251
2035	0%	0	0	0	5,800	$90,000	$1,296	5,800	$90,000	$1,296

Table 14.4
State of Nevada
NMSP Actuarial and Economic Analysis Baseline Scenario
Summary of Enrollment and Premium by BBSP and Standard QHP Segments - Rating Area 4

	BBSP				Standard QHP			Total		
			Premium			Premium			Premium	
Year	BBSP Take-Up %	Enrollment	Aggregate (thousands)	PMPM	Enrollment	Aggregate (thousands)	PMPM	Enrollment	Aggregate (thousands)	PMPM
2026	0%	0	0	0	2,200	$22,000	$816	2,200	$22,000	$816
2027	0%	0	0	0	2,200	$23,000	$860	2,200	$23,000	$860
2028	0%	0	0	0	2,300	$24,000	$867	2,300	$24,000	$867
2029	0%	0	0	0	2,300	$25,000	$913	2,300	$25,000	$913
2030	0%	0	0	0	2,300	$27,000	$962	2,300	$27,000	$962
2031	0%	0	0	0	2,400	$28,000	$971	2,400	$28,000	$971
2032	0%	0	0	0	2,400	$29,000	$1,023	2,400	$29,000	$1,023
2033	0%	0	0	0	2,400	$31,000	$1,078	2,400	$31,000	$1,078
2034	0%	0	0	0	2,400	$33,000	$1,136	2,400	$33,000	$1,136
2035	0%	0	0	0	2,500	$34,000	$1,149	2,500	$34,000	$1,149

Subsidies

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

- *FPL increases:* The 100% federal poverty level (FPL), used to calculate a PTC-eligible person's subsidy, is increased by 2.5% annually after 2023.[40]
- *Income affordability limits*: These limits are indexed over time. We based our indexing on a conservative estimate of past indexing (i.e., generating less pass-through funding) projected into the 10-year deficit neutrality window. We assume the annual increase in the income affordability limits is approximately 0.05% of income per year.

[40] We assume a larger increase in 2023 given current levels of inflation. See Consumer prices up 8.5 percent for year ended March 2022: The Economics Daily: U.S. Bureau of Labor Statistics (bls.gov) at https://www.bls.gov/opub/ted/2022/consumer-prices-up-8-5-percent-for-year-ended-march-2022.htm

Table 15
State of Nevada
NMSP Actuarial and Economic Analysis
Baseline Scenario
Average Aggregate Premiums and Member Subsidies Per Member Per Month (PMPM)

	On-Exchange					
	PTC-Eligible			Non-PTC-Eligible	Off-Exchange	Total Individual Market
Year	(1) Average Aggregate Gross Premium	(2) Average Aggregate APTC	(3) Average Aggregate Enrollee Net Premium	(4) Average Aggregate Enrollee Gross Premium	(5) Average Aggregate Enrollee Gross Premium	(6) Average Aggregate Gross Premium
2026	$630	$438	$193	$583	$532	$608
2027	$656	$456	$200	$608	$553	$633
2028	$682	$476	$206	$633	$575	$658
2029	$709	$496	$213	$660	$598	$685
2030	$737	$517	$220	$682	$622	$711
2031	$767	$539	$228	$712	$647	$740
2032	$797	$562	$236	$741	$673	$770
2033	$829	$585	$244	$774	$699	$801
2034	$861	$610	$252	$808	$727	$833
2035	$896	$635	$260	$836	$757	$866

Note: Total Individual Market Gross Premiums in column (6) are consistent with Table 14 above. Column (4) values are materially lower than gross premiums in the rest of the individual market as the catastrophic plans are included and constitute approximately 25% of the enrollment. Table 16 below illustrates the changes in each of the PMPM values in Table 15.

We note the following regarding Table 15:

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

Table 16
State of Nevada
NMSP Actuarial and Economic
Analysis Baseline Scenario
Annual Change in Average Aggregate Premiums and Member Subsidies PMPM

	On-Exchange					
	PTC-Eligible			Non-PTC-Eligible	Off-Exchange	Total Individual Market
Year	(1) Average Aggregate Gross Premium	(2) Average Aggregate APTC	(3) Average Aggregate Enrollee Net Premium	(4) Average Aggregate Enrollee Gross Premium	(5) Average Aggregate Enrollee Gross Premium	(6) Average Aggregate Gross Premium
2026	--	--	--	--	--	--
2027	4.00%	4.25%	3.41%	4.15%	4.00%	4.02%
2028	4.01%	4.27%	3.40%	4.22%	4.00%	4.03%
2029	4.02%	4.29%	3.40%	4.26%	4.00%	4.05%
2030	3.90%	4.17%	3.26%	3.37%	4.00%	3.87%
2031	4.05%	4.32%	3.41%	4.33%	4.00%	4.06%
2032	3.97%	4.21%	3.40%	4.10%	4.00%	3.99%
2033	3.93%	4.10%	3.53%	4.47%	4.00%	4.01%
2034	3.97%	4.25%	3.31%	4.38%	4.00%	4.02%
2035	3.99%	4.26%	3.33%	3.48%	4.00%	3.95%