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FIRST JUDICIAL DISTRICT COURT OF NEVADA
IN AND FOR CARSON CITY

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

Plaintiffs,

v.

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

Defendants.

Case No. 25OC00089 1B

Dept. No. I

PLAINTIFFS' APPENDIX TO MOTION FOR PRELIMINARY INJUNCTION

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We note the following regarding the annual changes illustrated in Table 16:

- Average aggregate gross premiums, as noted earlier, are increasing at 4% per year (within tolerance for rounding), for both on-exchange enrollees and off-exchange enrollees.
- Average aggregate enrollee net premiums are indexed to federal poverty levels, which are assumed to increase at 2.5% per year, and therefore are increasing less than gross premiums.
- Average aggregate APTCs, being the balancing item, are increasing more than gross premium annually.
- Non-PTC-eligible exchange enrollee average aggregate gross premiums are more volatile due their small size and a changing mix of enrollees from year to year. Various enrollees will move from non-PTC-eligible to PTC-eligible over time as the income limits increase more slowly than premiums.

Market Stabilization Scenario

This scenario reflects expected premiums, enrollment, and federal subsidies under the Nevada 1332 waiver.

Enrollment

The Market Stabilization scenario reflects the same enrollment assumptions as the Baseline scenario plus the following assumptions:

- *"BBSP Appeal" increases unsubsidized enrollment*: Because unsubsidized consumers will absorb the full benefit of the lower premiums of a BBSP, unsubsidized enrollment is projected to increase as more of the uninsured with incomes over 400% FPL take up coverage.

Projected enrollment is based on a simple linear elasticity coefficient[41] of between -0.003 and -0.005, meaning that a 1% rate decrease will result in an approximately 0.3% to 0.5% increase in coverage take-up in the target enrollment population.[42] Table 17 shows the development of the enrollment increases based on the estimated size of the uninsured population in Nevada in 2026 that will have incomes near or above 400% FPL and the resulting elasticity coefficient.

Table 17
State of Nevada
NMSP Actuarial and Economic Analysis
Market Stabilization Scenario
2026 Enrollment Elasticity – Members Above 400% FPL

		Market Stabilization Scenario
(a)	BBSP Appeal Enrollment Increase – Over 400%	450
(b)	Uninsured – Above 400% FPL	26,800
(c) =(a) / (b)	% Increased Assumed	1.7%
(d)	Premium Reduction	(3.2%)
(e) = (c) / (d)	Elasticity	-0.528

- *Decrease in subsidized enrollment*: A small number of subsidized enrollees under the Baseline scenario will lose subsidy eligibility (mainly younger and / or higher-income enrollees) as BBSP premiums drop below their current net premiums in the Baseline scenario and the enrollees no longer qualify for subsidies.

[41] Elasticity is defined as a consumer's sensitivity to price changes in making purchasing decisions. An elasticity of -1.00 indicates that a 1% price decrease will result in 1% more eligible consumers purchasing coverage. Elasticity of 0.00 means price changes do not affect purchasing decisions at all. Elasticity between -1.00 and 0.00 means that consumers have at least some sensitivity to price changes. Moreover, elasticity is very likely different at different income levels. However, we use a simple linear mechanism that ignores the income level aspect of consumer behavior as the additional complexity does not add additional precision of results or change our conclusions. We note that the elasticity implied in our enrollment increase estimates is reasonably within range of a published benchmark.

[42] See the discussion in "Understanding Recent Developments in the Individual Health Insurance Market" (2017), at https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701_individual_health_insurance_market_cea_issue_brief.pdf, which on page 6 cites a .004 coefficient. Our modeling does not use this figure strictly but assumes a coefficient within a range of this estimate is reasonable.

Table 18 shows the 10-year enrollment projection under the Market Stabilization scenario. Table 19 shows the change in enrollment from the Baseline scenario to the Market Stabilization scenario.

Table 18
State of Nevada
NMSP Actuarial and Economic Analysis
Market Stabilization 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	75,200	11,100	86,300	15,700	102,000
2027	76,400	11,900	88,300	16,200	104,500
2028	77,400	12,100	89,500	16,500	106,000
2029	78,400	12,300	90,700	16,700	107,400
2030	79,400	12,400	91,800	16,900	108,700
2031	80,500	12,600	93,100	17,100	110,200
2032	81,500	12,700	94,200	17,400	111,600
2033	82,600	12,900	95,500	17,600	113,100
2034	83,700	13,000	96,700	17,800	114,500
2035	84,800	13,100	97,900	18,000	115,900
Average Annual Increase	**1.34%**	**1.86%**	**1.41%**	**1.53%**	**1.43%**

- The 2026 Total Individual Market enrollment shown in column (5) for the beginning of the 10-year deficit neutrality window is slightly higher than Table 8 in Section II.D above, which illustrates the development of the 2026 number from 2022, due to the expected additional enrollment from the BBSP appeal.
- Column (1) enrollment increases over time due to population growth and some movement from column (2), as in the Baseline scenario.
- Column (4) increases relative to the Baseline scenario due to the "BBSP Appeal" as well.

The net total enrollment changes from Baseline are shown in Table 19.

Table 19
State of Nevada
NMSP Actuarial and Economic Analysis
Market Stabilization Scenario
Impact of NMSP on Individual Enrollment

Year	Change in PTC Eligible	Change in Non-PTC Eligible	Total Change
2026	(200)	800	600
2027	0	1800	1800
2028	0	2,000	2000
2029	0	2,100	2,100
2030	(100)	2,000	1,900
2031	0	2,000	2,000
2032	(100)	2,100	2,000
2033	(200)	2,300	2,100
2034	(200)	2,300	2,100
2035	(200)	2,200	2,000

Table 19 shows that the NMSP is expected to increase the nonsubsidized enrollment as gross premiums will be cheaper and nonsubsidized consumers will reap the full savings of a BBSP offering (i.e., the "BBSP Appeal"). Subsidized enrollment is projected to decrease slightly as subsidies decrease under the NMSP and current enrollees with small subsidies no longer qualify for subsidies.

Premiums

The Market Stabilization scenario reflects the same premium assumptions as the Baseline scenario plus the following assumptions:

- *BBSP adoption rate:* New and existing individual market enrollment is assumed to shift into BBSPs due to lower gross prices for unsubsidized consumers and lower net premiums (i.e., after subsidy) for subsidized consumers who switch to a BBSP. Adoption of BBSPs is assumed to increase over the course of the first four program years and level out at 50% of the individual market. The shift to BBSPs causes composite market-wide premiums to be lower, all else equal.

  The adoption rate of BBSPs is likely important for various other aspects of program management, provider satisfaction, and overall success of the program. For that reason, we assume adoption will be relatively high but that a material percentage of the market may not choose a BBSP (in this case, 50% for on-exchange enrollees).

- *BBSP premium rate progression:* Table 20 assumes the reference premium increases by 4% annually in the first four years, and the BBSP discount relative to the reference premium before reinsurance is approximately 3.2%, 5.2%, 6.6%, and 8.0% in the first through fourth years of the program, respectively. Note, this has the overall effect of keeping BBSP premium trend lower than overall market trend over this time period (2026 through 2029), and then BBSP premiums increase at the rate of the reference premium increase, which is assumed to be equal to overall individual market premium growth.

- *Morbidity of individual market:* Market morbidity is assumed to decrease (improve) slightly due to the increased enrollment as a result of the NMSP.

- *Reinsurance:* A reinsurance program will be introduced in the second year of the NMSP. The reinsurance parameters will target[43] statewide premium reductions of 7.2%, 7.4%, and 7.6% in the second through fourth years of the program, respectively. Reinsurance has the overall effect of reducing premiums across the entire individual market, although the actual premium reduction will vary by plan based on each carrier's evaluation of the impact of the reinsurance program on their specific experience.

Table 20 shows the 10-year premium projection under the Market Stabilization scenario. The PMPMs are averages based on the projected mix of plan selections which is based on FPL, age, and metal level. Note, membership mix differences between the BBSPs and standard QHPs mean the actual premium differences will not match the projected discount from the reference premium. The BBSP take-up percentage in 2029 and later in Table 20 is slightly less than 50% because off-exchange take up is expected to be lower than on-exchange.

[43] Actual parameters may change due to CMS pass-through funding determinations and claims experience throughout the course of the NMSP.

Table 20 State of Nevada NMSP Actuarial and Economic Analysis Market Stabilization 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	29%	29,100	$210,000	$601	72,700	$526,000	$603	101,800	$736,000	$602
2027	33%	35,000	$241,000	$573	69,500	$481,000	$576	104,500	$722,000	$575
2028	41%	43,800	$308,000	$585	62,200	$443,000	$594	106,000	$751,000	$590
2029	47%	50,700	$364,000	$598	56,700	$417,000	$613	107,400	$781,000	$606
2030	47%	51,300	$382,000	$621	57,400	$438,000	$636	108,700	$820,000	$629
2031	47%	52,000	$402,000	$644	58,200	$460,000	$659	110,200	$862,000	$652
2032	47%	52,700	$422,000	$668	58,900	$484,000	$685	111,600	$906,000	$677
2033	47%	53,400	$444,000	$693	59,700	$508,000	$710	113,100	$952,000	$702
2034	47%	54,100	$466,000	$718	60,400	$534,000	$737	114,500	$1,000,000	$728
2035	47%	54,800	$490,000	$745	61,100	$561,000	$765	115,900	$1,051,000	$755

Tables 20.1 through 20.4 show the same statewide 10-year premium projection under the Market Stabilization scenario for each of Nevada's four rating areas. As these tables illustrate, the average premiums in the more rural regions are still projected to be higher than in the more urban regions under the waiver; however, the magnitude of the difference is smaller because of the variance in the reinsurance coinsurance percentages across rating areas. The average premiums in Rating Area 3 in the Market Stabilization scenario are approximately 40% higher than the average premiums in Rating Area 1 by year 4 of the NMSP versus approximately 60% in the Baseline Scenario.

The differences in BBSP take-up assumptions in Tables 20.1 through 20. are driven by differences in member mix by on and off-change and by FPL and metal. Rating Area 1 has a higher proportion of members for whom we assume higher take-up (e.g., on-exchange silver under 200% FPL) than the other rating areas.

Table 20.1 State of Nevada NMSP Actuarial and Economic Analysis Market Stabilization 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	29%	23,200	$157,000	$563	57,200	$388,000	$566	80,400	$545,000	$565
2027	34%	27,900	$183,000	$545	54,100	$359,000	$553	82,000	$542,000	$550
2028	42%	34,900	$233,000	$556	48,300	$331,000	$571	83,200	$564,000	$565
2029	48%	40,300	$275,000	$570	44,000	$311,000	$589	84,300	$586,000	$580
2030	48%	40,800	$290,000	$592	44,600	$327,000	$611	85,400	$617,000	$602
2031	48%	41,400	$305,000	$613	45,100	$343,000	$635	86,500	$648,000	$624
2032	48%	41,900	$320,000	$637	45,700	$361,000	$659	87,600	$681,000	$649
2033	48%	42,500	$337,000	$660	46,300	$380,000	$684	88,800	$717,000	$673
2034	48%	43,100	$354,000	$684	46,800	$399,000	$711	89,900	$753,000	$698
2035	48%	43,600	$372,000	$711	47,400	$420,000	$738	91,000	$792,000	$725

Table 20.2
State of Nevada
NMSP Actuarial and Economic Analysis
Market Stabilization 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	27%	3,800	$31,000	$679	10,200	$83,000	$674	14,000	$114,000	$675
2027	31%	4,500	$35,000	$641	9,900	$75,000	$629	14,400	$110,000	$633
2028	39%	5,700	$45,000	$653	8,900	$69,000	$647	14,600	$114,000	$650
2029	45%	6,700	$53,000	$661	8,100	$65,000	$670	14,800	$118,000	$666
2030	46%	6,800	$56,000	$684	8,100	$68,000	$704	14,900	$124,000	$695
2031	45%	6,900	$59,000	$708	8,300	$72,000	$722	15,200	$131,000	$715
2032	45%	6,900	$62,000	$744	8,500	$76,000	$741	15,400	$138,000	$742
2033	45%	7,000	$65,000	$770	8,600	$79,000	$768	15,600	$144,000	$769
2034	45%	7,100	$68,000	$797	8,700	$83,000	$797	15,800	$151,000	$797
2035	45%	7,200	$71,000	$825	8,800	$87,000	$828	16,000	$158,000	$826

Table 20.3
State of Nevada
NMSP Actuarial and Economic Analysis
Market Stabilization 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	29%	1,500	$16,000	$886	3,700	$40,000	$903	5,200	$56,000	$898
2027	32%	1,800	$18,000	$819	3,800	$36,000	$782	5,600	$54,000	$794
2028	39%	2,200	$23,000	$855	3,500	$33,000	$782	5,700	$56,000	$810
2029	45%	2,600	$27,000	$854	3,200	$31,000	$804	5,800	$58,000	$826
2030	44%	2,600	$28,000	$895	3,300	$32,000	$817	5,900	$60,000	$851
2031	43%	2,600	$29,000	$937	3,400	$34,000	$831	6,000	$63,000	$877
2032	45%	2,700	$31,000	$946	3,300	$36,000	$897	6,000	$67,000	$919
2033	44%	2,700	$32,000	$991	3,400	$37,000	$912	6,100	$69,000	$947
2034	44%	2,700	$34,000	$1,038	3,500	$39,000	$928	6,200	$73,000	$976
2035	45%	2,800	$35,000	$1,048	3,400	$41,000	$1,001	6,200	$76,000	$1,022

Table 20.4 State of Nevada NMSP Actuarial and Economic Analysis Market Stabilization 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	27%	600	$6,000	$850	1,600	$15,000	$796	2,200	$21,000	$811
2027	32%	800	$6,000	$608	1,700	$12,000	$573	2,500	$18,000	$584
2028	40%	1,000	$7,000	$618	1,500	$11,000	$596	2,500	$18,000	$604
2029	44%	1,100	$9,000	$660	1,400	$10,000	$597	2,500	$19,000	$625
2030	44%	1,100	$9,000	$689	1,400	$10,000	$624	2,500	$19,000	$653
2031	44%	1,100	$9,000	$719	1,400	$11,000	$651	2,500	$20,000	$681
2032	46%	1,200	$10,000	$688	1,400	$11,000	$680	2,600	$21,000	$684
2033	46%	1,200	$10,000	$719	1,400	$12,000	$710	2,600	$22,000	$714
2034	46%	1,200	$11,000	$751	1,400	$12,000	$742	2,600	$23,000	$746
2035	44%	1,200	$11,000	$784	1,500	$13,000	$723	2,700	$24,000	$750

<u>Subsidies</u>

Premiums under the Market Stabilization scenario reflect the same key assumptions as the Baseline scenario plus the following assumption:

- *BBSP becomes the SLCS plan:* We assume a BBSP becomes the SLCS plan in each rating area and achieves the targeted savings relative to the reference premium. Similarly, we assume a BBSP also achieves savings relative to the SLCS premium modeled in the Baseline scenario. See additional discussion in Section II.B above related to why we assume the competitive landscape driven by BBSPs decreases the benchmark silver plan, regardless of whether a BBSP becomes the SLCS.

Table 21 State of Nevada NMSP Actuarial and Economic Analysis Market Stabilization 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	$624	$420	$204	$552	$526	$601
2027	$599	$386	$212	$525	$503	$575
2028	$614	$393	$221	$540	$516	$590
2029	$630	$400	$230	$555	$530	$606
2030	$654	$416	$238	$577	$550	$629
2031	$678	$432	$246	$597	$570	$652
2032	$704	$449	$254	$623	$591	$677
2033	$729	$467	$263	$644	$613	$702
2034	$757	$485	$272	$669	$636	$728
2035	$785	$504	$281	$697	$660	$755

We note the following regarding Table 21:

- Average aggregate gross premiums, APTCs, and enrollee net premiums are based on the projected mix of plan selections under the Market Stabilization scenario which is based on FPL, age, and metal level. We assume 50% of members enroll in a BBSP and the other 50% remain in their current plan (i.e., the same plan as in the Baseline scenario).

Table 22
State of Nevada
NMSP Actuarial and Economic Analysis
Market Stabilization Scenario
Change versus Baseline 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	(1.0%)	(3.9%)	5.7%	(5.4%)	(1.1%)	(1.2%)
2027	(8.7%)	(15.3%)	6.5%	(13.6%)	(9.0%)	(9.1%)
2028	(9.9%)	(17.4%)	7.3%	(14.8%)	(10.2%)	(10.3%)
2029	(11.2%)	(19.3%)	7.9%	(15.9%)	(11.4%)	(11.5%)
2030	(11.3%)	(19.5%)	8.1%	(15.4%)	(11.6%)	(11.6%)
2031	(11.6%)	(19.8%)	7.9%	(16.1%)	(11.8%)	(11.9%)
2032	(11.7%)	(20.0%)	7.9%	(16.0%)	(12.1%)	(12.1%)
2033	(12.0%)	(20.1%)	7.7%	(16.9%)	(12.3%)	(12.4%)
2034	(12.2%)	(20.4%)	7.8%	(17.3%)	(12.5%)	(12.6%)
2035	(12.4%)	(20.7%)	7.8%	(16.7%)	(12.8%)	(12.8%)

Commentary on Table 22:

- Average Aggregate Gross Premiums in column (1) decline under the Market Stabilization scenario relative to the Baseline scenario. The difference grows over time as BBSP premium discounts relative to the reference premium and BBSP take-up both increase through year 4 of the program.
- The change in Average Aggregate APTCs in column (2) relative to the Baseline scenario is greater than the BBSP premium discounts relative to both the reference premium by year (as noted in Table 6 in Section II.D above) and to the Baseline SLCS premium, as expected.
- Average Aggregate Enrollee Net Premiums in column (3) reflect projected plan selections. The average aggregate enrollee net premiums are increasing relative to the Baseline scenario because we assume only approximately 50% of the individual market adopts a BBSP in year 4 and after. Based on this assumption, some consumers' net premiums (after subsidy) will increase because they have not switched plans, and the subsidy decrease due to the waiver leaves the enrollee with a higher net premium.

The average net premium for subsidized members is sensitive to the BBSP take-up rate. If all consumers enroll in a BBSP, the Average Aggregate Enrollee Net Premiums will be no greater than in the Baseline scenario in each year. To illustrate how a higher BBSP adoption rate impacts the average aggregate enrollee net member premium, Exhibits E- 1 and E-2 in Appendix E present the same results as shown in Tables 21 and 22 assuming an 80% BBSP adoption rate.

The change in enrollee net premium modeled in the Market Stabilization Scenario for subsidized members also varies significantly across members. Exhibit 8 shows the BBSP take-up and illustrates how the average enrollee net premium changes between the Baseline Scenario and the Market Stabilization Scenario in 2029 for members with different enrollee net premium levels in the Baseline Scenario. Exhibit 8 also shows the change in average enrollee net premium for those who enroll in a BBSP versus those who do not.

Exhibit 9 shows the BBSP take-up and illustrates how the average enrollee net premium changes between the Baseline

Scenario and the Market Stabilization Scenario in 2029 for all members on-exchange, including those who are not eligible for subsidies, by income and metal level.

Finally, we calculate the savings in premium tax credits (PTCs) by multiplying APTC PMPMs by membership for the Baseline and Market Stabilization scenarios, calculating the difference in APTCs between the two scenarios, and adjusting for tax reconciliation.[44] The PTC membership under the Market Stabilization scenario reflects the decrease shown in Table 19 above due to some current enrollees with small subsidies who will no longer qualify for subsidies.

Table 23
State of Nevada
NMSP Actuarial and Economic Analysis
Market Stabilization Scenario
Impact of NMSP on Premium, Subsidies, and Pass-Through Funding

	Baseline			Market Stabilization			Change	
Year	PTC Membership	APTC PMPM	Annual APTC (thousands)	PTC Membership	APTC PMPM	Annual APTC (thousands)	Change in APTC	PTC Savings
2026	75,400	$438	$396,000	75,200	$420	$379,000	($17,000)	$15,000
2027	76,400	$456	$418,000	76,400	$386	$354,000	($64,000)	$58,000
2028	77,400	$476	$442,000	77,400	$393	$365,000	($77,000)	$69,000
2029	78,400	$496	$466,000	78,400	$400	$376,000	($90,000)	$81,000
2030	79,500	$517	$493,000	79,400	$416	$396,000	($97,000)	$87,000
2031	80,500	$539	$520,000	80,500	$432	$417,000	($103,000)	$93,000
2032	81,600	$562	$550,000	81,500	$449	$440,000	($110,000)	$99,000
2033	82,800	$585	$581,000	82,600	$467	$463,000	($118,000)	$106,000
2034	83,900	$610	$614,000	83,700	$485	$487,000	($127,000)	$114,000
2035	85,000	$635	$648,000	84,800	$504	$513,000	($135,000)	$122,000
5-Year Waiver Window								**$310,000**
10-Year Deficit Neutrality Window								**$844,000**
5-Year Waiver Window – With 10% Margin								**$279,000**
10-Year Deficit Neutrality Window – With 10% Margin								**$760,000**

We estimate the federal PTC savings under the Market Stabilization scenario to be $310 million over the five-year waiver period and $844 million over the 10-year deficit neutrality period.

As required by CMS, the federal subsidies under the Market Stabilization scenario do not exceed the federal subsidies in the Baseline scenario over the 10-year deficit neutrality period.

[44] PTC reconciliation involves truing up APTC (paid on estimated income) versus actual income on income tax forms filed with the IRS. Normally, PTCs are less than APTCs. See https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-Key-Components-Pass-through-Estimate-Feb-2021.xlsx.

VI. DATA AND METHODOLOGY

DATA SOURCES AND ADJUSTMENTS

Health care coverage and enrollment

The Silver State Health Insurance Exchange provided enrollment data as of early 2023. The exchange data included the following elements:

- Exchange individual identifier
- Household case identifier
- Federal poverty level (FPL) percentage
- Age
- ZIP Code
- County
- Plan level
- Net premium
- Advance premium tax credit (APTC) amount
- Health Insurance Oversight System (HIOS) issuer identifier
- CMS plan identifier
- Relationship to subscriber
- Enrollee status
- Status start date
- Status end date
- Last update date

We reviewed the exchange data for reasonableness and compared against publicly available sources. We summarized the key fields by various cuts to gauge feasibility of the data.

We mapped in each member's and contract's total SLCS plan premium amount from the publicly available Public Use Files (PUFs) based on their county. We also excluded a minimal amount of membership with invalid or missing entries for key fields such as county, age, and premium.

The exchange data represented a snapshot as of early 2023, and thus will not match the full year 2023 due to new enrollment, terminations, and midyear plan changes, among other reasons. We did account for membership that terminated prior to our snapshot.

Publicly available data

- Individual market Federal Risk Adjustment Reports
- Open enrollment PUFs
- Benefits and cost-sharing PUFs
- American Community Survey (ACS)
- National Health Expenditures (NHE) projections
- Commercial medical loss ratio form data submitted to CMS
- Statutory statement insurer financial data

Nevada Issuer EDGE Server Data

Six Nevada issuers provided 2022 full year High-Cost Risk Pool reports from the EDGE server. These reports contain member-level pharmacy and medical paid claims for the 2022 benefit year. We used this information to model estimated 2027 reinsurance costs.

Other

- State of Nevada Department of Health and Human Services guidance memo

METHODOLOGY

We summarized the 2023 exchange enrollment and premium information to create a baseline, grouped by metallic coverage level, rating area, age band, FPL, and contract size to produce approximately 3,000 model cells. In 2023, we calculated subsidies based on the member's selected premium, premium of SLCS plan available, household FPL, and current premium limits (based on the expanded ARP levels). For 2023 through 2035, we projected enrollment and premium increases for each scenario, and calculated the corresponding subsidies for each model cell. The following sections provide further detail on the assumptions for enrollment and premium changes.

Based on each scenario's ACA premium limits, we calculated revised subsidies for each model cell and year. The total subsidies in the Market Stabilization scenario are compared to the Baseline scenario to calculate the estimated PTF.

To model the estimated cost of reinsurance, we summarized 2022 member-level individual market claims by rating area and metal from the EDGE data and project forward through 2035. We adjusted for anticipated medical and pharmacy trend, Medicaid redeterminations, expiration of ARP subsidies, and the impact of BBSP plans on the market. Reinsurance was calculated based on members' total annual medical and pharmacy claims compared to the program parameters.

Enrollment assumptions

Population-driven enrollment growth

We assumed the overall individual market will grow by the population growth rate, at a minimum, absent other shocks to the market. We use an underlying general population growth rate to project individual market growth absent other shocks. The population of the State of Nevada is assumed to grow 1.3% annually after 2022.[45] We then layer in separate additional enrollment impacts for the expiration of the PHE and the loss of ARPA subsidies, detailed below. Other shocks that have historically impacted the individual market such as changes in broad economic conditions, pandemics, or policy changes at the state or federal lever could occur but are not known at this time.

Enrollment growth due to expiration of the PHE

We assumed exchange enrollment will increase in each income level between 2023 and 2026 due to the expiration of the PHE, as shown in Table 24. First, we estimated the total membership at each income level that we expect to lose Medicaid coverage upon expiration of the PHE by reviewing growth in Nevada Medicaid enrollment since the PHE started compared to pre-PHE enrollment. Although Medicaid disenrollment due to the expiration of the PHE will impact all income levels and eligibility groups, we expect the impact to be greater for higher-income members and for the Childless Adults eligibility group. For each cohort, we estimated the percentage that will take up group coverage, individual exchange coverage, or become uninsured upon disenrollment from Medicaid. We expect higher-income individuals will be more likely to have commercial group insurance available, and less likely to enter the individual market.

Table 24
State of Nevada
NMSP Actuarial and Economic Analysis
Modeling Assumptions
Individual Market Enrollment Increase Due to Expiration of the PHE

Income (% FPL)	Member Increase
Under 100%	295
100 to 133%	1,327
133 to 150%	1,994
150 to 200%	3,368
200 to 250%	3,998
250 to 300%	2,386
300 to 400%	1,040
Over 400%	1,291
Total	**15,700**

[45] Nevada Department of Taxation (October 1, 2022). Nevada County Age, Sex, Race, and Hispanic Origin Estimates and Projections 2000 to 2041: Estimates From 2000 to 2021 and Projections From 2022 to 2041. Table: Nevada Statewide ASRHO Summary File Estimated for 2000 to 2021 and Projected 2022 to 2041 W GQ, page 3. Retrieved November 9, 2022, from https://tax.nv.gov/uploadedFiles/taxnvgov/Content/TaxLibrary/2022_ASRHO_Estimates_and_Projections.pdf

Enrollment decrease due to the expiration of ARP subsidies

We assumed exchange enrollment will decrease in each income level between 2023 and 2026 due to the expiration of ARP subsidies, as shown in Table 25. To develop these assumptions, we estimated the increase in members due to ARP by measuring the 2021 and 2022 increases in enrollment. We assumed that a relatively comparable number of members will disenroll due to the expiration of ARP subsidies.

Table 25
State of Nevada
NMSP Actuarial and Economic Analysis
Modeling Assumptions
Individual Market Enrollment Decrease Due to Expiration of ARP Subsidies

Income (% FPL)	Member Decrease
Under 100%	733
100 to 133%	2,071
133 to 150%	3,682
150 to 200%	3,699
200 to 250%	3,080
250 to 300%	2,589
300 to 400%	3,206
Over 400%	10,768
Total	**29,830**

Premium assumptions

Consumer Price Index – Medical

We assumed the annual increase in the Consumer Price Index – Medical (CPI-M) is 3.7% in all future years, which is the annualized average change in the CPI-M from April 2002 through April 2022.

Standard QHP gross premium increases (before reinsurance)

From 2018 through 2022, the average annual change in SLCS plan premiums on the individual exchange is -1.58% nationwide (decreasing each year) and -2.0% in Nevada[46] (decreasing in three of the four years). The actual annual percentage changes fluctuated widely in many states during this time due to market circumstances that are not expected to recur. Therefore, we did not assume the recent decreases and fluctuations in exchange premiums will continue in the future.

We expect the annual trend on standard QHP exchange gross premiums (before reinsurance) to converge near medical inflation indices. However, medical inflation indices typically do not reflect all prospective drivers of health care costs. For example, the CPI-M does not account for emerging treatments or changes in utilization. Therefore, we assumed the standard QHP exchange gross premiums will increase by 0.3% more than CPI-M, or 4.0% per year.

Morbidity changes due to the expiration of the PHE

We assumed the new enrollees who join the exchange due to the expiration of the PHE reduce total individual market morbidity by 0.4%, and we assumed this improvement will be reflected through comparably lower exchange premiums. We derived the 0.4% estimate using Milliman's population shift model, which uses census data and self-reported health status to estimate population movements among various sectors, incomes, and health statuses across the United States.

[46] Kaiser Family Foundation. Percent Change in Average Marketplace Premiums by Metal Tier, 2018-2023. State Health Facts. Retrieved November 9, 2022, from https://www.kff.org/health-reform/state-indicator/percent-change-in-average-marketplace-premiums-by-metal-tier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Morbidity changes due to the expiration of ARP subsidies

We assumed the enrollees who leave the Silver State Individual Health Exchange due to the expiration of ARP subsidies increase morbidity by 2.5%, and we assumed this change in morbidity will be reflected through comparably higher exchange premiums. Silver State Individual Health Exchange members who enrolled after ARP subsidies went into effect are estimated to be about 10% healthier, on average, than members enrolled prior to the ARP subsidies.

Demographic and distribution assumptions

Overall BBSP take-up rate

We assumed new and existing Silver State Individual Health Exchange enrollees will enroll in BBSPs. The BBSPs will reduce the SLCS plan premium, which will result in lower federal premium subsidies for all subsidy-eligible enrollees. Any difference between the federal subsidy and the premium must be paid by the enrollee. For a fully subsidized enrollee to maintain the same level of out-of-pocket cost, they will likely need to shift to a BBSP. We assumed low-subsidy or nonsubsidized enrollees are less sensitive to these out-of-pocket cost increases than fully subsidized enrollees. Therefore, we assumed fully subsidized enrollees will enroll in a BBSP at higher rates than low-subsidy or nonsubsidized enrollees. The projected number of enrollees assumed to enroll in BBSP by income and metallic levels during the 10-year deficit neutrality window are shown in Exhibits 3 and 4, respectively.

To estimate our take-up of the PO, we assumed BBSPs as a whole could be treated as an exchange issuer. We then analyzed the historical market share for SLCS issuers at the county level as a proxy for what market share the BBSPs might receive, given they are assumed to be both the SLCS and LCS in this analysis. We used public data from the following sources:

- County-level Plan data from QHP Landscape files (Healthcare.gov Data Services Hub)
  https://data.healthcare.gov/datasets?keyword%5B0%5D=QHP
- Rate information from CMS's "Rate PUF"
  https://www.cms.gov/marketplace/resources/data/public-use-files
- Enrollment data from CMS's Issuer-Level Public Use File
  https://www.cms.gov/marketplace/resources/data/issuer-level-enrollment-data

We analyzed data for 2018 through 2022 and excluded counties with two or fewer issuers to better simulate the Nevada competitive environment. We calculated the market share in counties where the SLCS and the LCS were offered by the same issuer, calculated the weighted average market share across all counties, and calculated ranges of market share estimates.

Subsidized members under 100% FPL

PTC subsidies typically are not available to enrollees below 100% FPL because those residents are expected to enroll in Medicaid. It is our understanding that some legal immigrants are not eligible for Medicaid in Nevada, but they are eligible for PTC subsidies on the exchange.

Income levels

The FPL in 2022 and 2023 is $13,590 and $14,580, respectively, for a one-person household. For modeling purposes, we assumed all enrollees in each income level have the same FPL percentage, based on the approximate distribution of 2023 exchange enrollment within each bucket. The modeled FPL percentages for 2023 in each bucket are shown in Table 26.

Table 26 State of Nevada NMSP Actuarial and Economic Analysis Modeling Assumptions Modeled Household Income Levels – One-Person Household		
Income (% FPL)	**Modeled FPL %**	**Modeled 2023 Household Income**
Under 100%	100%	Less than $14,580
100 to 133%	120%	$17,496
133 to 150%	145%	$21,141
150 to 200%	190%	$27,702
200 to 250%	245%	$35,721
250 to 300%	280%	$40,824
300 to 400%	385%	$56,133
Over 400%	600%	$87,480

FPL increases

We assumed the FPL will increase each year with trend. The FPL is assumed to increase by 2.5% every year, based on CMS projections.

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 done 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. Our estimates are higher than historical changes to be conservative on PTF calculations.

Small Group Rates

In estimating the impact and potential migration from the small group market, we used public premium rate data from carriers in the individual and small group markets in Nevada in 2022 (CMS PUF files for individual and rate files from the SERFF filing system for small group). We reviewed rate increases in each market for 2023 and 2024 and concluded that the overall relationship of rates between markets has not changed materially. Table 27 below shows that small group rates are lower than individual rates across almost all metal levels and geographic areas.

Table 27 State of Nevada NMSP Actuarial and Economic Analysis Modeling Assumptions Small Group to Individual Premium Rate Relationship			
	Bronze	Silver	Gold
Rating Area 1	96.1%	96.3%	92.2%
Rating Area 2	89.5%	87.6%	85.3%
Rating Area 3	74.0%	73.0%	68.8%
Rating Area 4	85.1%	86.9%	86.8%

EXHIBITS

Exhibit 1 State of Nevada Nevada Market Stabilization Actuarial and Economic Analysis Individual Market Composite Monthly Premium			
Year	**Baseline**	**Waiver**	**Difference**
2026	$608.37	$601.20	-1.2%
2027	$632.82	$575.40	-9.1%
2028	$658.33	$590.41	-10.3%
2029	$684.98	$605.89	-11.5%
2030	$711.45	$629.04	-11.6%
2031	$740.37	$651.91	-11.9%
2032	$769.94	$676.83	-12.1%
2033	$800.81	$701.59	-12.4%
2034	$833.03	$727.98	-12.6%
2035	$865.91	$755.43	-12.8%

Exhibit 2
State of Nevada
Nevada Market Stabilization Actuarial and Economic Analysis
Individual Market Changes in SLCS Plan Monthly Premium from 1332 Waiver Implementation
All Rating Areas

	21-Year Old Monthly Premium				40-Year Old Monthly Premium			
Year	Baseline	Waiver	Difference	Percent Change	Baseline	Waiver	Difference	Percent Change
2026	$359.03	$347.61	($11.42)	-3.2%	$458.84	$444.24	($14.59)	-3.2%
2027	$373.39	$328.63	($44.76)	-12.0%	$477.19	$419.99	($57.20)	-12.0%
2028	$388.32	$335.74	($52.58)	-13.5%	$496.28	$429.08	($67.20)	-13.5%
2029	$403.86	$343.26	($60.59)	-15.0%	$516.13	$438.69	($77.44)	-15.0%
2030	$420.01	$356.10	($63.91)	-15.2%	$536.78	$455.10	($81.68)	-15.2%
2031	$436.81	$369.39	($67.42)	-15.4%	$558.25	$472.08	($86.17)	-15.4%
2032	$454.29	$383.15	($71.14)	-15.7%	$580.58	$489.66	($90.91)	-15.7%
2033	$472.46	$397.40	($75.05)	-15.9%	$603.80	$507.88	($95.92)	-15.9%
2034	$491.35	$412.17	($79.18)	-16.1%	$627.95	$526.76	($101.20)	-16.1%
2035	$511.01	$427.47	($83.54)	-16.3%	$653.07	$546.31	($106.76)	-16.3%

Exhibit 2.1
State of Nevada
Nevada Market Stabilization Actuarial and Economic Analysis
Individual Market Changes in SLCS Plan Monthly Premium from 1332 Waiver Implementation
Rating Area 1

	21-Year Old Monthly Premium				40-Year Old Monthly Premium			
Year	Baseline	Waiver	Difference	Percent Change	Baseline	Waiver	Difference	Percent Change
2026	$330.90	$320.34	($10.56)	-3.2%	$422.89	$409.39	($13.50)	-3.2%
2027	$344.13	$309.61	($34.52)	-10.0%	$439.80	$395.69	($44.11)	-10.0%
2028	$357.90	$316.49	($41.41)	-11.6%	$457.39	$404.47	($52.92)	-11.6%
2029	$372.21	$323.78	($48.44)	-13.0%	$475.69	$413.79	($61.90)	-13.0%
2030	$387.10	$336.13	($50.98)	-13.2%	$494.72	$429.57	($65.15)	-13.2%
2031	$402.59	$348.92	($53.67)	-13.3%	$514.51	$445.92	($68.59)	-13.3%
2032	$418.69	$362.18	($56.51)	-13.5%	$535.09	$462.87	($72.22)	-13.5%
2033	$435.44	$375.93	($59.51)	-13.7%	$556.49	$480.44	($76.05)	-13.7%
2034	$452.85	$390.17	($62.68)	-13.8%	$578.75	$498.64	($80.11)	-13.8%
2035	$470.97	$404.94	($66.03)	-14.0%	$601.90	$517.51	($84.39)	-14.0%

Exhibit 2.2
State of Nevada
Nevada Market Stabilization Actuarial and Economic Analysis
Individual Market Changes in SLCS Plan Monthly Premium from 1332 Waiver Implementation
Rating Area 2

	21-Year Old Monthly Premium				40-Year Old Monthly Premium			
Year	Baseline	Waiver	Difference	Percent Change	Baseline	Waiver	Difference	Percent Change
2026	$400.64	$387.89	($12.74)	-3.2%	$512.01	$495.72	($16.29)	-3.2%
2027	$416.66	$358.71	($57.95)	-13.9%	$532.49	$458.44	($74.06)	-13.9%
2028	$433.33	$366.33	($67.00)	-15.5%	$553.79	$468.17	($85.62)	-15.5%
2029	$450.66	$374.39	($76.27)	-16.9%	$575.94	$478.47	($97.47)	-16.9%
2030	$468.69	$388.15	($80.54)	-17.2%	$598.98	$496.05	($102.93)	-17.2%
2031	$487.43	$402.38	($85.06)	-17.5%	$622.94	$514.24	($108.70)	-17.5%
2032	$506.93	$417.10	($89.83)	-17.7%	$647.86	$533.06	($114.80)	-17.7%
2033	$527.21	$432.35	($94.86)	-18.0%	$673.77	$552.55	($121.23)	-18.0%
2034	$548.30	$448.16	($100.14)	-18.3%	$700.72	$572.74	($127.98)	-18.3%
2035	$570.23	$464.59	($105.64)	-18.5%	$728.75	$593.74	($135.01)	-18.5%

Exhibit 2.3
State of Nevada
Nevada Market Stabilization Actuarial and Economic Analysis
Individual Market Changes in SLCS Plan Monthly Premium from 1332 Waiver Implementation
Rating Area 3

	21-Year Old Monthly Premium				40-Year Old Monthly Premium			
Year	Baseline	Waiver	Difference	Percent Change	Baseline	Waiver	Difference	Percent Change
2026	$598.41	$579.40	($19.01)	-3.2%	$764.77	$740.48	($24.30)	-3.2%
2027	$622.35	$501.11	($121.24)	-19.5%	$795.36	$640.42	($154.94)	-19.5%
2028	$647.24	$510.75	($136.49)	-21.1%	$827.18	$652.74	($174.43)	-21.1%
2029	$673.13	$520.85	($152.28)	-22.6%	$860.26	$665.65	($194.61)	-22.6%
2030	$700.06	$538.80	($161.26)	-23.0%	$894.67	$688.58	($206.09)	-23.0%
2031	$728.06	$557.28	($170.78)	-23.5%	$930.46	$712.21	($218.25)	-23.5%
2032	$757.18	$576.32	($180.86)	-23.9%	$967.68	$736.54	($231.14)	-23.9%
2033	$787.47	$595.94	($191.53)	-24.3%	$1,006.39	$761.62	($244.77)	-24.3%
2034	$818.97	$616.13	($202.83)	-24.8%	$1,046.64	$787.42	($259.22)	-24.8%
2035	$851.73	$636.95	($214.78)	-25.2%	$1,088.51	$814.02	($274.49)	-25.2%

Exhibit 2.4
State of Nevada
Nevada Market Stabilization Actuarial and Economic Analysis
Individual Market Changes in SLCS Plan Monthly Premium from 1332 Waiver Implementation
Rating Area 4

	21-Year Old Monthly Premium				40-Year Old Monthly Premium			
Year	Baseline	Waiver	Difference	Percent Change	Baseline	Waiver	Difference	Percent Change
2026	$511.67	$495.43	($16.24)	-3.2%	$653.91	$633.16	($20.75)	-3.2%
2027	$532.13	$365.27	($166.86)	-31.4%	$680.07	$466.82	($213.25)	-31.4%
2028	$553.42	$371.09	($182.32)	-32.9%	$707.27	$474.26	($233.01)	-32.9%
2029	$575.55	$377.13	($198.42)	-34.5%	$735.56	$481.98	($253.58)	-34.5%
2030	$598.58	$388.61	($209.96)	-35.1%	$764.98	$496.65	($268.33)	-35.1%
2031	$622.52	$400.36	($222.16)	-35.7%	$795.58	$511.66	($283.92)	-35.7%
2032	$647.42	$412.35	($235.07)	-36.3%	$827.40	$526.99	($300.42)	-36.3%
2033	$673.32	$424.79	($248.53)	-36.9%	$860.50	$542.88	($317.62)	-36.9%
2034	$700.25	$438.01	($262.24)	-37.4%	$894.92	$559.77	($335.15)	-37.4%
2035	$728.26	$451.42	($276.84)	-38.0%	$930.72	$576.91	($353.81)	-38.0%

Exhibit 3
State of Nevada
Nevada Market Stabilization Actuarial and Economic Analysis
Individual Market Estimated Enrollees: 2026 through 2035 by Federal Poverty Level

Total Enrollment by FPL % - Baseline

Income Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Under 100%	2,030	2,060	2,080	2,110	2,140	2,160	2,190	2,220	2,250	2,280
100 to 133%	7,190	7,280	7,380	7,470	7,570	7,670	7,770	7,870	7,970	8,070
133 to 150%	12,980	13,140	13,310	13,490	13,660	13,840	14,020	14,200	14,390	14,570
150 to 200%	22,370	22,660	22,960	23,260	23,560	23,870	24,180	24,490	24,810	25,130
200 to 250%	18,490	18,730	18,980	19,220	19,470	19,720	19,980	20,240	20,500	20,770
250 to 300%	10,820	10,960	11,100	11,240	11,390	11,540	11,690	11,840	11,990	12,150
300 to 400%	8,070	8,170	8,280	8,380	8,490	8,600	8,720	8,830	8,940	9,060
Over 400%	19,450	19,700	19,960	20,220	20,480	20,740	21,010	21,290	21,560	21,840
Total Individual*	**101,380**	**102,700**	**104,040**	**105,390**	**106,760**	**108,150**	**109,550**	**110,980**	**112,420**	**113,880**

Total Enrollment by FPL % - With Waiver

Income Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Under 100%	2,040	2,090	2,120	2,140	2,170	2,200	2,230	2,260	2,290	2,320
100 to 133%	7,190	7,330	7,430	7,520	7,620	7,720	7,820	7,920	8,020	8,130
133 to 150%	12,980	13,240	13,420	13,590	13,770	13,950	14,130	14,320	14,500	14,690
150 to 200%	22,410	22,930	23,240	23,540	23,850	24,160	24,470	24,790	25,110	25,440
200 to 250%	18,520	18,970	19,220	19,470	19,720	19,980	20,240	20,500	20,770	21,040
250 to 300%	10,840	11,110	11,260	11,410	11,550	11,700	11,860	12,010	12,170	12,330
300 to 400%	8,150	8,400	8,510	8,620	8,740	8,850	8,960	9,080	9,200	9,320
Over 400%	19,780	20,400	20,760	21,070	21,340	21,620	21,900	22,190	22,480	22,770
Total Individual*	**101,920**	**104,470**	**105,940**	**107,370**	**108,770**	**110,180**	**111,610**	**113,060**	**114,530**	**116,020**

Change in Enrollment Due to Waiver

Income Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Under 100%	10	30	40	30	30	40	40	40	40	40
100 to 133%	0	50	50	50	50	50	50	50	50	60
133 to 150%	0	100	110	100	110	110	110	120	110	120
150 to 200%	40	270	280	280	290	290	290	300	300	310
200 to 250%	30	240	240	250	250	260	260	260	270	270
250 to 300%	20	150	160	170	160	160	170	170	180	180
300 to 400%	80	230	230	240	250	250	240	250	260	260
Over 400%	330	700	800	850	860	880	890	900	920	930
Total Individual*	**540**	**1,770**	**1,900**	**1,980**	**2,010**	**2,030**	**2,060**	**2,080**	**2,110**	**2,140**

**Changes at the FPL level may not sum to the total due to rounding.*

Exhibit 4
State of Nevada
Nevada Market Stabilization Actuarial and Economic Analysis
Individual Market Estimated Enrollees: 2026 through 2035 by Metal

Total Enrollment by Metal - Baseline

Plan Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Catastrophic	810	820	830	840	850	870	880	890	900	910
Bronze	40,180	40,710	41,240	41,770	42,310	42,860	43,420	43,990	44,560	45,140
Silver	56,560	57,300	58,040	58,800	59,560	60,340	61,120	61,910	62,720	63,530
Gold	3,830	3,880	3,930	3,980	4,030	4,080	4,140	4,190	4,240	4,300
Total Individual*	**101,380**	**102,700**	**104,040**	**105,390**	**106,760**	**108,150**	**109,550**	**110,980**	**112,420**	**113,880**

Total Enrollment by Metal - With Waiver

Plan Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Catastrophic	830	850	870	880	890	900	910	930	940	950
Bronze	40,490	41,630	42,230	42,810	43,370	43,930	44,500	45,080	45,670	46,260
Silver	56,740	58,040	58,830	59,610	60,390	61,170	61,970	62,770	63,590	64,420
Gold	3,860	3,950	4,010	4,070	4,120	4,170	4,230	4,280	4,340	4,390
Total Individual*	**101,920**	**104,470**	**105,940**	**107,370**	**108,770**	**110,180**	**111,610**	**113,060**	**114,530**	**116,020**

Change in Enrollment Due to Waiver

Plan Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Catastrophic	20	30	40	40	40	30	30	40	40	40
Bronze	310	920	990	1,040	1,060	1,070	1,080	1,090	1,110	1,120
Silver	180	740	790	810	830	830	850	860	870	890
Gold	30	70	80	90	90	90	90	90	100	90
Total Individual*	**540**	**1,770**	**1,900**	**1,980**	**2,010**	**2,030**	**2,060**	**2,080**	**2,110**	**2,140**

**Changes at the metal level may not sum to the total due to rounding.*

Exhibit 5
State of Nevada
Nevada Market Stabilization Actuarial and Economic Analysis
Individual Market Estimated Enrollees: 2026 through 2035 by Age Group

Total Enrollment by Age Group - Baseline

Age Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
0-14	12,540	12,700	12,870	13,040	13,210	13,380	13,550	13,730	13,910	14,090
14-20	5,520	5,590	5,670	5,740	5,820	5,890	5,970	6,050	6,120	6,200
21-25	4,690	4,750	4,810	4,870	4,930	5,000	5,060	5,130	5,200	5,260
26-30	7,510	7,600	7,700	7,800	7,900	8,010	8,110	8,220	8,320	8,430
31-35	8,420	8,520	8,640	8,750	8,860	8,980	9,090	9,210	9,330	9,450
36-40	8,320	8,430	8,540	8,650	8,760	8,870	8,990	9,110	9,220	9,340
41-45	7,790	7,890	8,000	8,100	8,200	8,310	8,420	8,530	8,640	8,750
46-50	8,370	8,480	8,590	8,700	8,810	8,930	9,040	9,160	9,280	9,400
51-55	10,410	10,550	10,690	10,820	10,970	11,110	11,250	11,400	11,550	11,700
56-60	12,940	13,110	13,280	13,450	13,630	13,810	13,990	14,170	14,350	14,540
60-65	13,180	13,350	13,520	13,700	13,880	14,060	14,240	14,420	14,610	14,800
Over 65	1,700	1,720	1,750	1,770	1,790	1,820	1,840	1,860	1,890	1,910
Total Individual*	**101,380**	**102,700**	**104,040**	**105,390**	**106,760**	**108,150**	**109,550**	**110,980**	**112,420**	**113,880**

Total Enrollment by Age Group - With Waiver

Age Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
0-14	12,610	12,920	13,100	13,280	13,450	13,630	13,810	13,980	14,170	14,350
14-20	5,550	5,690	5,770	5,850	5,930	6,000	6,080	6,160	6,240	6,320
21-25	4,710	4,830	4,900	4,960	5,030	5,090	5,160	5,220	5,290	5,360
26-30	7,550	7,740	7,840	7,950	8,050	8,160	8,260	8,370	8,480	8,590
31-35	8,460	8,670	8,790	8,910	9,030	9,150	9,260	9,380	9,510	9,630
36-40	8,360	8,570	8,690	8,810	8,920	9,040	9,160	9,280	9,400	9,520
41-45	7,830	8,030	8,140	8,250	8,360	8,470	8,580	8,690	8,800	8,920
46-50	8,410	8,620	8,740	8,860	8,980	9,090	9,210	9,330	9,450	9,580
51-55	10,470	10,730	10,880	11,030	11,170	11,320	11,460	11,610	11,760	11,920
56-60	13,010	13,340	13,520	13,710	13,880	14,070	14,250	14,430	14,620	14,810
60-65	13,250	13,580	13,770	13,960	14,140	14,320	14,510	14,700	14,890	15,080
Over 65	1,710	1,750	1,780	1,800	1,830	1,850	1,870	1,900	1,920	1,950
Total Individual*	**101,920**	**104,470**	**105,940**	**107,370**	**108,770**	**110,180**	**111,610**	**113,060**	**114,530**	**116,020**

Change in Enrollment Due to Waiver

Age Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
0-14	70	220	230	240	240	250	260	250	260	260
14-20	30	100	100	110	110	110	110	110	120	120
21-25	20	80	90	90	100	90	100	90	90	100
26-30	40	140	140	150	150	150	150	150	160	160
31-35	40	150	150	160	170	170	170	170	180	180
36-40	40	140	150	160	160	170	170	170	180	180
41-45	40	140	140	150	160	160	160	160	160	170
46-50	40	140	150	160	170	160	170	170	170	180
51-55	60	180	190	210	200	210	210	210	210	220
56-60	70	230	240	260	250	260	260	260	270	270
60-65	70	230	250	260	260	260	270	280	280	280
Over 65	10	30	30	30	40	30	30	40	30	40
Total Individual*	**540**	**1,770**	**1,900**	**1,980**	**2,010**	**2,030**	**2,060**	**2,080**	**2,110**	**2,140**

**Changes at the age group level may not sum to the total due to rounding.*

Exhibit 6
State of Nevada
Nevada Market Stabilization Actuarial and Economic Analysis
Individual Market Estimated Enrollees: 2026 through 2035 by APTC Eligibility

Total Enrollment by Subsidy Eligibility - Baseline

Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Subsidized	75,390	76,410	77,420	78,440	79,460	80,500	81,580	82,820	83,900	84,990
Unsubsidized	25,990	26,300	26,620	26,950	27,300	27,650	27,970	28,160	28,530	28,900
Total Individual*	**101,380**	**102,700**	**104,040**	**105,390**	**106,760**	**108,150**	**109,550**	**110,980**	**112,420**	**113,880**

Total Enrollment by Subsidy Eligibility - With Waiver

Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Subsidized	75,170	76,420	77,410	78,390	79,440	80,470	81,510	82,580	83,730	84,830
Unsubsidized	26,750	28,050	28,520	28,980	29,330	29,710	30,100	30,480	30,800	31,190
Total Individual*	**101,920**	**104,470**	**105,940**	**107,370**	**108,770**	**110,180**	**111,610**	**113,060**	**114,530**	**116,020**

Change in Enrollment Due to Waiver

Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Subsidized	(220)	10	(10)	(50)	(20)	(30)	(70)	(240)	(170)	(160)
Unsubsidized	760	1,750	1,900	2,030	2,030	2,060	2,130	2,320	2,270	2,290
Total Individual*	**540**	**1,770**	**1,900**	**1,980**	**2,010**	**2,030**	**2,060**	**2,080**	**2,110**	**2,140**

**Changes at the subsidized level may not sum to the total due to rounding.*

Exhibit 7
State of Nevada
Nevada Market Stabilization Actuarial and Economic Analysis
Individual Market Estimated Enrollees: 2026 through 2035 by Rating Area

Total Enrollment by Rating Area - Baseline

Rating Area	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Rating Area 1	80,050	81,090	82,150	83,220	84,300	85,390	86,500	87,630	88,770	89,920
Rating Area 2	13,940	14,120	14,300	14,490	14,680	14,870	15,060	15,260	15,460	15,660
Rating Area 3	5,190	5,260	5,330	5,400	5,470	5,540	5,610	5,690	5,760	5,830
Rating Area 4	2,200	2,230	2,260	2,280	2,310	2,340	2,370	2,410	2,440	2,470
Total Individual*	**101,380**	**102,700**	**104,040**	**105,390**	**106,760**	**108,150**	**109,550**	**110,980**	**112,420**	**113,880**

Total Enrollment by Rating Area - With Waiver

Rating Area	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Rating Area 1	80,460	82,040	83,180	84,310	85,400	86,510	87,640	88,780	89,930	91,100
Rating Area 2	14,030	14,400	14,610	14,810	15,000	15,200	15,400	15,600	15,800	16,000
Rating Area 3	5,220	5,640	5,720	5,800	5,870	5,950	6,030	6,110	6,190	6,270
Rating Area 4	2,210	2,390	2,420	2,450	2,490	2,520	2,550	2,580	2,620	2,650
Total Individual*	**101,920**	**104,470**	**105,940**	**107,370**	**108,770**	**110,180**	**111,610**	**113,060**	**114,530**	**116,020**

Change in Enrollment Due to Waiver

Rating Area	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Rating Area 1	410	950	1,030	1,090	1,100	1,120	1,140	1,150	1,160	1,180
Rating Area 2	90	280	310	320	320	330	340	340	340	340
Rating Area 3	30	380	390	400	400	410	420	420	430	440
Rating Area 4	10	160	160	170	180	180	180	170	180	180
Total Individual*	**540**	**1,770**	**1,900**	**1,980**	**2,010**	**2,030**	**2,060**	**2,080**	**2,110**	**2,140**

**Changes at the rating area level may not sum to the total due to rounding.*

Exhibit 8
State of Nevada
NMSP Actuarial and Economic Analysis
Impact on 2029 Net Member Premium
PTC-Eligible Members by Net Premium Band

	PTC-Eligible	Net Premium PMPM			Change in Net Premium PMPM		% Difference in Premium		
Baseline Net Premium Range	Baseline Membership	Baseline Scenario	NMSP - Non-BBSP Plans	NMSP - BBSP Plans	Non-BBSP Plans / Baseline	BBSP Plans / Baseline	Non-BBSP Plans / Baseline	BBSP Plans / Baseline	BBSP Take-up
$0 to $1	1,449	$0	$39	$4	$39	$4	99980%	9538%	56%
$1 to $50	2,241	$30	$86	$42	$56	$12	186%	39%	55%
$50 to $100	8,831	$81	$123	$83	$42	$2	51%	2%	55%
$100 to $150	15,412	$126	$165	$124	$39	-$3	31%	-2%	54%
$150 to $200	13,585	$172	$220	$168	$48	-$4	28%	-2%	53%
$200 to $250	13,829	$225	$268	$219	$43	-$6	19%	-3%	53%
$250 to $300	7,591	$272	$324	$268	$52	-$4	19%	-1%	49%
$300 to $400	8,121	$334	$378	$322	$45	-$11	13%	-3%	48%
$400 to $500	4,701	$442	$496	$428	$54	-$14	12%	-3%	46%
$500 to $600	1,428	$542	$589	$513	$46	-$29	9%	-5%	43%
$600 and up	1,251	$740	$783	$691	$43	-$49	6%	-7%	39%

Exhibit 9
State of Nevada
Nevada Market Stabilization Actuarial and Economic Analysis
Impact on 2029 Net Member Premium
Exchange Members by Metal and Income

		Exchange Members		Net Premium PMPM			Change in Net Premium PMPM		% Difference in Premium		
Metal	Income (% FPL)	Baseline Scenario	NMSP Scenario	Baseline Scenario	NMSP - Non-BBSP Plans	NMSP - BBSP Plans	Non-BBSP Plans / Baseline	BBSP Plans / Baseline	Non-BBSP Plans / Baseline	BBSP Plans / Baseline	BBSP Take-up
Bronze	Under 100%	229	231	$625	$575	$531	-$49	-$94	-8%	-15%	56%
Bronze	100 to 133%	823	829	$9	$36	$9	$27	$1	317%	7%	56%
Bronze	133 to 150%	1,152	1,162	$29	$75	$32	$45	$3	156%	10%	57%
Bronze	150 to 200%	4,829	4,884	$87	$137	$93	$50	$6	57%	7%	57%
Bronze	200 to 250%	8,088	8,188	$159	$208	$166	$50	$7	31%	5%	52%
Bronze	250 to 300%	6,969	7,070	$216	$266	$223	$50	$7	23%	3%	47%
Bronze	300 to 400%	5,428	5,585	$324	$368	$322	$44	-$2	14%	-1%	42%
Bronze	Over 400%	4,972	5,194	$674	$586	$540	-$88	-$134	-13%	-20%	38%
Silver	Under 100%	1,168	1,173	$864	$806	$744	-$58	-$121	-7%	-14%	56%
Silver	100 to 133%	6,432	6,470	$113	$154	$101	$41	-$12	37%	-10%	56%
Silver	133 to 150%	11,763	11,838	$138	$180	$127	$43	-$11	31%	-8%	56%
Silver	150 to 200%	16,870	17,046	$220	$261	$206	$41	-$14	19%	-6%	57%
Silver	200 to 250%	9,335	9,436	$291	$327	$277	$36	-$15	12%	-5%	52%
Silver	250 to 300%	3,233	3,273	$385	$418	$364	$34	-$21	9%	-5%	47%
Silver	300 to 400%	1,980	2,029	$525	$545	$487	$20	-$38	4%	-7%	42%
Silver	Over 400%	1,602	1,669	$818	$721	$665	-$96	-$152	-12%	-19%	38%
Gold	Under 100%	38	38	$887	$826	$762	-$62	-$126	-7%	-14%	46%
Gold	100 to 133%	47	48	$330	$353	$286	$24	-$44	7%	-13%	46%
Gold	133 to 150%	66	67	$328	$349	$289	$21	-$39	6%	-12%	46%
Gold	150 to 200%	376	379	$432	$454	$390	$22	-$42	5%	-10%	46%
Gold	200 to 250%	955	966	$458	$476	$418	$19	-$39	4%	-9%	41%
Gold	250 to 300%	703	711	$545	$560	$499	$15	-$45	3%	-8%	36%
Gold	300 to 400%	471	482	$695	$682	$619	-$13	-$76	-2%	-11%	32%
Gold	Over 400%	985	1,023	$902	$806	$743	-$96	-$159	-11%	-18%	27%

APPENDIX A

Actuarial Certification

Appendix A

State of Nevada
Section 1332 Waiver Application
Actuarial Certification

I, Frederick S. Busch, Principal and Consulting Actuary with the firm of Milliman, Inc., am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the standards of practice established by the Actuarial Standards Board. I have been employed by the State of Nevada through a subcontracting relationship with Manatt to perform an actuarial analysis and certification regarding the State of Nevada's operation of a Public Option (PO) program under a Section 1332 State Relief and Empowerment Waiver. I am generally familiar with the federal requirements for Section 1332 waiver proposals, commercial health insurance rating rules, Medicaid eligibility, insurance exchanges, the Patient Protection and Affordable Care Act's premium assistance structure, and other components of the ACA relevant to this Section 1332 State Relief and Empowerment Waiver proposal.

As required under 45 CFR 155.1308 (f)(4)(i), this certification provides documentation that my actuarial analyses support the State of Nevada's finding that the 1332 waiver complies with the following requirements for Section 1332 waivers as defined under 45 CFR 155.1308 (f)(3)(iv)(a)-(c):

- The proposal will provide coverage to at least a comparable number of the state's residents as would be provided absent the waiver
- The proposal will provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable for the state's residents as would be provided absent the waiver
- The proposal will provide access to coverage that is at least as comprehensive for the state's residents as would be provided absent the waiver

The assumptions and methodology used in the development of the actuarial certification have been documented in my report provided to the State of Nevada. The actuarial certification provided with this report is for the period from January 1, 2026, through December 31, 2030. To the extent state or federal regulations are modified through the end of the waiver period, it may be necessary for this actuarial certification and corresponding analyses to be amended.

The actuarial analyses presented with this certification are based on a projection of future events. Actual experience may be expected to vary from the experience assumed in the analyses.

In developing the actuarial certification, I have relied upon data and information provided by the Silver State Health Insurance Exchange, publicly available federal government data sets and reports, population data coming from the American Community Survey, and statutory financial statement data downloaded through S&P Global Market Intelligence. I have relied upon these third parties for audit of the data. However, I did review the data for reasonableness and consistency.

Frederick S Busch

Frederick S. Busch, FSA
Member, American Academy of Actuaries

February 6, 2024
Date

APPENDIX B
State Legislation
See Full Waiver Application's Appendix B

APPENDIX C
State of Nevada Guidance Memorandum

Joe Lombardo
Governor

Richard Whitley, MS
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF HEALTH CARE FINANCING AND POLICY

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

Stacie Weeks, JD
MPH
Administrator

GENERAL GUIDANCE LETTER 23-003

Date: November 20, 2023

From: Richard Whitley, DHHS Director
Stacie Weeks, DHCFP Administrator

Subject: Notice of Revised Carrier Premium Reduction Targets for Plans Established in NRS 695K

PURPOSE: This letter serves as updated state guidance on the premium reduction targets as revised by the Director pursuant to NRS 695K.200, which were previously outlined in the Department's General Guidance Letter 22-001, published on October 4, 2022.

AUTHORITIES:

NRS 695K.200: [...]
5. The Director, in consultation with the Commissioner and the Executive Director of the Exchange, may revise the requirements of subsection 4, provided that the average premiums for the Public Option must be at least 15 percent lower than the average reference premium in this State over the first 4 years in which the Public Option is in operation.

APPLICATION:
As provided in state law, the new premium reduction requirements will be effective for the Plan Year that is effective on January 1, 2026. It will apply to all carriers that contract with the Department to offer the new health insurance options, established under Chapter NRS 695K, referred to as Battle Born State Plans (BBSPs). The updates to the premium reduction target, as described in this guidance, is reflective of the updated actuarial analysis and the findings from Milliman, Inc. about the addition of a reinsurance program as part of the State's updated Section 1332 Innovation Waiver proposal.[1] These findings are available in the State's Section 1332 Innovation Waiver and the Milliman Actuarial Analysis, 2023, and available at: https://dhcfp.nv.gov/marketstabilization/.

This guidance shall apply, unless otherwise revised by the Director, to the Department's 5-year contract period with carriers for the BBSP program, starting Calendar Year 2026. For future contract periods, the Director will issue additional guidance regarding any premium reduction targets deemed necessary for the success of the waiver programs.

Updated Premium Reduction Target for Plan Years 2026-2030 for Participating Carriers

Pursuant to the Director's broad and express authority in subsection 5 of NRS 695K.200, the Director establishes a premium reduction target for the new BBSPs for Plan Years 2026-2030 as follows:

[1] State law requires the Director to submit a 1332 Waiver

The annual premium cost of a carrier's BBSP (silver plan) in the Silver State Health Insurance Exchange (SSHIX) must be lower than the average reference premium ("the benchmark") in each county by a percentage that increases each Plan Year through Plan Year 2030, as outlined below and cannot increase more than the increase in Consumer Price Index for Medical Care plus any adjustments necessary to reflect local changes in utilization and morbidity:

- For Plan Year 2026, this percentage must be at least three percent lower than the benchmark.
- For Plan Year 2027 to Plan Year 2029, BBSP carriers must achieve a cumulative premium reduction of at least 15 percent as compared to the benchmark. For Plan Years 2027 and 2028, the premium reduction amounts will be negotiated by the Director as part of the procurement and contracting process with carriers with the goal of ensuring that the 15 percent overall reduction target is achieved by participating carriers by Plan Year 2029.
- For Plan Year 2030, carriers must maintain a 15 percent premium reduction as compared to the benchmark.

For the purposes of the premium reduction targets for Plan Years 2026-2030, the benchmark (average reference premium) shall mean "the second-lowest cost silver level plan available through the SSHIX during the 2024 plan year by county trended forward for inflation according to the Consumer Price Index for Medical Care and any adjustments to reflect local changes in utilization and morbidity."

Impact of State-Based Reinsurance Program

For Plan Years 2027, 2028, 2029, and 2030—the percentage of the premium reduction target will be inclusive of the impact of a state reinsurance program on premium costs. The reinsurance program is intended to account for a substantial portion of the required premium reductions beginning Plan Year 2027. For Plan Years 2027 and 2028, the premium reduction amounts will be negotiated by the Director as part of the procurement and contracting process with carriers with the goal of ensuring that the 15 percent overall reduction target is achieved by participating carriers.

APPENDIX D
CCIIO Checklist for Section 1332 State Relief and Empowerment Waivers

Appendix D

CCIIO Checklist for Section 1332 State Relief and Empowerment Waivers

The table below lists each item in the CCIIO Checklist for Section 1332 State Relief and Empowerment Waivers Applications (Updated July 2019)[37] and discusses how Nevada addresses each issue and/or directs the reader to other parts of this report.

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

[37] CMS (July 2019). Checklist for Section 1332 State Relief and Empowerment Waivers (also called Section 1332 waivers or State Innovation Waivers) Applications. Retrieved November 9, 2022, from https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Checklist-for-Section-1332-State-Relief-and_Empowerment-Waivers.pdf.

Appendix D

<table>
<tr><th></th><th>HHS Citation and Description</th><th>Actuary Response</th></tr>
<tr><td>5.</td><td>45 CFR 155.1308(f)(4)(i)-(iii)
Actuarial analyses and actuarial certifications

Economic analyses

Data and assumptions

*Note a state can combine the elements of an actuarial analysis and economic analysis into one report or submit separate actuarial and economic reports</td><td>1. See Appendix A for the actuarial certification.

i. See Section IV.B for a demonstration that the Nevada Section 1332 waiver complies with the coverage requirement.
a. See the Exhibits section
ii. See Sections IV.A and IV.C for a demonstration that the Nevada Section 1332 waiver complies with the comprehensiveness and affordability requirements.
a. See the Exhibits section
b. See the Exhibits section

2. See Section V

3. See Section VI

The Nevada 1332 waiver impacts the individual market. The baseline projection and a comparison to the projection under the waiver are included in Sections IV and V.

The required analyses are included as noted below:

▪ Exhibit 3: Non-group market enrollees by income as a share of FPL.

▪ Exhibit 1: Overall average non-group market premium rate.

▪ Exhibit 2: SLCS plan rate.

▪ The State of Nevada uses the federal default age rating curve.

▪ Section V: Aggregate premiums and PTC.

▪ The State of Nevada uses a state-based platform. Costs are assumed to be the same both with and without the waiver.

▪ Sections IV through VI: Documentation of all assumptions and methodologies used to develop the projections and growth of healthcare spending.

Nevada is not considering establishing a Risk Stabilization Waiver Concept as part of this 1332 waiver application.</td></tr>
<tr><td>6.</td><td>45 CFR 155.1308(f)(4)(iv)
Draft timeline for implementation of the proposed waiver.</td><td>See Section 1D of waiver application</td></tr>
<tr><td>7.</td><td>45 CFR 155.1308(f)(4)(v)(A)-(E)
Additional Information.</td><td>See Section 5 of waiver application</td></tr>
<tr><td>8.</td><td>45 CFR 155.1308(f)(4)(vi)
Reporting targets.</td><td>See Section 5E of waiver application</td></tr>
<tr><td>9.</td><td>83 FR 53575
Administration's Principles.</td><td>Need from Manatt / Nevada</td></tr>
</table>

APPENDIX E
Sensitivity Test of 80% BBSP Take-up

Nevada Department of Health and Human Services
1332 Waiver Actuarial / Economic Analysis and Certification for NMSP

February 6, 2024

Appendix E-1
State of Nevada Market Stabilization Actuarial and Economic Analysis
Market Stabilization Scenario
Premiums and Member Subsidies Assuming 80% BBSP Take-up

	On-Exchange					
	PTC Eligible			Non-PTC Eligible	Off-Exchange	Total Individual Market
Year	Gross Premiums	APTC	Enrollee Net Premiums	Enrollee Gross Premiums	Enrollee Gross Premiums	Gross Premiums
2026	$618	$420	$198	$546	$520	$595
2027	$589	$387	$203	$517	$495	$566
2028	$601	$393	$208	$529	$505	$578
2029	$614	$400	$213	$541	$516	$590
2030	$637	$416	$221	$563	$535	$613
2031	$660	$432	$228	$582	$555	$635
2032	$685	$450	$236	$606	$576	$659
2033	$710	$467	$243	$627	$597	$683
2034	$737	$485	$252	$651	$620	$709
2035	$764	$504	$260	$679	$643	$736

Appendix E-2
State of Nevada Market Stabilization Actuarial and Economic Analysis
Market Stabilization Scenario
Impact of NMSP on Premium and Subsidies Assuming 80% BBSP Take-up

	On-Exchange					
	PTC Eligible			Non-PTC Eligible	Off-Exchange	Total Individual Market
Year	Gross Premiums	APTC	Enrollee Net Premiums	Enrollee Gross Premiums	Enrollee Gross Premiums	Gross Premiums
2026	(2.0%)	(3.9%)	2.5%	(6.4%)	(2.1%)	(2.2%)
2027	(10.1%)	(15.3%)	1.6%	(15.0%)	(10.5%)	(10.5%)
2028	(11.8%)	(17.3%)	0.9%	(16.5%)	(12.1%)	(12.2%)
2029	(13.4%)	(19.3%)	0.1%	(18.1%)	(13.7%)	(13.8%)
2030	(13.5%)	(19.4%)	0.2%	(17.6%)	(13.9%)	(13.9%)
2031	(13.9%)	(19.8%)	0.0%	(18.3%)	(14.1%)	(14.2%)
2032	(14.0%)	(19.9%)	0.0%	(18.2%)	(14.4%)	(14.4%)
2033	(14.2%)	(20.1%)	(0.2%)	(19.0%)	(14.6%)	(14.7%)
2034	(14.4%)	(20.4%)	(0.1%)	(19.4%)	(14.8%)	(14.9%)
2035	(14.7%)	(20.6%)	(0.2%)	(18.8%)	(15.1%)	(15.0%)

Appendix B: Nevada Legislation and Statute

Senate Bill No. 420–Senators Cannizzaro, Donate, Lange, Spearman; Brooks, Denis, Dondero Loop, D. Harris, Ohrenschall, Ratti and Scheible

Joint Sponsors: Assemblymen Benitez-Thompson and Frierson

CHAPTER..........

AN ACT relating to insurance; providing for the establishment of a public health benefit plan; prescribing certain goals and requirements relating to the plan; requiring certain health carriers to participate in a competitive bidding process to administer the plan; requiring certain providers of health care to participate in the plan; exempting rules and policies governing the plan from certain requirements; requiring the Executive Director of the Silver State Health Insurance Exchange to apply for a federal waiver to allow certain policies to be offered on the Exchange; requiring certain persons to report the abuse and neglect of older persons, vulnerable persons and children; requiring the State Plan for Medicaid to include coverage for the services of a community health worker and doula services; revising provisions relating to coverage of services for pregnant women under Medicaid; requiring the establishment of a statewide Medicaid managed care program if money is available; revising requirements relating to health insurance coverage of enteral formulas; making appropriations; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law requires the Department of Health and Human Services to administer the Medicaid program, which is a joint program of the state and federal governments to provide health coverage to indigent persons. (NRS 422.270, 439B.120) Existing law also creates the Silver State Health Insurance Exchange to assist natural persons and small businesses in purchasing health coverage. (Chapter 695I of NRS) **Section 10** of this bill requires the Director of the Department, in consultation with the Executive Director of the Exchange and the Commissioner of Insurance, to design, establish and operate a public health benefit plan known as the Public Option. **Section 2** of this bill sets forth the purposes of the Public Option, and **sections 3.5-9** of this bill define terms relevant to the Public Option. **Section 10** requires the Public Option to be available through the Exchange and for direct purchase and authorizes the Director to make the Public Option available to small employers in this State or their employees. **Section 10** requires the Public Option to meet the requirements established by federal and state law for individual health insurance or health insurance for small employers where applicable. **Section 10** also establishes requirements governing the levels of coverage provided by the Public Option and the premiums for the Public Option. **Sections 38 and 41** of this bill remove the requirements relating to premiums on January 1, 2030. **Section 11** of this bill requires the Director, the Commissioner and the Executive Director of the Exchange to apply for certain waivers to obtain federal financial support for the Public Option. **Section 39** of this bill requires the Director, the Commissioner and the Executive Director of the Exchange to contract for the performance of an actuarial study before submitting the initial waiver application. **Section 12** of this bill requires the Director to use a statewide competitive bidding process to solicit and enter into contracts with health carriers and other qualified persons to administer the Public Option. **Section 12** requires a health carrier that provides health care services to recipients of Medicaid through managed care to participate in the competitive bidding process. **Section 12** additionally authorizes the Director to directly administer the Public Option if necessary. **Sections 13, 21 and 29** of this bill require providers of health care, including health care facilities, who participate in Medicaid or the Public Employees' Benefits Program or provide care to injured employees under the State's workers' compensation program to enroll in the Public Option as a participating provider of health care. **Section 14** of this bill prescribes requirements governing the establishment of networks and the reimbursement of providers under the Public Option. **Section 15** of this bill establishes the Public Option Trust Fund to hold certain funds for the purpose of implementing the Public Option. **Section 20** of this bill exempts rules and policies governing the Public Option from provisions governing notice-and-comment rulemaking. **Sections 16, 19, 22, 32 and 34-37** of this bill make various changes so that the Public Option is treated similarly to comparable forms of public health insurance.

Section 16.5 of this bill requires the Executive Director of the Exchange to apply to the federal government for a waiver to authorize certain labor, agricultural and horticultural organizations to offer on the Exchange a policy of insurance to meet the unique needs of tradespersons that can serve as an alternative to the continuation of certain group health benefits. **Section 16.5** requires such a policy to be annually certified by the Executive Director in order to be offered on the Exchange. **Sections 16.3 and 16.8** of this bill make conforming changes to reflect the fact that a policy of insurance offered pursuant to **section 16.5** may not meet all requirements: (1) for individual health insurance prescribed by state law; or (2) to be considered a qualified health plan under federal law. **Section 39.5** of this bill requires the Executive Director to apply for the waiver and submit certain recommendations concerning such policies to the Legislature on or before January 1, 2025.

Sections 24-28 of this bill expand coverage under Medicaid in various manners. Specifically, **section 24** of this bill requires the Director of the Department to expand coverage under the State Plan for Medicaid for pregnant women by: (1) providing coverage for pregnant women whose household income is between 165 percent and 200 percent of the federally designated level signifying poverty if money is available; (2) providing that pregnant women who are determined by certain entities to qualify for Medicaid are presumptively eligible for Medicaid for a prescribed period of time, without submitting an application for enrollment in Medicaid which includes additional proof of eligibility; and (3) prohibiting the imposition of a requirement that a pregnant woman who is otherwise eligible for Medicaid and resides in this State must reside in the United States for a prescribed period of time before enrolling in Medicaid. **Section 25** of this bill requires Medicaid to cover the services of a community health worker who provides services under the supervision of a physician, physician assistant or advanced practice registered nurse. **Section 26** of this bill requires Medicaid to cover certain costs for doula services provided to Medicaid recipients by a doula who has enrolled with the Division of Health Care Financing and Policy of the Department. **Sections 17 and 33** of this bill require a registered doula to report the suspected abuse, neglect, exploitation, isolation or abandonment of older or vulnerable persons or the suspected abuse or neglect of a child. **Section 27** of this bill requires Medicaid to reimburse services provided to recipients of Medicaid who do not receive services through managed care by an advanced practice registered nurse to the same extent as if those services were provided by a physician if money is available to reimburse those services at those rates. If money is available, **section 28** of this bill requires Medicaid to cover breastfeeding supplies, certain prenatal screenings and tests and lactation consultation and support. **Section 18** of this bill makes a conforming change to indicate the proper placement of **sections 24-28** in the Nevada Revised Statutes.

Existing law establishes certain requirements that apply if a Medicaid managed care program is established in this State. (NRS 422.273) To the extent that money is available, **section 30** of this bill requires the Department to: (1) establish such a program to provide health care services to recipients of Medicaid in all geographic areas of this State; and (2) conduct a statewide procurement process to select health maintenance organizations to provide such services. To the extent that money is available, **section 30** requires the Medicaid managed care program to include a state-directed payment arrangement to require Medicaid managed care organizations to reimburse critical access hospitals and any affiliated federally-qualified health centers or rural health clinics for covered services at a rate that is equal to or greater than the rate those facilities receive for services provided to recipients of Medicaid on a fee-for-service basis.

Existing law requires certain health insurers, including local governments that adopt a system of group health insurance for their employees, to cover enteral formulas under certain conditions. (NRS 287.010, 689A.0423, 689B.0353, 695B.1923, 695C.1723) **Sections 16.35-16.47** of this bill specify that enteral formulas include formulas that are ingested orally. **Section 20.5** of this bill requires the Public Employees' Benefits Program to cover enteral formulas, including formulas that are ingested orally, under the same conditions as health insurers that are currently required to cover enteral formulas.

Section 38.3 of this bill appropriates money to the Division of Welfare and Supportive Services of the Department to pay the costs of making enhancements to its information technology system that are necessary to carry out the provisions of **sections 24-28** of this bill. **Sections 38.6 and 38.8** of this bill appropriate money to the Public Option Trust Fund and the Silver State Health Insurance Exchange, respectively, to implement the Public Option.

EXPLANATION – Matter in ***bolded italics*** is new; matter between brackets ~~[omitted material]~~ is material to be omitted.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Title 57 of NRS is hereby amended by adding thereto a new chapter to consist of the provisions set forth as sections 2 to 15, inclusive, of this act.

Sec. 2. ***It is hereby declared to be the purpose and policy of the Legislature in enacting this chapter to:***

1. Leverage the combined purchasing power of the State to lower premiums and costs relating to health insurance for residents of this State;

2. Improve access to high-quality, affordable health care for residents of this State, including residents of this State who are employed by small businesses;

3. Reduce disparities in access to health care and health outcomes and increase access to health care for historically marginalized communities; and

4. Increase competition in the market for individual health insurance in this State to improve the availability of coverage for residents of rural areas of this State.

Sec. 3. *As used in this chapter, unless the context otherwise requires, the words and terms defined in sections 3.5 to 9, inclusive, of this act have the meanings ascribed to them in those sections.*

Sec. 3.5. *"Certified community behavioral health clinic" means a community behavioral health clinic certified in accordance with section 223 of the Protecting Access to Medicare Act of 2014, Public Law No. 113-93.*

Sec. 4. *"Commissioner" means the Commissioner of Insurance.*

Sec. 5. *"Director" means the Director of the Department of Health and Human Services.*

Sec. 6. *"Exchange" means the Silver State Health Insurance Exchange.*

Sec. 6.5. *"Federally qualified health center" has the meaning ascribed to it in 42 C.F.R. § 405.2401.*

Sec. 7. *"Provider of health care" has the meaning ascribed to it in NRS 695G.070.*

Sec. 8. *"Public Option" means the Public Option established pursuant to section 10 of this act.*

Sec. 8.5. *"Rural health clinic" has the meaning ascribed to it in 42 C.F.R. § 405.2401.*

Sec. 9. *"Trust Fund" means the Public Option Trust Fund created by section 15 of this act.*

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

2. The Director:

(a) Shall make the Public Option available:

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

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

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

(c) Shall comply with all state and federal laws and regulations applicable to insurers when carrying out the provisions of sections 2 to 15, inclusive, of this act, to the extent that such laws and regulations are not waived.

3. The Public Option must:

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

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

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

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

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

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

6. As used in this section:

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

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

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

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

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

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

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

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

Sec. 11. *1. The Director, the Commissioner and the Executive Director of the Exchange:*

(a) Shall collaborate to apply to the Secretary of Health and Human Services for a waiver pursuant to 42 U.S.C. § 18052 to obtain pass-through federal funding to carry out the provisions of sections 2 to 15, inclusive, of this act; and

(b) Except as otherwise provided in subsection 4, may collaboratively apply to the Secretary of Health and Human Services for any other federal waivers or approval necessary to carry out the provisions of sections 2 to 15, inclusive, of this act, including, without limitation, and to the extent necessary, a waiver pursuant to 42 U.S.C. § 1315 of Title XIX of the Social Security Act. Such waivers or approval may include, without limitation, any waiver or approval necessary to:

(1) Combine risk pools for the Public Option with risk pools established for Medicaid, if the Director can demonstrate that doing so would lower costs, result in savings to the federal and state governments and not increase the costs of private insurance or Medicaid; or

(2) Obtain federal financial participation to subsidize the cost of health insurance for residents of this State with low incomes.

2. In preparing an application for any waiver described in subsection 1, the Director, the Commissioner and the Executive Director of the Exchange may contract with an independent actuary to assess the impact of the Public Option on the markets for health care and health insurance in this State and health coverage for natural persons, families and small businesses. The *actuary must have specialized expertise or experience with state health insurance exchanges, the type of waiver for which the application is being made, measures to contain the costs of providing health coverage, reforming procedures for the purchasing and delivery of government services and Medicaid managed care programs. A contract pursuant to this subsection is exempt from the provisions of chapter 333 of NRS.*

3. The Director, the Commissioner and the Executive Director of the Exchange shall:

(a) Cooperate with the Federal Government in obtaining any waiver for which he or she applies pursuant to this section.

(b) Deposit any money received from the Federal Government pursuant to such a waiver in the Trust Fund.

4. The Director, the Commissioner and the Executive Director of the Exchange shall not apply under the provisions of subsection 1 to waive any provision of federal law prescribing conditions of eligibility to purchase a qualified health plan, as defined in 42 U.S.C. § 18021, through the Exchange or receive federal advanced payment of premium tax credits pursuant to 42 U.S.C. § 18082 for such a purchase.

5. The Director may:

(a) Accept gifts, grants and donations to carry out the provisions of sections 2 to 15, inclusive, of this act. The Director shall deposit any such gifts, grants or donations in the Trust Fund.

(b) Employ or enter into contracts with actuaries and other professionals and may enter into contracts with other state agencies, health carriers or other qualified persons and entities as are necessary to carry out the provisions of sections 2 to 15, inclusive, of this act. Such contracts are exempt from the requirements of chapter 333 of NRS.

Sec. 12. *1. The Director, in consultation with the Commissioner and the Executive Director of the Exchange, shall use a statewide competitive bidding process, including, without limitation, a request for proposals, to solicit and enter into contracts with health carriers or other qualified persons or entities to administer the Public Option. If a statewide Medicaid managed care program is established pursuant to subsection 1 of NRS 422.273, the competitive bidding process must coincide with the statewide procurement process for that Medicaid managed care program.*

2. Each health carrier that provides health care services through managed care to recipients of Medicaid under the State

Plan for Medicaid or the Children's Health Insurance Program shall, as a condition of continued participation in any Medicaid managed care program established in this State, submit a good faith proposal in response to a request for proposals issued pursuant to subsection 1.

3. Each proposal submitted pursuant to subsection 2 must demonstrate that the applicant is able to meet the requirements of section 10 of this act.

4. When selecting a health carrier or other qualified person or entity to administer the Public Option, the Director shall prioritize applicants whose proposals:

(a) Demonstrate alignment of networks of providers between the Public Option and Medicaid managed care, where applicable;

(b) Provide for the inclusion of critical access hospitals, rural health clinics, certified community behavioral health clinics and federally-qualified health centers in the networks of providers for the Public Option and Medicaid managed care, where applicable;

(c) Include proposals for strengthening the workforce in this State and particularly in rural areas of this State for providers of primary care, mental health care and treatment for substance use disorders;

(d) Use payment models for providers included in the networks of providers for the Public Option that increase value for persons enrolled in the Public Option and the State; and

(e) Include proposals to contract with providers of health care in a manner that decreases disparities among different populations in this State with regard to access to health care and health outcomes and supports culturally competent care.

5. Notwithstanding the provisions of subsections 1 to 4, inclusive, the Director may directly administer the Public Option if necessary to carry out the provisions of sections 2 to 15, inclusive, of this act.

6. Any health carrier or other person or entity with which the Director contracts to administer the Public Option pursuant to this section or the Director, if the Director directly administers the Public Option pursuant to subsection 5, shall take any measures necessary to make the Public Option available as described in paragraph (a) of subsection 2 of section 10 of this act and, if required by the Director, paragraph (b) of that subsection. Such measures include, without limitation:

(a) Filing rates and supporting information with the Commissioner of Insurance as required by NRS 686B.010 to 686B.1799, inclusive; and

(b) Obtaining certification as a qualified health plan pursuant to 42 U.S.C. § 18031.

7. The Director shall deposit into the Trust Fund any money received from:

(a) A health carrier or other person or entity with which the Director contracts to administer the Public Option pursuant to subsection 1 which relates to duties performed under the contract; or

(b) If the Director directly administers the Public Option pursuant to subsection 5, any money received from any person or entity in the course of administering the Public Option.

8. As used in this section:

(a) "Critical access hospital" means a hospital which has been certified as a critical access hospital by the Secretary of Health and Human Services pursuant to 42 U.S.C. § 1395i-4(e).

(b) "Health carrier" means an entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the Commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including, without limitation, a sickness and accident health insurance company, a health maintenance organization, a nonprofit hospital and health service corporation or any other entity providing a plan of health insurance, health benefits or health care services.

Sec. 13. *1. Except as otherwise provided in subsection 2, each provider of health care who participates in the Public Employees' Benefits Program established pursuant to subsection 1 of NRS 287.043 or the Medicaid program, or who provides care to an injured employee pursuant to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS, shall:*

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

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

2. The Director and the Executive Officer of the Public Employees' Benefits Program may waive the requirements of subsection 1 when necessary to ensure that recipients of Medicaid and officers, employees and retirees of this State who receive benefits under the Public Employees' Benefits Program have sufficient access to covered services.

Sec. 14. ***1. In establishing networks for the Public Option and reimbursing providers of health care that participate in the Public Option, the Director shall, to the extent practicable:***

(a) Ensure that care for persons who were previously covered by Medicaid or the Children's Health Insurance Program and enroll in the Public Option is minimally disrupted;

(b) Encourage the use of payment models that increase value for persons enrolled in the Public Option and the State;

(c) Improve health outcomes for persons enrolled in the Public Option;

(d) Reward providers of health care and medical facilities for delivering high-quality services; and

(e) Lower the cost of care in both urban and rural areas of this State.

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

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

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

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

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

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

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

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

Sec. 15. ***1. There is hereby created in the State Treasury the Public Option Trust Fund as a nonreverting trust fund. The Trust Fund must be administered by the State Treasurer.***

2. The Trust Fund consists of:

(a) Any money deposited in the Trust Fund pursuant to sections 11 and 12 of this act;

(b) Any money appropriated by the Legislature for the purpose of carrying out the provisions of sections 2 to 15, inclusive, of this act; and

(c) All income and interest earned on the money in the Trust Fund.

3. Any interest earned on money in the Trust Fund, after deducting any applicable charges, must be credited to the Trust Fund. Money that remains in the Trust Fund at the end of a fiscal year does not revert to the State General Fund, and the balance in the Trust Fund must be carried forward to the next fiscal year.

4. Except as otherwise provided in subsection 5, the money in the Trust Fund must be used to carry out the provisions of sections 2 to 15, inclusive, of this act. Such money must not be used to pay administrative costs that are not directly related to the operations of the Public Option.

5. If the State Treasurer determines that there is sufficient money in the Trust Fund to carry out the provisions of sections 2 to 15, inclusive, of this act, for the current fiscal year, the Director may use a portion determined by the State Treasurer of any additional money in the Trust Fund to increase the affordability of the Public Option.

Sec. 16. NRS 683A.176 is hereby amended to read as follows:

683A.176 "Third party" means:

1. An insurer, as that term is defined in NRS 679B.540;

2. A health benefit plan, as that term is defined in NRS 687B.470, for employees which provides a pharmacy benefits plan;

3. A participating public agency, as that term is defined in NRS 287.04052, and any other local governmental agency of the State of Nevada which provides a system of health insurance for the benefit

of its officers and employees, and the dependents of officers and employees, pursuant to chapter 287 of NRS; ~~[or]~~

4. ***The Public Option established pursuant to section 10 of this act; or***

5. Any other insurer or organization that provides health coverage or benefits or coverage of prescription drugs as part of workers' compensation insurance in accordance with state or federal law.

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

Sec. 16.3. NRS 689A.020 is hereby amended to read as follows:

689A.020 Nothing in this chapter applies to or affects:

1. Any policy of liability or workers' compensation insurance with or without supplementary expense coverage therein.
2. Any group or blanket policy.
3. Life insurance, endowment or annuity contracts, or contracts supplemental thereto which contain only such provisions relating to health insurance as to:

(a) Provide additional benefits in case of death or dismemberment or loss of sight by accident or accidental means; or

(b) Operate to safeguard such contracts against lapse, or to give a special surrender value or special benefit or an annuity if the insured or annuitant becomes totally and permanently disabled, as defined by the contract or supplemental contract.

4. Reinsurance, except as otherwise provided in NRS 689A.470 to 689A.740, inclusive, and 689C.610 to 689C.940, inclusive, relating to the program of reinsurance.

5. ***Any policy of insurance offered on the Silver State Health Insurance Exchange in accordance with section 16.5 of this act.***

Sec. 16.35. NRS 689A.0423 is hereby amended to read as follows:

689A.0423 1. A policy of health insurance must provide coverage for:

(a) Enteral formulas for use at home that are prescribed or ordered by a physician as medically necessary for the treatment of inherited metabolic diseases characterized by deficient metabolism, or malabsorption originating from congenital defects or defects arising shortly after birth, of amino acid, organic acid, carbohydrate or fat; and

(b) At least $2,500 per year for special food products which are prescribed or ordered by a physician as medically necessary for the treatment of a person described in paragraph (a).

2. The coverage required by subsection 1 must be provided whether or not the condition existed when the policy was purchased.

3. A policy subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after ~~[January]~~ ***July*** 1, ~~[1998,]~~ ***2021,*** has the legal effect of including the coverage required by this section, and any provision of the policy or the renewal which is in conflict with this section is void.

4. As used in this section:

(a) ***"Enteral formula" includes, without limitation, a formula that is ingested orally.***

(b) "Inherited metabolic disease" means a disease caused by an inherited abnormality of the body chemistry of a person.

~~[(b)]~~ ***(c)*** "Special food product" means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be consumed under the direction of a physician for the dietary treatment of an inherited metabolic disease. The term does not include a food that is naturally low in protein.

Sec. 16.4. NRS 689B.0353 is hereby amended to read as follows:

689B.0353 1. A policy of group health insurance must provide coverage for:

(a) Enteral formulas for use at home that are prescribed or ordered by a physician as medically necessary for the treatment of inherited metabolic diseases characterized by deficient metabolism, or malabsorption originating from congenital defects or defects arising shortly after birth, of amino acid, organic acid, carbohydrate or fat; and

(b) At least $2,500 per year for special food products which are prescribed or ordered by a physician as medically necessary for the treatment of a person described in paragraph (a).

2. The coverage required by subsection 1 must be provided whether or not the condition existed when the policy was purchased.

3. A policy subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after ~~[January]~~ ***July*** 1, ~~[1998,]~~ ***2021,*** has the legal effect of including the coverage required by this section, and any provision of the policy or the renewal which is in conflict with this section is void.

4. As used in this section:

(a) ***"Enteral formula" includes, without limitation, a formula that is ingested orally.***

(b) "Inherited metabolic disease" means a disease caused by an inherited abnormality of the body chemistry of a person.

~~[(b)]~~ *(c)* "Special food product" means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be consumed under the direction of a physician for the dietary treatment of an inherited metabolic disease. The term does not include a food that is naturally low in protein.

Sec. 16.43. NRS 695B.1923 is hereby amended to read as follows:

695B.1923 1. A contract for hospital or medical service must provide coverage for:

(a) Enteral formulas for use at home that are prescribed or ordered by a physician as medically necessary for the treatment of inherited metabolic diseases characterized by deficient metabolism, or malabsorption originating from congenital defects or defects arising shortly after birth, of amino acid, organic acid, carbohydrate or fat; and

(b) At least $2,500 per year for special food products which are prescribed or ordered by a physician as medically necessary for the treatment of a person described in paragraph (a).

2. The coverage required by subsection 1 must be provided whether or not the condition existed when the contract was purchased.

3. A contract subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after ~~[January]~~ ***July*** 1, ~~[1998,]~~ ***2021,*** has the legal effect of including the coverage required by this section, and any provision of the contract or the renewal which is in conflict with this section is void.

4. As used in this section:

(a) ***"Enteral formula" includes, without limitation, a formula that is ingested orally.***

(b) "Inherited metabolic disease" means a disease caused by an inherited abnormality of the body chemistry of a person.

~~[(b)]~~ *(c)* "Special food product" means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be consumed under the direction of a physician for the dietary treatment of an inherited metabolic disease. The term does not include a food that is naturally low in protein.

Sec. 16.47. NRS 695C.1723 is hereby amended to read as follows:

695C.1723 1. A health maintenance plan must provide coverage for:

(a) Enteral formulas for use at home that are prescribed or ordered by a physician as medically necessary for the treatment of inherited metabolic diseases characterized by deficient metabolism, or malabsorption originating from congenital defects or defects arising shortly after birth, of amino acid, organic acid, carbohydrate or fat; and

(b) At least $2,500 per year for special food products which are prescribed or ordered by a physician as medically necessary for the treatment of a person described in paragraph (a).

2. The coverage required by subsection 1 must be provided whether or not the condition existed when the health maintenance plan was purchased.

3. Any evidence of coverage subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after ~~[January]~~ ***July*** 1, ~~[1998,]~~ ***2021,*** has the legal effect of including the coverage required by this section, and any provision of the evidence of coverage or the renewal which is in conflict with this section is void.

4. As used in this section:

(a) ***"Enteral formula" includes, without limitation, a formula that is ingested orally.***

(b) "Inherited metabolic disease" means a disease caused by an inherited abnormality of the body chemistry of a person.

~~[(b)]~~ ***(c)*** "Special food product" means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be consumed under the direction of a physician for the dietary treatment of an inherited metabolic disease. The term does not include a food that is naturally low in protein.

Sec. 16.5. Chapter 695I of NRS is hereby amended by adding thereto a new section to read as follows:

1. The Executive Director, in collaboration with the Director of the Department of Health and Human Services, shall apply to the Secretary of Health and Human Services for a waiver pursuant to 42 U.S.C. § 18052 to authorize an organization described in section 501(c)(5) of the Internal Revenue Code that processes health claims in this State to offer on the Exchange a policy of insurance to meet the unique needs of tradespersons, including, without limitation, persons who work temporary or seasonal jobs, that is capable of serving as an alternative to the continuation of group health benefits under the Consolidated Omnibus Budget Reconciliation Act of 1985.

2. The application for a waiver submitted pursuant to subsection 1 must include, without limitation, an application for a waiver of any provisions of federal law or regulations that would otherwise require a policy described in subsection 1 to meet the requirements of chapter 689A of NRS in order to be offered on the

Exchange or for persons who purchase the plan on the Exchange to receive applicable federal subsidies.

3. To be offered on the Exchange, a policy of insurance described in subsection 1 must:

(a) Meet all requirements established by the Federal Act for a qualified health plan, to the extent that those requirements do not prevent an organization described in section 501(c)(5) of the Internal Revenue Code from offering such a policy; and

(b) Be certified by the Executive Director. Such certification must be renewed annually.

4. The Executive Director shall prescribe:

(a) Requirements for certification of a policy of insurance pursuant to paragraph (b) of subsection 3; and

(b) Criteria to determine when a person becomes eligible for a policy of insurance described in subsection 1. Those criteria must address:

(1) Persons who recently began employment but have not yet met the requirements concerning hours of work necessary to receive insurance through their employer; and

(2) Persons who have recently lost their jobs.

5. When performing the duties described in subsections 1 and 4, the Executive Director shall consult with organizations described in section 501(c)(5) of the Internal Revenue Code and other interested persons and entities concerning the requirements for certification of a policy of insurance described in subsection 1 and the criteria described in paragraph (b) of subsection 4.

Sec. 16.8. NRS 695I.210 is hereby amended to read as follows:

695I.210 1. The Exchange shall:

(a) Create and administer a health insurance exchange;

(b) Facilitate the purchase and sale of qualified health plans consistent with established patterns of care within the State;

(c) Provide for the establishment of a program to assist qualified small employers in Nevada in facilitating the enrollment of their employees in qualified health plans offered in the small group market;

(d) ~~[Make]~~ ***Except as otherwise authorized by a waiver obtained pursuant to section 16.5 of this act, make*** only qualified health plans available to qualified individuals and qualified small employers ***;*** ~~[on or after January 1, 2014;]~~ and

(e) Unless the Federal Act is repealed or is held to be unconstitutional or otherwise invalid or unlawful, perform all duties that are required of the Exchange to implement the requirements of the Federal Act.

2. The Exchange may:

(a) Enter into contracts with any person, including, without limitation, a local government, a political subdivision of a local government and a governmental agency, to assist in carrying out the duties and powers of the Exchange or the Board; and

(b) Apply for and accept any gift, donation, bequest, grant or other source of money to carry out the duties and powers of the Exchange or the Board.

3. The Exchange is subject to the provisions of chapter 333 of NRS.

Sec. 17. NRS 200.5093 is hereby amended to read as follows:

200.5093 1. Any person who is described in subsection 4 and who, in a professional or occupational capacity, knows or has reasonable cause to believe that an older person or vulnerable person has been abused, neglected, exploited, isolated or abandoned shall:

(a) Except as otherwise provided in subsection 2, report the abuse, neglect, exploitation, isolation or abandonment of the older person or vulnerable person to:

(1) The local office of the Aging and Disability Services Division of the Department of Health and Human Services;

(2) A police department or sheriff's office; or

(3) A toll-free telephone service designated by the Aging and Disability Services Division of the Department of Health and Human Services; and

(b) Make such a report as soon as reasonably practicable but not later than 24 hours after the person knows or has reasonable cause to believe that the older person or vulnerable person has been abused, neglected, exploited, isolated or abandoned.

2. If a person who is required to make a report pursuant to subsection 1 knows or has reasonable cause to believe that the abuse, neglect, exploitation, isolation or abandonment of the older person or vulnerable person involves an act or omission of the Aging and Disability Services Division, another division of the Department of Health and Human Services or a law enforcement agency, the person shall make the report to an agency other than the one alleged to have committed the act or omission.

3. Each agency, after reducing a report to writing, shall forward a copy of the report to the Aging and Disability Services Division of the Department of Health and Human Services and the Unit for the Investigation and Prosecution of Crimes.

4. A report must be made pursuant to subsection 1 by the following persons:

(a) Every physician, dentist, dental hygienist, chiropractor, optometrist, podiatric physician, medical examiner, resident, intern, professional or practical nurse, physician assistant licensed pursuant to chapter 630 or 633 of NRS, perfusionist, psychiatrist, psychologist, marriage and family therapist, clinical professional counselor, clinical alcohol and drug counselor, alcohol and drug counselor, music therapist, athletic trainer, driver of an ambulance, paramedic, licensed dietitian, holder of a license or a limited license issued under the provisions of chapter 653 of NRS or other person providing medical services licensed or certified to practice in this State, who examines, attends or treats an older person or vulnerable person who appears to have been abused, neglected, exploited, isolated or abandoned.

(b) Any personnel of a hospital or similar institution engaged in the admission, examination, care or treatment of persons or an administrator, manager or other person in charge of a hospital or similar institution upon notification of the suspected abuse, neglect, exploitation, isolation or abandonment of an older person or vulnerable person by a member of the staff of the hospital.

(c) A coroner.

(d) Every person who maintains or is employed by an agency to provide personal care services in the home.

(e) Every person who maintains or is employed by an agency to provide nursing in the home.

(f) Every person who operates, who is employed by or who contracts to provide services for an intermediary service organization as defined in NRS 449.4304.

(g) Any employee of the Department of Health and Human Services, except the State Long-Term Care Ombudsman appointed pursuant to NRS 427A.125 and any of his or her advocates or volunteers where prohibited from making such a report pursuant to 45 C.F.R. § 1321.11.

(h) Any employee of a law enforcement agency or a county's office for protective services or an adult or juvenile probation officer.

(i) Any person who maintains or is employed by a facility or establishment that provides care for older persons or vulnerable persons.

(j) Any person who maintains, is employed by or serves as a volunteer for an agency or service which advises persons regarding the abuse, neglect, exploitation, isolation or abandonment of an older person or vulnerable person and refers them to persons and agencies where their requests and needs can be met.

(k) Every social worker.

(l) Any person who owns or is employed by a funeral home or mortuary.

(m) Every person who operates or is employed by a peer support recovery organization, as defined in NRS 449.01563.

(n) Every person who operates or is employed by a community health worker pool, as defined in NRS 449.0028, or with whom a community health worker pool contracts to provide the services of a community health worker, as defined in NRS 449.0027.

(o) Every person who is enrolled with the Division of Health Care Financing and Policy of the Department of Health and Human Services to provide doula services to recipients of Medicaid pursuant to section 26 of this act.

5. A report may be made by any other person.

6. If a person who is required to make a report pursuant to subsection 1 knows or has reasonable cause to believe that an older person or vulnerable person has died as a result of abuse, neglect, isolation or abandonment, the person shall, as soon as reasonably practicable, report this belief to the appropriate medical examiner or coroner, who shall investigate the cause of death of the older person or vulnerable person and submit to the appropriate local law enforcement agencies, the appropriate prosecuting attorney, the Aging and Disability Services Division of the Department of Health and Human Services and the Unit for the Investigation and Prosecution of Crimes his or her written findings. The written findings must include the information required pursuant to the provisions of NRS 200.5094, when possible.

7. A division, office or department which receives a report pursuant to this section shall cause the investigation of the report to commence within 3 working days. A copy of the final report of the investigation conducted by a division, office or department, other than the Aging and Disability Services Division of the Department of Health and Human Services, must be forwarded within 30 days after the completion of the report to the:

(a) Aging and Disability Services Division;

(b) Repository for Information Concerning Crimes Against Older Persons or Vulnerable Persons created by NRS 179A.450; and

(c) Unit for the Investigation and Prosecution of Crimes.

8. If the investigation of a report results in the belief that an older person or vulnerable person is abused, neglected, exploited,

isolated or abandoned, the Aging and Disability Services Division of the Department of Health and Human Services or the county's office for protective services may provide protective services to the older person or vulnerable person if the older person or vulnerable person is able and willing to accept them.

9. A person who knowingly and willfully violates any of the provisions of this section is guilty of a misdemeanor.

10. As used in this section, "Unit for the Investigation and Prosecution of Crimes" means the Unit for the Investigation and Prosecution of Crimes Against Older Persons or Vulnerable Persons in the Office of the Attorney General created pursuant to NRS 228.265.

Sec. 18. NRS 232.320 is hereby amended to read as follows:

232.320 1. The Director:

(a) Shall appoint, with the consent of the Governor, administrators of the divisions of the Department, who are respectively designated as follows:

(1) The Administrator of the Aging and Disability Services Division;

(2) The Administrator of the Division of Welfare and Supportive Services;

(3) The Administrator of the Division of Child and Family Services;

(4) The Administrator of the Division of Health Care Financing and Policy; and

(5) The Administrator of the Division of Public and Behavioral Health.

(b) Shall administer, through the divisions of the Department, the provisions of chapters 63, 424, 425, 427A, 432A to 442, inclusive, 446 to 450, inclusive, 458A and 656A of NRS, NRS 127.220 to 127.310, inclusive, 422.001 to 422.410, inclusive, ***and sections 24 to 28, inclusive, of this act,*** 422.580, 432.010 to 432.133, inclusive, 432B.6201 to 432B.626, inclusive, 444.002 to 444.430, inclusive, and 445A.010 to 445A.055, inclusive, and all other provisions of law relating to the functions of the divisions of the Department, but is not responsible for the clinical activities of the Division of Public and Behavioral Health or the professional line activities of the other divisions.

(c) Shall administer any state program for persons with developmental disabilities established pursuant to the Developmental Disabilities Assistance and Bill of Rights Act of 2000, 42 U.S.C. §§ 15001 et seq.

(d) Shall, after considering advice from agencies of local governments and nonprofit organizations which provide social services, adopt a master plan for the provision of human services in this State. The Director shall revise the plan biennially and deliver a copy of the plan to the Governor and the Legislature at the beginning of each regular session. The plan must:

(1) Identify and assess the plans and programs of the Department for the provision of human services, and any duplication of those services by federal, state and local agencies;

(2) Set forth priorities for the provision of those services;

(3) Provide for communication and the coordination of those services among nonprofit organizations, agencies of local government, the State and the Federal Government;

(4) Identify the sources of funding for services provided by the Department and the allocation of that funding;

(5) Set forth sufficient information to assist the Department in providing those services and in the planning and budgeting for the future provision of those services; and

(6) Contain any other information necessary for the Department to communicate effectively with the Federal Government concerning demographic trends, formulas for the distribution of federal money and any need for the modification of programs administered by the Department.

(e) May, by regulation, require nonprofit organizations and state and local governmental agencies to provide information regarding the programs of those organizations and agencies, excluding detailed information relating to their budgets and payrolls, which the Director deems necessary for the performance of the duties imposed upon him or her pursuant to this section.

(f) Has such other powers and duties as are provided by law.

2. Notwithstanding any other provision of law, the Director, or the Director's designee, is responsible for appointing and removing subordinate officers and employees of the Department.

Sec. 19. NRS 232.459 is hereby amended to read as follows:

232.459 1. The Advocate shall:

(a) Respond to written and telephonic inquiries received from consumers and injured employees regarding concerns and problems related to health care and workers' compensation;

(b) Assist consumers and injured employees in understanding their rights and responsibilities under health care plans, including, without limitation, the Public Employees' Benefits Program ~~[,]~~ ***and the Public Option,*** and policies of industrial insurance;

(c) Identify and investigate complaints of consumers and injured employees regarding their health care plans, including, without limitation, the Public Employees' Benefits Program ~~[,]~~ ***and the Public Option,*** and policies of industrial insurance and assist those consumers and injured employees to resolve their complaints, including, without limitation:

(1) Referring consumers and injured employees to the appropriate agency, department or other entity that is responsible for addressing the specific complaint of the consumer or injured employee; and

(2) Providing counseling and assistance to consumers and injured employees concerning health care plans, including, without limitation, the Public Employees' Benefits Program ~~[,]~~ ***and the Public Option,*** and policies of industrial insurance;

(d) Provide information to consumers and injured employees concerning health care plans, including, without limitation, the Public Employees' Benefits Program ~~[,]~~ ***and the Public Option,*** and policies of industrial insurance in this State;

(e) Establish and maintain a system to collect and maintain information pertaining to the written and telephonic inquiries received by the Office for Consumer Health Assistance;

(f) Take such actions as are necessary to ensure public awareness of the existence and purpose of the services provided by the Advocate pursuant to this section;

(g) In appropriate cases and pursuant to the direction of the Advocate, refer a complaint or the results of an investigation to the Attorney General for further action;

(h) Provide information to and applications for prescription drug programs for consumers without insurance coverage for prescription drugs or pharmaceutical services;

(i) Establish and maintain an Internet website which includes:

(1) Information concerning purchasing prescription drugs from Canadian pharmacies that have been recommended by the State Board of Pharmacy for inclusion on the Internet website pursuant to subsection 4 of NRS 639.2328;

(2) Links to websites of Canadian pharmacies which have been recommended by the State Board of Pharmacy for inclusion on the Internet website pursuant to subsection 4 of NRS 639.2328; and

(3) A link to the website established and maintained pursuant to NRS 439A.270 which provides information to the general public concerning the charges imposed and the quality of the services provided by the hospitals and surgical centers for ambulatory patients in this State;

(j) Assist consumers with accessing a navigator, case manager or facilitator to help the consumer obtain health care services;

(k) Assist consumers with scheduling an appointment with a provider of health care who is in the network of providers under contract to provide services to participants in the health care plan under which the consumer is covered;

(l) Assist consumers with filing complaints against health care facilities and health care professionals;

(m) Assist consumers with filing complaints with the Commissioner of Insurance against issuers of health care plans; and

(n) On or before January 31 of each year, compile a report of aggregated information submitted to the Office for Consumer Health Assistance pursuant to NRS 687B.675, aggregated for each type of provider of health care for which such information is provided and submit the report to the Director of the Legislative Counsel Bureau for transmittal to:

(1) In even-numbered years, the Legislative Committee on Health Care; and

(2) In odd-numbered years, the next regular session of the Legislature.

2. The Advocate may adopt regulations to carry out the provisions of this section and NRS 232.461 and 232.462.

3. As used in this section:

(a) "Health care facility" has the meaning ascribed to it in NRS 162A.740.

(b) "Navigator, case manager or facilitator" has the meaning ascribed to it in NRS 687B.675.

(c) "Public Option" means the Public Option established pursuant to section 10 of this act.

Sec. 20. NRS 233B.039 is hereby amended to read as follows:

233B.039 1. The following agencies are entirely exempted from the requirements of this chapter:

(a) The Governor.

(b) Except as otherwise provided in NRS 209.221, the Department of Corrections.

(c) The Nevada System of Higher Education.

(d) The Office of the Military.

(e) The Nevada Gaming Control Board.

(f) Except as otherwise provided in NRS 368A.140 and 463.765, the Nevada Gaming Commission.

(g) Except as otherwise provided in NRS 425.620, the Division of Welfare and Supportive Services of the Department of Health and Human Services.

(h) Except as otherwise provided in NRS 422.390, the Division of Health Care Financing and Policy of the Department of Health and Human Services.

(i) Except as otherwise provided in NRS 533.365, the Office of the State Engineer.

(j) The Division of Industrial Relations of the Department of Business and Industry acting to enforce the provisions of NRS 618.375.

(k) The Administrator of the Division of Industrial Relations of the Department of Business and Industry in establishing and adjusting the schedule of fees and charges for accident benefits pursuant to subsection 2 of NRS 616C.260.

(l) The Board to Review Claims in adopting resolutions to carry out its duties pursuant to NRS 445C.310.

(m) The Silver State Health Insurance Exchange.

(n) The Cannabis Compliance Board.

2. Except as otherwise provided in subsection 5 and NRS 391.323, the Department of Education, the Board of the Public Employees' Benefits Program and the Commission on Professional Standards in Education are subject to the provisions of this chapter for the purpose of adopting regulations but not with respect to any contested case.

3. The special provisions of:

(a) Chapter 612 of NRS for the adoption of an emergency regulation or the distribution of regulations by and the judicial review of decisions of the Employment Security Division of the Department of Employment, Training and Rehabilitation;

(b) Chapters 616A to 617, inclusive, of NRS for the determination of contested claims;

(c) Chapter 91 of NRS for the judicial review of decisions of the Administrator of the Securities Division of the Office of the Secretary of State; and

(d) NRS 90.800 for the use of summary orders in contested cases,

➥ prevail over the general provisions of this chapter.

4. The provisions of NRS 233B.122, 233B.124, 233B.125 and 233B.126 do not apply to the Department of Health and Human Services in the adjudication of contested cases involving the issuance of letters of approval for health facilities and agencies.

5. The provisions of this chapter do not apply to:

(a) Any order for immediate action, including, but not limited to, quarantine and the treatment or cleansing of infected or infested animals, objects or premises, made under the authority of the State

Board of Agriculture, the State Board of Health, or any other agency of this State in the discharge of a responsibility for the preservation of human or animal health or for insect or pest control;

(b) An extraordinary regulation of the State Board of Pharmacy adopted pursuant to NRS 453.2184;

(c) A regulation adopted by the State Board of Education pursuant to NRS 388.255 or 394.1694;

(d) The judicial review of decisions of the Public Utilities Commission of Nevada;

(e) The adoption, amendment or repeal of policies by the Rehabilitation Division of the Department of Employment, Training and Rehabilitation pursuant to NRS 426.561 or 615.178;

(f) The adoption or amendment of a rule or regulation to be included in the State Plan for Services for Victims of Crime by the Department of Health and Human Services pursuant to NRS 217.130;

(g) The adoption, amendment or repeal of rules governing the conduct of contests and exhibitions of unarmed combat by the Nevada Athletic Commission pursuant to NRS 467.075; ~~[or]~~

(h) The adoption, amendment or repeal of regulations by the Director of the Department of Health and Human Services pursuant to NRS 447.335 to 447.350, inclusive ~~[.]~~ ***; or***

(i) The adoption, amendment or repeal of any rule or policy governing the Public Option established pursuant to the chapter created by sections 2 to 15, inclusive, of this act.

6. The State Board of Parole Commissioners is subject to the provisions of this chapter for the purpose of adopting regulations but not with respect to any contested case.

Sec. 20.5. NRS 287.04335 is hereby amended to read as follows:

287.04335 If the Board provides health insurance through a plan of self-insurance, it shall comply with the provisions of NRS 687B.409, ***689B.0353,*** 689B.255, ***695C.1723,*** 695G.150, 695G.155, 695G.160, 695G.162, 695G.164, 695G.1645, 695G.1665, 695G.167, 695G.170 to 695G.174, inclusive, 695G.177, 695G.200 to 695G.230, inclusive, 695G.241 to 695G.310, inclusive, and 695G.405, in the same manner as an insurer that is licensed pursuant to title 57 of NRS is required to comply with those provisions.

Sec. 21. NRS 287.0434 is hereby amended to read as follows:

287.0434 The Board may:

1. Use its assets only to pay the expenses of health care for its members and covered dependents, to pay its employees' salaries and to pay administrative and other expenses.

2. Enter into contracts relating to the administration of the Program, including, without limitation, contracts with licensed administrators and qualified actuaries. Each such contract with a licensed administrator:

(a) Must be submitted to the Commissioner of Insurance not less than 30 days before the date on which the contract is to become effective for approval as to the licensing and fiscal status of the licensed administrator and status of any legal or administrative actions in this State against the licensed administrator that may impair his or her ability to provide the services in the contract.

(b) Does not become effective unless approved by the Commissioner.

(c) Shall be deemed to be approved if not disapproved by the Commissioner within 30 days after its submission.

3. Enter into contracts with physicians, surgeons, hospitals, health maintenance organizations and rehabilitative facilities for medical, surgical and rehabilitative care and the evaluation, treatment and nursing care of members and covered dependents. The Board shall not enter into a contract pursuant to this subsection unless:

(a) Provision is made by the Board to offer all the services specified in the request for proposals, either by a health maintenance organization or through separate action of the Board.

(b) The rates set forth in the contract are based on:

(1) For active and retired state officers and employees and their dependents, the commingled claims experience of such active and retired officers and employees and their dependents for whom the Program provides primary health insurance coverage in a single risk pool; and

(2) For active and retired officers and employees of public agencies enumerated in NRS 287.010 that contract with the Program to obtain group insurance by participation in the Program and their dependents, the commingled claims experience of such active and retired officers and employees and their dependents for whom the Program provides primary health insurance coverage in a single risk pool.

(c) For a contract with a physician, surgeon, hospital or rehabilitative facility, the physician, surgeon, hospital or rehabilitative facility has also complied with the requirements of section 13 of this act.

4. Enter into contracts for the services of other experts and specialists as required by the Program.

5. Charge and collect from an insurer, health maintenance organization, organization for dental care or nonprofit medical service corporation, a fee for the actual expenses incurred by the Board or a participating public agency in administering a plan of insurance offered by that insurer, organization or corporation.

6. Charge and collect the amount due from local governments pursuant to paragraph (b) of subsection 4 of NRS 287.023. If the payment of a local government pursuant to that provision is delinquent by more than 90 days, the Board shall notify the Executive Director of the Department of Taxation pursuant to NRS 354.671.

Sec. 22. NRS 333.705 is hereby amended to read as follows:

333.705 1. Except as otherwise provided in this section, a using agency shall not enter into a contract with a person to provide services for the using agency if:

(a) The person is a current employee of an agency of this State;

(b) The person is a former employee of an agency of this State and less than 2 years have expired since the termination of the person's employment with the State; or

(c) The person is employed by the Department of Transportation for a transportation project that is entirely funded by federal money and the term of the contract is for more than 4 years,

➥ unless the using agency submits a written disclosure to the State Board of Examiners indicating the services to be provided pursuant to the contract and the person who will be providing those services and, after reviewing the disclosure, the State Board of Examiners approves entering into a contract with the person. The requirements of this subsection apply to any person employed by a business or other entity that enters into a contract to provide services for a using agency if the person will be performing or producing the services for which the business or entity is employed.

2. The provisions of paragraph (b) of subsection 1 apply to employment through a temporary employment service. A temporary employment service providing employees for a using agency shall provide the using agency with the names of the employees to be provided to the agency. The State Board of Examiners shall not approve a contract pursuant to paragraph (b) of subsection 1 unless the Board determines that one or more of the following circumstances exist:

(a) The person provides services that are not provided by any other employee of the using agency or for which a critical labor shortage exists; or

(b) A short-term need or unusual economic circumstance exists for the using agency to contract with the person.

3. The approval by the State Board of Examiners to contract with a person pursuant to subsection 1:

(a) May occur at the same time and in the same manner as the approval by the State Board of Examiners of a proposed contract pursuant to subsection 7 of NRS 333.700; and

(b) Must occur before the date on which the contract becomes binding on the using agency.

4. A using agency may contract with a person pursuant to paragraph (a) or (b) of subsection 1 without obtaining the approval of the State Board of Examiners if the term of the contract is for less than 4 months and the head of the using agency determines that an emergency exists which necessitates the contract. If a using agency contracts with a person pursuant to this subsection, the using agency shall submit a copy of the contract and a description of the emergency to the State Board of Examiners, which shall review the contract and the description of the emergency and notify the using agency whether the State Board of Examiners would have approved the contract if it had not been entered into pursuant to this subsection.

5. Except as otherwise provided in subsection 9, a using agency shall, not later than 10 days after the end of each fiscal quarter, report to the Interim Finance Committee concerning all contracts to provide services for the using agency that were entered into by the using agency during the fiscal quarter with a person who is a current or former employee of a department, division or other agency of this State.

6. Except as otherwise provided in subsection 9, a using agency shall not contract with a temporary employment service unless the contracting process is controlled by rules of open competitive bidding.

7. Each board or commission of this State and each institution of the Nevada System of Higher Education that employs a consultant shall, at least once every 6 months, submit to the Interim Finance Committee a report setting forth:

(a) The number of consultants employed by the board, commission or institution;

(b) The purpose for which the board, commission or institution employs each consultant;

(c) The amount of money or other remuneration received by each consultant from the board, commission or institution; and

(d) The length of time each consultant has been employed by the board, commission or institution.

8. A using agency, board or commission of this State and each institution of the Nevada System of Higher Education:

(a) Shall make every effort to limit the number of contracts it enters into with persons to provide services which have a term of more than 2 years and which are in the amount of less than $1,000,000; and

(b) Shall not enter into a contract with a person to provide services without ensuring that the person is in active and good standing with the Secretary of State.

9. The provisions of subsections 1 to 6, inclusive, do not apply to:

(a) The Nevada System of Higher Education or a board or commission of this State.

(b) The employment of professional engineers by the Department of Transportation if those engineers are employed for a transportation project that is entirely funded by federal money.

(c) Contracts in the amount of $1,000,000 or more entered into:

(1) Pursuant to the State Plan for Medicaid established pursuant to NRS 422.063.

(2) For financial services.

(3) Pursuant to the Public Employees' Benefits Program.

(4) Pursuant to the Public Option established pursuant to section 10 of this act.

(d) The employment of a person by a business or entity which is a provider of services under the State Plan for Medicaid and which provides such services on a fee-for-service basis or through managed care.

(e) The employment of a former employee of an agency of this State who is not receiving retirement benefits under the Public Employees' Retirement System during the duration of the contract.

Sec. 23. Chapter 422 of NRS is hereby amended by adding thereto the provisions set forth as sections 24 to 28, inclusive, of this act.

Sec. 24. ***1. The Director shall, to the extent authorized by federal law, include in the State Plan for Medicaid authorization for a pregnant woman who is determined by a qualified provider to be presumptively eligible for Medicaid to enroll in Medicaid until the last day of the month immediately following the month of enrollment without submitting an application for enrollment in Medicaid which includes additional proof of eligibility.***

2. To the extent that money is available, the Director shall, to the extent authorized by federal law, include in the State Plan for Medicaid authorization for a pregnant woman whose household income is at or below 200 percent of the federally designated level signifying poverty to enroll in Medicaid.

3. Unless otherwise required by federal law, the Director shall not include in the State Plan for Medicaid a requirement that a pregnant woman who resides in this State and who is otherwise eligible for Medicaid must reside in the United States for a prescribed period of time before enrolling in Medicaid.

4. As used in this section, "qualified provider" has the meaning ascribed to it in 42 U.S.C. § 1396r-1(b)(2).

Sec. 25. *1. The Director shall include in the State Plan for Medicaid a requirement that the State, to the extent authorized by federal law, pay the nonfederal share of expenditures incurred for the services of a community health worker who provides services under the supervision of a physician, physician assistant or advanced practice registered nurse.*

2. As used in this section, "community health worker" has the meaning ascribed to it in NRS 449.0027.

Sec. 26. *1. The Director shall, to the extent authorized by federal law, include in the State Plan for Medicaid a requirement that the State pay the nonfederal share of expenditures incurred for doula services provided by an enrolled doula.*

2. The Department shall apply to the Secretary of Health and Human Services for a waiver granted pursuant to 42 U.S.C. § 1315 or apply for an amendment of the State Plan for Medicaid that authorizes the Department to receive federal funding to include in the State Plan for Medicaid coverage of doula services provided by an enrolled doula. The Department shall fully cooperate in good faith with the Federal Government during the application process to satisfy the requirements of the Federal Government for obtaining a waiver or amendment pursuant to this section.

3. A person who wishes to receive reimbursement through the Medicaid program for doula services provided to a recipient of Medicaid must submit to the Division:

(a) An application for enrollment in the form prescribed by the Division; and

(b) Proof that he or she possesses the required training and qualifications prescribed by the Division pursuant to subsection 4.

4. The Division, in consultation with community-based organizations that provide services to pregnant women in this

State, shall prescribe the required training and qualifications for enrollment pursuant to subsection 3 to receive reimbursement through Medicaid for doula services.

5. As used in this section:

(a) "Doula services" means services to provide education and support relating to childbirth, including, without limitation, emotional and physical support provided during pregnancy, labor, birth and the postpartum period.

(b) "Enrolled doula" means a doula who is enrolled with the Division pursuant to this section to receive reimbursement through Medicaid for doula services.

Sec. 27. ***1. To the extent that money is available, the Director shall include in the State Plan for Medicaid a requirement that, except as otherwise provided in subsection 2, the State must provide reimbursement for the services of an advanced practice registered nurse, including, without limitation, a certified nurse-midwife, to the same extent as if the services were provided by a physician.***

2. The provisions of subsection 1 do not apply to services provided to a recipient of Medicaid who receives health care services through a Medicaid managed care program.

3. As used in this section, "certified nurse-midwife" means a person who is:

(a) Certified as a nurse-midwife by the American Midwifery Certification Board, or its successor organization; and

(b) Licensed as an advanced practice registered nurse pursuant to NRS 632.237.

Sec. 28. ***1. To the extent that money is available, the Director shall include in the State Plan for Medicaid a requirement that the State pay the nonfederal share of expenditures incurred for:***

(a) Supplies for breastfeeding a child until the child's first birthday. Such supplies include, without limitation, electric or hospital-grade breast pumps that:

(1) Have been prescribed or ordered by a qualified provider of health care; and

(2) Are medically necessary for the mother or the child.

(b) Such prenatal screenings and tests as are recommended by the American College of Obstetricians and Gynecologists, or its successor organization.

2. The Director shall include in the State Plan for Medicaid a requirement that, to the extent that money and federal financial participation are available, the State must pay the nonfederal

share of expenditures incurred for lactation consultation and support.

3. As used in this section:

(a) "Medically necessary" has the meaning ascribed to it in NRS 695G.055.

(b) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 29. NRS 422.2372 is hereby amended to read as follows:

422.2372 The Administrator shall:

1. Supply the Director with material on which to base proposed legislation.

2. Cooperate with the Federal Government and state governments for the more effective attainment of the purposes of this chapter.

3. Coordinate the activities of the Division with other agencies, both public and private, with related or similar activities.

4. Keep a complete and accurate record of all proceedings, record and file all bonds and contracts, and assume responsibility for the custody and preservation of all papers and documents pertaining to the office of the Administrator.

5. Inform the public in regard to the activities and operation of the Division, and provide other information which will acquaint the public with the financing of Medicaid programs.

6. Conduct studies into the causes of the social problems with which the Division is concerned.

7. Invoke any legal, equitable or special procedures for the enforcement of orders issued by the Administrator or the enforcement of the provisions of this chapter.

8. ***Exclude from participation in Medicaid any provider of health care that fails to comply with the requirements of section 13 of this act.***

9. Exercise any other powers that are necessary and proper for the standardization of state work, to expedite business and to promote the efficiency of the service provided by the Division.

Sec. 30. NRS 422.273 is hereby amended to read as follows:

422.273 1. ***To the extent that money is available, the Department shall:***

(a) Establish a Medicaid managed care program to provide health care services to recipients of Medicaid in all geographic areas of this State. The program is not required to provide services to recipients of Medicaid who are aged, blind or disabled pursuant to Title XVI of the Social Security Act, 42 U.S.C. §§ 1381 et seq.

(b) Conduct a statewide procurement process to select health maintenance organizations to provide the services described in paragraph (a).

2. For any Medicaid managed care program established in the State of Nevada, the Department shall contract only with a health maintenance organization that has:

(a) Negotiated in good faith with a federally-qualified health center to provide health care services for the health maintenance organization;

(b) Negotiated in good faith with the University Medical Center of Southern Nevada to provide inpatient and ambulatory services to recipients of Medicaid; ~~[and]~~

(c) Negotiated in good faith with the University of Nevada School of Medicine to provide health care services to recipients of Medicaid ~~[.]~~ ***; and***

(d) Complied with the provisions of subsection 2 of section 12 of this act.

➥ Nothing in this section shall be construed as exempting a federally-qualified health center, the University Medical Center of Southern Nevada or the University of Nevada School of Medicine from the requirements for contracting with the health maintenance organization.

~~[2.]~~ ***3.*** During the development and implementation of any Medicaid managed care program, the Department shall cooperate with the University of Nevada School of Medicine by assisting in the provision of an adequate and diverse group of patients upon which the school may base its educational programs.

~~[3.]~~ ***4.*** The University of Nevada School of Medicine may establish a nonprofit organization to assist in any research necessary for the development of a Medicaid managed care program, receive and accept gifts, grants and donations to support such a program and assist in establishing educational services about the program for recipients of Medicaid.

~~[4.]~~ ***5.*** For the purpose of contracting with a Medicaid managed care program pursuant to this section, a health maintenance organization is exempt from the provisions of NRS 695C.123.

~~[5.]~~ ***6. To the extent that money is available, a Medicaid managed care program must include, without limitation, a state-directed payment arrangement established in accordance with 42 C.F.R. § 438.6(c) to require a Medicaid managed care organization to reimburse a critical access hospital and any federally-qualified health center or rural health clinic affiliated***

with a critical access hospital for covered services at a rate that is equal to or greater than the rate received by the critical access hospital, federally-qualified health center or rural health clinic, as applicable, for services provided to recipients of Medicaid on a fee-for-service basis.

7. The provisions of this section apply to any managed care organization, including a health maintenance organization, that provides health care services to recipients of Medicaid under the State Plan for Medicaid or the Children's Health Insurance Program pursuant to a contract with the Division. Such a managed care organization or health maintenance organization is not required to establish a system for conducting external reviews of adverse determinations in accordance with chapter 695B, 695C or 695G of NRS. This subsection does not exempt such a managed care organization or health maintenance organization for services provided pursuant to any other contract.

~~[6.]~~ *8.* As used in this section, unless the context otherwise requires:

(a) ***"Critical access hospital" means a hospital which has been certified as a critical access hospital by the Secretary of Health and Human Services pursuant to 42 U.S.C. § 1395i-4(e).***

(b) "Federally-qualified health center" has the meaning ascribed to it in 42 U.S.C. § 1396d(l)(2)(B).

~~[(b)]~~ *(c)* "Health maintenance organization" has the meaning ascribed to it in NRS 695C.030.

~~[(c)]~~ *(d)* "Managed care organization" has the meaning ascribed to it in NRS 695G.050.

(e) "Rural health clinic" has the meaning ascribed to it in 42 C.F.R. § 405.2401.

Sec. 31. (Deleted by amendment.)

Sec. 32. NRS 427A.605 is hereby amended to read as follows:

427A.605 1. The Director may establish a program to negotiate discounts and rebates for hearing devices and related costs, including, without limitation, ear molds, batteries and FM systems, for children in this State who are deaf or hard of hearing on behalf of entities described in subsection 2 who participate in the program.

2. The following persons and entities may participate in a program established pursuant to subsection 1:

(a) The Public Employees' Benefits Program;

(b) A governing body of a county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency that provides health coverage to employees through a self-insurance reserve fund pursuant to NRS 287.010;

(c) An insurer that holds a certificate of authority to transact insurance in this State pursuant to chapter 680A of NRS;

(d) An employer or employee organization based in this State that provides health coverage to employees through a self-insurance reserve fund;

(e) A governmental agency or nonprofit organization that purchases hearing devices for children in this State who are deaf or hard of hearing;

(f) A resident of this State who does not have coverage for hearing devices; ~~[and]~~

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

(h) Any other person or entity that provides health coverage or otherwise purchases hearing devices for children in this State who are deaf or hard of hearing.

3. A person or entity described in subsection 2 may participate in any program established pursuant to subsection 1 by submitting an application to the Department in the form prescribed by the Department.

Sec. 33. NRS 432B.220 is hereby amended to read as follows:

432B.220 1. Any person who is described in subsection 4 and who, in his or her professional or occupational capacity, knows or has reasonable cause to believe that a child has been abused or neglected shall:

(a) Except as otherwise provided in subsection 2, report the abuse or neglect of the child to an agency which provides child welfare services or to a law enforcement agency; and

(b) Make such a report as soon as reasonably practicable but not later than 24 hours after the person knows or has reasonable cause to believe that the child has been abused or neglected.

2. If a person who is required to make a report pursuant to subsection 1 knows or has reasonable cause to believe that the abuse or neglect of the child involves an act or omission of:

(a) A person directly responsible or serving as a volunteer for or an employee of a public or private home, institution or facility where the child is receiving child care outside of the home for a portion of the day, the person shall make the report to a law enforcement agency.

(b) An agency which provides child welfare services or a law enforcement agency, the person shall make the report to an agency other than the one alleged to have committed the act or omission,