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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. 25OC00109 1B

Dept. No. I

PLAINTIFFS' APPENDIX TO MOTION FOR PRELIMINARY INJUNCTION

Volume 9 of 18

INDEX

EXHIBIT #	DESCRIPTION	PAGES
F	August 23, 2024 Nevada Department of Health and Human Services request to resume consideration of Nevada's Section 1332 State Innovation Waiver	553-627

35340515_v1

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Division of Insurance Commissioner to seek a Section 1332 waiver.

Enclosed please find a revised version of Nevada's initial December 29, 2023, State Innovation Waiver Application (Application). The revised Application outlines new State initiatives, including strategies to encourage consumers to actively shop for their health insurance coverage and promote consumer awareness of lower-cost BBSPs, with updated actuarial analysis reflecting these State initiatives. It also includes a consumer premium rebate program to ensure that no Nevadan experiences an unavoidable increase in premium costs because of the new BBSPs being introduced into the market in 2026.

Granting this waiver will allow Nevada to make important investments in increasing access to affordable health insurance coverage and lowering health care costs. Thank you for considering our application and supporting Nevada's health care affordability and market stabilization goals.

Sincerely,

Richard Whitley
Director
Nevada Department of Health and Human Services

SECTION 1332 WAIVER APPLICATION ADDENDUM:

NEVADA COVERAGE AND MARKET STABILIZATION PROGRAM

DEPARTMENT OF

HEALTH AND HUMAN SERVICES

DIVISION OF HEALTH CARE FINANCING & POLICY

WAIVER APPLICATION ADDENDUM

Re-Submission Date: August 23, 2024

Contents

Section 1: Summary of Changes to Revised Waiver Application

A. Overview

On December 29, 2023, the State of Nevada submitted a Section 1332 State Innovation Waiver application, requesting to waive Section 1312(c)(1) of the Affordable Care Act in order to implement new public option plans, known as Battle Born State Plans (BBSPs), and a Market Stabilization Program for the individual market for plan years 2026 through 2030. On February 12, 2024, the Center for Consumer Information and Insurance Oversight (CCIIO), on behalf of the U.S. Department of Treasury and U.S. Department of Health and Human Services (the Departments), deemed Nevada's waiver application complete. A federal public comment period for the application was held from February 12, 2024 to March 14, 2024. On March 21, 2024, Nevada requested the Departments pause review of the waiver application while the State implemented updates to its proposal in response to the comments shared during the federal public comment period.

This revised application reflects updates made to the waiver application as follows:

1. Redesigned the reinsurance program to include uniform parameters across rating regions;
2. Adjustments to premium reduction targets to create a more level playing field for carriers;
3. Addition of a targeted premium relief program for enrollees experiencing unavoidable premium increases due to the BBSP premium reduction targets;
4. Strategies to promote active plan shopping and awareness of BBSPs and lower-cost options; and
5. New plan offering requirements.

B. Summary of Key Changes

1. Reinsurance Program with Uniform Parameters Across Rating Regions

In response to public comments received during the federal public comment period, Nevada has revised the application to assume uniform reinsurance parameters across all rating areas. Commenters shared that a tiered coinsurance design would make it more challenging for carriers to achieve the overall 15 percent premium reduction target in these areas, where provider reimbursement rates are already lower due to heightened provider competition. To address concerns expressed by commenters regarding the feasibility of meeting the premium reduction target, Nevada has decided to implement flat coinsurance parameters across all geographic rating areas for all carriers.

2. Adjustments to Premium Reduction Targets

In response to public comments, the State of Nevada will implement adjusted premium targets that will give carriers with less competitive 2025 premiums an opportunity to achieve the full 2029 premium reduction target of 15 percent over the first four years of the waiver program, rather than a single year. The Actuarial and Economic Analysis conducted by Milliman, Inc. assumes the adjusted premium targets will not impact the SLCS premium or pass-through funding (PTF) because at least two issuers will achieve the unadjusted premium reduction target.

3. Targeted Premium Relief Program

In response to public comments urging the State to consider providing premium support to enrollees to improve affordability, Nevada will institute a premium relief program for certain qualifying individuals who are

enrolled in Nevada's state-based health insurance exchange—the Silver State Health Insurance Exchange (SSHIX)—as of December of 2025 and reenroll in 2026 coverage. Premium relief will be provided to renewing individuals whose net premium is higher under the waiver program than it would have been without the waiver due to reductions in the second-lowest cost silver (SLCS) premium driven by lower gross premiums under the state statutorily-required BBSP premium reduction targets.

4. Strategies to Promote Active Plan Shopping and Awareness of BBSPs

Nevada will enact a suite of strategies to (1) encourage consumers to actively shop for their health insurance coverage and (2) promote awareness of the new BBSPs and lower cost options for coverage. These outreach strategies, summarized below, are intended to help Nevadans gravitate towards lower cost options, which will likely be the BBSPs in most geographic areas, as BBSPs will more often be less costly relative to other plans available on the marketplace.

- **BBSP Carrier Marketing and Outreach Requirements:** The State will require carriers under their BBSP contracts to widely market and promote their BBSP offerings during open enrollment. For instance, the State is exploring including contractual requirements for carriers to develop their own outreach campaigns and meeting certain parameters to be approved by the State prior to open enrollment.
- **Integrating Active Shopping Promotion into SSHIX Marketing Campaign:** Promotion of active plan selection will be woven into SSHIX's fall marketing campaign. For instance, SSHIX can include static messaging on the Nevada Health Link website to urge consumers to review the health coverage options available to them prior to SSHIX standard auto-enrollment procedures to remind consumers that premiums may be lower in other plans if they shop for coverage. This will complement any strategies SSHIX undertakes to encourage shopping due to the impending loss of enhanced premium subsidies.
- **Differentiating BBSPs and Plan Display:** The State plans to create a BBSP logo or some similar differentiating moniker for use on its website, plan preview tool, and application plan selection pages. SSHIX can require carriers to include "Battle Born State Plan" in plan names to differentiate the products on the Nevada Health Link. Additionally, the Nevada Health Link's default plan sorting mechanism, which sorts plans from lowest to highest net premium, will work to increase the visibility of BBSPs for consumers since BBSP premiums will be lower than other plan options in most geographic areas of the state.

Based on the expansion of planned State initiatives described above, the Actuarial Analysis' BBSP take-up rate for SSHIX enrollees was increased to 80%. This change in assumption has a small impact on PTF, but it materially reduces projected enrollee gross and net premiums with waiver.

5. New Plan Offering Requirements

The revised application also newly states that Nevada is requiring each BBSP carrier to offer at least one bronze BBSP, in addition to the statutory requirement to offer one silver and one gold BBSP. Nevada has decided to require carriers to offer a bronze BBSP—rather than simply encouraging it—to provide consumers an additional low-cost option within their existing metal-level.

Each BBSP carrier will also be required to offer one standard (i.e., non-BBSP) silver QHP in each geographical region it serves to allow the State to effectively estimate pass-through funding.

Section 2: Nevada Program Overview and Waiver Request

A. Overview

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

Nevada seeks to waive Section 1312(c)(1) of the ACA and its implementing regulations for the purpose of establishing the reforms described herein. If approved, the Section 1332 waiver is targeted to be effective January 1, 2026, for five years. The reforms will not affect any other provision of the ACA but are expected to result in a lower SLCS premium and a reduced market-wide index rate (relative to no waiver), thereby lowering gross premiums and reducing the federal cost of Premium Tax Credits (PTC).

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

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

The first initiative for addressing these issues is the development and implementation of a new Public Option program by the Nevada Director of Health and Human Services (the Director).[6] The Director must contract with carriers to offer new health insurance options to consumers through the SSHIX, which operates Nevada Health Link. These new options (hereinafter "Battle Born State Plans" [BBSP]) must be certified as Qualified Health Plans

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

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

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

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

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

[6] Nev. Rev. Stat. § 695K.200.

(QHP) and meet all state and federal requirements as standard QHPs, including providing the same minimum benefits and cost sharing. A carrier must make a good faith bid to offer BBSPs in order to be permitted to bid as a Medicaid Managed Care Organization in the procurement for 2026 through 2030. BBSPs must also be offered off-Exchange.

The major difference between BBSPs and other QHPs offered on the SSHIX is that carriers offering BBSPs must contract with the State to meet certain State priorities and requirements, including an annual premium reduction target.

First, to be considered for the Medicaid Managed Care procurement, carriers must submit a good faith bid that, at a minimum, meets their applicable Year 1 premium reduction target.[7] In Spring 2025 the final, updated reference premium for BBSPs will be released, with any pricing adjustments necessary based on information that was not known at the time of the release of the BBSP reference premium range. Carriers will adjust BBSP premiums as necessary to meet the premium reduction target and submit proposed rates to the Nevada Division of Insurance (DOI) for review, according to DOI's standard procedures.

Carriers that are certified to have offered a good faith bid will be notified by the State that they can proceed in the Medicaid Managed Care procurement. Following the good faith bid determination, the State will continue its review of carriers' proposals to determine which BBSPs will be offered in each geographic rating area, ultimately notifying carriers of their awards in Spring 2025.

As with every other carrier offering a QHP on the SSHIX, carriers must commit to fulfilling DOI requirements for operation as a commercial carrier in the State (including filing network adequacy information with the DOI) and must seek formal QHP certification of their BBSPs each year from SSHIX. Selected vendors will submit final BBSP premium rates for all metal levels for Plan Year 2026 to the DOI for review and approval.[8] This customary State process will verify actuarial soundness and confirm that solvency standards and all other requirements of standard QHPs have been met. The DOI will evaluate the rate filings for the BBSPs in the same manner as other rate filings to determine whether rates are excessive or inadequate and whether carrier solvency and all other requirements of QHPs have been met. The Division will also contract with an actuarial firm to ensure that carriers' BBSPs are on target to meet the Public Option law's premium reduction requirements.

While the introduction of the BBSPs and achieving the premium reduction targets are not expected to disrupt the insurance market, a suite of other initiatives are intended to mitigate any unexpected financial risk to carriers and limit the impact on provider networks, while strengthening the long-term sustainability of this market. This includes three new measures:

- **State-Based Reinsurance Program:** Reinsurance is aimed at alleviating any unexpected financial risk to participating carriers and their provider networks with the introduction of the BBSPs that meet premium reduction targets. The State intends to adjust the size of the reinsurance parameters as needed to ensure

[7] The preliminary reference premium released by September 2024 will account for carrier-specific rate positioning in 2025. The preliminary reference premium will be developed, in part, by reviewing published 2025 rates and benefit plans, projected to Plan Year 2026 using CPI-M plus an adjustment for local market factors.

[8] Any differences between a carrier's good faith bid for this RFP as it relates to the carrier's estimated premium rate for the silver BBSPs and the BBSP rates the carrier submits for review to the DOI for the rate review process should be attributable to quantifiable differences in factors that are uncertain at the time of the carrier's response or bid to this RFP. The carrier will provide documentation to support any such differences, if requested by the State.

that it can be fully funded by the pass-through funding (PTF) generated in the prior year after financing State administrative costs and the waiver's premium relief program.

- **Quality Incentive Payment Program:** If there is remaining PTF in any year of the waiver period after financing reinsurance, the State intends to use this funding to establish a Quality Incentive Payment Program for carriers offering BBSPs. This program will be designed to reward carriers and their providers for utilizing value-based efforts to improve health outcomes and quality of care. Through this new program, the State will be able to, for the first-time ever, drive changes in how health care is delivered and paid for in the individual market. Over time, these efforts should lead to a healthier population and therefore reduce risk to carriers. It should also lead to shared savings and financial rewards for network providers that are successful in these efforts with carriers.
- **"Practice in Nevada" Incentive Program for Health Care Providers:** If there is sufficient remaining PTF, the State intends to use such funding to finance a new state-run "Practice in Nevada" program. Nevada faces critical challenges in attracting health care providers—including primary care physicians, obstetricians, behavioral health practitioners, and other allied health professionals—to practice in the State. Currently, Nevada ranks last in the number of primary care providers per 100,000 individuals.[9] Therefore, increasing the number of providers through incentives is essential to addressing poor health outcomes and health disparities. It is also important for controlling the rise in the cost of health care and ensuring the stability of the State's insurance market. Because of the steep demand and supply gap for health care professionals in Nevada, having more medical professionals could help insurers avoid facing unreasonable price hikes from network providers that are in low supply in the State. For example, carriers with smaller market shares (i.e., covered lives) are likely to struggle to negotiate reasonable rates for certain services where only one provider entity is available in a region to provide such services to its members. Most recently, this challenge was notable in the State's Medicaid Managed Care program, where a carrier with a smaller portion of enrollment in the program faced unreasonable prices as compared to other carriers from a certain specialty provider type that is in low supply in the State.

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

B. Federal Provisions to Be Waived

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

Section 1312(c)(1) and its implementing regulations limit the factors by which issuers can vary premium rates for a particular plan from the index rate. The goal of the premium reduction targets for the BBSPs in SSHIX is to control health care costs and support coverage by reducing insurance premiums. Through NRS 695K and this waiver, the Director would condition eligibility to bid as an MCO carrier on submitting a good faith bid to offer a silver BBSP on the SSHIX that meets certain premium reduction targets each year, among other QHP

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

requirements.[10] These premium reductions are expected to be achieved through a combination of lower provider rates, administrative efficiencies, and the implementation of reinsurance. To allow these reductions, Nevada is requesting a waiver of the Single Risk Pool provision of the ACA, Section 1312(c)(1). Under the implementing regulations at 45 CFR 156.80(d)(2), an "issuer may vary premium rates for a particular plan from its market-wide index rate for a relevant state market based only on the following actuarially justified plan-specific factors." These regulations enumerate specific factors, including: (1) actuarial value and cost-sharing; (2) provider network; (3) delivery system; (4) utilization management practices; (5) benefits provided in addition to the EHB; (6) administrative costs; and (7) any expected impact of eligibility for catastrophic plans. A federal waiver of Section 1312(c)(1) will ensure carriers can make plan-level adjustments to the market-wide adjusted index rate for BBSP offerings that correspond to the new premium reduction targets.

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

The State intends to establish a reinsurance program with flat coinsurance across all regions. A flat reinsurance structure – as opposed to reinsurance in which coinsurance rates are higher in more rural rating areas – can mitigate carriers' concerns about meeting the premium reduction targets in Rating Area 1, the most populous region where provider reimbursement rates are already lower than in other regions. The reinsurance program is expected to reduce premiums market-wide by 7.3% by 2030, contributing to plans' ability to meet the premium reduction targets in the years 2027 through 2030 and generating further federal savings.

Section 3: Nevada Section 1332 Waiver Proposal

A. Enabling Statutory Authority

Enabling legislation requires the Director to apply for a Section 1332 waiver no later than January 1, 2024, to implement the reforms and requirements of NRS 695K to establish a new Public Option program and to capture all PTF made available to the State with such reforms.[11]

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

NRS 695K.300(5) also provides the Director with broad express authority to spend federal PTF made available to pay for the costs associated with administering the reforms of Chapter 695K and any associated waivers. It provides the Director with the authority to spend the remaining federal PTF to improve the affordability of the new coverage options established under the Public Option program. The State has determined that this includes the premium relief program and initiatives within the Nevada Market Stabilization Program, including a state-based

[10] Carriers are also required to offer a bronze and gold BBSP plan and a silver non-BBSP plan.
[11] NRS 695K.210, available at: https://www.leg.state.nv.us/nrs/NRS-695K.html#NRS695KSec210

reinsurance program, a Quality Incentive Payment Program for participating BBSP carriers, and the Practice in Nevada Incentive Program. Each of these initiatives under the Market Stabilization Program can help the State control the rise in the cost of health care in the individual insurance market and increase long-term affordability by improving the quality of health care among enrollees and bolstering the provider base in the State.

In addition to the Director's authority, the Commissioner of Insurance has specific authority in SB 482 (2019), Section 45, to apply for a Section 1332 waiver and implement a State plan that meets the waiver requirements as approved by the Departments.[12] Further, the Commissioner has broad authority in NRS 679B.400 to "develop measures to stabilize prices" and to "establish a mechanism to ensure the provision of adequate insurance at reasonable rates to the residents of this state."[13] This highlights an additional source of State authority to establish a reinsurance program, the Quality Incentive Payment Program, and the Practice in Nevada Incentive Program under the State's Market Stabilization Program.

B. The New Battle Born State Plans

Nevada Senate Bill (SB) 420 (2021) was signed into law on June 9, 2021, and later codified in NRS Chapter 695K. Under this new law, the Director is required to design and establish a Public Option program in the individual market.[14] The statutory design of this new program relies heavily on a State purchasing and contracting strategy of the State's Medicaid Managed Care program. The State will undertake a statewide Medicaid Managed Care procurement for a five-year contract that begins on January 1, 2026.

The State must require that carriers submitting a bid through the Medicaid Managed Care procurement also produce a good faith bid to offer silver and gold BBSP annually on the SSHIX. Using the contracting process, the State will also require carriers to offer a bronze BBSP. Currently, under existing MCO contracts, the MCO carriers must offer at least one silver and gold QHP on the SSHIX by the 2024 coverage year.[15] MCO carriers will still be required to offer a standard (i.e., non-BBSP) silver QHP on the SSHIX during the waiver period but will not be required to offer a standard gold QHP. The difference between current contracting practices with MCO carriers and the new BBSP program is that the State will be asking MCO carriers to offer QHPs that meet the new BBSP requirements. Carriers may offer other SSHIX products.

The State intends to define a good faith bid for a BBSP as any bid by a carrier that is deemed complete under State purchasing guidelines and complies with all State BBSP requirements. This includes submitting a bid that, at a minimum, meets the State-determined premium reduction requirements for each applicable county. The preliminary reference premium for the good faith bid determination process will be based on the SLCS plan available through the SSHIX during the 2024 plan year by county, projected to 2026 using CPI-M plus adjustments for local market factors. The bid must also include a commitment from the carrier that it can meet the annual premium reduction requirements established by DHCFP, as well as a commitment from the carrier's actuary that the rate proposal is reasonable within the bounds of data currently. This will include an attestation that the proposed rates for the BBSPs are a reasonable estimate and actuarially sound, given the information available. As noted above in Subsection 2A, following the good faith bid determination, the State will continue its review of

[12] Senate Bill 482 (2019), available at: https://www.leg.state.nv.us/App/NELIS/REL/80th2019/Bill/6923/Text.
[13] Nev. Rev. Stat., Chap. 679B, available at: https://www.leg.state.nv.us/nrs/NRS-679B.html#NRS679BSec400.
[14] The authorizing state legislation also permits the state to offer the plans in the small group market, but currently the state is not taking up this option.
[15] See Section 7.1.5.1 in the State's Medicaid Managed Care contract, available at: https://nevadaepro.com/bso/external/purchaseorder/poSummary.sdo?docId=40DHHS-NV21-9279&releaseNbr=0&external=true&parentUrl=close

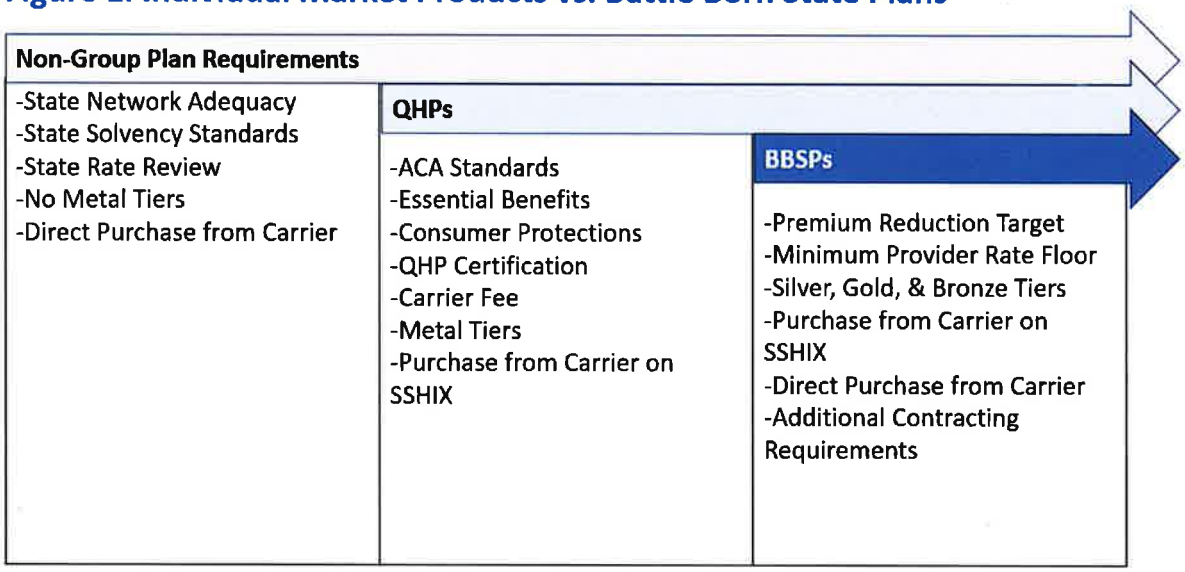
carriers' proposals to determine which BBSPs will be offered in each geographic rating area, ultimately notifying carriers of their awards in Spring 2025.

If a carrier bids on Medicaid and does not offer a good faith bid for a BBSP contract, the carrier will be ineligible to participate in the State's Medicaid Managed Care program for that upcoming contract period. The State expects at least four carriers, at a minimum, to submit bids to offer the new BBSPs for coverage year 2026 in order to be considered for a Medicaid Managed Care contract. The upcoming MCO contracts will be for a five-year period, beginning on January 1, 2026, and terminating on December 31, 2030. This timeline for the contract period aligns with this waiver request.

1. Product Design Overview and Premium Reduction Requirements

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

Figure 1: Individual Market Products vs. Battle Born State Plans



The BBSPs will include the same benefits as other QHPs.[16] In addition, BBSPs must meet certain statutory requirements for premium reductions and a reimbursement floor for network providers, ensuring rates, in the aggregate, are no lower than those paid by Medicare.

A key difference between BBSPs and non-BBSP QHPs is the requirement to meet premium reduction targets. Under NRS 695K, carriers offering the new BBSPs must satisfy a new premium reduction target on their silver plan rate

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

that is at least 15% lower than the average reference premium in each applicable geographic rating area by the fourth plan year (2029). The average reference premium will be based on the SLCS premium available in the SSHIX during the 2024 plan year by county, trended forward for inflation according to the Consumer Price Index for Medical Care (CPI-M) and any adjustments necessary to reflect local changes in utilization and morbidity. See Nevada DHCFP Guidance and Bulletin Update 23-003.[17]

To ensure annual premium rates for the BBSPs will be actuarially sound and meet provider reimbursement floor requirements, the Director has determined the premium reduction target should be 15% by the end of the first four years as permitted by State law.[18]

In the event that carriers cannot meet premium targets in any given year while meeting actuarial soundness or solvency requirements, the Director has the authority to adjust the premium reduction targets to ensure BBSPs are offered at a rate that is actuarially sound. DHHS guidance released in November 2023 outlines the State's approach to ensuring carriers are on track to meet premium reduction targets[19]:

- For Plan Year 2026, carrier premiums must be at least three percent lower than the reference premium. (The preliminary reference premium range for each geographic rating area will be released Quarter 3 of 2024. The final reference premiums will be released Spring 2025.)
- 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 reference premium. For Plan Years 2027 and 2028, the premium reduction amounts will be negotiated by the Director as outlined under the BBSP contracts 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 reference premium.

In response to stakeholder feedback that some issuers may not be able to achieve the full required premium reduction targets in 2026, the State of Nevada will adjust premium targets for 2026 through 2028 based on the carrier's 2025 market position in each geographic area. These adjusted premium targets will be based on each issuer's 2025 lowest cost silver premium relative to the 2025 SLCS premium in each county. All issuers will be required to achieve the 15 percent BBSP premium reduction target in 2029; however, the adjusted premium targets will allow issuers in less competitive positions in 2025 to spread the premium reduction needed to achieve the 2029 target more evenly over the first four years of the NMSP. The Actuarial and Economic Analysis conducted by Milliman, Inc. assumes the adjusted premium targets will not impact the SLCS premium or PTF because at least two issuers will achieve the unadjusted premium reduction target.

The premium reduction targets and reference premium will be established by the State and shared with issuers before rates are required to be submitted to the State each year. Nevada will leverage the procurement and contracting process to ensure compliance with the statutorily defined premium requirements. The Director will

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

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

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

use the State's contract authority with carriers offering the BBSPs to enforce these new targets with associated penalties and sanctions as outlined further in Subsection 3.

2. New Protections for Providers and Consumers

State law provides for certain protections to ensure that the premium reduction targets for the BBSPs do not undermine provider networks or access to care for consumers. These include:

- **Provider Reimbursement Requirements:** State law requires carriers offering the new BBSPs to ensure that their negotiated rates with network providers are the same or better, in the aggregate, than the rates paid by Medicare.[20] The Director intends to require each BBSP carrier to provide notice to its network providers for the BBSP plans of the Medicare rate floor requirement and the process by which providers may appeal to the Department for review of noncompliance by a carrier.
    - The State will be responsive to complaints filed by providers that contend that payment by a BBSP, in the aggregate, is not in compliance with this provision. The State will request the necessary data to review a rate challenge. The State will also require issuers to attest annually that their provider rates are equivalent to or better than Medicare rates. Issuers that are not in compliance could receive a financial penalty per their contract with the State. Significant noncompliance could mean a breach of contract.
    - Where a Medicare rate is unavailable, the Director intends to utilize other program fee schedules to help guide providers and carriers. Such information will be calculated annually as a percentage of Public Employees' Benefits Program (PEBP) or Medicaid rates for the same or similar service, or the Average Commercial Rate to the extent data is available nationally or from the State's All-Payers Claims Database which should be available for this usage in 2026.
- **Provider Network Participation Requirement**: Any provider who participates in the PEBP, Medicaid, or the State's workers' compensation program must agree to participate in at least one provider network for a BBSP or risk participation as a network provider in these other public programs. This requirement will be enforced through the State's contractual or enrollment agreements with providers to participate in-network in these programs.[21] The State will amend its provider enrollment agreements by Fall 2025 to reflect the BBSP participation requirements. The State has authority to amend these contracts at any time.
    - The Director may waive the provider participation and consumer access requirements if needed to ensure individuals who receive benefits through the State's PEBP, Medicaid, or the workers' compensation program have sufficient access to covered services from network providers.
    - The Director intends to develop a process for providers to seek a waiver of the network participation requirements for the BBSP offerings. Providers seeking such a waiver from participation as a BBSP-network provider must show a significant monetary loss in their total

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

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

patient revenues from serving patients who enroll in a BBSP. Such a loss must also pose a substantial risk to their financial stability due to the new BBSP revenue displacing a sizable portion of their payor mix and associated commercial revenue.
    - This scenario is unlikely. Based on 2022 Nevada market data, Milliman estimates that the Medicaid, Medicare, and employer markets combine for approximately 95% of total provider revenue (excluding pharmacy), and the individual market comprises only 3%. The size of the individual market relative to other markets limits the impact of any reimbursement changes specific to the individual market on the aggregate payment index across all providers and services.
- **Consumer Access Requirement**: Participating providers or facilities in a BBSP network must accept new patients enrolled in a BBSP to the same extent as the provider or facility accepts new patients enrolled in a standard QHP. The Director intends to require in the BBSP contract that carriers monitor BBSP network providers for compliance and notify consumers of this protection and a way to report any violations. Noncompliant providers may risk their provider enrollment in BBSP and Medicaid if they are not compliant with State law which would include this requirement.

The Nevada Division of Health Care Financing and Policy (Nevada Medicaid), which sits under the Director, oversees the State's MCO contracts with these carriers today and will provide the same oversight of compliance with respect to these new requirements for the BBSP contracts.

3. New State-Carrier Contracts

To enforce the statutory requirements for the BBSPs (including the premium reduction targets), the Director will utilize the legal tools under its new BBSP contracts with carriers, similar to the ways in which Nevada Medicaid enforces its existing contracts with carriers for its Medicaid Managed Care program, including the existing contract requirement that MCOs offer a QHP in the SSHIX. For example, MCO contracts include corrective action plans, financial penalties, and/or sanctions that can be imposed by the Director when carriers do not meet their contractual obligations.[22]

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

The State will also require, via the BBSP contract, that carriers meet an administrative cost containment requirement that is lower than prevailing individual market and QHP administrative expense loads (based on most recent publicly available rate filing data). Under this requirement, carriers offering BBSPs would be required to reduce a portion of their administrative expenses for the BBSP offerings, which will help reduce prices relative to non-BBSP offerings, all else being equal. The State is considering potential exclusions from what qualifies as an administrative expense to ensure that enrollee services remain robust, including activities related to quality improvement, enrollee outreach, care management, call centers, or nurse lines.

The new required administrative cost containment requirement will be set by the Director in the new BBSP

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

contracts and may rise each year, over the first four years of the program. These administrative efficiencies at the carrier level would count toward the required premium reduction target, reducing the share of premium reductions that must be achieved through provider reimbursement reductions in BBSPs. This will also help mitigate the risk of carriers cost shifting the entire burden of meeting an annual premium reduction target onto their provider networks. For BBSP carriers that do comply with this new requirement, the Director may use all financial penalties and sanctions set forth in the contract to enforce compliance.

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

- Advance quality and value-based payment design with providers,
- Improve continuity of care through better alignment of provider networks in the individual market and Medicaid Managed Care program, and
- Help address the State's growing health care workforce shortages and health disparities.[23]

4. New Strategies to Increase Active Shopping and Promote Low-Cost BBSP Enrollment

The State will coordinate with carriers and the SSHIX to implement a variety of strategies that (1) encourage consumers to actively shop for their health insurance coverage and (2) promote consumer awareness of lower cost options, like the BBSPs. The strategies the State will implement to achieve these goals are described below.

- **BBSP Carrier Marketing and Outreach Requirements:** The State will require carriers under their BBSP contracts to widely market and promote their BBSP offerings during each open enrollment. For instance, the State is exploring including contractual requirements for carriers to develop their own outreach campaigns meeting certain parameters to be approved by the State prior to open enrollment. This could include communications notifying consumers of the availability of BBSPs and of potential savings by actively shopping rather than remaining in their current plan. Carriers could highlight BBSPs to consumers to mitigate any premium increases due to the expiration of Inflation Reduction Act's (IRA) enhanced premium subsidies.

- **Integrating Active Shopping Promotion into the Broader SSHIX Marketing Campaign:** Promotion of active plan selection will be woven into SSHIX's fall marketing campaign. For instance, SSHIX can include static messaging on the Nevada Health Link website to urge consumers to review the health coverage options available to them on the Nevada Health Link to remind consumers that their premiums may be lower if they actively shop online. The State is also exploring including active-shopping promotion language in the dynamic enrollment and eligibility notices that consumers receive from SSHIX immediately prior to open enrollment.

- **Default Sorting and Plan Display:** The Nevada Health Link's default sort option lists plans from lowest to highest net premium. Since BBSP premiums will be priced lower than other plan options, maintaining that sorting function should ensure that BBSPs will be among the first search results consumers see, thus increasing the visibility of BBSPs and the likelihood consumers enroll in a BBSP.

- **Differentiating BBSPs:** The State plans to create a BBSP logo or some similar differentiating moniker for use on its website, plan preview tool, and application plan selection screen. SSHIX can require plan names to incorporate the BBSP name. SSHIX and issuers can market BBSPs as 'quality assured products' brought to consumers by the State pending review and approval by the SSHIX Board.

By investing in the strategies outlined above, the State can better ensure that consumers—especially those who

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

may experience in a change in the value of their PTC as a result of the loss of IRA's enhanced subsidies in 2026—understand their choices for insurance coverage and can make informed decisions to select the most affordable coverage option to meet their needs.[24] These outreach strategies, combined with consumers' tendency to enroll in plans based on price, are likely to help Nevadans gravitate towards BBSPs, which will often be more affordable relative to other plans available on the marketplace.[25]

Considering the State initiatives described above among additional considerations outlined in Section 4(A) of the Narrative, the BBSP take-up rate for SSHIX enrollees has been increased to 80% in the actuarial analysis. This assumption change has a small impact on PTF, but it materially reduces projected enrollee gross and net premiums with waiver.

C. Use of Federal Pass-Through Funds

The State understands that, if this waiver application is approved, an initial estimate of the federal PTF amount will be made available to the State the first or early second quarter of the corresponding plan year or coverage year. The final federal PTF amount or final administrative determination by the Departments will be shared in a letter prior to the payment of the federal PTF amount as provided in the specific terms and conditions of the approval letter (typically before the end of April of the corresponding plan or coverage year).

State law requires that any federal PTF received by the State as a result of the approval of this waiver must be reserved to first cover the State administrative costs to implement and operate the program and waiver.[26] These funds would replace the State's initial investment of State general funds to cover the "start-up" costs associated with implementation. As shown in the proposed budget in this application, these costs include staffing and vendor-related costs for both the Nevada DHHS, the DOI, and SSHIX.

Once the State administrative costs have been paid for with the new federal PTF, State law permits the Director to use a portion of the funding as determined by the State Treasurer to increase consumer affordability. Funding for the State's premium relief program will be the second set of expenses funded after state administrative costs.

For this waiver's purposes, the State has determined that the remaining funds after financing administrative costs and the premium relief program should be used by the Director to support a Market Stabilization Program in order to improve affordability in the BBSPs, along with other nongroup plans, as further described in Section 2.E. below. The reinsurance program cannot be fully implemented and financed by the State without an approved Section 1332 waiver. There are no dedicated State funding sources to finance a full reinsurance program; it will be wholly financed with federal PTF. Without the implementation of the waiver and State receipt of federal PTF

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[24] The revised Actuarial and Economic Analysis in this application reflects the State's greater emphasis on increased shopping under the waiver program.

[25] Research suggests that Marketplace enrollees largely choose plans based on price. In 2023, 81.4% of individuals between 100 and 150% FPL selected silver plans, as compared to 15% that selected bronze plans and 3.5% that selected gold plans. People in this income range who are eligible for a premium tax credit currently pay no up-front premium when enrolling in the silver benchmark or lowest-cost silver plan and are eligible for cost-sharing subsidies that substantially reduce their out-of-pocket costs. Similar cost-conscious trends are seen at other income levels. During the same year, 67% of individuals with incomes above 400% FPL selected bronze plans—typically their lowest-cost option – as compared to 11.3% that selected silver plans and 21.7% that selected gold plans. Significant enrollment in bronze offerings among this population suggests consumers favored plans with lower premiums. See: Holahan, Wengle, and O'Brien. How Do People Make Choices among Marketplace Plans? Available at: https://www.urban.org/sites/default/files/2023-09/How%20Do%20People%20Make%20Choices%20among%20Marketplace%20Plans.pdf

[26] See NRS 695K.300

achieved by premium reductions, the State would not be able to move forward in funding and implementing the reinsurance program.

D. DHHS Consideration of Initial Public Feedback

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

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

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

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

E. Targeted Premium Relief Program

The actuarial analysis shows that the enrollee net premium for about 24% of consumers will increase regardless of whether they switch to a BBSP or not. This is because of the BBSP premium reduction target's impact on the subsidies available to eligible consumers. More than 97% of these consumers are enrolled in bronze plans, and more than 75% have incomes between 200% and 400% FPL. The net premiums for these consumers under the waiver in 2026 are higher than without the waiver by less than $2 on average.

In response to public comment to provide premium support to improve affordability, State revised its waiver application to institute a premium relief program for certain qualifying individuals who are enrolled in the SSHIX as of December 2025 and renewing coverage in 2026. Premium relief will be granted to renewing individuals whose net premium each year of the waiver is higher under the waiver program than it would have been without the waiver due to PTC reductions driven by the BBSP gross premium reductions, and who cannot avoid this net premium increase by switching to a lower-priced plan within the same metal level.

New SSHIX enrollees or SSHIX enrollees with a gap in SSHIX enrollment in 2025 will not be eligible for the premium relief program. Milliman Inc. projects that approximately 20,000 enrollees could qualify for premium relief under the program in 2026.

The amount of premium relief available to consumers will not reflect changes in net premium that would have occurred without the waiver, including changes due to age, household size, household income as a percentage of FPL, ACA affordability limits, or metal selection. The Actuarial and Economic Analysis estimates the premium relief program will reduce the average aggregate enrollee net premium for PTC-eligible enrollees by

approximately $0.50 PMPM in 2026 and approximately $2 to $3 PMPM from 2027 through 2035. Premium relief payments will be paid for with federal PTF. Relief payments will be the second expense funded (after only state administrative expenses are paid for) and will be fully funded prior to reinsurance. The estimated annual costs of the premium relief program are outlined in Table 1 of Subsection 1 below.

Nevada intends to administer this premium relief program at the carrier level. Under this proposed design, the State would provide individual market carriers with a data file of eligible enrollees and the amount of their premium relief payment. Carriers would then lower the net premium for the individual enrollees by the premium relief amount. The State would retroactively reimburse carriers upon receipt of federal PTF. The timeline for reimbursements to carriers is under discussion and could be quarterly, semi-annually, or annually.

All carriers offering a QHP on the Nevada Health Link will be required to administer this program, as a condition of participation in the reinsurance program. Nevada is considering allowing small carriers with limited administrative capacity to apply for an exemption from this requirement, provided the carrier submits appropriate justification to the State. In such case, the State would administer the premium relief.

As a contingency, the State is also exploring administering the premium relief program directly to enrollees. This may be necessary during Plan Year 1 (2026) due to the timing of receipt of federal PTF. Under this program design, enrollees would receive direct outreach from the State. This approach imposes significant burden on the State to review and process enrollee applications. For these reasons, the State's preferred method is to pursue implementation via carriers.

Other details of the premium relief program are yet to be determined as of the date of waiver submission. The Actuarial and Economic Analysis's analysis of premium relief payments is based on preliminary estimates for the waiver application. The actual impact of the premium relief program may change once program details are defined, particularly at the individual level; however, Milliman, Inc. does not anticipate the impact of the final program design on aggregate average premiums to be materially different than the estimates provided in Table 7 of the Narrative. The State will seek stakeholder feedback as it continues to refine the design and administration of the premium relief program.

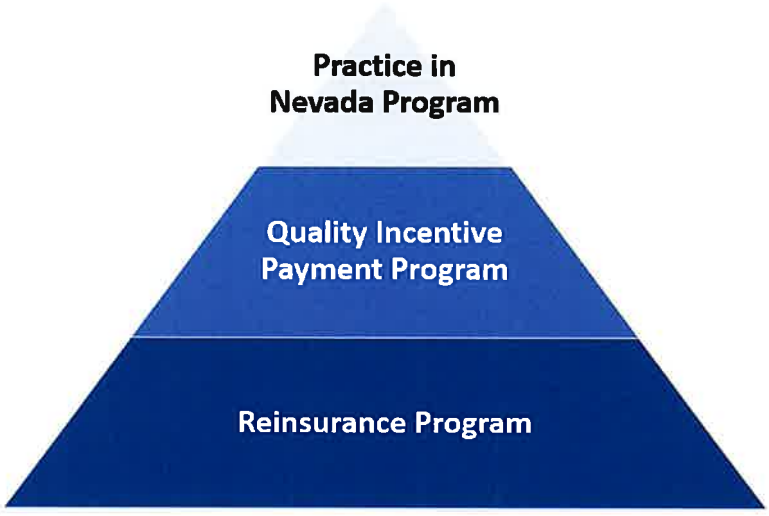
F. Nevada Market Stabilization Program

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

As summarized in Figure 2, the new Market Stabilization Program includes three core State market-focused investments. The operation and scale of these new investments would be reliant on the amount of federal PTF available to the State each year under an approved Section 1332 waiver, starting in year two. After funding all State operational costs and the premium relief program for the Section 1332 waiver program, the State intends to prioritize the remaining funds to finance these new programs.

The first of these investments consists of the establishment of a new state-based reinsurance program for all carriers operating in the State's individual market (i.e., offering nongroup plans). The second, if there is sufficient funding each year after fully financing a reinsurance program, includes a new Quality Incentive Payment Program to reward high-performing insurers that offer BBSPs and meet certain quality metrics or indicators tied to State priorities for the market. And third, if there is sufficient funding to fully finance a reinsurance and Quality Incentive Payment Program, the State intends to finance the Practice in Nevada Incentive Program, which would provide for loan repayment to certain health care providers willing to live and work for at least four years in a region of Nevada that qualifies as a federal HPSA. It is important to note that there are no dedicated State funding sources to finance these waiver programs; they will be wholly financed with federal PTF.

Figure 2: Nevada Market Stabilization Program



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

The State proposes to finance a new State reinsurance program for carriers operating in the State's individual market with the federal PTF. The program would reimburse issuers for a portion of the annual claims per enrollee that fall within the below specified range from a reinsurance pool. Through this new reinsurance program, the State seeks to share some of the financial risk with carriers for the cost of covering the individual market in a manner that would help lower costs for consumers ineligible for premium assistance. This, in turn, helps limit the potential risk and losses for carriers operating in the individual market.

In response to public comments received during the initial federal comment period, the State revised its application to implement flat coinsurance rates across all rating regions. In the initial draft waiver application, the State proposed to implement a reinsurance program in which coinsurance levels varied across the four rating areas in the State in order to provide greater relief to rural areas (rating areas 3 and 4), which have historically been exposed to higher gross premiums. Commenters highlighted that the tiered coinsurance rates require lower coinsurance for rating areas 1 and 2, resulting in the program having a smaller impact on premiums in those rating areas. Commenters expressed concern that it would be more challenging for carriers to achieve the overall 15 percent premium reduction target in these areas, where provider reimbursement rates are already lower due to heightened provider competition. For this reason, the State determined it will implement flat reinsurance parameters across all rating regions.

The reinsurance program will reflect the following parameters:

- Attachment point: $60,000
- Cap: $1,000,000
- Coinsurance: 28.5%

Based on the above reinsurance parameters, the Actuarial and Economic Analysis estimates that reinsurance will decrease premiums by approximately the following percentages:

- Rating area 1: 7.2%
- Rating area 2: 7.5%
- Rating area 3: 6.2%
- Rating area 4: 11.4%

The PTF generated by BBSPs in 2026 and 2027 will fund the state's cost of the administrative costs, the premium relief program, and reinsurance in 2027.

Table 1 below outlines projected pass-through funding and direct program costs for the premium relief and reinsurance programs. The cost of DHHS, SSHIX, and DOI administrative costs to run the NMSP is not reflected in Table 1.

Table 1
Projected Pass-Through Funding and Direct Program Costs (in Thousands)

Year	Pass-Through Funding	Premium Relief Program Costs	Cost of Reinsurance	Net Funding Remaining	Cumulative Net Funding Remaining*
2026	$15,000	($500)	$0	$14,500	$14,500
2027	$58,000	($2,000)	($54,000)	$2,000	$16,500
2028	$69,000	($2,000)	($58,000)	$9,000	$25,500
2029	$81,000	($3,000)	($62,000)	$16,000	$41,500
2030	$87,000	($2,000)	($67,000)	$18,000	$59,500
2031	$93,000	($2,000)	($74,000)	$17,000	$76,500
2032	$99,000	($2,000)	($80,000)	$17,000	$93,500
2033	$106,000	($2,000)	($87,000)	$17,000	$110,500
2034	$114,000	($3,000)	($95,000)	$16,000	$126,500
2035	$122,000	($3,000)	($104,000)	$15,000	$141,500
5-Year Waiver Window	**$310,000**	**($9,500)**	**($241,000)**	**NA***	**NA***
10-Year Deficit Neutrality Window	**$844,000**	**($21,500)**	**($681,000)**	**NA***	**NA***
5-Year Waiver Window – With 10% Margin on PTF and Premium Relief	**$279,000**	**($10,000)**	**($241,000)**	**NA***	**NA***
10-Year Deficit Neutrality Window – With 10% Margin on PTF and Premium Relief	**$760,000**	**($24,000)**	**($681,000)**	**NA***	**NA***

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

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

waiver/plan year, the State will adjust the parameters of the program. In turn, this also shifts more of the burden back on carriers in meeting the statutorily required premium reduction target of 15% over the first four years of the waiver period. In effect, the financing model of this reinsurance program is intended to have the effect of incentivizing carriers to meet the BBSP premium reduction targets so that sufficient funding is available each year to finance a robust reinsurance program.

The State's contracts with carriers for the BBSPs will include two sets of certified rates for achieving the premium reduction target—with and without reinsurance—to ensure the mandatory four-year statutory target can be achieved.

Table 2 below lists key dates for the State's implementation of the reinsurance program, pursuant to this waiver's approval.

Table 2: Proposed Reinsurance Implementation Timeline

	Plan Year			
	2026	**2027**	**2028**	**2029**
Preliminary Reinsurance Parameters Announced	NA	12/2025	12/2026	12/2027
PTF for Prior Year from CMS is Confirmed	NA	5/2026	5/2027	5/2028
Final Reinsurance Parameters Published	5/2025	5/2026	5/2027	5/2028
Rate Filings Due to Nevada DOI	6/2025	6/2026	6/2027	6/2028
Carriers Reimbursed for Claims from Previous Plan Year	NA	7/2028	7/2029	7/2030

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

Currently, the State uses a quality incentive or "bonus" payment program in its Medicaid Managed Care program to reward carriers for achieving certain quality targets or goals. For example, for Plan Year 2023, the State tied a bonus payment (equivalent to a 3% rate increase) for MCOs to a primary care spending target to incentivize MCOs to increase investment in the State's primary care provider system. The State is still analyzing MCO performance for this bonus payment, but early results show each of the four MCOs made significant progress in achieving this important goal for the State's Medicaid program. Additionally, for Plan Year 2023, the State tied a second bonus payment (equivalent to a 1% rate increase) for MCOs that achieved certain enhancements with provider networks to accelerate the use of value-based payment design across the recommended LAN Framework for alternative payment models. Early results of MCO performance indicate each MCO made significant progress in meeting the goals outlined for this bonus payment.

Through the Quality Incentive Payment Program for BBSPs, the State intends to require or incentivize carriers to align value-based initiatives across the Medicaid and individual markets and, if feasible and practical, with the value-based initiatives used in the Medicare market to achieve a best practice, "all-payer model" for these efforts in the State. An all-payer model is consistent with the best practices and models promoted by CMS' Center for

Medicare and Medicaid Innovation. See its recently released AHEAD model initiative. With this approach, the State can directly influence and improve how care is delivered and financed, aiming to stabilize Nevada's individual market by improving population health, which in turn reduces costs and risks to carriers.

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

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

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

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

The program is expected to be piloted in 2026 and 2027 for launch of bonus payments in 2028.

3. Practice in Nevada Incentive Program for Providers

One of the significant drivers of high health care costs and poor health outcomes in Nevada is the alarming provider workforce shortage in the State. The State proposes to utilize federal PTF to finance a new state-run workforce initiative—a loan repayment program that ties payment to a four-year commitment to live and work in Nevada. Anyone violating the loan repayment agreement would be required under the contract to pay back the financial assistance received from the State. As with the Quality Incentive Payment Program, the design features of the Practice in Nevada Incentive Program will be finalized via the development and finalization of the BBSP contracts. At a minimum, the State will require that providers live in the community in which they practice for at least four years and be willing to enter into a contract with the State to meet specific program requirements. The program will no supplant or duplicate federal workforce initiatives such as the National Health Service Corps loan repayment program.

This initiative advances several key goals of the waiver program. By dedicating resources to attract and retain providers—including primary care providers—the State can help expand access to health care services, especially among communities that have the most difficulty accessing providers, and drive improvements in health care outcomes for those and other communities.[27] Two key policy objectives of NRS 695K include improving access to high-quality, affordable health care for residents of the State and reducing health care disparities for historically marginalized communities. Additionally, pursuant to NRS 695K.220.4(c), the State must prioritize insurer applicants whose proposals strengthen the health care workforce in Nevada—particularly in rural areas. This incentive program for providers can serve as an effective strategy for accomplishing these goals outlined in statute. Further, by investing in providers and expanding access to primary care services, the State can help lower spending on unnecessary costs in the health care system, including spending on nonurgent emergency department utilization.[28]

G. Implementation Milestones

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

The second step is for the Director to conduct a statewide procurement for the new BBSPs alongside its next statewide Medicaid Managed Care procurement, which is anticipated to begin no later than January 1, 2025. The alignment of this procurement process with the Medicaid Managed Care procurement is intended to leverage the State's purchasing authority and its multi-billion-dollar contracts with carriers.[29] Specifically, State law requires any carrier seeking to be eligible to do business with Nevada Medicaid as an MCO to also submit a good faith bid to offer at least two BBSPs per rating region (i.e., one silver-level plan and one gold-level plan).[30] Other carriers not seeking an award as an MCO in the State's Medicaid Managed Care program may also submit a bid to offer a BBSP but are not required to do so.

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

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

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

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

[30] Using the contracting process, the State will also require carriers to offer a Bronze BBSP and a silver standard QHP.

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

Besides the milestones set forth in State law for the BBSPs, implementation of the Market Stabilization Program will begin in 2026.

Table 3 below lists these milestones and key dates for the State's implementation of NRS 695K and the Market Stabilization Program, pursuant to this 1332 waiver approval.

Table 3: Nevada Battle Born State Plan Implementation Timeline and Milestones	
Quarter 4, 2021	• Public workshops on product design held by the State.
Quarters 1-3, 2022	• Actuarial analysis and waiver development.
Quarter 4, 2022	• Nevada Medicaid hosts weekly "office hours" for the Public Option.
Quarter 3, 2023	• Development of a new Market Stabilization Program for waiver.
Quarter 4, 2023	• Finalize actuarial analysis and waiver draft. • Draft waiver application released November 20, 2023 for 30-day State public comment period. • DHHS hosts two hybrid (in-person and virtual) public workshops/hearings on draft waiver (November 27 and December 5). • DHHS hosts two tribal consultations (November 29 and December 7). • DHHS issues new bulletin to carriers on BBSP revised target and reinsurance program (November 20). • DHHS submits waiver application on December 29, 2023. .
Quarter 1-2, 2024	• CMS/Treasury determine completeness by February 12, 2024 and hold a 30-day federal public comment period from February 12, 2024 to March 14, 2024. • DHHS requests the Departments pause review of the waiver application on March 21, 2024 while the State implements updates to its application. • DHHS begins development of procurement materials and contracts for BBSPs.

Quarter 2, 2024	• DHHS issues a Request for Information to gather stakeholder feedback on aspects of the Market Stabilization Program on May 23, 2024. • DHHS continues development of procurement materials and contracts for BBSPs.
Quarter 3, 2024	• BBSP statewide procurement begins: State releases initial Step 1 RFP BBSP materials on August 5, 2024. • Interested carriers submit a Letter of Interest to State for bidding on BBSPs in order to move forward in procurement process by August 23, 2024. • State releases Step 2 RFP materials by September. • Interested carriers submit good faith bids for a silver BBSP.
Quarter 4, 2024	• State makes good faith bid determination for BBSP bids by October. • State releases Medicaid Managed Care RFP in October. • Interested carriers submit bids for MCO procurement. • CMS/Treasury make final determination on waiver application.
Quarter 1, 2025	• State evaluators for BBSP procurement review BBSP bids for BBSPs. • State sends Letter of Intent to award BBSP contracts.
Quarter 2-3, 2025	• Negotiation and awards final for BBSP contracts. • BBSP carriers submit Plan Year 2026 rate filings to DOI for review/approval. • State evaluators review BBSP rates for compliance with network and administrative cost reductions to comply with premium savings targets. • DOI completes rate analyses and approval processes. • BBSP carriers submit for SSHIX certification.
Quarter 4, 2025	• BBSPs are offered for enrollment during Open Enrollment.
Quarter 1, 2026	• BBSPs available on SSHIX for Plan Year 2026.
Quarter 2, 2026	• DHHS/DOI guidance to carriers on reinsurance and Quality Incentive Payment Program. • BBSP carriers submit rate filings to DOI for Plan Year 2027 for review/approval.
Quarter 3, 2026	• DOI completes rate analyses and approval processes.
Quarter 4, 2026	• BBSPs are offered for enrollment during Open Enrollment.
Quarter 1, 2027	• BBSPs available on SSHIX for Plan Year 2027. • Reinsurance program begins for Plan Year 2027.

H. Inter-agency Coordination

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

1. Nevada DOI

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

2. SSHIX

The SSHIX will continue to annually certify QHPs for participation in its online platform with premium subsidies for consumer shopping as it does today. For Coverage Year 2026 and beyond, QHP offerings will include BBSPs. SSHIX will also implement strategies to promote active plan shopping to help consumers make informed enrollment choices as a new product – the BBSP – is introduced to the individual market.

3. Nevada DHHS

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

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

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

I. Expected Federal Savings and Enrollment Changes

The Actuarial and Economic Analysis conducted by Milliman, Inc. estimates that the introduction of new BBSPs into the SSHIX with the support of a reinsurance program for the State's individual market could achieve nearly

$279–$310 million in federal savings in the first five years and $760–$844 million at the end of the first ten years.[31]

The Actuarial and Economic Analysis assumes BBSPs are likely to become the SLCS plan in every rating area (and county) within the state of Nevada. Currently there are four MCOs in the Managed Care Program. The State's Medicaid Managed Care awardees will be statewide starting in 2026 with at least two MCOs in each rating area. Carriers are informed of this change for the next contracting period and are reportedly expanding their provider networks to accomplish this and bid on the next MCO RFP, laying the groundwork for BBSP plans. Under the current Managed Care contracts, carriers are already required to offer a silver and gold plan in the SSHIX and therefore have familiarity with QHP product offerings. With MCOs' existing participation and further interest in SSHIX offerings, the State projects that among the carriers awarded MCO contracts, multiple (and possibly all) bids will be chosen to be offered as a BBSP in each rating area.[32] Therefore, we anticipate having more than one BBSP in each rating region. Moreover, multiple carriers offering BBSPs, combined with new premium reduction requirements and the State's contractual enforcement mechanisms in place indicate that the BBSPs are also likely to be the SLCS plan in each rating region.

The State plans to estimate the impact of the BBSP program for purposes of determining PTF through a multi-pronged approach. First, the State plans to conduct a Nevada-specific comparative analysis using historical data where the State will monitor the overall market trends before and after the implementation of the NMSP. The State anticipates this analysis will show lower rate increases, all else equal, starting in 2026. Next, the State will conduct a national comparative analysis where annual premium trends in Nevada will be compared against premium trends in other states, adjusting for various factors as appropriate.

Furthermore, Nevada will assess the rate filing information submitted by issuers in Nevada's individual marketplace, paying special attention to network factors and expense loads. We anticipate the network factor for BBSPs will be different than the network factor for standard QHPs, and BBSPs should have lower expense loads than standard QHPs.

Lastly, the State anticipates collecting industry medical and prescription drug pricing trend information in order to inform the establishment of the reference premium as required by SB420. Collectively, the analyses outlined above will be used by Nevada to estimate what rates would have been absent the waiver to isolate the impact of BBSPs.

For purposes of the actuarial review conducted by Milliman, it is assumed that the IRA's enhanced federal marketplace subsidies will expire on January 1, 2026, at the time the new BBSPs enter the Nevada market and SSHIX.[33]

Table 4 below shows the projected federal PTF from the BBSPs (i.e., specifically from the new premium reduction target for waiver years 2026–2030) and the new reinsurance program (for waiver years 2027 – 2030).

[31] See Nevada 1332 Actuarial and Economic Analysis by Milliman, Inc., 2023.

[32] The State will require bronze BBSP offerings through the BBSP contracting process.

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

Table 4: Summary of Projected Pass-Through Funding by Scenario			
Total Pass-Through Funding (PTF), (in Thousands)			
Time Period	**BBSP Policy Only**	**Reinsurance Policy Incremental Impact**	**Total**
Five-Year Waiver Window	$ 167,000	$143,000	$310,000
Five-Year Waiver Window (With 10% Margin)*	$150,000	$129,000	$279,000
Ten-Year Deficit Neutrality Window	$442,000	$402,000	$844,000
Ten-Year Deficit Neutrality Window (With 10% Margin)*	$398,000	$362,000	$760,000

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

As a result of the new BBSPs in SSHIX and the state-based reinsurance program, Milliman, Inc. also estimates the following incremental changes in enrollment Table 5, with BBSPs serving as the SLCS plan in each rating area. The Actuarial and Economic Analysis projects modest increases in enrollment due to the introduction of the BBSPs and slightly larger incremental increases in enrollment due to the implementation of reinsurance. These increases mainly result from individuals who are not eligible for federal financial assistance (including those with higher health care cost burdens) enrolling in unsubsidized coverage, which would be more affordable due to the gross premium reductions under the waiver program.

Table 5: Projected Individual Market Enrollment Change from Baseline			
Year	**BBSPs Only**	**Reinsurance Policy Incremental Impact**	**Total**
2026	600	0	600
2027	700	1,100	1,800
2028	700	1,100	1,800
2029	800	1,100	1,900
2030	900	1,100	2,000
2031	900	1,100	2,000
2032	900	1,200	2,100
2033	900	1,200	2,100
2034	900	1,200	2,100
2035	1,100	1,200	2,300
Values are rounded to the nearest hundred			

Section 4: Actuarial Analysis of Proposed Waiver

A. Impact on Section 1332 Guardrails

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

The Actuarial and Economic Analysis in this waiver application models two types of scenarios:

- Baseline Scenario ("Without Waiver"): The Baseline scenario illustrates projected enrollment, premiums, and federal costs without the Nevada Market Stabilization Program.
- Market Stabilization Scenario ("With Waiver"): This scenario illustrates the potential impact of the

Nevada Market Stabilization Program on enrollment, premiums, and PTF.

- **Affordability (1332(b)(1)(B))**

As required under 45 CFR 155.1308(f)(3)(iv)(B), the Section 1332 waiver must provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable as would be projected without the waiver. **The waiver satisfies this requirement by requiring that the BBSP premiums be lower than the reference premium by a specified percentage, incorporating initiatives to drive BBSP enrollment in those more affordable plans, and implementing a premium relief program for qualifying enrollees.**

By statute, the reference premium cannot be greater than the 2024 SLCS plan premium, trended to the benefit year based on a medical inflation index plus an adjustment for local market utilization and morbidity changes for the first four years of the waiver program. These constraints on the reference premium and BBSP premiums ensure that the BBSP premiums do not exceed projected premium amounts without the waiver. The State of Nevada will not force enrollees to select a BBSP; however, the SSHIX will encourage consumers to actively shop for the most affordable plans – which will likely be the BBSPs – and invest in marketing to distinguish the BBSPs from standard QHPs. The State will also require BBSP carriers to develop outreach campaigns to promote the BBSPs, which can include mailers and other communications notifying consumers of the availability of BBSPs and of potential savings by actively shopping rather than remaining in their current plan.

In response to public comments and in order to prioritize premium affordability for enrollees, the State is also implementing a premium relief program in which it will provide premium relief to consumers whose net premium increases under the waiver and who cannot avoid such an increase by switching to a lower-priced plan in their metal level.

Table 6 below shows the average gross premium under both the Baseline and With Waiver (i.e., Market Stabilization Plan) scenarios for both on and off-exchange enrollees. The average gross premiums under the With Waiver scenario reflect the projected BBSP take-up rate. **This table highlights that average gross premiums would fall due to the waiver relative to the Baseline scenario.**

Table 6
Projected Average Gross Premium Change From Baseline

Year	Baseline Scenario	Market Stabilization Scenario	Average Gross Premium Change Due to Waiver
2026	$593.38	$577.21	-2.7%
2027	$617.51	$547.60	-11.3%
2028	$641.90	$561.11	-12.6%
2029	$667.95	$575.80	-13.8%
2030	$695.02	$597.01	-14.1%
2031	$722.61	$619.01	-14.3%
2032	$751.41	$641.81	-14.6%
2033	$781.38	$664.97	-14.9%
2034	$812.76	$690.18	-15.1%
2035	$845.52	$714.63	-15.5%

Exhibits 1.1 through 1.5 in the Actuarial and Economic Analysis also show the projected average gross premium change each year by income, metal, age band, subsidized status, and rating area for on-exchange enrollees. **These exhibits show that the decrease in gross premiums under the waiver is generally greater for the following vulnerable populations in Nevada:**

- Lower-income individuals, who are disproportionately Hispanic, African American, American Indian, and Asian-Pacific Islander based on data regarding Nevada's earning disparities,[34]
- Older individuals, including individuals 65 and older, and
- Residents who live in rural and frontier/remote areas of the State (outside of Clark and Washoe Counties).

The average enrollee net premium is also projected to decrease relative to the Baseline in all years of the waiver period and the deficit neutrality window. Table 7 below highlights this, showing the average enrollee net premium under both the Baseline and Market Stabilization scenarios. **As shown in Table 7, the premium relief program will further reduce average net premiums under the waiver for some subsidized enrollees. In aggregate, the estimated impact of premium relief on average net premiums ranges from 0.2% in 2026 to roughly 0.5% thereafter.**

Table 7
Projected Average Net Premium Change From Baseline

	No Waiver	Market Stabilization Scenario				
Year	Baseline	BBSP Policy Only	BBSP with Reinsurance	BBSP with Reinsurance and Premium Relief	Average Net Premium Change Due to Waiver Before Premium Relief	Average Net Premium Change Due to Waiver After Premium Relief
2026	$276.03	$275.16	$275.16	$274.75	-0.3%	-0.5%
2027	$286.48	$285.19	$273.24	$271.64	-4.6%	-5.2%
2028	$297.19	$295.26	$282.43	$280.86	-5.0%	-5.5%
2029	$308.26	$305.57	$292.15	$289.82	-5.2%	-6.0%
2030	$319.65	$316.52	$302.16	$300.63	-5.5%	-5.9%
2031	$331.18	$328.13	$312.53	$311.02	-5.6%	-6.1%
2032	$343.17	$340.28	$323.50	$322.01	-5.7%	-6.2%
2033	$355.93	$352.27	$334.35	$332.88	-6.1%	-6.5%
2034	$368.89	$365.32	$346.44	$344.25	-6.1%	-6.7%
2035	$382.38	$378.62	$357.82	$355.67	-6.4%	-7.0%

The average net premium changes due to the waiver in Table 7 differ from average net premium changes in the initial waiver application submitted in February 2024 due to changes to the final BBSP take-up rate assumption. In revising the Actuarial and Economic Analysis, the State implemented a higher take-up rate on average that reflects the following factors:

- There will be more publicity around the BBSP offerings relative to simply being the SLCS plan in any given year.
- The State will require issuers under their BBSP contracts to widely market and promote their BBSP offerings during open enrollment.
- Active plan selection will be woven into the SSHIX Fall open enrollment campaign.
- For the same reasons that a BBSP is likely to be the SLCS plan, a BBSP will likely also be the lowest cost silver plan.
- On the Nevada Health Link's plan selection page, the default sort option lists plans by net premium from lowest to highest. This sorting function will ensure BBSPs are among the first plans visible to consumers on the platform.
- The BBSPs will be offered by well-established issuers, several of which already offer Marketplace plans,

[34] See U.S. Department of Labor. Earnings Disparities by Race and Ethnicity. Available at: https://www.dol.gov/agencies/ofccp/about/data/earnings/race-and-ethnicity

which are also Medicaid MCOs.

- Active enrollment in Colorado increased by almost 35% in the first year of the Colorado public option, from 47% in 2022 to 63% in 2023.
- BBSP plans will have a logo on the Nevada Health Link plan selection page that further draws attention to them.

In light of these State initiatives and considerations described above, the actuarial analysis' BBSP take-up rate was increased to 80% for SSHIX enrollees, which materially reduces projected enrollee net premiums.

- **Coverage (1332(b)(1)(C))**

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

Table 8 below summarizes net total enrollment changes from the Baseline, demonstrating that **the waiver provides coverage to at least as many residents as without the waiver.**

Table 8: Projected Individual Market Enrollment Change from Baseline

Year	BBSPs Only	Reinsurance Policy Incremental Impact	Total
2026	600	0	600
2027	700	1,100	1,800
2028	700	1,100	1,800
2029	800	1,100	1,900
2030	900	1,100	2,000
2031	900	1,100	2,000
2032	900	1,200	2,100
2033	900	1,200	2,100
2034	900	1,200	2,100
2035	1,100	1,200	2,300

Values are rounded to the nearest hundred

Additionally, Exhibit 4.5 in the Actuarial and Economic Analysis demonstrates the impact on enrollment by rating area, which is greater in underserved rural areas on a percentage basis. The Actuarial and Economic Analysis projects enrollment in rating areas 3 and 4 to increase by more than 3% and 5%, respectively, by 2027 due to the waiver, whereas the Analysis projects enrollment in rating areas 1 and 2 to increase by approximately 1.5% and 2%, respectively.

- **Comprehensiveness (1332(b)(1)(A))**

Section 31 CFR 33.108(f)(3)(iv)(A) requires that coverage provided under the waiver must be at least as comprehensive overall as coverage available without the waiver. **The Nevada 1332 waiver complies with this standard because SB 420 requires the new BBSPs to meet all QHP standards under the Affordable Care Act, which includes providing the full set of essential health benefits.**

The waiver does not make any changes to these benefits, nor does it alter any other coverage requirements for QHPs. Reinsurance does not have any impact on the comprehensiveness of coverage. Similarly, the use of PTF for provider quality incentives does not impact the comprehensiveness of coverage.

The waiver is not expected to impact comprehensiveness of coverage; therefore, by extension, there are no impacts to any specific populations of individuals or households, including those with higher health care cost burdens, low-income individuals, elderly individuals, or other vulnerable or underserved communities. The reductions in gross premiums may increase the ability for unsubsidized enrollees to purchase higher levels of coverage; however, based on the historically consistent enrollment by metal in Nevada despite changes in gross premiums, the Actuarial and Economic Analysis assumes enrollees choose to remain in the same metal as in the Baseline scenario.

- **Deficit Neutrality (1332(b)(1)(D))**

The 1332 waiver must be deficit neutral to the federal government compared to projections without the waiver. Table 9 below shows the projected Advanced Premium Tax Credits (APTCs) under the Market Stabilization scenario during the 10-year deficit neutrality window, demonstrating that **the waiver satisfies the deficit neutrality standard.**

The With Waiver scenario reduces federal outlays for premium subsidies relative to the Baseline scenario and these savings are paid to the state in the form of PTF such that total outlays under a waiver (subsidies paid to enrollees plus PTF to the state) are no greater than subsidies paid to enrollees without the waiver. The annual projected PTF amounts represent Milliman's best estimates of the savings in each year. Additionally, Milliman provides the projected PTF over the five-year waiver and 10-year deficit neutrality windows, and applies a 10% margin to account for unknown contingencies.

Table 9
Projected Pass-Through Funding (in Thousands)*

	Advanced PTCs		Total Pass-Through Funding**		
Year	No Waiver	With Waiver	BBSP Policy Only	Reinsurance Policy Incremental Impact	Total
2026	$386,000	$370,000	$15,000	$0	$15,000
2027	$408,000	$344,000	$26,000	$32,000	$58,000
2028	$431,000	$354,000	$35,000	$34,000	$69,000
2029	$455,000	$366,000	$44,000	$37,000	$81,000
2030	$481,000	$385,000	$47,000	$40,000	$87,000
2031	$508,000	$405,000	$50,000	$43,000	$93,000
2032	$537,000	$427,000	$52,000	$47,000	$99,000
2033	$567,000	$449,000	$55,000	$51,000	$106,000
2034	$599,000	$473,000	$57,000	$57,000	$114,000
2035	$633,000	$498,000	$61,000	$61,000	$122,000
5-Year Waiver Window			**$167,000**	**$143,000**	**$310,000**
10-Year Deficit Neutrality Window			**$442,000**	**$402,000**	**$844,000**
5-Year Waiver Window – With 10% Margin			**$150,000**	**$129,000**	**$279,000**
10-Year Deficit Neutrality Window – With 10% Margin			**$398,000**	**$362,000**	**$760,000**

** Values are rounded to the nearest million*

*** The Total Pass-Through Funding in each year is not equal to the difference between Advance PTCs with and without the waiver because of the 10% tax reconciliation factor that accounts for the difference in Advanced PTC and actual PTC claimed on tax filings.*

B. Impact on Health Equity

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

The Director must also prioritize bids for the BBSP that demonstrate alignment of provider networks between BBSP and MCO programs, where applicable, to help ensure continuity of care as people move up the income ladder and purchase health insurance in the individual market. In prioritizing alignment of provider networks, the State is minimizing the incidence of disruptions in care that disproportionately impact low-income Americans and lead to worse health outcomes and increased financial risk.[35]

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

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

Further, the above contractual provisions will empower the State to measure, track, and act on health care disparities, furthering the authorizing legislation's goal of improved access to health care and better health outcomes for historically marginalized communities.

Findings from the Actuarial and Economic Analysis developed by Milliman also highlight positive impacts of the waiver for more marginalized populations in Nevada, including low-income individuals, elderly individuals, and residents in rural areas. For instance:

- Exhibits 1.1 through 1.5 in the Actuarial and Economic Analysis show that the decrease in gross premiums under the waiver is generally greater for low-income individuals, elderly individuals, and residents in rural areas.
- Exhibit 3.1 shows that the average net premium (before the impact of the premium relief program) for those earning under 200% FPL decreases due to the waiver in almost every year of the waiver period.
- Exhibit 4.5 in the Actuarial and Economic Analysis outlines the impact on enrollment by rating area, which is greater in underserved rural areas on a percentage basis. The Actuarial and Economic Analysis projects enrollment in rating areas 3 and 4, which are disproportionately rural, to increase by more than 3% and 5%, respectively, by 2027 due to the waiver, whereas the Analysis projects enrollment in rating areas 1 and 2 to increase by approximately 1.5% and 2%, respectively.

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

- The Actuarial and Economic Analysis highlights that the implementation of the premium relief program will further reduce average aggregate enrollee net premium for PTC-eligible enrollees, shielding primarily middle-income consumers from premium increases.
- Further, the waiver is not expected to impact comprehensiveness of coverage; therefore, by extension, there are no impacts to any specific populations of individuals or households, including those with higher health care cost burdens, low-income individuals, elderly individuals, or other vulnerable or underserved communities.

Section 5: Additional Information

A. Administrative Burden

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

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

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

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

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

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

Nevada believes that the above administrative tasks are similar to other administrative functions currently performed by the federal government, so their impact is minimal. The waiver of Section 1312(c)(1) does not

necessitate any changes to the Federally Facilitated Exchange or to IRS operations and will not impact how advanced PTCs and PTC payments are calculated or paid.

B. Implementation of Non-Waived ACA Provisions

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

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

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

D. Compliance, Waste, Fraud, and Abuse

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

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

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

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

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

DHHS and DOI are audited as part of the Annual Comprehensive Financial Report (ACFR) and are included in the State Audit. The Legislature's Audit Subcommittee contracts with an external firm to conduct the audits,

and the audits are presented to the Legislature. The Nevada BBSP program and federal PTF will be subject to audit under the State's ACFR and Single Audit. The reinsurance program will also be subject to those audits and will be part of the annual report. The federal government is responsible for calculating the federal savings resulting from this waiver and for ensuring that this waiver does not increase federal spending.

E. State Reporting Requirements and Targets

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

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

Each quarterly report will include the following:

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

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

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

- Actual individual market enrollment in the State.
- Actual average individual market premium rate (i.e., total individual market premiums divided by total member months of all enrollees).
- The actual SLCS plan premium under the waiver and an estimate of the SLCS plan premium as it would have been without the waiver for a representative consumer (e.g., a 21-year-old nonsmoker) in each rating area.
- The actual amount of Advance Premium Tax Credit (APTC) paid, by rating area, for the plan year.
- The actual number of APTC recipients for the plan year. The number should be the number summed over all 12 months and divided by 12 to provide an annualized measure.

- Changes to the waiver programs, including the funding level the program will be operating at for the next plan year, or other program changes.
- Notification of changes to State law that may impact the waiver.
- Reporting of:
  - Federal PTF spent on subsidy programs adopted by DHHS. The unspent balance of federal PTF for the reporting year, if applicable.

F. Proposed State Operations Budget for Waiver Program

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

Table 10: Estimated Annual SFY Budget Costs for State Operations, Starting SFY 2026[36]	
Nevada Division of Insurance Operation Costs for Public Option	
Reinsurance Program Manager	$80,000.00 per SFY
Outside Waiver Support and Administrative Services	$180,000.00 per SFY
Estimated subtotal	**$260,000.00 per SFY**
Nevada Silver State Health Exchange Costs for Public Option	
Revised Notices	**One-Time Set-Up Cost of $50,000.000**
Outreach Promoting Plan Shopping	**One-Time Set-Up Cost of $150,000.00**
Estimated subtotal	**$200,000.00 One Time Cost**
Nevada Medicaid Operation Costs for Public Option	
New Staffing Costs for Contracts Oversight /Waiver Management	$400,000.00 per SFY
New Actuary and Transaction Fees[37]	$1,600,000.00 per SFY
Estimated subtotal	**$2,000,000.00 per SFY**
Estimated Total Operational Costs per SFY	**$2,260,000.00 per SFY**

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

G. Evidence of Public Notice and Tribal Consultation Requirements

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

[36] Estimated costs are subject to change.

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

29 and December 7), and two public hearings (November 27 and December 5). The presentations for the consultations and hearings are available in the Appendix.

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

The tribal consultations for the 1332 Waiver Application were held on November 29 and December 7, 2023, from 9:00 to 10:00 a.m. PST and 1:30 to 2:30 p.m. PST, respectively, both in-person and via Teams. The Division hosted the meetings and all Tribal Chairs and Tribal Health Clinic Directors from the Nevada Tribes were invited to the consultations.[38] During the consultations, staff members from the Division presented an overview of the 1332 Waiver Application and the anticipated impact of the Waiver on tribal communities. After the presentation, Division staff addressed questions from the meeting attendees. Commenters raised questions about the BBSPs, including network provider requirements, whether tribes would be able to sponsor premiums for BBSPs offered on the Exchange with federal funding, and if BBSPs would include an Indian Addendum to coordinate health coverage for tribes with providers in multiple states. The State confirmed that all requirements that apply to QHPs also apply to the BBSPs.

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

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

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

MILLIMAN REPORT

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

Prepared for Nevada Department of Health and Human Services

August 19, 2024

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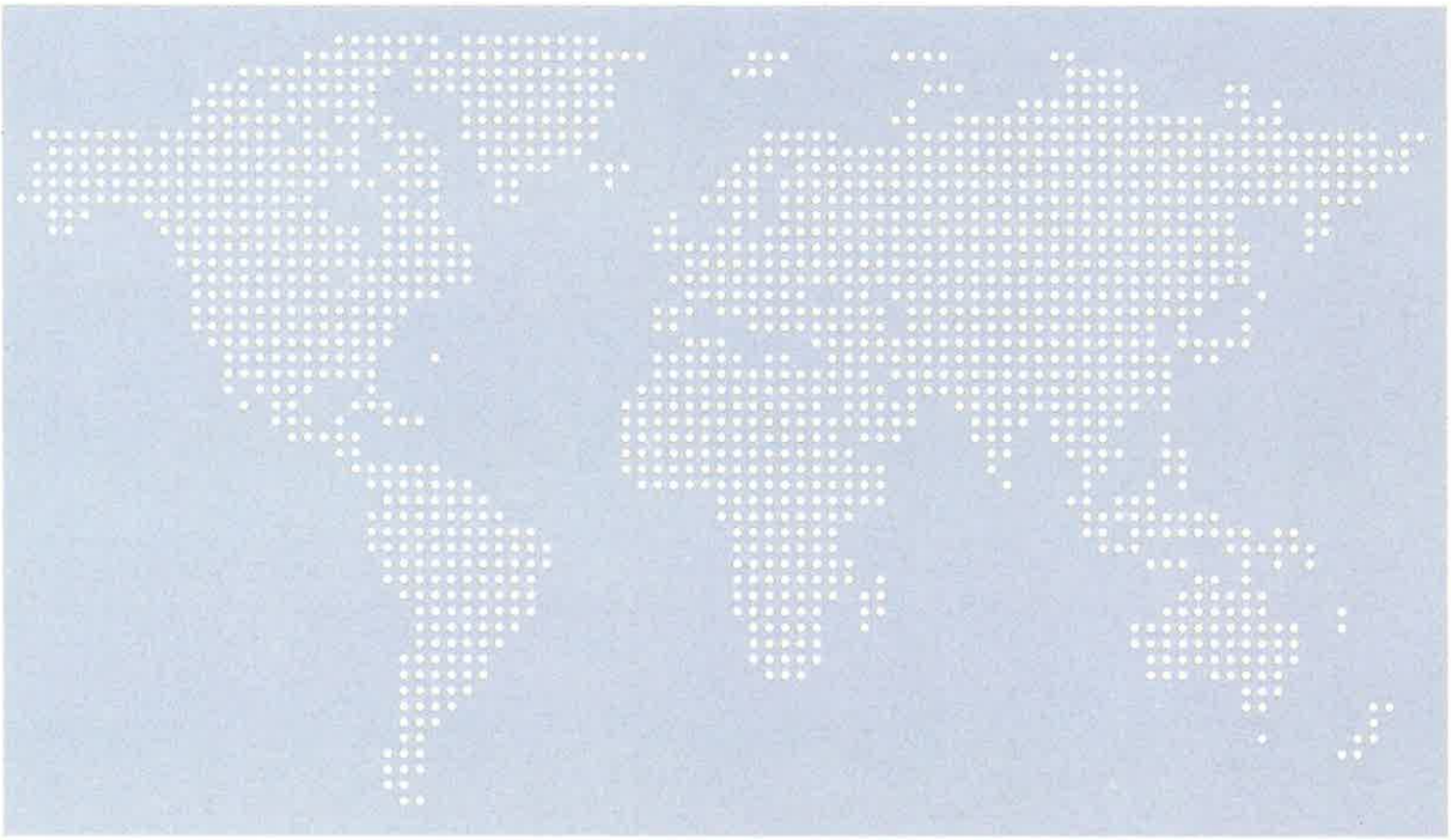

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Table of Contents

I. EXECUTIVE SUMMARY

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

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

Based on Section 2 of SB420, which can be found in Appendix B, the stated purpose of the PO is to lower individual market health insurance premiums and consumer out-of-pocket premium costs, improve access to health care, reduce disparities in health care access and outcomes, and improve the availability of coverage for residents of rural areas. Furthermore, the PO plan offerings, hereafter referred to as Battle Born State Plans (BBSPs), are expected to provide the opportunity for Nevadans to obtain a lower-priced product through reduced provider reimbursement, reduced issuer administrative expenses, and value-based purchasing initiatives designed to drive efficiency in utilization. The lower gross premiums driven by the introduction of BBSPs will reduce the benchmark plan premium in all rating areas in Nevada, thereby lowering federal outlays for premium subsidies, which then become available to the State of Nevada as PTF under the Section 1332 waiver.

In addition to the introduction of BBSPs, the State of Nevada intends to implement a reinsurance program in the individual market beginning in 2027. The stated intent of the reinsurance program is to transform the PO into a market stabilization program by reinvesting 1332 waiver PTF back into Nevada's individual health insurance market.[1] The reinsurance program implementation will occur after the implementation of BBSPs to allow for the accumulation of sufficient PTF to cover the State of Nevada's portion of the reinsurance program costs.

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

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

In response to stakeholder feedback, the State of Nevada will provide premium relief to certain qualifying individuals who are enrolled in the SSHIX as of December 2025 and reenroll in 2026 coverage. Premium relief will be granted to renewing individuals whose net premium (post-subsidy) is higher under the NMSP than it would have been without the NMSP due to PTC reductions driven by the NMSP premium reduction requirements. The specific details of the premium relief program are not yet determined as of the date of this report. Some considerations for the final program design include what can be accomplished operationally, assumptions used to calculate the premium relief, and how to communicate the amount of premium relief to consumers. The impact of the program modeled in this report reflects reasonable estimates based on preliminary discussions related to program design. The final structure of the premium relief program is not assumed to materially impact the PTF projections included in this report, but the details of the program will impact the PTF allocated for premium relief (see Table 1). If necessary, the reinsurance program parameters will be adjusted based on the actual surplus PTF remaining after funding the premium relief program to ensure sufficient PTF is available to fund the state's

[1] State of Nevada. "Governor Joe Lombardo Announces Plan to Transform the Nevada Public Option into NMSP." State of Nevada press release, October 11, 2023. https://gov.nv.gov/uploadedFiles/gov2022nvgov/content/Newsroom/PRs/2023/2023-10-11_DHHS_NVPublicOption-Memo.pdf , Accessed October 31, 2023.

share of the reinsurance program. As discussed in Section IV.A, the premium relief program will also reduce net premiums for some enrollees, and this impact may change depending on the final design of the premium relief program. Where applicable, we note the potential impact of the premium relief program on net premiums shown in this analysis. Estimates of annual costs for the premium relief program can be found in Table 1 below. We project ~20,000 enrollees could qualify for premium relief under the program in 2026.

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

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

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

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

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

For simplicity and no loss of accuracy, we assume the second lowest cost silver (SLCS) plan in the Market Stabilization scenario will be a BBSP.[2] We assume minimal change in total individual market enrollment, as PTC-eligible individuals' net premiums (i.e., enrollee premium after subsidies) will be largely the same[3] as in the Baseline scenarios assuming they are enrolled in the SLCS.

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

[2] For modeling purposes, whether a BBSP or standard QHP becomes the second lowest cost silver is not material and we assume the same effect on subsidies. See Section III.C of this report for additional detail.

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

Overview of updates

Since the submission of Nevada's 1332 Waiver Application on December 29, 2023, the State of Nevada has made the following policy change to the proposed NMSP:

- In response to stakeholder feedback, the State of Nevada is adding a premium relief program. The premium relief program will provide compensation to individuals who face an unavoidable net premium increase (i.e., one that cannot be remedied by shopping for a lower-cost plan in their metal level) due to lower premium tax credits (PTC) driven by the NMSP premium reduction targets.
- Based on stakeholder input, the State of Nevada is implementing adjusted premium targets that will allow issuers to achieve the 2029 premium reduction target more evenly over the first four years of the NMSP.
- The State will also engage in strategies to encourage active shopping for the most appropriate or lowest cost plan for each enrollee.

In addition, the actuarial and economic analysis reflects the following assumption changes:

- Based on stakeholder feedback, reinsurance parameters are assumed to be the same across all rating areas. The aggregate impact of this assumption change is relatively small, but the impact varies across rating areas and individuals.
- Based on an expansion of planned state initiatives in response to stakeholder feedback, the BBSP take-up rate was increased to 80%. This assumption change has a small impact on PTF, but it materially reduces projected enrollee gross and net premiums.
- The estimated income level distribution of individual market growth due to Medicaid redeterminations was updated. The impact of this update is minimal
- The premium trend assumptions for bronze and gold plans were updated to reflect recent market observations. The impact of this update is minimal.

The narrative and results shown in this report reflect these changes.

A. SUMMARY OF RESULTS

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

The results presented In Table 1 and throughout this report assume the reinsurance program, beginning with 2027 and for the remainder of the 10-year deficit neutrality window, will reflect a $60,000 attachment point, $1,000,000 cap, and 28.5% coinsurance, as described in further detail in Section II.B of this report. Actual reinsurance parameters in each of those years will be adjusted, as directed by the Director of DHHS, to align with actual experience, available funding, and NMSP objectives.

Table 1
State of Nevada
NMSP Actuarial and Economic Analysis
Projected Pass-Through Funding and Direct Program Costs (in Thousands)

Year	Pass-Through Funding	Premium Relief Program Costs	Cost of Reinsurance	Net Funding Remaining	Cumulative Net Funding Remaining*
2026	$15,000	($500)	$0	$14,500	$14,500
2027	$58,000	($2,000)	($54,000)	$2,000	$16,500
2028	$69,000	($2,000)	($58,000)	$9,000	$25,500
2029	$81,000	($3,000)	($62,000)	$16,000	$41,500
2030	$87,000	($2,000)	($67,000)	$18,000	$59,500
2031	$93,000	($2,000)	($74,000)	$17,000	$76,500
2032	$99,000	($2,000)	($80,000)	$17,000	$93,500
2033	$106,000	($2,000)	($87,000)	$17,000	$110,500
2034	$114,000	($3,000)	($95,000)	$16,000	$126,500
2035	$122,000	($3,000)	($104,000)	$15,000	$141,500
5-Year Waiver Window	**$310,000**	**($9,500)**	**($241,000)**	**NA***	**NA***
10-Year Deficit Neutrality Window	**$844,000**	**($21,500)**	**($681,000)**	**NA***	**NA***
5-Year Waiver Window – With 10% Margin on PTF and Premium Relief	**$279,000**	**($10,000)**	**($241,000)**	**NA***	**NA***
10-Year Deficit Neutrality Window – With 10% Margin on PTF and Premium Relief	**$760,000**	**($24,000)**	**($681,000)**	**NA***	**NA***

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

The state will use accumulated surplus PTF, after paying DHHS, SSHIX, and DOI administrative costs to run the NMSP and funding the premium relief program, to fund the state's cost of reinsurance. For example, the PTF generated by BBSPs in 2026 and 2027 will be used to fund the state's cost of the reinsurance program in 2027. PTF surplus from 2027 will be combined with PTF generated in 2028 to fund the state's cost of the reinsurance program in 2028, and so forth. The cost of DHHS, SSHIX, and DOI administrative costs to run the NMSP is not reflected in Table 1.

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

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

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

Affordability: The 1332 waiver must provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable as would be projected without the waiver. Based on federal guidance issued in 2021,[4] the affordability and comprehensiveness guardrails (described below) are evaluated by CMS in aggregate based on the actual coverage purchased by enrollees. The NMSP satisfies the affordability requirement as follows:

- Table 2 shows how the BBSPs reduce the SLCS premiums, and reinsurance further improves affordability under the NMSP.

  As described in Appendix C, the BBSPs are expected to be at least 3% lower than the average reference premium (see Appendix C) in 2026 and 15% lower by 2029. The projected change in the SLCS plan premium due to the BBSP policy is slightly greater than the BBSP premium reduction targets in 2026 through 2029 (see Table 12)

[4] Final Rule: Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond; Accessed March 29, 2024. https://www.govinfo.gov/content/pkg/FR-2021-09-27/pdf/2021-20509.pdf

due to projected changes in morbidity due to enrollment growth resulting from the waiver. Gross premiums for BBSPs are projected to achieve the premium reductions in the Total column in Table 3, whereas gross premiums for standard QHPs will decrease by the reinsurance impact only.

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

Year	BBSP Policy Only	Reinsurance Policy Incremental Impact	Total*
2026	-3.2%	0.0%	-3.2%
2027	-5.2%	-6.9%	-12.1%
2028	-6.6%	-7.0%	-13.7%
2029	-8.0%	-7.1%	-15.1%
2030	-8.0%	-7.3%	-15.4%
2031	-8.0%	-7.6%	-15.6%
2032	-8.0%	-7.8%	-15.8%
2033	-8.0%	-8.1%	-16.1%
2034	-8.0%	-8.3%	-16.3%
2035	-8.0%	-8.6%	-16.6%

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

- Table 3 illustrates that average gross premiums are projected to be lower in the Market Stabilization Scenario than in the Baseline scenario in all years of the five-year waiver window and the 10-year deficit neutrality window.

  The changes in average gross premiums in Table 3 below are slightly less than the target premium reductions for BBSPs shown in Table 2 because Table 3 reflects the projected aggregate gross premiums for enrollees who take up BBSP coverage and enrollees who remain enrolled in standard QHPs.

Table 3
State of Nevada
NMSP Actuarial and Economic Analysis
Projected Average Gross Premium Change From Baseline

	No Waiver	Market Stabilization Scenario		
Year	Baseline	BBSP Policy Only	BBSP with Reinsurance	Average Gross Premium Change Due to Waiver
2026	$593.38	$577.21	$577.21	-2.7%
2027	$617.51	$590.47	$547.60	-11.3%
2028	$641.90	$606.60	$561.11	-12.6%
2029	$667.95	$623.74	$575.80	-13.8%
2030	$695.02	$648.38	$597.01	-14.1%
2031	$722.61	$674.02	$619.01	-14.3%
2032	$751.41	$701.50	$641.81	-14.6%
2033	$781.38	$728.89	$664.97	-14.9%
2034	$812.76	$758.05	$690.18	-15.1%
2035	$845.52	$788.58	$714.63	-15.5%

- Table 4 illustrates that average net premiums are projected to be lower under the NMSP than in the Baseline scenario in all years of the five-year waiver window and the 10-year deficit neutrality window. The premium relief program will further reduce average net premiums under the waiver for some subsidized enrollees. In aggregate, the estimated impact of premium relief on average net premiums ranges from 0.2% in 2026 to roughly 0.5% thereafter.

The average net premium change is less than the average gross premium change due to the leveraging effect of subsidies for subsidized enrollees. For unsubsidized enrollees, the gross premium change and the net premium change are the same.

Table 4
State of Nevada
NMSP Actuarial and Economic Analysis
Projected Average Net Premium Change From Baseline

	No Waiver	Market Stabilization Scenario				
Year	Baseline	BBSP Policy Only	BBSP with Reinsurance	BBSP with Reinsurance and Premium Relief	Average Net Premium Change Due to Waiver Before Premium Relief	Average Net Premium Change Due to Waiver After Premium Relief
2026	$276.03	$275.16	$275.16	$274.75	-0.3%	-0.5%
2027	$286.48	$285.19	$273.24	$271.64	-4.6%	-5.2%
2028	$297.19	$295.26	$282.43	$280.86	-5.0%	-5.5%
2029	$308.26	$305.57	$292.15	$289.82	-5.2%	-6.0%
2030	$319.65	$316.52	$302.16	$300.63	-5.5%	-5.9%
2031	$331.18	$328.13	$312.53	$311.02	-5.6%	-6.1%
2032	$343.17	$340.28	$323.50	$322.01	-5.7%	-6.2%
2033	$355.93	$352.27	$334.35	$332.88	-6.1%	-6.5%
2034	$368.89	$365.32	$346.44	$344.25	-6.1%	-6.7%
2035	$382.38	$378.62	$357.82	$355.67	-6.4%	-7.0%

- Cost-sharing is not expected to be different under the waiver, for either BBSPs or standard qualified health plans (QHPs), than it is without the waiver.

  SB420 requires BBSPs to include both silver and gold plans, and DHHS intends to use the contracting process to require BBSP issuers to also offer a bronze BBSP. Since cost-sharing is based on an actuarial value (i.e., a percentage of plan costs) which is tied to the metal level, aggregate out-of-pocket costs for enrollees will decrease if they enroll in a plan with the same or higher metal level. As discussed in Section II.B, our modeling assumes all individuals enroll in a plan with the same metal due to the lower premiums available for the same coverage under the waiver. Therefore, non-premium cost-sharing will be at least as affordable under the waiver as it is without the waiver.

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

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

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

We expect modest increases in enrollment due to the introduction of the BBSPs and slightly larger incremental increases in enrollment due to the implementation of reinsurance.

Table 5 shows the projected incremental enrollment increases due to the BBSPs and reinsurance separately. These increases mainly result from individuals who were uninsured (including those with higher health care cost burdens) but who would find unsubsidized premiums under the waiver more affordable due to the gross premium reductions related to the NMSP. We assume the use of PTF for provider quality incentives does not impact the scope of coverage.

Table 5
State of Nevada
NMSP Actuarial and Economic Analysis
Projected Individual Market Enrollment Change From Baseline

	No Waiver	Enrollment Increase Due to Waiver		
Year	Baseline	BBSP Policy Only	Reinsurance Policy Incremental Impact	Total
2026	101,400	600	0	600
2027	102,700	700	1,100	1,800
2028	104,200	700	1,100	1,800
2029	105,500	800	1,100	1,900
2030	106,800	900	1,100	2,000
2031	108,200	900	1,100	2,000
2032	109,600	900	1,200	2,100
2033	111,100	900	1,200	2,100
2034	112,500	900	1,200	2,100
2035	113,900	1,100	1,200	2,300

** Values are rounded to the nearest hundred.*

Table 5 does not reflect projected enrollment in BBSPs versus standard QHPs. Rather, it reflects the projected enrollment growth attributable to the two primary policy components of the NMSP.

We project that individuals who enroll in the individual market in response to the BBSP policy component of the NMSP will enroll in BBSPs (as opposed to standard QHPs) since we assume the BBSPs' lower premiums are driving the decision to obtain coverage. Based on the BBSP premium reduction targets and reinsurance assumptions described throughout this report, enrollee net premiums for BBSPs are assumed to always be less expensive than enrollee net premiums for standard QHPs. Therefore, we assume individuals who enroll in SSHIX due to the waiver will enroll in a BBSP.

Comprehensiveness: The 1332 waiver must provide coverage at least as comprehensive, as defined by the ACA's essential health benefits (EHBs), as would be projected without the waiver. The Nevada 1332 waiver complies with this standard because SB420 requires the new BBSPs to meet all QHP standards under the Affordable Care Act, which includes providing the full set of essential health benefits. It does not make any changes to these benefits, nor does it alter any other coverage requirements for QHPs, for either BBSPs or standard QHPs. Reinsurance does not have any impact on the comprehensiveness of coverage. Similarly, the use of PTF for provider quality incentives does not impact the comprehensiveness of coverage.

The waiver is not expected to impact comprehensiveness of coverage; therefore, by extension, there are no disparate impacts to any specific populations of individuals or households, including those with higher health care cost burdens, low-income individuals, elderly individuals, or other vulnerable or underserved communities.

The reductions in gross premiums may increase the ability for unsubsidized enrollees to purchase higher levels of coverage; however, based on the historically consistent enrollment by metal in Nevada despite changes in gross premiums, we assume enrollees choose to remain in the same metal as in the Baseline scenario. Additional details are provided in Sections II and III of this report.

Deficit neutrality: The 1332 waiver must be deficit neutral to the federal government compared to projections without the waiver. Table 6 shows the projected Advanced Premium Tax Credits (APTCs) under the Market Stabilization scenario during the 10-year deficit neutrality window, demonstrating that the NMSP satisfies the deficit neutrality standard. The Market Stabilization scenario reduces federal outlays for premium subsidies relative to the Baseline scenario and these savings are paid to the state in the form of PTF, such that total outlays under a waiver (subsidies paid to enrollees plus PTF to the state) are no greater than subsidies paid to enrollees without the waiver. The annual projected PTF amounts represent our best estimates of the savings in each year. Additionally, we provide the projected PTF over the five-year waiver and 10-year deficit neutrality windows, and we apply a 10% margin to account for unknown contingencies.

The use of PTF for provider quality initiatives could reduce premiums in the waiver scenario further, including the SLCS, to the extent they improve patient outcomes and reduce overall costs. We conservatively do not make any assumptions to reflect the potential impact of the provider quality incentive program during the 10-year deficit neutrality window (i.e., PTF could be understated).

Table 6
State of Nevada
NMSP Actuarial and Economic Analysis
Projected Pass-Through Funding (in Thousands)*

	Advanced PTCs		Total Pass-Through Funding**		
Year	No Waiver	With Waiver	BBSP Policy Only	Reinsurance Policy Incremental Impact	Total
2026	$386,000	$370,000	$15,000	$0	$15,000
2027	$408,000	$344,000	$26,000	$32,000	$58,000
2028	$431,000	$354,000	$35,000	$34,000	$69,000
2029	$455,000	$366,000	$44,000	$37,000	$81,000
2030	$481,000	$385,000	$47,000	$40,000	$87,000
2031	$508,000	$405,000	$50,000	$43,000	$93,000
2032	$537,000	$427,000	$52,000	$47,000	$99,000
2033	$567,000	$449,000	$55,000	$51,000	$106,000
2034	$599,000	$473,000	$57,000	$57,000	$114,000
2035	$633,000	$498,000	$61,000	$61,000	$122,000
5-Year Waiver Window			**$167,000**	**$143,000**	**$310,000**
10-Year Deficit Neutrality Window			**$442,000**	**$402,000**	**$844,000**
5-Year Waiver Window – With 10% Margin			**$150,000**	**$129,000**	**$279,000**
10-Year Deficit Neutrality Window – With 10% Margin			**$398,000**	**$362,000**	**$760,000**

** Values are rounded to the nearest million.*
*** The Total Pass-Through Funding in each year is not equal to the difference between Advance PTCs with and without the waiver because of the 10% tax reconciliation factor that accounts for the difference in Advanced PTC and actual PTC claimed on tax filings.*

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

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

B. DATA RELIANCE AND IMPORTANT CAVEATS

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

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

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

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

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

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

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

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

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

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

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

Nevada Senate Bill 420 (SB420) was signed into law on June 9, 2021 and codified in Nevada Revised Statutes (NRS) 695K.[5] This law establishes a health benefit plan, the public option (PO) which is hereafter referred to as the Battle Born State Plan or BBSP, that will be administered by the State of Nevada through contracts with issuers. The BBSPs must be made available as qualified health plans through the Silver State Health Insurance Exchange (SSHIX) beginning in 2026. Some provisions of SB420 specifically related to the BBSP premium targets will expire on December 31, 2029. Therefore, some analyses in this report related to the premium targets focus on the first four years of the NMSP and assume the same level of savings thereafter, through the remaining duration of both the 5-year wavier window and the 10-year deficit neutrality window. A reference to the full text of SB420 is provided in Appendix B.

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

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

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

Levels of Coverage

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

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

If unsubsidized enrollees choose a higher level of coverage in response to the lower premiums available because of the NMSP, actual coverage levels will increase but PTF will not be impacted. However, historical enrollment levels overall and by metal level in Nevada show that historical premium changes in the individual market have not resulted in material changes in enrollment by metal level. Furthermore, we assume most enrollees who are likely to disenroll due to net premium increases will disenroll upon the expiration of enhanced subsidies, so these disenrollments are reflected in the ARP enrollment change assumptions which are described further in Sections II.E and VI. Therefore, we assume enrollees included in the Baseline scenario would switch to a BBSP at their current metal level rather than change their coverage level or become uninsured.

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

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

- Some lower-income enrollees with larger subsidies who currently have zero net premium bronze plans could maintain zero net premium either by keeping their plan or by switching to a bronze BBSP, depending on market pricing of bronze plans and changes in subsidies.
- Lightly subsidized enrollees (generally higher-income and / or younger ages) are more likely to see increases in net premiums while maintaining bronze coverage, particularly if they do not switch to a bronze BBSP. There may be fewer zero premium bronze plans available beginning in 2026 as subsidies decrease due to the expiration of enhanced subsidies, which is not related to the waiver. This impact on the availability of zero premium bronze plans due to the expiration of enhanced subsidies is modeled in both the Baseline and Market Stabilization scenarios.
- Enrollees with income above 400% FPL (i.e., unsubsidized after the expiration of enhanced subsidies) will be able to obtain premium decreases by switching to a bronze BBSP.

A bronze BBSP offering increases PTF (see Section III.D for additional discussion), all else equal.

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

Access

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

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

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

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

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

Premium amounts

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

1. The 2024 premium for the SLCS available through the SSHIX, trended to the premium year at the Medicare Economic Index (MEI).

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

2. The SLCS premium in the prior year.

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

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

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

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

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

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

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

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

In response to stakeholder feedback that some issuers may not be able to achieve the full required premium reduction targets in 2026, the State of Nevada will adjust issuer and county-specific premium targets for 2026 through 2028 based on the issuer's 2025 market position. These adjusted premium targets will be based on the amount of each issuer's 2025 lowest-cost silver plan premium relative to the 2025 SLCS premium in each county. At least two issuers will be required to achieve the unadjusted premium target in each county, which will ensure the BBSP program will collectively achieve the required premium reduction of 3% below the reference premium in 2026. All issuers will be required to achieve the BBSP premium reduction target in 2029; however, the adjusted premium targets will allow issuers in less competitive positions in 2025 to spread the premium reduction needed to achieve the statutorily required 2029 target of 15% more evenly over the first four years of the NMSP.

The analyses in this report assume the adjusted premium targets will not impact the SLCS premium or PTF because at least two issuers will achieve the unadjusted premium reduction target.

SB420 does not include specific requirements for bronze and gold BBSP premiums. However, we assume premiums for BBSP bronze plans and BBSP gold plans will be based on the same underlying pricing assumptions as BBSP silver plans so projected premium relativities between metals remain similar to current premium relativities.

The analyses in this report assume assumptions applied to silver BBSP plans will also apply to bronze BBSP premiums and gold BBSP premiums, except as otherwise noted.

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

Provider reimbursement

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

Based on Milliman's proprietary research and Milliman's Consolidated Health Cost Guidelines (HCG) Source Database (CHSD), we estimate provider reimbursement (excluding pharmacy) for QHPs in Nevada in 2022 was approximately 169% of Medicare in aggregate.[9] We assume provider reimbursement for standard QHPs will remain the same as QHP provider reimbursement without the waiver, and provider reimbursement for BBSPs will be approximately 11% lower in aggregate by 2029 (i.e., approximately 150% of Medicare).

Based on 2022 Nevada market data, we estimate that the Medicaid, Medicare, and employer markets combine for approximately 95% of total provider revenue (excluding pharmacy), and the individual market comprises only 3%. The size of the individual market relative to other markets limits the impact of any reimbursement changes specific to the individual market on the aggregate payment index across all providers and services.

Nevada will leverage procurement and contracting requirements as enforcement mechanisms to ensure BBSP provider reimbursement levels are appropriate to achieve the NMSP premium reduction requirements.

The State will be responsive to complaints filed by providers that contend that payment by a BBSP, in the aggregate, is not in compliance with this provision. The State will request the necessary data to review a rate challenge. The State will also require issuers to attest annually that their provider rates are equivalent to or better than Medicare rates. Issuers that are not in compliance could receive a financial penalty per their contract with the State. Significant noncompliance could mean a breach of contract.

B. GENERATING PASS-THROUGH FUNDING UNDER A 1332 WAIVER

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

Competitive landscape driven by BBSPs decreases the benchmark silver plan

Our modeling assumes more than one BBSP will be offered in each rating area for the reasons stated in the narrative section of the waiver application. Therefore, a BBSP is expected to become the SLCS plan in all rating areas[10] in Nevada in 2026. While a BBSP is highly likely to be the SLCS plan in all years of the program, it becomes even more likely in the second through fourth years of the NMSP, as the discounts relative to the reference premium and standard QHP premiums increase. It is possible that a benchmark (i.e., SLCS) plan would not be a BBSP under the following circumstances:

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

[9] Aggregate provider reimbursement as a percentage of Medicare reimbursement is based on statewide Nevada individual market claims, excluding pharmacy claims. Average provider reimbursement levels will vary by issuer and by provider.

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

area. Therefore, we expect at least two BBSPs will also be available in each rating area, so the overall impact on the results related to the risk of a standard QHP being the SLCS plan is expected to be minimal.

- In the first year of the NMSP, when required discounts to the reference premium are only 3% per the State of Nevada's guidance in Appendix C, issuers could choose to price standard QHPs very competitively or recontract provider agreements for standard QHPs to reduce underlying cost structure, or both. If this happens, the premiums for one or more standard QHPs could be lower than the premiums for some BBSPs, and a standard QHP could become the SLCS plan. However, in such a situation, the impact to PTF would be the same as if a BBSP were the SLCS plan since this behavior would not appear in the Baseline (no waiver) scenario, assuming the waiver is given credit by CMS for the change in standard QHP pricing and provider contracting.[11] We discuss this risk in more detail in Section III.C.

The competitive situation as of 2024, which is the most recent year for which premium data is publicly available, is shown in Table 7 below. Table 7 shows that, with the exception of Rating Area 2, there are at least two issuers offering plans with premiums within 5% of the SLCS plan.[12] Assuming these issuers also offer BBSP plans that are compliant with the required premium reductions in SB420 and Appendix C, it is highly likely and a reasonable modeling assumption that the benchmark plan will be a BBSP plan and at least 3% lower than in a Baseline (no waiver) scenario. In 2024, seven distinct issuers offer silver plans in Rating Area 2. We anticipate the current level of competition in Rating Area 2 combined with the integration of the BBSP procurement process with the Medicaid managed care procurement, we anticipate that the benchmark plan in Rating Area 2 will also be a BBSP plan and at least 3% lower than in a Baseline (no waiver) scenario. Although SB420 requires issuers of Medicaid managed care plans to submit good faith BBSP bids, it does not preclude non-managed care plans from bidding to offer BBSPs.

Table 7
State of Nevada
NMSP Actuarial and Economic Analysis
Nevada 2024 Individual Exchange Market
Top 10 Lowest-Cost Silver Plans by Rating Area

Rating Area 1		Rating Area 2		Rating Area 3		Rating Area 4	
Issuer Name	% Difference to SLCS	Issuer Name	% Difference to SLCS	Issuer Name	% Difference to SLCS	Issuer Name	% Difference to SLCS
Health Plan of Nevada*	-0.2%	SilverSummit*	-2.9%	Hometown Health	-0.6%	SilverSummit*	-2.9%
Health Plan of Nevada*	0.0%	SilverSummit*	0.0%	HMO Nevada*	0.0%	SilverSummit*	0.0%
HMO Nevada*	2.0%	SilverSummit*	1.9%	Hometown Health	0.1%	SilverSummit*	0.4%
HMO Nevada*	4.6%	SilverSummit*	3.7%	HMO Nevada*	0.2%	SilverSummit*	1.9%
HMO Nevada*	5.4%	SilverSummit*	6.8%	HMO Nevada*	0.5%	SilverSummit*	2.1%
Health Plan of Nevada*	5.7%	SilverSummit*	7.2%	Hometown Health	0.9%	HMO Nevada*	4.7%
SilverSummit*	6.7%	SilverSummit*	8.8%	Hometown Health	0.9%	HMO Nevada*	4.8%
Aetna	8.7%	Aetna	9.0%	Hometown Health	1.0%	HMO Nevada*	5.2%
SilverSummit*	9.9%	SilverSummit*	9.1%	Hometown Health	1.1%	SilverSummit*	5.2%
SilverSummit*	10.0%	Hometown Health	9.8%	HMO Nevada*	1.2%	SilverSummit*	5.6%

** Current Nevada Medicaid MCO.*

Eight issuers offer plans on the SSHIX in 2024, including all four current Medicaid MCOs (Anthem, Molina, SilverSummit, and United HealthCare). Three SSHIX plans do not offer one of the 10 lowest-cost silver plans in any rating area, so they are not mentioned in Table 7; these plans are Imperial, Molina, and SelectHealth. Anthem and United HealthCare are listed on SSHIX under the issuer names HMO Nevada and Health Plan of Nevada, respectively. Aetna plans are listed on the SSHIX as Altius.

Reference premium tracks closely to individual market before reinsurance

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

[11] CMS' interpretation of market responses to the BBSPs is not known. If CMS does not credit the BBSPs with market responses in standard QHP plan pricing, PTF may be impacted.
[12] Health Plan of Nevada and HMO Nevada in Rating Area 1, Hometown Health and HMO Nevada in Rating Area 3, and SilverSummit and HMO Nevada in Rating Area 4.

Table 8 shows a simple illustration of the mechanics behind how the NMSP generates PTF under a 1332 waiver, given the requirements of SB420 and the State of Nevada's methodology outlined in Appendix C.

Table 8
State of Nevada
NMSP Actuarial and Economic Analysis
Illustration of Reference Premium Trended at Market Rate

		2024	2026	2027	2028	2029
(1)	Second Lowest Cost Silver Plan* (Baseline)	$524.23	$579.23	$602.40	$626.49	$651.55
(2)	*Assumed Annualized Trend*		5.1%	4.0%	4.0%	4.0%
(3)	Reference Premium	$524.23	$579.23	$602.40	$626.49	$651.55
(4)	*Assumed Annualized Trend*		5.1%	4.0%	4.0%	4.0%
(5)	BBSP Premium		$560.80	$529.44	$540.91	$553.00
(6)	*Cumulative Difference From Reference Premium*		-3.2%	-12.1%	-13.7%	-15.1%
(7)	*Cumulative Difference From Baseline*		-3.2%	-12.1%	-13.7%	-15.1%

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

We note the following in Table 8:

- Line 1 shows the projection for the SLCS in 2024, trended at 5.1% annually through 2026 and 4% annually thereafter.[13] The 4% trend is based on projections of per capita spending in the private insurance markets from CMS National Health Care Expenditure data, reduced by approximately 1% for value-based care initiatives in the Nevada market. We assume the expiration of enhanced subsidies will increase morbidity by approximately 2.5% in 2026; however, we simplified this adjustment in Table 8 by increasing the annualized trend from 2024 to 2026 by 1.2%. Additional references and information on this can be found in Section VI of this report. This represents a forecast of the individual market premiums in the absence of the NMSP.

- Line 3 is the calculated reference premium as defined by SB420 and reflecting the State of Nevada's methodology and guidance outlined in Appendix C. It is assumed that medical unit costs will trend at the CPI-M index, which we estimate in this modeling at 3.7%.[14] We also assume that an appropriate utilization and morbidity adjustment will be chosen that will be consistent with overall individual market dynamics in Nevada. In this illustration, that adjustment is assumed to be approximately 1.4% annually between 2024 and 2026 and 0.3% thereafter, *such that the reference premium trend equals the overall market change in premiums in the absence of the NMSP.* Additional information and references on this can be found in Section VI of this report.

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

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

Table 8 illustrates how BBSPs can achieve the required 15% savings relative to the reference premium. Because the reference premium tracks to the market, the BBSP premiums will also be 15% below the Baseline SLCS (i.e., the SLCS absent the waiver).

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

[13] The modeled 2024 premium is based on actual 2023 premiums, trended forward one year at 3.6% based on observed average 2024 rate increases and a 0.4% decrease for anticipated market morbidity due to the redeterminations of Medicaid eligibility following the end of the PHE. After 2024, premium is trended at the 4% projected trend assumption. Premium amounts in 2025 do not have a direct bearing on our modeling. Therefore, we intentionally do not include a column for 2025 in Tables 6 and 7.

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

For example, if the reference premium were to be trended at a rate lower than the overall individual market, BBSP premiums would be lower than the Baseline SLCS premium by more than 15% by 2029. In Table 9 below, we assume a reference premium trend of 3%, which is below the overall individual market trend and is not adjusted for changes in morbidity, for illustrative purposes.

Table 9
State of Nevada
NMSP Actuarial and Economic Analysis
Illustration of Reference Premium Trended Below Market Rate

		2024	2026	2027	2028	2029
(1)	Second Lowest Cost Silver Plan* (Baseline)	$524.23	$579.23	$602.40	$626.49	$651.55
(2)	*Assumed Annualized Trend*		5.1%	4.0%	4.0%	4.0%
(3)	Reference Premium	$524.23	$556.16	$572.84	$590.03	$607.73
(4)	*Assumed Annualized Trend*		3.0%	3.0%	3.0%	3.0%
(5)	BBSP Premium		$538.47	$503.47	$509.43	$515.81
(6)	*Cumulative Difference From Reference Premium*		-3.2%	-12.1%	-13.7%	-15.1%
(7)	*Cumulative Difference From Baseline*		-7.0%	-16.4%	-18.7%	-20.8%

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

In the example in Table 9, the reference premium is only trending at 3% (Line 4) while the overall individual market is trending at 5.1% through 2026 and 4% thereafter (Line 2). This implies that the BBSP premiums could be as much as approximately 21% less (Line 7) than the overall market absent the waiver rather than the 15% described in SB420.

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

In summary, SB420 generates PTF primarily through a) the requirement that BBSP premiums are a certain percentage below the reference premium over the course of the first four years of the NMSP, and b) the likelihood that this requirement results in the SLCS or benchmark premium in all areas being no greater than the BBSP target premium. We assume no additional savings from the BBSPs related to annually indexing the reference premium to an artificially low measure of health care inflation (illustrated in Table 9) that is not reflective of the overall individual market absent the waiver. Nor do we assume that BBSPs will contain materially greater advantages in provider reimbursement cost structure, medical management, or value-based purchasing (VBP) to support lower premiums beyond the required 15% reduction versus the reference premium. Under the assumption that the reference premium is properly indexed to the overall individual market without the waiver, as is the intent of the DHHS Guidance in Appendix C, the NMSP will continue to generate PTF under the waiver beyond the first four years of the program due to the availability of BBSPs.

Sources of BBSP premium savings

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

- *Reductions in provider reimbursement unit costs*: It is expected that unit costs paid to facilities and professional providers in Nevada will be reduced to support the lower BBSP premium targets.
- *Reductions in administrative costs*: Issuers will be required to price BBSPs with a smaller expense load relative to standard QHPs to reduce the portion of BBSP premium reductions placed on providers. The required administrative expense targets will be set by the Director and will grade in over the first four years of the program.
- *Improved cost structures and efficiencies due to value-based purchasing initiatives*: Based on discussions with DHHS and the provisions in SB420 related to value-based purchasing, it is expected that the state will see an increased use of these initiatives with providers across both Medicaid MCOs and BBSPs. When these initiatives are aligned across markets in this manner, it increases the likelihood that providers will experience success with respect to their patient populations and outcomes, in addition to reduced administrative burden. The actual scope and impact of these initiatives will likely vary by issuers offering BBSPs, and specific estimates of the impact of these initiatives are outside the scope of this analysis. Because of this variability in the expected impact of value-based purchasing initiatives, we do not explicitly model the impact of these

initiatives in this report. Our modeling implicitly accounts for premium savings generated by value-based purchasing initiatives through the provider reimbursement reductions.

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

Reinsurance program structure

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

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

This analysis assumes that premium reduction targets under the NMSP will be achieved by some combination of the above initiatives. It should be noted that if any one of the sources of savings does not materialize or materializes less than expected, the remaining savings from other sources must increase for the BBSPs to achieve the statutorily required premium reduction by 2029.

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

C. FEDERAL 1332 WAIVER REQUIREMENTS

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

Waivable Provision

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

Section 1332 waiver guardrails

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

1. Affordability of premiums and cost-sharing

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

   The State of Nevada will not force enrollees to select a BBSP; however, the SSHIX will take steps to encourage consumers to actively shop for the most affordable plans – which will likely be the BBSPs - and invest in marketing to distinguish the BBSPs. In Sections IV and V, we demonstrate that the affordability of the waiver is consistent

with or better than affordability in the individual market without the waiver. The addition of reinsurance in 2027 ensures all gross premiums on the individual market will be more affordable with the waiver than without the waiver in the second year of the NMSP.

Although we project the affordability guardrail will be met, the actual premium savings realized by individuals may vary based on the enrollee's level of subsidy and plan selection. Note, "lightly subsidized" and "heavily subsidized" are qualitative, descriptive-only terms intended to provide relational context for the portion of an enrollee's gross premium that is subsidized by PTCs, but they are not defined by any specific subsidy amounts or income levels. For example, a lightly subsidized enrollee would receive a relatively small PTC as a percentage of the gross premium, whereas a heavily subsidized enrollee might receive PTCs that cover most or all of the gross premium.

- ***Unsubsidized:*** In 2026, current enrollees who are not eligible for any subsidies will realize the entire premium savings driven by the NMSP if they switch to a BBSP plan. Starting in 2027, if they elect a standard QHP, they will realize the savings attributable to the reinsurance portion of the NMSP. If they select a BBSP, they will realize the savings attributable to both the reinsurance and BBSP programs.

- ***Lightly subsidized:*** Current enrollees who receive small subsidies may realize some net premium savings (i.e., after subsidy) if the BBSP gross premium falls below the enrollee's current net premium and they elect a BBSP. Any savings driven by the NMSP for these enrollees will be shared with the federal government, which is then passed through to the State of Nevada under the waiver. If they elect a standard QHP instead of a lower-cost BBSP, these enrollees may pay higher net premiums because they will be paying the difference between the pre-NMSP subsidies (based on a higher benchmark silver plan) and the lower post-NMSP subsidies (based on a lower BBSP benchmark plan). Enrollees selecting a QHP with higher net premiums over a lower-cost option (i.e., a BBSP with a waiver) is a choice that currently exists in the marketplace (without a waiver).

- ***Heavily subsidized:*** The impact of the NMSP on net premiums for current enrollees who receive substantial subsidies will depend on whether they elect a lower-cost BBSP or a higher-cost standard QHP. The net premium for silver and gold plan enrollees and some bronze plan enrollees who switch to a BBSP may be less than without the NMSP. If they do not elect a BBSP, their net premium will likely increase to offset the decrease in federal subsidies. The net premium for some bronze plan enrollees may increase, even if they switch to a BBSP; however, the median net monthly premium increase for these enrollees versus the Baseline scenario is less than $2 in 2026 and less than $10 in 2029.

The federal premium subsidy structure will remain unchanged with the introduction of the BBSPs. The out-of-pocket premium cost for the SLCS plan for a member will continue to be limited to a percentage of household income prescribed under the ACA. *With the exception of some bronze plan enrollees and some subsidized enrollees who choose to remain enrolled in higher cost standard QHPs, the enrollee net premiums under the waiver will be no greater than, and in most cases lower than, enrollee net premiums absent the waiver in aggregate; and cost-sharing requirements will be unchanged by the waiver.*

2. Comparable number of state residents covered

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

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

3. Comparable coverage

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

4. No increase to federal deficit

   Section 31 CFR 33.108(f)(3)(iv)(D) states that the waiver will not increase the federal deficit, either over the five-year waiver period or the 10-year federal deficit neutrality window. CMS requires the total of various costs to be considered when determining the impact on the federal deficit. Section V of this report details those costs and

the treatment of them in this waiver modeling. It also shows the projected federal subsidies during the 10-year federal deficit neutrality window under both the Market Stabilization scenario and the Baseline scenario. The Market Stabilization scenario presented in this report illustrates that the Nevada 1332 waiver is not expected to increase the federal deficit when compared to the Baseline scenario without the waiver. The analysis shows that federal costs are expected to decline due to the lowering of the SLCS benchmark premium, which lowers the aggregate federal subsidies.

Other federal requirements

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

1. Current law requirement

   Guidance from CMS, including 86 FR 53459, states that the analysis must only reflect law and legislation that has currently been enacted. As of the date of this document, the enhanced subsidies are intended to sunset at the end of 2025. We cannot predict whether the enhanced subsidies will be further extended beyond 2025. Therefore, the actuarial and economic analysis is prepared based on current law under which enhanced subsidies expire after 2025. As previously mentioned, the waiver must assume current law (state and federal). This includes applying the State of Nevada's interpretation of statute regarding the premium reduction target; see Appendix C for state-specific guidance regarding the methodology to be utilized by the State of Nevada.[15]

2. Health coverage analysis

   Section 31 CFR 33.108(f)(4)(ii)(B) requires that the 1332 waiver include a detailed analysis of the impact of the waiver on health insurance coverage in the State of Nevada. Based on the provisions of the SB420 legislation, we reasonably assume the Nevada NMSP will not have a material impact on enrollment in other markets. Specifically, the populations eligible to enroll in BBSPs are the individual market and the uninsured. Employer groups, including small employers, are not eligible to enroll in the BBSPs.[16] The enrollment changes in the markets other than the individual and uninsured that are modeled in the actuarial analysis are attributable to forces unrelated to the NMSP, including population growth and shifts, the expiration of enhanced subsidies, and the end of the PHE.

3. Demographic information

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

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

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

[15] See NRS 695K.200; Section 10.5

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

4. Explanation of assumptions

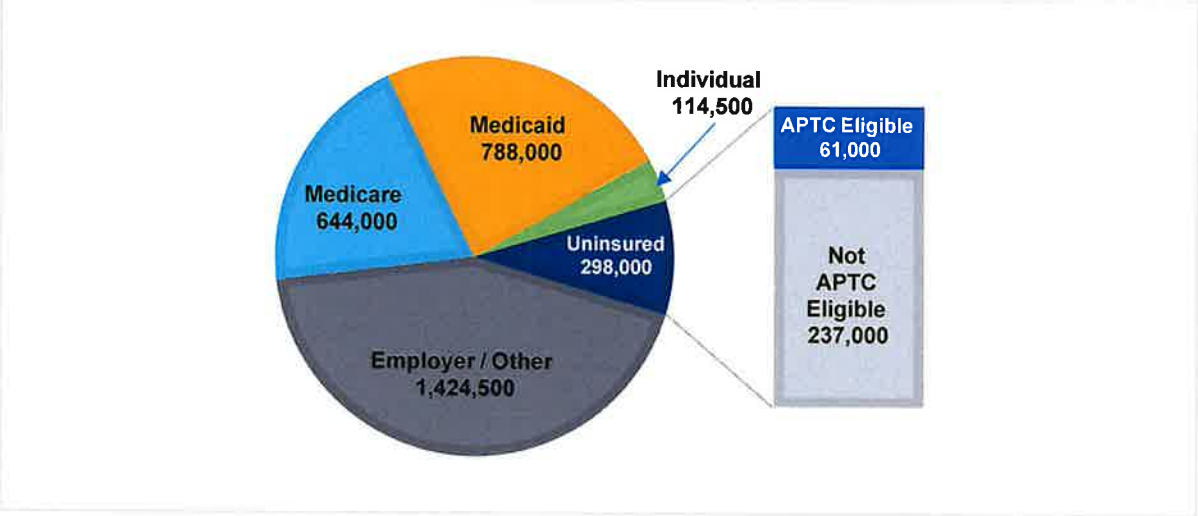
   Section 31 CFR 33.108(f)(4)(iii)(B) requires that the 1332 waiver include an explanation of the key assumptions used to develop the estimates of the effect of the waiver on coverage and the federal budget, such as individual and employer participation rates, behavioral changes, premium and price effects,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

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

D. CURRENT NEVADA COVERAGE LANDSCAPE

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

Figure 1: Sources of Coverage for Nevada Residents in 2022



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

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

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

Medicare

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

Employer-sponsored coverage

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

Medicaid

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

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

Individual coverage

Since the inception of the ACA, health care coverage on the SSHIX has been available on a guaranteed issue basis to Nevadans who are not eligible for other coverage (employer, Medicare, Medicaid) and have qualifying immigration status. This includes people with household incomes greater than 138% of the FPL and some specific populations with incomes less than 138% of the FPL, such as legal immigrants, who are not eligible for Medicaid. The SSHIX rating areas and their 2024 populations[19] are as follows:

- Rating Area 1 has a population of approximately 2.4 million in 2024 and includes Clark and Nye counties.
- Rating Area 2 has a population of approximately 500,000 in 2024 and includes Washoe county.
- Rating Area 3 has a population of approximately 175,000 in 2024 and includes Douglas, Lyon, and Storey counties.
- Rating Area 4 has a population of approximately 130,000 in 2024 and includes the following counties: Churchill, Esmerelda, Eureka, Humboldt, Lander, Lincoln, Elko, mineral, Pershing, and White Pine.

[17] Medicare enrollment does not impact the determination that Nevada's 1332 waiver meets the required guardrails discussed in this report.
[18] Dolan, R., et al. (December 17, 2020). Medicaid Maintenance of Eligibility (MOE) Requirements: Issues to Watch. Kaiser Family Foundation. Retrieved November 8, 2022, from https://www.kff.org/medicaid/issue-brief/medicaid-maintenance-of-eligibility-moe-requirements-issues-to-watch/
[19] World Population Review population of counties in Nevada. Retrieved May 1, 2024, from https://worldpopulationreview.com/states/nevada/counties

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

The expiration of the PHE and potential end to enhanced subsidies introduced under ARP and extended by the IRA will both have significant impacts on the individual market in Nevada. In particular, material changes in enrollment and morbidity could occur that will affect PTF estimates modeled in this report. As with Medicaid, we do not expect the exact timing of these events to have a material impact on the results of the waiver analysis, and we assume these changes will occur between 2022 and the beginning of the NMSP in 2026.

In 2021, the Biden administration announced administrative changes that affected certain individuals previously unable to enroll in exchange coverage due to the so called "family glitch." Proposed rules for these changes were released in October 2022. These changes made it easier for these individuals and their families to enroll, in many cases. This may result in a potential increase in enrollment in Nevada's individual market, coming primarily from the uninsured.[20] However, the increase would be small and would appear in both the Baseline and Market Stabilization scenarios, with an immaterial impact overall on PTF. Therefore, we do not make any specific assumptions for the impact of this change in our modeling, with the estimated effect being similar with or without the waiver.

Uninsured

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

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

E. PROJECTED 2026 NEVADA COVERAGE LANDSCAPE

The NMSP will begin in 2026; however, as described above, we anticipate changes in the Nevada coverage landscape between 2022 and 2026 due to the expiration of the PHE and the impending expiration of enhanced subsidies. To advance the enrollment and population estimates from 2022 to 2026 for purposes of establishing a baseline scenario for modeling PTF, the impacts from the PHE, ARP, and general population growth are shown in Table 10. These values are rounded to emphasize that they are estimates of enrollment based on a four-year projection with material known changes to the coverage landscape during the projection timeframe, as well as potential unknown changes. There is uncertainty related to these projections, but they represent reasonable expectations given current information and for purposes of this modeling.

Table 10
State of Nevada
NMSP Actuarial and Economic Analysis
Estimated Nevada Market Enrollment Shifts 2022-2026

	Individual	Uninsured PTC-Eligible*	Uninsured Non-PTC-Eligible**	Medicaid / CHIP***	Employer-Sponsored / Medicare / Other	Total
2022 Enrollment	114,500	61,000	237,000	788,000	2,068,500	3,269,000
PHE Ends	15,700	33,000	0	(191,000)	142,300	0
ARP Ends	(29,800)	18,600	11,200	0	0	0
Population Growth	1,000	3,200	12,600	41,800	109,700	168,300
2026 Enrollment	101,400	115,800	260,800	638,800	2,320,500	3,437,300

**Includes members who may not qualify for subsidies based on income and gross SLCS premium.*
***Includes members eligible for employer-sponsored insurance or Medicaid, or who do not qualify for the individual market due to immigration status.*
****Excludes dual-eligible members to avoid double-counting; these members are included in the Medicare enrollment.*

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

We note the following regarding Table 10:

- The projected enrollment changes were developed prior to the initial waiver application submitted in January 2024. We reviewed the aspects of the enrollment projection that are directly relevant to this analysis, specifically the projected changes in the individual market and the uninsured PTC-eligible population, and we believe they remain reasonable for purposes of the actuarial and economic analysis for the Nevada 1332 waiver.

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

- We assume beneficiaries disenrolled from Medicaid will enroll in employer-sponsored and individual coverage or become uninsured approximately in proportion to current market sizes (i.e., proportional allocation).

- We assume the expiration of enhanced subsidies at the end of 2025 will result in some current individual market enrollees transitioning to uninsured PTC-eligible status because required out-of-pocket premiums will increase for many enrollees.

- Moreover, given the structure of the enhanced subsidies, specifically that those with incomes over 400% FPL are eligible for subsidies, the ending of enhanced subsidies will make these enrollees ineligible for subsidies. Hence, a material portion of the uninsured population over 400% FPL move into the uninsured non-PTC-eligible segment.

- We estimate the total number of enrollees transitioning out of individual coverage due to the expiration of enhanced subsidies (29,800) by reviewing the change in historical enrollment from 2019 to the open enrollment of 2022 in the State of Nevada. The detailed assumptions used to develop these projected enrollment impacts are described in more detail in Section VI below.

- We assume population growth at 1.3% annually,[21] except that we adjust population growth in the individual market to reflect observed enrollment changes from 2022 to 2023.

- The percentage by which enrollment increases following the expiration of the PHE (and associated resumption of Medicaid redeterminations) and decreases due to the expiration of enhanced subsidies is assumed to vary based on income level. These assumptions result in varying enrollment impacts by both income level and age. See the Data and Methodology in Section VI for more detail.

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

III. DESCRIPTION OF SCENARIOS

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

A. DESCRIPTION OF SCENARIOS

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

PTF is the difference between the net federal spending (outlays minus revenues) that would have been generated without the waiver (the Baseline scenario) and the net federal spending after the waiver. To the extent the Section 1332 waiver reduces net federal outlays[22] for premium tax credits, these savings can be passed through to the State of Nevada (i.e., PTF) to be used for various purposes, such as reducing enrollee out-of-pocket premium costs (either subsidized or unsubsidized) or providing further incentives to either enroll in coverage (if uninsured) or stay enrolled (if currently enrolled). SB420 does require that the state's PTF first be used to fund administrative costs to operate the BBSPs before it is used to fund other initiatives.

Table 11 lists the key assumptions that impact each scenario. A brief description of each is provided below. Detailed methodology and sourcing can be found in Section VI of this report.

Table 11
State of Nevada
NMSP Actuarial and Economic Analysis
Scenario Assumptions

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

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

Table 12 State of Nevada NMSP Actuarial and Economic Analysis Scenario Assumption Descriptions		
	Assumption	**Brief Description**
Enrollment	General population growth	Individual market enrollment after 2023 is assumed to grow at the statewide population growth rate, or 1.3%, at a minimum. This growth is assumed to apply uniformly (e.g., across income levels, age groups, metallic levels).
	ACA family glitch	We do not model any impact on enrollment due to changes in the ACA family glitch regulation. See Section II.D for additional information.
	Expiration of the PHE	We assume the Medicaid disenrollment process due to the expiration of the PHE is completed prior to the effective date of the NMSP in 2026, most likely during 2024. Individual market enrollment is assumed to increase due to the expiration of the PHE as Medicaid disenrollment occurs. The impact varies by income level to account for Medicaid eligibility categories.
	Expiration of enhanced subsidies	If enhanced subsidies expire after 2025, as currently scheduled, a portion of current SSHIX enrollees are assumed to disenroll from individual coverage at the beginning of 2026, driven by increases in net (post-subsidy) premiums. The projected enrollment changes due to the expiration of enhanced subsidies decreases enrollment in the individual market and increases the uninsured pool.
	BBSP appeal	Some uninsured Nevadans who are not subsidy-eligible (mainly near or above 400% FPL) are assumed to enroll in the ACA coverage, either on or off the exchange, due to the lower premiums available through the BBSPs and heightened awareness of the exchange due to NMSP marketing and communications.
	BBSP bronze offering	The BBSPs, by legislation, are only required to have silver and gold level offerings. However, issuers will be contractually required to also offer bronze BBSPs. See Section III.C for a detailed discussion.
	Reinsurance	We assume some uninsured Nevadans who are not subsidy-eligible will enroll in ACA coverage due to lower premiums available after the implementation of reinsurance. We assume a higher enrollment growth percentage due to reinsurance in Rating Areas 3 and 4 than in Rating Areas 1 and 2 because the higher premiums in Rating Areas 3 and 4 result in a larger premium decrease.
Premiums	Standard QHP premium trend	Gross premiums (before reinsurance) for standard QHPs and off-exchange offerings are modeled consistent with actual 2024 premium rates in the SSHIX by metal level. In 2025, gross premiums (before reinsurance) for standard QHPs and off-exchange offerings are assumed to increase 4%[23] per year for silver plans both with and without the waiver and 4.25% for bronze and gold plans. Premium growth for bronze and gold offerings is projected to converge to 4% by 2030. The 4% assumption is based on CMS projections of per capita national health expenditures and the impact of additional value-based purchasing initiatives that will be part of Nevada's broader efforts to move a larger share of Medicaid and BBSP payments to a value-based purchasing framework. The trend variation for bronze and gold plans is based on observations of recent experience. We expect premium trends for all metals to converge to maintain reasonable relativities based on differences in actuarial value.
	Individual market morbidity	Morbidity is the overall illness burden of a population, independent of the population's average age. Higher morbidity increases prices in a risk pool such as Nevada's Individual market, all else equal. End of PHE: We assume premiums for existing standard QHPs on the SSHIX decrease by 0.4% in 2023 due to improved morbidity from the additional enrollment transitioning from Medicaid after the expiration of the PHE. Expiration of enhanced subsidies: The exit of enrollees who leave the individual market due to the expiration of enhanced subsidies is assumed to increase morbidity by 2.5%. Increased enrollment due to BBSP appeal: Morbidity is projected to improve 0.2% in 2026 and 0.1% in 2027 relative to the baseline due to additional enrollment from the lower-priced BBSPs. No additional morbidity changes are assumed to happen beyond 2027.
	Premium reduction target	We assume the NMSP will achieve the premium reduction targets described in the agency's memorandum of guidance in Appendix C. We assume the annual BBSP premium reduction targets (before reinsurance) are 3.0% in 2026, 5.0% in 2027, 6.5% in 2028, and 8.0% in 2029.

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

Table 12 State of Nevada NMSP Actuarial and Economic Analysis Scenario Assumption Descriptions		
	Assumption	**Brief Description**
	Reinsurance	We assume reinsurance will reflect the following parameters: ▪ Attachment point: $60,000 ▪ Cap: $1,000,000 ▪ Coinsurance: 28.5% Based on these reinsurance parameters, we estimate reinsurance will decrease premiums by approximately the following percentages: ▪ Rating Area 1: 7.2% ▪ Rating Area 2: 7.5% ▪ Rating Area 3: 6.2% ▪ Rating Area 4: 11.4%
Subsidies	Indexed FPL	The federal poverty level (FPL) is assumed to increase by 2.5% every year after 2023.[24]
	ACA affordability limits	The maximum amount of premium for which an ACA enrollee is responsible as a percentage of their income is indexed based on National Health Expenditure data and projections published by CMS. We analyzed the changes in these values year over year prior to enhanced subsidies becoming available in 2021. Based on the historical change, we projected income limits through the duration of the 10-year deficit neutrality window.
	BBSP adoption rate	Fully subsidized enrollees are assumed to enroll in a BBSP at a higher rate than lower or nonsubsidized enrollees.
	Premium relief program	The estimated cost of the premium relief program each year is shown in Table 1.

Each of the assumptions in Table 12 is developed independently based on our best estimates; however, actual experience relative to each assumption will most likely differ to varying degrees. Furthermore, the amount of time between this analysis and the beginning of the NMSP introduces additional potential for variability to the projected impact of the NMSP on enrollment and costs because it extends the duration of the projection and the opportunity for unforeseen events. We apply an additional 10% discount to the five-year waiver and 10-year deficit estimates to reflect cumulative conservatism across all assumptions. The potential variances include, but are not limited to, enrollment volume and distribution, plan selection, regulatory changes, utilization and cost trend, and member agency.

Except for the variances in premium trend noted in Table 12, all premium and subsidy assumptions in Table 12 are applied equally to all metals. SB420 does not include specific requirements for bronze and gold BBSPs; however, we assume premiums for BBSP bronze and gold plans will be lower than premiums for standard QHP bronze and gold plans, respectively, in proportion to the difference between BBSP silver plans and standard QHP silver plans.

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

B. ACA MARKET DYNAMICS

To inform waiver modeling assumptions, we reviewed historical open enrollment data for the Silver State Health Insurance Exchange (SSHIX) and other states. As shown in Table 13, the distribution of enrollment by metal level in Nevada has remained relatively consistent from 2020 to 2024.

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

Table 13 State of Nevada NMSP Actuarial and Economic Analysis Historical Nevada Individual Market Exchange Enrollment by Metal					
	2020	2021	2022	2023	2024
Catastrophic	1.0%	0.6%	0.4%	0.3%	0.3%
Bronze	40.0%	38.9%	37.5%	39.2%	36.8%
Silver	55.0%	56.7%	57.4%	55.5%	58.5%
Gold	4.0%	3.8%	4.7%	4.9%	4.5%

In addition, we reviewed the metal level changes on SSHIX between 2020 and 2021 and between 2021 and 2022 based on enrollment data provided by SSHIX, and approximately 6.5% of enrollees changed metal levels in each year. ***Because the historical enrollment distribution by metal level is materially consistent in each year and the percentage of members who switch metals is low, our modeling does not assume any plan switching across metal levels.***

The percentage of returning enrollees who actively enroll in Nevada has fluctuated but has generally remained between 30% and 40%, except in 2020. We show historical active enrollment percentages for returning enrollees in Nevada and other states in Table 14.

Table 14 State of Nevada NMSP Actuarial and Economic Analysis Historical Exchange Enrollment Data					
	2020	2021	2022	2023	2024
% of Re-enrollees who actively enroll					
Nevada	44.7%	33.9%	34.3%	39.0%	31.1%
Colorado	59.5%	45.1%	46.6%	63.2%	58.3%
All SBM	36.3%	28.0%	29.8%	28.2%	28.0%
All FFM	71.2%	73.0%	72.1%	72.3%	70.1%
FFM Only: % of Active re-enrollees who switch plans					
Total FFM			56.2%	57.7%	55.0%
Minimum			23.9%	30.7%	29.6%
Median			37.9%	45.9%	44.8%
Maximum			75.0%	75.7%	66.4%
FFM Only: % of Total enrollees who switch plans					
Total FFM			40.5%	41.7%	38.6%
Minimum			17.0%	18.4%	19.8%
Median			26.7%	31.5%	30.3%
Maximum			54.1%	61.7%	47.9%

Note: Plan switching data was not readily available for years prior to 2022.

We note the following additional observations in Table 14:

- States that use the federally facilitated marketplace[25] (FFM) have notably higher active enrollment percentages from 2020 through 2024 than states with state-based exchanges, such as Nevada and Colorado.
- Active enrollment in Colorado increased significantly in 2023, which was the first year of the Colorado Public Option.

Although some degree of plan switching has occurred historically and is likely to exist in the Baseline scenario, we do not model plan switching in the Baseline scenario (i.e., absent the waiver) because this plan switching would also occur in the Market Stabilization scenario. Therefore, the impact of this plan switching would be normalized and would not impact our projected impact of the waiver. *The incremental plan switching driven by the waiver is modeled in the analysis as the BBSP take-up rate.*

[25] 2024 Marketplace Open Enrollment Period Public Use Files | CMS; https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2024-marketplace-open-enrollment-period-public-use-files

C. DISCUSSION OF BBSP IMPACT ON SECOND LOWEST COST SILVER PLAN

Throughout this analysis, we assume BBSPs will become the SLCS plan in every rating area (and county) within the state of Nevada. In this section we explain why this is a reasonable assumption. However, we also note how the presence of BBSPs is likely to generate additional competition to put downward pressure on standard QHP rates. Note that our modeling does not assume any explicit impact of BBSPs on standard QHP premiums since PTF is not dependent on standard QHP pricing, and assuming no change to standard QHP premiums is a more conservative assumption when evaluating whether the waiver satisfies the affordability guardrail.

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

BBSP as SLCS

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

Standard QHP s as SLCS

Although BBSPs will be offered by MCOs or QHPs that may already offer standard QHPs, the BBSP offerings starting in 2026 can be considered as a new competitor. Indeed, increased competition in the market is one of the stated objectives of Nevada SB420 and an acknowledged policy impact of public options generally.[26] Market research also provides empirical evidence that increased individual market competition is associated with lower premium rates and lower annual rate increases.[27, 28, 29, 30, 31] Thus, in the event a BBSP does not become the SLCS, it is reasonable to assume that the NMSP did, in fact, generate downward premium pressure on the plan or plans that becomes the SLCS, even though it is not a BBSP. This assumption is consistent with assumptions cited in approved 1332 public option waivers in other states.[32]

Although the evidence that the change in the SLCS is attributable to the waiver is less direct under this scenario, the State intends to obtain data and other information from the state's issuers, which will be defined through the procurement and contracting process, and from other states to analyze and estimate market trends absent the NMSP and develop a range of potential impacts of the NMSP on standard QHP premiums for purposes of determining PTF in these situations. The State is coordinating with the Division of Insurance to implement requirements for BBSP issuers to submit both BBSP and standard QHP rates accompanied by explanations of how BBSPs impacted standard QHP pricing. For issuers who only offer standard QHPs, we will compare pricing factors to both BBSP and standard QHP offerings from other issuers to assess whether the price drivers are similar to BBSP price drivers. The State will collaborate with other stakeholders and other states with similar experience to develop specific data requests and templates for this purpose.

The Market Stabilization scenario does not model any changes to standard QHP premiums in response to the BBSPs entering the market. The waiver analysis reflects the more direct and likely possibility that a BBSP becomes the SLCS, which produces equivalent outcomes.

BBSP impact on PTF

The State plans to estimate the impact of the BBSP program for purposes of determining PTF through a multi-pronged approach.

[26] https://www.americanprogress.org/article/4-myths-public-option/
[27] https://www.nber.org/papers/w20140
[28] https://www.ajmc.com/view/aca-marketplace-premiums-and-competition-among-hospitals-and-physician-practices
[29] https://pubmed.ncbi.nlm.nih.gov/26643622/
[30] https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2015.0738?journalCode=hlthaff
[31] https://ideonapi.com/resources/blog/increased-competition-individual-aca-market/
[32] Colorado 1332 Waiver Amendment Submission 11-30 Final2 (2).pdf, page 58; https://drive.google.com/file/d/1SUy-iNz3i7IlRTPTqy2OJgNYH1oyN5mX/view

First, the State plans to conduct a Nevada-specific comparative analysis using historical data where the State will monitor the overall market trends before and after the implementation of the NMSP. The State anticipates this analysis will show lower rate increases, all else equal, starting in 2026. Next, the State will conduct a national comparative analysis where annual premium trends in Nevada will be compared against premium trends in other states, adjusting for various factors as appropriate.

Next, Nevada will assess the rate filing information submitted by issuers in Nevada's individual marketplace, paying special attention to network factors and expense loads. We anticipate the network factor for BBSPs will be different than the network factor for standard QHPs, and BBSPs should have lower expense loads than standard QHPs. If an issuer does not offer standard QHP plans, or if an issuer that does offer standard QHPs in the early years does not offer them in the future, no comparison of direct pricing information in the rate filings can be made, and the impact of BBSPs will need to be determined indirectly.
Lastly, the State anticipates collecting industry medical and prescription drug pricing trend information in order to inform the establishment of the reference premium as required by SB420. Collectively, the analyses outlined above will be used by Nevada to estimate what rates would have been absent the waiver to isolate the impact of BBSPs.

D. DISCUSSION OF BBSP TAKE-UP RATE ASSUMPTIONS

Impact of a bronze BBSP offering

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

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

Under a waiver scenario where a BBSP becomes the SLCS plan, many existing silver plan consumers under a Baseline scenario may switch to the benchmark plan or something close in price to that plan. Likewise, many bronze purchasers under the Baseline scenario will be expected to purchase a bronze-level BBSP under the Market Stabilization scenario. If the NMSP would not include bronze BBSP offerings, we would expect some amount of previous bronze purchasers to take coverage under a silver BBSP, thereby using up the entire available subsidy. However, our modeling does assume the NMSP will include bronze BBSPs.

One key downstream implication of including bronze BBSPs for this waiver analysis is that the take-up assumption in the BBSPs does impact the overall PTF calculation. A higher assumed take-up rate in the BBSPs increases PTF, as it is assumed more bronze purchasers will also take up BBSP coverage and use only a portion (as opposed to all) of their available subsidy.[33] Said differently, if the BBSPs only offered silver and gold plans, take-up in the BBSPs would have no impact at all on PTF. The actual take-up of the BBSPs will only be impactful on PTF if we assume bronze-level BBSPs are offered.

Overall BBSP take-up rate

In our analysis, we assume a price advantage for BBSPs due to the requirements of SB420 and the State's enforcement mechanisms through the procurement and contracting process. This price advantage implies some consumers will see additional value in the BBSPs and will take up BBSP coverage. It is difficult to predict consumer behavior in the presence of the BBSPs' price advantage, and this difficulty stems from several factors:

[33] Since bronze gross premiums are generally lower than silver and gold plan premiums, subsidies for bronze plans are likewise generally less than subsidies for silver and gold plans. Therefore, if issuers offer a bronze BBSP, we assume a portion of current bronze individual market enrollees and new individual market enrollees will select the bronze BBSP instead of a silver or gold BBSP, thereby reducing subsidies under the waiver and increasing PTF.

- Although price is an important factor, consumers do not always choose a plan based on price.[34]
- Provider networks will be required to align with Medicaid's broad provider networks to a certain extent; however, other product features of BBSPs offered by the various individual exchange insurers are not known at this time.

To encourage more active consumer selection, the State of Nevada will undertake several initiatives which are described below. Notwithstanding these initiatives, we assume some material share of the market will voluntarily enroll in standard QHP coverage for various reasons. We use several analyses to support the estimated take-up rate of BBSPs using publicly available data from marketplaces, both state-based and those utilizing the federal platform, HealthCare.gov.

Share of market for SLCS issuer

Since we assume it is highly likely that a BBSP will become the SLCS in all rating areas,[35] historical SLCS market share is a potential indicator of BBSP take-up in the absence of the state initiatives to encourage BBSP enrollment noted above. In other words, these estimates would be a minimum bound for BBSP take-up estimates.

We analyzed public enrollment data for states utilizing HealthCare.gov to determine the market share typically commanded by the SLCS. For the four years from 2019 through 2022, between 30 and 40 percent of enrollees in states utilizing HealthCare.gov who reside in a county with more than two issuers were enrolled in the SLCS plan. The median enrollment in the SLCS by county in counties with at least two issuers was slightly higher, ranging between 35% and 50% over the same four years. Key drivers of the SLCS plan's market share include the number of issuers in the county and the difference between the SLCS premium and the next higher premium.

Figure 2 shows the distribution of county-years (1 county in a year) that have an SLCS issuer that has the market share shown on the X axis. For example, the second bar from the left illustrates that approximately 14% of counties across the five years of 2019-2022 had an SLCS that garnered between 10% and 20% of the total market (all metals). Based on this historical data, there is roughly a 62% chance that the SLCS issuer will garner more than 30% of the market. Again, note that these market shares do not include the impact of any specific initiative to raise awareness of the benefit of active enrollment and shopping for a more affordable plan, such as those the State plans to undertake.

Figure 2: Percentage of Counties by SLCS Market Share 2019 to 2022

[34] Consumer inertia is discussed in more detail here: https://www.thecgo.org/research/sources-of-consumer-inertia-in-the-individual-health-insurance-market/

[35] See Section III.C for additional explanation.

Auto-enrollment and plan switching

The historical percentage of enrollees who auto-enroll in their health plans is also a potential indicator of BBSP take-up since it is a measure of enrollee engagement in plan selection. As shown in Table 14 in Section III.B of this report, we examined historical open enrollment data to estimate the percentage of enrollees who are active shoppers for health coverage (i.e., not enrolled in their current plan by default) and the percentage of those active shoppers who change plans. The auto-enrollment rate on SBMs averaged more than 70%, implying relatively few active shoppers, while the auto-enrollment in states utilizing the federally facilitated marketplace (FFM) HealthCare.gov averaged less than 30%, implying a much greater rate of active purchasing. Nevada had an auto-enrollment rate of more than 60% each year from 2021 to 2024, so fewer than 40% of enrollees in Nevada made an active choice to either remain in the current plan or switch plans. The median percentage of active enrollees who switch plans in FFM states is approximately 45%. We reviewed historical SSHIX data in Rating Area 1 in Nevada from 2020 through 2022, and approximately 14% of enrollees switched plans each year.

State initiatives

To close the gap between Nevada's historical active enrollment experience and the higher level of engagement for states that use the FFM, Nevada intends to implement a variety of state outreach and enrollment initiatives. The strategies the State will implement to achieve these goals are described below.

- **Issuer marketing and outreach requirements:** The State will require issuers under their BBSP contracts to widely market and promote the new BBSPs to Nevada consumers during open enrollment. For instance, the State is exploring including contractual requirements for issuers to develop their own marketing and outreach campaign meeting certain parameters, to be approved by the State prior to open enrollment. This will include mailers and other communications notifying consumers of the availability of BBSPs and of potential savings by actively shopping rather than remaining in their current plan. Issuers could highlight BBSPs as a way to mitigate any premium increases felt by many consumers due to the expiration of enhanced IRA subsidies.

- **Integrating active shopping promotion into the broader SSHIX marketing campaign:** Promotion of active plan selection will be woven into SSHIX's fall marketing campaign. For instance, SSHIX can include static messaging on the Nevada Health Link website to urge consumers to review the health coverage options available to them on the Nevada Health Link prior to its standard auto-enrollment procedures to remind consumers that premiums may be lower in other plans if they shop online. The State is also exploring including language in the dynamic enrollment and eligibility notices consumers receive from SSHIX immediately prior to open enrollment.

- **Default sorting and plan display:** The Nevada Health Link's default sort option lists plans from lowest to highest premium. Since BBSPs' premiums will be priced lower than other plan options, maintaining that sorting function should ensure that BBSPs will be among the first search results consumers see, thus increasing the visibility of BBSPs and the likelihood consumers enroll in a BBSP.

- **Differentiating BBSPs:** The State plans to create a BBSP logo or some similar differentiating moniker for use on its website and plan preview tool and its application plan selection pages. SSHIX can require plan names to incorporate the BBSP name. SSHIX and issuers can market BBSPs as 'quality assured products' brought to consumers by the State.

These marketing and outreach strategies, when combined with the tendency for consumers to enroll in plans based on price, support that Nevada can achieve active enrollment rates more consistent with FFM states. [36]

Final take-up rate assumption

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

- There will be more publicity around the BBSP offerings relative to simply being the SLCS in any given year.

- The State will require issuers under their BBSP contracts to widely market and promote the BBSPs during open enrollment.

[36] See: Holahan, Wengle, and O'Brien. How Do People Make Choices among Marketplace Plans? Available at: https://www.urban.org/sites/default/files/2023-09/How%20Do%20People%20Make%20Choices%20among%20Marketplace%20Plans.pdf

- Active plan selection will be woven into the SSHIX Fall open enrollment campaign.
- For the same reasons that a BBSP is likely to be the SLCS, a BBSP will likely also have the lowest cost silver (LCS) status.
- Within the Nevada Health Link application, the default sort option lists plans by net premium from lowest to highest. Since BBSPs are expected to have lower premiums than other plan options, this sorting function will ensure BBSPs are among the first plans visible to consumers on the platform.
- The BBSPs will be offered by well-established issuers in the market who are also Medicaid MCOs. They will not be a "new entrant" to the market from a consumer perspective.
- Active enrollment in Colorado increased by almost 35% in the first year of the Colorado public option, from 47% in 2022 to 63% in 2023.
- BBSPs will have certain notation or a logo in the Nevada Health Link plan selection page that further draws attention to them.

Therefore, under the Market Stabilization scenario, we assume a take-up for enrollees on-exchange of 80% in all years of the NMSP.

Reinsurance

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

However, unsubsidized individuals will receive the full benefit of the price reduction under a reinsurance program. Hence, to the extent premium reductions due to reinsurance may provide additional incentives for some uninsured individuals to enroll in the individual market, we assume enrollment in BBSPs will also increase slightly due to the implementation of reinsurance.

Small employer migration

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

Using publicly available premium rate data for the small group and individual markets, we compared premium rates in 2022 and trended them forward to 2024 using average rate increases that were approved by the Nevada Department of Insurance for benefit years 2023 and 2024. This analysis shows that small group rates are currently lower than individual market rates by 4% to 26% depending on rating area and metal level, and approximately 16% lower on average.[37] We include details on the variance among small group premiums relative to individual in Section VI.

Under a waiver scenario, individual market gross premiums are projected to decrease by approximately 11% to 15% relative to the Baseline starting in Year 2 of the NMSP. This analysis of the current premiums in both the small group and individual markets in Nevada indicates that, with the reduction in individual prices stemming from the NMSP, available premium rates in the individual market will reach some degree of parity with small group premium rates. This implies that, based on price alone, some incremental number of employers could consider offering an ICHRA benefit to some or all of their employees as average prices in these markets converge.[38] However, employers are not inclined to shop purely on the lowest price and will likely also consider their benefit offerings relative to other employers to attract the best talent. Employers still retain some degree of paternalism, as well, wanting to provide their employees with optimal benefit package whenever possible.

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

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