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Attorneys for Plaintiffs

FIRST JUDICIAL DISTRICT COURT OF NEVADA
IN AND FOR CARSON CITY

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

Plaintiffs,

v.

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

Defendants.

Case No. 25 OC 00109 1B

Dept. No. 1

PLAINTIFFS' APPENDIX TO MOTION FOR PRELIMINARY INJUNCTION

Volume 3 of 18

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EXHIBIT #	DESCRIPTION	PAGES
D	Section 1332 Waiver Application December 27, 2022 (part 2)	130-204

35340515_v1

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Table 43
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2A: No ARP Public Option – PTF Accumulation
Impact of Public Option on Premium and Subsidies

	Scenario 2: Baseline – No Waiver			Scenario 2A: No ARP Public Option With PTF Accumulation			Change	
Year	PTC Membership	APTC PMPM	Annual APTC (thousands)	PTC Membership	APTC PMPM	Annual APTC (thousands)	APTC Savings (thousands)	PTC Savings (thousands)
2026	83,100	$441	$440,000	83,100	$418	$417,000	($23,000)	$21,000
2027	84,200	$460	$465,000	83,500	$413	$414,000	($51,000)	$46,000
2028	85,500	$479	$491,000	84,500	$406	$412,000	($79,000)	$71,000
2029	86,600	$499	$519,000	85,600	$398	$409,000	($110,000)	$99,000
2030	87,800	$520	$548,000	86,800	$415	$432,000	($116,000)	$104,000
2031	88,900	$542	$579,000	87,900	$433	$457,000	($122,000)	$110,000
2032	90,100	$565	$611,000	89,100	$451	$483,000	($128,000)	$115,000
2033	91,300	$589	$646,000	90,200	$471	$510,000	($136,000)	$122,000
2034	92,500	$614	$682,000	91,400	$492	$539,000	($143,000)	$129,000
2035	93,700	$640	$720,000	92,700	$512	$570,000	($150,000)	$135,000
	5-Year Waiver Window							$341,000
	10-Year Deficit Neutrality Window							$952,000
	5-Year Waiver Window – With 10% Margin							$307,000
	10-Year Deficit Neutrality Window – With 10% Margin							$857,000

We estimate the federal PTC savings under Scenario 2A: No ARP Public Option – PTF Accumulation to be $307 million over the five-year waiver period and $857 million over the 10-year deficit neutrality period.

As required by CMS, the federal subsidies under Scenario 2A: No ARP Public Option – PTF Accumulation do not exceed the federal subsidies in the No ARP Baseline – No Waiver scenario over the 10-year deficit neutrality period.

Scenario 2B: No ARP Public Option – State Premium Wrap

This scenario reflects expected premiums, enrollment, and federal subsidies, assuming the expiration of the enhanced ARP subsidies and the commencement of the PO in 2026, with additional premium subsidies funded by the State of Nevada for PO enrollees starting in program year 2 (2027). These additional subsidies are funded with pass-through funding from the 1332 waiver.

Enrollment

The No ARP Public Option – State Premium Wrap scenario reflects the same key assumptions as the No ARP Baseline scenario plus the following assumptions:

- *"Public Option Appeal" increases unsubsidized enrollment*: Identical to Scenario 1A: ARP Public Option – PTF Accumulation, because unsubsidized consumers will absorb the full benefit of lower premiums from a PO offering, we assume those uninsured who are not eligible for PTCs will see more value in enrolling and enrollment will increase relative to the Baseline. See Table 37 for the enrollment elasticity development for this cohort.

- *Additional premium subsidies:* At the State of Nevada's direction, we assumed additional premium subsidies will be targeted toward lower-income enrollees in PO plans. We assumed the additional premium subsidies will be available only to all PTC-eligible individual market enrollees. See additional comments related to offering the state premium subsidy wrap broadly or only to PO enrollees in Section 3B above.

  The maximum PO enrollee premium costs as a percentage of income with the additional subsidies are shown in Table 10. These subsidies are directed at the lowest income levels under 400% FPL as the intent would

be, to the extent possible, to replace ARP subsidies. Based on our estimates of available pass-through funding, we assume these additional premium subsidies will be offered beginning in 2027.

- *Incremental enrollment growth due to additional premium subsidies:* In addition to the unsubsidized enrollment growth noted above, uninsured Nevadans who are eligible for premium subsidies but not taking up coverage are expected to be more incentivized, relative to the Baseline scenario, to enroll in the individual coverage due to the lower net premiums (post-subsidy) made possible by the state Premium Wrap. Table 44 shows the implied elasticity of unsubsidized enrollees in this scenario.

Table 44
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2B: No ARP Public Option – State Premium Wrap
Illustrative 2028 Enrollment Elasticity with State Premium Wrap

		Scenario 2B
(a)	Premium Wrap Enrollment Increase	9,900
(b)	Uninsured – PTC-Eligible	116,200
(c) =(a) / (b)	% Increased Assumed	8.5%
(d)	Average Premium Reduction	(37.8%)
(e) = (c) / (d)	Elasticity	-0.226

Tables 45 and 46 illustrate enrollment in the individual market over the 10-year deficit neutrality window and the change in enrollment from the No ARP Baseline scenario, respectively.

Table 45
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2B: No ARP Public Option – State Premium Wrap
Individual Market Enrollment by Segment

	On-Exchange			Off-Exchange	
Year	(1) PTC-Eligible	(2) Non-PTC-Eligible	(3) Total	(4) Total	(5) Total Individual Market
2026	83,100	8,400	91,500	15,800	107,300
2027	88,000	9,600	97,600	16,200	113,800
2028	94,000	10,100	104,100	16,700	120,800
2029	94,400	11,300	105,700	17,100	122,800
2030	96,500	10,600	107,100	17,300	124,400
2031	97,800	10,600	108,400	17,600	126,000
2032	99,100	10,800	109,900	17,800	127,700
2033	100,400	10,900	111,300	18,000	129,300
2034	101,700	11,000	112,700	18,300	131,000
2035	103,100	11,100	114,200	18,500	132,700

Table 46
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2B: No ARP Public Option – State Premium Wrap
Impact of PO on Individual Enrollment

Year	Change in PTC Eligible	Change in Non-PTC Eligible	Total Change
2026	-	800	800
2027	3,800	2,100	5,900
2028	8,500	3,000	11,500
2029	7,800	4,300	12,100
2030	8,700	3,500	12,200
2031	8,900	3,400	12,300
2032	9,000	3,600	12,600
2033	9,100	3,600	12,700
2034	9,200	3,700	12,900
2035	9,400	3,700	13,100

Premiums

Scenario 2B: No ARP Public Option – PTF Accumulation reflects the same premium assumptions as Scenario 2A.

Scenario 2B: No ARP Public Option – State Premium Wrap reflects the same premium assumptions as Scenario 2.

No ARP Baseline – No Waiver for non-PO plans plus the following assumptions:

- *PO premium rate progression:* Consistent with Table 46, Table 47 assumes the reference premium increases by 4% annually in the first four years and the PO discount relative to the reference premium is approximately 4%, 8%, 12%, and 16% in the first through fourth years of the program, respectively.

Table 47 shows the 10-year premium projection under Scenario 2B: No ARP Public Option – State Premium Wrap for enrollees. Note, membership mix differences between the PO and non-PO plans mean the actual premium differences will not match the 4% annual targets.

Table 47
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2B: No ARP Public Option – State Premium Wrap
Summary of Enrollment and Premium

		Public Option		Non-Public Option		Total Enrollment	
Year	Take-Up %	Enrollment	Premiums	Enrollment	Premiums	Enrollment	Premiums PMPM
2026	39%	42,200	$585	65,100	$593	107,300	$590
2027	45%	51,600	$577	62,200	$616	113,800	$598
2028	55%	66,500	$570	54,300	$641	120,800	$602
2029	60%	73,500	$566	49,300	$664	122,800	$605
2030	60%	74,400	$589	50,000	$689	124,400	$629
2031	60%	75,400	$612	50,600	$718	126,000	$655
2032	60%	76,400	$637	51,300	$746	127,700	$681
2033	60%	77,400	$662	51,900	$777	129,300	$708
2034	60%	78,400	$689	52,600	$808	131,000	$737
2035	60%	79,400	$716	53,300	$840	132,700	$766

Subsidies

Premiums under the No ARP Public Option – State Premium Wrap scenario reflect the same key assumptions as the No ARP Baseline scenario plus the following assumptions:

- PO offerings become the SLCS plan across the state and achieve targeted savings relative to the reference premium and relative to the SLCS plan assumed in the No ARP Baseline scenario. See additional discussion in Section 2D above related to the PO becoming the SLCS plan.
- State premium subsidy wrap direct costs are not considered in Table 50 below as they are not a part of the deficit neutrality guardrail. However, the enrollment impact is detailed in the Enrollment section Tables 45 and 46 above and the corresponding increase in federal subsidies is considered in Table 50.
- For informational purposes, Table 48 does show the estimated PMPM State Premium Wrap in column (3). Also, column (4) shows consumer net premiums that include the effect of the premium subsidy wrap.

Table 48
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2B: No ARP Public Option – State Premium Wrap
Premiums and Member Federal Subsidies Per Member Per Month (PMPM)

	On-Exchange					Off-Exchange	Total Individual Market
	PTC-Eligible				Non-PTC-Eligible		
Year	(1) Gross Premiums	(2) APTC	(3) State Premium Wrap	(4) Enrollee Net Premiums	(5) Enrollee Gross Premiums	(6) Enrollee Gross Premiums	(7) Gross Premiums
2026	$610	$418	$0	$192	$551	$514	$590
2027	$624	$414	$27	$183	$514	$522	$598
2028	$628	$407	$28	$193	$519	$524	$602
2029	$637	$403	$29	$205	$481	$527	$605
2030	$656	$416	$29	$211	$540	$548	$629
2031	$682	$434	$30	$218	$569	$570	$655
2032	$709	$452	$31	$226	$589	$593	$681
2033	$737	$472	$32	$234	$614	$616	$708
2034	$767	$492	$33	$242	$641	$641	$737
2035	$797	$513	$33	$251	$670	$667	$766

Table 49
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2B: No ARP Public Option – State Premium Wrap
Change vs. Baseline in Premiums and Member Subsidies PMPM

	On-Exchange				Off-Exchange	Total Individual Market
	PTC-Eligible			Non-PTC-Eligible		
Year	(1) Gross Premium	(2) APTC	(3) Enrollee Net Premiums	(4) Enrollee Gross Premiums	(5) Enrollee Gross Premiums	(6) Gross Premiums
2026	(1.7%)	(5.2%)	10.3%	(2.2%)	(1.7%)	(1.8%)
2027	(3.3%)	(10.1%)	(7.4%)	(12.2%)	(4.1%)	(4.2%)
2028	(6.5%)	(15.0%)	(4.4%)	(15.3%)	(7.5%)	(7.3%)
2029	(8.8%)	(19.3%)	(1.3%)	(24.5%)	(10.5%)	(10.4%)
2030	(9.6%)	(20.0%)	(1.4%)	(18.3%)	(10.5%)	(10.4%)
2031	(9.7%)	(20.0%)	(1.6%)	(17.2%)	(10.5%)	(10.3%)
2032	(9.7%)	(20.0%)	(1.5%)	(18.1%)	(10.5%)	(10.5%)
2033	(9.7%)	(19.9%)	(1.2%)	(17.7%)	(10.5%)	(10.4%)
2034	(9.7%)	(19.9%)	(1.3%)	(17.5%)	(10.5%)	(10.4%)
2035	(9.8%)	(19.9%)	(1.2%)	(17.2%)	(10.5%)	(10.4%)

Table 50
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2B: No ARP Public Option – State Premium Wrap
Impact of Public Option on Premium and Subsidies

Year	Scenario 2: Baseline – No Waiver			Scenario 2B: Public Option – State Premium Wrap			Change	
	PTC Membership	APTC PMPM	Annual APTC (thousands)	PTC Membership	APTC PMPM	Annual APTC (thousands)	APTC Savings	PTC Savings
2026	83,100	$441	$440,000	83,100	$418	$417,000	($23,000)	$21,000
2027	84,200	$460	$465,000	88,000	$414	$437,000	($28,000)	$25,000
2028	85,500	$479	$491,000	94,000	$407	$459,000	($32,000)	$29,000
2029	86,600	$499	$519,000	94,400	$403	$456,000	($63,000)	$57,000
2030	87,800	$520	$548,000	96,500	$416	$482,000	($66,000)	$59,000
2031	88,900	$542	$579,000	97,800	$434	$509,000	($70,000)	$63,000
2032	90,100	$565	$611,000	99,100	$452	$538,000	($73,000)	$66,000
2033	91,300	$589	$646,000	100,400	$472	$568,000	($78,000)	$70,000
2034	92,500	$614	$682,000	101,700	$492	$601,000	($81,000)	$73,000
2035	93,700	$640	$720,000	103,100	$513	$635,000	($85,000)	$77,000
	5-Year Waiver Window							$191,000
	10-Year Deficit Neutrality Window							$540,000
	5-Year Waiver Window - With 10% Margin							$172,000
	10-Year Deficit Neutrality Window - With 10% Margin							$486,000

To illustrate how a higher PO adoption rate reduces the net member premium increase, Exhibits F-7 and F-8 in Appendix F present the same results as shown in Tables 48 and 49 assuming an 80% PO adoption rate.

Relative to Scenario 2A: No ARP Public Option – PTF Accumulation, the State Premium Wrap scenario results in federal PTC savings of $172 million in the five-year waiver window and the $486 million in the 10-year deficit neutrality window.

VI. DATA AND METHODOLOGY

DATA SOURCES AND ADJUSTMENTS

Health care coverage and enrollment

The Silver State Health Insurance Exchange provided 2022 enrollment data as of March 2022. The exchange data included the following elements:

- Exchange individual identifier
- Household case identifier
- Federal poverty level (FPL) percentage
- Age
- ZIP Code
- County
- Plan level
- Net premium
- Advance premium tax credit (APTC) amount
- Health Insurance Oversight System (HIOS) issuer identifier
- CMS plan identifier
- Relationship to subscriber
- Enrollee status
- Second lowest cost silver (SLCS) plan premium amount
- Status start date
- Status end date
- Last update date
- Flags for the following:
  - Active re-enrollees
  - Automatic re-enrollees
  - Total re-enrollees
  - New consumers
  - Total enrollees

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

In our review, we noticed irregularities in the SLCS plan premium amount by member for contracts with more than one member. We accounted for this by mapping in each member's and contract's total SLCS plan premium amount from the publicly available Public Use Files (PUFs) based on their county. We also excluded a minimal amount of membership with invalid or missing entries for key fields such as county, age, and premium.

The exchange data represented a snapshot as of March 2022, and thus will not match the full year 2022 due to new enrollment, terminations, and midyear plan changes, among other reasons. We did account for membership that terminated prior to March 2022.

Publicly available data

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

Other

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

METHODOLOGY

We summarize the 2022 exchange enrollment and premium information to create a baseline, grouped by metallic, rating area, age band, FPL, and contract size to produce approximately 3,000 model cells. In 2022, we calculate subsidies based on the member's selected premium, premium of SLCS plan available, household FPL, and current premium limits (based on the expanded ARP levels). For 2023 through 2035, we project enrollment and premium increases for each scenario, and calculate the corresponding subsidies for each model cell. The following sections provide further detail on the assumptions for enrollment and premium changes.

Based on each scenario's ACA premium limits, we calculate revised subsidies for each model cell and year. The difference between the total subsidies in each PO scenario is compared to the corresponding baseline scenario to calculate the estimated pass-through funding.

Enrollment assumptions

Population-driven enrollment growth

We assume the exchange will grow by the population growth rate, at a minimum. The population of the State of Nevada is assumed to grow 1.3% annually after 2022.[27]

Enrollment growth due to expiration of the PHE

We assume exchange enrollment will increase in each income level between 2022 and 2026 due to the expiration of the PHE, as shown in Table 51. First, we estimated the total membership at each income level that we expect to lose Medicaid coverage upon expiration of the PHE by reviewing growth in Nevada Medicaid enrollment since the PHE started compared to pre-PHE enrollment. Although Medicaid disenrollment after the end of the PHE will impact all income levels and eligibility groups, we expect the impact to be greater for higher-income members and for the Childless Adults eligibility group. For each cohort, we estimate the percentage that will take up group coverage, individual exchange coverage, or go uninsured upon disenrollment from Medicaid. We expect higher-income individuals will be more likely to have commercial group insurance available, and less likely to enter the individual market.

Table 51 State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Modeling Assumptions
Individual Market Enrollment Increase Due to Expiration of the PHE

Income (% FPL)	Member Increase
Under 100%	302
100 to 133%	1,277
133 to 150%	1,993
150 to 200%	3,401
200 to 250%	4,032
250 to 300%	2,426
300 to 400%	1,026
Over 400%	1,243
Total	**15,700**

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

Enrollment decrease due to the expiration of ARP

We assume exchange enrollment will increase in each income level between 2022 and 2026 due to the expiration of ARP, as shown in Table 52. To develop these assumptions, we estimated the increase in members due to ARP by measuring the 2021 and 2022 increases in enrollment. We assume that a relatively comparable number of members will disenroll due to the expiration of ARP.

Table 52
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Modeling Assumptions
Enrollment Decrease Due to Expiration of ARP

Income (% FPL)	Member Decrease
Under 100%	1,487
100 to 133%	2,617
133 to 150%	6,381
150 to 200%	5,402
200 to 250%	4,757
250 to 300%	4,117
300 to 400%	2,582
Over 400%	2,800
Total	**30,143**

Incremental enrollment growth due to additional premium subsidies

We assume the additional premium subsidies in the State Premium Wrap scenarios will result in incremental enrollment growth. Because enrollment growth in the Silver State Individual Health Exchange was higher in the second year after the additional ARP subsidies were introduced than the first year and outreach and marketing efforts may take time to reach the appropriate groups, we believe it is reasonable to assume the enrollment increase due to the PO may not all occur in the first year. Therefore, we assume this enrollment growth will be spread over two years. The assumed total enrollment growth due to PO appeal under each ARP framework is shown by income level in Table 53.

Table 53
State of Nevada
Nevada Public Option Actuarial and Economic Analysis

	State Premium Wrap Enrollment Impact	
	With ARP	Without ARP
Under 100%	0%	38%
100 to 133%	0%	30%
133 to 150%	0%	23%
150 to 200%	9%	16%
200 to 250%	11%	6%
250 to 300%	7%	0%
300 to 400%	3%	0%
Over 400%	0%	0%

Premium assumptions

Consumer Price Index – Medical

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

Non-PO premium increases

From 2018 through 2022, the average annual change in SLCS plan premiums on the individual exchange is -1.58% nationwide (decreasing each year) and -2.0% in Nevada[28] (decreasing in three of the four years). The actual annual percentage changes fluctuated widely in many states during this time due to market circumstances that are not expected to recur. Therefore, we do not assume the recent decreases and fluctuations in exchange premiums will continue in the future.

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

Morbidity changes due to the expiration of the PHE

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

Morbidity changes due to the expiration of ARP

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

Demographic and distribution assumptions

PO adoption rate

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

Subsidized members under 100% FPL

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

Income levels

The FPL in 2021 and 2022 is $12,880 and $13,590.29, respectively. For modeling purposes, we assume all enrollees in each income level have the same FPL percentage, based on the approximate distribution of 2022 exchange enrollment within each bucket. The modeled FPL percentages for 2022 in each bucket are shown in Table 54.

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

[29] Office of the Assistant Secretary for Planning and Evaluation (ASPE). Prior HHS Poverty Guidelines and Federal Register References. Retrieved November 9, 2022, from https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines/prior-hhs-poverty-guidelines-federal-register-references.

Table 54
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Modeling Assumptions
Modeled Household Income Levels

Income (% FPL)	Modeled FPL %	Modeled 2022 Household Income
Under 100%	100.0%	less than $13,590
100 to 133%	120.0%	$16,308
133 to 150%	142.0%	$19,298
150 to 200%	180.0%	$24,462
200 to 250%	230.0%	$31,257
250 to 300%	280.0%	$38,052
300 to 400%	355.0%	$48,245
Over 400%	625.0%	$84,938

FPL increases

We assume the FPL will increase each year with trend. The FPL is assumed to increase by 6% in 2023 due to recent inflation trends, and 2.5% every year after, based on CMS projections.

ACA affordability limits

The maximum amount of premium for which an ACA enrollee is responsible as a percentage of their income is indexed based on National Health Expenditure data and projections done by CMS. We analyzed the changes in these values year over year prior to ARP subsidies becoming available in 2021. Based on the historical change, we projected income limits through the duration of the 10-year deficit neutrality window. Our estimates are higher than historical changes to be conservative on pass-through funding calculations.

EXHIBITS

Exhibit 1A.1 State of Nevada Nevada Public Option Actuarial and Economic Analysis Scenario 1A: ARP Public Option - PTF Accumulation Individual Market Composite Monthly Premium			
Year	**Baseline**	**Waiver**	**Difference**
2026	$591.08	$580.87	-1.7%
2027	$614.64	$590.03	-4.0%
2028	$639.24	$594.02	-7.1%
2029	$664.93	$597.53	-10.1%
2030	$691.74	$621.23	-10.2%
2031	$719.18	$646.42	-10.1%
2032	$747.90	$672.27	-10.1%
2033	$777.88	$699.25	-10.1%
2034	$808.64	$727.36	-10.1%
2035	$841.30	$756.29	-10.1%

Exhibit 1A.2
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 1A: ARP Public Option - PTF Accumulation
Individual Market Changes in SLCS Plan Monthly Premium from 1332 Waiver Implementation

	21-Year Old Monthly Premium				40-Year Old Monthly Premium			
Year	Baseline	Waiver	Difference	Percent Change	Baseline	Waiver	Difference	Percent Change
2026	$348.67	$334.59	-$14.08	-4.0%	$445.60	$427.61	-$17.99	-4.0%
2027	$362.62	$332.59	-$30.03	-8.3%	$463.42	$425.05	-$38.37	-8.3%
2028	$377.12	$330.93	-$46.19	-12.2%	$481.96	$422.93	-$59.03	-12.2%
2029	$392.21	$329.28	-$62.92	-16.0%	$501.24	$420.83	-$80.41	-16.0%
2030	$407.89	$342.46	-$65.44	-16.0%	$521.29	$437.66	-$83.63	-16.0%
2031	$424.21	$356.15	-$68.06	-16.0%	$542.14	$455.16	-$86.98	-16.0%
2032	$441.18	$370.40	-$70.78	-16.0%	$563.83	$473.37	-$90.46	-16.0%
2033	$458.83	$385.22	-$73.61	-16.0%	$586.38	$492.31	-$94.07	-16.0%
2034	$477.18	$400.62	-$76.55	-16.0%	$609.83	$512.00	-$97.84	-16.0%
2035	$496.27	$416.65	-$79.62	-16.0%	$634.23	$532.48	-$101.75	-16.0%

Exhibit 1A.3
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 1A: ARP Public Option - PTF Accumulation
Individual Market Estimated Enrollees: 2026 through 2035 by FPL

Total Enrollment by FPL % - Baseline

Income Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Under 100%	3,170	3,210	3,250	3,300	3,340	3,380	3,430	3,470	3,520	3,560
100 to 133%	6,710	6,790	6,880	6,970	7,060	7,150	7,250	7,340	7,440	7,530
133 to 150%	20,680	20,940	21,220	21,490	21,770	22,060	22,340	22,630	22,930	23,220
150 to 200%	27,850	28,210	28,580	28,950	29,320	29,700	30,090	30,480	30,880	31,280
200 to 250%	24,340	24,650	24,970	25,300	25,630	25,960	26,300	26,640	26,990	27,340
250 to 300%	22,270	22,560	22,860	23,150	23,460	23,760	24,070	24,380	24,700	25,020
300 to 400%	11,960	12,110	12,270	12,430	12,590	12,760	12,920	13,090	13,260	13,430
Over 400%	20,120	20,390	20,650	20,920	21,190	21,470	21,750	22,030	22,320	22,610
Total Individual	137,090	138,870	140,680	142,510	144,360	146,240	148,140	150,070	152,020	153,990

Total Enrollment by FPL % - With Waiver

Income Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Under 100%	3,180	3,220	3,270	3,320	3,360	3,400	3,450	3,490	3,540	3,580
100 to 133%	6,710	6,800	6,890	6,980	7,070	7,160	7,250	7,350	7,440	7,540
133 to 150%	20,680	20,950	21,230	21,510	21,790	22,070	22,360	22,650	22,940	23,240
150 to 200%	27,870	28,250	28,630	29,020	29,400	29,780	30,170	30,560	30,950	31,360
200 to 250%	24,360	24,690	25,020	25,360	25,690	26,020	26,360	26,700	27,050	27,400
250 to 300%	22,300	22,600	22,910	23,220	23,520	23,830	24,140	24,450	24,770	25,090
300 to 400%	12,050	12,250	12,460	12,670	12,840	13,000	13,170	13,340	13,520	13,690
Over 400%	20,380	20,770	21,170	21,580	21,860	22,150	22,430	22,720	23,020	23,320
Total Individual	137,530	139,540	141,580	143,650	145,520	147,410	149,330	151,270	153,230	155,230

Change in Enrollment Due to Waiver

Income Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Under 100%	10	10	20	20	20	20	20	20	20	20
100 to 133%	0	10	10	10	10	10	0	10	0	10
133 to 150%	0	10	10	20	20	10	20	20	10	20
150 to 200%	20	40	50	70	80	80	80	80	70	80
200 to 250%	20	40	50	60	60	60	60	60	60	60
250 to 300%	30	40	50	70	60	70	70	70	70	70
300 to 400%	90	140	190	240	250	240	250	250	260	260
Over 400%	260	380	520	660	670	680	680	690	700	710
Total Individual	440	670	900	1,140	1,160	1,170	1,190	1,200	1,210	1,240

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

Exhibit 1A.4
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 1A: ARP Public Option - PTF Accumulation
Individual Market Estimated Enrollees: 2026 through 2035 by Metal

Total Enrollment by Metal - Baseline

Plan Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Catastrophic	810	820	830	840	850	870	880	890	900	910
Bronze	54,580	55,280	56,000	56,730	57,470	58,220	58,970	59,740	60,520	61,300
Silver	75,570	76,550	77,550	78,550	79,580	80,610	81,660	82,720	83,800	84,880
Gold	6,140	6,220	6,300	6,380	6,460	6,550	6,630	6,720	6,800	6,890
Total Individual	137,090	138,870	140,680	142,510	144,360	146,240	148,140	150,070	152,020	153,990

Total Enrollment by Metal - With Waiver

Plan Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Catastrophic	810	820	830	840	850	870	880	890	900	910
Bronze	54,830	55,680	56,540	57,410	58,160	58,910	59,680	60,450	61,240	62,040
Silver	75,710	76,770	77,840	78,930	79,960	81,000	82,050	83,120	84,200	85,290
Gold	6,160	6,250	6,340	6,440	6,520	6,610	6,690	6,780	6,870	6,960
Total Individual	137,520	139,520	141,560	143,620	145,490	147,380	149,300	151,240	153,210	155,200

Change in Enrollment Due to Waiver

Plan Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Catastrophic	0	0	0	0	0	0	0	0	0	0
Bronze	250	400	540	680	690	690	710	710	720	740
Silver	140	220	290	380	380	390	390	400	400	410
Gold	20	30	40	60	60	60	60	60	70	70
Total Individual	430	650	880	1,110	1,130	1,140	1,160	1,170	1,190	1,210

** Changes at the Metal level may not sum to the Total due to rounding.*

Exhibit 1A.5
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 1A: ARP Public Option - PTF Accumulation
Individual Market Estimated Enrollees: 2026 through 2035 by Age Group

Total Enrollment by Age Group - Baseline

Age Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
0-14	17,000	17,220	17,440	17,670	17,900	18,130	18,370	18,610	18,850	19,090
14-20	7,460	7,560	7,660	7,760	7,860	7,960	8,060	8,170	8,280	8,380
21-25	6,340	6,420	6,510	6,590	6,680	6,760	6,850	6,940	7,030	7,120
26-30	10,150	10,280	10,420	10,550	10,690	10,830	10,970	11,110	11,260	11,400
31-35	11,380	11,530	11,680	11,830	11,990	12,140	12,300	12,460	12,620	12,790
36-40	11,250	11,400	11,550	11,700	11,850	12,000	12,160	12,320	12,480	12,640
41-45	10,560	10,700	10,830	10,980	11,120	11,260	11,410	11,560	11,710	11,860
46-50	11,330	11,480	11,620	11,780	11,930	12,080	12,240	12,400	12,560	12,720
51-55	14,060	14,240	14,430	14,620	14,810	15,000	15,190	15,390	15,590	15,800
56-60	17,470	17,700	17,930	18,160	18,400	18,640	18,880	19,130	19,370	19,630
60-65	17,780	18,010	18,250	18,480	18,720	18,970	19,210	19,460	19,720	19,970
Over 65	2,300	2,330	2,360	2,390	2,420	2,450	2,490	2,520	2,550	2,580
Total	137,100	138,900	140,700	142,500	144,400	146,200	148,100	150,100	152,000	154,000

Total Enrollment by Age Group - With Waiver

Age Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
0-14	17,050	17,300	17,550	17,810	18,040	18,280	18,510	18,750	19,000	19,250
14-20	7,480	7,590	7,690	7,800	7,900	8,010	8,110	8,220	8,320	8,430
21-25	6,350	6,440	6,540	6,630	6,710	6,800	6,890	6,980	7,070	7,160
26-30	10,180	10,330	10,480	10,630	10,770	10,910	11,050	11,190	11,340	11,480
31-35	11,420	11,580	11,750	11,920	12,080	12,240	12,390	12,560	12,720	12,880
36-40	11,290	11,450	11,620	11,790	11,940	12,100	12,250	12,410	12,580	12,740
41-45	10,590	10,740	10,900	11,060	11,200	11,350	11,500	11,650	11,800	11,950
46-50	11,360	11,530	11,700	11,870	12,020	12,180	12,340	12,500	12,660	12,820
51-55	14,110	14,310	14,520	14,740	14,930	15,120	15,320	15,520	15,720	15,920
56-60	17,530	17,790	18,060	18,320	18,560	18,800	19,050	19,300	19,550	19,800
60-65	17,850	18,110	18,380	18,650	18,890	19,140	19,390	19,640	19,900	20,160
Over 65	2,310	2,340	2,370	2,400	2,430	2,470	2,500	2,530	2,560	2,600
Total	137,520	139,520	141,560	143,620	145,490	147,380	149,300	151,240	153,210	155,200

Change in Enrollment Due to Waiver

Age Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
0-14	50	80	110	140	140	150	140	140	150	160
14-20	20	30	30	40	40	50	50	50	40	50
21-25	10	20	30	40	30	40	40	40	40	40
26-30	30	50	60	80	80	80	80	80	80	80
31-35	40	50	70	90	90	100	90	100	100	90
36-40	40	50	70	90	90	100	90	90	100	100
41-45	30	40	70	80	80	90	90	90	90	90
46-50	30	50	80	90	90	100	100	100	100	100
51-55	50	70	90	120	120	120	130	130	130	120
56-60	60	90	130	160	160	160	170	170	180	170
60-65	70	100	130	170	170	170	180	180	180	190
Over 65	10	10	10	10	10	20	10	10	10	20
Total	420	620	860	1,120	1,090	1,180	1,200	1,140	1,210	1,200

** Changes at the Age Group may not sum to the Total due to rounding.*

Exhibit 1A.6
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 1A: ARP Public Option - PTF Accumulation
Individual Market Estimated Enrollees: 2026 through 2035 by APTC Eligibility

Total Enrollment by Subsidy Eligibility - Baseline

Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Subsidized	117,710	119,370	121,290	123,090	124,770	126,620	128,410	130,100	131,960	133,800
Unsubsidized	19,380	19,510	19,390	19,420	19,590	19,620	19,730	19,970	20,050	20,190
Total	137,090	138,870	140,680	142,510	144,360	146,240	148,140	150,070	152,020	153,990

Total Enrollment by Subsidy Eligibility - With Waiver

Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Subsidized	117,880	119,230	120,710	121,710	123,860	125,580	127,290	129,040	131,020	132,720
Unsubsidized	19,650	20,310	20,870	21,940	21,660	21,830	22,040	22,230	22,220	22,500
Total	137,530	139,540	141,580	143,650	145,520	147,410	149,330	151,270	153,230	155,230

Change in Enrollment Due to Waiver

Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Subsidized	170	(140)	(580)	(1,380)	(910)	(1,040)	(1,120)	(1,060)	(940)	(1,080)
Unsubsidized	270	800	1,480	2,520	2,070	2,210	2,310	2,260	2,170	2,310
Total	440	670	900	1,140	1,160	1,170	1,190	1,200	1,210	1,240

** Changes at the Subsidized level may not sum to the Total due to rounding.*

Exhibit 1B.1 State of Nevada Nevada Public Option Actuarial and Economic Analysis Scenario 1B: ARP Public Option - State Premium Wrap Individual Market Composite Monthly Premium			
Year	**Baseline**	**Waiver**	**Difference**
2026	$591.08	$580.87	-1.7%
2027	$614.64	$589.73	-4.1%
2028	$639.24	$593.08	-7.2%
2029	$664.93	$596.94	-10.2%
2030	$691.74	$620.62	-10.3%
2031	$719.18	$645.33	-10.3%
2032	$747.90	$671.56	-10.2%
2033	$777.88	$698.50	-10.2%
2034	$808.64	$726.13	-10.2%
2035	$841.30	$755.49	-10.2%

Exhibit 1B.2
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 1B: ARP Public Option - State Premium Wrap
Individual Market Changes in SLCS Plan Monthly Premium from 1332 Waiver Implementation

	21-Year Old Monthly Premium				40-Year Old Monthly Premium			
Year	Baseline	Waiver	Difference	Percent Change	Baseline	Waiver	Difference	Percent Change
2026	$348.67	$334.59	-$14.08	-4.0%	$445.60	$427.61	-$17.99	-4.0%
2027	$362.62	$332.37	-$30.24	-8.3%	$463.42	$424.77	-$38.65	-8.3%
2028	$377.12	$330.50	-$46.62	-12.4%	$481.96	$422.38	-$59.58	-12.4%
2029	$392.21	$328.85	-$63.36	-16.2%	$501.24	$420.27	-$80.97	-16.2%
2030	$407.89	$342.00	-$65.89	-16.2%	$521.29	$437.08	-$84.21	-16.2%
2031	$424.21	$355.69	-$68.53	-16.2%	$542.14	$454.57	-$87.58	-16.2%
2032	$441.18	$369.91	-$71.27	-16.2%	$563.83	$472.75	-$91.08	-16.2%
2033	$458.83	$384.71	-$74.12	-16.2%	$586.38	$491.66	-$94.72	-16.2%
2034	$477.18	$400.10	-$77.08	-16.2%	$609.83	$511.32	-$98.51	-16.2%
2035	$496.27	$416.10	-$80.16	-16.2%	$634.23	$531.78	-$102.45	-16.2%

Exhibit 1B.3
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 1B: ARP Public Option - State Premium Wrap
Individual Market Estimated Enrollees: 2026 through 2035 by FPL

Total Enrollment by FPL % - Baseline

Income Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Under 100%	3,170	3,210	3,250	3,300	3,340	3,380	3,430	3,470	3,520	3,560
100 to 133%	6,710	6,790	6,880	6,970	7,060	7,150	7,250	7,340	7,440	7,530
133 to 150%	20,680	20,940	21,220	21,490	21,770	22,060	22,340	22,630	22,930	23,220
150 to 200%	27,850	28,210	28,580	28,950	29,320	29,700	30,090	30,480	30,880	31,280
200 to 250%	24,340	24,650	24,970	25,300	25,630	25,960	26,300	26,640	26,990	27,340
250 to 300%	22,270	22,560	22,860	23,150	23,460	23,760	24,070	24,380	24,700	25,020
300 to 400%	11,960	12,110	12,270	12,430	12,590	12,760	12,920	13,090	13,260	13,430
Over 400%	20,120	20,390	20,650	20,920	21,190	21,470	21,750	22,030	22,320	22,610
Total Individual	137,090	138,870	140,680	142,510	144,360	146,240	148,140	150,070	152,020	153,990

Total Enrollment by FPL % - With Waiver

Income Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Under 100%	3,180	3,220	3,270	3,320	3,360	3,400	3,450	3,490	3,540	3,580
100 to 133%	6,710	6,800	6,890	6,980	7,070	7,160	7,250	7,350	7,440	7,540
133 to 150%	20,680	20,950	21,230	21,510	21,790	22,070	22,360	22,650	22,940	23,240
150 to 200%	27,870	29,470	31,160	31,580	31,990	32,400	32,820	33,250	33,680	34,120
200 to 250%	24,360	26,000	27,750	28,120	28,490	28,860	29,230	29,610	30,000	30,390
250 to 300%	22,300	23,380	24,520	24,850	25,170	25,500	25,830	26,170	26,510	26,850
300 to 400%	12,050	12,430	12,820	13,040	13,210	13,380	13,550	13,730	13,910	14,090
Over 400%	20,380	20,770	21,170	21,580	21,860	22,150	22,430	22,720	23,020	23,320
Total Individual	137,530	143,020	148,800	150,970	152,940	154,920	156,940	158,980	161,050	163,140

Change in Enrollment Due to Waiver

Income Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Under 100%	10	10	20	20	20	20	20	20	20	20
100 to 133%	0	10	10	10	10	10	0	10	0	10
133 to 150%	0	10	10	20	20	10	20	20	10	20
150 to 200%	20	1,260	2,580	2,630	2,670	2,700	2,730	2,770	2,800	2,840
200 to 250%	20	1,350	2,780	2,820	2,860	2,900	2,930	2,970	3,010	3,050
250 to 300%	30	820	1,660	1,700	1,710	1,740	1,760	1,790	1,810	1,830
300 to 400%	90	320	550	610	620	620	630	640	650	660
Over 400%	260	380	520	660	670	680	680	690	700	710
Total Individual	440	4,150	8,120	8,460	8,580	8,680	8,800	8,910	9,030	9,150

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

Exhibit 1B.4
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 1B: ARP Public Option - State Premium Wrap
Individual Market Estimated Enrollees: 2026 through 2035 by Metal

Total Enrollment by Metal - Baseline

Plan Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Catastrophic	810	820	830	840	850	870	880	890	900	910
Bronze	54,580	55,280	56,000	56,730	57,470	58,220	58,970	59,740	60,520	61,300
Silver	75,570	76,550	77,550	78,550	79,580	80,610	81,660	82,720	83,800	84,880
Gold	6,140	6,220	6,300	6,380	6,460	6,550	6,630	6,720	6,800	6,890
Total Individual	137,090	138,870	140,680	142,510	144,360	146,240	148,140	150,070	152,020	153,990

Total Enrollment by Metal - With Waiver

Plan Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Catastrophic	810	820	830	840	850	870	880	890	900	910
Bronze	54,830	57,090	59,470	60,380	61,160	61,960	62,770	63,580	64,410	65,240
Silver	75,710	78,660	81,770	82,910	83,990	85,080	86,190	87,310	88,440	89,590
Gold	6,160	6,430	6,710	6,810	6,900	6,990	7,080	7,170	7,270	7,360
Total Individual	137,520	143,010	148,780	150,950	152,910	154,900	156,910	158,950	161,020	163,110

Change in Enrollment Due to Waiver

Plan Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Catastrophic	0	0	0	0	0	0	0	0	0	0
Bronze	250	1,810	3,470	3,650	3,690	3,740	3,800	3,840	3,890	3,940
Silver	140	2,110	4,220	4,360	4,410	4,470	4,530	4,590	4,640	4,710
Gold	20	210	410	430	440	440	450	450	470	470
Total Individual	430	4,140	8,100	8,440	8,550	8,660	8,770	8,880	9,000	9,120

** Changes at the Metal level may not sum to the Total due to rounding.*

Exhibit 1B.5
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 1B: ARP Public Option - State Premium Wrap
Individual Market Estimated Enrollees: 2026 through 2035 by Age Group

Total Enrollment by Age Group - Baseline

Age Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
0-14	17,000	17,220	17,440	17,670	17,900	18,130	18,370	18,610	18,850	19,090
14-20	7,460	7,560	7,660	7,760	7,860	7,960	8,060	8,170	8,280	8,380
21-25	6,340	6,420	6,510	6,590	6,680	6,760	6,850	6,940	7,030	7,120
26-30	10,150	10,280	10,420	10,550	10,690	10,830	10,970	11,110	11,260	11,400
31-35	11,380	11,530	11,680	11,830	11,990	12,140	12,300	12,460	12,620	12,790
36-40	11,250	11,400	11,550	11,700	11,850	12,000	12,160	12,320	12,480	12,640
41-45	10,560	10,700	10,830	10,980	11,120	11,260	11,410	11,560	11,710	11,860
46-50	11,330	11,480	11,620	11,780	11,930	12,080	12,240	12,400	12,560	12,720
51-55	14,060	14,240	14,430	14,620	14,810	15,000	15,190	15,390	15,590	15,800
56-60	17,470	17,700	17,930	18,160	18,400	18,640	18,880	19,130	19,370	19,630
60-65	17,780	18,010	18,250	18,480	18,720	18,970	19,210	19,460	19,720	19,970
Over 65	2,300	2,330	2,360	2,390	2,420	2,450	2,490	2,520	2,550	2,580
Total	137,090	138,870	140,680	142,510	144,360	146,240	148,140	150,070	152,020	153,990

Total Enrollment by Age Group - With Waiver

Age Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
0-14	17,050	17,800	18,580	18,850	19,100	19,350	19,600	19,850	20,110	20,370
14-20	7,480	7,770	8,080	8,190	8,300	8,410	8,520	8,630	8,740	8,850
21-25	6,350	6,600	6,860	6,950	7,040	7,130	7,230	7,320	7,420	7,510
26-30	10,180	10,600	11,030	11,190	11,340	11,480	11,630	11,780	11,940	12,090
31-35	11,420	11,880	12,360	12,540	12,700	12,870	13,030	13,200	13,370	13,550
36-40	11,290	11,740	12,220	12,400	12,560	12,720	12,890	13,060	13,230	13,400
41-45	10,590	11,020	11,480	11,640	11,790	11,950	12,100	12,260	12,420	12,580
46-50	11,360	11,820	12,300	12,480	12,640	12,810	12,970	13,140	13,310	13,490
51-55	14,110	14,660	15,250	15,470	15,670	15,880	16,080	16,290	16,500	16,720
56-60	17,530	18,210	18,920	19,200	19,450	19,700	19,960	20,220	20,480	20,740
60-65	17,850	18,550	19,280	19,570	19,820	20,080	20,340	20,610	20,870	21,150
Over 65	2,310	2,360	2,430	2,460	2,490	2,520	2,560	2,590	2,620	2,660
Total	137,520	143,010	148,780	150,950	152,910	154,900	156,910	158,950	161,020	163,110

Change in Enrollment Due to Waiver

Age Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
0-14	50	580	1,140	1,180	1,200	1,220	1,230	1,240	1,260	1,280
14-20	20	210	420	430	440	450	460	460	460	470
21-25	10	180	350	360	360	370	380	380	390	390
26-30	30	320	610	640	650	650	660	670	680	690
31-35	40	350	680	710	710	730	730	740	750	760
36-40	40	340	670	700	710	720	730	740	750	760
41-45	30	320	650	660	670	690	690	700	710	720
46-50	30	340	680	700	710	730	730	740	750	770
51-55	50	420	820	850	860	880	890	900	910	920
56-60	60	510	990	1,040	1,050	1,060	1,080	1,090	1,110	1,110
60-65	70	540	1,030	1,090	1,100	1,110	1,130	1,150	1,150	1,180
Over 65	10	30	70	70	70	70	70	70	70	80
Total	430	4,140	8,100	8,440	8,550	8,660	8,770	8,880	9,000	9,120

** Changes at the Age Group may not sum to the Total due to rounding.*

Exhibit 1B.6
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 1B: ARP Public Option - State Premium Wrap
Individual Market Estimated Enrollees: 2026 through 2035 by APTC Eligibility

Total Enrollment by Subsidy Eligibility - Baseline

Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Subsidized	117,710	119,370	121,290	123,090	124,770	126,620	128,410	130,100	131,960	133,800
Unsubsidized	19,380	19,510	19,390	19,420	19,590	19,620	19,730	19,970	20,050	20,190
Total	137,090	138,870	140,680	142,510	144,360	146,240	148,140	150,070	152,020	153,990

Total Enrollment by Subsidy Eligibility - With Waiver

Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Subsidized	117,880	122,710	127,900	129,000	131,100	133,060	134,870	136,720	138,800	140,610
Unsubsidized	19,650	20,320	20,900	21,970	21,830	21,860	22,070	22,260	22,240	22,530
Total	137,530	143,020	148,800	150,970	152,940	154,920	156,940	158,980	161,050	163,140

Change in Enrollment Due to Waiver

Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Subsidized	170	3,340	6,610	5,910	6,330	6,440	6,460	6,620	6,840	6,810
Unsubsidized	270	810	1,510	2,550	2,240	2,240	2,340	2,290	2,190	2,340
Total	440	4,150	8,120	8,460	8,580	8,680	8,800	8,910	9,030	9,150

** Changes at the Subsidized level may not sum to the Total due to rounding.*

Exhibit 2A.1 State of Nevada Nevada Public Option Actuarial and Economic Analysis Scenario 2A: No ARP Public Option - PTF Accumulation Individual Market Composite Monthly Premium			
Year	**Baseline**	**Waiver**	**Difference**
2026	$600.49	$589.52	-1.8%
2027	$624.42	$598.55	-4.1%
2028	$649.40	$602.78	-7.2%
2029	$675.47	$606.68	-10.2%
2030	$702.06	$630.65	-10.2%
2031	$730.38	$656.16	-10.2%
2032	$760.03	$682.28	-10.2%
2033	$790.30	$709.55	-10.2%
2034	$821.91	$737.93	-10.2%
2035	$854.90	$767.65	-10.2%

Exhibit 2A.2
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2A: No ARP Public Option - PTF Accumulation
Individual Market Changes in SLCS Plan Monthly Premium from 1332 Waiver Implementation

	21-Year Old Monthly Premium				40-Year Old Monthly Premium			
Year	Baseline	Waiver	Difference	Percent Change	Baseline	Waiver	Difference	Percent Change
2026	$358.04	$343.60	-$14.44	-4.0%	$457.57	$439.12	-$18.45	-4.0%
2027	$372.36	$341.54	-$30.81	-8.3%	$475.87	$436.49	-$39.38	-8.3%
2028	$387.25	$339.84	-$47.41	-12.2%	$494.91	$434.32	-$60.59	-12.2%
2029	$402.74	$338.15	-$64.59	-16.0%	$514.70	$432.15	-$82.55	-16.0%
2030	$418.85	$351.67	-$67.18	-16.0%	$535.29	$449.44	-$85.85	-16.0%
2031	$435.61	$365.74	-$69.87	-16.0%	$556.70	$467.42	-$89.29	-16.0%
2032	$453.03	$380.37	-$72.66	-16.0%	$578.97	$486.11	-$92.86	-16.0%
2033	$471.15	$395.58	-$75.57	-16.0%	$602.13	$505.56	-$96.57	-16.0%
2034	$490.00	$411.41	-$78.59	-16.0%	$626.22	$525.78	-$100.44	-16.0%
2035	$509.60	$427.86	-$81.73	-16.0%	$651.27	$546.81	-$104.45	-16.0%

Exhibit 2A.3
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2A: No ARP Public Option - PTF Accumulation
Individual Market Estimated Enrollees: 2026 through 2035 by FPL

Total Enrollment by FPL % - Baseline

Income Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Under 100%	1,660	1,690	1,710	1,730	1,750	1,780	1,800	1,820	1,850	1,870
100 to 133%	4,050	4,110	4,160	4,210	4,270	4,330	4,380	4,440	4,500	4,550
133 to 150%	14,210	14,400	14,580	14,770	14,970	15,160	15,360	15,560	15,760	15,960
150 to 200%	22,370	22,660	22,960	23,260	23,560	23,870	24,180	24,490	24,810	25,130
200 to 250%	19,520	19,770	20,030	20,290	20,550	20,820	21,090	21,370	21,640	21,920
250 to 300%	18,100	18,340	18,580	18,820	19,060	19,310	19,560	19,820	20,070	20,340
300 to 400%	9,340	9,460	9,590	9,710	9,840	9,970	10,100	10,230	10,360	10,490
Over 400%	17,290	17,510	17,740	17,970	18,200	18,440	18,680	18,920	19,170	19,420
Total Individual	106,560	107,940	109,350	110,770	112,210	113,670	115,140	116,640	118,160	119,690

Total Enrollment by FPL % - With Waiver

Income Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Under 100%	1,680	1,710	1,740	1,770	1,800	1,820	1,840	1,870	1,890	1,920
100 to 133%	4,060	4,110	4,170	4,230	4,280	4,340	4,390	4,450	4,510	4,570
133 to 150%	14,220	14,420	14,610	14,810	15,000	15,190	15,390	15,590	15,790	16,000
150 to 200%	22,420	22,740	23,060	23,390	23,690	24,000	24,310	24,630	24,950	25,270
200 to 250%	19,560	19,830	20,110	20,390	20,660	20,930	21,200	21,470	21,750	22,040
250 to 300%	18,150	18,410	18,670	18,930	19,180	19,430	19,680	19,940	20,200	20,460
300 to 400%	9,490	9,690	9,890	10,090	10,230	10,360	10,490	10,630	10,770	10,910
Over 400%	17,720	18,170	18,640	19,120	19,370	19,620	19,880	20,130	20,400	20,660
Total Individual	107,300	109,080	110,890	112,730	114,200	115,680	117,190	118,710	120,250	121,820

Change in Enrollment Due to Waiver

Income Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Under 100%	20	20	30	40	50	40	40	50	40	50
100 to 133%	10	0	10	20	10	10	10	10	10	20
133 to 150%	10	20	30	40	30	30	30	30	30	40
150 to 200%	50	80	100	130	130	130	130	140	140	140
200 to 250%	40	60	80	100	110	110	110	100	110	120
250 to 300%	50	70	90	110	120	120	120	120	130	120
300 to 400%	150	230	300	380	390	390	390	400	410	420
Over 400%	430	660	900	1,150	1,170	1,180	1,200	1,210	1,230	1,240
Total Individual	740	1,140	1,540	1,960	1,990	2,010	2,050	2,070	2,090	2,130

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

Exhibit 2A.4
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2A: No ARP Public Option - PTF Accumulation
Individual Market Estimated Enrollees: 2026 through 2035 by Metal

Total Enrollment by Metal - Baseline

Plan Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Catastrophic	810	820	830	840	850	870	880	890	900	910
Bronze	43,830	44,400	44,980	45,560	46,160	46,760	47,360	47,980	48,600	49,240
Silver	57,130	57,870	58,620	59,390	60,160	60,940	61,730	62,530	63,350	64,170
Gold	4,790	4,850	4,910	4,980	5,040	5,110	5,170	5,240	5,310	5,380
Total Individual	106,560	107,940	109,350	110,770	112,210	113,670	115,140	116,640	118,160	119,690

Total Enrollment by Metal - With Waiver

Plan Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Catastrophic	810	820	830	840	850	870	880	890	900	910
Bronze	44,270	45,070	45,880	46,710	47,320	47,930	48,560	49,190	49,830	50,480
Silver	57,380	58,260	59,150	60,060	60,840	61,630	62,430	63,240	64,060	64,900
Gold	4,820	4,900	4,980	5,070	5,130	5,200	5,270	5,340	5,400	5,470
Total Individual	107,280	109,050	110,850	112,680	114,140	115,630	117,130	118,650	120,200	121,760

Change in Enrollment Due to Waiver

Plan Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Catastrophic	0	0	0	0	0	0	0	0	0	0
Bronze	440	670	900	1,150	1,160	1,170	1,200	1,210	1,230	1,240
Silver	250	390	530	670	680	690	700	710	710	730
Gold	30	50	70	90	90	90	100	100	90	90
Total Individual	720	1,110	1,500	1,910	1,930	1,960	1,990	2,010	2,040	2,070

** Changes at the Metal level may not sum to the Total due to rounding.*

Exhibit 2A.5
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2A: No ARP Public Option - PTF Accumulation
Individual Market Estimated Enrollees: 2026 through 2035 by Age Group

Total Enrollment by Age Group - Baseline

Age Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
0-14	13,490	13,660	13,840	14,020	14,200	14,390	14,570	14,760	14,950	15,150
14-20	5,760	5,840	5,920	5,990	6,070	6,150	6,230	6,310	6,390	6,470
21-25	4,870	4,930	5,000	5,060	5,130	5,200	5,260	5,330	5,400	5,470
26-30	7,910	8,020	8,120	8,230	8,330	8,440	8,550	8,660	8,770	8,890
31-35	8,870	8,980	9,100	9,220	9,340	9,460	9,580	9,710	9,830	9,960
36-40	8,770	8,880	9,000	9,110	9,230	9,350	9,470	9,600	9,720	9,850
41-45	8,220	8,330	8,430	8,540	8,650	8,770	8,880	9,000	9,110	9,230
46-50	8,820	8,940	9,060	9,170	9,290	9,410	9,540	9,660	9,780	9,910
51-55	10,930	11,070	11,210	11,360	11,510	11,660	11,810	11,960	12,120	12,280
56-60	13,530	13,710	13,880	14,070	14,250	14,430	14,620	14,810	15,000	15,200
60-65	13,840	14,020	14,200	14,380	14,570	14,760	14,950	15,150	15,340	15,540
Over 65	1,550	1,570	1,590	1,610	1,640	1,660	1,680	1,700	1,720	1,740
Total	106,560	107,940	109,350	110,770	112,210	113,670	115,140	116,640	118,160	119,690

Total Enrollment by Age Group - With Waiver

Age Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
0-14	13,580	13,800	14,030	14,260	14,450	14,630	14,820	15,020	15,210	15,410
14-20	5,790	5,890	5,980	6,070	6,150	6,230	6,310	6,390	6,480	6,560
21-25	4,900	4,980	5,050	5,130	5,200	5,270	5,340	5,410	5,480	5,550
26-30	7,960	8,090	8,220	8,360	8,460	8,570	8,690	8,800	8,910	9,030
31-35	8,930	9,070	9,220	9,370	9,500	9,620	9,740	9,870	10,000	10,130
36-40	8,820	8,970	9,120	9,270	9,390	9,510	9,630	9,760	9,890	10,010
41-45	8,270	8,410	8,550	8,690	8,800	8,920	9,030	9,150	9,270	9,390
46-50	8,880	9,030	9,180	9,330	9,450	9,570	9,700	9,830	9,950	10,080
51-55	11,000	11,190	11,370	11,560	11,710	11,870	12,020	12,180	12,330	12,490
56-60	13,630	13,860	14,100	14,330	14,520	14,710	14,900	15,090	15,290	15,490
60-65	13,940	14,180	14,420	14,660	14,850	15,050	15,240	15,440	15,640	15,850
Over 65	1,560	1,590	1,610	1,640	1,660	1,680	1,700	1,720	1,740	1,770
Total	107,280	109,050	110,850	112,680	114,140	115,630	117,130	118,650	120,200	121,760

Change in Enrollment Due to Waiver

Age Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
0-14	90	140	190	240	250	240	250	260	260	260
14-20	30	50	60	80	80	80	80	80	90	90
21-25	30	50	50	70	70	70	80	80	80	80
26-30	50	70	100	130	130	130	140	140	140	140
31-35	60	90	120	150	160	160	160	160	170	170
36-40	50	90	120	160	160	160	160	160	170	160
41-45	50	80	120	150	150	150	150	150	160	160
46-50	60	90	120	160	160	160	160	170	170	170
51-55	70	120	160	200	200	210	210	220	210	210
56-60	100	150	220	260	270	280	280	280	290	290
60-65	100	160	220	280	280	290	290	290	300	310
Over 65	10	20	20	30	20	20	20	20	20	30
Total	720	1,110	1,500	1,910	1,930	1,960	1,990	2,010	2,040	2,070

** Changes at the Age Group may not sum to the Total due to rounding.*

Exhibit 2A.6
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2A: No ARP Public Option - PTF Accumulation
Individual Market Estimated Enrollees: 2026 through 2035 by APTC Eligibility

Total Enrollment by Subsidy Eligibility - Baseline

Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Subsidized	83,130	84,210	85,530	86,640	87,780	88,930	90,140	91,330	92,520	93,750
Unsubsidized	23,430	23,730	23,820	24,120	24,430	24,740	25,010	25,310	25,640	25,950
Total	106,560	107,940	109,350	110,770	112,210	113,670	115,140	116,640	118,160	119,690

Total Enrollment by Subsidy Eligibility - With Waiver

Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Subsidized	83,120	83,460	84,480	85,590	86,780	87,920	89,060	90,220	91,430	92,690
Unsubsidized	24,180	25,620	26,410	27,140	27,420	27,760	28,120	28,490	28,820	29,130
Total	107,300	109,080	110,890	112,730	114,200	115,680	117,190	118,710	120,250	121,820

Change in Enrollment Due to Waiver

Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Subsidized	(10)	(750)	(1,050)	(1,050)	(1,000)	(1,010)	(1,080)	(1,110)	(1,090)	(1,060)
Unsubsidized	750	1,890	2,590	3,020	2,990	3,020	3,110	3,180	3,180	3,180
Total	740	1,140	1,540	1,960	1,990	2,010	2,050	2,070	2,090	2,130

** Changes at the Subsidized level may not sum to the Total due to rounding.*

Exhibit 2B.1 State of Nevada Nevada Public Option Actuarial and Economic Analysis Scenario 2B: No ARP Public Option - State Premium Wrap Individual Market Composite Monthly Premium			
Year	**Baseline**	**Waiver**	**Difference**
2026	$600.49	$589.52	-1.8%
2027	$624.42	$598.39	-4.2%
2028	$649.40	$602.22	-7.3%
2029	$675.47	$605.18	-10.4%
2030	$702.06	$629.27	-10.4%
2031	$730.38	$654.87	-10.3%
2032	$760.03	$680.60	-10.5%
2033	$790.30	$708.00	-10.4%
2034	$821.91	$736.54	-10.4%
2035	$854.90	$765.83	-10.4%

Exhibit 2B.2
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2B: No ARP Public Option - State Premium Wrap
Individual Market Changes in SLCS Plan Monthly Premium from 1332 Waiver Implementation

	21-Year Old Monthly Premium				40-Year Old Monthly Premium			
Year	Baseline	Waiver	Difference	Percent Change	Baseline	Waiver	Difference	Percent Change
2026	$358.04	$343.60	-$14.44	-4.0%	$457.57	$439.12	-$18.45	-4.0%
2027	$372.36	$339.32	-$33.04	-8.9%	$475.87	$433.65	-$42.22	-8.9%
2028	$387.25	$335.43	-$51.83	-13.4%	$494.91	$428.67	-$66.23	-13.4%
2029	$402.74	$333.75	-$68.99	-17.1%	$514.70	$426.54	-$88.17	-17.1%
2030	$418.85	$347.10	-$71.75	-17.1%	$535.29	$443.60	-$91.69	-17.1%
2031	$435.61	$360.99	-$74.62	-17.1%	$556.70	$461.34	-$95.36	-17.1%
2032	$453.03	$375.43	-$77.60	-17.1%	$578.97	$479.80	-$99.17	-17.1%
2033	$471.15	$390.45	-$80.71	-17.1%	$602.13	$498.99	-$103.14	-17.1%
2034	$490.00	$406.06	-$83.93	-17.1%	$626.22	$518.95	-$107.27	-17.1%
2035	$509.60	$422.31	-$87.29	-17.1%	$651.27	$539.71	-$111.56	-17.1%

Exhibit 2B.2
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2B: No ARP Public Option - State Premium Wrap
Individual Market Estimated Enrollees: 2026 through 2035 by FPL

Total Enrollment by FPL % - Baseline

Income Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Under 100%	1,660	1,690	1,710	1,730	1,750	1,780	1,800	1,820	1,850	1,870
100 to 133%	4,050	4,110	4,160	4,210	4,270	4,330	4,380	4,440	4,500	4,550
133 to 150%	14,210	14,400	14,580	14,770	14,970	15,160	15,360	15,560	15,760	15,960
150 to 200%	22,370	22,660	22,960	23,260	23,560	23,870	24,180	24,490	24,810	25,130
200 to 250%	19,520	19,770	20,030	20,290	20,550	20,820	21,090	21,370	21,640	21,920
250 to 300%	18,100	18,340	18,580	18,820	19,060	19,310	19,560	19,820	20,070	20,340
300 to 400%	9,340	9,460	9,590	9,710	9,840	9,970	10,100	10,230	10,360	10,490
Over 400%	17,290	17,510	17,740	17,970	18,200	18,440	18,680	18,920	19,170	19,420
Total Individual	106,560	107,940	109,350	110,770	112,210	113,670	115,140	116,640	118,160	119,690

Total Enrollment by FPL % - With Waiver

Income Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Under 100%	1,680	1,910	2,170	2,210	2,240	2,270	2,300	2,330	2,360	2,390
100 to 133%	4,060	4,700	5,460	5,530	5,600	5,680	5,750	5,820	5,900	5,980
133 to 150%	14,220	16,010	18,040	18,280	18,510	18,750	19,000	19,250	19,500	19,750
150 to 200%	22,420	24,460	26,700	27,070	27,420	27,780	28,140	28,510	28,880	29,250
200 to 250%	19,560	20,400	21,280	21,580	21,860	22,140	22,430	22,720	23,020	23,320
250 to 300%	18,150	18,410	18,670	18,930	19,180	19,430	19,680	19,940	20,200	20,460
300 to 400%	9,490	9,690	9,890	10,090	10,230	10,360	10,490	10,630	10,770	10,910
Over 400%	17,720	18,170	18,640	19,120	19,370	19,620	19,880	20,130	20,400	20,660
Total Individual	107,300	113,760	120,840	122,820	124,410	126,030	127,670	129,330	131,010	132,710

Change in Enrollment Due to Waiver

Income Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Under 100%	20	220	460	480	490	490	500	510	510	520
100 to 133%	10	590	1,300	1,320	1,330	1,350	1,370	1,380	1,400	1,430
133 to 150%	10	1,610	3,460	3,510	3,540	3,590	3,640	3,690	3,740	3,790
150 to 200%	50	1,800	3,740	3,810	3,860	3,910	3,960	4,020	4,070	4,120
200 to 250%	40	630	1,250	1,290	1,310	1,320	1,340	1,350	1,380	1,400
250 to 300%	50	70	90	110	120	120	120	120	130	120
300 to 400%	150	230	300	380	390	390	390	400	410	420
Over 400%	430	660	900	1,150	1,170	1,180	1,200	1,210	1,230	1,240
Total Individual	740	5,820	11,490	12,050	12,200	12,360	12,530	12,690	12,850	13,020

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

Exhibit 2B.2
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2B: No ARP Public Option - State Premium Wrap
Individual Market Estimated Enrollees: 2026 through 2035 by Metal

Total Enrollment by Metal - Baseline

Plan Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Catastrophic	810	820	830	840	850	870	880	890	900	910
Bronze	43,830	44,400	44,980	45,560	46,160	46,760	47,360	47,980	48,600	49,240
Silver	57,130	57,870	58,620	59,390	60,160	60,940	61,730	62,530	63,350	64,170
Gold	4,790	4,850	4,910	4,980	5,040	5,110	5,170	5,240	5,310	5,380
Total Individual	106,560	107,940	109,350	110,770	112,210	113,670	115,140	116,640	118,160	119,690

Total Enrollment by Metal - With Waiver

Plan Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Catastrophic	810	820	830	840	850	870	880	890	900	910
Bronze	44,270	45,930	47,710	48,560	49,190	49,830	50,480	51,140	51,800	52,480
Silver	57,380	62,000	67,120	68,130	69,020	69,920	70,820	71,750	72,680	73,620
Gold	4,820	4,970	5,140	5,220	5,290	5,360	5,430	5,500	5,570	5,640
Total Individual	107,280	113,730	120,800	122,760	124,360	125,980	127,610	129,270	130,950	132,660

Change in Enrollment Due to Waiver

Plan Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Catastrophic	0	0	0	0	0	0	0	0	0	0
Bronze	440	1,530	2,730	3,000	3,030	3,070	3,120	3,160	3,200	3,240
Silver	250	4,130	8,500	8,740	8,860	8,980	9,090	9,220	9,330	9,450
Gold	30	120	230	240	250	250	260	260	260	260
Total Individual	720	5,790	11,450	11,990	12,150	12,310	12,470	12,630	12,790	12,970

** Changes at the Metal level may not sum to the Total due to rounding.*

Exhibit 2B.2
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2B: No ARP Public Option - State Premium Wrap
Individual Market Estimated Enrollees: 2026 through 2035 by Age Group

Total Enrollment by Age Group - Baseline

Age Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
0-14	13,490	13,660	13,840	14,020	14,200	14,390	14,570	14,760	14,950	15,150
14-20	5,760	5,840	5,920	5,990	6,070	6,150	6,230	6,310	6,390	6,470
21-25	4,870	4,930	5,000	5,060	5,130	5,200	5,260	5,330	5,400	5,470
26-30	7,910	8,020	8,120	8,230	8,330	8,440	8,550	8,660	8,770	8,890
31-35	8,870	8,980	9,100	9,220	9,340	9,460	9,580	9,710	9,830	9,960
36-40	8,770	8,880	9,000	9,110	9,230	9,350	9,470	9,600	9,720	9,850
41-45	8,220	8,330	8,430	8,540	8,650	8,770	8,880	9,000	9,110	9,230
46-50	8,820	8,940	9,060	9,170	9,290	9,410	9,540	9,660	9,780	9,910
51-55	10,930	11,070	11,210	11,360	11,510	11,660	11,810	11,960	12,120	12,280
56-60	13,530	13,710	13,880	14,070	14,250	14,430	14,620	14,810	15,000	15,200
60-65	13,840	14,020	14,200	14,380	14,570	14,760	14,950	15,150	15,340	15,540
Over 65	1,550	1,570	1,590	1,610	1,640	1,660	1,680	1,700	1,720	1,740
Total	106,560	107,940	109,350	110,770	112,210	113,670	115,140	116,640	118,160	119,690

Total Enrollment by Age Group - With Waiver

Age Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
0-14	13,580	14,190	14,860	15,110	15,300	15,500	15,700	15,910	16,110	16,320
14-20	5,790	6,210	6,670	6,780	6,860	6,950	7,040	7,130	7,230	7,320
21-25	4,900	5,260	5,670	5,760	5,830	5,910	5,980	6,060	6,140	6,220
26-30	7,960	8,460	9,000	9,140	9,260	9,380	9,500	9,630	9,750	9,880
31-35	8,930	9,450	10,030	10,190	10,320	10,460	10,590	10,730	10,870	11,010
36-40	8,820	9,340	9,910	10,070	10,200	10,330	10,460	10,600	10,740	10,880
41-45	8,270	8,760	9,300	9,450	9,580	9,700	9,830	9,950	10,080	10,210
46-50	8,880	9,420	10,000	10,170	10,300	10,430	10,570	10,700	10,840	10,980
51-55	11,000	11,680	12,420	12,630	12,790	12,960	13,130	13,300	13,470	13,640
56-60	13,630	14,460	15,370	15,620	15,830	16,030	16,240	16,450	16,670	16,880
60-65	13,940	14,760	15,660	15,920	16,130	16,340	16,550	16,760	16,980	17,200
Over 65	1,560	1,720	1,910	1,940	1,960	1,990	2,010	2,040	2,060	2,090
Total	107,280	113,730	120,800	122,760	124,360	125,980	127,610	129,270	130,950	132,660

Change in Enrollment Due to Waiver

Age Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
0-14	90	530	1,020	1,090	1,100	1,110	1,130	1,150	1,160	1,170
14-20	30	370	750	790	790	800	810	820	840	850
21-25	30	330	670	700	700	710	720	730	740	750
26-30	50	440	880	910	930	940	950	970	980	990
31-35	60	470	930	970	980	1,000	1,010	1,020	1,040	1,050
36-40	50	460	910	960	970	980	990	1,000	1,020	1,030
41-45	50	430	870	910	930	930	950	950	970	980
46-50	60	480	940	1,000	1,010	1,020	1,030	1,040	1,060	1,070
51-55	70	610	1,210	1,270	1,280	1,300	1,320	1,340	1,350	1,360
56-60	100	750	1,490	1,550	1,580	1,600	1,620	1,640	1,670	1,680
60-65	100	740	1,460	1,540	1,560	1,580	1,600	1,610	1,640	1,660
Over 65	10	150	320	330	320	330	330	340	340	350
Total	720	5,790	11,450	11,990	12,150	12,310	12,470	12,630	12,790	12,970

** Changes at the Age Group may not sum to the Total due to rounding.*

Exhibit 2B.2
State of Nevada
Nevada Public Option Actuarial and Economic Analysis
Scenario 2B: No ARP Public Option - State Premium Wrap
Individual Market Estimated Enrollees: 2026 through 2035 by APTC Eligibility

Total Enrollment by Subsidy Eligibility - Baseline

Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Subsidized	83,130	84,210	85,530	86,640	87,780	88,930	90,140	91,330	92,520	93,750
Unsubsidized	23,430	23,730	23,820	24,120	24,430	24,740	25,010	25,310	25,640	25,950
Total	106,560	107,940	109,350	110,770	112,210	113,670	115,140	116,640	118,160	119,690

Total Enrollment by Subsidy Eligibility - With Waiver

Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Subsidized	83,120	87,960	94,040	94,370	96,500	97,830	99,120	100,420	101,730	103,100
Unsubsidized	24,180	25,800	26,800	28,450	27,910	28,200	28,550	28,910	29,280	29,610
Total	107,300	113,760	120,840	122,820	124,410	126,030	127,670	129,330	131,010	132,710

Change in Enrollment Due to Waiver

Group	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Subsidized	(10)	3,750	8,510	7,730	8,720	8,900	8,980	9,090	9,210	9,350
Unsubsidized	750	2,070	2,980	4,330	3,480	3,460	3,540	3,600	3,640	3,660
Total	740	5,820	11,490	12,050	12,200	12,360	12,530	12,690	12,850	13,020

** Changes at the Subsidized level may not sum to the Total due to rounding.*

APPENDIX A
Actuarial Certification

Appendix A

State of Nevada
Section 1332 Waiver Application
Actuarial Certification

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

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

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

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

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

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

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

December 16, 2022
Date

APPENDIX B
State Legislation

December 16, 2022

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

Joint Sponsors: Assemblymen Benitez-Thompson and Frierson

CHAPTER.....

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

Legislative Counsel's Digest:

Existing law requires the Department of Health and Human Services to administer the Medicaid program, which is a joint program of the state and federal governments to provide health coverage to indigent persons. (NRS 422.270, 439B.120) Existing law also creates the Silver State Health Insurance Exchange to assist natural persons and small businesses in purchasing health coverage. (Chapter 695I of NRS) **Section 10** of this bill requires the Director of the Department, in consultation with the Executive Director of the Exchange and the Commissioner of Insurance, to design, establish and operate a public health benefit plan known as the Public Option. **Section 2** of this bill sets forth the purposes of the Public Option, and **sections 3.5-9** of this bill define terms relevant to the Public Option. **Section 10** requires the Public Option to be available through the Exchange and for direct purchase and authorizes the Director to make the Public Option available to small employers in this State or their employees. **Section 10** requires the Public Option to meet the requirements established by federal and state law for individual health insurance or health insurance for small employers where applicable. **Section 10** also establishes requirements governing the levels of coverage provided by the Public Option and the premiums for the Public Option. **Sections 38 and 41** of this bill remove the requirements relating to premiums on January 1, 2030. **Section 11**

of this bill requires the Director, the Commissioner and the Executive Director of the Exchange to apply for certain waivers to obtain federal financial support for the Public Option. **Section 39** of this bill requires the Director, the Commissioner and the Executive Director of the Exchange to contract for the performance of an actuarial study before submitting the initial waiver application. **Section 12** of this bill requires the Director to use a statewide competitive bidding process to solicit and enter into contracts with health carriers and other qualified persons to administer the Public Option. **Section 12** requires a health carrier that provides health care services to recipients of Medicaid through managed care to participate in the competitive bidding process. **Section 12** additionally authorizes the Director to directly administer the Public Option if necessary. **Sections 13, 21 and 29** of this bill require providers of health care, including health care facilities, who participate in Medicaid or the Public Employees' Benefits Program or provide care to injured employees under the State's workers' compensation program to enroll in the Public Option as a participating provider of health care. **Section 14** of this bill prescribes requirements governing the establishment of networks and the reimbursement of providers under the Public Option. **Section 15** of this bill establishes the Public Option Trust Fund to hold certain funds for the purpose of implementing the Public Option. **Section 20** of this bill exempts rules and policies governing the Public Option from provisions governing notice-and-comment rulemaking. **Sections 16, 19, 22, 32 and 34-37** of this bill make various changes so that the Public Option is treated similarly to comparable forms of public health insurance.

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

Sections 24-28 of this bill expand coverage under Medicaid in various manners. Specifically, **section 24** of this bill requires the Director of the Department to expand coverage under the State Plan for Medicaid for pregnant women by: (1) providing coverage for pregnant women whose household income is between 165 percent and 200 percent of the federally designated level signifying poverty if money is available; (2) providing that pregnant women who are determined by certain entities to qualify for Medicaid are presumptively eligible for Medicaid for a prescribed period of time, without submitting an application for enrollment in Medicaid which includes additional proof of eligibility; and (3) prohibiting the imposition of a requirement that a pregnant woman who is otherwise eligible for Medicaid and resides in this State must reside in the United States for a prescribed period of time before enrolling in Medicaid. **Section 25** of this bill requires Medicaid to cover the services of a community health worker who provides services under the supervision of a physician, physician assistant or advanced practice registered nurse. **Section 26** of this bill requires Medicaid to cover certain costs for doula services provided to Medicaid recipients by a doula who has enrolled with the Division of Health Care Financing and Policy of the Department. **Sections 17 and 33** of this bill require a registered doula to report the

suspected abuse, neglect, exploitation, isolation or abandonment of older or vulnerable persons or the suspected abuse or neglect of a child. **Section 27** of this bill requires Medicaid to reimburse services provided to recipients of Medicaid who do not receive services through managed care by an advanced practice registered nurse to the same extent as if those services were provided by a physician if money is available to reimburse those services at those rates. If money is available, **section 28** of this bill requires Medicaid to cover breastfeeding supplies, certain prenatal screenings and tests and lactation consultation and support. **Section 18** of this bill makes a conforming change to indicate the proper placement of **sections 24-28** in the Nevada Revised Statutes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. The Director:

(a) Shall make the Public Option available:

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

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

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

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

3. The Public Option must:

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

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

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

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

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

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

6. As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

2. In preparing an application for any waiver described in subsection 1, the Director, the Commissioner and the Executive Director of the Exchange may contract with an independent actuary to assess the impact of the Public Option on the markets for health care and health insurance in this State and health coverage for natural persons, families and small businesses. The

actuary must have specialized expertise or experience with state health insurance exchanges, the type of waiver for which the application is being made, measures to contain the costs of providing health coverage, reforming procedures for the purchasing and delivery of government services and Medicaid managed care programs. A contract pursuant to this subsection is exempt from the provisions of chapter 333 of NRS.

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

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

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

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

5. The Director may:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8. As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. The Trust Fund consists of:

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

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

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

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

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

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

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

683A.176 "Third party" means:

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

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

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

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

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

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

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

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

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

1. Any policy of liability or workers' compensation insurance with or without supplementary expense coverage therein.

2. Any group or blanket policy.

3. Life insurance, endowment or annuity contracts, or contracts supplemental thereto which contain only such provisions relating to health insurance as to:

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

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

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

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

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

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

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

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

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

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

4. As used in this section:

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

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

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

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

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

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

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

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

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

4. As used in this section:

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

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

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

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

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

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

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

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

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

4. As used in this section:

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

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

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

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

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

(a) Enteral formulas for use at home that are prescribed or ordered by a physician as medically necessary for the treatment of inherited metabolic diseases characterized by deficient metabolism,

or malabsorption originating from congenital defects or defects arising shortly after birth, of amino acid, organic acid, carbohydrate or fat; and

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

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

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

4. As used in this section:

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

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

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

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

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

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

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

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

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

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

4. The Executive Director shall prescribe:

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

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

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

(2) Persons who have recently lost their jobs.

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

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

695I.210 1. The Exchange shall:

(a) Create and administer a health insurance exchange;

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

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

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

(e) Unless the Federal Act is repealed or is held to be unconstitutional or otherwise invalid or unlawful, perform all duties

that are required of the Exchange to implement the requirements of the Federal Act.

2. The Exchange may:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) A coroner.

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

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

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

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

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

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

(j) Any person who maintains, is employed by or serves as a volunteer for an agency or service which advises persons regarding the abuse, neglect, exploitation, isolation or abandonment of an

older person or vulnerable person and refers them to persons and agencies where their requests and needs can be met.

(k) Every social worker.

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

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

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

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

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

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

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

(a) Aging and Disability Services Division;

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

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

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

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

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

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

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

232.320 1. The Director:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

232.459 1. The Advocate shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. As used in this section:

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

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

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

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

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

(a) The Governor.

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

(c) The Nevada System of Higher Education.

(d) The Office of the Military.

(e) The Nevada Gaming Control Board.

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

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

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

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

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

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

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

(m) The Silver State Health Insurance Exchange.

(n) The Cannabis Compliance Board.

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

3. The special provisions of:

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

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

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

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

➥ prevail over the general provisions of this chapter.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

287.0434 The Board may:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) For financial services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5. As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

share of expenditures incurred for lactation consultation and support.

3. As used in this section:

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

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

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

422.2372 The Administrator shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 31. (Deleted by amendment.)

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

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

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

(a) The Public Employees' Benefits Program;

(b) A governing body of a county, school district, municipal corporation, political subdivision, public corporation or other local

governmental agency that provides health coverage to employees through a self-insurance reserve fund pursuant to NRS 287.010;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

and the investigation of the abuse or neglect of the child must be made by an agency other than the one alleged to have committed the act or omission.

3. Any person who is described in paragraph (a) of subsection 4 who delivers or provides medical services to a newborn infant and who, in his or her professional or occupational capacity, knows or has reasonable cause to believe that the newborn infant has been affected by a fetal alcohol spectrum disorder or prenatal substance use disorder or has withdrawal symptoms resulting from prenatal substance exposure shall, as soon as reasonably practicable but not later than 24 hours after the person knows or has reasonable cause to believe that the newborn infant is so affected or has such symptoms, notify an agency which provides child welfare services of the condition of the infant and refer each person who is responsible for the welfare of the infant to an agency which provides child welfare services for appropriate counseling, training or other services. A notification and referral to an agency which provides child welfare services pursuant to this subsection shall not be construed to require prosecution for any illegal action.

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

(a) A person providing services licensed or certified in this State pursuant to, without limitation, chapter 450B, 630, 630A, 631, 632, 633, 634, 634A, 635, 636, 637, 637B, 639, 640, 640A, 640B, 640C, 640D, 640E, 641, 641A, 641B, 641C or 653 of NRS.

(b) Any personnel of a medical facility licensed pursuant to chapter 449 of NRS who are engaged in the admission, examination, care or treatment of persons or an administrator, manager or other person in charge of such a medical facility upon notification of suspected abuse or neglect of a child by a member of the staff of the medical facility.

(c) A coroner.

(d) A member of the clergy, practitioner of Christian Science or religious healer, unless the person has acquired the knowledge of the abuse or neglect from the offender during a confession.

(e) A person employed by a public school or private school and any person who serves as a volunteer at such a school.

(f) Any person who maintains or is employed by a facility or establishment that provides care for children, children's camp or other public or private facility, institution or agency furnishing care to a child.

(g) Any person licensed pursuant to chapter 424 of NRS to conduct a foster home.

(h) Any officer or employee of a law enforcement agency or an adult or juvenile probation officer.

(i) Except as otherwise provided in NRS 432B.225, an attorney.

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

(k) Any person who is employed by or serves as a volunteer for a youth shelter. As used in this paragraph, "youth shelter" has the meaning ascribed to it in NRS 244.427.

(l) Any adult person who is employed by an entity that provides organized activities for children, including, without limitation, a person who is employed by a school district or public school.

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

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

6. If a person who is required to make a report pursuant to subsection 1 knows or has reasonable cause to believe that a child has died as a result of abuse or neglect, the person shall, as soon as reasonably practicable, report this belief to an agency which provides child welfare services or a law enforcement agency. If such a report is made to a law enforcement agency, the law enforcement agency shall notify an agency which provides child welfare services and the appropriate medical examiner or coroner of the report. If such a report is made to an agency which provides child welfare services, the agency which provides child welfare services shall notify the appropriate medical examiner or coroner of the report. The medical examiner or coroner who is notified of a report pursuant to this subsection shall investigate the report and submit his or her written findings to the appropriate agency which provides child welfare services, the appropriate district attorney and a law enforcement agency. The written findings must include, if obtainable, the information required pursuant to the provisions of subsection 2 of NRS 432B.230.

7. The agency, board, bureau, commission, department, division or political subdivision of the State responsible for the licensure, certification or endorsement of a person who is described in subsection 4 and who is required in his or her professional or occupational capacity to be licensed, certified or endorsed in this State shall, at the time of initial licensure, certification or endorsement: