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FIRST JUDICIAL DISTRICT COURT OF NEVADA
IN AND FOR CARSON CITY

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

Plaintiffs,

v.

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

Defendants.

Case No. 25 OC 00109 1B

Dept. No. 1

PLAINTIFFS' APPENDIX TO MOTION FOR PRELIMINARY INJUNCTION

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35340515_v1

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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:

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

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

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

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

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

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

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

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

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

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

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

10. As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Compile a report which includes:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. This section does not apply to:

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

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

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

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

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

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

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

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

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

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

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

2. The Director:

(a) Shall make the Public Option available:

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

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

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

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

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

3. The Public Option must:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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CHAPTER 695K - PUBLIC OPTION

GENERAL PROVISIONS

ADMINISTRATION; OPERATION

PUBLIC OPTION TRUST FUND

GENERAL PROVISIONS

NRS 695K.010 Purpose and policy of Legislature in enacting chapter. [Effective January 1, 2026.] 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.

(Added to NRS by 2021, 3616, effective January 1, 2026)

NRS 695K.020 Definitions. [Effective January 1, 2026.] As used in this chapter, unless the context otherwise requires, the words and terms defined in NRS 695K.030 to 695K.110, inclusive, have the meanings ascribed to them in those sections.

(Added to NRS by 2021, 3616, effective January 1, 2026)

NRS 695K.030 "Certified community behavioral health clinic" defined. [Effective January 1, 2026.] "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.

(Added to NRS by 2021, 3616, effective January 1, 2026)

NRS 695K.040 "Commissioner" defined. [Effective January 1, 2026.] "Commissioner" means the Commissioner of Insurance.

(Added to NRS by 2021, 3616, effective January 1, 2026)

NRS 695K.050 "Director" defined. [Effective January 1, 2026.] "Director" means the Director of the Department of Health and Human Services.

(Added to NRS by 2021, 3616, effective January 1, 2026)

NRS 695K.060 "Exchange" defined. [Effective January 1, 2026.] "Exchange" means the Silver State Health Insurance Exchange.

(Added to NRS by 2021, 3617, effective January 1, 2026)

NRS 695K.070 "Federally qualified health center" defined. [Effective January 1, 2026.] "Federally qualified health center" has the meaning ascribed to it in 42 C.F.R. § 405.2401.

(Added to NRS by 2021, 3617, effective January 1, 2026)

NRS 695K.080 "Provider of health care" defined. [Effective January 1, 2026.] "Provider of health care" has the meaning ascribed to it in NRS 695G.070.

(Added to NRS by 2021, 3617, effective January 1, 2026)

NRS 695K.090 "Public Option" defined. [Effective January 1, 2026.] "Public Option" means the Public Option established pursuant to NRS 695K.200.

(Added to NRS by 2021, 3617, effective January 1, 2026)

NRS 695K.100 "Rural health clinic" defined. [Effective January 1, 2026.] "Rural health clinic" has the meaning ascribed to it in 42 C.F.R. § 405.2401.

(Added to NRS by 2021, 3617, effective January 1, 2026)

NRS 695K.110 "Trust Fund" defined. [Effective January 1, 2026.] "Trust Fund" means the Public Option Trust Fund created by NRS 695K.300.

(Added to NRS by 2021, 3617, effective January 1, 2026)

ADMINISTRATION; OPERATION

NRS 695K.200 Design, establishment and operation; availability; requirements; premiums. [Effective January 1, 2026, through December 31, 2029.]

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 this chapter, 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).

(Added to NRS by 2021, 3617, effective January 1, 2026)

NRS 695K.200 Design, establishment and operation; availability; requirements. [Effective January 1, 2030.]

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

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

(Added to NRS by 2021, 3617; A 2021, 3645, effective January 1, 2030)

NRS 695K.210 Application for federal waivers and approvals; acceptance of gifts, grants and donations; deposit of money; contracts for services. [Effective January 1, 2026.]

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 this chapter; 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 this chapter, 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 governmental 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 this chapter. 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 this chapter. Such contracts are exempt from the requirements of chapter 333 of NRS.

(Added to NRS by 2021, 3618, effective January 1, 2026)

NRS 695K.220 Administration: Contract with health carrier or other qualified person or entity or performance by Director; duties of administrator; deposit of money. [Effective January 1, 2026.]

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 NRS 695K.200.

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 this chapter.

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 NRS 695K.200 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.

(Added to NRS by 2021, 3619, effective January 1, 2026)

NRS 695K.230 Duties of certain providers of health care; exception. [Effective January 1, 2026.]

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.

(Added to NRS by 2021, 3620, effective January 1, 2026)

NRS 695K.240 Establishment of networks and reimbursement of providers of health care: Requirements. [Effective January 1, 2026.]

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.

(Added to NRS by 2021, 3621, effective January 1, 2026)

PUBLIC OPTION TRUST FUND

NRS 695K.300 Creation; administration; sources of money; interest; nonreversion; uses.

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 NRS 695K.210 and 695K.220;

(b) Any money appropriated by the Legislature for the purpose of carrying out the provisions of this chapter; 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 this chapter. 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 this chapter 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.

(Added to NRS by 2021, 3621)

Excerpt: Nevada SB 482 (2019)

Sec. 45.

1. The Commissioner may apply to the Secretary of Health and Human Services pursuant to 42 U.S.C. § 18052 for a waiver for state innovation of applicable provisions of the Patient Protection and Affordable Care Act, Public Law 111-148, with respect to health insurance coverage in this State for a plan year beginning on or after January 1, 2020.

2. The Commissioner may implement a state plan that meets the waiver requirements in a manner consistent with state and federal law and as approved by the Secretary of Health and Human Services.

Excerpt: Nevada Revised Statute Chapter 679B.120

The Commissioner shall:

1. Organize and manage the Division, and direct and supervise all its activities;
2. Execute the duties imposed upon him or her by this Code;
3. Enforce the provisions of this Code;
4. Have the powers and authority expressly conferred upon him or her by or reasonably implied from the provisions of this Code"

Excerpt: Nevada Revised Statute Chapter 679B.400

1. The Legislature finds and declares that:

   (a) Stabilizing the cost of insurance is of vital concern to the residents of this state; and

   (b) It is necessary to establish a comprehensive system to collect, analyze and distribute information concerning the cost of insurance in order to stabilize that cost effectively.

2. The purposes of NRS 679B.400 to 679B.460, inclusive, are to:

   (a) Promote the public welfare by studying the relationship of premiums and related income of insurers to costs and expenses of insurers;

   (b) Develop measures to stabilize prices for insurance while continuing to provide insurance of high quality to the residents of this state;

   (c) Permit and encourage competition between insurers on a sound financial basis to the fullest extent possible;

   (d) Establish a mechanism to ensure the provision of adequate insurance at reasonable rates to the residents of this state; and

   (e) Protect the rights of customers of insurance in this state.

Appendix C: Public Comment and Tribal Consultation Materials

Medicaid Seeks Public Comment for New State Innovation Waiver

Carson City, NV November 20, 2023

The Nevada Division of Health Care Financing and Policy (Nevada Medicaid) today announced the beginning of a 30-day public comment period for a State Section 1332 State Innovation Waiver application. The public comment period is open from November 20 through December 20, 2023. Stakeholders, the public, patients, insurers, and providers are encouraged to provide feedback. This is the first formal step in submitting a proposal to the Centers for Medicare and Medicaid Services for the implementation of new state health insurance options as required by Nevada Revised Statutes 695K.

As part of the waiver application, Nevada Governor Joe Lombardo is proposing to establish a new Market Stabilization Program to help mitigate the potential risks posed to the state's health care system by the implementation of the new health insurance options.

The proposal includes seeking federal approval for implementing:
- A state-based reinsurance program at no cost to the state.
- An annual bonus payment program to reward health insurance carriers that make strides in improving health outcomes and quality of care.
- A loan repayment program designed to support health care providers who commit to living and practicing in Nevada for at least four years.

"The new initiatives outlined in this waiver application aim to improve access to health care for Nevadans, while strengthening the marketplace for those who purchase their own health insurance," Nevada Medicaid Administrator Stacie Weeks said.

Public notices, meetings, public comment methods, 1332 Actuarial Analysis/Economic Analysis, and the draft of the 1332 State Waiver Application are available here: https://dhcfp.nv.gov/MarketStabilization/.

Contact

Ky Plaskon
Public Information Officer, Division of Health Care Financing and Policy
KyPlaskon@dhcfp.nv.gov

Joe Lombardo
Governor

Richard Whitley, MS
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF HEALTH CARE FINANCING AND POLICY

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

Stacie Weeks,
JD MPH
Administrator

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REVISED NOTICE OF PUBLIC WORKSHOP

1332 Waiver Application Presentation and Public Comment ~~Workshop~~ Meeting

Date of Publication:	November 9, 2023
Date of Revision:	**November 13, 2023**
Date and Time of Meeting:	November 27, 2023, at 1:00 PM to 3:00 PM
Name of Organization:	The State of Nevada, Department of Health and Human Services (DHHS), Division of Health Care Financing and Policy (DHCFP)
Place of Meeting:	Division of Public and Behavioral Health (DPBH) 4150 Technology Way Third Floor Conference Room #303 Carson City, Nevada 89706 Note: This Public Meeting will be held in person at the DPBH location listed above. Please use the teleconference/Microsoft Teams options provided below for the virtual option. If accommodations are requested, please advise using the information at the end of this agenda.

Note: *If at any time during the meeting an individual who has been named on the agenda or has an item specifically regarding them included on the agenda is unable to participate because of technical or other difficulties, please email Michael Gorden at michael.gorden@dhcfp.nv.gov and note at what time the difficulty started so that matters pertaining specifically to their participation may be continued to a future agenda if needed or otherwise addressed.*

*General Public Comments (No action may be taken upon a matter raised under public comment period unless the matter itself has been specifically included on an agenda as an action item. To provide public comment telephonically, you may join the meeting by dialing (775) 321-6111 and when prompted to provide the Meeting ID, enter 816 527 440#. You may then press *5 to raise your hand during the public comment periods to provide your comment. Comments will be limited to three minutes per person. Persons making comment will be asked to begin by stating their name for the record and to spell their last name. Those who wish to provide a written comment may submit their comment via mail to 1100 E. William Street, Ste. 101, Carson City, Nevada 89701 or via email to ~~documentcontrol@dhcfp.nv.gov~~1332WaiverProgram@dhcfp.nv.gov). Written comments will be accepted between November 20, 2023, and December 20, 2023.*

Please be cautious and do not click on links in the chat area of the meeting unless you have verified they are safe. If you ever have questions about a link in a document purporting to be from Nevada Medicaid, please do not hesitate to contact michael.gorden@dhcfp.nv.gov for verification.

Webinar: https://tinyurl.com/PW112723

Select "Join," enter your name and email and then select "Join."
The meeting should not require a password.

Audio Only: (775) 321-6111
Conference ID: 816 527 440#

PLEASE DO NOT PUT THIS NUMBER ON HOLD (*hang up and rejoin if you must take another call*)

YOU MAY BE UNMUTED BY THE HOST WHEN SEEKING PUBLIC COMMENT, PLEASE HANG UP AND REJOIN IF YOU ARE HAVING SIDE CONVERSATIONS DURING THE MEETING OR THOSE MAY BE HEARD BY OTHERS AND RECORDED

This meeting may be recorded to facilitate note-taking or other uses. By participating you consent to recording of your participation in this meeting.

Agenda

1. Presentation and public comment on the State's Section 1332 Innovation Waiver~~Nevada Market Stability Program (previously known as Public Option)~~

   a. The purpose of this workshop is to bring awareness that Nevada ~~will~~ is seeking a State Innovation Waiver under Section 1332 of the Affordable Care Act (ACA) (also known as a Section 1332 Waiver) in accordance with State statutory requirements of Chapter 695K of the Nevada Revised Statutes (NRS). State law requires the Director of Health and Human Services to establish a Public Option program, in which the Director contracts with health carriers to offer new health insurance options in the State's health exchange, starting January 1, 2026. The state-contracted health plans ~~(i.e., Nevada Qualified Health Plans – NQHPs)~~ must meet certain premium reduction targets and pay providers at or above Medicare rates.

   As part of this waiver request, the Governor is seeking federal authority to also establish and finance a new Market Stabilization Program (MSP). The key ~~goals~~provisions of this new program would ~~be to~~: (1) implement a reinsurance program to stabilize the individual health insurance marked and mitigate ~~the~~ any financial risk of the new premium reduction targets on health carriers and their provider networks; (2) reward health carriers and their provider networks for efforts to improve health outcomes and quality; and (3) ~~ensure greater stability for health carriers in Nevada's individual health insurance market~~increase the State's health care provider base with a "Practice in Nevada" incentive program.

   Consistent with federal requirements, the Section 1332 Waiver program will provide coverage to at least as many Nevadans; be at least as affordable with comparable benefits that are at least as comprehensive as they otherwise would have been without the waiver under federal law – all without increasing the federal deficit.

   Waiver application text and actuarial analysis will be posted on November 20, 2023, for public review and comment. All public comments are due by December 20, 2023. Please submit your public comments during this 30-day period to: 1332WaiverProgram@dhcfp.nv.gov.

   The waiver text, notice of public comment and Tribal consultation, and public comments

received will be posted at the Division's Market Stabilization Program webpage located here: https://dhcfp.nv.gov/marketstabilization/.

b. Public comment regarding subject matter.

2. Public comment regarding any other issue

3. Adjournment

NOTE: To use the long link to the meeting in the event there are issues with the URL shortener, please use the following complete link:
https://teams.microsoft.com/l/meetup-join/19%3ameeting_ZmM5ODBjOTAtZmFjMC00ZGIyLTllMWItMWVlMjQzMDUwZGY2%40thread.v2/0?context=%7b%22Tid%22%3a%22e4a340e6-b89e-4e68-8eaa-1544d2703980%22%2c%22Oid%22%3a%22cc4c7a00-e2be-4dda-a27b-3405a8271b9c%22%7d

Nevada Medicaid is unaware of any financial impact to other entities or local government due to this public hearing, other than as stated above.
PLEASE NOTE: Items may be taken out of order. Items may be pulled or removed from the agenda at any time. All public comment may be limited to three minutes.

The DHCFP is exempt from Chapter 233B according to NRS 233B.039 and is not required to comply with the Nevada Administrative Procedure Act in this process. This meeting is conducted by and with state agency staff which is not a public body for purposes of NRS 241 related to Nevada Open Meeting Law but every effort is made to be transparent in notice and information provided to encourage public awareness and participation.

This notice and agenda have been posted online at http://dhcfp.nv.gov and http://notice.nv.gov, as well as Carson City, Las Vegas, Elko, and Reno central offices for DHCFP. E-mail notice has been made to such individuals as have requested notice of meetings (to request notifications please contact michael.gorden@dhcfp.nv.gov , or at 1100 East William Street, Suite 101, Carson City, Nevada 89701.

DHCFP, 1100 E. William St., Suite 101, Carson City, Nevada 89701
DHCFP, 1010 Ruby Vista Drive, Suite 103, Elko, Nevada 89801
DHCFP, 1210 S. Valley View, Suite 104, Las Vegas, Nevada 89102
DHCFP, 745 W. Moana Lane, Suite 200, Reno, Nevada 89509

If you require a physical copy of supporting material for the public meeting, please contact michael.gorden@dhcfp.nv.gov , or at 1100 East William Street, Suite 101, Carson City, Nevada 89701. Supporting material will also be posted online as referenced above.

Note: We are pleased to make reasonable accommodations for members of the public with a disability and wish to participate. If accommodated arrangements are necessary, notify DHCFP as soon as possible in advance of the meeting, by e-mail at michael.gorden@dhcfp.nv.gov in writing, at 1100 East William Street, Suite 101, Carson City, Nevada 89701.

Joe Lombardo
Governor

Richard Whitley, MS
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF HEALTH CARE FINANCING AND POLICY

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

Stacie Weeks, JD MPH
Administrator

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NOTICE OF PUBLIC WORKSHOP

1332 Waiver Application Presentation and Public Comment Meeting

Date of Publication:	November 15, 2023
Date and Time of Meeting:	December 5, 2023, at 1:00 PM to 3:00 PM
Name of Organization:	The State of Nevada, Department of Health and Human Services (DHHS), Division of Health Care Financing and Policy (DHCFP)
Place of Meeting:	Division of Health Care Financing and Policy (Las Vegas District Office) 1210 S. Valley Blvd, Suite #104 Las Vegas, Nevada 89102 Note: This Public Meeting will be held in person at the DPBH location listed above. Please use the teleconference/Microsoft Teams options provided below for the virtual option. If accommodations are requested, please advise using the information at the end of this agenda.

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Webinar: https://tinyurl.com/PW12052023

Select "Join," enter your name and email and then select "Join."
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1. Presentation and public comment on the State's Section 1332 Innovation Waiver

   a. The purpose of this workshop is to bring awareness that Nevada is seeking a State Innovation Waiver under Section 1332 of the Affordable Care Act (ACA) (also known as a Section 1332 Waiver) in accordance with State statutory requirements of Chapter 695K of the Nevada Revised Statutes (NRS). State law requires the Director of Health and Human Services to establish a Public Option program, in which the Director contracts with health carriers to offer new health insurance options in the State's health exchange, starting January 1, 2026. The state-contracted health plans must meet certain premium reduction targets and pay providers at or above Medicare rates.

   As part of this waiver request, the Governor is seeking federal authority to also establish and finance a new Market Stabilization Program (MSP). The key provisions of this new program would: (1) implement a reinsurance program to stabilize the individual health insurance marked and mitigate any financial risk of the new premium reduction targets on health carriers and their provider networks; (2) reward health carriers and their provider networks for efforts to improve health outcomes and quality; and (3) increase the State's health care provider base with a "Practice in Nevada" incentive program.

   Consistent with federal requirements, the Section 1332 Waiver program will provide coverage to at least as many Nevadans; be at least as affordable with comparable benefits that are at least as comprehensive as they otherwise would have been without the waiver under federal law – all without increasing the federal deficit.

   Waiver application text and actuarial analysis will be posted on November 20, 2023, for public review and comment. All public comments are due by December 20, 2023. Please submit your public comments during this 30-day period to: 1332WaiverProgram@dhcfp.nv.gov.

   The waiver text, notice of public comment and Tribal consultation, and public comments received will be posted at the Division's Market Stabilization Program webpage located here: https://dhcfp.nv.gov/marketstabilization/.

   b. Public comment regarding subject matter.

2. Public comment regarding any other issue

3. Adjournment

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DHCFP, 1010 Ruby Vista Drive, Suite 103, Elko, Nevada 89801
DHCFP, 1210 S. Valley View, Suite 104, Las Vegas, Nevada 89102
DHCFP, 745 W. Moana Lane, Suite 200, Reno, Nevada 89509

If you require a physical copy of supporting material for the public meeting, please contact michael.gorden@dhcfp.nv.gov , or at 1100 East William Street, Suite 101, Carson City, Nevada 89701. Supporting material will also be posted online as referenced above.

Note: We are pleased to make reasonable accommodations for members of the public with a disability and wish to participate. If accommodated arrangements are necessary, notify DHCFP as soon as possible in advance of the meeting, by e-mail at michael.gorden@dhcfp.nv.gov in writing, at 1100 East William Street, Suite 101, Carson City, Nevada 89701.

Joe Lombardo
Governor

Richard Whitley, MS
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF HEALTH CARE FINANCING AND POLICY

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

Stacie Weeks, JD
MPH
Administrator

November 6, 2023

Inter-Tribal Council of Nevada
Serrell Smokey, ITCN President
Tribal Chairman of Washoe Tribe
919 Highway 395 South
Gardnerville, Nevada 89410

Dear Tribal Members:

In accordance with established consultation guidelines, the Division of Health Care Financing and Policy (DHCFP) is notifying Nevada tribes of the following:

The 2021 Legislature signed into law the "Public Option" through Senate Bill 420. This bill requires the Nevada Department of Health and Human Services (Department) to contract with health carriers to offer a public health insurance option no later than January 1, 2026. This reform aligns with the state's efforts to control the growth of health care costs, while improving access to coverage for Nevadans. The state-contracted health plans (i.e., Nevada Qualified Health Plans (NQHPs) will be available for purchase through Nevada Health Link marketplace, starting January 1, 2026. These plans must meet certain premium reduction targets and pay their providers at or more than Medicare rates.

To implement this new option, the Department must seek the state's first-ever Section 1332 Waiver of the Affordable Care Act in coordination with the Nevada Department of Insurance and Nevada Health Link. This letter is intended to provide formal notice of this waiver and the opportunity for tribes to provide feedback and comment prior to the state's submission on January 1, 2024.

As part of this waiver request, the Governor is seeking to establish a new Market Stabilization Program to mitigate some of the concerns raised by stakeholders about the risk of cost shifting onto providers as a result of the premium reduction targets. This program includes a new reinsurance program to help control high costs in the individual, nongroup market, along with a quality bonus payment for high performing plans and a loan repayment program for providers willing to live and work in the state of Nevada for at least four years.

The draft application for the waiver will be posted online on the Division of Health Care Financing and Policy (DHCFP) website for a 30-day public comment period on November 15, 2023. To receive federal approval of this new waiver, the new option or program must satisfy four federal requirements. These include:

- Health coverage will be as affordable as without the waiver;
- Coverage under the waiver will be available to at least as many people as would be expected to be covered without the waiver;
- Coverage under the waiver will be as comprehensive as it would have been without the waiver; and
- The waiver is deficit neutrality for the federal government.

The Department looks forward to hearing from Tribal Leaders about any questions and/or feedback they may have. We would like to offer the following meeting times during this period for DHCFP to present to Tribal Leaders:

Wednesday, November 29, 2023 at 9am (calendar invite to follow)

Thursday, December 7, 2023 at 1:30pm (calendar invite to follow)

DHCFP will enter into a 30-day public comment period upon completion of the Nevada Plan for Market Stability Waiver within the next two weeks and looks forward to meeting with Tribal Leaders during this period of time to present and take back any feedback.

There is no anticipated fiscal impact to Tribal Governments.

Please look for calendar invites from Monica Schiffer to discuss the Nevada Plan for Market Stability. If you would like a consultation regarding this proposed change in policy, please contact Monica at (775) 684-3653 or mschiffer@dhcfp.nv.gov who will schedule a meeting. We would appreciate a reply within 30 days from the date of this letter. If we do not hear from you within this time, we will consider this an indication that no individual consultation is requested.

Sincerely,

Casey Angres
Casey Angres (Nov 6, 2023 08:48 PST)

Casey Angres
Division Compliance Chief, DHCFP

cc: Sandie Ruybalid, CPM, Deputy Administrator, DHCFP
Malinda Southard, D.C., CPM, Deputy Administrator, DHCFP
Michael Gorden, Waiver & Stakeholder Director, DHCFP
Monica Schiffer, Tribal & Community Liaison, DHCFP

Joe Lombardo
Governor

Richard Whitley
Director

Nevada Battle Born State Plans and Market Stabilization Program Tribal Consultation

Division of Health Care Financing and Policy

November 29 and December 7, 2023

Department of Health and Human Services

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

Purpose and Agenda

In its effort to implement State law, the Division is soliciting feedback and comments from Nevada Tribal communities on the State's 1332 waiver application.

Agenda

- Waiver Overview: Battle Born State Plans & Nevada Market Stabilization Program
- Impact to Tribal Communities
- Questions & Public Comment

Overview: Battle Born State Plans

- State law requires the Nevada Director of Health and Human Services to contract with health carriers to offer new health insurance options – referred to in the waiver as Battle Born State Plans (BBSPs).
- These new options must be available to consumers who shop for health insurance in the State's health exchange (Nevada Health Link), starting January 1, 2026.
- These new options will, for the most part, mirror other plans in the Nevada Health Link except that they must meet an annual premium reduction target and pay their provider networks rates that at or better than Medicare.

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

Overview: Market Stabilization Program

- The second key initiative is a Market Stabilization Program.
- The waiver proposes to use federal savings from the BBSPs to finance this program.
- The key goals of the program are to:
  - **Mitigate the potential risk** of the new premium reduction targets on health carriers and their provider networks;
  - Reward health carriers and their provider networks if they **improve health outcomes and quality of care**; and
  - **Ensure market stability** in Nevada's individual health insurance market with the introduction of the new health insurance options and reforms.

Overview: Market Stabilization Program (cont.)

To achieve these goals, the Governor has outlined three new initiatives:

1. **A state-based reinsurance program** at no cost to the state that is aimed at alleviating any unexpected financial risk to participating carriers and their provider networks with the introduction of the BBSPs;
2. **A quality incentive payment program** to reward high-performing health carriers and their provider networks; and
3. **A "Practice in Nevada" program** to provide incentive more providers to live and practice in Nevada, especially in rural regions of the State.

These programs, if approved, would begin in Plan Year 2027 after the State receives its first year of federal savings under the waiver from Plan Year 2026.

BBSP Statutory Requirements

State law requires the Director to contract with health carriers to offer the new Battle Born State Plans and use the Director's **Medicaid contracting authority** to enforce certain state requirements.

Participating carriers must:

- Offer these new plans through the Nevada Health Link and **meet all federal and state standards for qualified health plans** under the Affordable Care Act.
- Offer at least **one Silver and one Gold** Battle Born State Plan.
- Offer plans that will **meet certain premium reduction targets** which will increase gradually to at least 15% percent over the first four years.
- Pay **providers rates that are no lower than Medicare rates.**

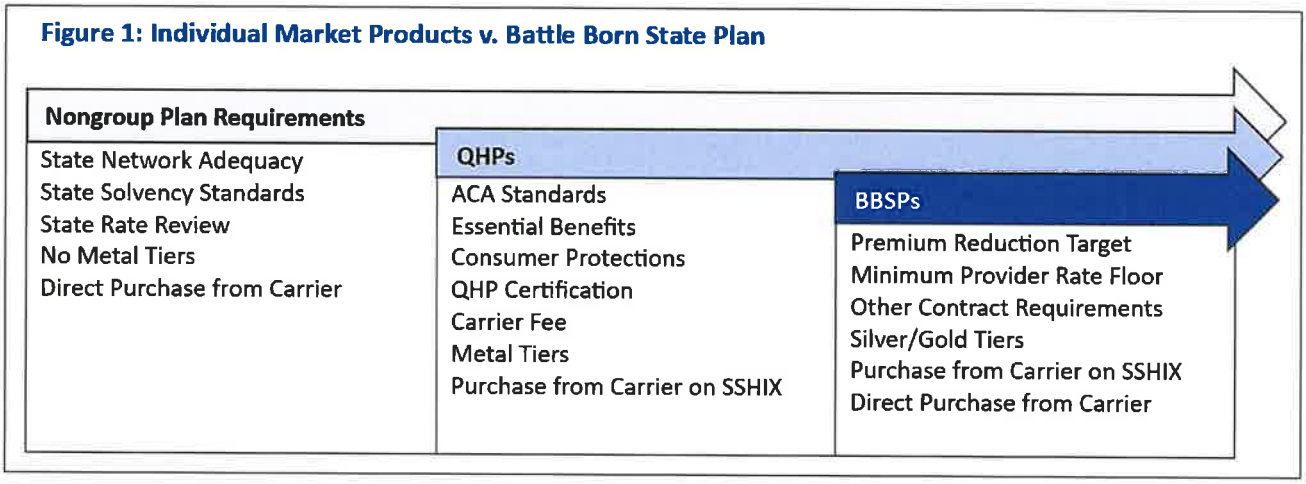
New State Procurement Process

- Under State law, the Director must implement **a new procurement process** to establish the new contracts with health carriers, creating a State-private model for operating the new health plans.
- This procurement must take place at the same time as the State's next **Medicaid managed care procurement** (slated for January 1, 2025 or earlier).
- Any health carriers seeking to participate in the State's Medicaid managed care program must submit **a good faith bid** to also contract with the State to offer and administer the new Battle Born State Plans.
- The Division will use the new **contract as its tool to enforce** the statutory requirements for the Battle Born State Plans, including the premium reduction target.
- Currently, the Division contracts with four health carriers for its Medicaid managed care program (Anthem, Health Plan of Nevada, Silver Summit, Molina).

BBSP Design

- The Battle Born State Plans will need to comply with existing nongroup and qualified health plan rules, as well as an **additional layer** of new requirements set forth in a contract with the State.

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



Other New BBSP Requirements

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

1332 Waiver & Actuarial Study

- The 1332 Waiver is expected to lower premiums and generate savings for the federal government due to lower premium tax credits.
- Nevada can bring home these savings to fund other State-based programs that strengthen the health insurance market and access to care.
- The 1332 Waiver is expected to achieve an estimated **$279 million in federal savings** in the first five years, and **$760 million** at the end of the first ten years.
- The new reinsurance program is anticipated to relieve pressure on health carriers and their provider networks by nearly half once it's up and running.

The Process

1. Actuarial study & waiver development
2. Post for state public comment period
3. Public workshops / hearings and Tribal consultation
4. Federal submission
5. Completeness review
6. Federal public comment period
7. Negotiations/ Federal Decision

Impact to Tribal Communities

Impact to Tribal Communities

- Mandated premium reductions will reduce premiums for consumers purchasing Battle Born State Plans, which includes consumers who are **American Indian/Alaskan Natives (AI/AN).**
  - According to the 2023 Open Enrollment Public Use File, there were **516 AI/AN members** enrolled in coverage through the Nevada Health Link in 2023.[1]
- The Battle Born State Plan program ***does not impact existing protections*** available to American Indian/Alaskan Natives through the Nevada Health Link:
  - American Indian/Alaskan Natives who earn less than 300% of the Federal Poverty Level (FPL) remain exempt from cost sharing and qualify for premium tax credits.
  - The Modified Adjusted Gross Income calculation for American Indian/Alaskan Natives will continue to exclude some revenue earned on reservations from Federal Trust payments.
  - American Indian/Alaskan Natives may still change QHPs once a month, without worrying about enrollment dates.[2]

1. See 2023 Marketplace Open Enrollment Public Use Files. 2. See Nevada Health Link.

Impact to Tribal Communities (cont.)

- The Battle Born State Plan will not impact existing financial assistance provided under the Division of Health Care Financing and Policy (Medicaid) in which American Indian/ Alaskan Natives eligible for Medicaid do not pay premiums and do not have any other cost sharing.
- The BBSPs will not impact health care services provided through IHS, Tribal or urban Indian health programs.
- The BBSPs do require more robust and aligned networks with Medicaid, including essential community providers.
- As a reminder, Qualified Health Plans, which will include BBSPs, must include at least 35% of available essential community providers in each plan's service area in the provider network, and must offer contracts in "good faith" to all Indian Health Service providers.
- Participating health carriers are also required to pay tribal providers participating in BBSP networks no lower than what they pay in Medicare.

Public Comment

Questions & Comments

The Division will now collect questions and comments from the tribal representatives regarding the waiver application and new Battle Born State Plans.

Any questions will be answered in writing in the next two weeks. The Division will be accepting written public comment on the State's 1332 waiver application ***until December 20, 2023.*** *The 1332 waiver application will be submitted to the federal government* ***by January 1, 2024.***

Waiver Materials can be found online at:

Nevada Market Stabilization Program (nv.gov)

Contact Information

Michael Gorden – Waiver & Stakeholder Director, Division of Health Care Financing and Policy; michael.gorden@dhcfp.nv.gov

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

Acronyms

ACA – Affordable Care Act

AI/AN – American Indian/Alaskan Natives

BBSP – Battle Born State Plan

DHCFP – Division of Health Care Financing and Policy (NV Medicaid Program)

MSP – Market Stabilization Program

QHP – Qualified Health Plan

Joe Lombardo
Governor

Richard Whitley
Director

Nevada Battle Born State Plans and Market Stabilization Program Public Hearing

Division of Health Care Financing and Policy

November 27, 2023, and December 5, 2023

Department of Health and Human Services

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

Purpose and Agenda

The Division is hosting two public meetings to engage stakeholders on the State's 1332 Waiver application, which must be submitted for federal approval no later January 1, 2024, per state law.

This waiver seeks federal approval for the State to receive the federal savings from its implementation of new state-contracted health insurance options and a reinsurance program to establish and finance a Market Stabilization Program.

Agenda

- Waiver Overview: Battle Born State Plans & Market Stabilization Program
- Questions & Public Comment
- Next Steps

Overview: Battle Born State Plans

- State law requires the Nevada Director of Health and Human Services to contract with health carriers to offer new health insurance options – referred to in the waiver as Battle Born State Plans (BBSPs).
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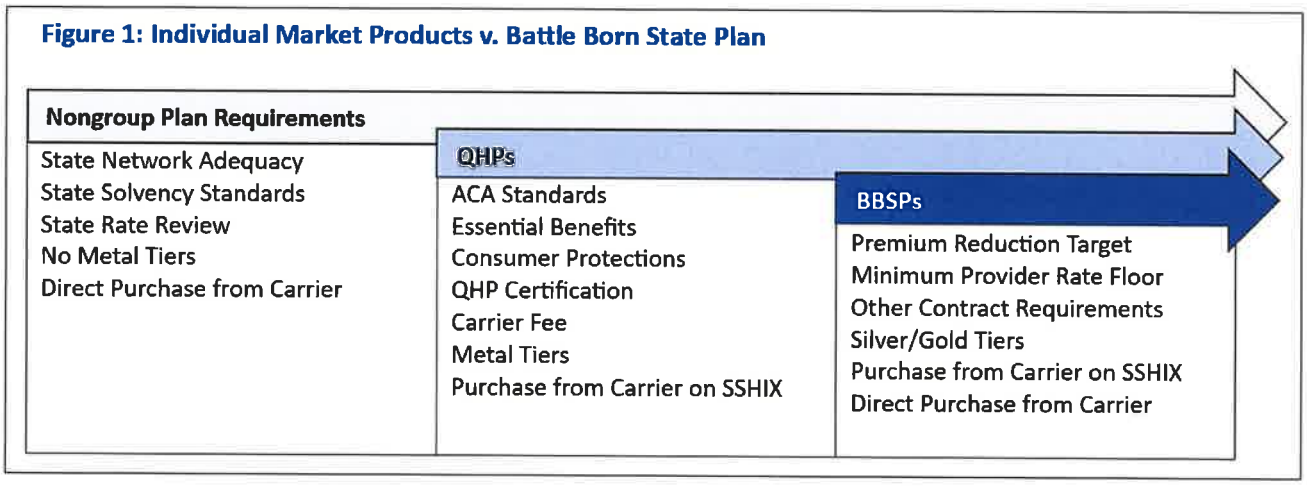

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5. Completeness review
6. Federal public comment period
7. Negotiations/ Federal Decision

Public Comment

Next Steps

- Public comments will be accepted through December 20, 2023.
- The 1332 waiver application will be submitted to the federal government by January 1, 2024.

Contact Information

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

Malinda Southard – Deputy Administrator, Community Supports & Engagement, Division of Health Care Financing and Policy; msouthard@dhcfp.nv.gov

Michael Górden – Waiver & Stakeholder Director, Division of Health Care Financing and Policy; michael.gorden@dhcfp.nv.gov

Acronyms

ACA – Affordable Care Act

BBSP – Battle Born State Plan

DHCFP – Division of Health Care Financing and Policy (NV Medicaid Program)

MSP – Market Stabilization Program

The Nevada Coverage and Market Stabilization Program Section 1332 Waiver

State Responses to Public Comments

The Nevada Department of Health and Human Services (DHHS) held a public comment period on its draft waiver application beginning on November 20, 2023 and ending on December 20, 2023. During this comment period, two public hearings were held in person and via webinar on November 27 and December 5 and two tribal consultations were held in person and via webinar on November 29 and December 7. The State received a total of 52 comments from consumer advocates, hospitals and providers, carriers, and other stakeholders. The State received 32 comments in strong support of the waiver while multiple comments included concerns that are addressed below. The below represents a summary of comments Nevada received through the public hearings and written comments and the State's responses to those comments. All written comments submitted are available on the Nevada Coverage and Stabilization Program landing page.

1. Public Comment: The State received more than 30 comments in support of the Nevada Coverage and Market Stabilization Program under the Section 1332 waiver. Commenters expressed support for provisions of the waiver that could help lower the costs of health care coverage, invest in provider workforce development, and seek value-based payment reforms. Supporters also pointed to the promise of the Public Option (i.e., Battle Born State Plans, or BBSPs) in providing consumers enhanced job mobility, guarding against medical debt, and narrowing health disparities.
    a. State Response: DHHS appreciates commenters' support for the waiver application and the shared goals to expand access to affordable coverage, improve quality, and invest in health practitioners in the State. DHHS also appreciates commenters' urging to improve health coverage affordability in the individual insurance market.
2. Public Comment: Several commenters underscored the importance of improving affordability in the individual market. A few commenters urged the State to use pass-through funding for a premium subsidy rather than a state-based reinsurance program, while another commenter expressed opposition to using taxpayer funds (e.g., federal pass-through funding) to subsidize carriers in meeting their required premium reductions.
    a. State Response: DHHS has undertaken careful consideration of this policy design, and earlier drafts of the actuarial report modeled for a state-based premium subsidy using federal pass-through funds. The nature of the deficit neutrality guardrail for Section 1332 waivers limits the impact of any premium subsidies to substantially improve health coverage affordability. The State would receive reduced pass-through funds if it were to implement a state-based premium subsidy, as new enrollment would increase federal spending and that increased federal spending would reduce available pass-through funding. In other words, states are unable to make premium subsidies (or similarly cost-sharing subsidies) "too attractive" since doing so erodes the pass-through funding. The State has determined that investing in reinsurance, quality incentive payments, and the provider workforce are effective tools to ensure a healthy and stable individual marketplace that improves long-term affordability of care for Nevadans, while still maintaining the pass-through funding needed to maintain the program.
3. Public Comment: One commenter expressed concern that the Nevada Division of Insurance (DOI) would administer the BBSP, referencing existing auto insurance policies that have increased car insurance premiums in the State.
    a. State Response: DHHS will be responsible for administering the BBSPs, not DOI. DHHS will oversee the procurement and contracting process and will provide ongoing monitoring of compliance of requirements established in the contract between the State and BBSP carriers. While the DOI will not administer the BBSPs, it will continue to lead the rate review process, license the carriers, and

oversee plan solvency for plans offered in the individual health insurance market, which includes BBSPs, like all other nongroup products.

4. Public Comment: One commenter suggested the State create funding benchmarks to ensure sufficient funds are available to invest in the Quality Incentive Payment Program and the Practice in Nevada Program.
    a. State Response: The State agrees that investments in quality improvement and the provider workforce are vitally important in Nevada. Based on the actuarial analysis by Milliman, it is anticipated that starting in Year 2 of the program, as a result of the entry of the BBSPs into the market, the federal savings generated each year would cover the cost of financing a reinsurance program across the individual market while garnering millions of dollars in additional remaining funds each year for the Quality Incentive Payment Program and Practice in Nevada Program.
5. Public Comment: A few commenters expressed concern that the premium reduction requirements will result in a cost shift from carriers to providers through reduced reimbursement rates. Commenters stated the cost shift could incentivize providers to leave the State or reduce the scope of services provided, exacerbating provider shortage challenges. Other commenters expressed concern that providers would recoup their reduced reimbursement by seeking higher reimbursement rates from other health care purchasers, putting upward pressure on premiums across payers.
    a. State Response: The BBSPs' provider reimbursement rates will likely have a minimal impact on provider behavior due to the fact that the BBSP is being targeted at the individual market in Nevada, representing a very small proportion of a provider's revenue. In December 2022 the actuarial firm Milliman conducted an assessment (see Appendix D in 2022 waiver draft) to determine the impact of the BBSPs on providers and concluded that the law's provider participation requirement would likely have little effect on provider participation in BBSP offerings and providers would be likely to contract with the BBSP at the required rates to achieve premium targets. Additionally, the state-based reinsurance program to be implemented under the Section 1332 waiver is anticipated to help subsidize the reduction in premiums under the new BBSPs, which will count towards achieving the required premium reduction targets. The State projects that starting in Year 2, the reinsurance program will account for roughly half of required premium reductions. Furthermore, the State plans to require carriers to meet an administrative cost constraint that is stricter than prevailing individual market Qualified Health Plan (QHP) administrative expense loads to ensure carriers and providers share the weight of achieving premium savings, equally. In other words, BBSP carriers cannot cost shift all of the savings needed to achieve the premium reduction target onto their providers, or they risk a breach of contract and associated penalties.
6. Public Comment: Commenters expressed concern that the law's provider reimbursement design using Medicare rates as a floor (or establishing rates for services not covered in Medicare) does not adequately compensate providers and could in practice become a reimbursement ceiling. One commenter urged the State to permit physicians to negotiate rates not covered within Medicare.
    a. State Response: The Medicare rates, and comparable rates identified by DHHS for services not covered by Medicare, will serve only as a floor for reimbursement. Providers and BBSPs are expected to negotiate rates for participation, just as they do today for private health insurance. Depending on the provider and BBSP negotiations, provider rates may be higher than Medicare in some instances. The reference to Medicare rates (and comparable rates for non-Medicare services) is intended to protect providers from receiving rates below Medicare. Providers who feel like rates, in the aggregate, are not at least as high as Medicare rates can appeal for DHHS review. If a carrier is deemed out of compliance, they will face certain penalties under their contract and be required to correct the improper reimbursement scheme.

7. Public Comment: One commenter noted that the waiver application's actuarial analysis does not adequately explore the impact of provider reimbursement rate reductions on provider participation in the BBSPs, which the commenter stated could result in BBSPs having fewer participating providers and in turn the perception of BBSPs as a lower quality insurance product.
    a. State Response: BBSP provider networks will be robust due to several factors. First, there is a requirement for providers who participate in Medicaid, the Public Employees' Benefit Plan, or the workers' compensation program to also be in-network with at least one BBSP. Second, the State has existing network adequacy requirements for QHPs. Also, BBSPs' provider reimbursement rates will most likely have a marginal impact on provider behavior because the BBSP is being targeted at the individual market in Nevada, representing a small proportion of a provider's revenue. Further, while the State is implementing a reimbursement floor for provider payments under the BBSPs tied to Medicare rates, it anticipates providers and health carriers offering BBSPs to continue to negotiate their rates for all services as they do today.
8. Public Comment: A few commenters urged the State to encourage carriers offering BBSPs to reimburse providers at rates above Medicare, including by developing incentive payments for instituting commercial reimbursement rates or by conditioning participating in value-based payment arrangements on carriers reimbursing providers at commercial rates.
    a. State Response: The State appreciates commenters' feedback and intends to solicit additional input in a future RFI on how it can reward plans for quality and other state priorities. This could include offering rates that are above Medicare rates in the BBSPs, among other design considerations.
9. Public Comment: A few commenters expressed concern with the requirement that providers who participate in the Public Employees' Benefits Program, Medicaid, or the State's workers' compensation program must agree to participate in at least one provider network for a BBSP, stating that this requirement could disrupt providers' payer mix and drive providers out of the market, in turn reducing the number of participating providers in the Medicaid program.
    a. State Response: A Milliman analysis conducted in December 2022 (see Appendix D in 2022 waiver draft) found that the BBSPs' provider participation requirements will likely have a marginal impact on provider revenue and participation given the small proportion of revenue impacted. Additionally, under current law DHHS retains authority to waive the BBSP provider participation requirements when necessary to ensure that those who receive coverage under Medicaid and the Public Employees' Benefits Program have sufficient access to covered services. DHHS is considering establishing a process for offering a waiver for those providers who can show that the BBSP will have a substantial negative impact on their provider revenues based on their patient mix.
10. Public Comment: A few commenters highlighted strong support for the Practice in Nevada Program. Commenters requested additional information about eligibility for the program, urged the State to consider expanding eligibility for the Practice in Nevada program to all providers statewide, and requested the State prioritize pass-through funding for the Practice in Nevada program.
    a. State Response: The State appreciates commenters' feedback and will work with stakeholders and policymakers to finalize the details of program design – including Practice in Nevada Program eligibility – throughout 2024. At a minimum, the State will require providers to commit to living and practicing in the State for at least four consecutive years and making such commitment through a contract with the State which will require providers to return the funds if such commitment is not met.
11. Public Comment: One commenter suggested DHHS limit who can enroll in the BBSPs to minimize disruption to the commercial insurance market.

a. State Response: The State does not have authority to limit who can enroll in the BBSPs. The BBSPs must be available as QHPs as required by Nevada Revised Statute 695K. The Affordable Care Act (ACA) requires guaranteed issue for all QHPs, meaning insurance companies are required to issue a health plan to any applicant regardless of health status or other factors. This federal requirement is one of the few that cannot be waived under a Section 1332 waiver. Moreover, it is very unlikely that BBSPs will disrupt the commercial insurance market. Few consumers currently enrolled in the commercial market would have a financial incentive to leave their current coverage and enroll in a BBSP. Any consumer with an offer of affordable minimum essential coverage (MEC) from their employer does not qualify for an advance premium tax credit (APTC) for purchase of a plan within the Nevada Health Link, including a BBSP. In addition, the ACA's employer shared responsibility provision, which requires large employers to offer affordable coverage or pay a fee, keeps large employers engaged in offering health benefits and means that most consumers employed by large businesses do currently have an offer of affordable MEC and therefore will likely not be driven to enroll in the BBSP. Note that this same argument was made with the implementation of the new federal premium tax credits and exchanges after the Affordable Care Act passed and no major disruption occurred to the commercial insurance market at that time.

12. Public Comment: A few commenters expressed concern that insurers will be unable to meet the BBSP premium reduction requirements, noting there is little room to make administrative or in many cases provider cuts, particularly with the providers serving rural regions of the state.
    a. State Response: If the waiver is approved, the State would subsidize a portion of carriers' premium reductions through the state-based reinsurance program, which is anticipated to reduce premiums and help insurers achieve the required premium reductions. The State estimates that the reinsurance program in 2027 can help to offset the burden of premium reductions on carriers and their provider networks by subsidizing the reduction in rates by about half. The State is also exploring how it will calibrate the trend factor to consider multiple factors influencing premiums and costs in Nevada's market.
13. Public Comment: A few commenters expressed concern with the State's proposal to implement an administrative cost constraint that is stricter than the prevailing QHP administrative expense load in the Medical Loss Ratio (MLR), stating carriers will struggle to reduce administrative expenses and that this could undermine services benefiting consumers.
    a. State Response: This policy is intended to mitigate the risk of carriers cost-shifting the entire burden of meeting an annual premium reduction target onto their provider networks. Further, the State is already subsidizing a portion of carriers' premium reductions through the State's reinsurance program, which is anticipated to reduce premiums and will count towards the required premium reductions. The State estimates that the reinsurance program in 2027 can help to offset the burden of premium reductions on carriers and their provider networks by subsidizing the reduction in rates by about half.
14. Public Comment: A few commenters urged for transparency in how the State calculates pass-through funding and determines available funds for the reinsurance program. Commenters also expressed concern with the tiered structure of the reinsurance program in which reinsurance will have a lesser impact on reducing premiums in Rating Areas 1 and 2.
    a. State Response: The Centers for Medicare and Medicaid Services (CMS) and the Department of the Treasury are responsible for calculating the amount of pass-through funding. The federal government then communicates federal pass-through funding amounts to the state prior to the payment of the pass-through funding. While the State acknowledges carriers' concerns with the tiered reinsurance design, it is supportive of this design in order to address longstanding affordability disparities by geographic region in the State. In implementing a geographic tiered

structure, DHHS can reduce premiums more in the highest-cost, more rural geographic areas (i.e., Rating Areas 3 and 4). However, DHHS is open to modeling other scenarios for reinsurance if such models align with goals of improving access to lower premiums for more consumers, statewide.

15. Public Comment: One commenter expressed concern that the State is relying on federal pass-through funds rather than a pre-determined set of funding to finance the State's reinsurance program.
    a. State Response: The State does not anticipate seeking additional funding for this program if not obtained through the waiver in the form of federal pass-through funding. Further, the waiver application's actuarial report projects that starting in Year 2, there will be sufficient funding from federal pass-through funds to finance the first year of the reinsurance program. Based on the actuarial analysis by Milliman, it is anticipated that starting in Year 2 of the program, the entry of the BBSPs into the market will generate enough federal savings each year to cover the cost of financing a reinsurance program across the individual market, while garnering millions of dollars in additional remaining funds each year for the Quality Incentive Payment Program and Practice in Nevada Program. Depending on the amount of federal pass-through funds received each year, the State retains the authority to adjust the attachment point and limits on the reinsurance program to ensure the funds available cover the cost of the program.
16. Public Comment: A few commenters expressed concern with conditioning eligibility to offer a bid in the Medicaid Managed Care Program on submitting a good faith bid to offer a BBSP, stating that this could result in less competition in the bid process since plans may not have the ability to propose a BBSP which will not enter the Exchange market until 2026. Commenters are also concerned that tying the BBSPs to the Managed Care program could risk destabilizing the Medicaid program as a whole if carriers cannot meet BBSP requirements.
    a. State Response: Nevada's Medicaid Managed Care procurement is competitive, with seven carriers submitting bids to participate in the program during the last procurement in 2021. Further, carriers in Nevada offering Managed Care Plans already participate in the individual insurance market due to an existing contractual requirement that Managed Care Plans also offer an Exchange product. This requirement has not destabilized the Medicaid program. Additionally, the alignment of the BBSP procurement process with the Medicaid Managed Care procurement is intended to leverage the State's purchasing authority in the Medicaid program to ensure that good faith bids for BBPS are provided and achieved. The State will evaluate bids for the Managed Care plans and BBSPs separately, and each procurement will result in separate contracts with DHHS – one for Medicaid managed care and one for the new BBSP program. If a carrier does not offer a good faith bid for the BBSP, they will be deemed ineligible to participate (through the procurement) in Medicaid Managed Care program.
17. Public Comment: A few commenters questioned if the State can effectively reduce costs and improve affordability with the implementation of the BBSPs given the challenges encountered by other states implementing premium reductions under their public option programs.
    a. State Response: Unique to the Market Coverage and Stabilization Program in Nevada, DHHS will enforce statutory requirements for the BBSPs – including the premium reduction targets – by using the legal tools under its new contracts with carriers, similar to the ways in which the State's Medicaid program enforces its existing contracts with Managed Care Plan carriers. These tools include corrective action plans, financial penalties, and/or sanctions that can be imposed by the Director if carriers do not meet contractual obligations. In leveraging its robust contracting oversight authority, the State can more effectively ensure that carriers will meet the premium reduction targets and other requirements of state law for the BBSP program.

November 20, 2023

DHHS
400 West King Street, Suite 300
Carson City, Nevada 89703

RE: Nevada Draft Section 1332 State Innovation Waiver Application Public Notice

Thank you for the opportunity to provide comments on Nevada's section 1332 State Innovation Waiver application.

My name is Pauline Lavoie and me and my daughter have struggled for years to secure affordable insurance. A few years ago, I had to quit my job to find work that gave me the flexibility I needed for my daughter. I am fortunate to be able to work and still have time to take and pick my daughter up from school and her extracurricular activities, help her with homework, and have dinner together. Unfortunately, choosing this flexibility has meant giving up the health coverage available through my previous job. Since then, finding affordable and adequate coverage for her and myself has been challenging. Being a working mom is difficult enough, and I know a lot of moms in this exact situation.

Thankfully, Nevada passed the Public Option and not only will this provide affordable coverage - with the approval of this waiver Nevada can finally invest in the critical healthcare infrastructure like a provider pipeline and stabilization so that Nevada can finally address our decade long provider shortage.

I am particularly supportive of Public Option plans being offered because, unlike the junk plans that I so often see presented as an affordable option, these plans will be qualified health plans that cover basic necessities like preventative care.

And, Nevada's ability to leverage Medicaid insurance contracts means that families like mine will be able to actually see 15% reduction in premiums because we all know those insurance companies will do anything to keep those billion dollar contracts.

For the first time in a very long time, the Public Option and the millions of dollars we can get from this waiver will provide hope to families like mine that have, for so long, struggled with securing healthcare coverage and actually accessing healthcare.

Thank you for the opportunity to provide comments on the section 1332 waiver application in support of Nevada's Public Option.

Please approve this waiver and deliver hope to families like mine.

Sincerely,

Pauline Lavoie
Lunabears@yahoo.com

Support Letter for Nevada's Public Option
Cullen McGinnis

My name is Cullen McGinnis, and I have lived in Nevada my whole life and am from an immigrant family. I have watched my family struggle with high healthcare costs and I have experienced this myself as someone who has lived with asthma since I was a child. In 2018 my grandfather had heart surgery and afterwards he had to live in an assisted living facility. He did not recover from this surgery and he would go on to pass away in that center shortly afterwards. The cost for that surgery and his rehabilitation afterwards was a significant burden to my family and it added to the stress and suffering of my family during that time. A public option would have allowed my family to have access to affordable health insurance. I know that many Asian Pacific Islanders have experienced something similar, as many of us live in multigenerational homes and struggle with the high cost of caring for our aging family.

In my personal experience as someone living with asthma I have had to pay high prices for my inhaler that I need to function. Even with insurance my inhalers cost me hundreds of dollars. In the past this has led me to ration my medication or to even go without until I could afford it, often to the detriment of my health. 32% of API and Native Nevadans have reported rationing medication due to high cost as well, so we can see that high medication costs are a huge burden to our community.

I know that once I turn 26 the high cost of health insurance will become a huge burden to me, especially as someone with a pre existing condition. High costs in Nevada have led me to consider that my future may be brighter in other states where there is more public investment in healthcare and where costs are lower and outcomes are better. Many young Nevadans grapple with this reality as well, and it would be a shame for Nevada to lose talented people to states that have created a more competitive health insurance market.

76% of API and Native Nevadans reported that they worry about health insurance becoming unaffordable. High healthcare costs are becoming untenable for many in my community, and we should not have to go into debt to receive necessary medical attention or preventative care. By creating a public option and introducing a more competitive market, health insurance costs will go down for us.

I hope that the public option will be properly implemented so that healthcare costs can go down and I can continue to afford to live in this state that I have called home for my whole life.

As someone who struggles with chronic illness, I need access to medical care often that I can't afford without health insurance. High health insurance prices are a burden and barrier to accessing the care I need as a recent college graduate. I support the public option to create more reasonably priced health insurance plans so people like me can access the care they need.

Navigating Healthcare as Filipino American Immigrants

I am Lorenzita Santos, the daughter of Filipino immigrants, writing to shed light on the profound impact of healthcare costs on my family. My father, grappling with diabetes for most of his life, bore the weight of healthcare expenses, particularly during the 2008 recession when he juggled three jobs to cover groceries, our home, and insulin.

Affordability Struggles

Healthcare costs have always been a concern, affecting not only my family but also the broader Filipino community. Shockingly, the AAPI community, to which we belong, is twice as likely to be diagnosed with diabetes than other communities. Affordable healthcare is crucial for the well-being of hardworking immigrant families.

The Public Option: A Solution

In the midst of these challenges, the Public Option emerges as a vital step forward. By offering reasonably priced plans with sufficient coverage, it signifies a positive shift toward protecting families and immigrant communities like ours. Keeping insurance costs low becomes a lifeline for those navigating the complexities of healthcare affordability.

Urgent Need for Change

Nevada's high uninsured rate, particularly within the AAPI community, underscores the urgency for solutions like the Public Option. Over 340,000 Nevadans, including a significant AAPI population, grapple with being uninsured. The Public Option is more than a policy shift; it's a promise to safeguard the health and well-being of families like mine.

Sincerely,

Lorenzita Santos

As the Community Engagement Director at One APIA Nevada, my commitment to advocating for a public health option in Nevada stems from the urgent need to enhance healthcare affordability and accessibility.

High healthcare costs have been a significant barrier, preventing Nevadans from seeking necessary medical care or obtaining comprehensive insurance coverage. I have encountered many cases where community members face financial strain due to exorbitant medical bills, forcing them to forgo essential treatments or preventive care.

A public health option is a critical step towards mitigating these challenges, as it promotes affordability by leveraging tax dollars to benefit Nevada consumers. The approval of the waiver and the consequent funding for healthcare workforce development are paramount. The scarcity of healthcare providers in Nevada not only limits access to care but also contributes to escalating costs. By investing in workforce development, we not only address the shortage of healthcare professionals but also pave the way for a more competitive healthcare landscape in Nevada.

We must take steps to make quality healthcare accessible, affordable, and equitable for all Nevadans.

Shelby Parkes
One APIA Nevada

NAACP
Las Vegas Branch

November 25, 2023

State of Nevada
Department of Health & Human Services
Mr. Richard Whitley, Director
400 W. King St., Suite 300
Carson City, Nev. 89703

Director Whitley,

The Las Vegas Branch of the NAACP stands in unwavering support for the implementation of Nevada's state-based health exchange. Implementing a public option will improve access to quality healthcare for all residents and play a crucial role in mitigating the health inequities faced by Black people and communities of color.

Communities of color, specifically Black people face higher rates of chronic illnesses, limited access to care, and poorer health outcomes compared to their white counterparts. A public option will provide affordable and comprehensive coverage, addressing financial constraints and systemic barriers that hinder access to quality healthcare.

Creating a state-based health exchange will reduce health disparities by ensuring that marginalized communities can access the care they need. By focusing on proactive measures like regular check-ups and screenings, we can identify health issues sooner and prevent them from escalating. **This approach improves health outcomes and reduces the financial burden on individuals *and the state***.

States with public health exchanges experience significant cost savings. Studies from the Center for American Progress or the National Partnership for Women and Families have shown that states operating their own healthcare exchanges can save millions of dollars annually through administrative efficiencies and reduced costs associated with uncompensated care. These savings are essential in a state like Nevada that lack diverse income streams.

In conclusion, Nevada's public option healthcare system is a vital step towards achieving health equity and justice for all residents. It ensures affordable and comprehensive coverage, empowering Black people and communities of color to access the care they deserve. The cost savings associated with a public state health exchange benefit both the state's economy and the well-being of its residents. It's truly a win-win.

Sincerely yours,

Quentin-Michael Savwoir
President, NAACP Las Vegas

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LEUKEMIA & LYMPHOMA SOCIETY®

December 5, 2023

Good afternoon.

I am Adam Zarrin (Z-A-R-R-I-N), the Director of State Government Affairs for the Leukemia & Lymphoma Society (LLS). Our mission is to cure blood cancers and improve the quality of life of patients and their families.

Last week, we shared how Americans nationwide feel trapped by medical debt. Others bravely shared their stories from across Nevada about their struggle to afford their medical bills.

This is not surprising when nearly 7 in 10 adults in the U.S. say they are concerned about affording healthcare.

We also encouraged the Department to focus on individuals and their experiences with the healthcare system. Our comments today are focused on how the state's policy can improve the quality of life for patients.

Affordable, high-quality insurance is necessary to prevent medical debt.

The public option plans will continue efforts to improve health plan options for Nevadans.

We are glad that the proposed waiver is projected to increase marketplace enrollment.

It would also reduce individual premiums, starting at 3 percent in 2026 and almost 14 percent in 2028. And it would do so without jeopardizing provider networks and quality of care for patients.

The Department can further improve these outcomes by funding the subsidies it contemplated in the first draft of the waiver. These subsidies immediately help patients in a meaningful way.

Patients still have out-of-pocket costs besides their premiums. Co-pays, co-insurances, and travel cause patients to consider delaying treatment. Or lead to the medical debt that traps patients.

Using pass-through funds for a premium subsidy will benefit patients more directly than reinsurance. So again, the state should consider including it as they did in their first draft of the waiver.

The public option will bring needed investments to improve Nevada's healthcare system.

Overall, the public option does what it set out to do -- reduce premiums, improve coverage, and save the state money.

LEUKEMIA & LYMPHOMA SOCIETY®

Thank you to the Department and the Legislature for their leadership in improving patients' quality of life.

We hope that the waiver will continue through its process toward approval so that patients can enjoy the benefits of the public option.

We appreciate your consideration. Thank you.

National Office 3 International Drive Suite 200 Rye Brook, NY 10573 • main 914.949.5213 • www.LLS.org

We want to thank Sen. Cannizzaro for passing and Governor Lombardo for implementing SB 420.

This innovative policy and implementation plan takes a new approach to delivering affordable, quality healthcare to Nevadans and offers the opportunity to dramatically reduce the cost of healthcare in this state.

By leveraging the state's purchasing power through Medicaid, the state is able to drive down costs for consumers on the individual market and enact critical reforms in the Medicaid market. While all Nevadans will be able to benefit from this policy, one of the biggest beneficiaries will be Nevada families that make too much money for federal premium support but are still priced out of health insurance.

These are not rich families. These are middle-income and in some cases low income families that have not been at the center of the healthcare affordability conversation.

For a family of four with two working parents, they would not qualify for any premium support if each parent makes just $60,000 a year. That is just slightly higher than the average annual salary in Nevada of about $59,000 a year or $28 an hour, according to Ziprecruiter.

These families need help and support and this policy delivers exactly that.

For the first time, these families have a policy, a Public Option, which will allow them to see reduced premiums so they are able to secure more affordable, quality insurance.

For the first time, we have a state policy focused on consumers left in the gap between income levels that allow a family to ***actually*** afford insurance and government coverage and subsidies for low-income families.

In addition to the real benefits, the state's 1332 waiver application also has important provisions dedicated to addressing Nevada's decades-long provider shortage problem.

Nevada was ranked 48th in the nation with regard to the availability of primary care physicians and a report by UNR's School of Medicine found that Nevada needs more than 2,500 additional providers just to meet the national average. Some of the main ways that we can address this is funding workforce development initiatives like state based residency training slots, expanding