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March 14, 2024

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

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

*Submitted electronically via [stateinnovationwaivers@cms.hhs.gov](mailto:stateinnovationwaivers@cms.hhs.gov)*

**RE: Nevada Section 1332 Waiver Application – AHIP Comments**

Dear Secretary Becerra and Secretary Yellen,

On behalf of AHIP and our member plans, thank you for the opportunity to offer comments on Nevada’s Section 1332 State Innovation Waiver Application (“Waiver Application”) to implement the Nevada Coverage and Market Stabilization Program (“Market Stabilization Program”). AHIP is the national association whose members provide quality, affordable health care coverage to hundreds of thousands of Nevadans through Medicaid managed care plans, qualified health plans (QHPs) offered through the Silver State Health Insurance Exchange, employers, and labor unions. We are committed to making health care better and coverage more affordable and accessible for everyone.

All Nevadans deserve access to affordable, comprehensive coverage. AHIP is committed to working with Nevada on efforts to ensure health insurance coverage—premiums and cost-sharing—are affordable for all Nevadans by addressing the underlying costs of care. AHIP supports state innovation and 1332 waiver flexibilities to implement programs that are tailored to their health insurance markets to promote affordability and access to comprehensive coverage. However, the Nevada 1332 Waiver Application and Market Stabilization Program are fundamentally flawed and would not achieve the goal of promoting affordability and coverage for Nevadans. **Thus, we recommend the Departments not approve the Nevada Waiver Application.**

The Waiver Application and Market Stabilization Program include several problematic provisions that would undermine the stability of Nevada’s health insurance markets. Specifically, they would:

1. Set unrealistic and unattainable premium reduction targets;

2. Exacerbate Nevada's existing provider shortage;
3. Force reductions in programs directly benefiting patients;
4. Establish an unfunded reinsurance program that is contingent on meeting aggressive premium reduction targets in year one; and
5. Threaten competition and access to care in both the individual health insurance markets and Medicaid managed care.

We address each of these problems in detailed comments below.

### **Unattainable Premium Reduction Targets**

The Nevada Market Stabilization Program would require new Battle Born State Plans (BBSPs), offered through the State's health insurance marketplace, to reduce premiums by 15% relative to a reference premium within the first four years. The state's actuarial analysis assumes 3% BBSP savings will be achieved in the first year, and over 7% premium reductions over four years. The state's analysis expects reinsurance will provide additional savings to achieve a total of 15% premium reduction.

While we share the goal of making health care more affordable for Nevadans, **the Market Stabilization Program fails to address underlying factors driving up the costs of health care, like high prescription drug costs.** According to AHIP's health care premium dollar, 22 cents of every health care premium dollar is spent on prescription drug expenses.<sup>1</sup> Instead of addressing these underlying health care premium cost drivers, **the Market Stabilization Program sets arbitrary premium reduction requirements and creates additional standards including those that undermine the ability of issuers to lower premiums.**

***The math simply does not work.*** For example, the Waiver Application does not address how issuers could meet the BBSP premium reduction target in rating area 1 under the following conditions: (1) the reinsurance coinsurance percentage is the lowest; (2) provider reimbursement levels are the lowest (given that this is the population center in the state and the greatest level of provider competition); and (3) aggregate provider reimbursements cannot be below 100% Medicare fee-for-service per the statute.

AHIP has concerns with the tiered structure of the reinsurance program, whereby different rating areas have different coinsurance levels. As specified in the state Milliman analysis, the proposed tiering has significantly lower coinsurance for rating areas 1 and 2, than for rating area 3. This would result in the reinsurance program having a much smaller impact on premiums in those rating areas, making it challenging for issuers to meet the 15% premium reduction targets.

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<sup>1</sup> <https://www.ahip.org/resources/where-does-your-health-care-dollar-go>

The Milliman actuarial analysis explicitly recognizes the more limited impact reinsurance will have on premiums in rating area 1. Specifically, Milliman exhibit 2.1 in the state actuarial analysis estimated that a 15% premium reduction will not be achieved in 2030. Milliman estimates a 13.2% total premium reduction (not 15%) with 8 percentage points coming from the BBSPs and 5.2 percentage points via reinsurance in rating area 1 for 2030.

We are deeply concerned that the Market Stabilization Program is set up to fail and that issuers will not be able to meet the required premium reduction targets with required actuarially sound premiums. We are specifically concerned about the provider reimbursement reductions and administrative cost constraints.

### **Provider Reimbursement Reductions and Network Adequacy**

**The Market Stabilization program's provider reimbursement reductions would exacerbate Nevada's existing provider shortage problem, making it more difficult for Nevadans to access the care they need.** Nevada currently ranks 45<sup>th</sup> in the nation for active physicians per 100,000 population, 49<sup>th</sup> for primary care physicians, and 49<sup>th</sup> for general surgeons.<sup>2</sup> The actuarial analysis, conducted by Milliman, included in the State's Waiver Application does not sufficiently address the implications of these premium reductions on network adequacy for BBSPs or provider shortages across the State. We are concerned that provider reimbursement reductions will limit access to adequate provider networks, especially in rural areas of the state.

Setting reimbursement rates for doctors and hospitals below commercial market rates is unrealistic and unsustainable. In a recent analysis Wakely Consulting Group found that current commercial reimbursement rates for the average Nevada physician are already at or near 100% Medicare FFS reimbursement levels.<sup>3</sup> As a result, there is little room for significant premium savings for the average physician and it is unclear how reductions will be achieved. Wakely notes similar limitations in achieving premium savings through hospital reimbursement cuts.<sup>4</sup> First, to the extent that hospital reimbursements approach 100% Medicare FFS, very little savings could be achieved as the law requires reimbursement rates in aggregate that are comparable to or greater than Medicare reimbursement rates. Second, each hospital is only mandated to contract with one BBSP. If a hospital only contracts with one BBSP, then it can be assumed the hospital would maintain higher rates with all other issuers with whom they contract. As a result, likely only one issuer will have the opportunity to use that hospital's discounted rate to support premium reductions.

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<sup>2</sup> <https://dpbh.nv.gov/uploadedFiles/dpbhnavgov/content/About/AdminSvcs/DPBH-SHA-2022.pdf>

<sup>3</sup> <https://nevashealthcarefuture.org/wp-content/uploads/2023/10/Wakely-Nevada-Public-Option-Actuarial-Analysis.pdf>

<sup>4</sup> *ibid*

It is also unclear how issuers will develop adequate networks for BBSPs under the provider reimbursement reduction requirements. As mentioned, providers are only required to participate in one BBSP network, creating little incentive for providers to accept lower reimbursement rates for multiple BBSP networks. **Wakely anticipates issuers will have difficulty developing adequate networks for BBSPs because providers will be unwilling to accept lower reimbursement rates for services covered by BBSP networks relative to other network arrangements, and that the Program's network and coverage requirements will make it especially challenging to develop adequate networks in rural areas.**

Nevada already faces a shortage of primary care providers, doctors, and nurses. Rural regions are especially challenged. We anticipate provider reimbursement rate reductions will limit issuers' abilities to develop adequate networks for BBSPs, reducing access to care, and potentially quality of care, for Nevadans enrolled under BBSPs. This would create two tiers of individual market products—QHPs with greater provider participation and BBSPs with narrower networks and fewer options for enrollees. While Medicaid and Public Employees Benefits Program (PEBP) providers are required to participate in a BBSP, providers may choose to participate in only *one* BBSP, rather than all BBSPs, meaning BBSP networks may not include as much breadth as QHP or Medicaid MCO networks. This would exacerbate the already challenging network adequacy requirements of Nevada's provider shortages. The State has indicated that yet-to-be-determined requirements will ensure alignment between BBSP and Medicaid MCO provider networks. While we appreciate the goal of promoting continuing of care when consumers have a change in eligibility and move between health plans, the Market Stabilization program requirements for provider reimbursements, provider contracting, and premium reductions do not support alignment across Medicaid and BBSP networks.

Because the second lowest cost silver plan (SLCSP) is expected to be a BBSP and premium tax credit eligibility is tied to the SLCSP premium, artificially lowered BBSP premiums will reduce the value of premium tax credits available to eligible enrollees in each of Nevada's four rating areas. This will have a direct negative impact on the amount of premium tax credit Nevadans are eligible for to purchase coverage. If consumers perceive QHPs as larger, higher-quality networks offering greater access to care, or lower cost-sharing in the form of lower copayments and coinsurance for services, they may opt to enroll in these QHPs rather than BBSPs. Nevadans would be forced to pay more out-of-pocket to access the providers they need. Subsidy-eligible consumers will have less purchasing power to enroll in comprehensive, quality coverage through QHPs and consumers will be forced to decide if they can afford to pay more in out-of-pocket premiums to enroll in, or keep, coverage they perceive as greater quality. Lower enrollment in BBSPs will reduce passthrough funding to support the reinsurance program and ultimately undermine the ability of the Market Stabilization Program to make coverage more affordable for Nevadans. **Unaddressed, the limitations of the provider reimbursement reductions could have serious consequences for Nevadans and the State's health insurance market.**

### **Administrative Cost Constraints**

**Programs that benefit consumers will be undermined due to additional administrative cost reduction requirements for BBSPs.** The Waiver Application sets new administrative cost constraints for BBSPs. The Affordable Care Act medical loss ratio (MLR) standard requires that individual market issuers spend at least 80% of premiums on medical costs and quality improvement activities and issue rebates to consumers if this threshold is not met. The ACA MLR program is working. The AHIP Health Care Dollar shows issuers spend 4.2 cents of every dollar on other administrative expenses and only 3.6 cents of every dollar account for profit.<sup>5</sup> Administrative costs include programs that directly benefit consumers by lowering costs of care, increasing access, and improving outcomes, such as 24/7 nurse lines, medical interpreters and translation services, fraud, waste, and abuse programs, and interactive technology and transparency tools. These programs are critically important for consumers and purchasers of health care, allowing issuers to offer high-quality, innovative products that help enrollees meet their health needs.

The proposed administrative constraints assume Nevada issuers have excessive administrative costs that could be cut, but this is not true. Nevada has a competitive individual health insurance market which places downward pressure on premiums and administrative expenses. Applying additional restrictions on administrative costs for BBSPs would limit the ability of issuers to serve their enrollees.

**There are no provisions in the Market Stabilization Program that would result in lower costs. In fact, additional requirements on issuers may increase costs.** In the Waiver Application, the State indicates it is considering excluding certain administrative expenses and focusing reductions on salaries and risk margin. Insurers need an appropriate risk margin as approved by the Division of Insurance in the past to ensure that adequate premium is collected to cover members' health care costs. If risk margins are inadequate, the state risks significantly reduced competition and could lead to financial challenges and issuer insolvencies that significantly and negatively impact consumers and providers, as seen in other states that have experienced recent issuer insolvencies. It is unclear how the state is encouraging competition and a level playing field between BBSP and non-BBSP plans when BBSPs might be forced to operate at a loss or at zero risk margins, relying on non-BBSP risk margins for issuer solvency.

AHIP's Health Care Dollar analysis found approximately 82.4 cents of every premium dollar goes to prescription drugs and medical services. Risk margin or profits is 3.6 cents of every premium dollar. Further, taxes and fees represent 3.8 cents of the health care premium dollar, which insurers have no ability to reduce.<sup>6</sup> Requiring half of the premium reduction targets to

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<sup>5</sup> <https://www.ahip.org/resources/where-does-your-health-care-dollar-go>

<sup>6</sup> *ibid*

come from reduced issuer admin costs representing, on average, 3.6% of premium costs is unrealistic and ignores the source and drivers of rising healthcare costs.

The Wakely analysis found, “a 3% increase in loss ratio could reduce a low-cost insurer’s risk margins to 0%, which does not allow for an actuarially appropriate margin of error in estimating claims and risk adjustment expenses. This would have negative implications for competition, deter new entrants, and potentially cause some issuers to exit the market.”<sup>7</sup>

AHIP and other stakeholders have raised these concerns directly with the State and through public comments but the State has not meaningfully responded to concerns about the ability of issuers to meet more stringent administrative cost constraints or the potential for such restrictions to negatively impact programs that directly benefit consumers.

### **Unfunded Reinsurance Program**

**Relying on BBSP premium savings to fund the state’s portion of the reinsurance program is not a viable model and threatens to undermine the ability of reinsurance to lower premiums in Nevada.** AHIP has historically supported 1332 reinsurance waivers, which have a proven track record of achieving premium reductions. In other states’ reinsurance waivers, the state’s portion of the reinsurance program is funded through general funds, a tax on issuers, a user fee, or other similar financing mechanisms. By contrast, Nevada would not directly contribute **any** funding to support the program. Instead, the State proposes to rely on pass-through funding resulting from assumed future reductions in 2025, the first year of the waiver.

Reinsurance funding that is dependent on unproven and unrealistic premium reductions would make the individual market extremely fragile. The Market Stabilization Program assumes premium reduction targets will result in federal pass-through funding, which in turn will contribute to lower premiums, and create a chain reaction of interdependent premium reductions and passthrough funding. There is virtually no margin for error and if any of these targets is missed, it undermines the program and stability of the individual market. Notably, rates will be inadequate if issuers assume a fully funded reinsurance program but the actual passthrough funding cannot support the program.

The contingency of reinsurance funding on the BBSP requirements creates significant challenges for evaluating the waiver and market stability. The reinsurance proposal cannot be adequately evaluated because its funding is uncertain. Stakeholders cannot intelligently comment because the reinsurance program and unproven premium reduction targets are bundled and contingent on each other. Funding for the reinsurance program would rely on both unrealistic premium

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<sup>7</sup> <https://nevadashealthcarefuture.org/wp-content/uploads/2023/10/Wakely-Nevada-Public-Option-Actuarial-Analysis.pdf>

reduction targets, as discussed above, and on the BBSP program first reimbursing itself. While the reinsurance program was included in the waiver program to stabilize the individual market, the proposal is speculative. If issuers are not able to meet premium reduction targets, the State will not achieve sufficient passthrough funding to support the reinsurance program and lower premiums for Nevadans. While the Waiver Application contemplates fining issuers up to the premium reduction shortfall to make up for lost federal passthrough funding, this would represent **very significant** fines. Such fines would have a significant impact on issuer solvency, finances, and possibly their ability to remain in the state, undermining the stability of the individual market and access to coverage for Nevadans.

Rather than stabilizing the individual market, the uncertainty of an unfunded reinsurance program undermines the goals of affordability and could create instability in Nevada's individual market. Reinsurance has a strong track record of lowering premiums in the states where it has been successfully implemented. We are deeply concerned that the proposed reliance on unrealistic premium reductions would set a precedent for other states and that failure in Nevada, or other states, would undermine the integrity of 1332 reinsurance waivers. Other states with more traditional funding methods to support their 1332 reinsurance waivers often finance the state's portion through a premium tax, user fee, or state general fund, reliable funding sources compared with unproven premium reduction savings that have not materialized in other states.

**We do not support the proposed financing model and we strongly urge the Departments to work with Nevada to require a strong contingency financing model to support the reinsurance program if premium reduction targets are not met to fund the Program.**

Nevada seeks approval for a multi-year waiver and should demonstrate that it can operate the waiver as drafted throughout the waiver period. Nevada has indicated that it may utilize financial penalties if an issuer fails to meet premium reduction targets, including penalties worth all or some of the value of the federal passthrough funding that the State would have otherwise received if the issuer had met its premium reduction target. The Waiver Application projects BBSPs will produce 3.2% premium reductions in the first year and 8% in years four and beyond—this would expose issuers to significant fines over the 5-year contract that Nevada expects issuers would enter into for BBSPs. This is neither a sound financing model nor good public policy. Issuers who work in good faith to meet the requirements of state law should not be penalized for faulty public policy and unattainable premium reduction targets. We urge the Departments to require Nevada to provide a sound alternative financing plan to support reinsurance throughout the term of the waiver.

### **Impact for Medicaid Managed Care**

The Market Stabilization Program requires that issuers bidding to participate in Medicaid managed care also bid to offer silver and gold level BBSPs. This proposed requirement goes above and beyond the existing requirement that Medicaid managed care issuers offer silver and

gold level QHPs. We are particularly concerned that scoring for Medicaid managed care contracts would be based on the issuer's BBSP offering. This approach could deter new entrants to the Medicaid managed care market and undermine consumer choice.

Issuers participating in Nevada's managed care program have expertise in developing products and networks to meet the unique needs of the State's Medicaid beneficiaries. While some issuers may excel at providing a high-quality Medicaid managed care product, they may not be similarly positioned in the individual market. The Medicaid and individual markets are separate markets with distinct populations, unique provider contracting practices and considerations, and distinct regulatory requirements. Requiring issuers to offer BBSPs as a condition of participating in the Medicaid managed care program would unnecessarily jeopardize competition and choice in the Medicaid market, which currently enrolls over 640,000 Nevadans. AHIP strongly opposes policies that could reduce choice and competition in Nevada's Medicaid MCO market.

### **Experience in Other States**

While each state's health insurance markets are unique, we should look to experience in other states to inform policy.

Colorado's public option program similarly set premium reduction targets and has yet to successfully drive down costs, increase competition and choice, or make health care more affordable by the metrics set forth in Colorado law. In 2023, only one issuer in one metro area was able to meet the 5% premium reduction target, and it did so by offering plans with unsustainable, actuarially unsound rates. No issuer met the premium reduction targets in 2024. It remains unclear whether any issuer in CO will be able to meet the premium reduction targets for plan year 2025. Experience in CO is important to understand as other states consider modeling similar aggressive premium reduction targets after the CO requirements. While Colorado and Nevada have unique markets, the core limitations of premium reduction targets that have made them unattainable in other states would similarly make them unattainable in Nevada.

We are deeply concerned that the required premium reductions would result in premiums that result in insufficient margins or an issuer operating at a loss and that this could put Nevada issuers at risk of insolvency. Recent issuer insolvencies in other states have demonstrated the importance of oversight and enforcement of actuarially sound and reasonable premiums requirements and the role of state regulators in ensuring issuers meet other standards to ensure financial viability. Insolvencies in states with large, competitive health insurance markets have caused serious ripple-effects for remaining issuers, health care providers, and the enrollees. While Nevada has a competitive market, it is a significantly smaller market than other states and an insolvency in Nevada would threaten the stability of the individual market. The Wakely report aptly noted that Nevada has a competitive individual insurance market, especially in Rating Area 1, and if business cases existed to lower premiums to such competitive levels, market forces



would have already driven the premium reductions.<sup>8</sup> Competition and market forces have not driven this level of premium reduction and the Market Stabilization Program does not create new levers that issuers can pull to lower premiums. Instead, the Program creates arbitrary premium reduction targets that are not only out of sync with but likely contradict the principles of actuarial soundness. We are concerned required premium reductions would create instability in the individual market that would deter new entrants and would not sufficiently protect against insolvencies of existing issuers.

### **Recommendations**

AHIP supports the use of 1332 waivers to innovate and allow states to adopt approaches tailored to their health insurance markets. However, such approaches should be based on sound policy and achievable, sustainable standards. The Nevada Coverage and Market Stabilization Program does not meet this standard. **Thus, we strongly recommend the Departments not approve the Nevada 1332 Waiver Application.**

Sincerely,



Jeanette Thornton  
Executive Vice President, Policy and Strategy

CC: Chiquita Brooks-LaSure, Administrator, CMS  
Dr. Ellen Montz, Deputy Administrator and Director, Center for Consumer Information and Insurance Oversight, CMS  
Jeff Wu, Deputy Director Policy, Center for Consumer Information and Insurance Oversight, CMS

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<sup>8</sup> <https://nevadashealthcarefuture.org/wp-content/uploads/2023/10/Wakely-Nevada-Public-Option-Actuarial-Analysis.pdf>



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March 14, 2024

Dr. Ellen Montz  
Deputy Administrator and Director  
Center for Consumer Information and  
Insurance Oversight  
Centers for Medicare & Medicaid Services  
7500 Security Blvd.  
Baltimore, MD 21244

Submitted via the Web Portal, [stateinnovationwaivers@cms.hhs.gov](mailto:stateinnovationwaivers@cms.hhs.gov).

**RE: Nevada Section 1332 Waiver Application**

Dear Deputy Administrator Montz:

The Blue Cross Blue Shield Association (BCBSA) appreciates the opportunity to provide comments on Nevada's application for a waiver under Section 1332 of the Affordable Care Act (section 1332 waiver).

BCBSA is a national federation of independent, community-based and locally operated BCBS companies (Plans) that collectively cover, serve, and support 1 in 3 Americans in every ZIP code across all 50 states and Puerto Rico. BCBS Plans contract with 96% of hospitals and 95% of doctors across the country and serve those who are covered through Medicare, Medicaid, an employer, or purchase coverage on their own.

BCBSA has long advocated for commonsense solutions to ensure a robust, competitive private marketplace that offers individuals a broad range of choices to meet their needs at the best possible price. We have supported the development of reinsurance programs through section 1332 waivers to stabilize markets allowing states to deliver quality and affordable health coverage.

**Recommendations.** BCBSA recommends that the Department not approve the current Nevada waiver application given that it does not provide adequate support to demonstrate that the projected savings from the proposed public option are reasonably achievable. Given the statutory requirement for budget neutrality, which depends on the ability of CMS to accurately assess program savings, BCBSA is concerned by the precedent that would be set if the Department approves a waiver with inadequately supported public option savings projections that may not materialize. We urge the Department to clarify that savings projections for public option plans must fully and appropriately reflect current provider reimbursement levels, any reimbursement rate “floor,” the extent to which additional reductions from current market reimbursement levels may reasonably be achieved by health insurance issuers, and impacts to Federal spending in other market segments, such as Medicaid.

Nevada’s waiver stands or falls on the potential savings from the public option. While there is a reinsurance component, it is funded entirely through assumed public option savings. Experience with other states suggests that the projected savings from the public option are unlikely to materialize. While BCBSA strongly supports effective reinsurance programs, to successfully stabilize the market and generate long-term premium reductions any such program must have a stable source of funding.

BCBSA also requests that CMS and Treasury provide clear and more detailed information on how they calculate federal pass-through funds, explicitly focusing on the public option framework under the 1332 waiver, similar to guidance provided to the Treasury model published annually. Enhancing transparency around the public option and the associated federal pass-through funding calculations will allow stakeholders to make more informed decisions.

**Background.** Nevada’s section 1332 waiver application proposes the implementation of a new Nevada Public Option, which would become effective in January 2026. The program aims to achieve a 15 percent premium reduction target through the combination of the public option (“Battle Born State Plans” or “BBSPs”) and reinsurance. Table 6 in the State’s waiver application identifies the source of premium savings as the following.<sup>1</sup>

<b>Table 6: Projected Second Lowest-Cost Silver Premium Changes from Baseline</b>			
<b>YEAR</b>	<b>BBSPS ONLY</b>	<b>REINSURANCE</b>	<b>TOTAL</b>
2026	-3.2%	0.0%	-3.2%
2027	-5.2%	-6.8%	-12.0%
2028	-6.6%	-6.9%	-13.5%
2029	-8.0%	-7.0%	-15.0%

The State waiver application makes it clear that, “There are no dedicated State funding sources to finance a full reinsurance program; it will be wholly financed with federal pass-through funds.

<sup>1</sup> Nevada’s 1332 Waiver Application, Page 25.

Without the implementation of the waiver and State receipt of federal pass-through funds achieved by premium reductions, the State would not be able to move forward in funding and implementing the reinsurance program.”<sup>2</sup> The structure of the State waiver application and any reinsurance program is contingent upon the public option premium savings and resulting federal pass-through funding to fund the State’s portion of the reinsurance program. As we discuss below, the actuarial analysis submitted in support of the State’s application fails to adequately account for several relevant factors and thus overstates the level of savings likely to be achieved by the proposed public option.

The waiver application also contemplates financially penalizing the public option carrier up to an amount, “that is worth all or some of the value of the federal pass-through funding that the State would have otherwise received if the carrier had met its agreed-upon premium reduction target.”<sup>3</sup> From our perspective, it is unlikely that any shortfall in unprovided public option premium reductions and resulting federal pass-through funding for the state’s reinsurance costs will be offset by financial penalties on one or more public option carriers. This type of penalty could have a significant and detrimental impact on consumer plan choice and insurer competition in the market.

**Public Option Savings.** Nevada’s Health and Human Services department projects potential savings of \$279 million to \$310 million in the first five years and \$760 million to \$840 million in federal pass-through funds over the first decade. The realization of such savings will depend on several unpredictable variables, including the level of public option savings actually achieved, market dynamics, and enrollment numbers. There is a substantial risk that these projections may not fully materialize if the underlying assumptions are not met. The state’s actuarial consultant acknowledges this in their report, stating assumptions are “based on actuarial judgement given that no public option program similar to Nevada’s program and that has enrollment experience exists”<sup>4</sup>.

According to an actuarial [analysis](#) conducted by the Wakely Consulting Group, physician rates, on average, are likely already at or near 100% of Medicare Fee-for-Service. Because the Nevada Public Option statute has a floor for average physician reimbursement at 100% Medicare FFS, little to no premium savings can be expected via physician reimbursement cuts. In addition, reducing premiums by 16% may require reducing hospital reimbursement rates by 25-30%.

Lastly, Nevada is a competitive insurance market where payers compete, including by keeping administrative costs and risk margins to a minimum already. Further, administrative costs

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<sup>2</sup> Nevada’s 1332 Waiver Application, Page 12.

<sup>3</sup> Nevada’s 1332 Waiver Application, Page 21.

<sup>4</sup> Karan Rustagi, FSA, MAAA, [Nevada Public Option Actuarial Analysis](#), Wakely Consulting Group, October 24, 2023.

benefit consumers by lowering the costs of care, increasing access, and improving access through programs such as 24/7 nurse lines, fraud, waste and abuse programs, and transparency tools. The State in the waiver application recognizes these consumer benefits and is considering excluding quality improvement, consumer outreach, care management, call centers, or nurse lines as a source of potential administrative cost savings and premium reductions for the public option.<sup>5</sup> Whether the state does or does not exclude administrative costs that benefit consumers as a source of potential premiums savings, the State's projections that the public option premium reduction targets can be achieved through insurer administrative and/or risk margin reductions is unlikely. Actuarially sound premiums must be sufficient to cover claims, administrative costs, and risk margins. To the extent the public option results in an actuarially unsound premiums, the result may be lower competition, insurer market exits, and/or insurer insolvency. The above three factors indicate that Nevada's projections for the public option premium reductions may not be realistic to achieve, which undermines the State's source of funding for the reinsurance program.

In addition, experience with other states suggests that the projected savings<sup>6</sup> from the public option may not be realized. This [article](#) highlights concerns regarding the Colorado Public Option's ability to meet its goals, especially regarding premium reduction targets. In its second year, only one plan reported in their March 1, 2023, filings to the state of being able to meet the 2024 targets, with all other insurers indicating they could not achieve the mandated 10% reduction in rates.

**Reinsurance Funding.** The state's waiver application funds reinsurance using the uncertain public option savings. This approach introduces risk to consumers as the actual savings may fall short of projections, potentially leading to less financial support for the reinsurance program intended to stabilize premiums. As stated in the Background section above, we do not expect that any shortfall in public option premium reductions and resulting federal pass-through funding for the state's reinsurance costs will be offset by financial penalties on one or more public option carriers.

The State's reinsurance funding structure provides uncertainty for consumers and the stability of the insurance market. Effective reinsurance programs require a stable and reliable funding source, which ensures that the program will meet the statutory budget neutrality requirement. Should the public option underperform due to premium targets that cannot be met due to, lower enrollment than anticipated, higher health care costs, or market dynamics the necessary funds for a state reinsurance program would not materialize.

We appreciate your consideration of our comments. If you have any questions or want additional information, please contact Andrea Cooke at [andrea.cooke@bcbsa.com](mailto:andrea.cooke@bcbsa.com).

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<sup>5</sup> Nevada's 1332 Waiver Application, Page 11.

<sup>6</sup> [Health insurers balk at price demands in Colorado governor's signature health insurance program – Colorado Consumer Health Initiative \(cohealthinitiative.org\)](#)

Sincerely,

A handwritten signature in black ink, appearing to read "K. Haltmeyer", with a long horizontal flourish extending to the right.

Kris Haltmeyer  
Vice President, Policy Analysis  
Policy & Advocacy



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**To: The Department of Health and Human Services and the Department of the Treasury**  
**From: Claire Heyison and Sarah Lueck, Center on Budget and Policy Priorities**  
**RE: Nevada’s Section 1332 Waiver Application**

To Whom it May Concern:

The Center on Budget and Policy Priorities (CBPP) is a nonpartisan research and policy organization based in Washington, D.C. Founded in 1981, the Center conducts research and analysis to inform public debates and policymakers about a range of budget, tax and programmatic issues affecting individuals and families with low or moderate incomes. We appreciate the opportunity to comment on Nevada’s section 1332 waiver application.

CBPP supports Nevada’s goals, stated in its application, to improve access to and affordability of health care, while ensuring a stable marketplace for people who buy insurance in the individual insurance market. The state rightly highlights the problem of its relatively high rate of uninsurance: Nevada has the sixth highest uninsured rate in the nation and the highest uninsured rate among states that have adopted the Affordable Care Act (ACA) Medicaid expansion.<sup>1</sup> We are hopeful that the state’s proposal to implement public option plans will eventually lead to policies that more directly address the affordability and access challenges Nevadans are experiencing, particularly people with low incomes who are most likely to be uninsured or to forgo needed care due to cost. In Colorado and Washington, public option plans have generated savings for enrollees while offering more generous coverage.<sup>2</sup>

However, we are concerned that Nevada’s proposal to invest federal savings from its public option plans into a reinsurance program will not substantially reduce uninsurance or improve health care affordability in the state. Most uninsured Nevadans have low or moderate incomes or are

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<sup>1</sup> KFF, “State Health Facts: Health Insurance Coverage of the Total Population,” 2022, <https://www.kff.org/other/state-indicator/total-population/>.

<sup>2</sup> Christine Monahan et. al., “State Public Option Plans Are Making Progress on Reducing Consumer Costs,” The Commonwealth Fund, November 27, 2023, <https://www.commonwealthfund.org/blog/2023/state-public-option-plans-are-making-progress-reducing-consumer-costs>.

barred from health coverage because of their immigration status.<sup>3</sup> Reinsurance would not significantly increase coverage among these groups and has the potential to negatively impact those who receive or are eligible for PTCs. Instead of investing in proven policies that improve or expand coverage and affordability for the most impacted groups, such as improvements to financial assistance and expanding coverage eligibility, the waiver would reduce premiums for people who qualify for marketplace coverage but earn too much to receive PTCs, a group that makes up just five percent of Nevada's uninsured population.<sup>4</sup> And despite a substantial investment only a small number of these relatively higher income individuals would gain coverage as a result of the reinsurance program.

Nevada's 1332 waiver would require insurers that submit a bid to offer Medicaid Managed Care plans in the state to also offer public option health plans, called Battle Born State Plans (BBSPs), on the Affordable Care Act (ACA) marketplace. Issuers would be required to decrease BBSP premiums by at least 15 percent within four years and establish provider reimbursement rates at or above Medicare rates.<sup>5</sup> The state expects the public option program to generate \$311 million in federal savings on premium tax credit (PTC) spending over five years.<sup>6</sup> If Nevada's waiver is approved, the state projects 80 percent of these funds will be used to finance the reinsurance program.

In competitive markets, reinsurance payments typically result in lower total premiums. But very few people with marketplace coverage pay the total premium. In 2023, 86 percent of Nevada's marketplace enrollees received the advance premium tax credit (PTC), which limits people's contributions to the premium amount based on their incomes.<sup>7</sup> And because the tax credit is calculated based on the premium of the second lowest cost silver plan in a given area (the benchmark), a reinsurance program that reduces the benchmark premiums means less financial help for people who are PTC eligible.

Nevada expects that reinsurance will result in 9,770 new, higher-income enrollees in ACA marketplace coverage in the first five years of the program (from 2027 to 2031), a gain that it predicts will be slightly offset by a small number of lower-income marketplace enrollees leaving the marketplace. Assuming that these estimates are correct, just three percent of the state's 342,000

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<sup>3</sup> KFF, "State Health Facts: Distribution of Eligibility for ACA Health Coverage Among the Remaining Uninsured," 2022, <https://www.kff.org/affordable-care-act/state-indicator/distribution-of-eligibility-for-aca-coverage-among-the-remaining-uninsured/>.

<sup>4</sup> *Ibid.*

<sup>5</sup> Nevada Department of Health and Human Services, "Nevada Section 1332 Innovation Waiver Request - Battle Born State Plans (BBSPs) and Market Stabilization Program (MSP)," January 1, 2024, [https://dhcfnv.gov/uploadedFiles/dhcfpnavgov/content/MarketStabilization/FinalNV1332Application\\_vF2024v2.pdf](https://dhcfnv.gov/uploadedFiles/dhcfpnavgov/content/MarketStabilization/FinalNV1332Application_vF2024v2.pdf).

<sup>6</sup> Fritz Busch *et al.*, "1332 Waiver Actuarial / Economic Analysis and Certification for Nevada's Public Option," Milliman, December 16, 2022, [https://dhcfnv.gov/uploadedFiles/dhcfpnavgov/content/MarketStabilization/Archive\\_1332\\_Actuarial\\_Economic\\_Analysis\\_vF.pdf](https://dhcfnv.gov/uploadedFiles/dhcfpnavgov/content/MarketStabilization/Archive_1332_Actuarial_Economic_Analysis_vF.pdf).

<sup>7</sup> KFF, "State Health Facts, Marketplace Effectuated Enrollment and Financial Assistance," 2022, <https://www.kff.org/other/state-indicator/effectuated-marketplace-enrollment-and-financial-assistance/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.



uninsured people would gain coverage under this proposal.<sup>8</sup> If the enhanced PTCs do not expire in 2025, as is assumed by the state's analysis, the waiver's impact on uninsurance could be smaller or even negative. Meanwhile, reinsurance will not make health coverage or health care more affordable for the state's 80,000 PTC-eligible marketplace enrollees<sup>9</sup> and 100,000 PTC-eligible people who are uninsured.<sup>10</sup>

Reinsurance not only doesn't help subsidized marketplace enrollees. It can negatively impact affordability and enrollment for them, by reducing their purchasing power, raising the minimum cost for coverage, removing \$0 premium options for some people, and potentially deterring enrollment. Recent research on Georgia's reinsurance program finds it was associated with a 30 percent increase in the minimum cost of a marketplace plan for people with incomes from 251 to 400 percent of the federal poverty level, due to a smaller spread between the premium for the lowest cost plan and that of the benchmark cost silver plan. Because of these premium increases, approximately 21,000 marketplace enrollees with incomes from 200 to 400 percent FPL left the marketplace in 2022 and 2023, eclipsing the 3,381 people with incomes above 400 percent FPL that the state predicted would gain marketplace coverage due to reinsurance during this period.<sup>11</sup>

Given these concerns, we urge HHS and Treasury to probe more deeply the impact of the proposed reinsurance program on both enrollment and affordability and more closely evaluate the impact of Nevada's proposal on low-income Nevadans as part of the Departments' review of the waiver proposal's impact on vulnerable populations. Like changes that were made after application submission in New York (where payments to insurers were added to prevent a small increase in premiums for unsubsidized people), HHS and Treasury should require modifications to the state's waiver proposal to offset any net premium increases affecting vulnerable populations.

In addition, the state is proposing to begin the reinsurance program in 2027. Prior to 2027, it is possible that Congress will extend the enhancements to the premium tax credit that are scheduled to expire at the end of 2025 under current law. This would represent a significant change in federal law and one that could magnify or shift to different income levels the negative impact of reinsurance on subsidized people, low-income people, or on enrollment and affordability overall. Consistent with the provision in the "Specific Terms and Conditions" for any approved 1332 waiver, the Departments should re-evaluate the reinsurance program if such a change in federal law occurs and determine any changes that might be needed. To promote market stability, this reevaluation should occur as soon as possible after such a change, prior to the reinsurance program taking effect.

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<sup>8</sup> KFF, "State Health Facts: Distribution of Eligibility for ACA Health Coverage Among the Remaining Uninsured," 2022, <https://www.kff.org/affordable-care-act/state-indicator/distribution-of-eligibility-for-aca-coverage-among-the-remaining-uninsured/>.

<sup>9</sup> KFF, "State Health Facts, Marketplace Effectuated Enrollment and Financial Assistance," 2022, <https://www.kff.org/other/state-indicator/effectuated-marketplace-enrollment-and-financial-assistance/>.

<sup>10</sup> KFF, "State Health Facts: Distribution of Eligibility for ACA Health Coverage Among the Remaining Uninsured," 2022, <https://www.kff.org/affordable-care-act/state-indicator/distribution-of-eligibility-for-aca-coverage-among-the-remaining-uninsured/>.

<sup>11</sup> David M. Anderson *et. al.*, "Georgia's Reinsurance Waiver Associated With Decreased Premium Affordability And Enrollment," *Health Affairs*, Vol. 43, No. 3, March 2024 <https://doi.org/10.1377/hlthaff.2023.00971>.

CBPP also makes the following recommendations as the Departments review this waiver:

- The current waiver application would allow insurers to include premium reductions resulting from reinsurance as part of the insurer’s progress toward meeting state premium targets. The state estimates that reinsurance payments would account for about half of the reduction in premium rates under the waiver in 2027.<sup>12</sup> This approach undermines one of the goals of a public option, which is to reduce underlying health care costs, and would reduce insurers’ incentives and leverage in pursuing lower provider rates. We encourage CMS to work with the state to exclude premium reductions resulting from reinsurance from counting toward premium reduction targets for BBSPs.
- As written, Nevada proposes it would be able to waive premium targets if an insurer claims it cannot meet them. Nevada should require insurers to provide supporting evidence of these claims, require insurers to take certain steps to lower premiums before the premium reduction target is waived, and facilitate negotiations between insurers and providers. For example, Colorado’s waiver application for its public option program notes that carriers that are unable to meet the state’s premium targets may enter into non-binding arbitration with providers. Colorado’s waiver also authorizes the state insurance commissioner to “conduct a public hearing on the rates and, after considering evidence presented at the hearing, require providers to accept rates necessary to meet the reduction requirements, subject to a series of limiting factors.”
- Similarly, HCPs who don't want to participate in a BBSP's network can get an exemption if they show a significant monetary loss in total patient revenues. “Significant monetary loss” should be clearly defined to ensure that this exemption is not misused.
- In its waiver application, Nevada considers including a contract provision that would require BBSPs to reduce administrative costs in order to generate savings. CMS should encourage Nevada to pursue this approach.
- Nevada intends to use federal savings in excess of the cost of reinsurance to finance a quality incentive payment program. The Departments should ensure, as part of the reporting requirements for 1332 waivers, that Nevada includes data and other information to evaluate the effectiveness of this initiative and to allow meaningful public comment over time.

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<sup>12</sup> Nevada Department of Health and Human Services, “Nevada Section 1332 Innovation Waiver Request - Battle Born State Plans (BBSPs) and Market Stabilization Program (MSP),” January 1, 2024, [https://dhcfp.nv.gov/uploadedFiles/dhcfpnv.gov/content/MarketStabilization/FinalNV1332Application\\_vF2024v2.pdf](https://dhcfp.nv.gov/uploadedFiles/dhcfpnv.gov/content/MarketStabilization/FinalNV1332Application_vF2024v2.pdf).

March 1, 2024

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

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

*Submitted via [stateinnovationwaivers@cms.hhs.gov](mailto:stateinnovationwaivers@cms.hhs.gov)*

RE: Nevada Section 1332 State Innovation Waiver Application

Dear Secretary Becerra and Secretary Yellen,

The Committee to Protect Health Care is a mobilization of doctors committed to expanding access to affordable health care. We are pleased to submit comments to the Center for Medicare & Medicaid Services (CMS) and Department of the Treasury in support of Nevada's Section 1332 State Innovation Waiver application to create the Nevada Coverage and Market Stabilization Program. We believe this proposal is a strong foundation to increase health coverage options for Nevadans while building upon existing state efforts to promote health care affordability. We are excited to see the continued efforts to ensure access to affordable health insurance coverage through the creation of Battle Born State Plans and appreciate the opportunity to share our perspective on the design of the state's federal 1332 waiver.

#### *Current Coverage and Affordability Landscape in Nevada*

Even with expanded access to public and private health insurance coverage during the pandemic, Nevada suffers the [highest uninsured rate](#) of any state that has expanded Medicaid. More than 340,000 (11%) Nevadans are uninsured, with Hispanic (20%) and American Indian/Alaskan Native (21%) populations being disproportionately impacted. [Nearly half](#) of uninsured Nevadans report the major reason they are uninsured is due to coverage being "too expensive." For those who are able to access health insurance, individual marketplace premiums have continued to [rise](#). Many insured Nevadans [report](#) experiencing health care affordability burdens, while even more worry about affording health care costs both now and in the future. Due to this, [more than half](#) of Nevadans reported delaying or going without health care due to cost in 2022.

#### *Increasing Affordability for Nevadans*

We are supportive of the state taking a unique approach to strengthen the long term sustainability of the market in Nevada by leveraging the savings created by the Public Option for three new initiatives – a state-based reinsurance program, quality incentive payment program

tied to improved outcomes for participating carriers and providers and the “Practice in Nevada” provider incentive program. Nevada’s Coverage and Market Stabilization Program aims to lower the cost of health insurance for more than [100,000](#) Nevadans on the individual market, while bringing up to \$310 million in federal passthrough funding into the state in the first five years.

One of the overarching goals of the Public Option was to reduce the cost of health coverage and the number of Nevada residents forced to go without health insurance because they can’t afford it. With the Public Option and reinsurance working together, individual marketplace premiums will fall 15% over four years. For those without access to coverage, this premium reduction will be a lifeline that will save people money and allow them to more easily plan and budget for their family’s needs.

#### *Maintaining Access to Care for People*

Reimbursement for providers who participate in one of Nevada’s public option plans are expected to meet or exceed Medicare rates, with special attention paid to critical safety net providers, including critical access hospitals, federally qualified health centers, and rural health clinics, to ensure access to these essential providers. Furthermore, the quality incentive payment targets through the Marketplace Stabilization Program’s “waterfall” approach will incentivize better care delivery that prioritizes positive health care outcomes and shifts away from [costly](#) fee-for-service. Carriers will have the option to leverage several incentive models, such as offering providers valued-based payment bonuses tied to quality metrics, setting primary care spending targets or engaging in efforts to increase health care workforce capacity. These programs are [proven](#) to improve health outcomes for people, all while providing financial certainty for providers and ensuring Nevadans maintain access to robust provider networks and health plan choices.

#### *Addressing the Provider Shortage in Nevada*

Nevadan’s health coverage issues are exacerbated by the state [not having enough](#) physicians to meet Nevada’s growing health needs. Every county in Nevada is experiencing a shortage of medical professionals, and in 2021, Nevada was ranked [48th](#) in the nation with regard to the availability of primary care physicians per 100,000 residents, leading to [long wait times](#) for primary and specialty care. Drawing doctors to complete their graduate medical education in Nevada [has become more difficult](#) as the state’s population has increased but graduate residency spots have not. Thus, many of Nevada’s 300 medical school graduates [complete their residency](#) elsewhere, [never](#) returning to practice in Nevada.

The "Practice in Nevada" program and other workforce development provisions proposed in Nevada’s waiver application provide unique solutions to support the state’s health care infrastructure, while improving access to health care for Nevadans. By dedicating resources to attract and retain providers through a new loan repayment program, Nevada is following the lead of [several](#) other state initiatives to address health care workforce recruitment and retention.

#### *Conclusion*

Thank you for the opportunity to provide comments in support of the section 1332 waiver application to create Nevada’s Coverage and Market Stabilization Program. If you have any

questions or are interested in further discussion of our comments on the proposed 1332 waiver application, please do not hesitate to reach out.

Sincerely,

Dr. Rob Davidson

Executive Director

Committee to Protect Health Care

Miles Baker

Chief of Staff

Committee to Protect Health Care



March 14, 2024

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

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

Dear Secretary Yellen and Secretary Becerra:

The Healthcare Leadership Council (HLC) strongly opposes and urges you to reject Nevada’s revised 1332 waiver application due to the significant damage the implementation of a “public option” in the state would have on choice.

HLC is a coalition of chief executives from all disciplines within American healthcare. It is the exclusive forum for the nation’s healthcare leaders to jointly develop policies, plans, and programs to achieve their vision of a 21st century healthcare system that makes affordable high-quality care accessible to all Americans. Members of HLC – hospitals, academic health centers, health plans, pharmaceutical companies, medical device manufacturers, laboratories, biotech firms, health product distributors, post-acute care providers, group purchasing organizations, home care providers, and information technology companies – advocate for measures to increase the quality and efficiency of healthcare through a patient-centered approach.

While HLC and our member companies support value-driven policy solutions that empower patients and reduce costs, we believe advancing a public option will not advance these goals. When the Nevada legislature passed SB 420 in 2021, our concern was immediate regarding the negative impacts it could have on Nevadan patients and their access to affordable, high-quality healthcare.

Creating a state-government controlled “public option” through SB 420 would have numerous negative consequences for Nevadans, including reduced healthcare competition within the state’s marketplace. This new government-controlled health

insurance system's unsustainable mandates and increased costs on payers could drive health plans out of the state, lessening Nevadans' choices for coverage. The public option's potential to distort the coverage market also poses substantial risk for Nevadans covered by employer-provided plans.

In addition to its impact on consumers, the creation of a public option risks worsening Nevada's already significant healthcare provider shortage due to unsustainably low reimbursement rates. Today, Nevada ranks 48<sup>th</sup> in the nation in primary care physicians per capita. Further reducing the number of providers in the state would worsen already critically low levels of access when we should be working to expand it.

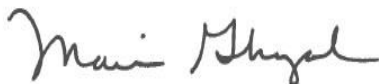
While the state has attempted to mitigate some negative effects of SB 420 with the market stabilization plan and revised 1332 waiver application, these efforts fail to address the numerous problems associated with SB 420's "public option." In fact, the waiver application's content—which includes incentive plans for both insurance plans and healthcare providers—highlights the many harmful consequences of SB 420's underlying policy. By including these revisions, the state highlights the tremendous harm that the "public option" would cause, even as it continues to move towards its implementation.

HLC shares the goal of ensuring that every Nevadan has access to affordable, high-quality healthcare, but it is clear to us that SB 420 and the revised 1332 waiver will not help achieve this. In fact, implementing this deeply flawed system will likely do just the opposite, burdening Nevada's families, caregivers and communities with unaffordable costs and negative consequences.

We encourage you to reject Nevada's revised 1332 waiver application. Instead, policymakers at all levels of government should advance proven healthcare policy solutions that will provide long-term value and ensure continued and expanded access to affordable, high-quality healthcare.

Thank you for your consideration of this important matter. If you have any questions, please do not hesitate to contact Katie Mahoney, Executive Vice President and Chief Policy Officer, at [kmahoney@hlc.org](mailto:kmahoney@hlc.org) or (202) 449-3442.

Sincerely,



Maria Ghazal  
President and CEO

March 13, 2024

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

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

Dear Secretary Yellen and Secretary Becerra:

On behalf of the Henderson Chamber of Commerce (Chamber) and the nearly 150,000 Nevadans working among our 1,900 member businesses, as well as an association health plan provider who insures more than 9,300 Nevadans, we are writing today to express our concern with Nevada's 1332 waiver application to implement the Public Option in Nevada under Senate Bill 420, which Nevada legislators passed in 2021.

While we are all united in the belief that Nevadans deserve access to quality health care, the Chamber still has serious concerns about the impact the Public Option could have on Nevada's families who currently access their health care through employer-sponsored plans and benefits. Unfortunately, the state's efforts to push through this 1332 waiver application only further underscore and highlight these concerns, which is why we must urge you not to approve it.

Our biggest concern with the Public Option as outlined by SB 420 remains how it would undermine employer-sponsored health plans while reducing options, jeopardizing access, and increasing costs for thousands of Nevadans. When Nevada lawmakers were originally debating SB 420, the Chamber joined other business and economic development associations, health groups, and stakeholders to oppose the bill and the implementation of a state government-controlled Public Option.

In previous comments to the Nevada Department of Health and Human Services, we outlined the risk the Public Option poses to Nevadans who rely on employer-provided health benefits as well as access to care in our communities. Moreover, the move to government-controlled health care could damage Nevada's insurance marketplace, limiting options for Nevada consumers while doing little to meaningfully address our state's uninsured population.

The Chamber is committed to helping Nevada employees and their families access the quality care they need at reliable prices through the small group market, which is why our organization led the coalition launch of a fully insured association health plan in 2018. Moreover, hundreds



of small employers statewide provide health plans that, like ours, help reduce costs or increase access to quality care for Nevadans. We remain committed to that vision, and it has been our experience that employer-led health insurance plans offer greater advantages than those managed and offered by the state.

We urge you to help protect Nevadans' access to quality care by rejecting this revised 1332 waiver application.

Thank you for your time and consideration.

Sincerely,

A handwritten signature in blue ink that reads "Emily Osterberg". The signature is written in a cursive, flowing style.

Emily Osterberg  
Director of Government Affairs  
Henderson Chamber of Commerce



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March 11, 2024

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

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

Dear Secretary Yellen and Secretary Becerra:

On behalf of the Latin Chamber of Commerce—the premier business organization serving Nevada since 1976—I am grateful for the opportunity to comment on Nevada's revised 1332 waiver application to implement the Nevada Public Option under Senate Bill 420. Just as we did when the Nevada legislature debated SB 420 in 2021, the Chamber has serious concerns about the consequences of the Nevada Public Option for our state, and we strongly urge you not to approve Nevada's revised 1332 waiver application.

In 2021, the Latin Chamber opposed SB 420 due to factors including the higher costs the Public Option could cause for Nevadans who get their coverage through employer-provided health care plans—the majority of Nevada's working population. Along with a broad coalition of stakeholders, we spoke out on our concerns about the consequences that passage of SB 420 and the Nevada Public Option could have on coverage, quality, choice, and access to health care across our state.

On top of the risks it poses to employer-sponsored plans, the Nevada Public Option could drive private health plans out of the market altogether, reducing competition and limiting coverage choices for Nevadans. There is also a serious potential for this new system to worsen, not improve, Nevada's already significant health care workforce shortage, and to undermine Nevadans' ability to stay with their chosen health care providers.

None of these concerns have disappeared or diminished over time, regardless of what the state is currently attempting to do with its revised 1332 application. If anything, the lengths that Nevada policymakers have had to go through to push this revised waiver application forward only highlight the many flaws in SB 420. Unfortunately, what this revised waiver application does not do is fix the fundamental problems of SB 420 or address the many negative consequences that creating the Public Option could have on Nevada's job creators, families, and communities.

All Nevadans should be able to access affordable, high-quality health care coverage, and the Chamber supports efforts to expand coverage through commonsense policies that improve upon the strong public-private partnerships that already exist in health care. However, the many risks that the Nevada Public Option pose to Nevadans, local businesses, and our entire health care system—as well as the minimal impact it will have on reducing the state's uninsured population—make it an option that is not worth pursuing. Please reject this revised 1332 waiver application and help protect access to care, choice, quality, and competition in Nevada's health care system.

Sincerely,

Peter Guzman  
President and CEO

March 14, 2024

Administrator Chiquita Brooks-LaSure  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Submitted to: [stateinnovationwaivers@cms.hhs.gov](mailto:stateinnovationwaivers@cms.hhs.gov)

**Re: Nevada Section 1332 State Innovation Waiver, 2024**

Dear Administrator Brooks-LaSure,

On behalf of the Medicaid Health Plans of America (MHPA), we thank you for the opportunity to provide input on Nevada's recently submitted Section 1332 State Innovation Waiver.

MHPA is the only national trade association with a sole focus on Medicaid, representing more than 152 MCOs serving more than 51 million Medicaid beneficiaries in 40 states, the District of Columbia and Puerto Rico. MHPA's members include both for-profit and non-profit, national, regional, as well as single-state health plans that compete in the Medicaid market. Nearly three-quarters of all Medicaid beneficiaries receive health care through MCOs, and the Association provides research and advocacy services that support policy solutions to enhance the delivery and coordination of comprehensive, cost-effective, and quality health care for Medicaid beneficiaries.

### Waiver Requirements

This Section 1332 waiver application will require Medicaid Managed Care Organizations (MCOs) bidding to participate in Nevada's State Medicaid Program to produce a good faith bid to offer at least a Silver and Gold Public Option health plan (known in the state as a "Battle Born State Plan, or BBSP). Bids for BBSPs will be required to meet a 15% premium reduction target and provide a formal attestation and rate certification attesting that the rates for BBSPs are actuarially sound. Medicaid MCOs that do not submit a qualifying good faith BBSP bid will be ineligible to participate in Nevada's State Medicaid Program. Nevada expects premium reductions for BBSPs to be achieved through provider reimbursement reductions, administrative efficiencies, and reinsurance, under the waiver application.

### MHPA Comments

We appreciate efforts by the state of Nevada to make healthcare more accessible for Nevadans. Individuals in Nevada should have access to high quality, affordable coverage regardless of income, health status, or eligibility for Marketplace subsidies. However, we are concerned that the 1332 waiver application submitted by Nevada could negatively impact choice and competition for Nevadans who receive care through the individual market or the State Medicaid Program. Further, expected provider reimbursement reductions are likely to exacerbate the existing workforce shortage in Nevada and do not align with CMS' goal of improving access and addressing provider workforce shortages, including in the Medicaid program. We recommend that CMS reject this waiver application and work with the State of Nevada to develop an alternative 1332 waiver which improves access without negatively impacting provider participation and member choice in the state. Our specific comments in response to this application can be found below:

## Medicaid Managed Care RFP Process

We are concerned that tying eligibility to participate in Nevada's State Medicaid Program to submitting a good faith BBSP bid that includes specific premium reduction requirements will negatively impact competition, and therefore member choice, in Nevada's health insurance markets. Not all Medicaid MCOs currently participate in the state currently. Given the need to develop infrastructure and a workforce to submit a competitive bid, new MCOs may be discouraged from participating in an RFP for both Medicaid and BBSP in 2025. We recommend that CMS reject the provision that requires MCOs to submit a good faith bid on a BBSP to ensure that Nevada can continue to maintain a competitive and innovative program that serves the needs of more than 887,000 Medicaid and CHIP enrollees ([as of October 2023](#)) in that state.

## Provider Reimbursement Reductions

Nevada's [2022 State Health Assessment](#) notes that the state currently ranks 45<sup>th</sup> in the nation for active physicians per 100,000 population, 49<sup>th</sup> for primary care physicians, and 49<sup>th</sup> for general surgeons. In 2021, an estimated 67.3% of Nevadans resided in a federally designated primary medical care Health Professional Shortage Area (HPSA). The assessment notes that shortages are particularly severe in geographic regions such as North Las Vegas and Washoe County where residents are more likely to be low-income and qualify for Medicaid. Further, the average distance between acute care hospitals in rural Nevada and the next level of care or tertiary care hospital is 109 miles and the average distance to the nearest hospital is 56 miles. With many of these regions experiencing snowfall in the winter, the journey can be particularly dangerous. Access to behavioral health care is a challenge as well, with just 249.8 mental health providers per 100,000 population. A testimonial from a rural Nevadan in the assessment notes:

*"...in this being a rural community, it is very difficult to get and maintain health care. Usually if you need to see a specialist you have to go to Reno or Carson City that's just the given. I know I remember when my husband and I first moved here there was a young doctor he had recently graduated and he had to put it in his five years or whatever it is but as soon as he was done, he was out. We can't retain and keep people."*

We are concerned that lowering existing reimbursement rates for providers in Nevada will exacerbate the existing workforce shortages in the State. With proposed provider reimbursement reductions, BBSPs will be required to attract providers by leveraging their Medicaid provider networks and requiring providers to be in network for both programs. Given the ongoing workforce shortage, some providers may choose not to participate in either network in favor of higher reimbursement rates from the employer-sponsored market, further curtailing access for low-income Medicaid beneficiaries. With lower reimbursement rates, medical practitioners are also likely to continue leaving Nevada for markets with higher average salaries. Providers that remain are likely to shift the cost burden of sustaining their workforce to other health plans, including employer-sponsored groups and self-funded plans. With these proposed changes, Nevadans are likely to see negative impacts to provider quality and access, which is already challenging in the state.

## Closing Remarks

Once again, thank you for the opportunity to provide comments on Nevada's Section 1332 State Innovation Waiver. Ensuring high quality, affordable health coverage for Nevadans is of paramount importance to MHPA. We appreciate the opportunity to share our perspective and look forward to continuing to work with CMS and the state of Nevada to make a meaningful difference in the lives of Medicaid beneficiaries.

Please feel free to reach out to me directly at [sattanasio@mhpa.org](mailto:sattanasio@mhpa.org) with any questions or should you need any additional information.

Sincerely,

/s/

Shannon Attanasio  
Vice President, Government Relations and Advocacy



We are writing in support of Nevada's 1332 waiver application for pass through dollars in connection with their Public Option healthcare insurance policy passed during the 2021 Nevada Legislative Session in Senate Bill 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. In fact, other states that have attempted Public Option policies are modeling the evolution of their policies based on this groundbreaking initiative.

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.

This is critically important: the Public Option and the associated pass through dollars that we can get through the 1332 waiver present the only real hope we have as a state to drive down premiums and provide more affordable, quality insurance options to Nevada families.



And while reinsurance would not have been our preferred policy choice for the use of the pass through dollars - we believe that Governor Sisolak's original proposal to provide direct consumer premium supports offers a better return to consumers and empower Nevada families - nonetheless reinsurance will reduce overall costs for Nevada families and help put Nevada's health insurance market on solid footing.

In addition to the real benefits of the Public Option and reinsurance, 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 pay parity and scope for APRNs and tearing down barriers that prevent healthcare providers from moving to and practicing in Nevada.

These are important reforms and we encourage the state and CMS to look at comprehensive reforms and best practices that Nevada can engage in, along with the funding that will be provided through approval of the 1332 waiver, to truly rebuild and expand Nevada's network of healthcare providers. We need a healthcare infrastructure that can actually meet the needs of Nevada families and the 1332 waiver application provisions focused on workforce development are essential - we are strongly in support of them and thankful for their inclusion.

Finally, we wanted to point out and applaud the outcome based payment reforms included in SB420 and the 1332 waiver application. For far too long, Nevadans have been suffering under a healthcare system that is among the most expensive in the country with some of the worst healthcare outcomes. It is indeed the inverse of the type of healthcare system you actually want; instead of low cost, high quality we suffer from high cost, low quality.

By modernizing Nevada's payment system so that we incentivize healthcare providers to focus on patients outcomes, Nevada can drastically and practically address this issue. We can deliver in the individual market some of the same reforms that we are seeing in the Medicare and Medicaid market. Over the long-term, these incentive based payment solutions can finally



change our healthcare system that has been focused on maximizing profits for insurers while demonstrating indifference to patient care and patient outcomes.

We want to remind everyone, including current providers that all MCOs offer exchange plans already and have been required to for years. We encourage DHHS and Medicaid to continue to explore additional administrative actions and reforms that can realign Nevada's healthcare system to the benefit of consumers and Nevada families and not simply deliver an additional point or two in profit margins to some of the largest healthcare corporations in the world.

While this proposal is not perfect, it represents a dramatic leap forward in terms of better health policies and better health outcomes for Nevada families. Every Nevada family, including mine, has endured the problems of a broken healthcare system where premiums cost too much, deductibles are too high, physicians are too few and healthcare outcomes too poor. That needs to change and this 1332 waiver represents Nevada's best shot at achieving that success. Please do not bow to industry pressure or beltway do gooders who would rather profit off Nevada families or be self righteous than do what is right.

Nevada families are crying out for help - they need these dollars and this support. We implore you to do the right thing and approve Nevada's 1332 waiver application.



March 13, 2024

Centers for Medicare & Medicaid Services  
Sent electronically to: [stateinnovationwaivers@cms.hhs.gov](mailto:stateinnovationwaivers@cms.hhs.gov)

RE: Nevada's Section 1332 Waiver Application

Dear CMS:

The statute enacting Nevada's Public Option law, SB 420, is the foundation upon which Nevada's 1332 Waiver request is built. The mandates and ambiguities inherent in SB420's language make it weak and unstable, as evidenced by a pending court case challenging its constitutionality.

The Nevada Hospital Association supports greater access to health insurance, and it appreciates the Governor's effort to provide some stability through the Market Stabilization Plan, but major concerns still exist. We write to express our concerns and ask CMS to not grant the waiver at this time.

Access to care is a perennial problem in Nevada. Nearly 70% of the state's population resides in a federally designated Primary Medical Care Health Professional Shortage Area (HPSA), nearly 87% of Nevadans live in a federally designated Mental Health HPSA, and more than 65% reside in a federally designated Dental Health HPSA.

Recruiting and retaining physicians in the state is a constant struggle. Nevada needs more than 1,500 physicians just to meet national averages. With respect to physician specialists, Nevada is below the national average in 33 of 39 physician specialties. Without physicians, healthcare facilities cannot address the needs of their communities.

The Public Option program, though well intentioned, will exacerbate our shortage of physicians because reimbursement rates will be too low.

SB420 mandates that health insurance premiums be reduced 15% below the competitive health insurance market in the first four years of the program. This is a quick and dramatic reduction. Based on the analysis of actuaries, the State has twice reduced the percentage of reduction in an attempt to make the Program actuarially sound. The enacting legislation establishes a "floor" for reimbursement rates for providers. Insurance companies must pay providers at least Medicare rates. We are concerned that Medicare rates will not only be the "floor" but will also be the "ceiling." Currently, Medicare rates do not cover, in most cases, a healthcare provider's cost to provide care to patients.

Low premium rates will entice many consumers to switch from commercial insurance products to the Public Option. Moving patients from full commercial rates to lower reimbursement rates will hurt physicians. Some may retire, leave the state, restrict the services they deliver, or look to other states to

establish a practice. Nevada's struggle to recruit and retain physicians will become more difficult. As a result, patients will find it more difficult to access necessary health care services in a timely manner.

Moreover, patients may see their access to care limited. The drastic reductions in premiums will place insurance companies under great financial pressure. Patients in the Public Program will likely experience insurance coverage denials for services as insurance companies work to control expenses.

Nevada has a small private commercial insurance market. Most residents have health insurance coverage through Medicaid, Medicare, or large self-insured employers. To preserve our private health insurance market, eligibility for the Public Option should be limited based on need or income. If eligibility is not limited and many people join, the cost shift to Nevadans who maintain commercial health insurance will be too great and commercial health insurance will become unaffordable. Citizens will be forced to move to the Public Option Program because it is cheaper. Without actuarial soundness in rates, the public option will descend into a death spiral and the competitive disadvantage will cause traditional commercial health insurance to disappear, and providers will leave the state due to poor reimbursement rates. Again, this adversely affects patient access to care.

The Public Option Program should focus on providing health insurance to those who need it most: people who are ineligible for other programs or who pay extraordinarily high premiums and deductibles.

While creative, Governor Lombardo's Market Stabilization Program, the subject of the 1332 Waiver request, would only serve to support an unstable Program. It would protect all health insurance carriers in the individual market from extraordinary losses, provide incentives for insurance companies and healthcare providers, and direct resources to build the state's healthcare workforce. These are all laudable objectives.

Unfortunately, the underlying problems with the foundational legislation are too great. Therefore, the program should not move forward.

Thank you for your consideration.

Regards,



Patrick Kelly  
President & CEO  
Nevada Hospital Association



March 14, 2024

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

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

**Re: Nevada Section 1332 Waiver Application – NvAHP Comments**

Dear Secretary Yellen and Secretary Becerra:

On behalf of the Nevada Association of Health Plans (NvAHP) – a statewide trade association representing [ten member companies](#) that provide commercial health insurance and government programs to Nevadans – we submit these comments today to express our concerns with Nevada’s Section 1332 State Innovation Waiver Application (“waiver application”) to implement the Nevada Coverage and Market Stabilization Program, which includes the operation of a Public Option health insurance offering on the Silver State Exchange, as required by statute (“Public Option program”).

Our mission is to ensure the growth and development of a high-quality and affordable health care delivery system throughout the State of Nevada (“State”), and while we understand and value the importance of innovating and adapting to meet the healthcare needs of Nevadans, a state government-controlled Public Option program is simply not the answer.

The NvAHP has actively engaged and collaborated with the State throughout the multi-year public participation process since the passage of Senate Bill 420 in 2021. We submitted a total of nine (9) letters beginning with the public design phase, continued through stakeholder engagement and waiver application design, to finally arriving at today, which is the review of the waiver application by your respective Departments. Our members continue to have serious concerns about the Public Option program and do not believe that it will achieve greater healthcare affordability and coverage for Nevadans. In fact, we consider the Public Option program to be fundamentally flawed, to which we explain further below. *As a result, we strongly urge the Departments to not approve the Nevada waiver application.*

**Medicaid Managed Care Impact**

The State’s waiver application expressly mandates health insurance providers to submit a “good faith bid” response to the Public Option program procurement *if* the health insurance provider is also interested in being considered for the upcoming statewide Medicaid Managed Care procurement. As the waiver application provides, a health insurance provider would be ineligible for consideration and participation in the State’s Medicaid Managed Care program if the same health insurance provider does not provide a bid that meets the requirements the State outlines in the Public Option procurement.

The NvAHP is very concerned that the selection of managed care organizations is completely dependent on whether a health insurance provider meets the requirements of the Public Option program and not based on the health insurance provider's Medicaid managed care procurement response. This concern is further heightened since the Public Option program process is new and untested in Nevada, and as we have seen in other states, tying these two separate and different programs so closely together creates a serious risk of destabilizing the Medicaid Managed Care program if the Public Option program fails.

Our members are concerned with the adverse impact these requirements may have on the Medicaid Managed Care program and the Nevadans that managed care organizations serve. Current managed care organizations have developed expertise in developing products and networks that meet the unique needs of the State's Medicaid population, and while some health insurance providers may excel at providing a high-quality Medicaid managed care product, they may not be similarly positioned to achieve the same success in the individual market.

The concept that Medicaid Managed Care bid proposals will be immediately rejected and not considered simply because bid proposals do not meet the requirements of a distinct and entirely separate program that will not serve Medicaid members seems unduly punitive. Based on this and the risk of destabilizing the State's Medicaid Managed Care program, the Departments should deny Nevada's 1332 waiver application.

### **Administrative Cost Constraint Imposition**

The NvAHP also disagrees with the creation of an administrative cost constraint that is stricter than the prevailing individual market Qualified Health Plan ("QHP") administrative expense load Medical Loss Ratio ("MLR").

As you are both aware, the Affordable Care Act ("ACA") MLR provision already requires commercial health insurance providers to spend a certain percentage of premiums on medical care and limits the portion of premium dollars that can be spent on administration, marketing, and risk margin. As a result, administrative costs are already capped as a percentage of premium with or without the Public Option program. Any additional constraints would be duplicative of the existing ACA requirements, which begs the questions as to why this is being considered.

As the individual ACA market matured and stabilized over the past nine years, health insurance providers have aggressively priced their offerings to compete, almost eliminating required MLR rebates. Health insurance providers have streamlined their administrative expenses to lower overall pricing and capture more membership, ensuring a sustainable risk pool.

The framework of this administrative cost constraint presumes that health insurance providers have excessive administrative costs that can be easily cut. Nevada is a competitive insurance market and the costs to administer and offer a Public Option plan would be no different than what is required to offer and administer a non-Public Option plan. To the contrary, it is very likely that administrative costs for Public Option plans will increase since the State is expected to mandate additional benefit design requirements that are not required for non-Public Option plans.

The imposition of a stricter administrative cost constraint is a threat to issuer competition and consumer choice in the Nevada market, which is another reason why the Departments should not approve the State's waiver application.

### **Premium Reduction Targets**

The NvAHP does not see a path for achieving the premium reduction targets set forth by statute. While we understand that these targets must be met to be in compliance with state law, premiums must still be actuarially sound. We have already explained that a stricter MLR for Public Option plans is not realistic, which forces health insurance providers to consider if “cuts” to reimbursement rates will help to meet the targets. However, we are very aware of the workforce shortage issues Nevada faces, which is further exacerbated in the rural counties of the State.

To illustrate this point, outside of Nevada's two most populous counties, Critical Access Hospitals ensure that Nevadans can receive medical care when needed. These hospitals are reimbursed at much higher rates than the 100% of Medicare hospitals in Clark and Washoe counties receive. CMS has designated these locations to receive higher reimbursement rates so that they may continue to operate on lower patient counts than their counterparts.

The mandated premium reduction targets will result in reimbursement reductions that will negatively impact rural healthcare sites and the Nevadans that utilize them for care. Because of this significant impact, the Department should deny the State's 1332 waiver application.

### **Market Stabilization Reinsurance Program**

Finally, it is critical that the NvAHP relay the concerns that we have with the proposed reinsurance program. We believe that a successful reinsurance program should not exclusively rely on federal pass-through funds that are also dependent on an unproven Public Option program. This risk only places significant pressure and unknowns on health insurance providers. Furthermore, the contingency of reinsurance funding on the Public Option program creates challenges and barriers to a proper evaluation of the waiver application and its impact on market stability. Simply put, the reinsurance proposal cannot be adequately evaluated because its funding is perpetually uncertain; therefore, the Departments should not approve the State's waiver application.

### **Recommendation**

As we initially noted, the NvAHP applauds innovation and we are constantly looking for ways to make healthcare more accessible and affordable. However, we also believe that to successfully do so, sound policy is necessary. We stand behind our position that the Public Option program is fundamentally flawed. Thus, we strongly recommend the Departments not approve the Nevada waiver application.

Sincerely,

/s/ Shelly Capurro

*NvAHP, Legislative Representative*

CC: Chiquita Brooks-LaSure, Administrator, CMS  
Dr. Ellen Montz, Deputy Administrator and Director, Center for Consumer Information and Insurance Oversight, CMS  
Jeff Wu, Deputy Director Policy, Center for Consumer Information and Insurance Oversight, CMS



March 13, 2024

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

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

**Re: Nevada Section 1332 Waiver Application**

Dear Secretary Yellen and Secretary Becerra:

Thank you for the opportunity to provide feedback on Nevada's Section 1332 Waiver Application.

The undersigned organizations represent millions of individuals facing serious, acute and chronic health conditions. We have a unique perspective on what individuals and families need to prevent disease, cure illness and manage chronic health conditions. The diversity of our organizations and the populations we serve enable us to draw upon a wealth of knowledge and expertise that is an invaluable resource regarding any decisions affecting the Affordable Care Act and the people that it serves. We urge the Department of the Treasury and the Department of Health and Human Services (Departments) to make the best use of the recommendations, knowledge and experience our organizations offer here.

Our organizations are committed to ensuring that Nevada's healthcare programs provide quality and affordable healthcare coverage. To that end, we support implementation of a new coverage program to improve access to affordable coverage, as required by Senate Bill 420.

The state's waiver application seeks pass-through funding primarily to support an individual market reinsurance program. Though we agree that reinsurance can play a role in addressing affordability, the benefits of such a program flow primarily to individuals at higher incomes who are not eligible for federal premium tax credits. It does not make coverage cheaper for people — generally at lower incomes — who already qualify for federal subsidies.<sup>1</sup> For this reason, many of our organizations urged the state to use pass-through dollars to fund a premium subsidy program for low-income Nevadans during the state comment period. In the absence of an accompanying premium subsidy program, we believe it is particularly important that the new Battle Born State Plans (BBSP), as well as the non-reinsurance elements of the state's waiver proposal, are implemented in ways that will safeguard access to care for low-income residents and that are likely to produce demonstrable reductions in health disparities.

We appreciate the additional detail that the state has added to its waiver application regarding its intended approach to BBSP contracting, its proposed incentive program for providers to practice in Nevada, and its quality incentive payment initiative for carriers. We note, for example, that the state has signaled it will use these policy levers to ensure BBSP plans have adequate networks and to promote continuity of care. Uninterrupted access to a robust network of providers is essential for the patients we represent to get the primary and specialty care that they need to manage their health conditions. If well designed, the BBSP contracting process and these programs could help to increase access to providers. The state's application also emphasizes that it will use these initiatives to improve health equity, including for rural and historically marginalized communities. It is critical for the state to follow through with and expand upon these commitments. Our organizations encourage the Departments to work with the state to do this, and to ensure that the non-reinsurance policy tools necessary to realize these gains are sufficiently funded.

Thank you for the opportunity to provide comments.

Sincerely,

ALS Association  
American Lung Association  
Asthma and Allergy Foundation of America  
*CancerCare*  
Child Neurology Foundation  
Chronic Disease Coalition  
Cystic Fibrosis Foundation  
Epilepsy Foundation  
Hemophilia Federation of America  
National Kidney Foundation  
National Multiple Sclerosis Society  
National Patient Advocate Foundation  
Susan G. Komen  
The AIDS Institute  
The Leukemia & Lymphoma Society

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<sup>1</sup> This is because of how ACA premium tax credits are calculated. In practice, from a consumer standpoint, reinsurance functions as a premium subsidy for people who are otherwise unsubsidized: in general, it lowers premiums for those who earn too much to qualify for a federal premium tax credit but does not improve affordability for those who, because they are at lower incomes, receive the premium tax credit.





2/29/2024

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

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

*Submitted via [stateinnovationwaivers@cms.hhs.gov](mailto:stateinnovationwaivers@cms.hhs.gov)*

RE: Nevada Section 1332 State Innovation Waiver Application

Dear Secretary Becerra and Secretary Yellen,

United States of Care (USofCare) is pleased to submit comments to the Center for Medicare & Medicaid Services (CMS) and Department of the Treasury regarding Nevada's Section 1332 State Innovation Waiver application to create the Nevada Coverage and Market Stabilization Program.

[USofCare](#) is a non-partisan, non-profit organization working to ensure everyone has access to quality, affordable health care, regardless of health status, social need, or income. We have seen through our research that the high cost of care is the biggest issue of concern to people, across demographic backgrounds, such as race, ethnicity, and geography. The high price of care impacts every part of people's experience with the health care system, from rising premiums to high deductibles and cost-sharing. Due to this, USofCare has [continued to support](#) efforts to [create](#) and implement the new public health insurance option ("public option"), which now hinges on the 1332 waiver approval.

In Nevada, [that is no different](#), and **the proposed 1332 waiver provides a solution to lower health care costs for hundreds of thousands of Nevadans**. Even with expanded access to public and private health insurance coverage during the pandemic, Nevada suffers the [highest uninsured rate](#) of any state that has expanded Medicaid. More than 340,000 (11%) Nevadans are uninsured, with Hispanic (20%) and American Indian/Alaskan Native (21%) populations being disproportionately impacted. [Nearly half](#) of uninsured Nevadans report the major reason they are uninsured is due to coverage being "too expensive." For those who are able to access health insurance, individual marketplace premiums have continued to [rise](#). Many insured Nevadans [report](#) experiencing health care affordability burdens, while even more worry about affording health care costs both now and in the future. Due to this, [more than half](#) of Nevadans reported delaying or going without health care due to cost in 2022.

**USofCare supports the framework proposed by Nevada’s Division of Health Care Financing and Policy (“the Division”) to utilize a federal 1332 waiver as part of the creation and development of the new public option. We believe this proposal is a strong foundation to increase affordable health coverage options for Nevadans while building upon existing state efforts to promote health care affordability. We strongly urge The Departments to approve the waiver.** We are excited to see the continued efforts to ensure access to affordable health insurance coverage through the creation of “Battle Born State Plans” and appreciate the opportunity to share our perspective on the design of the state’s federal 1332 waiver.

#### *Increasing Affordability for Nevadans*

USofCare supports the State’s innovative approach to strengthen the long term sustainability of the market in Nevada by leveraging the savings created by the Public Option for three new initiatives – a state-based reinsurance program, quality incentive payment program tied to improved outcomes for participating carriers and providers, and the “Practice in Nevada” provider incentive program. **Nevada’s Public Option and Market Stabilization Program are expected to lower the cost of health insurance for more than [100,000](#) Nevadans on the individual market, while bringing up to \$310 million in federal passthrough funding into the state in the first five years.**

One of the overarching goals of the Public Option originally authorized in [Senate Bill 420](#) (2021) was to reduce the cost of health coverage and the number of Nevada residents forced to go without health insurance because they can’t afford it. With the Public Option and reinsurance programs working together, individual marketplace premiums are expected to fall 15% over four years. **For those without access to coverage, this premium reduction will be a lifeline that will save people money and allow them to more easily plan and budget for their family’s needs, which is increasingly important for Nevadans.**

#### *Maintaining Access to Care for People*

Reimbursement for providers who participate in one of Nevada’s public option plans are expected to meet or exceed Medicare rates, with special attention paid to critical safety net providers, including critical access hospitals, federally qualified health centers, and rural health clinics, to ensure people continue to have access to these essential providers. Furthermore, the quality incentive payment targets through the Marketplace Stabilization Program’s “waterfall” approach will incentivize better care delivery that prioritizes positive health care outcomes and shifts away from [costly](#) fee-for-service. This move is supported by [our research](#), which found that more than 65% of people do not believe that a fee-for-service approach where doctors and providers are compensated based on the number of patients they see and the number of treatments they prescribe works well in delivering high quality care for people.

Due to Battle Born State Plans being operated through the Medicaid agency, the state will be able to leverage existing tools to improve care delivery, such as requiring public option plans to meet primary care spending targets, incorporate specific payment models, or engage in efforts to improve health equity. By expanding what works within the existing Medicaid Managed Care

infrastructure, Nevada's public option aims to improve quality of care and health outcomes while providing financial certainty, sustainability for providers, and ensuring Nevadans maintain access to robust provider networks and health plan choices.

#### *Addressing the Provider Shortage in Nevada*

Nevadan's health coverage issues are exacerbated by the state [not having enough](#) physicians to meet Nevada's growing health needs. Every county in Nevada is experiencing a shortage of medical professionals, and in 2021, Nevada was ranked [48th](#) in the nation with regard to the availability of primary care physicians per 100,000 residents. Many of Nevada's 300 medical school graduates [complete their residency](#) elsewhere, [never](#) returning to practice in Nevada.

The "Practice in Nevada" program and other workforce development provisions proposed in Nevada's waiver application provide unique solutions to support the state's health care infrastructure, while improving access to health care for Nevadans. By dedicating resources to attract and retain providers through a new loan repayment program, Nevada is following the lead of [several](#) other state initiatives to address health care workforce recruitment and retention.

#### *Future Considerations*

**While we would have liked to see inclusion of direct consumer subsidies and funding benchmarks to ensure sufficient funding for all components of the Marketplace Stabilization Program, this proposed 1332 waiver is a strong path forward for Nevada, which we support.** Thank you for the opportunity to provide comments in support of the section 1332 waiver application to create Nevada's Public Option and Market Stabilization Program. If you have any questions or are interested in further discussion of our comments on the proposed 1332 waiver application, please do not hesitate to reach out.

Sincerely,

Kelsey Wulfkuhle  
State Advocacy Manager  
[kwulfkuhle@usofcare.org](mailto:kwulfkuhle@usofcare.org)

Liz Hagan  
Director of Policy Solutions  
[ehagan@usofcare.org](mailto:ehagan@usofcare.org)



March 13, 2024

Administrator Chiquita Brooks-LaSure  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
7500 Security Boulevard  
Baltimore, MD 21244

Re: Nevada Section 1332 State Innovation Waiver

Dear Administrator Brooks-LaSure,

On behalf of the Vegas Chamber “Chamber”, thank you for the opportunity to provide input on Nevada’s recently submitted Section 1332 State Innovation Waiver. As the largest and broadest-based business organization in Nevada, the Chamber is focused on helping Nevada businesses succeed and grow. It has been part of the core mission of the Vegas Chamber to support employers, their employees, and the Southern Nevada community since its founding in 1911.

Overwhelmingly, our members identify healthcare as one of their biggest challenges regarding employee retention and recruitment in our community. That is why the Chamber has been a longtime proponent that every Nevadan should have access to affordable healthcare coverage.

However, the Chamber believes that Senate Bill 420, since its introduction and adoption by the State Legislature in 2021, does not support that objective. Instead, it will hinder and impede Nevadans’ access to quality, affordable healthcare and have many unintended consequences. The reality is that expanding access to affordable healthcare needs to be a market-driven process with sustainable solutions and should not be reliant on government mandates and directives.

The Chamber maintains that Nevada’s Public Option program will not reduce health care costs, but rather, it will shift costs onto other Nevadans, which is not equitable and can be devastating to Nevadans. It is a program that will not help Nevada’s families but has the potential to harm access to health providers and services. Furthermore, mandating a state insurance plan to offer a rate five percent lower than commercial rates is another cost-shift. As you know, evidence from other states that have implemented similar Public Option programs indicates that insurance costs go up, which is very concerning to employers and employees and their families. Our priority is to support Nevadans and their families, and that is why the Chamber continues to be opposed to the program.

While the State is trying to mitigate many of the above-mentioned concerns with its 1332 Waiver Application, the need for the waiver application highlights the challenges and problems associated with the Public Option program and the negative impact it will have on Nevadans’ access to healthcare. Please note that the Chamber does appreciate the efforts by Governor Lombardo and the agency to mitigate the

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Las Vegas, NV 89106  
702.641.5822 • VegasChamber.com

negative effects on SB 420. But unfortunately, this does not go far enough in addressing the fundamental flaws of the legislation and the program.

If we can provide any further assistance or information, please contact us at 702.641.5822 Thank you for your time and consideration on this important policy matter.

Sincerely,



Mary Beth Sewald  
President & CEO



Hugh Anderson  
Government Affairs Committee, Chairman



**NEVADA'S**  
**HEALTH CARE FUTURE**

March 14, 2024

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

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

Dear Secretary Yellen and Secretary Becerra:

We appreciate the opportunity to comment on the state of Nevada's 1332 waiver application to implement the Nevada Public Option. Nevada's Health Care Future (NVHCF) is committed to proven solutions that build on what's working in our health care system today, so every Nevadan has access to the high-quality health care they need and deserve.

Implementing the Nevada Public Option will ultimately harm access to affordable health coverage and high-quality care for Nevadans. While Nevada's current administration has made some effort to acknowledge the flaws of Nevada Senate Bill 420, which established the Public Option, the fundamental structural flaws of the underlying policy remain – putting Nevadans at risk of harmful consequences if the state is allowed to implement this new health insurance system.

Our position is backed by strong evidence and thorough analysis by respected experts. Prior to the state's revised 1332 waiver application, NVHCF commissioned Wakely Actuarial Consulting to perform an actuarial analysis of SB 420. While Wakely's analysis, which is enclosed herein, did not factor in reinsurance, their findings highlight SB 420's structural flaws. They conclude that, if enacted, the bill would exacerbate Nevada's already significant health care provider shortage, put increased financial hardship on hospitals, and ultimately threaten access to care for Nevada patients. Currently, Nevada ranks 48<sup>th</sup> in the country for primary care physicians per capita,<sup>1</sup> and two thirds of Nevadans live in federally designated primary care Health Professional Shortage Areas (HPSAs).<sup>2</sup> Residents' access to care should not be put at additional risk.

The analysis also warns that the Public Option could reduce health care competition in Nevada, cause some insurers to exit the market and deter new entrants. We have already seen similar

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<sup>1</sup> [https://store.aamc.org/downloadable/download/sample/sample\\_id/506/](https://store.aamc.org/downloadable/download/sample/sample_id/506/)

<sup>2</sup> <https://dpbh.nv.gov/uploadedFiles/dpbhnavgov/content/About/AdminSvcs/DPBH-SHA-2022.pdf>

consequences in other states. In Colorado, the state Public Option's unsustainable rate-setting regulations have already led four insurers to exit the market, and Coloradans continue to face higher premiums despite the law's promise to reduce the cost of coverage.

In Washington state, the first to fully implement a state government public option, premiums have continued to rise and despite guarantees from state officials, it has done almost nothing to lower the state's uninsured rate.

Colorado and Washington's experiences are a reminder that there is no successful Public Option in any state in America. The Public Option has failed in every state where it has been tried, and there is no evidence to suggest Nevada would fare any better under this proposal.

In fact, it is clear that Nevada could endure similar consequences under its own Public Option, posing a substantial threat to health care choice, affordability and access for Nevadans, in direct contradiction to the promises Public Option supporters made in hastily passing SB 420 into law.

Upon examination of the state's revised waiver application, it is apparent that it relies on numerous misguided assumptions, each carrying potential harmful consequences for Nevada residents. Our primary concerns include:

- With many providers and hospitals already at or close to 100% of Medicare fee-for-service (FFS) reimbursement rates, and without any meaningful drivers contained in this policy to lower the cost of care, there is very little chance of carriers meeting the state's premium reduction targets.
- The many new requirements and mandates for payers that SB 420 imposes could increase, rather than decrease, administrative costs, depending on factors such as unique network requirements or unique benefit design requirements. Even worse, any reduction in carriers' required risk margins could pose a significant threat to competition and consumer choice in the state, the complete opposite of the purported objectives of SB 420.
- Particularly in light of the above concerns, the assumption that the creation of Public Option plans will help lower non-public option premiums is deeply misguided.
- The degree to which the waiver ties the procurement process for Medicaid contracts directly to carriers' submission of Public Option plans for Nevada's individual market could destabilize the Medicaid program.
- With its revised application, the state proposes putting into place a market stabilization program that implements and relies upon the Public Option. Tying the state's proposed reinsurance program to the creation of the Public Option is a risky strategy, and the facts suggest this is not a viable model for financing the reinsurance program.

In summary, Nevada's revised 1332 waiver application fails to address the fundamental problems within SB 420's Public Option provisions. Moreover, its significant risks to health care accessibility and affordability for Nevadans remain quite concerning. Notably, the proposal's projected impact in reducing the number of uninsured Nevadans by just 2,200 strongly suggests that coverage gains could better be achieved by building upon the success of our current health care system where private coverage and existing public programs work together to expand access to coverage and care.

In addition to these serious concerns regarding the underlying policy and its consequences for Nevadans, we would direct your attention to pending litigation filed jointly in Nevada's First Judicial District Court by state Senator Robin L. Titus, MD, and the National Taxpayers Union. Their lawsuit calls into question the state's authority to implement the waiver, alleging that SB 420 violates three separate provisions of the Nevada Constitution.

Given the fact that under section 1332(a)(1)(C) and (b)(2), a state law that authorizes implementation of the state plan is a threshold requirement for a 1332 waiver, we request, at a minimum, that the Centers for Medicare & Medicaid Services (CMS) stay review of the application pending the outcome of this ongoing litigation.

The surest way, however, to protect Nevadans from the negative consequences of this proposal is to deny this waiver application outright.

Nevada's Health Care Future has always focused on enhancing health care accessibility by identifying what is working in our health care system and building on our existing system's successes rather than starting from scratch. We are committed to supporting policy proposals that align with these goals. Thank you for providing us with the opportunity to voice our significant concern regarding SB 420 and Nevada's 1332 waiver application.

Sincerely,

A handwritten signature in black ink that reads "Kelley M. Robertson". The signature is written in a cursive, flowing style.

Kelley M. Robertson  
Executive Director  
Partnership for America's Health Care Future Action  
Nevada's Health Care Future

Enclosures (1)



## Partnership For America's Health Care Future Action, Inc.

### Nevada Public Option Actuarial Analysis

Date: October 24, 2023

Developed by:

**Wakely Consulting Group**

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## Introduction

Wakely Consulting Group, LLC (Wakely), a Health Management Associates (HMA) Company, was retained by Partnership for America's Health Care Future Action, Inc. ("Partnership") to provide actuarial support in an analysis of Nevada Senate Bill 420 (SB420), which establishes a public option. We also reviewed the state-sponsored Milliman report titled "1332 Waiver Actuarial / Economic Analysis and Certification for Nevada's Public Option". This memorandum was prepared to summarize our analysis and some of the potential effects of SB420.

We understand that this report may be shared with outside parties. When it is shared, it should be shared in its entirety. Wakely does not intend to create a reliance by outside parties receiving this report. Outside parties receiving this report should retain their own qualified experts in interpreting the results. It is the responsibility of the organizations receiving this report to review the assumptions carefully and notify Wakely of any potential concerns.

## Key Findings

In December 2022, the State of Nevada released an actuarial and economic analysis to estimate potential federal pass-through funding related to the establishment of a public option under an Affordable Care Act (ACA) Section 1332 waiver. This analysis assumed that all premium reduction requirements in SB420 could and would be fully realized throughout the state.<sup>1</sup>

Our analysis reviews several factors that the prior State actuarial and economic analysis did not consider. We believe that the projections in the State December 2022 study would have been different if consideration had been given to which assumptions were realistic to achieve.

We find that:

- Physician rates, on average, are likely already at or near 100% of Medicare Fee-for-Service. Because the Nevada Public Option statute has a floor for average physician reimbursement at 100% Medicare FFS, little to no Nevada Public Option premium savings can be expected via physician reimbursement cuts. Further, Nevada is facing a significant provider shortage, which could be further exacerbated by reduced reimbursement rates.
- A 3% increase in loss ratio could reduce a low-cost insurer's risk margins to 0%. We note that a 0% risk margin does not allow for an actuarially appropriate margin of error in estimating claims and risk adjustment expenses and could have negative implications for competition, deter new entrants, and potentially cause some insurers to exit the market.
- To reduce premiums by 16%, the hospitals reimbursement rates may need to be reduced by 25-30%. We note that reductions of this magnitude may put financial hardship on hospitals whose overall margins are sensitive to reimbursement rates in the commercial market.
- We also note that there are limitations in hospital reimbursement cuts as a source of premium savings. First, to the extent that hospital reimbursements approach 100% Medicare FFS, the statutory limit may be a factor. Second, hospitals are only mandated to contract with one public option plan. If each hospital does the minimum required by the Public Option statute, any potential hospital savings will be distributed across insurers further limiting each insurer's ability to achieve a 16% premium reduction.

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<sup>1</sup> Nevada Department of Health and Human Services. Milliman Report, "1332 Waiver Actuarial/ Economic Analysis and Certification for Nevada's Public Option." December 16, 2022.

## Executive Summary

Wakely was retained by the Partnership to independently determine if a 16% premium reduction is realistic given existing provider reimbursement rates, insurer administrative costs, and necessary insurer risk margins for actuarially sound premiums. We used a combination of Wakely proprietary data and publicly available data to estimate prevailing provider reimbursement rates.

We analyzed three scenarios as described below to understand the impact on insurer margins and hospital reimbursements. We also performed literature review to understand second-order effects on providers and Nevada enrollees in the individual Affordable Care Act members. The key impacts are summarized below followed by a summary of scenario testing.

### Impact on providers

- The hospital reimbursement reductions needed to achieve a 16% premium reduction are approximately 25-30%. Such levels of reimbursement reductions are likely to put financial hardship on hospitals given that typical hospital operating margins are significantly lower than this revenue reduction <sup>2,3</sup>. While hospital revenues from the Individual ACA market may be small relative to their overall revenue stream, hospitals rely on reimbursements from commercially insured patients to offset negative margins on Medicare and Medicaid patients. The reduction in reimbursement rates on the individual market may create an outsized strain on hospital finances, particularly in rural and underserved communities, due to payments in government programs set well below the actual cost of providing care.
- As noted in the 'Provider Access and Network Adequacy Considerations' section of this report, Nevada is facing a critical shortage of primary care providers, doctors, and nurses. Provider reimbursement reductions could exacerbate these existing shortages.
- Providers are only mandated to contract with one public option plan. If each provider does the minimum required by the statute, then there is a potential for a situation to emerge where several insurers are unable to achieve the provider reimbursement reductions necessary to meet the premium targets.

### Impact on insurers

- The premium targets are calculated based on the second lowest cost silver plan. Insurers who have higher priced plans will need a greater reduction in premiums to achieve the targets. If business cases existed to lower premiums to such competitive levels, we believe market forces would have already driven the premium reductions and the public option does not create any new economic forces to drive these premium reductions. This

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<sup>2</sup> [https://www.medpac.gov/wp-content/uploads/2023/03/Mar23\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf)

<sup>3</sup> [https://www.kaufmanhall.com/sites/default/files/2023-01/KH\\_NHFR\\_2023-01.pdf](https://www.kaufmanhall.com/sites/default/files/2023-01/KH_NHFR_2023-01.pdf)

statement is especially true of rating area 1 where seven insurers compete.

- The premium reduction targets do not consider other headwinds and forward-looking trend projections that could impact the ability to achieve the statutory threshold. The premium targets are calculated using Medicare Economic Index (MEI) (in the Section 10.4(b) of SB420 as originally written) and CPI-M with an adjustment for Nevada utilization and morbidity (which replaces MEI in the general guidance letter 22-001 dated October 4, 2022). Both MEI and CPI-M can be inadequate and inappropriate choice for trending premiums as described further in the Background section.
- Actuarially sound premiums must be sufficient to cover claims, administrative costs, and risk margins. If provider reimbursement reductions are insufficient for a 16% premium reduction, insurers may not have sufficient margin to absorb the additional claims liability and may find themselves in financial difficulty. This may result in insurers exiting the individual ACA market and lower insurer competition in the market.
- When premiums are reduced, the dollars available to insurers to fund administrative costs and risk margins is also reduced without a commensurate reduction in expenses because this is limited to 20% of premiums per Affordable Care Act Medical Loss Ratio (MLR) requirements. Given the competitive nature of the Las Vegas market, to the extent that administrative expenses could have been reduced to drive premium competitiveness, insurers would already have reduced those expenses.

We also note that since the fees assessed to operate the marketplace is calculated as a percent of premiums, there will also be less funding available to the state as premiums are reduced.

We studied three scenarios that differ in how the premium reduction was achieved (provider reimbursement reduction with or without increase to insurer medical loss ratio) and the choice of data (market average data or data from the insurer with second lowest cost silver plan). The choice of data provides insight into whether insurers with differing medical insurance risk profiles would be impacted differently. For example, a hypothetical carrier with perfectly healthy members who had no claims would theoretically not be able to reduce premiums simply by reducing provider reimbursement rates. We used Medical Loss Ratio (MLR) to measure insurer administrative expense and risk margin ratios.

Scenario 1: Reimbursement reduction needed after a 3% increase to MLR using data for the plan with the second lowest cost silver plan.

Scenario 2: Reimbursement reduction needed (without any changes to MLR) using data for the plan with the second lowest cost silver plan.

Scenario 3: Reimbursement reduction needed (without any changes to MLR) using data from all insurers.

Since approximately 80% of the potential members who would enroll in the public option reside in Las Vegas area (referred to as rating area 1 by Nevada), our analysis is based on premiums in rating area 1.

The results of our analysis are summarized in the table below.

**Table 1: Reductions in Provider Reimbursement Rates in Rating Area 1**

Scenario	Reimbursement Reduction in Las Vegas		
	Inpatient	Outpatient	Professional
Scenario 1	-24.5%	-24.5%	0.0%
Scenario 2	-30.4%	-30.4%	0.0%
Scenario 3	-30.4%	-30.4%	0.0%

In scenario 1, we based our analysis on Silver Summit’s most recent publicly available data as Silver Summit had the second lowest Silver premiums in 2023<sup>4</sup>. To increase the loss ratio by 3 percentage points, we needed to reduce the risk load by 100% and per member per month (PMPM) administrative expenses by 8%. We note that a 0% risk margin does not allow for an actuarially appropriate margin of error in estimating claims and risk adjustment expenses.

To achieve the full 16% premium reduction, the non-pharmacy medical costs needed to be reduced by 18.9%. This cost reduction would require a 24.5% reduction in hospital reimbursement rates in Las Vegas / Rating area 1. We estimated that the professional reimbursement rates were already approximately at 100% of Medicare so we assumed no further reduction. The hospital reimbursement reduction of 24.5% is higher than total medical cost reduction of 18.9% because professional fees could not be reduced by 18.9% without reducing reimbursement below 100% of Medicare.

In scenario 2, to achieve the same outcome of 16% premium reduction, we needed to reduce the hospital reimbursements by 30.4% and maintain the professional fees at approximately 100% of Medicare. The issuer risk margin is fixed at 3% and PMPM administrative expenses were reduced by 8%.

In scenario 3, we reduced the hospital reimbursement by 30.4% and maintain the professional fees at 100% of Medicare (same as scenario 2). The scenarios 2 and 3 claims cost reduction levels are expected to be similar because the two carriers had similar claims expense on a risk-neutral basis, and we assumed that risk transfers would also be reduced by 16% as market average premiums

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<sup>4</sup> Note that while we used Silver Summit’s data to prepare various estimates, these estimates were not reviewed by Silver Summit. Should Silver Summit conduct similar analyses, Silver Summit may come to different conclusions. Estimates in this report are Wakely’s estimates using Silver Summit’s data without Silver Summit’s participation.

are theoretically reduced by 16%. The PMPM administrative expenses were reduced by 8%. The hospital reimbursement result was identical between two scenarios coincidentally.

We raise the question whether Medicare reimbursement levels for hospital services are adequate. In 2021, IPPS hospitals' Medicare margin was -8.3% (-6.2% when including a share of federal relief funds)<sup>5</sup>. MedPAC projects that margin will decline in 2023. Low reimbursement levels may result in access and solvency issues for providers.

The above points collectively raise the question whether a 16% premium reduction is realistic/feasible without significant disruption to access to care, choice of plan, and competition.

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<sup>5</sup> [https://www.medpac.gov/wp-content/uploads/2023/03/Mar23\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf)



## Background

The Nevada Public Option statute (SB420) seeks to establish a public option. One of the key goals of the public option is to lower the premiums in the ACA individual market by 16% relative to a reference premium over 5 years. There are three primary sources of premium savings:

- Lower hospitals reimbursements
- Lower physician reimbursements
- Lower insurer administrative costs and/or risk margins

The expectation from insurers is to negotiate lower reimbursements from their providers (hospitals and physicians). The reimbursement rates for medical services cannot be lower than what Medicare pays for the same services in aggregate. The insurers are also expected to lower their administrative costs and/or risk margins. The requirement for providers is that if they accept Medicaid and state plans (among other requirements), then they must participate in at least one Nevada Public Option plan.

We consider insurer and provider negotiation dynamics. The Nevada Public Option does not dictate how provider rates are negotiated or set. Instead, state law establishes a provider reimbursement floor requiring that health insurers offering Public Option plans pay providers at rates that are no lower than Medicare rates in aggregate. This creates two challenges:

1. There is no mechanism to force provider reimbursements lower. Providers retain negotiating leverage with insurers. Providers must contract with only one public option plan and lack significant incentive to further reduce prices more than what the private market already achieved. Furthermore, network adequacy requirements and requirements to align with the Medicaid network further strengthen provider leverage.
2. Tensions exist between networks adequacy standards and “alignment with Medicaid network.” It is possible that no insurer would have an adequate network if Nevada “public option provider contracts” are sufficiently distributed across insurers.

The resulting reduced reimbursement rate environment would put significant pressure on the insurers when attempting to form provider networks for their members, as providers and hospitals would be very unlikely to accept such severe cuts to payments for their services. As discussed in more detail in another section, this would also likely exacerbate provider shortages in Nevada. The primary recipients of these negative effects could ultimately be Nevadans seeking care in the state.

The statutory premium targets are calculated in a way that is inconsistent with actuarial rate setting process. Section 10.4(a) of SB420 defines reference premium as the lower of the 2024 second lowest silver plan premium (SLCS) on the Nevada exchange in 2024 trended to the premium year

at the Medicare Economic Index (MEI), and the SLCS premium in the prior year. We note that actuaries do not use MEI to set premiums for several reasons including but not limited to:

- MEI was intended for use in Medicare and not the individual market.
- MEI measures practice cost inflation<sup>6</sup> for Medicare physicians and is not intended to measure premium changes which are impacted by more factors than just physician payment rates. For example, MEI will not capture the impact of new drugs releases such as the expensive gene therapies expected to be approved in the coming years.
- MEI uses historical data not forward-looking expectations. Actuaries use both historical data and projected changes in costs and utilization to set trends in premium development.

In the general guidance letter 22-001 dated October 4, 2022, MEI is replaced by CPI-M with an adjustment for Nevada utilization and morbidity but neither the choice of CPI-M nor the adjustments are defined. Like the MEI, CPI-M uses historical data only and does not factor in forward-looking expectations of medical costs or premiums.

This disconnect between actuarial trend and MEI/CPI-M can result in unrealistic expectations of the achievability of the stated premium reductions to the extent that the actuaries' expectations of trends diverge materially from published MEI/CPI-M.

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<sup>6</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4191233/>

## Results

We estimated the impact on insurer risk margin (and loss ratio) and on provider reimbursement rates of the efforts to reduce premiums by 16%.

We studied three scenarios:

1. Scenario 1 reviews the medical claims cost reduction needed to produce a 16% premium reduction for an insurer that had the second lowest silver premiums in 2023 based on publicly available data submitted by the insurer for 2021. We assume that part of the 16% reduction would be achieved by such an insurer being able to reduce their risk margins to 0% and reduce their administrative per member per month (PMPM) expenses by 8%.
2. Scenario 2 is like scenario 1 except insurers may not have the ability to reduce risk margins. Under this scenario, the entire 16% premium reduction must be achieved through provider reimbursement reductions and the administrative expense reductions like in scenario 1 but without a change to risk margin.
3. Scenario 3 is like scenario 1 except that we perform the study based on market average data instead of a specific insurer's data. The rationale behind this scenario was to understand the impact on a risk-neutral basis, that is, the medical cost reduction needed for an insurer with market average morbidity. Insurers with significantly different morbidity than the market average risk can have significant portion of their premiums being used to fund risk transfer payments as opposed to medical claims and that could have an impact on the reductions needed to the portion of the premiums that is medical cost.

We also comment on the impact on provider shortages and access to care based on literature review.

## **Scenario 1: Reimbursement reductions needed for an insurer with the second lowest cost silver plan with increase to MLR**

In this scenario, we used the 2021 publicly reported data for Silver Summit because it was the insurer with the second lowest cost silver plan in 2023. We first increased the MLR by 3% (i.e., reduced risk margin to 0%) and then estimated the medical cost reduction needed to achieve the full 16% premium reduction. Components of premiums that are based on a percent of premiums were adjusted so they reflect the same percent of premiums as before. Administrative expenses (on a PMPM basis) were reduced by 8% to reflect reduced broker commissions and potential aggressive efforts by insurers to reduce operating expenses. Note that reducing administrative expenses by 8% is an aggressive assumption. To the extent that these expenses could have reduced, the insurers would have already reduced them especially in highly competitive market such as rating area 1 (Las Vegas).

### **Impact on Risk Margin / Loss Ratio**

Consistent with the Nevada Department of Health and Human Services (DHHS) guidance noted in Milliman's report 'Nevada Public Option 1332 Actuarial and Economic Analysis' dated December 16, 2022, we assumed that a part of the premium reduction would be achieved through a 3% increase in medical loss ratio. To increase MLR, either administrative expenses (as a percentage of premiums) or risk margin or both must be reduced. For this scenario, we assumed risk margin would be reduced from 3% to 0% of premiums. We also assumed that the administrative dollars available to the insurer would be reduced. However, despite the reduction, the administrative expenses represent a higher percent of the reduced premiums and therefore, not a contributor in increasing the MLR.

Note that as premiums are reduced, the administrative dollars available to insurers to operate an insurance company are also reduced because insurers typically set aside a percentage of the premiums for administrative expenses. These administrative dollars are used to fund the expenses including but not limited to the following:

- Agent and broker fees and commissions
- Prevention of fraud, waste, and abuse
- Efforts to improve health quality and increase the likelihood of desired health outcomes such as preventing hospital readmissions, improving patient safety, wellness and health promotion, and health information technology
- Customer service, product design, network contracting, provider accreditation

Insurer administrative expenses are limited to 20% of premiums<sup>7</sup>. A reduction in premiums funded primarily by reducing provider reimbursements and insurer margins does not reduce any of the above expenses but reduces the funding available to cover these expenses. Depending on each insurer's individual circumstances, such services may have to be reduced in response to lower available funding. We assumed that administrative expenses would be reduced by 8%. A portion of this reduction would be achieved by broker commissions scaling down with premiums but most of it may need to be achieved by reducing operating expenses and the corresponding services being funded through those operating expenses.

## Impact on Provider Reimbursement

We achieved the remaining reduction in premium (beyond what was achieved by the MLR increase above) by reducing other components of premium such as risk adjustment transfers and medical costs.

Silver Summit expects to pay 26.6% of its premiums as risk transfers. Risk adjustment transfers are calculated as the difference in the insurer's risk relative and the market average risk multiplied by market average premiums. We estimated that the risk adjustment payables would also scale down by 16% because we assume that the market average premium would likely be reduced by 16%.

We also adjusted the components of premiums that are typically calculated on a percent of premium basis such as exchange fees and taxes. These components still represent the same percentage of premium as reported in the rate filing but on a per member per month (PMPM) basis, they scale down 16.0% with premiums.

We then estimated the medical (non-pharmacy) paid claims reduction needed to achieve the full 16% premium reduction. We assumed pharmacy costs would remain unchanged because the main statutory levers to achieve premium reduction are limited to hospital, physician, and insurer cost structures with no mention of pharmacy costs.

Lastly, we translated the medical cost reduction to provider reimbursement rates reduction.

We based this analysis on rating area 1, which includes Las Vegas because it has 80% of the state's ACA enrollment.

A summary of our findings is presented in the table below:

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<sup>7</sup> This statement is a simplification that is adequate for the discussion purposes.

**Table 2: Summary of MLR Effects on the SLCSP for Rating Area 1 (Scenario 1)**

Components of Premium	Total Variance from 2023 Actuals
Paid Claims - Medical	-18.9%
Paid Claims - Pharmacy	0.0%
Risk Adjustment Payables/Receivables	-16.0%
Administrative Expenses	-8.0%
Risk Margin	-100.0%
Tax	-16.0%
Premium	-16.0%
MLR	3.0%

As shown above, the medical costs need to be reduced by 18.9% in addition to reducing the risk margin to 0% to achieve a 16% reduction in premiums.

The reimbursement rates as a percent of Medicare (% of MCR) vary between inpatient, outpatient, and professional. SB420 section 14 requires that “reimbursement rates under the Public Option must be, in the aggregate, comparable to or better than reimbursement rates available under Medicare.” If all provider reimbursements are reduced equally by 18.9%, then depending on the starting reimbursement levels, it is possible that some providers reimbursement levels are reduced below the floor of Medicare reimbursement levels even if the average reimbursement level exceed Medicare levels. For example, hospitals may have payment levels above Medicare after reductions, but physician pay may be cut to levels below Medicare (not allowable by SB420) if the starting physician payment rates were closer to Medicare levels than hospital payment rates. To test whether payment rates for some providers go below Medicare levels, we estimated the payment rates before and after reductions separately for inpatient, outpatient, and professional. To the extent that payment rates for any service category must be reduced below 100% of Medicare to achieve the target reduction, we floored the payment rate at 100% of Medicare and further reduced the payment rates on other service category until the aggregate payment rate across all services was 18.8% lower. We note that payment rates at 100% of Medicare are considered inadequate by many providers.

The table below shows the rating area 1 average reimbursement rates by service category before and after the reduction to bring medical costs down by 18.9%.

**Table 3: Estimated Reimbursement as % of FFS Medicare (Scenario 1)**

Category of Service	% MCR Implied in Rating Area 1	Reduction Required	% MCR for Target Premium
Inpatient	159%	24.5%	120%
Outpatient	207%	24.5%	156%
Professional	100%	0.0%	100%
<b>Total Medical (non-pharmacy)</b>	<b>153%</b>	<b>18.9%</b>	

We estimated that to drive an 18.9% reduction in average medical claims costs, we would need a 24.5% reduction to reimbursement to inpatient and outpatient services because reimbursement levels for professional services in rating area 1 are already at 100% of Medicare. Therefore, the reduction in inpatient and outpatient reimbursement must be increased to account for the inability to further decrease professional reimbursement.

## Scenario 2: Reimbursement reductions needed for an insurer with second lowest cost silver plan without an increase to MLR

This scenario is like scenario 1 except that we assume that insurers do not reduce risk margins. The premium reduction of 16% is achieved by reducing medical claims cost and administrative expenses similar to scenario 1.

### Impact on Risk Margin / Loss Ratio

There is no impact to the risk margin in this scenario. In this scenario we assumed that carriers would not be able to increase their medical loss ratios by 3.

### Impact on Provider Reimbursement

Like scenario 1, we adjusted administrative expenses and risk adjustment transfers first. We then estimated the reduction needed to medical claims cost (keeping pharmacy costs constant) to achieve premiums that are 16% lower than 2023 premiums. This analysis was also based on rating area 1.

A summary of our findings is presented in the table below:

**Table 4: Summary of MLR Effects on the SLCSP for Rating Area 1 (Scenario 2)**

Components of Premium	Total Variance from 2023 Actuals
Paid Claims - Medical	-23.4%
Paid Claims - Pharmacy	0.0%
Risk Adjustment Payables/Receivables	-16.0%
Administrative Expenses	-8.0%
Risk Margin	-16.0%
Tax	-16.0%
Premium	-16.0%
MLR	-1.3%

As shown in the table above, the reduction needed to medical costs is 23.4%. The claims reduction is higher than scenario 1 because the risk margin as a percent of premium is held constant. The MLR is reduced by 1.3% because the administrative costs are reduced by a lower amount than the premiums.

The table below shows the rating area 1 average reimbursement rates by service category before and after the reduction to bring medical costs down by 23.4%.



**Table 5: Estimated Reimbursement as % of FFS Medicare (Scenario 2)**

Category of Service	% MCR Implied in Rating Area 1	Reduction Required	% MCR for Target Premium
Inpatient	159%	30.4%	111%
Outpatient	207%	30.4%	144%
Professional	100%	0.0%	100%
<b>Total Medical (non-pharmacy)</b>	<b>153%</b>	<b>23.4%</b>	

We estimated that to drive a 23.4% reduction in average medical claims costs, we would need a 30.4% reduction to reimbursement to inpatient and outpatient services because reimbursement levels for professional services in rating area 1 are already at 100% of Medicare. Therefore, the reduction in inpatient and outpatient reimbursement must be increased to account for the inability to further decrease professional reimbursement.

### Scenario 3: Reimbursement reductions needed for an insurer with market average risk

This scenario is like scenario 2 except that we used statewide market information from all insurers combined instead of the information for the insurer with the second lowest cost silver premium in 2023 (Silver Summit).

#### Impact on Risk Margin / Loss Ratio

There is no impact to risk margin in this scenario.

#### Impact on Provider Reimbursement

Like scenario 2, we adjusted administrative expenses and risk adjustment transfers first in the same way as scenario 2. We then estimated the reduction needed to medical claims cost (keeping pharmacy costs constant) to achieve premiums that are 16% lower than 2023 premiums. This analysis was also based on rating area 1.

A summary of our findings is presented in the table below:

**Table 6: Summary of MLR Effects on the SLCS plan for Rating Area 1 (Scenario 2)**

Components of Premium	Total Variance from 2023 Actuals
Paid Claims - Medical	-23.4%
Paid Claims - Pharmacy	0.0%
Risk Adjustment Payables/Receivables	0.0%
Administrative Expenses	-8.0%
Risk Margin	-16.0%
Tax	-16.0%
Premium	-16.0%
MLR	-1.0%

As shown in the table above, the reduction needed to medical costs is 23.4%. The claims reduction is identical to scenario 2 because the two carriers had similar risk-adjusted claims. The risk adjustment transfers across all insurers sum to 0 and therefore there is no change in risk transfers for an insurer with market average risk. The MLR is reduced by 1.0% because the administrative costs are reduced by a lower amount than the premiums .

The table below shows the rating area 1 average reimbursement rates by service category before and after the reduction to bring medical costs down by 23.4%.

**Table 7: Estimated Reimbursement as % of FFS Medicare (Scenario 2)**

Category of Service	% MCR Implied in Rating Area 1	Reduction Required	% MCR for Target Premium
Inpatient	159%	30.4%	111%
Outpatient	207%	30.4%	144%
Professional	100%	0.0%	100%
<b>Total Medical (non-pharmacy)</b>	<b>153%</b>	<b>23.4%</b>	

We estimated that to drive an 23.4% reduction in average medical claims costs, we would need a 30.4% reduction to reimbursement to inpatient and outpatient services because reimbursement levels for professional services in rating area 1 are already at 100% of Medicare. Therefore, the reduction in inpatient and outpatient reimbursement must be increased to account for the inability to further decrease professional reimbursement.

In addition to the three scenarios above, we qualitatively discuss the impact on providers, provider access, and network adequacy in the next section below.

## Provider Access and Network Adequacy Considerations

In 2021, IPPS hospitals' Medicare margin was -8.3% (-6.2% when including a share of federal relief funds)<sup>8</sup>. MedPAC projects that margin will decline in 2023. The proposed waiver and its effects on reimbursement may extend to the provider network available to potential public option members in Nevada. Insurers will likely have difficulty establishing contracting networks for their public option members, as many providers will unlikely accept lower reimbursement levels for services for these members as compared to their other membership pools.

In addition, insurers and providers will be constrained by the network and coverage requirements established by the waiver. These requirements add further difficulty in establishing provider networks for public option members. They may be especially difficult in rural areas where the mandated level of coverage is already unsustainable even before considering the required reimbursement levels<sup>9</sup>.

Nevada is already suffering from a physician shortage, ranking 48th<sup>10</sup> in the nation in physicians per capita. A recent study on primary care in the United States published by the Milbank Memorial Fund noted that there exist significant pressures on the primary care market in the US, including underinvestment and a shrinking workforce.<sup>11</sup> The Kaiser Family Foundation estimates that only about 43% of the need for primary care in the state is met, and that Nevada needs over 200 more primary care providers to fulfill this gap.<sup>12</sup> Additionally, the CEO of Nevada Hospital Association noted that hospitals are facing shortages of nurses<sup>13</sup>. These pressures are directly related to downward pressure on provider reimbursement for primary care services, and these effects are exacerbated in more rural areas, which comprises a material amount of the Nevada market. Indeed, the report recommends that investment and reimbursement for primary care *increase* to improve the attractiveness of the market and gain and retain practicing care providers. While our analysis

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<sup>8</sup> [https://www.medpac.gov/wp-content/uploads/2023/03/Mar23\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf)

<sup>9</sup> According to ruralhealthinfo.org, rural Nevada is served by 13 critical access hospitals and 19 rural health clinics both of which are paid on a cost + 1% basis before considering sequestration which reduced reimbursement by 2%.

<sup>10</sup> <https://www.8newsnow.com/news/local-news/nevada-doctor-shortage-the-state-ranks-48-when-it-comes-to-number-of-physicians-per-capita/>

<sup>11</sup> [https://www.milbank.org/wp-content/uploads/2023/02/Milbank-Baseline-Scorecard\\_final\\_V2.pdf](https://www.milbank.org/wp-content/uploads/2023/02/Milbank-Baseline-Scorecard_final_V2.pdf)

<sup>12</sup> <https://www.kff.org/other/state-indicator/primary-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22collId%22:%22Location%22,%22sort%22:%22asc%22%7D>

<sup>13</sup> <https://thenevadaindependent.com/article/nevada-needs-more-nurses-and-more-physicians-but-what-will-it-take-to-make-it-happen>

floors professional payment rates in rating area 1 at 100% of Medicare, we note that even the threat of having payment rates reduced may exacerbate provider shortage.

The proposed waiver's required reductions in reimbursement will create an even more unfavorable market dynamic for primary care in Nevada. If insurers are unable to establish networks in the state for their public option members, the benefits of the lower premiums will be largely lost in reduced access or quality of care as providers decline to accept lower reimbursement for services that they already provide. In addition, potential new providers may view Nevada as a less attractive location than other states to establish a practice due to lower potential revenue.

We did not assume that reduced reimbursement for providers would be offset by increased utilization and increased reimbursement rates driven by the uninsured purchasing coverage in response to lower premiums. To the extent that currently uninsured members are eligible for fully subsidized plans, the reduction in premiums does not necessarily benefit them. A Guinn Center study found that in 2019, 37% of the uninsured were eligible for Medicaid, 19% were eligible for ACA subsidies, and 12% were eligible for an affordable employer-sponsored insurance plan. Another 27% of the uninsured were ineligible for Medicaid or ACA subsidies because of immigration status. These members are unlikely to purchase coverage in response to reductions in Individual Exchange premiums.

In theory, all else equal, lower premiums may result in more uninsured members taking up insurance coverage. However, a significant majority of the uninsured were eligible for significantly subsidized coverage already or ineligible for ACA subsidies or Medicaid because of immigration status. Consequently, it is very unlikely that the Nevada Public Option will change the health insurance enrollment behavior for these segments of the uninsured.

## Other Key Considerations

The Medicare Economic Index (MEI) may be an inadequate reflection of trends in the commercial market and is not reflective of prospective trends. As such, using MEI may produce actuarially unsound rates. Section 10.4(b) of SB420 states that the public option premiums cannot increase in any year by more than MEI. Milliman used the Consumer Price Index – Medical (CPI-M) estimate of 3.7% to model general medical inflation, plus an adjustment for utilization and morbidity to model public option premium growth. The report assumes the overall reference premium trend to be 4%. We note that the average allowed PMPM trend across all individual ACA insurers in NV between 2021 and 2023 was 6.1%.

The effective elimination of risk margin presents a material concern on insurer’s ability to remain in the market and provide Nevadans with access to insurance. Risk margin is a key factor in a health plan’s ability to conduct business in a market, as risk margin often funds required surplus that is needed to ensure the claims-paying ability of the plan, as well as satisfy regulatory and statutory requirements.<sup>14</sup> Including a reasonable surplus in the setting of rates is included in the American Academy of Actuaries (AAA) practice standards for this reason.<sup>15</sup> If insurers are unable to generate a reasonable risk margin, their business becomes unsustainable over the long term, and they may exit the Nevada market. Insurer exits reduce competitiveness in the market which can have adverse effects on members and providers, and could also adversely impact the state’s ability to meet requirements and guardrails laid out in the 1332 waiver application.

Other considerations include:

- Any state or federal benefit mandates after the 2024 benefit year (reference premium) will make the premium reductions even harder to achieve unless adjustments are allowed for differences in benefits and the pricing actuarial value.
- Future changes to the risk adjustment program can materially change the economics of insuring certain populations. To the extent that risk adjustment program changes materially alter how morbidity is compensated, some plans may need to adjust pricing accordingly.
- Some plans, especially the lowest and second lowest cost silver plans, may be underpriced in the reference year and the statute does not account for correcting the mispricing.

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<sup>14</sup> [https://www.actuary.org/sites/default/files/files/publications/premiums\\_settings\\_mar2010.pdf](https://www.actuary.org/sites/default/files/files/publications/premiums_settings_mar2010.pdf)

<sup>15</sup> [https://www.actuary.org/sites/default/files/files/RRPN\\_100512\\_final.pdf](https://www.actuary.org/sites/default/files/files/RRPN_100512_final.pdf)

## Key Caveats

A key assumption implicit in this analysis is that Silver Summit's rates are actuarially-sound in 2023. If the rates are inadequate, an additional reduction will be needed from providers to achieve the 16%. If the rates are excessive, then a lower provider reimbursement may be needed to achieve the 16% premium reduction than what is estimated in our analysis.

We caution that these estimates by service category are still averages and that within these service categories, some providers may be assumed to have reimbursement levels below Medicare levels. To floor the reimbursement levels at 100% at the provider level, it would require that other providers accept an even larger reduction than what is estimated here.

We did not assume reimbursement reductions would be offset by higher demand for services at a higher reimbursement rate by uninsured members purchasing coverage in response to premium reduction. Lower rates of uninsured do not necessarily result in reduced cost shifting<sup>16</sup>. 2017 Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) Annual Report showed that the hospital prices continued to increase despite significant reductions in uncompensated care.

Insurers ability to reduce administrative expenses as premiums are reduced can vary greatly from insurer to insurer. We did not study insurer individual circumstances and whether their ability to reduce administrative expensive by 8% is realistic. To the extent that an insurer prices using a high MLR, such an insurer may be able to keep administrative expenses the same on a PMPM basis and still stay above the 80% MLR requirement. Other carriers that price at 80% MLR may need to reduce administrative expenses by more than 8% to stay above the minimum 80% MLR.

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<sup>16</sup> <https://hcpf.colorado.gov/colorado-cost-shift-analysis>

## Data & Methodology

We used a stepwise process to estimate the reduction needed in the medical claims costs to produce a 16% reduction in Silver Summit's premiums for the SLCS plan. We then used Wakely proprietary data to estimate the average reimbursements rates in Nevada statewide, Las Vegas, and the reduced reimbursement rates needed to achieve the premium targets.

### Estimating Medical Cost Reduction

For scenarios 1 and 2, we used the 2023 Rate Public Use Files (PUFs) to identify the second lowest silver plan in Nevada rating area 1 in 2023 to be Silver Summit.

We then used the 2023 Uniform Rate Review Template (URRT) data<sup>17</sup> that insurers offering health plans must include with annual rate filings in each state. Plan year 2023 URRTs include claims experience information for plan year 2021 and projected claims, risk adjustment, non-benefit expenses (such as administrative expense, taxes, and exchange fees), and premiums for the 2023 benefit year. We used the data for Nevada individual ACA market for Silver Summit in scenarios 1 and 2 and aggregated the individual ACA information across all insurers in Nevada for scenario 3. This information enabled us to re-create Silver Summit's 2023 premium development and the premium development for all insurers combined.

Section 10.4(a) of SB420 defines reference premium as the lower of the 2024 second lowest silver plan premium (SLCS) on the Nevada exchange in 2024 trended to the premium year at the Medicare Economic Index (MEI), and the SLCS premium in the prior year. As of the timing of analysis, 2024 premiums or the MEI that would be used were not available, and therefore, we used SLCS 2023 premium as the reference premium.

We assumed that the insurers would be able to reduce administrative expenses by 8% to reflect lower broker commissions and reduction in services offered to members. We then estimated the reduction needed to risk margin to produce a 3% increase in MLR in scenario 1.

We adjusted the components of premiums that are generally estimated on a percent-of-premium basis to reflect that premiums will be reduced by 16%. That is, we assumed that the risk margin, taxes, exchange fees, and premiums would all be calculated using the same percent of premiums as reported in the rate filings but on a PMPM basis, they would be reduced by 16%.

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<sup>17</sup> <https://www.cms.gov/ccio/resources/data-resources/marketplace-puf>



We re-constructed the premiums using these modified components of premiums. We then estimated the reduction needed for medical claims to achieve the remainder of the full 16% reduction in premiums.

The stepwise process is shown in the figure below for scenario 1.

**Table 9: Estimating Impact on Risk Margin and Medical Cost of 16% Premium Reduction**

Public Option Rate Reduction	2023, Pre-PO	Change	Step 1: Target 3% increase in MR by adjusting Risk Margin	Change	Step 2: 16% reduction in premium and % of premium components	Change	Step 3: Medical claim reduction required	Total Variance from 2023 Actuals
Paid Claims - Medical (IP, OP, Prof, Other)	\$416.81		\$416.81			18.9%	\$338.03	-18.9%
Paid Claims - Pharmacy	\$156.29		\$156.29				\$156.29	0.0%
Risk Adjustment (payable is positive)	-\$150.40		-\$150.40	16.0%	-\$126.34		-\$126.34	-16.0%
Administrative Expenses	\$73.11		\$73.11	-8.0%			\$67.26	-8.0%
Risk Margin	\$22.40	100.0%	\$0.00	16.0%	\$18.81		\$0.00	-100.0%
Taxes & Exchange Fees	\$47.29		\$47.29	16.0%	\$39.72		\$39.72	-16.0%
Premium	\$565.48		\$543.09	16.0%	\$475.01		\$474.96	-16.0%
Loss Ratio	81.6%	3.0%	84.6%		n/a		84.6%	3.0%

**Reimbursement Level Estimation**

We used the estimate of reduction in medical claims to estimate the provider reimbursement that would be required to meet the market premium reduction target.

We first estimated the aggregate provider reimbursement levels as a ratio of Medicare reimbursement for the Nevada statewide individual market. We repriced the 2021 Wakely ACA (WACA) data adjusted to reflect Nevada morbidity using 2021 Medicare payment rates trended to 2023. The table below shows the estimated payment rates in Nevada statewide individual ACA market as a percent of Medicare.

**Table 10: Nevada ACA Statewide Average Reimbursement Rates before Reduction**

Category of Service	2023 ACA % of Medicare - Nevada
Inpatient	182%
Outpatient	236%
Professional	105%
<b>Total</b>	<b>172%</b>

We used Silver Summit’s 2023 rating area factors which are intended to reflect unit cost differences by rating area to estimate the rating area 1 provider reimbursement rates<sup>18</sup>. These estimates are shown below. We assumed that the reimbursement levels would not go below 100% of Medicare and therefore, we floored the professional services reimbursement rates at 100% and reduced inpatient and outpatient to cover the difference.

**Table 11: Nevada ACA Rating Area 1 Reimbursement Rates before Reduction**

Category of Service	2023 ACA % of Medicare - Nevada
Inpatient	159%
Outpatient	207%
Professional	100%
<b>Total</b>	<b>153%</b>

We then applied the medical cost reductions calculated previously to estimate the reimbursement rates after reductions. We floored the reimbursement rate for any service category at 100% of Medicare and reduced the remaining service category reimbursement levels such that the average reimbursement was 18.9% lower for scenario 1. The resulting reimbursement rates are shown below.

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<sup>18</sup> Note that for scenario 3 where we used Nevada statewide average costs to estimate reimbursement rates, we considered using 2021 Geographic Cost Factors published in the 2021 CMS Risk Adjustment Report. While this methodology produced different estimates of percent of Medicare, the reduction needed to provider reimbursement was different than stated in this report in an immaterial way (less than 1%).

**Table 12: Nevada ACA Rating Area 1 Reimbursement Rates after Reduction**

<b>2023 ACA % of Medicare - Nevada</b>			
<b>Category of Service</b>	<b>Scenario 1</b>	<b>Scenario 2</b>	<b>Scenario 3</b>
Inpatient	120%	111%	111%
Outpatient	156%	144%	144%
Professional	100%	100%	100%
<b>Total</b>	<b>124%</b>	<b>117%</b>	<b>117%</b>

## Disclosures and Limitations

### Responsible Actuary

I, Karan Rustagi, am the actuary responsible for this communication. I am a Fellow of the Society of Actuaries (FSA) and member of the American Academy of Actuaries (MAAA). I meet the Qualification Standards of the American Academy of Actuaries to issue this report.

### Intended Users

This memorandum was prepared to summarize our analysis of Nevada's proposed 1332 waiver that would introduce a public option to the individual ACA market in the state. In addition, we reviewed Milliman's supporting analysis of Nevada's 1332 application and the conclusions therein. We relied on publicly available information and on discussions with and data provided by the Partnership in developing this memorandum. This information has been prepared for the sole use of the Partnership. Distributions to third parties should be made in its entirety and should only be evaluated by qualified users. Any third parties receiving this report should retain their own actuarial experts in interpreting results.

### Risks and Uncertainties

The assumptions and resulting estimates included in this report are inherently uncertain. Users of the results should be qualified to use them and understand the results and the inherent uncertainty. Actual results may vary, potentially materially, from our estimates. Wakely does not warrant or guarantee that the estimated values for premiums or provider reimbursement rates included in the report will be attained. It is the responsibility of those receiving this output to review the assumptions carefully and notify Wakely of any potential concerns.

### Conflict of Interest

Wakely provides actuarial services to a variety of clients throughout the health industry. Our clients include commercial, Medicare, and Medicaid health plans, the federal government and state governments, medical providers, and other entities that operate in the domestic and international health insurance markets. Wakely has implemented various internal practices to reduce or eliminate conflict of interest risk in serving our various clients. I, Karan Rustagi, am financially independent and free from conflict concerning all matters related to performing the actuarial services underlying this analysis. In addition, Wakely is organizationally and financially independent to the Partnership.

## **Subsequent Events**

The release of updated rate filing data for 2024, the 2022 CMS risk adjustment report, changes in participation of insurers and their premiums, and any changes in the design of the public option plan may impact estimates included in this report. Changes in state and federal law and/or economic environment may also impact our estimates.

## **Contents of Actuarial Report**

This document and the supporting exhibits/files constitute the entirety of actuarial report and supersede any previous communications on the project.

## **Deviations from ASOPs**

Wakely completed the analysis using sound actuarial practice. To the best of my knowledge, the report and methods used in the analysis comply with the appropriate Actuarial Standards of Practice (ASOP) with no known deviations. A summary of ASOP compliance is listed below:

ASOP No. 23, Data Quality

ASOP No. 28, Statements of Actuarial Opinion Regarding Health Insurance Liabilities and Assets

ASOP No. 41, Actuarial Communication

ASOP No. 42, Health and Disability Actuarial Assets and Liabilities Other than Liabilities for Incurred Claims

ASOP No. 45, The Use of Health Status Based Risk Adjustment Methodologies

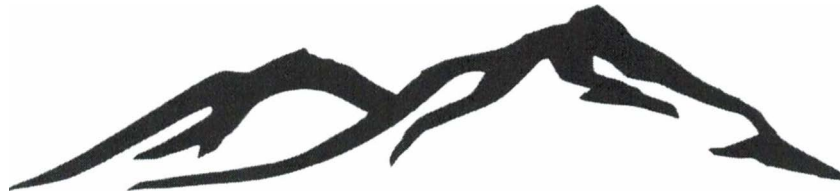
Please do not hesitate to call if you have any questions or if we may be of additional assistance. Thank you for the opportunity to work on this important project.

Sincerely,



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Karan Rustagi, FSA, MAAA  
Director and Senior Consulting Actuary  
720.531.6134 | [karan.rustagi@wakely.com](mailto:karan.rustagi@wakely.com)



## Child, Adolescent and Adult Psychiatry

March 3, 2024

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

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

*Submitted via [stateinnovationwaivers\(a,cms.hhs.gov](https://stateinnovationwaivers(a,cms.hhs.gov)*

RE: Nevada Section 1332 State Innovation Waiver Application

Dear Secretary Becerra and Secretary Yellen:

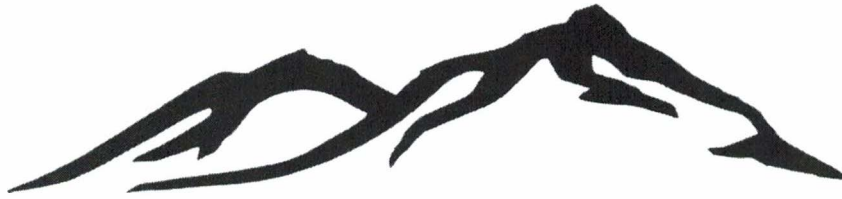
I'm a psychiatrist from Reno in support of the framework proposed to create a public health insurance option in Nevada.

Health care in Nevada has become more expensive and difficult to access for too many. Eleven percent of Nevadans are uninsured, and even insured Nevadans report experiencing health care affordability burdens. At the same time, patients seeking care are experiencing long wait times for both primary and specialty visits. In 2021, Nevada was ranked 48th in the United States with regard to primary care physician availability per 100,000 residents. To get an appointment with a psychiatrist can take many months, if you can get in to see one.

Thankfully, the public option and its proposed initiatives can help alleviate these issues, which are impacting patients like mine on a daily basis. By making health care coverage more affordable and encouraging more physicians to "Practice in Nevada" this framework will make it easier for patients to get care when they need it, not just when they can afford it or months down the line when a doctor is finally available. The public option will also encourage competition, incentivizing better care delivery that prioritizes positive health outcomes.

I look forward to the implementation of this framework and the health benefits it will bring to my patients and community. I encourage the Nevada Department of Health and Human Services to

**[address removed] Reno, NV 89509**  
**[phone number removed]**



11/11/2014 12:45:44 PM

## Child, Adolescent and Adult Psychiatry

continue looking at ways to bring health care providers into Nevada, make healthcare more affordable, and increase access.

Thank you for the opportunity to provide these comments.

Sincerely,

*[signature and name removed]*

A faint, illegible signature in light blue ink, located below the text "[signature and name removed]".

PM, MD

Child, Adolescent and Adult Psychiatrist  
Reno

[address removed] Reno, NV 89509  
[phone number removed]

Thank you to the Nevada Department of Health and Human Services (DHHS) and the Nevada Division of Health Care Financing and Policy for the opportunity to provide comments on Nevada's section 1332 State Innovation Waiver application.

I have spent the majority of my life being the sole provider of my household of 7. In 2017 I found myself out of the job I held my entire adult life which had given the entirety of my family insurance. Searching in the job market found me relocating myself, my wife, and 5 children to the Las Vegas Valley in pursuit of a more affordable life. The new job didn't have health insurance provided as my previous job did, so for my first 3 years in the Valley we bit the bullet and went without Health Insurance as a family. That meant no check ups or doctor's appointments, my youngest son accrued 6 cavities in this time.

My eldest son passed out due to heat exhaustion in this time period, after his visit to the emergency room we found a medical bill towering over the cost of \$8,000 which we couldn't afford. I wouldn't wish this uncertainty and economic anxiety on any Nevadan. Having a Public Option would mean that families like mine would have never had to look down the barrel of a world without access to Health Care. The well being of myself and my children wouldn't be left at the hands of the job I am employed by and provide a lifeline to those of us who can't afford it. I support Nevada's creation of a Public Option that'll make sure no one will have to go through what I went through.

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

Sincerely,  
KC

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**Grassroots NV Public Option comment**

Date 02/17/2024

Nevada Department of Health and Human Services  
400 West King Street, Suite 300  
Carson City, Nevada 89703

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

Thank you to the Nevada Department of Health and Human Services (DHHS) and the Nevada Division of Health Care Financing and Policy for the opportunity to provide comments on Nevada's section 1332 State Innovation Waiver application.

Even with expanded access to public and private health insurance coverage during the pandemic, Nevada suffers the highest uninsured rate of any state that has expanded Medicaid. [Nearly half](#) of uninsured Nevadans report the major reason they are uninsured is due to coverage being "too expensive". For those who are able to access health insurance, individual marketplace premiums have continued to [rise](#). As a result, many Nevadans, like myself go without care or are forced to make difficult choices between necessities like food, rent and getting the care we need.



Hello, my name is *[name removed]* and I hope this story can help shed some light on the struggles surrounding healthcare. I am 24 years old. I have type one diabetes and a rare form of spinal arthritis. I was diagnosed at five years old with diabetes and autoimmune disease. At 17 I developed a rare form of spinal arthritis. There is no cure for either of my chronic illnesses. Most of my life I had to take medication's, and the one thing that constantly remains is how much money it takes to keep me alive. How much funding is available for the drugs that I can't afford? As an adult now what insurance plan do I apply for ? Do I even qualify for these programs as an adult ? All is a huge burden on me? Going into adulthood I now have a strong respect for my mother, because financially, I never had to worry about those things as a child. She worked multiple jobs even did hair nails on the side for extra money, just to ensure my health and childhood was as close to normal as possible. I am an adult now and financially responsible for my own health and I must say the cost of my medication is extremely expensive. I cannot afford to live alone. I still stay with my mom because I don't make enough money to afford school and residence.

I am happy to learn that there is an option that will enable me to afford healthcare and be able to live an independent life. I'm sure I don't just speak for myself when I say healthcare is a human right and should be available and affordable to all.

I support Nevada's creation of a Public Option that meets the same standards and offers the same essential benefits as private plans offered in the individual market. For those without access to coverage, this new affordable coverage option will be a lifeline that will save people money and allow them to more easily plan and budget for their family's needs.

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

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#### Support Testimony on the Implementation of Nevada's Public Option

CM  
Reno, Nevada

My name is *[name removed]* 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 during that difficult time.

As a community member of the AAPI community 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. The implementation of a public option in Nevada will bring down healthcare

costs for our state, and encourage young people to stay in the state if their healthcare costs become more reasonable compared to other parts of the country.

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Hello. My name is [name removed]. In 2018, I worked at [name of employer] as staff teacher. They scheduled me under 38 hours a week to keep me from getting benefits. One day I started to feel overwhelming pain and not having insurance I waited before seeking medical attention hoping I would get better. I did not. When I finally received it I was close to death as a cyst was growing on my ovary and causing my body to go septic. The bills I received after sent me to collections and nearly bankrupted me. If the public option had been in place I might have been able to have saved my body from being mutilated, risking my ability to have children, and saved myself from crippling debt.

Thank you,  
DRF

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Date 03/28/2024

Nevada Department of Health and Human Services  
[400 West King Street, Suite 300](#)  
[Carson City, Nevada 89703](#)

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

Thank you to the Nevada Department of Health and Human Services (DHHS) and the Nevada Division of Health Care Financing and Policy for the opportunity to provide comments on Nevada's section 1332 State Innovation Waiver application.

Even with expanded access to public and private health insurance coverage during the pandemic, Nevada suffers the highest uninsured rate of any state that has expanded Medicaid. [Nearly half](#) of uninsured Nevadans report the major reason they are uninsured is due to coverage being "too expensive". For those who are able to access health insurance, individual marketplace premiums have continued to [rise](#). As a result, many Nevadans, like myself go without care or are forced to make difficult choices between necessities like food, rent and getting the care we need.

Since my last letter there hasn't been much of a happy update. I'm still currently working two lower paying jobs while trying to obtain permanent residence for myself and my children. I am a CNA and I work for two different companies, both companies offer benefits. Unfortunately, the premiums are extremely high. I am a single mother with four young children and to pay out of my paycheck for myself and my family is crazy. I would not be able to survive. Living in a system designed to watch you struggle just feels inhuman. There should be resources available for people like me. I feel defeated and like I'm fighting a total uphill battle. Learning about the Public Options Plan gives me a little bit of hope that I will be able to obtain suitable medical insurance for my four children and I. Medical costs are outrageous and extremely hard to obtain. For me this is a necessity, priority, and an individual's human

right to obtain affordable Medical. I am excited for the public options plan because it gives me comfort to know I'm one step closer to having what I need for me and my family.

' I am excited for the public options plan because it gives me comfort to know I'm one step closer to having what I need for me and my family.'

I support Nevada's creation of a Public Option that meets the same standards and offers the same essential benefits as private plans offered in the individual market. For those without access to coverage, this new affordable coverage option will be a lifeline that will save people money and allow them to more easily plan and budget for their family's needs.

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

Sincerely,  
RB

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February 26, 2024  
Chiquita Brooks-LaSure, Administrator  
Centers for Medicare & Medicaid Services, Department of Health & Human Services  
P.O. Box 8016  
Baltimore, MD 21244-8016  
*Submitted via stateinnovationwaivers@cms.hhs.gov*  
RE: Nevada Section 1332 State Innovation Waiver Application

Dear Administrator Brooks-LaSure,

Thank you for the opportunity to share comments on Nevada's section 1332 State Innovation Waiver application to create the Nevada Coverage and Market Stabilization Program. As a pediatrician in Las Vegas, I support the framework proposed to create a public health insurance option in Nevada. I believe it will help increase health coverage options for Nevadans, including my patients.

Furthermore, I support the state leveraging the savings created by the public option for the "Practice in Nevada" provider incentive program. This program can help address the dire shortage of health care providers in our state — a shortage being felt by providers like me and our patients every day.

This shortage is especially acute for developmental and behavioral health in our state. My patients have often waited over a year to receive a diagnosis of autism. While they are waiting they are missing out on critical services; these services are most effective when started at as early an age as possible. I saw one patient recently that had been expelled from kindergarten for behavioral issues while waiting to see a child psychiatrist. When he finally saw us 9 months later, he was diagnosed with ADHD which is easily treatable with medication. But in that time period he has fallen over a year behind academically. Stories like these are all too common for

pediatricians in our state.

My patients and all Nevadans deserve to be able to access care affordably and when they need it. Your division can help ensure greater access to affordable care across the state. Thank you for your work to do so.

Sincerely,  
Dr. RL  
Pediatrics  
Las Vegas

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Dear Secretary Becerra and Secretary Yellen,

As a cardiologist I'm supportive of the framework the Division has proposed to create a public health insurance option in Nevada. It will build a strong foundation to increase health coverage options for Nevadans while promoting health care affordability.

Doctors hear all the time from our patients how the high cost of health care prevents them from seeking care. Some patients come in after suffering for months, even years, from a problem that could have been treated earlier. Others stop coming because they lose their insurance. Too many patients fall in a gap, not qualifying for federal premium support but also not able to afford coverage.

That's why the public option is so important, and why doctors like me support the design of the federal 1332 waiver. The public option will increase health care affordability and access for patients like mine. With a public option and reinsurance, individual marketplace premiums will decrease 15 percent over four years. Nevada's Coverage and Market Stabilization Program can lower the cost of health insurance for up to, or even more than, 100,000 Nevadans on the individual market.

The state can, and should, help patients even further by leveraging additional available funding to directly subsidize premium tax credits to offset premium and out-of-pocket costs.

When patients are better able to afford and access care, they're better able to live, work, learn, and care for their families. That makes our communities and our whole state healthier and stronger. Thank you for your work to help my patients.

JZ M.D.  
Reno, NV

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Thank you to the Nevada Department of Health and Human Services (DHHS) and the Nevada Division of Health Care Financing and Policy for the opportunity to provide comments on Nevada's section 1332 State Innovation Waiver application.

Even with expanded access to public and private health insurance coverage during the pandemic, Nevada suffers the highest uninsured rate of any state that has expanded Medicaid. [Nearly half](#) of uninsured Nevadans report the major reason they are uninsured is due to coverage being "too

expensive”. For those who are able to access health insurance, individual marketplace premiums have continued to [rise](#). As a result, many Nevadans, like myself, go without care or are forced to make difficult choices between necessities like food, rent and getting the care we need.

My job does offer benefits, but they are far from affordable for me as a graduate student with an extremely tight budget. I am covered under my parents insurance, but must travel two hours into California in order to seek any sort of care. This prevents me from seeking necessary care frequently.

The Public Option would be a more affordable healthcare option on the open exchange in Nevada, and would make care much more accessible for someone like me. Individual plans feel out of reach, and a discount would allow me to comfortably access care in my home state of Nevada.

I support Nevada’s creation of a Public Option that meets the same standards and offers the same essential benefits as private plans offered in the individual market. For those without access to coverage, this new affordable coverage option will be a lifeline that will save people money and allow them to more easily plan and budget for their family’s needs.

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

Sincerely,  
ML

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Thank you to the Nevada Department of Health and Human Services (DHHS) and the Nevada Division of Health Care Financing and Policy for the opportunity to provide comments on Nevada’s section 1332 State Innovation Waiver application.

Even with expanded access to public and private health insurance coverage during the pandemic, Nevada suffers the highest uninsured rate of any state that has expanded Medicaid. [Nearly half](#) of uninsured Nevadans report the major reason they are uninsured is due to coverage being “too expensive”. For those who are able to access health insurance, individual marketplace premiums have continued to [rise](#). As a result, many Nevadans, like myself, go without care or are forced to make difficult choices between necessities like food, rent and getting the care we need.

As a Nevadan diagnosed with Relapsing-Remitting MS in 2017 and serving as a District Activist Leader with the National MS Society, I strongly endorse the passage of the bill to implement the Public Option in our state. Having personally grappled with the challenges of insurance pre-authorizations and witnessed the struggles of countless individuals facing high healthcare costs, I believe the Public Option is a vital step towards addressing the gaps in our current system. The bill's enactment would signify a significant stride towards accessible and affordable healthcare for all Nevadans. By sharing my story and advocating for this crucial change, I hope to contribute to a progressing healthcare system that prioritizes the well-being of individuals over financial barriers. I urge policymakers to consider the transformative impact the Public Option can have on the lives of people like me and to actively support its passage to benefit our community's health and prosperity.

I support Nevada's creation of a Public Option that meets the same standards and offers the same essential benefits as private plans offered in the individual market. For those without access to coverage, this new affordable coverage option will be a lifeline that will save people money and allow them to more easily plan and budget for their family's needs.

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

Sincerely,  
KK

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March 14, 2024

Centers for Medicare & Medicaid Services (CMS) and the Department of the Treasury

RE: Nevada Draft Section 1332 State Innovation Waiver Application

For decades, wealthy insurance companies have raised health insurance rates and profited at the expense of hard-working Nevadans.

Thankfully, during the 221 Legislative session, Nevada passed Senate Bill 420 by Senator Nicole Cannizzaro, a Public Option Health Insurance that requires insurance companies to provide quality health insurance at a lower rate to Nevadans. The Public Option isn't made up of cheap junk insurance plans that won't cover anything. Instead, it meets all federal and state requirements like preventative screening, vaccines, birth control, and reproductive care. This opens up an amazing opportunity for community members to have more freedom and access when choosing which health insurance plan best fits themselves and their families, which Nevada desperately needs.

Currently, 11.6 percent of Nevadans are not covered by public or private insurance. This ranks NV in the bottom ten states for health insurance coverage. The Public Option will provide an affordable option for those not eligible for public insurance like Medicaid or Medicare, whose employers don't provide insurance, or those who are self-employed.

Unfortunately, we know that the insurance industry that has gouged Nevada families for decades isn't happy about this and will use every scare tactic in the book to try and kill the Public Option.

Don't let them!

For someone like me who has several health concerns, including diabetes and psoriatic arthritis, I have been unable to leave jobs because I couldn't afford health insurance and was unable to take jobs without health insurance. This is a problem facing numerous Nevadans as they struggle with health issues and a lack of available and affordable health insurance options. The Public Option will allow me and others more flexibility in employment, including working in the gig economy like many other Nevadans. No one should be forced to stay at an employer just because they cannot afford private insurance. The Public Option will allow Nevadans more freedom and autonomy in their healthcare decisions.

With the approval of the 1332 waiver, Nevada will be able to reinvest in things like healthcare provider development and payment systems that focus on the quality of coverage, not how many services you use. That means people like me will not only have coverage but be able to see a doctor when we need them (something that is currently a problem regardless of insurance status because of our longstanding provider shortage) and know that my treatments will be better tailored to me because when I do better and am healthier, providers get paid more. Nevada's Public Option Insurance is governing at its best because it prioritizes the needs of community members. It allows hardworking Nevadans to access affordable health care, giving them more freedom to make decisions that will improve their lives.

Sincerely,

LLC

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**Grassroots NV Public Option Written Comment**

02/17/24

Nevada Department of Health and Human Services  
400 West King Street, Suite 300  
Carson City, Nevada 89703

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

Thank you to the Nevada Department of Health and Human Services (DHHS) and the Nevada Division of Health Care Financing and Policy for the opportunity to provide comments on Nevada's section 1332 State Innovation Waiver application.

Even with expanded access to public and private health insurance coverage during the pandemic, Nevada suffers the highest uninsured rate of any state that has expanded Medicaid. [Nearly half](#) of uninsured Nevadans report the major reason they are uninsured is due to coverage being "too expensive". For those who can access health insurance, individual marketplace premiums have continued to [rise](#). As a result, many Nevadans, like myself, go without care or are forced to make difficult choices between necessities like food, rent, and getting the care we need.

My husband found cancer in his liver and had to have a doctor for every organ of his body. He was put on the transplant list and given extensive medication. It cost us around 500 to 600 dollars a month. In a short period we almost lost our house; while my family lived in and out of California in hotels. Fortunately a friend of mine had loaned me an RV to make living in California possible during his treatment. Having a public health insurance option would have saved us the time and efforts to find adequate coverage instead of bouncing around health insurances to cover my husband's medical expenses.

I support Nevada's creation of a Public Option that meets the same standards and offers the same essential benefits as private plans offered in the individual market. For those without access to coverage, this new affordable coverage option will be a lifeline that will save people money and allow them to more easily plan and budget for their family's needs.

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

Sincerely,  
EF

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**Grassroots NV Public Option Written Comment**

02/17/24

Nevada Department of Health and Human Services  
400 West King Street, Suite 300  
Carson City, Nevada 89703

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

Thank you to the Nevada Department of Health and Human Services (DHHS) and the Nevada Division of Health Care Financing and Policy for the opportunity to provide comments on Nevada's section 1332 State Innovation Waiver application.

Even with expanded access to public and private health insurance coverage during the pandemic, Nevada suffers the highest uninsured rate of any state that has expanded Medicaid. [Nearly half](#) of uninsured Nevadans report the major reason they are uninsured is due to coverage being "too expensive". For those who can access health insurance, individual marketplace premiums have continued to [rise](#). As a result, many Nevadans, like myself, go without care or are forced to make difficult choices between necessities like food, rent, and getting the care we need.

Healthcare costs are out of control. The prices make me terrified to ever get sick. My last visit to the quick care cost me \$1,100.00, and that was WITH insurance and all they did was just tell me I had the flu. It is to the point, suffer until it's at its worst then maybe seek help with the risk of bankruptcy.

I work in the healthcare industry, and they provided horrible insurance, so I had to seek out private health insurance that cost a lot compared to how much I was making. At that time I was living alone, so I had to seek out roommates so I could keep up rent, health insurance, and my other bills.

Everyone is so scared about socialized medicine; last year I was getting charged \$500 a month for health insurance and even now almost \$400. A public option would have given me an opportunity to have coverage at an affordable price in a much more timely manner.

I support Nevada's creation of a Public Option that meets the same standards and offers the same essential benefits as private plans offered in the individual market. For those without access to coverage, this new affordable coverage option will be a lifeline that will save people money and allow them to more easily plan and budget for their family's needs.

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

Sincerely,  
EA



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Sent from my iPhone

In regards to BBSP, I wanted to comment that the present insurance system is a mess, with costly insurance plans, which have large deductibles and excessive fees. We need affordable insurance plans, or people won't use them and those costs for emergency room visits will be passed on to all of us. It's crazy that we have a government that has \$846 billion to spend on a military, but can't provide affordable health insurance. Whatever can be done to help is a move in the right direction.

ED

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February 26, 2024

Chiquita Brooks-LaSure, Administrator  
Centers for Medicare & Medicaid Services, Department of Health & Human Services  
P.O. Box 8016  
Baltimore, MD 21244-8016

Submitted via [stateinnovationwaivers@cms.hhs.gov](mailto:stateinnovationwaivers@cms.hhs.gov)

RE: Nevada Section 1332 State Innovation Waiver Application

Dear Administrator Brooks-LaSure,

I'm writing to support the state's section 1332 State Innovation Waiver application to create the Nevada Coverage and Market Stabilization Program. As a doctor in Douglas County, I support the framework proposed to create a public health insurance option in our state.

In my 33 years of practice, I've seen countless patients harmed by Nevada's high health care costs and lack

of insurance coverage. I have seen many times where people had to choose between prescription medications and other essentials like food or utilities. I have seen bad outcomes because of delays in diagnostic or therapeutic care. These problems are magnified in sparsely populated and underserved areas.

The public option will prevent Nevadans from having to suffer in these ways. With the state taking this unique approach, it will:

- Make health care coverage more affordable and accessible for tens of thousands of Nevadans
- Reduce premiums and lower out-of-pocket costs for patients
- Increase access to essential providers, including in rural areas Winnemucca, where I have provided emergency department care, rural Douglas county where I live, as well as Lyon and Storey counties where I still provide medical services.
- Incentivize better care delivery that shifts away from costly fee-for-service toward better health outcomes
- Encourage more health care providers to practice in Nevada, reducing our shortage and increasing access

All these benefits will mean healthier patients and a state that leads on health care and improving health

outcomes. Doctors thank you for your work toward these goals and for the opportunity to comment on the section 1332 waiver application.

Sincerely,  
Dr. NS  
Hospice Medical Director  
Carson City

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A comment from JM regarding the public option in Nevada:

I am an educator who has proudly served our school district for over two decades. I've always seen teaching as my calling and my students as my second family. I enjoyed the work, but eventually realized it was time to retire. I had been on the district's health insurance plan for decades, and now I am alone, exploring the individual markets before I am eligible for Medicare in six months. However, after researching the marketplace I realized that my health insurance would be \$800 per month. I was shocked. In order to pay for this new, expensive bill, I had to return to substitute teaching to pay for my health insurance.

My story is not unique, and it speaks to a larger issue: the sky-high cost of healthcare in our country. It's a problem that calls for immediate reform. Educators like me, who have devoted their lives to shaping young minds, shouldn't have to make such painful choices between health and livelihood.

Nevadans, and all Americans, deserve an affordable and accessible healthcare system. It's time for our leaders to consider a public option that provides lower health costs for all. Let's ensure that educators and countless others can retire without the weight of financial stress, and that healthcare becomes a right, not a privilege.

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Nevada needs affordable health insurance that can be purchased. My family and I have had employer health insurance coverage and have never had to worry about being covered for medical expenses. It is scary to think that I may need it one day and will be priced out from being able to purchase healthcare coverage because of the Federal Government money being used as a reinsurance for insurance companies. Thank you for considering this before the vote.

AW

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**Reno Family Healthcare Costs**

*by CPC*

Nevadans have long deserved affordable options for healthcare. As a head of household, insuring my family of three cost me \$448 a month. My employer contributes a large portion on top of the amount that I put in. Yet, we typically only have maintenance healthcare and dental work done. While the monthly amount of health care is a cost that we are used to being taken out of our paychecks, the question must be asked if there is a better path forward. In Nevada, the democratic controlled legislature has crafted a better path forward through a Public Option.

The public option would allow people to opt into a state operated insurance program

that will compete with other health insurance providers in the state. This is significant for a few reasons, mainly that through the public option, prices to insure yourself and your family goes down and it will create an insurance plan that will be vastly more affordable for people to obtain. The public option is not only sound policy, but it is a tool which will insure 9,Nevadans within 5 years of its implementation thanks to its more affordable price. In addition, it will give the government the greater ability to negotiate prescription drug prices downward which in our time of major inflation would provide real economic relief for families, especially sectors of our state that are most vulnerable. Many in our community rightfully may see this and misunderstand it as a government grab into healthcare choice and lament the thought of the government forcing people to get healthcare through their scheme. Our Governor, Joe lambardo, appears to be on that side of the issue. However, I strongly urge Nevadans to see the facts and the benefits of having a public option.

Firstly, competition has always proven to improve the quality of services in all industries. With the entry of a state backed insurance plan, the traditional insurance companies with be forced to compete for Nevadans. They will have to lower costs and improve their services in order to entice us for our business! A public option to you would above all else give you an OPTION. In addition, uninsured individuals will have a health care plan that is in reach. This opportunity will provide Nevadans with an alternative to our current system which is overwhelming Nevadans. It is important that we strengthen the Public option, expand it and preserve it.

Currently, governor Lombardo is seeking to repeal or replace parts of or the entire legislation. However, we've heard this rhetoric before in debates with healthcare reforms in the past. The public option in Nevada is slated to begin in January of 2024. We must support it now and let the governor know that we support it and will see its survival though. Nevadans deserve a new option in healthcare.

*CPC is a graduate of the University of Nevada, Reno and manager in the automotive industry. In his spare time, he advocates for affordable housing and economic justice.*

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#### **Grassroots NV Public Option comment template**

11/15/2023

Nevada Department of Health and Human Services  
400 West King Street, Suite 300  
Carson City, Nevada 89703

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

Thank you to the Nevada Department of Health and Human Services (DHHS) and the Nevada Division of Health Care Financing and Policy for the opportunity to provide comments on Nevada's section 1332 State Innovation Waiver application.

Even with expanded access to public and private health insurance coverage during the pandemic, Nevada suffers the highest uninsured rate of any state that has expanded Medicaid. [Nearly half](#) of uninsured Nevadans report the major reason they are uninsured is due to

coverage being “too expensive”. For those who are able to access health insurance, individual marketplace premiums have continued to rise. As a result, many Nevadans, like myself go without care or are forced to make difficult choices between necessities like food, rent and getting the care we need.

Hello my name is [name removed] and I am new to Nevada. Coming from California. Their medical system is structured different. The income threshold for families in California is much higher to obtain supportive services. I moved to Vegas from California for many reasons. But once I got here I quickly began to see and rethink my decision coming here. The supportive services are scarce and the housing crisis is extremely sad. But my main issue is medical. I currently work for a temporary agency that does not offer medical insurance. I make above the income medium, in Nevada to obtain Government Medical Services. I am not knowledgeable on the laws that govern Nevada, but what I do know is, I have been shut down and denied certain services because I make too much money but definitely not enough to survive here. I received a flyer explaining the Public Option Health Plan and I’m excited to know there will be an option available for people like me that are stuck in the middle. I defiantly support Public Option and I can’t wait for enrollment to start. This will be a good Option for the the people of Nevada. I defiantly support Public Option and I can’t wait for enrollment to start. I will have relief knowing my family will be covered. This will be a good Option for the people of Nevada. I support Nevada’s creation of a Public Option that meets the same standards and offers the same essential benefits as private plans offered in the individual market. For those without access to coverage, this new affordable coverage option will be a lifeline that will save people money and allow them to more easily plan and budget for their family’s needs.

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

Sincerely,

JG

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February 27, 2024  
Chiquita Brooks-LaSure, Administrator  
Centers for Medicare & Medicaid Services, Department of Health & Human Services  
P.O. Box 8016  
Baltimore, MD 21244-8016

Submitted via [stateinnovationwaivers@cms.hhs.gov](mailto:stateinnovationwaivers@cms.hhs.gov)

RE: Nevada Section 1332 State Innovation Waiver Application

Dear Administrator Brooks-LaSure,

Thank you for the opportunity to provide comments on Nevada’s section 1332 State Innovation Waiver application to create the Nevada Coverage and Market Stabilization Program. I’m an internal medicine physician in Las Vegas, writing in support of the framework proposed to create a public health insurance option in Nevada. This proposal will help increase health coverage options for Nevadans while making care more affordable.

Nevada has the highest uninsured rate of any state that has expanded Medicaid, with more than 340,000 uninsured residents. Nearly half of these residents report the main reason they're uninsured is due to coverage being too expensive.

As a doctor, I'm sadly all too familiar with what happens to patients when they forgo insurance, and, consequently, often forgo care. Treatable health conditions worsen, becoming more uncomfortable, painful, and expensive to treat.

When a patient has to decide between affording their heart medications without insurance help or paying their rent, many times they choose their rent. This leads to these patients being hospitalized for complications which then leads to more expensive hospital bills because they are uninsured. The cycle repeats itself. Without health insurance, patients have to choose between keeping the lights on or paying for their COPD medications, many of which are expensive without insurance. Again, they will choose to keep the lights on and subsidize on expired inhalers in hopes that it will work.

By making health coverage affordable for these uninsured Nevadans, and by lowering health care costs across the state, the public option will help prevent tragic stories like these, making my patients and our communities healthier. That's why I'm proud to support the 1332 State Innovation Waiver application to create the Nevada Coverage and Market Stabilization Program.

Thank you.

Sincerely,  
HT, DO, FACOI