Questions Received During Weekly Office Hours in October & November

The following questions were received from stakeholders in the weekly office hours held by the Division of Health Care Financing and Policy (DHCFP, aka Nevada Medicaid) during October and November in 2022. The answers below reflect the information available to DHCFP at the time of these meetings. Some information and decisions are subject to change based on upcoming actuarial findings and other efforts regarding the implementation of the Nevada Public Option.

Contents

September Webinar-Related Questions

1. **What is the role of Nevada Medicaid (DHCFP) in the development/administration of the Public Option?**

The Administrator of Nevada Medicaid has been delegated by the Director of the Nevada Department of Health and Human Services (DHHS) to implement and administer the Nevada Public Option.

2. **Where does the $1 billion in savings referenced in the Sept. 23, 2022 webinar presentation and potential new federal revenue to the state come from?**

The savings is "projected" savings which reflects the estimated amount of federal spending over a ten-year period that the state of Nevada is estimated to "save" the federal government by offering a Public Option with respect to reduced federal spending (i.e., advanced premium tax credits) in the state's health insurance exchange (Nevada Health Link). When premiums go down in the state health insurance exchanges, the federal government spends less in terms of federal taxpayer dollars on buying down premium costs to improve the affordability of coverage for consumers. One of the key goals of the state's Section 1332 waiver is to seek federal approval for Nevada to capture this federal savings so that it can be reinvested back into Nevada's health care system.

3. **Slide 6 of the webinar presentation from September 23, 2022 indicates that the Nevada Public Option will have "network alignment with MCO networks."**

    a. **Can you describe this requirement in greater detail?**

    State law requires the Director to administer the Public Option through contracts with health carriers. To award such contracts, DHCFP must conduct a statewide procurement for new contracts with health carriers to offer the Public Option. See NRS 695K.220. State law also requires the Director to prioritize awards to health carriers submitting bids that demonstrate

alignment between provider networks for the Public Option and Medicaid managed care programs. For example, "aligning networks" could include awarding a health carrier more "points" in the procurement process for building similar provider networks for Medicaid managed care and the Public Option products or for demonstrating that their Public Option provider networks largely overlap with those of their Medicaid products that are operating in the applicable region.

The goal of this effort is to better align provider networks across Medicaid and the private individual health insurance market, where feasible. The expectation is that, through greater alignment, consumer experience will improve and the likelihood of achieving continuity of care for consumers transitioning between markets will increase. The specific requirements for how "alignment" will be measured or scored in the procurement process have not yet been determined by DHCFP. The intent is to seek public feedback on this element in a future Request for Information (RFI) in the spring or summer of 2023.

b. Will MCOs be required to use their Medicaid-networks for the Nevada Public Option? Or are you considering some other type of standard?

If a health carrier seeks to participate as a Medicaid managed care organization (MCO) through future state procurements, we expect that the health carrier would simultaneously submit a good faith bid for the Public Option as required by NRS 695K.220. Because state law requires that the Director of DHHS (via the Administrator of Nevada Medicaid) prioritize bids that demonstrate alignment between networks, DHCFP intends to require MCOs to demonstrate areas of alignment between their provider networks for both programs as part of their bids for Medicaid and the Public Option. As previously mentioned, how DHCFP intends to define and measure alignment is yet to be determined. The intent is to solicit public feedback on this element in a future RFI in the spring or summer of 2023. DHCFP is considering including exceptions to alignment requirements where access to providers is limited by constraints with certain types of providers due to this requirement.

c. What about health carriers that are not MCO's in the state that would like to bid to offer the Public Option? How will network alignment with MCO networks be evaluated?

State law permits health carriers that are not participating in Medicaid managed care from submitting a bid to participate in the Public Option. Even though these health carriers do not currently have Medicaid provider networks, we anticipate requiring some level of overlap with respect to network adequacy standards in Medicaid managed care. This may consist of requiring non-Medicaid managed care plans to identify networks that include key safety-net (Medicaid-specific) providers. As previously mentioned, how DHCFP intends to define and measure alignment of networks is yet to be determined. The intent is to solicit public feedback on this element in a future RFI in the spring or summer of 2023.

4. **Slide 6 of the webinar presentation from September 23, 2022 indicates that the Nevada Public Option will have "new caps on administrative load in premiums for health plans participating in Public Option to offset impact of premium reductions on providers."**

   a. **Can you describe this cap in greater detail?**
   Currently, DHCFP is considering the application of a new Medical Loss Ratio (MLR) requirement through its contracts with health carriers that would be specific to the Public Option. This MLR would likely be higher than what is used by some health carriers today in the state's individual health insurance market.

DHCFP is also considering a tiered approach for this new requirement, where the increase would be applied across the first four years, to give health carriers the ability to meet this new MLR requirement over time. The goal is to ensure that the burden of having to achieve lower premiums is shared across providers and health carriers.

DHCFP intends to solicit feedback on this new requirement and how it might be best implemented in the market through an upcoming RFI in 2023.

b. **How will this offset impact of premium reductions on providers?**

As you know, there are already existing MLR requirements for the individual and small group markets. By meeting a higher MLR (higher than approx. 80% which is where the average appears to be today), the expectation is that health carriers will need to find more administrative efficiencies (savings from adjustments in salaries, profits, and other administrative-related expenses) for the Public Option plans. These administrative efficiencies will result in lower premiums which reduces the burden on provider reimbursement levels when health carriers are reaching the targeted premium savings in the Public Option plans.

c. **Won't this cap increase costs for consumers who like their existing plan and are not enrolling in the Nevada Public Option?**

Not necessarily, but this depends on how health carriers that offer Public Option plans manage actual expenses with the MLR adjustment. DHCFP is exploring mechanisms to control how the MLR requirements are met by health carriers and is also working with its actuary for the Public Option to examine the impact of a higher MLR threshold for Public Option plans on premium rates generally. DHCFP intends to solicit feedback on this new requirement and how to avoid cost shifting in an upcoming RFI in 2023.

d. **What happens if the administrative cap results in rates that do not meet actuarial soundness standards?**

At this time, based on the actuarial review of the market, we do not anticipate that an increase in the MLR or the 4% premium reduction (as revised by Director) which adds up to 16% over four years will result in rates that are actuarially unsound or will lead to insolvency for health carriers.

5. During the webinar, it was stated that providers would be rewarded for better outcomes in the Public Option. How does this work?

This comment was made in reference to the state law requirement that the Director must prioritize bids for the Public Option that increase the use of value-based payment design with providers. Value-based payment design can be used to reward providers for achieving better health outcomes and finding efficiencies in the delivery of care. This includes performance-based payments to providers and risk-based payments where savings achieved are shared with providers. DHCFP anticipates utilizing its scoring process for the procurement to meet this requirement.

DHCFP also intends to seek feedback on approaches to increase the use of value-based payment design through the Public Option program.

6. **On slide six of the webinar presentation, the state indicates that: "Nevada Public Option uses a statewide procurement and contracting strategy with health plans to offer low-cost coverage to consumers and that "new state procurement is tied to state's Medicaid managed care procurement to leverage state's largest purchasing power with health plans."**

This information is in reference to NRS 695K.220 regarding the requirement that the Director conduct a procurement and issue awards (or contracts) to health carriers to offer Public Option products. This is a similar concept behind state procurements used in Medicaid managed care programs, where states utilize certain strategies to help drive and enforce state priorities in the Medicaid market that are outlined in contracts with health carriers.

a. What specific requirements will DHCFP have for the rates for the Nevada Public Option? For example, will DHCFP require a maximum profit & risk load in the rate filing?

Rates with respect to consumer premiums must meet the premium reduction targets set forth in state law and in accordance with subsequent guidance issued by DHCFP pursuant to the Director's authority to revise the premium reduction targets. As for provider reimbursement rates, these rates must be no lower than the rates used by Medicare as set forth in state law. The procurement would instead request that health carriers submit proposed rates that meet or exceed the premium reduction targets as part of their bids. Health carriers receiving awards for the Public Option would file their proposed rates, annually, with the Department of Insurance for approval, as they do today. DHCFP and its actuary would thereafter monitor the rate filings to ensure health carriers are in compliance with the premium reduction targets agreed to in their Public Option contracts. If rates approved by the Department of Insurance do not meet the agreed-upon rates in the contract, DHCFP intends to utilize certain contractual remedies and sanctions accordingly. DHCFP is also considering adjusting the premium reduction targets in certain years if health carriers anticipate making up the difference in future years within the four-year contract period.

DHCFP intends to solicit feedback through an RFI on what remedies and sanctions would be reasonable and effective to ensure compliance by health carriers with the new premium reduction targets set forth in contract.

b. Will DHCFP require a maximum administrative expense for the Nevada Public Option? Are other requirements anticipated?

DHCFP is considering adding a requirement for health carriers offering Public Option plans to meet a higher Medical Loss Ratio (MLR) than the average MLR met by health carriers in the state's individual health insurance market. This would be accomplished through the procurement and DHCP's authority to impose requirements as part of its contracting process with health carriers. It would not be a state regulatory requirement, and nor would it apply to all health carriers operating in the state's individual health insurance market, which includes the Nevada Health Link.

By increasing the MLR for these products, DHCFP hopes to share the burden of the new premium reduction targets across health carriers and providers, so that it is not solely borne by the providers through rate reductions.

DCHFP intends to seek feedback on the use of a higher MLR in the Public Option through its upcoming RFI in spring or summer of 2023.

c. Will there be any requirements for MCOs other than "offering a good faith bid" to participate in the Public Option?

DHCFP is still considering what standards to apply across both markets through the new dual procurements and how it will treat the good faith requirement for the Public Option in its managed care procurement scoring process.

d. What will happen if an MCO's good faith bid cannot meet the annual premium reduction target for the Nevada Public Option? Will the MCO be disqualified from the Medicaid bid?

This depends on how DHCFP ultimately defines "a good faith bid" for purposes of the procurement and whether an exception is made in the Medicaid managed care procurement for health carriers that can justify their inability to meet the targets in the Public Option due to exigent circumstances like insolvency issues. DHCFP is also considering whether it is necessary to score health carriers in the Medicaid managed care procurement according to their ability to operate successfully in both programs. This would include their capacity to meet premium reduction targets in the Public Option program.

7. **On slide six of the webinar presentation from September 23, 2022, it states that "DHCFP intends to issue a Request for Information for public feedback on the procurement and contracting strategy for Public Option products in Spring 2023." How can the state-contracted 1332 waiver actuarial analysis that is expected by the end of November be meaningful without knowing the specifics of the state procurement and contracting strategy?**

DHCFP does not anticipate any decisions regarding the state's procurement and contracting strategy to materially affect the 1332 waiver application, actuarial analysis, and the pass-through funding estimates at this time. If the federal government, however, determines in its review that certain elements, like contractual mechanisms for enforcing the premium reduction targets should be outlined prior to their approval of the calculations, we would seek feedback through other public venues like a public workshop or hearing to gather this information. We expect that this would reasonably align with the timeline of the federal waiver review process next summer and fall.

8. **On slide nine of the webinar presentation for September 23, 2022, the state indicates that the Public Option is expected to provide more affordable coverage to 55,300 Nevadans in year one and up to 92,500 by year five. Are these Nevadans that are uninsured and have no other healthcare options (i.e., no subsidies)?**

These numbers reflect both insured and uninsured individuals today. The insured individuals expected to purchase the Public Option products are currently enrolled in products through the Nevada Health Link. It is expected that this population will choose to purchase the Public Option as a more affordable product. The uninsured population that is included in these estimates reflects about 10-12% of the group of uninsured individuals who are eligible for subsidized coverage through Nevada Health Link but are not yet enrolled in these products. The expectation is that the increased affordability of the Public

Option will entice this population to shop on Nevada Health Link for health insurance and ultimately purchase a Public Option product.

Actuarial-Related Questions

1. **The preliminary actuarial findings presented provide estimates on enrollment in Public Option products. Did these estimates include newly-enrolled or uninsured individuals? Who constitutes the enrollees in the Public Option?**

At this time, the enrollees in the Public Option are expected to include both newly and currently enrolled individuals who will purchase the Public Option through Nevada Health Link (the state's health insurance exchange).

The newly enrolled are estimated to make up about 10-12 percent of the population that is currently uninsured and eligible, but not yet enrolled in coverage through the Nevada Health Link. The remaining population expected to enroll in the Public Option products are anticipated to include individuals who are already enrolled today in products in the Nevada Health Link.

2. **Where does the savings come from that was referenced in the webinar overview of the preliminary actuarial findings?**

Currently, the federal government subsidizes (i.e., advanced premium tax credits) the cost of health insurance for many individuals who purchase health plans through the Nevada Health Link. By lower premiums being offered with the Public Option in the Nevada Health Link, the federal government is expected to spend less on these subsidies as costs will be lower for consumers. The 1332 waiver, if approved, would allow Nevada to capture these "savings" to the federal government and repurpose them for efforts that further improve affordability of health care for Nevadans. See question #4 under Waiver-Related Questions for more information. TWaiver-Related Questions

1. **What federal requirement(s) (i.e., Affordable Care Act provisions) would the state be seeking to waive in its 1332 Waiver?**

Currently, we expect to seek a waiver of Section 1312(c)(1) of the Affordable Care Act to provide the State with sufficient authority to require health carriers to reduce Public Option premiums to meet the mandated premium reductions/targets.

2. **When will the actuarial analysis be complete?**

The final report regarding the actuarial analysis is expected to be completed and posted online on DHCFP's Public Option webpage along with the 1332 waiver application by the end of November 2022. Once posted, the state public comment period for this report and the 1332 waiver application will begin. The plan is to collect written public comment and host two public hearings over at least a 45-day period.

3. **How long does it take for a 1332 waiver application to be approved?**

If the federal government determines a state's 1332 waiver application is complete, then it will conduct its own 30-day public comment period. Thereafter, a final decision from the federal government, as to whether to approve or deny the waiver request should take no more than 180 days.

4. **How are the federal pass-through funds "Savings" calculated?**

For the waiver, DHCFP must provide estimates regarding the projected federal savings with the waiver reform, which in this case is a new premium reduction target via a new Public Option. To estimate, DHCFP's actuary will apply a baseline of "without-waiver" projections based on actuarial assumptions (in this case without a Public Option) to "with-waiver" projections with respect to premium levels in the state's health insurance exchange (Nevada Health Link). The difference between the "without-waiver" and "with-waiver" estimates is what is used to determine the pass-through funding that is anticipated to be received by the state. This should equal the estimated savings to the federal government with respect to federal advanced premium tax credits under a Public Option scenario in Nevada.

5. **What if the pass-through savings projections come in over or under the approved estimates under the 1332 waiver?**

The pass-through funding amounts under a 1332 waiver are projections only. Once the waiver is implemented, the federal government will calculate the actual federal pass-through funding amount to be received by the state on an annual basis. Each year, the pass-through funding amounts are updated to reflect the latest data and changes in federal and state law, as applicable. For waivers approved to date, the pass-through funding amount has been calculated using a methodology developed by the Treasury Department's Office of Tax Analysis in consultation with the CMS Office of the Actuary using a tax microsimulation model that represents the U.S. population and simulates income taxes, including credits such as the advanced premium tax credits, and payroll taxes, over a ten-year budget period. More information about the methodology is available on the Center for Consumer Information and Insurance Oversight (CCIIO) website.

Pass-through funding amounts can vary (in both directions) from the state's initial estimates in their approved waivers for a variety of reasons, including:

- Changes in federal and/or state law after the state's initial application.
- Changes in economic conditions (including, for example, changes in expected enrollment) between the time of the application and the time of the determination of the pass-through funding amount.
- Differences between initial and final premium estimates.
- Final actual premiums under the waiver and final estimated premiums without the waiver are usually different from premiums estimated at the time of the waiver application. Some reasons for this potential difference could include:
    - Differences in the assumptions used by health carriers in their rate filings relative to the assumptions used by the state in their initial estimates.
    - Differences in the impact of the waiver due to differences between individual plan-level premium rate impacts and average premium rate impacts. States sometimes make simplifying assumptions in their applications regarding the impact the waiver may have on premium rates and assume the premium rate impact will be the same on every plan in their waiver application. However, when health carriers file their rates with the reinsurance program, those rates may vary the waiver's impact by plan. This includes the impact on the second-lowest cost silver plan rates, which can directly influence advanced premium tax credit

amounts. Thus, variances in plan-level premiums rate impacts with and without the waiver can have significant impacts on the estimated pass-through payments.

6. **How will the state be paid pass-through funds by the federal government?**

Generally, states receive an initial estimate of the federal pass-through funding amount in the fall of each year (before the beginning of the plan/waiver year). The initial federal pass-through funding amounts estimated in the fall of each year are informational and may be adjusted by the federal government as necessary to reflect or reconcile subsequent developments such as changes in federal or state laws. The final federal pass-through funding amount or final administrative determination will be shared in a letter to the state prior to the payment of the pass-through funding amount as provided in the specific terms and conditions of the approval letter (typically before the end of April of the plan year).

7. **Is the Milliman actuarial study the whole waiver application? When will it be posted for the public to review?**

No, the Milliman study is one component of the entire 1332 waiver application. The remaining components of the waiver application are set forth in federal regulation here. DHCFP intends to post the waiver application on the Public Option website, which includes the Milliman actuarial study and report, by the end of November of 2022.

8. **When will the waiver be submitted to federal government?**

At this time, the intent is to submit the 1332 waiver application, which includes the actuarial report, to the federal government in early-to-mid March. The federal agencies that will be reviewing the application include the U.S. Department of Health & Human Services (HHS), specifically the Center for Consumer Information and Insurance Oversight (CIIO) at HHS.

9. **Have other states seen success with 1332 waivers and receipt of pass-through funding?**

Yes, 16 states have received 1332 waiver approvals from the federal government, most of which are for establishing reinsurance programs to stabilize market premiums. The waivers specific to reinsurance have allowed these states to capture federal pass-through funds that have been reinvested back into their health care systems. These funds are based on the amount in federal advanced premium tax credits that the reinsurance program has saved the federal government.

Also, Colorado recently received a 1332 waiver approval from the federal government related to its new Public Option efforts, which included approval of pass-through funding related to expected premium reductions.

Public Option Product Design Questions

1. **What about the small group market? Is the state planning to offer a small group public option product or only an individual market product?**

State law requires DHCFP to offer an individual market product as a qualified health plan through the Nevada Health Link (the state's health insurance exchange). State law also gives DHCFP the option to offer a small group product as part of the Public Option program. After six public design sessions and discussions with consultants and sister agencies, it was determined that a small group product requires more analysis and a separate study specific to the market in Nevada. Therefore, at this time, DHCFP is not planning to utilize the Public Option program to provide small group insurance products in the state's small group market.

2. **Will the state use a standardized plan design?**

At this time, the state does not anticipate requiring a standardized plan design through its contracting strategy with health carriers, as long as the Public Option products offered by health carriers meet the minimum requirements for the Public Option. See NRS 695K.200 for these requirements.

However, the state does expect health carriers to innovate in their product design for the Public Option with respect to their responses to the procurement. This includes proposing products aimed at meeting certain state priorities, like aligning networks with Medicaid managed care (to extent feasible), utilizing benefit and provider network strategies that aim to address health disparities and workforce challenges, and committing to value-based payment designs with network providers.

3. **How will health carriers be expected to meet the Medicare floor for rates when not all services offered in the individual market are covered by Medicare (i.e. dental, pediatrics, pregnancy, etc)?**

DHCFP does not anticipate setting rates for services in the Public Option, including those not covered by Medicare. Therefore, DHCFP expects providers and health carriers offering the Public Option will continue to negotiate their rates for all services as they do today for private health insurance. DHCFP does not interpret state law to require health carriers offering the Public Option to pay Medicare rates only to providers for services covered by Medicare. Instead, DHCFP interprets this to mean that health carriers may not pay less than Medicare for Medicare-covered services. Therefore, this requirement should be used as a floor and not a ceiling during negotiations between providers and health carriers.

DHCFP intends to solicit feedback in a future RFI on ways to enforce this requirement through its contract with health carriers and how it can reward plans for offering rates that are above Medicare rates in the Public Option in addition to providing exceptions payments that are based on a value-based payment model.

4. **Can you talk a little bit more about premium reduction changes in the new DHCFP Bulletin on the Public Option? Why did DHCFP decide to move forward with those changes?**

The premium reduction target is a key driver of the actuarial analysis and pass-through funding estimates. Therefore, DHCFP determined it was necessary to address concerns regarding the existing premium reduction targets and utilize its authority to revise them to ensure the 1332 waiver reflects its intended approach under state law.

5. **How is cultural competency and diversity in networks being considered in this new program?**

Like increasing alignment between Medicaid and Public Option networks, state law requires that the Director also promote "contract[s] with providers of health care in a manner that decreases disparities

among different populations in this state with regard to access to health care and health outcomes and supports culturally competent care. Therefore, in the procurement process, DHCFP is considering a scoring regimen for plans according to their proposed approaches to provider contracting that satisfies this requirement.

DHCFP intends to seek feedback on various approaches with providers that could meet this requirement through an upcoming RFI.

6. **Regarding potential savings and potential enrollees, how did the actuary arrive at an average of $100 million a year in savings for about 55,000 persons given that it's $1 billion over ten years?**

The pass-through funding amount in year one is projected to be much smaller than $100 million, but it grows over time as the premium reduction target increases along with enrollment in the Public Option products. The amount of funding reflected as pass-through funding represents the difference between the amount of advanced premium tax credits that the federal government would have otherwise had to spend to buy down premium costs in the Nevada Health Link. Many consumers who are expected to purchase Public Option products are currently enrolled in other plans and are anticipated to enroll in Public Option products for additional savings. The number of enrollees in the Public Option is anticipated to grow over time, increasing the savings.

Market-Impact Questions

1. **What will prevent a small employer from dropping small group insurance and giving their employees the money to switch to Public Option plans?**

This risk exists today, where the small group market continues to present affordability challenges for small businesses. Employers of small businesses can currently offer subsidies to their employees to purchase private plans (through Nevada Health Link for example) in lieu of purchasing a cost small group plan for their employees. At this time, it is not expected that the Public Option will substantially increase this activity amongst small businesses based on the current cost differential between products in the small group market and the individual market.

However, DHCFP's actuary for the Public Option continues to review data on this issue, specifically the impact over time of the premium reduction target to this market, to ensure it is appropriately addressed in the final actuarial report. This includes reviewing the impact to provider revenue if small businesses do ultimately find that giving their employees a subsidy to purchase Public Option products is more financially advantageous than purchasing higher cost small group coverage.

2. **Will there be a penalty for small employers that drop coverage due to the Public Option or a requirement that they are not eligible for the Public Option?**

DHCFP does not anticipate creating a Public Option product for the small group market. However, as mentioned above, small businesses could drop their small group products and offer employees a subsidy to purchase a Public Option plan through Nevada Health Link. DHCFP does not have the authority to penalize small businesses for this activity. Furthermore, this activity is lawful today for small businesses to offer subsidies for employees to use in Nevada Health Link toward the purchase of health insurance.

3. **Has there been a thought about an income limit on the Public Option for consumers?**

There is nothing in state law that would provide DHCFP with the authority to impose an income limit on consumers. Also, an income limit below 400% Federal Poverty Level (FPL) would impact the state's ability to capture or maximize new federal savings through a 1332 waiver as advanced premium tax credits are available to consumers up to 400% of FPL. Capturing the savings for this subsidy-eligible population is a critical component of the new state law because the pass-through funds are necessary to support the state's efforts to further improve affordability of health care in today's market with the new pass-through funds (e.g., additional premium subsidies).

4. **Will the Division of Insurance lower the rates for health carriers in Public Option even though it could impact the solvency of the company?**

The Division of Insurance (DOI) will be reviewing rates submitted by health carriers for the individual health insurance market like they do today. There are no changes to this process with the introduction of the Public Option to this market. Health carriers that are awarded contracts for the Public Option are expected to submit rates annually to DOI for review and approval, as they do today when offering health insurance products. These expectations will be outlined in their contracts with the state with respect to the Public Option.

To enforce the new premium reduction targets for the Public Option plans, DHCFP plans to request that health carriers contractually commit to meeting estimated premium targets over the first four-year contract period. Currently, DHCFP anticipates allowing for some flexibility each year with respect to these targets to address any drastic changes in morbidity, medical costs, or inflation in the individual health insurance market even if such changes are specific to certain health carriers. DHCFP must meet the 15 percent premium reduction target by year four of the program, as required by state law.

DHCFP intends to seek feedback on mechanisms for enforcing the premium reduction targets in the contracts including whether the state should include financial penalties or other sanctions if the premium reduction targets set forth in contract are not met during the contract period.

Statute-Related Questions

1. **Is DHCFP planning to seek legislative changes next session to the Public Option based on the actuarial analysis?**

Legislative proposals for the 2023 session are confidential until the Governor's budget is released. We cannot comment on this item at this time. However, DHCFP maintains committed to a successful program, which includes weighing various legislative changes as an option if needed.

2. **What does the statute mean with respect to administering the plans?**

Under NRS 695K.220, the *administration* of the Public Option plans is described as follows:

(1) The Director […] shall use a statewide competitive bidding process, including, without limitation, a request for proposals, to solicit and enter into contracts with health carriers to […] administer the Public Option.

[…]

(5) the provisions of subsections 1 to 4, inclusive, the Director may directly administer the Public Option if necessary to carry out the provisions of this chapter.

DHCFP has determined that it is not necessary for the agency to directly administer the Public Option and that it can carry out the provisions of this chapter through the required contracting and procurement procedures set forth in NRS 695K.220 and the tying requirement of participation with its Medicaid managed care program. Therefore, DHCFP will be administering the Public Option as fully insured products through its authority to contract with health carriers, similar to how the state administers its Medicaid managed care program through contracts with health carriers. This consists of requiring health carriers to bear the financial risk for the population covered and to meet all state and federal health insurance laws.

3. **Where does the pass-through saving go and what can it be used for by the state?**

State law requires that any pass-through funds received by Nevada from the 1332 waiver to be deposited into a state trust fund. This funding must be used to fund state operations for the program, which includes state staff to oversee waiver compliance and to monitor contract performance of health carriers that participate in the Public Option program in addition to marketing and other items related to enrollment in the new products. Additional funds (leftover) after the debts related to state operation costs are paid can be allocated by the Director to policies that improve affordability of coverage for Nevadans. Additionally, the federal government requires states seeking 1332 waivers with pass-through funds to include in their applications how they plan to use the funds. Therefore, a 1332 waiver approval will likely include terms that restrict the usage of these funds in addition to what is outlined in state law.

At this time, DHCFP anticipates proposing that the pass-through funds be used to support new state premium subsidies (or wraps) for all health plans offered through the Nevada Health Link, which includes the Public Option plans. The goal of this effort is to further decrease the cost of health care coverage for Nevadans with the goal of increasing enrollment in health plans through Nevada Health Link and to ensure a stable marketplace for health carriers. DHCFP will seek feedback on this approach as part of the state's public comment period for the 1332 waiver application.