

Assembly Bill No. 374—Assemblymen Sprinkle, Frierson, Araujo, Carlton, Cohen; Elliot Anderson, Benitez-Thompson, Bilbray-Axelrod, Brooks, Bustamante Adams, Carrillo, Daly, Diaz, Flores, Fumo, Jauregui, Joiner, McCurdy II, Miller, Neal, Ohrenschall, Spiegel, Swank, Thompson, Watkins and Yeager

CHAPTER.....

AN ACT relating to health care; requiring the Department of Health and Human Services, if authorized by federal law, to establish a health care plan within Medicaid which is available for purchase by certain persons; requiring the Director of the Department to seek any necessary waivers from the Federal Government to establish such a plan and to provide certain incentives to persons who purchase coverage through such a plan; including the Nevada Care Plan within the qualified health plans that are available through the Silver State Health Insurance Exchange; making an appropriation; and providing other matters properly relating thereto.

**Legislative Counsel's Digest:**

The Patient Protection and Affordable Care Act (Public Law 111-148, as amended) provides a refundable federal income tax credit and cost-sharing reductions to certain eligible persons who earn not more than 400 percent of the federally designated poverty level in order to offset the cost of certain health care plan premiums. (26 U.S.C. § 36B, 42 U.S.C. § 18071; 45 C.F.R. § 155.305) The Act further requires that such credits and cost-sharing reductions only be made available to purchase health insurance which is offered on a state health insurance exchange, which includes, without limitation, the Silver State Health Insurance Exchange established by this State in 2011. (26 U.S.C. § 36B, 42 U.S.C. § 18071; NRS 6951.200) Existing federal law authorizes the Secretary of the United States Department of Health and Human Services to waive certain Medicaid requirements or provisions of the Act to promote state health care innovation. (42 U.S.C. §§ 1315, 18052)

Existing federal law states that the purpose of the Medicaid program is to promote access to health insurance for certain low-income persons. (42 U.S.C. § 1396) Existing law authorizes this State to enroll Medicaid recipients in a managed care program provided by a health maintenance organization pursuant to a contract with the Nevada Department of Health and Human Services. (42 U.S.C. § 1396u-2; NRS 422.273) Existing federal law also authorizes a state to receive its Federal Medical Assistance Percentage (FMAP) allotment of money from the Federal Government to reimburse providers of health care for medical services which are provided as part of a managed care program. (42 U.S.C. §§ 1396d, 1396u-2) Existing law requires this State to develop a State Plan for Medicaid which includes, without limitation, a list of the medical services provided to Medicaid recipients. (42 U.S.C. § 1396a; NRS 422.063) Existing law also prohibits a state from using FMAP or other federal Medicaid money to reimburse a provider of health care for medical services which are provided to a person who earns more than 138 percent of the federally designated poverty level or for other expenses



which are unrelated to the administration of Medicaid. (42 U.S.C. §§ 1396a, 1396b(a)(7); 42 C.F.R. 433.15(b))

**Section 2** of this bill requires the Director of the Nevada Department of Health and Human Services to seek any necessary waiver of certain provisions of federal law to allow the Nevada Care Plan, if established pursuant to **section 3** of this bill, to be offered by certain insurers or for purchase through the Silver State Health Insurance Exchange to persons who are otherwise ineligible for Medicaid. Additionally, **section 2** requires the Director to seek any necessary federal waiver to allow persons to use the federal income tax credits and cost-sharing reductions authorized by the Act to purchase coverage through the Nevada Care Plan. **Section 5** of this bill revises the definition of “qualified health plan” to include the Nevada Care Plan so that it may be offered for purchase in the same manner as other health plans through the Silver State Health Insurance Exchange, if established.

**Section 3** of this bill requires the Department, to the extent allowed by federal law, to establish the Nevada Care Plan within Medicaid and make coverage through the Plan available for purchase to any person who is not otherwise eligible for Medicaid. **Section 3** further requires the benefits offered by the Nevada Care Plan to be the same as those provided to Medicaid recipients who do not participate in the Medicaid managed care program, except that transportation services that are provided when there is not an emergency are not required to be covered.

**Section 5.5** of this bill makes an appropriation to the Division of Health Care Financing and Policy of the Department for costs associated with establishing and administering the Nevada Care Plan.

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

---

---

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

**Section 1.** Chapter 422 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 and 3 of this act.

**Sec. 2.** *The Director shall apply to the Secretary of the United States Department of Health and Human Services for any necessary waiver pursuant to 42 U.S.C. § 1315 or § 18052, as applicable, to:*

*1. Allow the Director to enter into a contract with one or more insurers to provide coverage to persons who enroll in the Nevada Care Plan established pursuant to section 3 of this act and which may be made available for purchase through the Silver State Health Insurance Exchange established by NRS 695I.200; and*

*2. Allow a person who is determined eligible for advance payments of the premium tax credit and cost-sharing reductions pursuant to 45 C.F.R. § 155.305 to use such credits and reductions to purchase coverage through the Nevada Care Plan.*

**Sec. 3.** *1. To the extent allowed by federal law, the Director shall establish the Nevada Care Plan within Medicaid and make*



*coverage available for purchase through the Plan to any person who is not otherwise eligible for Medicaid.*

*2. The coverage provided to a person who enrolls in the Nevada Care Plan must be the same as the coverage provided to recipients of Medicaid who do not participate in a Medicaid managed care program, except that transportation services that are provided when there is not an emergency, including, without limitation, pursuant to NRS 422.27495, are not required to be included in such coverage.*

*3. If the Secretary of the United States Department of Health and Human Services grants any necessary waiver described in section 2 of this act:*

*(a) The Director may enter into a contract with one or more providers of insurance to provide the coverage described in this section to persons who enroll in the Nevada Care Plan; and*

*(b) May make the Nevada Care Plan available for purchase through the Silver State Health Insurance Exchange established by NRS 695I.200.*

*4. The Director shall, in consultation with the Commissioner of Insurance and the Executive Director of the Silver State Health Insurance Exchange, adopt such regulations as necessary to carry out the provisions of this section.*

*5. As used in this section, "provider of insurance" has the meaning ascribed to it in NRS 679A.118.*

**Sec. 4.** (Deleted by amendment.)

**Sec. 5.** NRS 695I.080 is hereby amended to read as follows:

695I.080 Except as otherwise provided in NRS 695I.370, "qualified health plan" ~~has the meaning ascribed to it in~~ **means:**

*1. A health plan which meets the requirements of § 1301 of the Federal Act ~~+~~; or*

*2. The Nevada Care Plan if established pursuant to section 3 of this act.*

**Sec. 5.5.** 1. There is hereby appropriated from the State General Fund to the Division of Health Care Financing and Policy of the Department of Health and Human Services for the administrative expenses to establish and administer the Nevada Care Plan pursuant to sections 2 and 3 of this act the following sums:

For the Fiscal Year 2017-2018 .....	\$89,540
For the Fiscal Year 2018-2019 .....	\$89,540

2. Any balance of the sums appropriated by subsection 1 remaining at the end of the respective fiscal years must not be committed for expenditure after June 30 of the respective fiscal years by the entity to which the appropriation is made or any entity



to which money from the appropriation is granted or otherwise transferred in any manner, and any portion of appropriated money remaining must not be spent for any purpose after September 21, 2018, and September 20, 2019, respectively, by either the entity to which the money was appropriated or the entity to which the money was subsequently granted or transferred, and must be reverted to the State General Fund on or before September 21, 2018, and September 20, 2019, respectively.

**Sec. 6.** 1. This section and sections 1 and 2 of this act become effective upon passage and approval.

2. Section 5.5 of this act becomes effective on July 1, 2017.

3. Sections 3, 4 and 5 of this act become effective upon passage and approval for the purpose of adopting regulations and performing any other preparatory administrative tasks that are necessary to carry out the provisions of this act and on January 1, 2019, for all other purposes.

