Nevada Strategies to
Curb Excess Costs in the System

Premium Rate Review

States can limit excessive health insurance premium increases through rate review, in which regulators assess proposed hikes to ensure they reflect accurate data and reasonable cost projections. The Affordable Care Act (ACA) set federal standards for effective review, and states meeting these are recognized by the Centers for Medicare and Medicaid Services (CMS). States may also establish the authority to approve or deny rate increases and incorporate affordability criteria into their evaluations. Strategies examined in this section include:

- Effective Rate Review Per CMS
- Authority to Modify or Reject Premium Rate Increases
- Affordability Criteria Included in Premium Rate Review

Hospital Price Regulation

Some states have pursued hospital cost control through reference-based pricing or global budgets. Reference-based pricing sets payment at a fixed rate, typically a multiple of Medicare, while global budgets establish a prospective annual payment for defined services, shifting responsibility to providers and payers to manage costs within that limit. This section tracks states that utilize:

- Medicare Reference-Based Pricing
- Hospital Global Budgets

Affordable Coverage

States can expand access to affordable coverage by offering state-funded premium subsidies for Marketplace plans or by operating subsidized health coverage such as a Public Option or Basic Health Plan. Public Options are state-administered insurance programs designed to increase competition and control costs through negotiated provider rates. These program designs vary across states, with differences in cost-containment strategies, network adequacy requirements, and reimbursement structures. Strategies examined in this section include:

- Whether the State has Implemented a Public Option
- Whether the Public Option Includes a Provider Participation Mandate
- If the state Operates a Basic Health Plan
- If the State Provides State-Based Premium Subsidies for Marketplace Coverage

Prescription Drug Pricing

Rising prescription drug costs continue to strain households, employers, and state budgets, with specialty drugs driving a growing share of spending. Unlike most consumer goods, drug prices in the U.S. often increase year over year, even after launch, and lack of transparency across the supply chain enables sustained price escalation. Manufacturers and pharmacy benefit managers (PBMs) use rebates, coupons, and contracting practices that can obscure true costs and shift expenses to consumers.

States are adopting a range of strategies to improve transparency, promote generic utilization, and curb excessive pricing. These include regulating PBM practices such as spread pricing, restricting the use of manufacturer coupons, requiring rebate transparency, and establishing collaborative purchasing or rebate arrangements. This section examines whether states have implemented tools to lower drug prices, enhance accountability, and expand access to affordable medications through:

- Prescription Drug Pricing Consortiums
- Prohibitions on Drug Manufacturer Coupons for Specialty Drugs
- Prohibitions on Copay Accumulator Programs
- Biologic Substitution Laws to Increase Generic Utilization
    - Authorization Flexibilities
    - Notification Requirements
- Drug Carve Outs in Medicaid Managed Care
- FFS Policies to Promote Generic Utilization
    - Mandatory Generics
- Supplemental Rebate Programs or Arrangements
- Drug Rebate Transparency and Reporting Requirements
- Spread Pricing Restrictions
- Prohibitions on Retroactive Claims Reductions or “Clawbacks”
- Prohibitions on Cost-Disclosure and Gag Clause Restrictions

Medicaid Costs

Medical Loss Ratio remittance ensures managed care organizations (MCOs) spend a minimum percentage of premium revenue on actual medical care and quality improvement rather than administrative costs or profit. If they fail to meet the threshold, excess funds are returned to the state. By enforcing MLR standards, states help guarantee that Medicaid beneficiaries receive value for the funds allocated to their care, improving transparency and trust in managed care systems. Returned funds can be reinvested into Medicaid programs, expanding coverage or enhancing benefits without increasing state budgets.

Site-neutral policies standardize reimbursement rates across care settings (e.g., hospital outpatient departments vs. physician offices), reducing incentives for providers to steer patients toward higher-cost settings. Aligning payments helps curb unnecessary spending and mitigates cost growth in Medicaid programs, which is critical for states managing tight budgets.

- States Utilize Medical Loss Ratio Remittance
- Medicaid Site Neutral Requirements

Curb Excess Costs in the System

Premium Rate Review

Policy	Status as of June 2025	Summary
Effective Rate Review per Centers for Medicare and Medicaid Services (CMS)	● Has an effective rate review process	
Authority to Modify or Reject Premium Rate Increases	● Has the authority to modify or reject premium rate increases*	Nevada has the authority to approve or deny rate filings in the individual and small group market. We are unable to corroborate whether the state has approval authority over fully-insured large group health plans in 2025.
Affordability Criteria Included in Premium Rate Review	⊗ Does not incorporate affordability criteria into premium rate review	

● State Has Active Policy or Program ◉ Policy or Program Partially Implemented ⊗ State Does Not Have an Active Policy or Program * No Source, or Limited Information Found

Curb Excess Costs in the System

Hospital Price Regulation

Policy	Status as of June 2025	Summary
Medicare Reference-Based Pricing	⊗ State does not use reference-based pricing tied to Medicare rates to regulate hospital pricing	Starting January 1, 2026, Nevada will offer Public Option plans with reimbursement rates at or above Medicare levels. In 2025, the state considered AB 349 to cap hospital and provider charges to the Public Employees' Benefits Program and local governments at 175% of Medicare, but the bill did not pass.
Hospital Global Budgets	⊗ State has not implemented hospital global budgets	

● State Has Active Policy or Program ◉ Policy or Program Partially Implemented ⊗ State Does Not Have an Active Policy or Program ✱ No Source, or Limited Information Found

Curb Excess Costs in the System

Affordable Coverage

Policy	Status as of June 2025	Summary
Public Option	⊗ State does not offer an active public option insurance plan	Nevada SB 420, passed in 2021, initiated efforts to create a statewide Public Option, with plans expected to launch in January 2026. These plans will be required to meet qualified health plan standards and reduce premiums by at least 5% per zip code until 2030, targeting a 15% overall reduction. While reimbursement rates are not planned to be capped at a certain threshold, a rate floor for critical access hospitals and primary care providers will likely be included.
Public Option Includes Provider Participation Mandate	⊗ State does not does not offer a public option, with or without a participation mandate	
Basic Health Plan	⊗ State does not operate a Basic Health Plan	
State-Based Premium Subsidies	⊗ State does not offer supplementary state-funded premium subsidies	

● State Has Active Policy or Program ◉ Policy or Program Partially Implemented ⊗ State Does Not Have an Active Policy or Program ✱ No Source, or Limited Information Found

Curb Excess Costs in the System

Prescription Drug Pricing

Policy	Status as of June 2025	Summary
Biologic Substitution Laws: Prescriber Permission Requirements	State does not require express authorization for biologic substitution	Pharmacists in Nevada may substitute an interchangeable biosimilar for the originator biologic without prior approval from the prescribing physician if the substitution is less expensive than the biological product prescribed.
Biologic Substitution Laws: Prescriber Notification Requirements	Pharmacists are required to notify prescribers of biologic substitution	Pharmacists in Nevada are required to notify the prescribing physician of a substitution within three business days.
Drug Purchasing Consortium	State participates in a drug purchasing consortium (see note)	Nevada is a member of ArrayRx (formerly the Northwest Prescription Drug Consortium) as well as the National Medicaid Pooling Initiative.
Drug Coupon Prohibitions	State does not prohibit the use of drug manufacturer coupons*	
Medicaid Managed Care Organization (MCO) Carve Out	State Medicaid carves out any drug classes from their MCO benefits (see note)*	As of July 1, 2023, Nevada carves out the following drugs/classes from MCO benefits: Spinal muscular atrophy agents.
Mandatory Generics in Medicaid Fee-for-Service (FFS)	Medicaid Fee-for-Service (FFS) programs and pharmacists are required to substitute a generic version of a drug	Nevada has policies or tools to promote mandatory generics.

State Has Active Policy or Program | Policy or Program Partially Implemented | State Does Not Have an Active Policy or Program | * No Source, or Limited Information Found

Curb Excess Costs in the System

Prescription Drug Pricing

Policy	Status as of June 2025	Summary
Supplemental Rebate Programs	Medicaid Pharmacy Supplemental Rebate Agreement (SRA) in place	
Drug Rebate Transparency and Reporting Requirements	Pharmacy benefit managers are required to report rebate data to the state	
Spread Pricing Restrictions	State prohibits pharmacy benefit managers from engaging in spread pricing	
Pharmacy Benefit Manager Reimbursement and Clawbacks	State does not prohibit PBMs from retroactively reducing reimbursement to pharmacies (“clawbacks”)	
Cost-Disclosure and Gag Clause Restrictions	State law prohibits gag clauses in pharmacy contracts	
Prohibits Copay Accumulator Programs	State does not prohibit copay accumulator programs	

State Has Active Policy or Program | Policy or Program Partially Implemented | State Does Not Have an Active Policy or Program | * No Source, or Limited Information Found

Curb Excess Costs in the System

Medicaid Costs

Policy	Status as of June 2025	Summary
Medical Loss Ratio Remittances (MLR) for Medicaid Managed Care Population	State requires MLR remittances for its Medicaid managed care population	
Medicaid Site Neutral Payments	State has not enacted Medicaid site neutral payment legislation*	

State Has Active Policy or Program | Policy or Program Partially Implemented | State Does Not Have an Active Policy or Program | * No Source, or Limited Information Found

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