2017 Filing Guidance Part II

Review Timeline

- May 2nd — Filings and binders due
- May 13th — DOI sends first objection letter
- May 27th — Carrier response due in SERFF
- June 10th — DOI sends second objection letter
- June 24th — Carrier response due in SERFF
- July 8th — DOI sends third objection letter
- July 22nd — Carrier response due in SERFF
- August 12th — DOI makes final determinations

DOI Website Rates Posting Timeline

- May 6th all rate filings simultaneously displayed
- May 20th all proposed rates simultaneously displayed along with approved EOC
- October 2nd all approved rates simultaneously displayed
- November 1st SOBs and links to provider networks and formularies displayed

Common 2017 EOC Objections

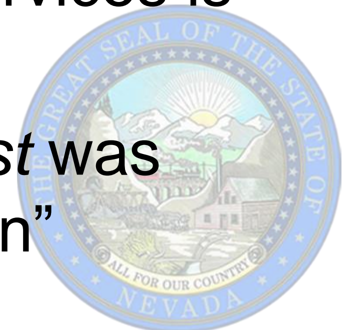
- "Please include additional language in your EOCs consistent with AB 292 that informs members of their rights under this law"
- "This section needs to include coverage for early refills of topical ophthalmic products due to inadvertent wastage by patients pursuant to SB 217"
- "This section needs to provide coverage for synchronized medication packs dispensed by a pharmacy pursuant to SB 250"
- "Senate Bill 137 mandates that a health plan is always secondary to a dental plan for certain services"

Common 2017 EOC Objections

- “Your visit limit for ABA is your actuarial equivalency of $36,000. For 2017, carriers must provide the actuarial equivalency of $72,000 of coverage”
- “Please include an exception to your OTC exclusion for FDA approved OTC contraceptive methods”
- “Please explain how this exclusion is compliant with MHPAEA”
- “This exclusion is not compliant with DOI Bulletin 15-002”
- “Treatment for complications from Bariatric Surgery must be covered the same as any other illness”

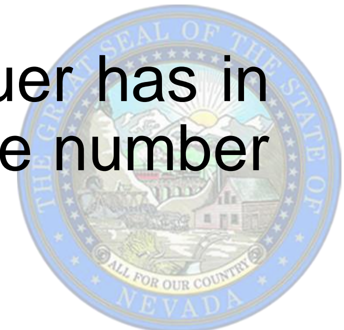
Common 2017 EOC Objections

- “Please explain how excluding treatment for injuries resulting from attempted suicide is not a violation of MHPAEA”
- “Since gambling disorder is now considered a substance-related and addictive disorder and is no longer categorized as an impulse control disorder in the DSM-5, please explain why coverage for medically necessary gambling disorder treatments and services is excluded”
- “The definition of *Autism Behavior Interventionist* was revised by AB 6 passed during the 2015 Session”



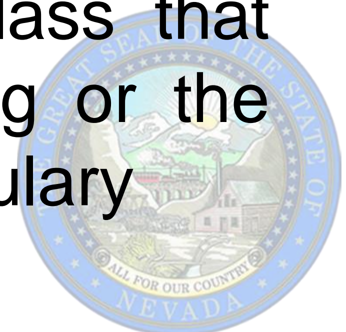
Marketwide Review Tools

- Master Review Tool
  - Aggregates data from the Plans & Benefits, Service Area, and Essential Community Provider (ECP)/Network Adequacy (NA), and Prescription Drug templates
  - Serves as a data input file to the other stand-alone tools
- ECP Tool
  - Calculates the total number of ECPs an issuer has in each plan's network and compares this to the number of available ECPs in that service area



Marketwide Review Tools

- Formulary Drug Count Review Tool
  - Compares the count of unique chemically distinct drugs in each USPv6 category and class for each drug list with the benchmark
  - Utilizes 2017 Nevada EHB Benchmark Formulary data
  - Identifies each USPv6 category and class that has fewer than the greater of one drug or the number of drugs in the Benchmark Formulary



Marketwide Review Tools

- Non-Discrimination Tool
  - Performs an outlier analysis for all plans within each market segment in Nevada
  - Goes through a group of pre-determined benefits and identifies plans that have a significantly higher copay or coinsurance for those benefits
  - Outliers identified by this tool could potentially be discriminatory
- Formulary Outlier Review Tool
  - Identifies and flags as outliers those plans that have unusually large numbers of drugs subject to prior authorization and/or step therapy requirements in 25 USP classes

QHP Review Tools

- Data Integrity Tool
  - Identifies critical data errors within and across templates
  - Conducts validation checks beyond the standard HIOS and SERFF checks
  - Looks across templates for consistency in key fields
  - Produces error reports that describe the error and its location in the template

QHP Review Tools

- Meaningful Difference Tool
  - Compares all plans an issuer offers to check whether there are multiple plans that would appear virtually identical to a consumer
  - Only reviews benefits that are displayed to consumers
- Cost Sharing Tool
  - Runs 4 different checks for cost sharing standards: Maximum Out of Pocket (MOOP) Review, Cost Sharing Reduction (CSR) Plan Variation Review, Standardized Plan Design Review, and Catastrophic Plan Review

QHP Review Tools

- Plan ID Crosswalk Tool
  - Checks that the Plan ID Crosswalk Template has been completed accurately and is compliant with 45 C.F.R. 155.335(j)
  - Ensures that all counties in all QHPs that were offered in 2016 are included in the crosswalk
  - Verifies that plans are crosswalked to valid 2017 plans
  - Checks that the crosswalk reasons selected are consistent with plan offerings

2017 Network Adequacy

Network Adequacy Regulation

- Applies to individual and small group health benefit plans
- Exemption for a carrier with fewer than 1,000 covered lives in the preceding calendar year or 1,250 lives anticipated in the next year
- Exemption for grandfathered plans

Network Adequacy Regulation

- Standards defined in CMS Letter to Issuers is default set of standards if no standards are released by the Commissioner
- Advisory Council recommends requirements and standards for network plans to the Commissioner by 9/15 of each year
- Commissioner releases requirements and standards for network plans after 10/15 of each year
- Commissioner revises requirements and standards for network plans if they do not conform to the standards released in a future CMS Letter to Issuers

Network Adequacy Submission

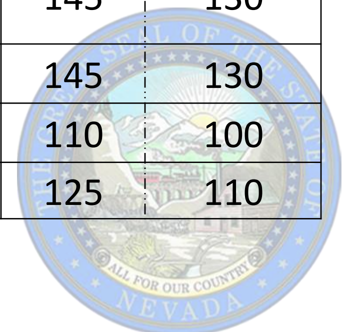
- Carriers must submit network plan applications no later than May 2nd
- Application consists of validated CMS ECP/Network Adequacy Template and 2017 Nevada Declaration Document within each risk pool binder

Network Adequacy Timeline

- May 2nd — Network Plan applications due
- May 13th — DOI sends first objection letter
- May 27th — Carrier response due in SERFF
- June 10th — DOI sends second objection letter
- June 24th — Carrier response due in SERFF
- July 8th — DOI sends third objection letter
- July 22nd — Carrier response due in SERFF
- July 29th — DOI makes final determinations

2017 Network Adequacy Standards

Type	Specialty	Metro		Micro		Rural		CEAC	
		Max Time (Mins)	Max Distance (Miles)	Max Time (Mins)	Max Distance (Miles)	Max Time (Mins)	Max Distance (Miles)	Max Time (Mins)	Max Distance (Miles)
Provider	Primary Care	15	10	30	20	40	30	70	60
	Endocrinology	60	40	100	75	110	90	145	130
	Infectious Diseases	60	40	100	75	110	90	145	130
	Mental Health	45	30	60	45	75	60	110	100
	Oncology - Medical/Surgical	45	30	60	45	75	60	110	100
	Oncology - Radiation/Radiology	60	40	100	75	110	90	145	130
	Rheumatology	60	40	100	75	110	90	145	130
Facility	Hospitals	45	30	80	60	75	60	110	100
	Outpatient Dialysis	45	30	80	60	90	75	125	110

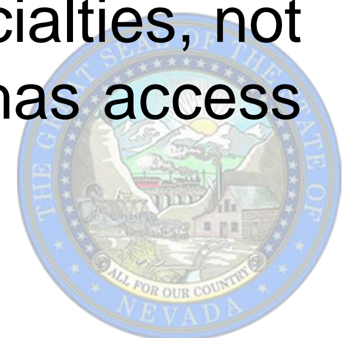


Nevada County Designations

Rank	Population Density	County / Population	Designation
1	351.5/sq mi	Carson City, NV / 55,274	Metro
2	242.1/sq mi	Clark, NV / 1,951,269	Metro
3	64.4/sq mi	Washoe, NV / 421,407	Metro
4	63.7/sq mi	Douglas, NV / 46,997	Micro
5	25.7/sq mi	Lyon, NV / 51,980	Micro
6	15.2/sq mi	Storey, NV / 4,010	Rural
7	5.0/sq mi	Churchill, NV / 24,877	CEAC
8	2.8/sq mi	Elko, NV / 48,818	CEAC
9	2.4/sq mi	Nye, NV / 43,946	CEAC
10	1.7/sq mi	Humboldt, NV / 16,528	CEAC
11	1.3/sq mi	Mineral, NV / 4,772	CEAC
12	1.1/sq mi	White Pine, NV / 10,030	CEAC
13	1.1/sq mi	Pershing, NV / 6,753	CEAC
14	1.0/sq mi	Lander, NV / 5,775	CEAC
15	0.5/sq mi	Lincoln, NV / 5,345	CEAC
16	0.5/sq mi	Eureka, NV / 1,987	CEAC
17	0.2/sq mi	Esmeralda, NV / 783	CEAC

Network Adequacy Methodology

- We will be using a random sample of 5% of the 0-64 aged population to test Network Adequacy
- For each specialty and standard, issuer-submitted data will be reviewed to make sure that the plan provides access to at least one provider in each listed provider type for at least 90 percent of enrollees
- For example, a plan covering Clark, Washoe and Nye will have to ensure that 90% of the population in all of Clark, Washoe and Nye has access to each of the Specialties, not that 90% of Clark has access, 90% of Washoe has access and 90% of Nye has access, individually



Network Adequacy Methodology

- Examples of our Provider Counting Method:

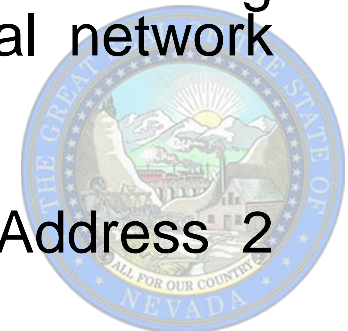
➢ The following codes fall under Primary Care: 001 - General Practice, 002 – Family Medicine, 003 – Internal Medicine, 005 – Primary Care - Physician Assistant, 006 - Primary Care - Nurse Practitioner

➢ The following codes fall under Hospitals: 040 – General Acute Care Hospital, 043 – Critical Care Services – Intensive Care Units (ICU)

➢ Most of the other specialties contain only one code

Network Adequacy Review Process

- May 2nd Network Plan applications due. The Division will do a preliminary review of the data submitted and provide an objection within 2-3 days if it is determined that the submission is incomplete or insufficient to begin Network Adequacy review
- Issues experienced in prior years
  - Incomplete provider list such as omitting providers for a particular city or county within the service area, e.g. forgetting to include providers in Pahrump
  - Submitting incorrect network providers such as submitting small group network providers for an individual network plan
  - Incorrect or invalid provider addresses
  - Suites and Office numbers should be in the Address 2 Column

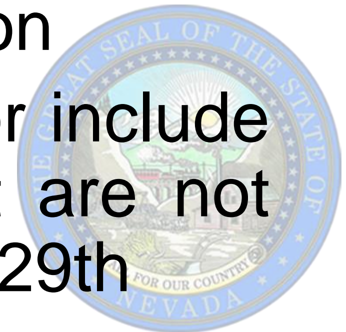


Network Adequacy Review Process

- May 13th DOI sends objection letter identifying deficiencies in network plan
- May 27th Carrier submits revised Network Adequacy template or a justification and access plan
- The timeline allows for additional objections and responses, but due to the strict time constraints, carriers are encouraged to address any objections as promptly as possible

Network Adequacy Review Process

- Justification should describe any established patterns of care and the availability of providers in the specialty type related to the deficiency within the applicable geographic service area. See the Justifying Deficiencies slide for more detail
- Access Plan should be based upon established patterns of care
- For known deficiencies, carriers should submit Access Plans with the preliminary submission
- Network plans which satisfy all standards or include approved access plans for standards that are not satisfied will be approved no later than July 29th



Network Adequacy Review Process
Justifying Deficiencies

The justification should include the following:

1. An explanation of how the issuer will provide reasonable access to healthcare providers in the county(ies) identified and any other considerations and information that the issuer believes is pertinent, such as applicable patterns of care, information about provider availability in the area, and applicable policies and procedures.
2. The explanation cited in number 1 should address each county/specialty combination specifically listed in the objection.
3. The issuer should state if it has received enrollee complaints about the lack of access to healthcare providers in the identified county(ies), and if so, the number of these complaints and an explanation of how the complaints were resolved.
4. An explanation of the current recruitment efforts in each county specifically listed in the objection.
5. An explanation of the applicable policy or pattern of care when in-network providers are not available and enrollees are required to use an out-of-network provider for treatment purposes.