2017 Filing Guidance Part I

Future Webinars

- March 7th at 1:30PM Rate Filings
- March 24th at 10:30AM Network Adequacy
- April 7th at 10:30AM Filing Guidance Part II

Filing Timeline

- All form/rate and binder submissions for non-grandfathered individual and small group health benefit plans and stand-alone dental plans must be submitted no later than May 2, 2016

- Individual and small group health EOCs were due March 1, 2016

Risk Pool Filings

- All risk pool products must be submitted within a single form/rate SERFF filing
- Plans within a product vary by cost sharing structure, network, formulary or service area
- Benefit variability within a product will not be allowed
- Cost share variability within a plan will not be allowed

Risk Pool Binder Submissions

- A binder is required for each market segment (individual and small group) from each carrier
- Must include validated Plan Management templates
- Must include the following network adequacy supporting data and documentation:
  - CMS Network Adequacy Template
  - Declaration Document

Risk Pool Binder Templates

The following validated templates are required for each non-QHP risk pool:

- Plans and Benefits Template
- Prescription Drug Template
- Network ID Template
- Service Area Template
- ECP/Network Adequacy Template
- Rate Data Template
- Business Rules Template

Health Form/Rate Filings

- Redlined versions of SOBs for existing plans
- Clean copies of the SOBs and EOCs for each approved plan along with Formulary and Provider URLs must be submitted for display on the DOI website no later than 10/21/16
- AV calculator input and output for each plan
- Data and documentation supporting autism dollar limit substitution

Actuarial Value – AV Calculator

- Actuarial support should include:
  - A description and explanation of any differences between results from the Plans & Benefits template and stand-alone AV calculator
  - A description of any features not included in the AV calculator
  - Actuarial certification of AV calculator results

Actuarial Value - Unique Plan Design

- Actuarial support should include:
  - Reasons plan design incompatible with AV calculator
  - Design differences cited must be material
  - Identification of alternative method pursuant to:
    1. 45 CFR 156.135(b)(2) or
    2. 45 CFR 156.135(b)(3)
  - Standardized plan population data used
  - Description of data, assumptions and methods used
- May use the FFM's Unique Plan Design Supporting Documentation and Justification form

P&B Template Actuarial Value

- Actuarial value must be generated within the Plans & Benefits Template for all plans that are not unique plan designs
- The Template generated AV must match the output from the AV calculator

Dental Form Filings

- Redlined versions of all forms for existing plans must be submitted
- Stand-Alone Dental Plan AV Supporting Documentation & Justification, signed by a certified actuary
- Explanations of Type I, Type II, Type III, and Type IV dental services must be included within each schedule of benefits
  - Every service does not need to be listed in the Schedule of Benefits; however, important services of each category should be listed
- A detailed list of pediatric dental services must be included in the Evidence of Coverage

2017 Nevada EHB Benchmark Plan

- HPN Solutions HMO Platinum 15/0/90%
- Plan includes embedded pediatric dental and vision consistent with NV CHIP and FEDVIP, respectively
- HPN actuarial equivalent substitutions for prior dollar limits become coverage floor
- Habilitation in parity with rehabilitation but combined limit not allowed in 2017
- Plan exclusionary language was effective 1/1/2014 and may no longer by compliant with state or federal rules

Plans & Benefits EHB Add-In

- Auto populates benefit explanation field based upon the 2014 HPN Solutions HMO Platinum 15/0/90% plan
- A carrier will need to correct this field for QHPs to describe its own medical management requirements or other limitations
- The auto populated combined visit limit of 120 for Outpatient Rehabilitation Services and Habilitation Services is not compliant for 2017 and must be changed

Additional Form Requirements

- Minimum coverage of the actuarially equivalent of $72,000 must be provided for autism
- Stand-alone dental plans are primary for services provided by an oral and maxillofacial surgeon
- Coverage mandated for early refills of topical ophthalmic products due to inadvertent wastage by patients
- Coverage mandated for synchronized medication packs dispensed by a pharmacy
- Combined habilitation and rehabilitation benefit limits prohibited

Telehealth AB 292

- A policy of health or dental insurance must include coverage for services through telehealth to the same extent as though provided in person or by other means
- A carrier shall not:
  - Require an insured to establish a relationship in person
  - Refuse to provide coverage because of the distant site from which a provider delivers services through telehealth
  - Refuse to provide coverage because of the originating site at which an insured receives services through telehealth
- A policy of health or dental insurance must not require an insured to obtain prior authorization for any service provided through telehealth that is not required for the service when provided in person

Plan Service Area

- QHP and SADP service areas must equal one or more rating territories
- Nevada's rating territories for 2017 are unchanged
- Off-exchange plan service areas may use partial counties
- The Service Area Template does support service areas defined by a collection of Zip Codes

US DOL FAQs October 23, 2015

- Carriers must provide access to lactation counseling providers within network
- Breastfeeding equipment must be provided without cost sharing for the duration of breastfeeding
- Carriers cannot impose cost sharing for consultation prior to colonoscopy
- Pathology exam on a polyp biopsy must be covered without cost sharing
- Genetic counseling and BRCA testing must be provided without cost sharing for women found to be at increased risk
- Criteria for making medical necessity determinations must be disclosed upon request following prior authorization denial

Prescription Drugs

- Health plans must cover at least the greater of: (1) one drug in every United States Pharmacopeia (USP) therapeutic category & class; or (2) the same number of drugs in each USP category & class as Nevada's benchmark plan
- Our benchmark is Solutions HMO Platinum 15/0/90%

Formulary Modifications

- A carrier shall neither remove a drug nor increase the cost share for a drug from an approved formulary for an individual benefit plan unless:
  - The drug is not approved by the FDA;
  - The FDA issues a notice, guidance or warning concerning the safety of the drug; or
  - The drug is approved by the FDA for use without a prescription.
- Final drug lists must be submitted by 9/16/16
- Individual market formularies will be approved and locked down on 10/14/16

Formulary Template

- Issuers should complete cost-sharing fields in the Prescription Drug Template for the most typical or most utilized benefit cost-share design
- Issuers can describe any cost-sharing features that do not directly fit into the Prescription Drug Template in the Benefit Explanation field of the Plans & Benefits Template
- Issuers should place preventive drugs in a separate Zero Cost Share Preventive tier in the Prescription Drug Template

Division of Insurance Website

- Proposed 2017 rates and approved redlined EOCs will be posted on the DOI website on May 20th
- Approved 2017 rates will be posted on October 2nd
- Clean copies of the Schedule of Benefits and Evidence of Coverage for each approved plan must be submitted for display on the DOI website no later than 10/21/16
- The approved schedule of benefits and evidence of coverage for each plan will be posted by November 1st
- Website will use “Plan Marketing Name” from Plans & Benefits Template

MOOP and Deductible Guidance

- For 2017 individual and small group health benefit plans, the maximum out-of-pocket will be
  - $7,150 single, $14,300 family
- For 2017 HSA plans, the maximum out-of-pocket will be
  - $ single, $ family
- For 2017 HSA plans, the minimum deductible will be
  - $ single, $ family

MOOP and Deductible Guidance

- For the 73 percent AV silver plan variations, the maximum out-of-pocket will be
  - $5,700 single, $11,400 family
- For the 87 percent and 94 percent AV silver plan variations, the maximum out-of-pocket will be
  - $2,350 single, $4,700 family

Student Health Insurance

- Rates and forms are subject to prior approval
- Coverage does not have to be at a metallic level but must have a minimum actuarial value of 60 percent
- Carriers must disclose, in any plan materials summarizing the terms of the coverage, the actuarial value of the coverage and the metal level (or next lowest metal level) the coverage would satisfy
- Carriers must include, in any plan materials summarizing the terms of the coverage, information on other options available including coverage with financial assistance through the Marketplace

Student Health Insurance Rates

- Carriers may establish one or more separate risk pools for each college or university
- Premium rates for each risk pool must reflect the claims experience of individuals who comprise the risk pool, and any adjustments to rates within a risk pool must be actuarially justified
- In developing rates for student health products, reasonable consideration must be given to other coverage options that may be available to students
- Students with significant health needs may have more attractive options within the individual health market, particularly for Student Health Center Gatekeeper plans

Small Group Issues

- Composite premium approach
  - Two-tiered Composite premium: adults (age 21 and older) and children (under 21)
- Tobacco rating: applied separately, on a per-member basis
- Carriers cannot impose contribution or participation rules for small employers that apply for coverage between 11/15 and 12/15 of each year
- Quarterly rate updates allowed:
  - Standardized rate effective dates (January 1, April 1, July 1, October 1). No monthly trend adjustments.
  - Plans included in risk pool on January 1 must be available upon request for the entire calendar year
  - New plans may be added quarterly

Pediatric Dental

- Pediatric dental is not required to be embedded in a medical plan outside the Exchange if the issuer is reasonably assured certified stand-alone coverage has been obtained
- Nevada will consider self-attestation by an applicant to be “reasonable assurance”
- The issuer must obtain “reasonable assurance” that the consumer has certified stand-alone coverage every year at renewal

Benefit Waiting Periods

- Waiting periods are generally not allowed for essential health benefits
- Carriers may require a reasonable waiting period for pediatric orthodontia
- The DOI will not approve pediatric orthodontia waiting periods in excess of 12 months

SOB: Embedded Pediatric Dental

- Explanations of Type I, Type II, Type III, and Type IV dental services must be included
  - Important services of each category must be listed
  - A detailed list of pediatric dental services must be included in the Evidence of Coverage

SOB: Embedded Pediatric Dental

- The calendar year deductible applicable to pediatric dental services must be prominently displayed on page 1 of the benefit schedule
- For pediatric dental, Type I dental services (preventive and diagnostic services) cannot be subject to the deductible

Stand-Alone Dental Plans

- 2017 SADPs are allowed an out-of-pocket maximum of $350 for one covered child and $700 for two or more covered children
- Type I dental services (preventive and diagnostic services) should not be subject to a deductible
- Binders are required for all SADPs seeking certification for sale on or off the exchange
- Individual SADP expense ratio limited to 25%

AV for Stand-Alone Dental

- SADP cannot use the AV calculator
- Must demonstrate that the plan offers essential health benefits at:
  - A low level of coverage – 70%
  - A high level of coverage – 85%
- Allows for a de minimis range of +/- 2%
- Must be certified by an actuary

QIS Report

- For carriers that have participated on the Nevada exchange for two consecutive years with an enrollment in excess of 500 covered lives, a Quality Improvement Strategy is required within the binder submission

2017 Exchange Fees

- 3.15 percent of premium for QHPs and SADPs
- SSHIX will bill and collect the fees directly from carriers

Q & A