

Division of Insurance

Plan Year 2018 Filing Guidance



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Future Webinars

- May 18th at 9:00AM Open Q&A
- June 1st at 9:00AM Open Q&A
- June 29th at 9:00AM Open Q&A



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Filing Timeline for Exchange Carriers

- All QHP and on-Exchange SADP binders must be submitted in SERFF no later than June 12th
 - Network adequacy application for all networks must be included within this binder
- Rate filings and form filings for new carriers due May 17th
- All QHP and non-QHP form filings for existing carriers due June 12th
- All rate filings for existing QHP carriers due June 12th



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Filing Timeline Off-Exchange

- Rate filings and form filings for new carriers due May 17th
- All non-QHP form filings for existing carriers due June 12th
- Rate filings for existing carriers due July 17th
- All non-QHP and off-Exchange SADP binders must be submitted in SERFF no later than June 12th
 - All risk pool plans should be included within this binder
 - Network adequacy application for networks must be included within this binder



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Risk Pool Filings

- Any set of plans that share a network type and a set of benefits is a product
- 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



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Binder Submissions

- A single binder for each risk pool is required (individual and small group) from each carrier due June 12th
- Must include validated Plan Management templates
- Must include the following network adequacy supporting data and documentation:
 - CMS Network Adequacy Template
 - Declaration Document



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Binder Templates

The following validated templates are required for each 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



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Health Form Filings

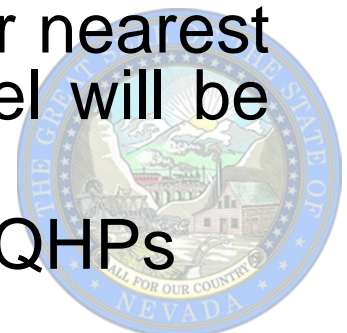
- QHP forms and non-QHP forms may be submitted using separate form filings
- Redlined versions of SOBAs and EOCs for existing plans
- Clean copies of the SOBAs and EOCs for each approved plan along with Formulary and Provider URLs must be submitted for display on the DOI website no later than 10/20/17
- AV calculator input and output for each plan



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Removing Plans From a Product

- Individual carriers may remove plans from a product each year
- If a product is not being discontinued, all policyholders within the remaining service area of this product must receive a notice of renewal with altered terms pursuant to NRS 687B.420
 - Policyholders must be mapped to a plan within this product at the same metallic level (or nearest metallic level if no plan at the same level will be available)
 - Mapping not required from non-QHPs to QHPs



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5-Year Ban on Market Reentry

- A product may be considered the same product when offered by a different carrier within a carrier's controlled group
- The ceding carrier would not be considered to have performed a market withdrawal when transferring all of its products within its controlled group
- A carrier may replace all of its existing products with new products without triggering a market withdrawal, as long as the carrier matches new products with existing products for purposes of subjecting the new products to Federal rate review requirements



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Final CMS Rule - Past-Due Premium

- A carrier may attribute to any past-due premium amounts owed to that carrier the initial premium payment made in accordance with the terms of the health insurance policy to effectuate coverage
- If the carrier is a member of a controlled group, the carrier may attribute any past-due premium amounts owed to any other carrier that is a member of such controlled group, for coverage in the 12-month period preceding the effective date of the new coverage
- A different carrier other than the carrier owed the premium or a member of the same controlled group may not deny coverage for premiums owed



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Final CMS Rule - Past-Due Premium

- This applies both inside and outside of the Exchange in the individual, small group, and large group markets
- A carrier shall not hold the dependent of a previous policyholder, when that dependent was covered under that previous policyholder's policy, or the employee, when his or her employer was the previous policyholder, responsible for past-due premium of the previous policyholder
- A policyholder is responsible for the payment of premium for any month during which the carrier has paid or was liable for the payment of claims
 - A QHP enrollee with APTC is responsible for the payment of premium for the first month of the three month grace period, net of any APTC paid on their behalf to the carrier



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Claims Payments During Grace Period

- Carriers are required to pay all appropriate claims for services rendered to the enrollee during any months of coverage for which past-due premiums are collected
- In the case of enrollees in the 3 consecutive month grace period
 - a QHP carrier must pay all appropriate claims for services rendered to the enrollee during the first month of the grace period regardless of whether past-due premiums are paid
 - must notify providers of the possibility for denied claims when an enrollee is in the second and third months of the grace period
 - Carrier can keep the first month's APTC, but must refund the payments received for the second and third month if the consumer fails to catch up during that time



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Partial Premium Payments

- Carriers may set and apply a threshold for the acceptance of partial premium payments
 - Provided that it is uniformly applied for individuals or employers in similar circumstances in the applicable market segment;
 - Without regard to health status; and
 - Consistent with applicable nondiscrimination requirements
- Carriers that choose to apply a payment threshold policy must apply the policy in a uniform manner to all enrollees, and are expected to do so for the entire plan year
- The policy must be applied uniformly to the initial premium payment and any subsequent premium payments, and to any amount outstanding at the end of a grace period



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Open Enrollment for 2018 and Beyond

- Open enrollment for each upcoming benefit year begins on November 1st and runs through December 15th
- In the small employer market, carriers cannot impose participation or contribution requirements for employers that apply for or renew coverage between November 15th and December 15th



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SEP Changes

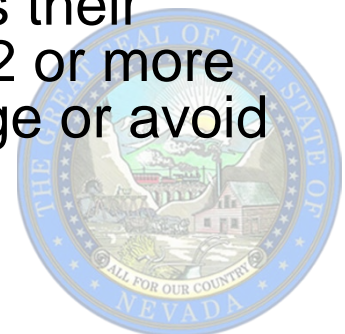
- Dependents may enroll in the same plan as the primary or a different QHP at any metal level
 - Parent cannot follow new dependent to a different QHP or metal level
 - Parent may move with new dependent if business rules of the existing QHP do not allow new dependent to be added
- A new spouse or domestic partner may only enroll if at least one partner had minimum essential coverage or lived in a foreign country or in a U.S. territory at least 1 day during the preceding 60 days before marriage
- Consumers claiming eligibility under the permanent move SEP would also have to show coverage for one or more days during the previous 60 days
- Carriers allowed to reject SEP enrollments for loss of minimum essential coverage where the applicant earlier lost coverage for non-payment of premiums



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SEP Verification on Healthcare.gov

- Implementation of pre-enrollment verification of special enrollment periods will be phased in beginning June 2017, focusing first on the categories with the highest volume and of most concern
 - Loss of minimum essential coverage
 - Permanent move
 - Medicaid/CHIP denial
 - Marriage, and adoption
- Consumers may start their coverage no more than 1 month later than their effective date would ordinarily have been, if the special enrollment period verification process delays their enrollment such that they would be required to pay 2 or more months of retroactive premium to effectuate coverage or avoid cancellation



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SEPs No Longer Available

- Consumers who enrolled with APTC that is too large because of a redundant or duplicate policy
- Consumers who were affected by a temporary error in the treatment of Social Security Income for tax dependents
- Lawfully present non-citizens that were affected by a temporary error in the determination of their eligibility for APTC
- Lawfully present non-citizens with incomes below 100 percent of Federal Poverty Level (FPL) who experienced certain processing delays
- Consumers who were eligible for or enrolled in COBRA and not sufficiently informed about their coverage options



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Actuarial Value Changes

- Broader de minimis range
 - -4 percentage points to +2 percentage points
- Expanded bronze de minimis range
 - -4 percentage points to +5 percentage points
 - Covers and pays for at least one major service, other than preventive services, before the deductible; or
 - Meets the requirements to be a high deductible health plan within the meaning of 26 U.S.C. 223(c)(2)



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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 for unique plan designs
 - A description of any features not included in the AV calculator
 - Actuarial certification of AV calculator results



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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



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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



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2018 Nevada EHB Benchmark Plan

- HPN Solutions HMO Platinum 15/0/90% (no change from PY 2017)
- 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



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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 2018 and must be changed



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Division Proposals Pending Before Legislature – AB83

- Individual rate filing URRT and actuarial memorandum would be considered proprietary (sec. 92)
- Discontinuation of product notice to policyholders reduced from 180 to 90 days (secs. 98, 110, 112, 114)
- Exclusive provider organization plan designs allowed in group markets (secs. 109, 113, 134)
- Carriers must establish mechanism for notifying providers on an ongoing basis the specific health care services for which the participating provider of health care will be responsible, including, without limitation, any restrictions or conditions on the health care services (sec. 66)



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Division Proposals Pending Before Legislature – AB83

- Network contracts must prohibit provider from billing the covered person for amounts owed by the carrier (secs. 66, 67)
- Network contracts must require provider to continue to deliver health care services for the remaining term of the contract to a covered person in the event of carrier insolvency (sec. 68)
- Carriers must notify network providers of their responsibilities with respect to any applicable administrative policies and programs of the health carrier (sec. 71)
- Carriers must establish mechanism by which network providers may determine whether the person to whom the health care services are to be provided is a covered person or is within a grace period for the payment of a premium during which the health carrier may hold a claim for health care services pending receipt of the payment of the premium (Sec. 81)



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Other Proposals Pending Before Legislature

- AB381- A small group carrier shall only move a prescription drug from lower cost tier to a higher cost tier on January 1st and July 1st
 - Exception made if drug is replaced by a generic
- AB382 – Protects consumers from surprise billing



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Requirements from 2015 Session

- 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



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Telehealth

- 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



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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



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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 by 10/15 of each year
- Commissioner revises requirements and standards for network plans if they do not at least satisfy the standards released in a future CMS Letter to Issuers



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Network Adequacy Submission

- Carriers must submit network plan applications no later than June 12th
- Application consists of validated CMS ECP/Network Adequacy Template, 2018 Nevada Declaration Document within each risk pool binder, and the Autism Provider Template



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Network Adequacy Timeline

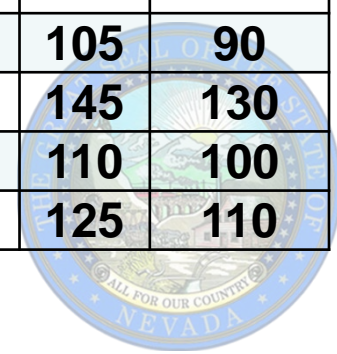
- June 12th Network Plan applications due
- June 26th DOI sends first objection letter
- July 10th Carrier response due in SERFF
- July 24th DOI sends second objection letter
- August 7th Carrier response due in SERFF
- August 21st DOI sends third objection letter
- September 4th Carrier response due in SERFF
- September 10th DOI makes final determinations



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2018 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
	Pediatrics	25	15	30	20	40	30	105	90
	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



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Nevada County Designations

County	Designation
Carson City	Metro
Clark	Metro
Washoe	Metro
Douglas	Micro
Lyon	Micro
Storey	Rural
Churchill	CEAC
Elko	CEAC
Nye	CEAC
Humboldt	CEAC
Mineral	CEAC
White Pine	CEAC
Pershing	CEAC
Lander	CEAC
Lincoln	CEAC
Eureka	CEAC
Esmeralda	CEAC



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CMS ECP/Network Adequacy Template

Please note the following in preparing the Network Adequacy section:

- In classifying a facility as a hospital consider the definition of hospital under NRS 449.012 as well as the definition provided by the Centers for Medicare and Medicaid Services
- For any providers acting as a Distant site as defined by NRS 629.515 4.(a) please indicate by adding (T) after the provider's last name
- Check data for error
 - Addresses with no city, state, or zip codes
 - Typographical errors in provider names or street addresses

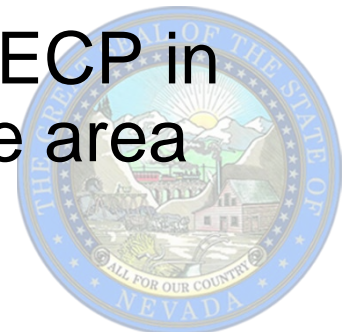


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2018 Essential Community Provider Standards

A carrier must:

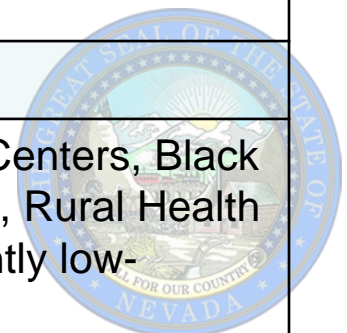
- Contract with at least 20% of available Essential Community Providers (ECP) in each plan's **service area**
- Offer contracts in good faith to all available Indian health care providers in the **service area**
- Offer contracts in good faith to at least one ECP in each category in each **county** in the service area



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Essential Community Provider (ECP) Categories

Major ECP Category	ECP Provider Types
Family Planning Providers	Title X Family Planning Clinics and Title X “Look-Alike” Family Planning Clinics
Federally Qualified Health Center (FQHC)	FQHC and FQHC “Look-Alike” Clinics, Outpatient health programs/facilities operated by Indian tribes, tribal organizations, programs operated by Urban Indian Organizations
Hospitals	Disproportionate Share Hospital (DSH) and DSH-eligible Hospitals, Children’s Hospitals, Rural Referral Centers, Sole Community Hospitals, Free-standing Cancer Centers, Critical Access Hospitals
Indian Health Care Providers	Indian Health Service (IHS providers), Indian Tribes, Tribal organizations, and urban Indian Organizations
Ryan White Providers	Ryan White HIV/AIDS Program Providers
Other ECP Providers	STD Clinics, TB Clinics, Hemophilia Treatment Centers, Black Lung Clinics, Community Mental Health Centers, Rural Health Clinics, and other entities that serve predominantly low-income, medically underserved individuals

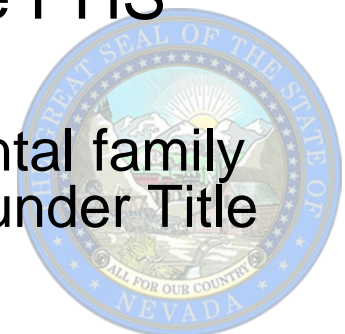


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2018 ECP Write-ins

A carrier may write in any provider that submitted a timely ECP petition and:

- Is currently eligible to participate in the 340B Drug Program described in section 340B of the PHS Act; or
- Is a not-for-profit or State-owned provider that would be an entity described in section 340B of the PHS Act but did not receive Federal funding under the relevant section of law referred to in section 340B of the PHS Act
 - Such providers include not-for-profit or governmental family planning service sites that do not receive a grant under Title X of the PHS Act



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Nevada Declaration Document Changes

All carriers subject to the Network Adequacy requirements must submit a NV Declaration Document. The following are the significant changes for plan year 2018.

➤ Autism Provider List

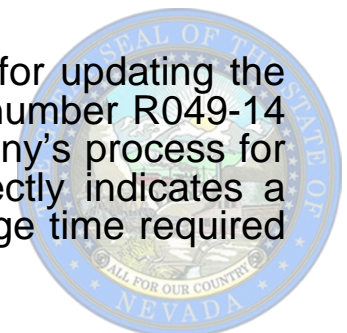
Please provide a list of all providers designated as providing autism services or autism applied behavioral analysis such as registered behavioral technician, behavior interventionists, board certified behavior analysts, or any other autism provider designation for each Network ID defined within the CMS Network ID template. Use the Autism Provider Template provided on the Division's website.

➤ Telehealth Providers

Provide a list of Telehealth services. For any providers acting as a Distant site as defined by NRS 629.515 4.(a) please indicate by adding (T) after the provider's last name on the CMS ECP/Network Adequacy template.

➤ Provider Directories

Provide a detailed description of the company's process and procedures for updating the provider directory to comply with Nevada regulations filed under LCB file number R049-14 which have not been codified. Include a detailed description of the company's process for responding to a consumer complaint concerning a directory that incorrectly indicates a provider is accepting new patients. Your response must include the average time required from the date of complaint to the date the provider directory is updated.



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Network Adequacy Review Process

- 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 types for at least 90 percent of enrollees in the service area.
- 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
- Access plan should be based upon established patterns of care



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Wellness Programs

- NRS 686A.110 prohibits health carriers from paying, allowing or giving, directly or indirectly, anything of value as an inducement to purchasing insurance coverage UNLESS the item of value is specified in the policy
- The program must be reasonably designed to promote health or prevent disease
- Rewards cannot be used to pay premium
- A program satisfies this standard if it has a reasonable chance of improving the health of, or preventing disease in, participating individuals, and it is not overly burdensome, is not a subterfuge for discriminating based on a health factor, and is not highly suspect in the method chosen to promote health or prevent disease
- The full reward under the wellness program must be available to all similarly situated individuals



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Activity-Only Wellness Rewards

- An activity-only wellness program requires an individual to perform or complete an activity related to a health factor in order to obtain a reward
- The full reward under the activity-only wellness program must be available to all similarly situated individuals
- A reward under an activity-only wellness program is not available to all similarly situated individuals unless
 - The program allows a reasonable alternative standard for obtaining the reward for any individual if it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; and
 - The program allows a reasonable alternative standard for obtaining the reward for any individual for whom it is medically inadvisable to attempt to satisfy the otherwise applicable standard



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Coverage for Non-Opioid Pain Management Therapies

- Non-opioid pain management therapies have been identified as viable strategies for the management of chronic pain. A wide range of non-opioid treatment options should be made available to meet the unique needs of each patient, but the following therapies should be prioritized:
 - Chiropractic
 - Acupuncture
 - Cognitive Behavioral Health



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Reimbursement for Treatments by Chiropractor

- Nevada Revised Statutes currently mandate reimbursement for treatments by a chiropractor to an amount not less than that for similar treatments by other physicians
- Provider reimbursement parity is established for identical CPT codes
- A carrier that has an average reimbursement level for a specific CPT code for chiropractors that is significantly below the average reimbursement level for another provider type would violate NRS



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Health Carrier Audits

- Later this year, the Division of Insurance will collect data from each carrier to determine whether reimbursement for services commonly performed by chiropractors and other types of providers is compliant with NRS
- Safe harbor compliance for a specific CPT established if the average reimbursement level for chiropractors in a geographic area is at least equal to the average reimbursement level for all other types of providers combined within that area



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Plan Service Area

- QHP and SADP service areas must equal one or more rating territories
- Nevada's rating territories for 2018 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



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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%



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Formulary Modifications

- A carrier shall neither remove a drug nor increase the cost share for a drug from an approved formulary for an individual health benefit plan during the calendar year
- Final drug lists must be submitted by 9/15/17
- Individual market formularies will be approved and locked down on 10/20/17



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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



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Division of Insurance Website

- The Division will not post proposed 2018 rates
- Approved 2018 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 10/20/17
- The approved schedule of benefits and evidence of coverage for each plan will be posted by November 1st
- Website will generally use “Plan Marketing Name” from Plans & Benefits Template



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MOOP and Deductible Guidance

- For 2018 individual and small group health benefit plans, the maximum out-of-pocket will be
 - \$7,350 single, \$14,700 family
- For 2018 HSA plans, the maximum out-of-pocket will be
 - \$ single, \$ family
- For 2018 HSA plans, the minimum deductible will be
 - \$ single, \$ family



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MOOP and Deductible Guidance

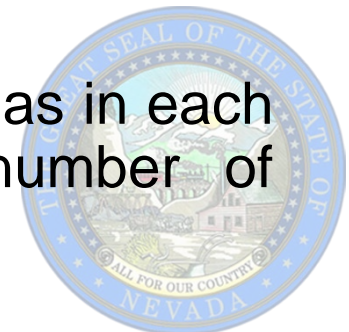
- For the 73 percent AV silver plan variations, the maximum out-of-pocket will be
 - \$5,850 single, \$ 11,700 family
- For the 87 percent and 94 percent AV silver plan variations, the maximum out-of-pocket will be
 - \$2,450 single, \$4,900 family



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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
 - New Silver/Gold check at the county level to ensure issuers offer at least one silver and one gold plan in every county in every medical market covered
- 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



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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 2018 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
 - RxNorm Drug Name Extract has been updated using the October 3, 2016 monthly release of RxNorm



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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



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Marketwide Review Tools

- 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 27 USP classes
 - Added USP categories & classes:
 - Antiemetics, Emetogenic Therapy Adjuncts
 - Antivirals, Anti-hepatitis B (HBV) Agents
 - Antivirals, Anti-hepatitis C (HCV) Agents



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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



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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 5 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, and Expanded Bronze Plan Review



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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 2017 are included in the crosswalk
 - Verifies that plans are crosswalked to valid 2018 plans
 - Checks that the crosswalk reasons selected are consistent with plan offerings



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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
 - Filings due the 15th of the 4th month prior to effective date
 - Plans may be added or removed quarterly



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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



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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



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Benefit Waiting Periods

- Waiting periods are not allowed for essential health benefits
- Carriers can no longer require a waiting period for pediatric orthodontia



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SADP Network Adequacy

- An access plan is required that demonstrates that the SADP carrier has standards and procedures in place to maintain an adequate network consistent with NAIC's Health Benefit Plan Network Access and Adequacy Model Act (NAIC Model Act)



Division of Insurance

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



Division of Insurance

SOB: Embedded Pediatric Dental

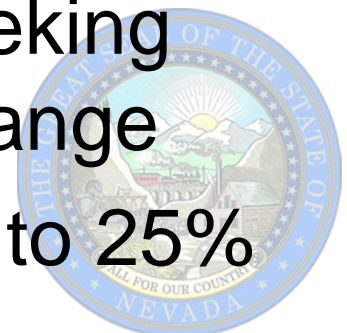
- The calendar year deductible applicable to pediatric dental services must be prominently displayed on page 1 of the benefit schedule
- For pediatric dental, Type I dental services (preventive and diagnostic services) cannot be subject to the deductible



Division of Insurance

Stand-Alone Dental Plans

- 2018 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%



Division of Insurance

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

