

Division of Insurance

Draft 2019 Health Benefit Plan and SADP Filing Guidance v2



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Filing Timeline for Exchange Carriers if CMS Allows September Final Data Transfer

- All QHP and on-Exchange SADP binders must be submitted in SERFF no later than June 8th
 - Rates template not required for this initial submission unless carrier is new to Nevada
 - Network adequacy application for QHP networks must be included within this binder
- Rate filings and form filings for new carriers due June 8th
- All form filings for existing carriers due July 13th
- Rate filings for existing carriers due July 13th



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Filing Timeline for Exchange Carriers if CMS Does Not Allow September Data Transfer

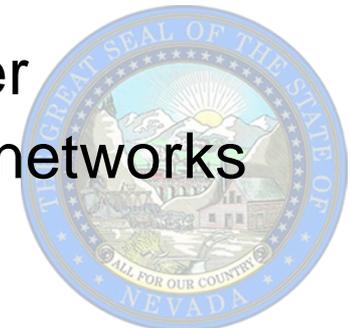
- All QHP and on-Exchange SADP binders must be submitted in SERFF no later than June 8th
 - Network adequacy application for QHP networks must be included within this binder
- Rate and form filings for all Exchange carriers due June 8th



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Filing Timeline Off-Exchange Carriers

- Rate filings and form filings for new carriers due June 8th
- All form filings for existing carriers due July 13th
- Rate filings for existing carriers due July 13th
- All non-QHP and off-Exchange SADP binders must be submitted in SERFF no later than July 13th
 - All plans should be included within this binder
 - Network adequacy application for non-QHP networks must be included within this binder



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Risk Pool Filings

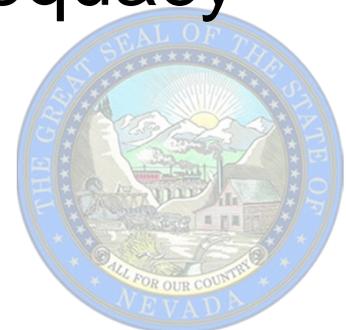
- All risk pool plans must be submitted within a single form filing
- Plans within a product vary by cost sharing structure, network, formulary or service area
- Benefit variability within a product will not be allowed
- Cost share variability within a plan will not be allowed
- Riders for non-EHBs allowed off Exchange



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Binder Submissions

- Separate binder for on Exchange 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



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Binder Templates

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

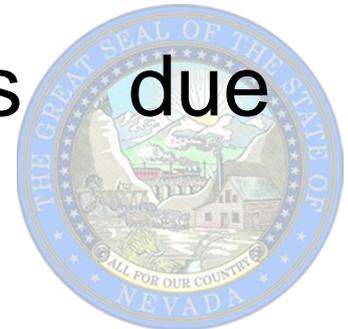
- Plans and Benefits Template
- Prescription Drug Template
- Network ID Template
- Service Area Template
- ECP/Network Adequacy Template
- Rate Data Template
- Business Rules Template



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Health Form Filings

- Redlined versions of SOBs and EOCs for existing plans
- AV calculator input and output for each plan
- Clean copies of the SOBs and EOCs due September 28th for display on DOI website
- Formulary and Provider URLs due October 19th



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2017 Nevada Enrolled Legislation

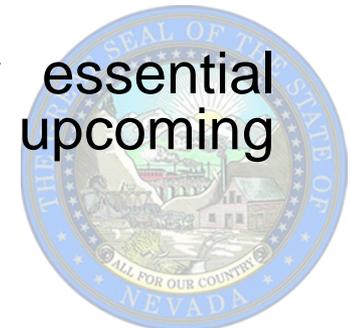
- AB227 – Expands relationships recognized as valid domestic partnerships
- AB304 - New definition for “autism spectrum disorder”
- AB381 - A small group carrier shall only move a prescription drug from lower cost tier to a higher cost tier on January 1st and July 1st



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2017 Nevada Enrolled Legislation

- SB262 – Payment for treatment relating solely to mental health or the abuse of alcohol or drugs must be made directly to the provider of health care that provides the treatment if the provider
 - Is an out-of-network provider; and
 - Has delivered a written assignment of benefits to the carrier
- SB286 - New definitions for “registered behavior technician” and “state certified behavior interventionist”
 - “autism behavior interventionist” definition has been repealed
- SB539 – Individual carriers required to identify essential diabetes drugs removed from a formulary for an upcoming year



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AB249 and SB233

- It is no longer sufficient to only reference USPSTF and HRSA within forms for women's preventive health benefits
 - AB249 and SB233 mandates may be broader than USPSTF and HRSA
- Each Evidence of Coverage should include all benefits specified within NRS



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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)



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2019 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



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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 2019 and must be changed



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Telehealth

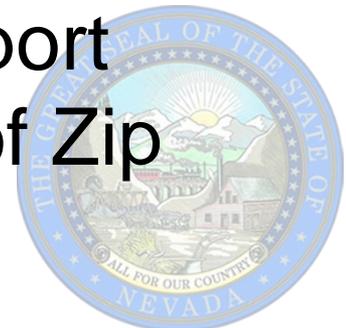
- A policy of health or dental insurance must include coverage for services through telehealth to the same extent as though provided in person or by other means
- A carrier shall not:
 - Require an insured to establish a relationship in person
 - Refuse to provide coverage because of the distant site 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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Plan Service Area

- QHP and SADP service areas must equal one or more rating territories
- Nevada's rating territories for 2019 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 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 September 14th
- Individual and small group market formularies will be approved and locked down on September 19th



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Formulary Template

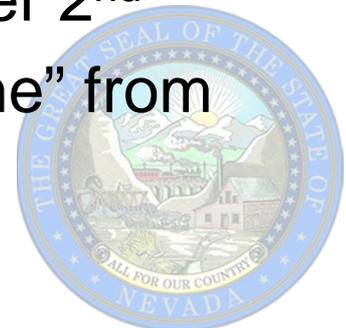
- Issuers should complete cost-sharing fields in the Prescription Drug Template for the most typical or most utilized benefit cost-share design
- Issuers can describe any cost-sharing features that do not directly fit into the Prescription Drug Template in the Benefit Explanation field of the Plans &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



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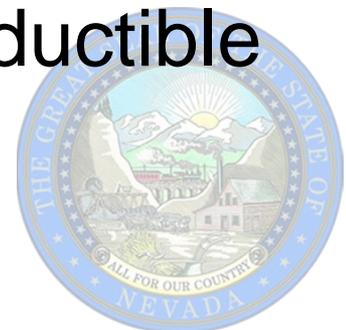
- The Division will not post proposed 2019 rates
- Approved 2019 rates will be posted on October 2nd
- Clean copies of the Schedule of Benefits and Evidence of Coverage for each approved plan must be submitted for display on the DOI website no later than September 28th
- The approved schedule of benefits and evidence of coverage for each plan will be posted by October 2nd
- Website will generally use “Plan Marketing Name” from Plans & Benefits Template



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MOOP and Deductible Guidance

- For 2019 individual and small group health benefit plans, the maximum out-of-pocket will be
 - \$7,900 single, \$15,800 family
- For 2019 HSA plans, the maximum out-of-pocket will be
 - \$ single, \$ family
- For 2019 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
 - \$6,300 single, \$ 12,600 family
- For the 87 percent and 94 percent AV silver plan variations, the maximum out-of-pocket will be
 - \$2,600 single, \$5,200 family



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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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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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SOB: Embedded Pediatric Dental

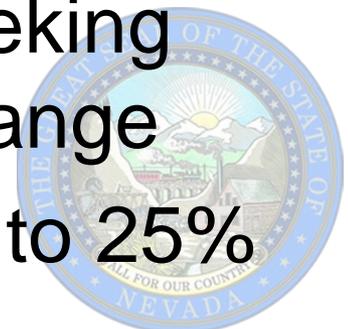
- The calendar year deductible applicable to pediatric dental services must be prominently displayed on page 1 of the benefit schedule
- For pediatric dental, Type I dental services (preventive and diagnostic services) cannot be subject to the deductible



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Stand-Alone Dental Plans

- 2019 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%



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Dental Form Filings

- Redlined versions of all forms for existing plans must be submitted
- 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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AV for Stand-Alone Dental

SADPs will no longer be subject to AV requirements in 2019



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EHB Benchmark Options for 2019 and Beyond

January 8, 2018



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Option 1- Maintain Current Benchmark

- The current EHB-benchmark plan will be used for 2019 and 2020 if Nevada takes no action
 - Largest plan by enrollment in the small group market in Nevada on 3/31/2014
 - Fully compliant with ACA
 - Includes pediatric dental and vision
 - Does not include dollar benefit limits
 - Includes all Nevada health benefit mandates



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Option 2- Use EHB-benchmark plan currently used in another State

- Would not require extensive analysis since it is already approved by CMS for another State
- Would not include all benefits mandated under Nevada law
 - Nevada mandates would have to be added to selected benchmark plan



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Option 3- Replace categories from other State EHB-benchmark plans

- Replace one or more of the 10 categories in Nevada's current plan with the same category or categories from another State's benchmark plan
 - For example, can select drug coverage from State A and hospitalization coverage from State B



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10 EHB Categories

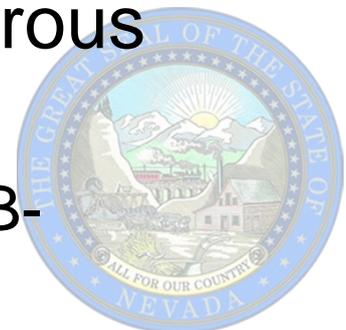
- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services
- Prescription drugs
- Rehabilitative and habilitative services
- Laboratory services
- Preventive and wellness services
- Pediatric services



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Option 4- Select a set of benefits

- Must be equal in scope to a typical employer plan
 - A small or large employer plan sold in one or more states with enrollment of at least 5,000 enrollees; or
 - A self-insured group health plan sold in one or more states with enrollment of at least 5,000 enrollees
- Is no more generous than the most generous comparison plan
 - Comparison plans used during the 2017 EHB-benchmark plan selection process



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Selection and Submission Process

- Plan must provide an appropriate balance of coverage for the 10 EHB categories
- Plan must not have benefits unduly weighted towards any of the categories of benefits
- Must provide reasonable public notice and an opportunity for public comment on the State's selection of an EHB-benchmark plan
- Must determine an EHB-benchmark plan's generosity
 - by an actuary who is a member of American Academy of Actuaries
- Must affirm benefits equal to typical employer plan



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Timeline for Submission to CMS

- March 16, 2018 for plan year 2019
- July 1, 2018 for plan year 2020

