State of Nevada

DEPARTMENT OF BUSINESS AND INDUSTRY

Division of Insurance
2026 Health Benefit Plan Filing Guidance

Webinar: 05/01/2025 09:00 am Pacific
Please mute your microphone

Guidance located at: https://doi.nv.gov/Insurers/Life_and_Health/ACA_Plans/

NOTE: Please refer to this slide deck while creating the SERFF submissions, it provides the directions required to submit correct and complete filings.

Scott J. Kipper, Commissioner of Insurance

Filing Submission Deadlines*

	Rates	Forms	Binders
All Individual Medical Plans	June 2nd	June 2nd	June 2nd
All Small Group Medical Plans	July 14th	July 14th	July 14th
All Dental Plans	June 2nd	June 2nd	June 2nd

*These deadlines are applicable to Rate, Form, Binder Filings (includes Network Adequacy) and to the **Battle Born State Plan** submissions.

Battle Born State Plans (BBSP)

For carriers approved to sell BBSPs for PY26, a carrier must offer:

a. at least one BBSP of each metal level - Bronze, Silver, and Gold;

b. one QHP Silver Non-BBSP; and

c. all must be made available in each of Nevada's 4 rating areas.

Unless submitting the BBSPs under a separate legal entity, a single filing of each type (rate, form and binder) should be submitted to include all plans.

Battle Born State Plans (BBSP) continued

If a carrier is planning to "crosswalk" membership from an existing plan to a new BBSP

a. the carrier must provide the appropriate notifications to the Division and to existing enrollees per NRS 689A.630(2) to discontinue the existing plan and

b. map the existing membership to a **new** HIOS ID and use "Discontinuing product; enrollment into a different product" as the reason for the crosswalk.

Battle Born State Plans (BBSP) continued

All carriers must include three sets of counterfactual rates based on the following scenarios:

- Rates assuming no BBSP's in the market and no reinsurance (Supporting Doc Tab)
- Rates assuming BBSP's exist in the market and no reinsurance (Supporting Doc Tab)
- Rates assuming BBSP's exist in the market and reinsurance is provided (Rate/URRT Tab)

NOTE: Rate and URRT templates, and a memorandum are required for all three scenarios.

Rate Filing Requirements

Nevada Rate Review Process

- All health benefit plan rate filings will be reviewed by consulting actuaries and/or DOI staff.
  - Carriers to pay for cost of external reviewing actuaries (NRS 686B.112)
  - Unique plan design support is required

Silver Loading

- Apply a single silver load to all Silver plans offered on the Exchange
- Use carrier specific CSR distribution if credible
- Use statewide CSR distribution if carrier specific data is non-credible
- Provide Excel exhibit supporting silver load development

Basis for PY26 Rate Filings – Part I

- The Affordable Care Act (ACA), including federal regulatory and sub-regulatory guidance in effect on the filing submission due date.
- Nevada State law
- Other state guidance, e.g., this slide deck.

Basis for PY26 Rate Filings – Part II

- Actuarial Value (AV) Calculator for 2026
- 2026 Unified Rate Review Template (URRT) and instructions
- Updated Nevada rate filing template (NVT) and instructions
  - Version 4.2.2 as posted on the Division's website.
  - 2024 Risk Adjustment values will be updated once RATEE reports are received from carriers.

Detailed Rate Review Timeline

- The dates following are based on the expected date of the initial objection letter and turnaround times.
- Adjust all subsequent dates based on receipt of initial objections.
- The final timeline will be posted on the Division website.

Detailed Rate Review Timeline

Description	Responsibility	Individual Plans	Small Group Plans
Rate Filing Due	Carriers	06/02/2025	07/14/2025
First Objection to Carriers	Division	06/09/2025	07/21/2025
Response to First Objection	Carriers	06/16/2025	07/28/2025
Second Objection to Carrier	Division	06/23/2025	08/04/2025
Response to Second Objection	Carriers	06/30/2025	08/11/2025
Third Objection to Carrier	Division	07/07/2025	08/18/2025
Response to Third Objection	Carriers	07/14/2025	08/25/2025
Proposed Rate Changes posted on Division's website	Division	08/01/2025	08/1/2025
Rate Decisions to Carriers ("Final" if no modification required)	Division	07/28/2025	**09/08/2025**
Final Modification to Division	Carriers	08/07/2025	09/18/2025
Final Rate Decisions to Carriers	Division	08/18/2025	**09/29/2025**
Final Data Transfer to SSHIX	Division	08/29/25	NA
Final Approved Rates posted on Division's website	Division	10/01/2025	10/01/2025

Confidentiality of Information Filed

- State law requires the Division to hold the URRT and the actuarial memorandum confidential.

- For information that is not required to be kept confidential under state law and that you believe to be proprietary, submit a written request for it to receive confidential treatment pursuant to NRS 679B.190(5)(b). We recommend that the carrier:
  - Include the request in the cover letter for the filing,
  - Include the request in a "Note to Reviewer" in SERFF, and
  - Indicate "proprietary and confidential" directly on each document subject to the request, regardless of the file format (excel, PDF, word, etc.).

Division of Insurance Website - Rates

- Proposed 2026 rates will not be posted
- Proposed rate filing information (min, max, average rate changes) will be posted by August 1st
- Approved 2026 individual and small group rates will be posted by October 1st
- Updated small group quarterly rates **will not** be posted on the Division's website
- Data from Plan & Benefits, Service Area and Rate Templates will be posted on the website, so please complete correctly

Rate Submission Requirements

- Add Form Filing/Binder SERFF #s to "Corresponding Filing Tracking Number" field under <General Information>
- Separate filings for rates and forms
  - Health benefit plans
- All documents must be submitted in SERFF
- Follow standardized naming convention for CMS templates, as provided in this guidance

Rate Submission Requirements (cont.)

The Nevada Rate Filing Template (NVT) has been updated to remove sheets that were not heavily used by the Division or External Reviewers.

- Sheets 3, 6, 7, and 8 will remain.
- Sheet 5 has been removed but the Division will still require carriers to submit the induced utilization component of the plan rate that was previously entered on this sheet. This should be included within the actuarial memorandum as a new exhibit or as part of an existing exhibit.
- XML version will no longer be required to be produced.
- For the remaining sheets, certain sections were dependent upon sheets that have now been removed and will now need to be manually populated.
- Please reach out to the Division with any questions on the update.

Standardized Naming Convention

- CarrierName_MMDD_YYYYQ#mkt_v#_Template.xml
  - CarrierName: Up to 6 Characters which identify the carrier
  - MMDD_YYYY: month, date and four-digit plan year
  - Q#: "Q" followed by the quarter number, "1" for annual and "3" for small group quarterly filings
  - mkt: "i" for individual "s" for small group filings
  - v#: v followed by the version number (increment for each update to the filing)
  - Template: indicate one of the following: NVT, RT, URRT, PBT, SAT
    - NVT – Nevada Rate Filing Template
    - RT – Federal Rates Template
    - URRT - URR Template
    - PBT - Plan and Benefit Template
    - SAT - Service Area Template

Submitting Templates and Support

- Use separate headers for each template under “Supporting Documentation” tab, including most current version identifier.
- Please submit AV calculator screen shots as a single consolidated file
- Service Area Templates (SAT) and Network ID Templates (NT) should be unique to each filing; i.e., if the service area/network is not in the Plans and Benefits Template, it should not be in the SAT or NT.

SERFF Submissions - I

- Rate/Rule Tab of SERFF
  - Rate Data Template (XLS and XML formats)
  - Consumer Disclosure – Part II
    - Required for **all** submissions
  - Actuarial Memorandum – Part III (**redacted**)
    - Public version - any information that is a trade secret or confidential commercial/financial information should be redacted

Redacted Actuarial Memorandum

- Federal guideline: https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Instructions_for_the_Redacted_Actuarial_Memorandum_20150416.pdf
  - Carriers can redact any information that is a trade secret or confidential commercial or financial information as defined in HHS's Freedom of Information Act (FOIA) regulations at 45 CFR § 5.65.
  - Carriers must not redact information unless its release would likely result in specific, reasonably foreseeable, and substantial competitive harm.
    - Be prepared to explain how each redacted item meets the federal criteria for redaction.

SERFF Submission - II

- URRT Tab
  - 2026 Unified Rate Review Template (URRT) - Part I (confidential)
    - both XLS and XML formats
  - Actuarial Memorandum - Part III, (redacted and unredacted)
    - Format must follow the order of the 2026 URR instructions

SERFF Submission - III

- Supporting Documents tab of SERFF
  1. Exhibits supporting the Actuarial Memorandum (in Excel format, with working formulas)
     - ✓ One Excel workbook named "AM Exhibits" so it is easily identifiable
     - ✓ Clearly label each sheet
  2. 2026 Nevada rate filing template (version 5)
     - ✓ XLS format
  3. Completed rate filing checklist
  4. Validated/renamed templates (.xml/.xlsm), under separate headers, from the Binder templates tab (Six – PBT, DT, NT, SAT, ECP/NA, BRT)
  5. Actuarial Value Equivalent (AVE) Substitution Support
  6. Unique Plan Design Support
  7. All AV Screenshots via a single AV Calculator file

Actuarial Value Equivalent (AVE)

Supporting Documentation tab –

- ✓ Add Actuarial Value Equivalent support for the following, if limits apply. If unlimited, provide a statement as such.

  - Applied Behavioral Analysis (ABA) benefit limit *(for Autism treatment)*
    - Must specify the ABA benefit limits (or "Unlimited")
      - A maximum benefit of not less than the actuarial equivalent of $72K per year for ABA, justified by an actuary

  - Coverage for special food for PKU
    - Actuarial equivalent of $2,500 minimum or "Unlimited"

SB 439 Defrayal Update

- If carriers believe impacts from SB 439 are present in experience used to develop rates, an adjustment should be included to remove this impact. This applies to QHPs only, non-QHPs should not contain an adjustment.
- The most recent estimate developed by the Division based on carrier data is $2.66 PMPM on an allowed basis. This is based on methodology that sorts drugs within a category-class from most to least utilized as measured by cost on a PMPM basis. Drugs appearing above the required EHB benchmark count under this ranking are considered to be outside of the EHB Benchmark plan and subject to defrayal.
- Carriers may use the Division estimate or develop their own estimate and provide documentation on the methodology and data used.

Actuarial Memorandum

- Is an actuarial communication subject to Actuarial Standard of Practice (ASOP) No. 41
- Provide sufficient detail so that a qualified health actuary would be able to evaluate the submission.
- Provide quantitative support
- Provide narrative descriptions
  - The methodology, data source, assumptions, justification, etc., for all adjustments need to be clearly communicated

Actuarial Memorandum Exhibits (4.4.3.5 and 4.4.3.6)

The Division understands that index rate exhibits in the URRT and NVT may not accurately reflect carrier's actual rate development methodology. Therefore, please verify that the actuarial memorandum contains a numerical exhibit with a direct, sequential, step-by-step derivation of the Index Rate and Market-Adjusted Index rate from an initial step, such as allowed claims.

NOTE: While most carriers have provided this information in the annual filings, some carriers are omitting components, embedding the information within memorandum verbiage or referring the reviewer to other documents.

Actuarial Memorandum Exhibits

- Under the Terminated Plans section, provide a tabular Exhibit, with plan mappings where applicable, and listing the terminated:
  - HIOS ID's
  - Marketing Names
  - Affected Rating Areas

Formula for Timely Approvals - I

- Follow 2026 federal and state guidance
- Submit complete, well-documented filings:
  - URRT
  - Actuarial memorandum: Detailed description of methods and assumptions, including changes since prior year, with supporting exhibits
    - Format in order of URRT instructions, with same headings
    - Provide sufficient detail in narrative and numerical demonstrations so that another qualified actuary could evaluate the submission (per ASOP No. 41) – see checklist
    - Provide all supporting exhibits in Excel with working formulas
  - NV Rate Filing Template (v5) completed in accordance with instructions

Formula for Timely Approvals - II

- Ensure that issues raised in prior year's objection letters are addressed in current filing
- Prior to submission, review for consistency, all information in the rate, form and binder filings for the single risk pool
- Once review starts, any changes to the forms and/or binders must be coordinated with the rate filing and vice versa.
- Any questions, contact the Division

Common Areas of Objections

- Rate increase calculation, components of rate increase

- One or more of the following items were not fully supported or justified
  - Trend development or other projection factors
  - Manual rate development
  - Plan level adjustments
  - Geographic factor development
  - Risk adjustment transfer payment development

- Version control between filings
  - Carriers with multiple iterations of any template must identify the new template, via versioning (*e.g., PBT_xxx_v1, RT_zzz_v2*), in all filings where they appear

Example: Calculating the Threshold Rate Increase

Plan	Current Annual Premium	Annual Premium Based on Proposed Rates	Rate Change
A	$10,000,000	$11,000,000	10.00%
B	$20,000,000	$19,000,000	-5.00%
C	$15,000,000	$18,000,000	20.00%
D	$ 5,000,000	$ 5,000,000	0.00%
Total	$50,000,000	$53,000,000	6.00%
Weighted average rate change: ($53M/$50M)-1 = 6.00%			

Risk Adjustment

- Clearly document the methodology, data, assumptions used to determine the estimated adjustment to the index rate

- Reflect any planned changes to the risk adjustment program
  - Risk adjustment fees should be reported as a non-benefit expense, not netted against the risk adjustment transfer payment.

NV RATEE Program

- 05/01/2025 RATEE file from carrier
- Deadline: First Monday of May (05/05/2025)
- Confidentiality

2026 Rating Parameters – No Change

- Age curve 3:1 federal default
- Geographic rating areas:
  1. Clark and Nye counties
  2. Washoe county
  3. Carson City, Lyon, Douglas and Storey counties
  4. All other counties
- Maximum tobacco rating factor allowed - 1.5
  - May vary by age
  - Only allowed for age 21+
- Separate individual and small group risk pools

2026 Exchange Fee

- Exchange Fee – 2.95% of premium for QHPs and SADPs

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:
    - 45 CFR 156.135(b)(2) or
    - 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

AV Calculator De Minimus Ranges*

- Expanded Bronze: Change to +5% / -4%
- Silver CSR Variations: Change to +1% / -1%
- All Others: +2% / -4%

Small Group Issues

- 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 are allowed for **Q3 only**:
  - Standardized rate effective dates (January 1, April 1, July 1, October 1). Monthly trend adjustments are not allowed.
  - Q3 updates due March 15th
  - Plans **may not** be added with the 7/1 update

Form and Binder Requirements

2026 Filing Timeline for Individual Carriers

- All Individual QHP and Non-QHP binder and form filings must be submitted in SERFF no later than June 2, 2025

- The NV DOI will provide final decision by August 29, 2025

2026 Filing Timeline for Small Group Carriers

- All Small Group binder and form filings must be submitted in SERFF no later than July 14, 2025

- The NV DOI will provide final decision by September 29, 2025

Risk Pool Filings

- All products from the same risk pool must be submitted within a single SERFF filing
- Benefit variability within a product will not be allowed
- Cost share variability within a plan will not be allowed
- Riders for non-EHBs only allowed off Exchange

Social Security #s and Off-Exchange Individual Plans

Reminder:

Carriers must be compliant with the guaranteed availability rules at 45 CFR 147.104. Individuals who apply for, and are denied, coverage due to a lack of a social security number (and otherwise eligible under federal law) may file an appeal with the carrier. The Division will expect the carrier to overturn the eligibility denial and provide a retrospective effective date to when coverage would have started if such coverage were approved when first applied.

Binder Submissions

- Separate binders for individual and small group filings for each carrier
- Must include the validated Plan Management templates
- Must include a completed Binder Checklist and all required Supporting Documentation. Refer to Nevada Division of Insurance (nv.gov) for a copy of the Division guidance and associated documents
- Inclusive of all HIOS IDs in the Form filing, the carrier must use the *Associate Schedule Items* function.
- **Changes to initial versions of the validated CMS templates in the Binder must be replicated under Supporting Documentation in the Rate filings. A revised version number of any new iteration is expected and required and must match across all filing types, i.e., Rate and Binder.**

Template Naming Convention

CarrierName_MMDD_YYYYmkt_v#_Template.xml

- CarrierName: Up to 6 Characters which identify the carrier
- MMDD_YYYY: month, day and four-digit plan year
- mkt: “i” for individual “s” for small group filings
- v#: v followed by the version number (increment for each update to the filing)
- Template: indicate one of the following - PBT, DT, NT,SAT, ECP, RT, BRT, URRT
  - PBT - Plan and Benefit Template
  - DT – Prescription Drug Template
  - NT – Network Template
  - SAT - Service Area Template
  - ECP - Essential Community Providers Template
  - RT – Federal Rates Template
  - BRT – Business Rating Rules Template
  - URRT – Unified Rate Review Template

Binder Submissions - Tab Explanation

- "Plans": Automatically populates (in sequential, numerical order) from the Plans and Benefits Template.
- "Associate Schedule Items": Links the Binder to the associated Form or Rate Filing, providing accuracy across the three filing types and **is a required task for each carrier.**
- "Fees": N/A
- "Templates": Added by the carrier and validated through SERFF.
- "Supporting Documentation": see following slides.
- "Company and Contact": Automatically updated via SERFF. **NOTE: ensure information is current and accurate.**
- "Correspondence": Houses objections, responses, reviewer/filer notes, amendments from the carrier, dispositions and certifications, etc.

Binder - Associate Schedule Items Function

The next four slides provides “how to” instructions.

NOTE: Confidentiality precludes a demonstration during this “All Carrier” guidance but the Division can host separate meetings with each carrier to demonstrate these instructions.

If a demonstration is desired, please provide to the Division the appropriate staff member contact information via email following today’s guidance. The Division will schedule demonstrations between 5/5/25 and 5/9/25; these are expected to take no more than 60 minutes.

"How To" Associate Schedule Items – Binder to RATE Filing

The **first** HIOS ID appearing under the *Plans* tab in the Binder is to be associated to the applicable:

Rate Filing Rate/Rule Schedule tab:

- ✓ Rate Template (renamed)
- ✓ URRT Part II – Rate Change Justification
- ✓ Actuarial Memorandum - redacted version

Rate Filing URRT tab:

- ✓ URRT Part I
- ✓ Actuarial Memorandum - unredacted

NOTE: the first HIOS ID will be associated to the rate **and** the form filing, subsequent HIOS IDs will be associated to the **form** filing only.

"How To" Associate Schedule Items – Binder to RATE Filing

The **first** HIOS ID (continued):

Rate Filing Supporting Documentation tab:

- ✓ Actuarial Value Equivalent Substitution Support
- ✓ Nevada rate filing template
- ✓ All AV Screenshots via a single AV Calculator file
- ✓ Six renamed Excel (.xlsm version) CMS templates (PBT, DT, NT, SAT, ECP, BRT) to address version control. *List the templates separately in the Rate filing.**
- ✓ Unique Plan Design support

*If there is a file limitation error for any of the templates, please send a "Note to Reviewer" in the Binder as follows : "In the <Carrier> Rate filing, only the zip file containing the .xlm files has been uploaded as the .xlsm file exceeds the file size limit". Then, please rename the .xlsm file in the Binder Template tab to match the zip file added to the Rate filing, to ensure version control, and upload it back to the Binder. The Division will download the renamed .xlsm version from the Binder.

"How To" Associate Schedule Items – Binder to FORM Filing

The **first** HIOS ID in the *Plans* tab of the Binder is to be associated to **all** versions of the Evidence of Coverage (EOC) in the Form Filing/Form Schedule tab, i.e., a carrier has more than one EOC.

After the EOC(s) is/are associated, the carrier associates the first HIOS ID to its corresponding SOBs, inclusive of all variants (e.g., -00, -01, -02, etc).

Example: The first HIOS ID in the *Plans* tab (HIOS ID 99999NV9999999_00) is a bronze plan; it is to be associated to the corresponding SOBs for that bronze plan –

- 99999NV9999999_00 SOB
- 99999NV9999999_01 SOB
- 99999NV9999999_02 SOB
- 99999NV9999999_03 SOB
- 99999NV9999999_04 SOB

"How To" Associate Schedule Items – Binder to FORM Filing

Each HIOS ID thereafter, in the *Plans* tab, must be associated to its corresponding SOBs in the Form Filing/Form Schedule tab.

Example: The second HIOS ID in the *Plans* tab (HIOS ID 99999NV8888888_00) is a silver plan and is to be associated to the corresponding SOBs for that Silver plan –

- 99999NV8888888_00 SOB
- 99999NV8888888_01 SOB
- 99999NV8888888_02 SOB
- 99999NV8888888_03 SOB
- 99999NV8888888_04 SOB
- 99999NV8888888_05 SOB
- 99999NV8888888_06 SOB

Binder Submissions – *Version Control*

To ensure accurate review by the Division, SSHIX and outside Actuaries, it is **imperative**, when revised/updated CMS templates are uploaded to SERFF, that:

- any revised template in the Binder is clearly identified by a new version number and
- it is also added to the Rate filing. NOTE: the *Associate Schedule Items* function should reflect this change.

EXAMPLE: PBT Revision for Individual Filing:

1. An objection in the Rate Filing requires a revised PBT, i.e., a new version.
2. The revised PBT (with versioning change noted in the .xml file name) is uploaded to the *Templates* tab in the **Binder and validated**.
3. The .xlsm version of the PBT is renamed, ex.: ABCIns_MMDD_2026Q1i_v**2**_PBT.xlsm.
4. The new versions (.xml/.xlsm) of the PBT are added under *Supporting Documentation* tab in the Rate filing. *NOTE: the association of the replaced, revised template to the Binder should be maintained but carrier should confirm*.

Binder Submissions – *Version Control (cont.)*

When a carrier voluntarily makes a revision to a CMS template, the carrier must notify the Division and, the SSHIX **via email** of the change and include

- ✓ the SERFF number of the filing affected,
- ✓ the reason for the revision and
- ✓ the revised naming convention of the template.

All revised templates require re-review via the CMS tool sets and, for the SSHIX, may require a re-transfer of data.

DIVISION OF INSURANCE

Protect Consumers, Ensure Solvency

Binder Checklist

PY26 BINDER COMPLETION CHECKLIST		
Item	Applies to	Division Comments
Validated Templates	ALL	Validated and housed in "Templates" tab
The following items are to be housed in the Supporting Documentation Tab		
Statement of Detailed Attestation Responses for SBM Issuers	SSHIX Medical and Dental	
Quality - QIS Implementation Plan and Progress Report Form	SSHIX Medical	
Discrimination - Treatment Protocol Supporting Documentation and Justification	Medical – as needed	
NV Network Adequacy Declaration Document (includes Telehealth Exhibit)	Medical	MODIFIED
Combined Prescription Drug Supporting Documentation and Justification	Medical – as needed	
YOY Deficiency Response	Medical	Replaces the Network Adequacy Year Over Year Exhibit and is required only if deficient in the previous year, i.e., "Passed/Approved with Stipulations"
Binder Checklist	ALL	
ECP UI Data	N/A	Not applicable to SBE
Indian Healthcare Provider letter documentation	ALL	
URLs for machine readable-files and cost estimator tool	ALL	NOTE: The cost estimator tool is not applicable to SADPs.
Data Integrity Tools (DIT) and Completed CMS Review Tools results	ALL	
Certificate of Accreditation	SSHIX Medical	
Supplemental templates provided to issuers from SSHIX	All	Will be used to post information to Division website
Supplemental Provider Listing for Outpatient Dialysis, Hospitals and Oral Surgeon (for medical plans with embedded pediatric dental)	Medical	
Plan Listing	Medical	For reference to confirm completeness of items in the Associate Schedule Items tab
Plan ID Crosswalk Template	SSHIX Medical	
Org chart and narrative for outsourced operations (include subcontractors)*	ALL	
Justification for Network Adequacy/Essential Community Provider (ECP) Objections(s)	Medical – as needed	Template provided replaces Network Access Plan
Supplemental Provider Listing (Oral Surgeon)	Dental	
Actuarial Memorandum (and redacted version if necessary)	Dental	
License	As needed – New carrier	

The following will not be required in the PY26 medical Binder filing to avoid duplication of effort. The carrier is to use the naming conventions below when adding these items, under Supporting Documentation, in the carrier's Rate Filing. The carrier is to use the Associate Schedule Item function in the Binder to associate these items from the Rate filing to the Binder:

1. Renamed Templates (.xlsm) from Templates tab (one line item for each of the seven. Ex. Renamed Plans and Benefits Template, Renamed Drug Template, etc.)
2. Actuarial Value Equivalent Substitution Support
3. Unique Plan Design Support

Binder Submissions – Supporting Documentation

Refer to the *Binder Checklist* for details regarding the applicability of the items below

Statement of Detailed Attestation Responses for SBM Issuers	Certificate of Accreditation
Quality - QIS Implementation Plan and Progress Report Form	Supplemental templates provided to issuers from SSHIX
Discrimination - Treatment Protocol Supporting Documentation and Justification	Supplemental Provider Listing (Outpatient Dialysis/Oral Surgeon, Hospital) Medical filing
NV Network Adequacy Declaration Document (includes Telehealth Exhibit)	Supplemental Provider Listing (Oral Surgeon) – Standalone Dental filing
Combined Prescription Drug Supporting Documentation and Justification	Plan Listing
YOY Deficiency Response	Plan ID Crosswalk Template
Binder Checklist	Org chart and narrative for outsourced operations (include subcontractors)
ECP UI Data (N/A for SBE)	Justification for Network Adequacy/Essential Community Provider (ECP) Objections(s)
Indian Healthcare Provider letter documentation	Actuarial Memorandum (and redacted version if necessary)
URLs for machine readable-files and cost estimator tool	License
Data Integrity Tools (DIT) and completed Review Tools results	

Binder Submissions – Supporting Documentation II

Each carrier **must** include results from the review tools for Medical QHP ECPs, Drug Count and Cost Sharing under "Supporting Documentation". The tools and instructions can be found at Review Tools (cms.gov). The carrier must have a finalized DIT and Data Consolidation Tool prior to generating the review tools.

Filings submitted without these review tools will result in an objection.

NOTE: Areas of concern and/or a proactive justification, identified from the review tools as an inability to meet requirement(s), can be included in a "Note to the Reviewer" as part of the initial submission for Division/SSHIX consideration and may minimize the number of objections.

Form Filings Instructions Part I

- *General Information* tab-
  - ✓ Add Rate Filing/Binder SERFF #s to "Corresponding Filing Tracking Number"

- *Form Schedule* Tab –
  - ✓ Redline versions of existing SOBs (all plan variants) and EOCs
  - ✓ If applicable, clean copies of new SOBs (all plan variants) and EOC.

Form Filings Instructions Part I (cont.)

Supporting Documentation tab –

✓ All AV Screenshots via a single AV Calculator file;

✓ Upload completed Excel forms checklist under the "Supporting Documentation" tab (must correspond to redlined Pg. #'s)

- http://doi.nv.gov/Insurers/Life_and_Health/ACA_Plans/Form_Filings_and_Plan_Certification/

Form Filings Instructions Part II (Naming Convention)

This revision is specific to the file names within the Form Schedule tab and will provide a seamless posting of carrier documents to the Nevada DOI website for PY26 and forward.

A unique file name is required for each form, please use the following order when naming the files:

1. **Unique HIOS ID**
2. **Unique File Name** *(applies to "SCH" only)*
    i. CSR variant (as applicable)
    ii. Metal level
    iii. Abbreviated descriptors such as HSA, HDHP
3. **Form type**
    i. Certificate (CERT)
    ii. Evidence (EOC)
    iii. Policy (POL)
    iv. Benefit Schedule (SCH)
    v. Application (APP)
4. **Version type**
    i. Redline version (r)
    ii. Clean copy (c)
5. **Version number**
    i. v1, v2, v3, etc.

Form Filings Instructions Part II (Naming Convention cont.)

Examples for Carrier XYZ Form Submission

Certificates

- Use **this**: 99999NV001_ONXCERT_r_v1
- Not **this**: MyCompanyfullmarketingnameonexchangecertificate_99999NV0010017_CERT_r_v1

Benefit Schedules

- Use **this**: 99999NV0010017_00_S_HSA_SCH_r_v1
- Not **this**: MyCompanyfullmarketingname**Silver**HighOptioncsrversion_99999NV0010017_00_SCH_r_v1

Combined Certificate and Benefit Schedules (Carriers may see delivery issues with file size)

- Use **this**: 99999NV0010017_00_S_HSA_SCH_CERT_r_v1
- Not **this**: MyCompanyfullmarketingname**Silver**HighOptioncsrversion_99999NV0010017_00_SCH_r_v1

Form Filings Instructions Part III

The final objection in the individual and small group filings will be to replace any redlines with a clean copy in SERFF. Once the clean copies are added to SERFF, the filing will be approved. After approval, the carrier is to **email** clean copies of the approved forms, see below:

- **Clean copies** of the Individual and Small Group approved policy forms (Certificate, Schedule of Benefits, etc.) must be **emailed** to the Division for website posting.
  1. Use the clean copy forms from the filing. *NOTE: there is a 50-character file name limit for display purposes.*
  2. For the SOBs, send the off exchange (**"-00"**) variant version only.
  3. Confirm all links are working within policy forms.
  4. NOTE: the Division website is limited to posting one sample of each type of document (EOC, SOB and URLs) for every HIOS ID. Carriers should provide consolidated forms as appropriate when benefits (RX, vision, dental, etc.) are outlined in separate documents but are included in the rates.

Removing Plans from a Product

- Carriers may remove plans from a product each year
- All affected policyholders must receive a notice of cancellation pursuant to NRS 687B.420
  - Policyholders must be mapped to a plan within the same product and at the same metallic level (or nearest metallic level if no plan at the same level will be available)

PY26 Nevada EHB Benchmark Plan

- HPN Solutions HMO Platinum 15/0/90% (no change from PY 2025)
- Benchmark plan includes embedded pediatric dental and vision consistent with NV CHIP and FEDVIP, respectively
- 45 CFR 156.115 prevents combined limits for rehabilitation and habilitation services
  - Rehabilitation Services
    - 120 visits per year, no combined limit with Habilitation Services
  - Habilitation Services
    - 120 visits per year, no combined limit with Rehabilitation Services

83nd Legislative Session Proposed Bills

*The Division is tracking the following bills (it is not an exhaustive list) and each carrier is encouraged to review **all** bills for applicability*

83rd Legislative Session Proposed Bills				
Description	**2025 Bill**		**Description**	**2025 Bill**
Syphilis testing for pregnant women ***(Effective 01/01/2026)***	AB360		Prenatal genetic screening	SB344
Lung cancer screening	SB387		Opioid Alternates and prior authorization requirements	SB337
Fertility preservation	AB428		Prior authorization	AB463
Doula services mandate and Testosterone replacement therapy mandate	SB192		Step Therapy as medical management HIV and Hepatitis C	SB354
Pharmacy Benefit Managers cost-share language	SB316		Behavioral Health Mandate ***(Effective 07/01/2026)***	SB165
Unlimited speech therapy for stuttering	AB169		Special enrollment for pregnancy	SB217
Appeals for dental	AB202			

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
- Nevada's benchmark plan is Solutions HMO Platinum 15/0/90%
- Non state mandated drugs in excess of a state's EHB benchmark plan are considered EHB and the cost share rules must apply.

Prescription Drugs (cont.)

- Issuers **must** include a separate tier (Tier 1) for Zero Cost Share Preventive tier in the Prescription Drug Template per NRS[1].

- Per prior guidance[2] a carrier is not allowed to exclude Rx coupons from cost-sharing limits except in situations where a **generic is available**.

[1]*NRS 689A.0418(9), NRS 689B.0378(10), NRS 689C.1676(9)*

[2]*Per Civil Action No. 22-2604 (JDB), HIV & Hepatitis Pol'y Inst. v. U.S. Dep't of Health & Hum. Servs., https://www.federalregister.gov/documents/2020/05/14/2020-10045/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2021*

CMS Guidance regarding Medicare

Specific to non-grandfathered individual health insurance coverage, a carrier can't:

- exclude enrollment based on the theoretical possibility of enrollment in another health plan
- modify benefit coverage or non-renew coverage based on Medicare eligibility.

[1]https://www.cms.gov/Medicare/Eligibility-and-Enrollment/Medicare-and-the-Marketplace/Downloads/Medicare-Marketplace_Master_FAQ_4-28-16_v2.pdf
[2]This is true regardless of whether an individual is (or is presumed) eligible for Medicare on the basis of age, disability, or end-stage renal disease but not actually enrolled in Medicare.
[3]Non-discrimination provisions that may apply to non-grandfathered individual health insurance coverage, among others, include those in the guaranteed availability regulation (45 CFR 147.104(e)); the essential health benefits regulations (45 CFR 156.125); and, with respect to individual market QHPs, the QHP certification standards (45 CFR 156.200(e)), as applicable.

Plan Service Areas

- QHP service areas must equal one or more rating territories
- Nevada's rating territories for 2026 are unchanged
  - Rating Area 1 (Clark, Nye)
  - Rating Area 2 (Washoe)
  - Rating Area 3 (Carson City, Douglas, Lyon, Storey)
  - Rating Area 4 (Churchill, Elko, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Mineral, Pershing, White Pine)
- Off-exchange plan service areas may use partial counties
  - May be defined by a collection of Zip Codes

Formulary Modifications

- A carrier shall neither remove a drug nor increase the cost share for a drug from an approved formulary for an individual or small group health 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.

- Individual and small group formularies will be approved and locked down when the rate and form filings finalized.

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

MOOP and Deductible Guidance

- For 2026 individual and small group health benefit plans, the maximum out-of-pocket will be
  - $10,600 single, $21,200 family
- For 2026 HSA plans, the maximum out-of-pocket will be
  - $8,500 single, $17,000 family
- For 2026 HSA plans, the minimum deductible will be
  - $1,700 single, $3,400 family

MOOP and Deductible Guidance (cont.)

- For the 73 percent AV silver plan variation, the maximum out-of-pocket will be
  - $8,450 single, $16,900 family
- For the 87 percent and 94 percent AV silver plan variations, the maximum out-of-pocket will be
  - $3,500 single, $7,000 family

Subrogation or Reduction in Benefits

- NRS 689A.230 (2) prohibits "other valid coverage" from including automobile medical and 3rd party liability coverage and subrogation in individual health plans

- NRS 689B.063 (2) and NAC 689B.195 prohibits reducing benefits based on other health coverage through a franchise plan or first-party auto insurance

Pediatric Dental

- Pediatric dental is not required to be embedded in a medical plan if the issuer is reasonably assured certified stand-alone coverage has been obtained
- The issuer must obtain “reasonable assurance” that the off-exchange applicant has certified stand-alone coverage every year at renewal
- Nevada will consider self-attestation by an off-exchange applicant to be “reasonable assurance”
- Certified Dental plans are currently available in both the Individual and Small Group market.

Benefit Waiting Periods for Pediatric Dental

- Waiting periods are not allowed for essential health benefits
- Waiting periods are not allowed for pediatric orthodontia

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
- The calendar year deductible applicable to Pediatric Dental Services must be prominently displayed on page 1 of the schedule of benefits
- Type I Pediatric Dental Services (preventive and diagnostic) cannot be subject to the deductible

Division of Insurance Website

- The approved EOC and SOB for each individual and small group plan will be posted by November 1st
- Website will generally use “Plan Marketing Name” from Plans & Benefits Template

Plan Marketing Names

- Issuers may add cost sharing and/or other benefit information to a plan marketing name
- If included, the information must accurately reflect the plan benefits on a plan variant level, including any limitations or cost variations based on provider network or drug formulary tiering, benefit category, or service type.
- NOTE: Carriers submitting a BBSP in a QHP filing must include an identifier in the naming convention of each plan, e.g., “Silver Plan Name (Battle Born State Plan)”, “Bronze Plan Name (Battle Born State Plan)”, etc.

DIVISION OF INSURANCE

Protect Consumers, Ensure Solvency

Non-Integrated Deductible

Example 1: Plan has $2,000 medical and $500 drug deductible	
Compliant: ABC Health $2,000 Health Deductible; OR ABC Health $2,500 Ded; OR ABC Health 2500	Not Compliant: ABC Health 2000 Deductible

Example 2: Plan deductible only applies to tier 1 providers	
Compliant: ABC Health $2,000 Medical In-Network Tier 1 Deductible	Not Compliant: ABC Health 2000 Deductible

Cost-Sharing

Example 1: Plan cost sharing amount only applies for a limited number of visits	
Compliant: ABC Health Preferred Silver - 3 $0 Copay PCP visits	Not Compliant: ABC Health Preferred Silver $0 Primary

Example 2: Plan has $0 copay for 90-day supply of generic prescription drugs from mail provider	
Compliant: ABC Health Silver Care 0 Copay for Generic Mail Order Drugs from Select Provider	Not Compliant: ABC Health Silver Care 0 Drug Copay

Cost-Sharing Cont.

Example 3: Plan has $0 copay for visits scheduled with in-network (e.g., "ABC-care," a plan-specific name for in-network providers) or with a specific network tier of providers	
Compliant: ABC Health Bronze $0 Copay PCP visits with ABC-care provider	Not Compliant: ABC Health Bronze $0 PCP

Example 4: Plan has $0 copay for in-network telehealth visits only	
Compliant: ABC Health Bronze 0 Copay for Virtual PCP visits with ABC-care providers	Not Compliant: ABC Health Bronze $0 PCP; OR ABC Health Bronze $0 Doctor Visits; OR ABC Health Bronze Free Doc Visits

Example 5: Plan has a copay structure that differs based on provider or other benefit type	
Compliant: ABC Health $50 Copay PCP / $70 Copay specialist; OR ABC Health $50 Copay PCP	Not Compliant: ABC Health $50 Doctor visits

Benefit Information

Example 1: Plan has integrated deductible of $1,500 based on information in the Plans & Benefits Template	
Compliant: ABC Care $1,500	Not Compliant: ABC Care $500 Ded

Example 2: Plan refers to transportation benefits in variant marketing name (e.g., ABC Health Bronze Value +Transportation)	
Compliant: Plan brochure includes description of transportation benefit with information on cost, quantity, and transportation type; SBC may also list this benefit under “Other Covered Services.”	Not Compliant: Transportation benefit is not mentioned in plan brochure or any other materials

Name Consistency

Example 1:	
Compliant: **Plan Variant Marketing Name:** ABC Plan CommunityHealth Plus 2000 Medical Deductible, 3 $0 Copay PCP visits, Telehealth+ **Plan Name Listed on SBC:** ABC Plan CommunityHealth Plus	Not Compliant: **Plan Variant Marketing Name:** ABC Plan CommunityHealth Plus 2000 Medical Deductible, 3 $0 Copay PCP visits, Telehealth+ **Plan Name Listed on SBC:** CoveragePlus ABC Health 5000 Telehealth Low cost PCP

DIVISION OF INSURANCE

Protect Consumers, Ensure Solvency

No Required Benefits

Example 1:	
Compliant: ABC Health 2000 Medical Deductible, 3 $0 Copay PCP visits, Telehealth+	Not Compliant: ABC Health 2000 Medical Deductible, 3 $0 Copay PCP visits, No pre-existing condition limitations

HDHP/HSA Accuracy

Example 1:	
Compliant: ABC Health $0 Deductible, $0 PCP visits, SuperSaver	Not Compliant: ABC Health $0 Deductible, $0 PCP visits, SuperSaver, HSA

- Network Adequacy Requirements -

Network Adequacy Submission and Timelines

Individual Health Plans

- June 2rd — Deadline for carrier submissions in Plan Binders
- August 29th — DOI makes final determinations

Small Group Health Plans

- July 14th — Deadline for carrier submissions in Plan Binders
- September 29th — DOI makes final determinations

Objections/Responses

- The DOI anticipates a two-week turn around after a submission
- Under normal circumstances the carriers will have one week to respond to any objections

Required Documentation

1. Validated CMS ECP/Network Adequacy Template
2. Nevada Network Adequacy Declaration Document
3. YOY Deficiency Response, when prior year was "Passed/Approved with Stipulations"
4. Supplemental Outpatient Dialysis/Oral Surgeon/Hospital Workbook

Network Adequacy PY26

PY26 Federal Requirements – On Exchange Plans

- Applies to QHP individual health benefit plans

PY26 State Law: NAC 687B.768 – Off Exchange Plans

- Applies to non-QHP individual and small group health benefit plans
- Exemption for a non-QHP 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

Because there are two sets of NA standards beginning in PY26, the Division is providing filing direction in the following three slides for IND QHPs offering plans on and off the exchange.

Network Adequacy – Quest Analytics

- Software program, used by CMS, to measure network adequacy (Time and Distance Standards) results for the Nevada eligible enrollees.
  - Nevada population is derived from census file found at QHP Application Materials\Network Adequacy\Application Resources\PY##QHP Population Sample File
  - Service area and network information are derived from carrier submitted CMS templates.
  - Quest has a character limit on queries, please ensure the <Specialty Types> column does not exceed 255 characters.

Network Adequacy PY26 – cont.

Time and Distance Scenario 1 IND On/Off QHPs

(*On/off plans with different service areas **and** different provider networks*)

Provide an SAT that produces unique service area ids and an NT that produces unique network IDs.

For each row, enter one County for that Service Area ID (unless the Service Area covers entire state)

HIOS Issuer ID:*

Issuer State:* NV

Create Service Area IDs

Service Area ID* Required: Enter the Service Area ID	Service Area Name* Required: Enter the Service Area Name	State* Required: Does this Service Area cover the entire state?	County Name Required if State is "No": Select the County - FIPS this Service Area covers	Partial County Required if State is "No": Does this Service Area include a partial county?
NVS001	OnX State	Yes		
NVS002	OffX State	Yes		
NVS003	OnX Svc Area 1	No	Clark - 32003	No
NVS003	OnX Svc Area 1	No	Washoe - 32031	No
NVS003	OnX Svc Area 1	No	Nye - 32023	No
NVS004	OffX Svc Area 1	No	Clark - 32003	No
NVS004	OffX Svc Area 1	No	Washoe - 32031	No
NVS004	OffX Svc Area 1	No	Nye - 32023	No

Use each network ID only once.

HIOS Issuer ID*

Issuer State* NV

Create Network IDs

Network Name* Required: Enter the Network Name	Network ID* Required: Select the Network ID
OnX Providers	NVN001
OffX Providers	NVN002

Network Adequacy PY26 – cont.

Time and Distance Scenario 2 IND On/Off QHPs
*(On/off plans using the same provider network **and** same/different service area)*

Provide an SAT that produces unique on/off service area ids.

Example:
OnX Plan1/NVN001/NVS001
OffX Plan 2/NVN001/NVS002

For each row, enter one County for that Service Area ID (unless the Service Area covers entire state)

HIOS Issuer ID:*
Issuer State:* NV

Create Service Area IDs

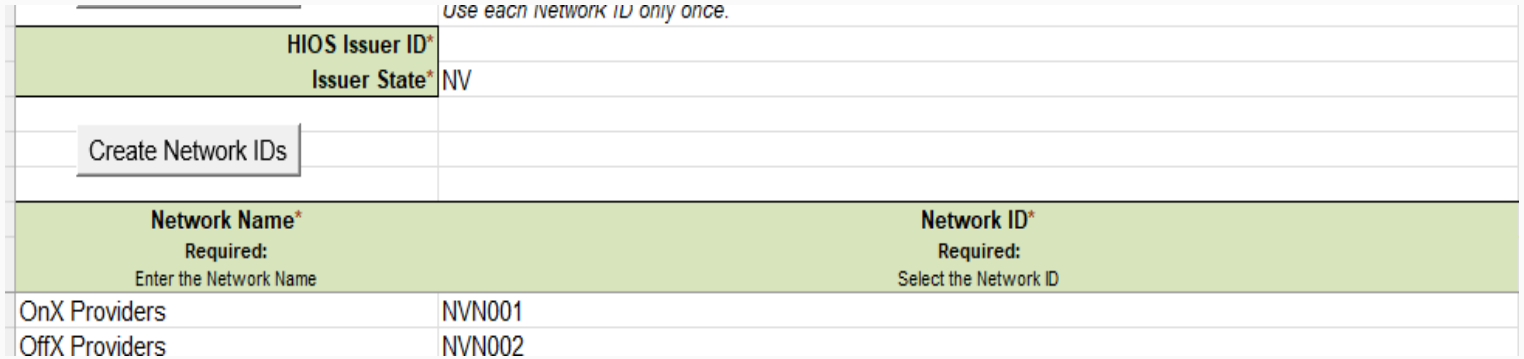
Service Area ID* Required: Enter the Service Area ID	Service Area Name* Required: Enter the Service Area Name	State* Required: Does this Service Area cover the entire state?	County Name Required if State is "No": Select the County - FIPS this Service Area covers	Partial County Required if State is "No": Does this Service Area include a partial county?
NVS001	OnX State	Yes		
NVS002	OffX State	Yes		
NVS003	OnX Svc Area 1	No	Clark - 32003	No
NVS003	OnX Svc Area 1	No	Washoe - 32031	No
NVS003	OnX Svc Area 1	No	Nye - 32023	No
NVS004	OffX Svc Area 1	No	Clark - 32003	No
NVS004	OffX Svc Area 1	No	Washoe - 32031	No
NVS004	OffX Svc Area 1	No	Nye - 32023	No

Network Adequacy PY26 – cont.

Time and Distance Scenario 3 IND On/Off QHPs
(*On/off plans using <u>different</u> provider networks **but** the same service area*)

Provide an NT that produces unique on/off network ids.

Example:
OnX Plan1/NVN001/NVS001
OffX Plan 2/NVN002/NVS001



Network Adequacy Standards PY26: QHPs

PROVIDER TIME AND DISTANCE STANDARDS BY COUNTY TYPE					
Individual Providers	**Code**	**Metro**	**Micro**	**Rural**	**CEAC**
Allergy and Immunology	007	45/30	80/60	90/75	125/110
Cardiology	008	30/20	50/35	75/60	95/85
Cardiothoracic Surgery	035	60/40	100/75	110/90	145/30
Chiropractor	010	45/30	80/60	90/75	125/110
Dental - ***Grouping****		45/30	80/60	90/75	125/110
Dental - General	201	*Same as above*			
Dental - Pediatric Dental	P201				
Dental - Orthodontist	202				
Dental- Periodontist	203				
Dental - Endodontist	204				
Dental - Prosthodontist	206				
Dermatology	011	45/30	60/45	75/60	110/100
Emergency Medicine	037	45/30	80/60	75/60	110/100
Endocrinology	012	60/40	100/75	110/90	145/130
ENT/Otolaryngology	013	45/30	80/60	90/75	125/110
Gastroenterology	014	45/30	60/45	75/60	110/100
General Surgery	015	30/20	50/35	75/60	95/85
Gynecology, OB/GYN	016	15/10	30/20	40/30	70/60
Infectious Diseases	017	60/40	100/75	110/90	145/130
Nephrology	018	45/30	80/60	90/75	125/110
Neurology	019	45/30	60/45	75/60	110/100
Neurosurgery	020	60/40	100/75	110/90	145/130

Network Adequacy Standards PY26: QHPs – cont.

Individual Providers	Code	Metro	Micro	Rural	CEAC
Occupational Therapy	050	45/30	80/60	75/60	110/100
Oncology – Medical/Surgical	021	45/30	60/45	75/60	110/100
Oncology – Radiation	022	60/40	100/75	110/90	145/130
Ophthalmology	023	30/20	50/35	75/60	95/85
Orthopedic Surgery	025	30/20	50/35	75/60	95/85
Outpatient Clinical Behavioral Health (Licensed, accredited, or certified professionals) - ***Grouping****		15/10	30/20	40/30	70/60
Marriage and Family Therapist	105	*Same as above*			
Addiction (Substance Use Disorder) Counselor	106				
Counselor (Mental Health and Professional)	107				
Behavioral Health - Advanced Practice Registered Nurse	108				
Addiction Medicine Physician	800				
Behavioral Analyst	801				
Licensed Clinical Social Workers (LCSW)	102				
Psychologist	103				
Physical Medicine and Rehabilitation	026	45/30	80/60	90/75	125/110
Physical Therapy	049	45/30	80/60	75/60	110/100
Plastic Surgery	027	60/40	100/75	110/90	145/130
Podiatry	028	45/30	60/45	75/60	110/100

Network Adequacy Standards PY26: QHPs – cont.

Individual Providers	Code	Metro	Micro	Rural	CEAC
Primary Care - ***Grouping****		15/10	30/20	40/30	70/60
General Practice	001	*Same as above*			
Family Medicine	002				
Internal Medicine	003				
Geriatrics	004				
Primary Care - Physician Assistance	005				
Primary Care - Advanced Registered Nurse Practitioner	006				
Primary Care – Pediatric	101				
Psychiatry	029	45/30	60/45	75/60	110/100
Pulmonology	030	45/30	60/45	75/60	110/100
Rheumatology	031	60/40	100/75	110/90	145/130
Speech Therapy	051	45/30	80/60	75/60	110/100
Urology	033	45/30	60/45	75/60	110/100
Vascular Surgery	034	60/40	100/75	110/90	145/130

Network Adequacy Standards PY26: QHPs – cont.

Facilities	Code	Metro	Micro	Rural	CEAC
Acute Inpatient Hospitals (Must have Emergency services available 24/7)	040	45/30	80/60	75/60	110/100
Cardiac Catheterization Services	042	60/40	160/120	145/120	155/140
Cardiac Surgery Program	041	60/40	160/120	145/120	155/140
Critical Care Services – Intensive Care Units (ICU)	043	45/30	160/120	145/120	155/140
Diagnostic Radiology (Free-standing; hospital outpatient; ambulatory health facilities with Diagnostic Radiology)	047	45/30	80/60	75/60	110/100
Inpatient or Residential Behavioral Health Facility Services - ***Grouping****		70/45	100/75	90/75	155/140
Inpatient Psychiatry (Free-standing inpatient psychiatric facility and psychiatric beds within an Acute Care Hospital)	052	*Same as above*			
Substance Use Disorder Rehabilitation Facility (Hospital unit and residential treatment facility)	072				
Children's Substance Use Disorder Rehabiliation Facility	P076				
Mental Health Residential Treatment Facility (Mental Illness, Psychiatric)	076				
Children's Residential Treatment Facility (Mental Illness; Psychiatric)	P076				
Mammography	048	45/30	80/60	75/60	110/100
Outpatient Infusion/Chemotherapy	057	45/30	80/60	75/60	110/100
Skilled Nursing Facilities	046	45/30	80/60	75/60	95/85
Surgical Services (Outpatient or ASC)	045	45/30	80/60	75/60	110/100
Urgent Care	080	45/30	80/60	75/60	110/100

Network Adequacy Standards PY26: Non-QHPs

Type	Specialty (Code)	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 (001-006)	15	10	30	20	40	30	70	60
	Endocrinology (012)	60	40	100	75	110	90	145	130
	Infectious Disease (017)	60	40	100	75	110	90	145	130
	Psychiatrist (029)	45	30	60	45	75	60	110	100
	Psychologist (103)	45	30	60	45	75	60	110	100
	LCSW (102)	45	30	60	45	75	60	110	100
	Oncology – Medical/Surgical (021)	45	30	60	45	75	60	110	100
	Oncology – Radiation/Radiology (022)	60	40	100	75	110	90	145	130
	Pediatrics (101)	25	15	30	20	40	30	105	90
	Rheumatology (031)	60	40	100	75	110	90	145	130
Facility	Hospitals (040 & 043)	45	30	80	60	75	60	110	100
	Outpatient Dialysis (044)	45	30	80	60	90	75	125	110

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 type for at least 90 percent of the population sample 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

Essential Community Provider Standards

A carrier must:

- Contract with at least **35%** of available Essential Community Providers (ECP)
  - ✓ in each plan's **service area** and
  - ✓ 35%, each, of the Family Planning Providers and the Federally Qualified Health Centers in the 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
- Offer contracts in good faith to **all** available ECPs in all counties designated as Counties with Extreme Access Considerations (CEAC) included in the plan's service area

ACUTE INPATIENT HOSPITALS PY26

- Please refer to the Network Adequacy General Acute Care Hospital (NA GACH) List available at https://www.qhpcertification.cms.gov/s/Network%20Adequacy, for the list of hospitals used to populate the CMS ECP/NA template. *NOTE: Issuers can provide feedback, to CMS regarding the accuracy of the list, within the hospital list itself.*

- Nevada hospitals (Specialty Code 040) that **are not** on the NA GACH List must be included in the Supplemental Template.

- **Do not** include Urgent Care Centers as Acute Care Hospitals.

- **Do not** include VA Hospitals.

Network Adequacy Supplemental Provider Template

- A supplemental network adequacy file, in Excel, is required for outpatient dialysis (non-QHPs), oral surgery providers and non-NA GACH Hospitals. The template is included on the Division website; you may combine all three provider types into one file.
  - Replicate the column format, e.g., "Zip" is not a numeric field.

National Provider Identifier (NPI)*	Provider First Name	Provider Last Name	Facility Name	Provider Grouping*	Specialty Types*	Does this provider offer telehealth?*	Street Address*	Street Address 2	City*	State*	County*	Zip*	Appointment Scheduling Provider Phone Number	Network IDs*
##########	FNAME	LNAME		Behavioral Health	102 Social Worker									
##########	FNAME	LNAME		Advanced Practitioner	005 Primary Care - Physician Assistant									
##########			HOSPITAL	Facility	040 Acute Inpatient Hospitals (Must have Emergency services available 24/7)									

PY25 YOY Deficiency Response Exhibit

If a carrier received a network adequacy review result of "Approved/Passed with Stipulations", that carrier must complete a new exhibit: *"YOY Deficiency Response"*. NOTE: as previously identified in the slides *Binder Submissions – Supporting Documentation* and *Binder Checklist*, this exhibit replaces the "*Network Adequacy Year Over Year*" worksheet.

Sample

Network ID:	<CARRIER TO ADD NVN>	
Service Area ID	<CARRIER TO ADD NVS>	
PY25 DEFICIENCY RECTIFIED FOR:		
PROVIDER TYPE	PY25 # OF PROVIDERS	PY26 # OF PROVIDERS
Pediatrics	100	150
Psychiatry	200	250

Nevada County Designations Reference for Network Time and Distance Standards

County	Designation	Rating Area	County	Designation	Rating Area
Clark	Metro	**1**	**Esmeralda**	CEAC	**4**
Nye	CEAC		**Eureka**	CEAC	
Washoe	Metro	**2**	**Humboldt**	CEAC	
Carson City	Metro	**3**	**Lander**	CEAC	
Douglas	Micro		**Lincoln**	CEAC	
Lyon	Micro		**Mineral**	CEAC	
Storey	Rural		**Pershing**	CEAC	
Churchill	CEAC	**4**	**White Pine**	CEAC	
Elko	CEAC				

PY25 Binder and Form Issues

- **Carriers must utilize the "Associate Schedule Items" function in the Binder to attach the policy forms, rating information and renamed templates from the Form and Rate filings, e.g., Certificate of Coverage, Schedule of Benefits, URRT Parts I-III, etc.**
- Carriers included Veteran Affairs hospitals in the required network submissions; they **are not** to be included.
- Carriers are to provide clean copies of approved policy forms for Individual and Small Group filings: in the filing after approval and also sent to the Division **via email**.
- There were requested revisions after **final** Division approval. Carriers should thoroughly check submissions before final Division approval.
  - Individual Plans: After 8/29, requires both SSHIX & DOI approval
  - Limited Data Correction Window: 10/6 – 10/10
  - Absolutely no changes after 10/31 - **Division will favor the consumer in decisions**.

Comments from the Silver State Health Exchange

- Exchange guidance aligns with that presented by the Division.
- An on-Exchange specific deck will be sent today to all carrier contacts on file with the Exchange.
- The Exchange recognizes and understand the uncertainty and anxiety around proposed legislation, the Exchange will provide updates as they become available.
- For questions or for a copy of the Exchange deck, please contact pmanagement@exchange.nv.gov.

Contact Us

- Rate Development
  - Maile Campbell, Lead Actuary
    mcampbell@doi.nv.gov
- Rate and Binder Filings
  - Jeremy Christensen, Actuarial Analyst III
    jchristensen@doi.nv.gov
- Form Filings and Network Adequacy
  - Reida Wagner, Actuarial Analyst II
    rlwagner@doi.nv.gov

QUESTIONS?