

Division of Insurance

2023 Health Benefit Plan Filing Guidance

Webinar: May 2, 2022 9:00 am Pacific

Please see Final Notice of Benefit and Payment Parameters for Highlighted Info.

April 12, 2022



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Filing Submission Deadlines

	Rates	Forms	Binders
All individual Medical plans	June 1st	June 1st	June 1st
All small group Medical plans	July 13th	July 13th	July 13th
All exchange-certified dental plans	June 1st	June 1st	June 1st

* These deadlines are applicable to Rate, Form, Binder and Network Adequacy submission



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- Rate Filing Requirements -



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NV 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)



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ARPA Subsidy Expiration

- File rates using the assumption of expiration



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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



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COVID-19

- Detailed breakdown and quantitative and qualitative support for:
 - Morbidity
 - Unit Cost & Utilization
 - Other
- Either option is acceptable
 - 2021 experience with adjustments
 - 2019 trending forward with adjustments
- Detailed quantitative and qualitative support for any adjustments



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Basis for 2023 Rate Filings - I

- The Affordable Care Act (ACA), including federal regulatory and sub-regulatory guidance in effect on the filing submission due date.
- Nevada State law.
- Final Notice of Benefit and Payment Parameters for 2023
- Other state guidance, e.g., this slide deck.



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Basis for 2023 Rate Filings - II

- Actuarial Value (AV) Calculator for 2023
- 2023 Unified Rate Review Template (URRT) and instructions
- Updated Nevada rate filing template and instructions
 - Version 4.2 as posted on the Division's website.



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Detailed Rate Review Timeline

- The following dates 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 our website.



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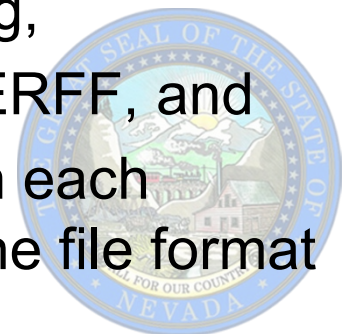
Detailed Rate Review Timeline

Description	Responsibility	Individual Plans	Small Group Plans
Rate Filing Due	Carriers	6/1/2022	7/13/2022
First Objection to Carriers	Division	6/15/2022	7/27/2022
Response to First Objection	Carriers	6/24/2022	8/3/2022
Second Objection to Carriers	Division	7/1/2022	8/10/2022
Response to Second Objection	Carriers	7/11/2022	8/24/2022
Third Objection to Carriers	Division	7/18/2022	9/1/2022
Response to Third Objection	Carriers	7/25/2022	9/7/2022
Proposed Rate Changes posted on Division's website	Division	8/1/2022	8/1/2022
Final Rate Decisions to Carriers	Division	8/17/2022	9/15/2022
Final Rate Modifications to DOI	Carriers	8/23/2022	9/23/2022
Final Data Transfer to SSHIX	Division	8/26/2022	NA
Final Approved rates posted on the Division's website	Division	10/1/2022	10/1/2022

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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 you:
 - 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.).



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Division of Insurance Website - Rates

- Proposed 2023 rates will not be posted
- Proposed rate filing information (min, max, average rate changes) will be posted on August 1st
- Approved 2023 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
- Information from Plan & Benefits, Service Area, and Nevada templates will be posted on the website, so please complete correctly



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Rate Submission Requirements

- Separate filings for rates and forms
 - Health benefit plans
- All documents must be submitted in SERFF
- Follow standardized naming convention for templates



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Standardized Naming Convention

- CarrierName_YYYYQ#mkt_v#_Template.xml
 - CarrierName: Up to 6 Characters which identify the carrier
 - YYYY: 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



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Submitting Templates and Support

- Use separate headers for each template
- Please submit AV calculator screen shots as a single file



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SERFF Submissions - I

- Rate/Rule Tab of SERFF (public access)
 - 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



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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](https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Instructions%20for%20the%20Redacted%20Actuarial%20Memorandum%2020150416.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.



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SERFF Submissions - II

- Supporting Documents tab of SERFF
 - 2023 Unified Rate Review Template (URRT) - Part I (confidential)
 - both XLS and XML formats
 - Actuarial Memorandum - Part III, (confidential)
 - Format must follow the order of the 2023 URR instructions
 - Exhibits supporting the Actuarial Memorandum (in Excel format, with working formulas)



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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



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SERFF Submissions - III

- Supporting Documents tab of SERFF
 - Plan & benefits template
 - Both XLS and XML formats
 - Service area template
 - Both XLS and XML formats
 - 2023 Nevada rate filing template (version 4.2)
 - Both XLS and XML formats
 - AV Calculator screenshots and support for unique plan designs
 - Documentation for \$ limit substitutions
 - Completed rate filing checklist



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Formula for Timely Approvals - I

- Follow 2023 federal and state guidance
 - COVID-19 documentation
- 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 URR 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 (v4.2) completed in accordance with instructions



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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 DOI



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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



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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: $(\$53M/\$50M)-1 = 6.00\%$



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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.



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NV RATEE Program

- 04/29/2022 RATEE file from carrier
- Deadline: First Friday of May
- Confidentiality



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2023 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



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2023 Exchange Fee

- Exchange Fee - 3.05% of premium for QHPs and SADPs
 - Same as 2022



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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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Changes to AV Calculator De Minimis Ranges

- Expanded Bronze: Change to +5% / -2%
- Silver QHP's: Change to +2% / 0%
- Silver CSR Variations: Change to +1% / 0%
- Other: +2% / -2%



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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



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- Form and Binder Requirements -



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2023 Filing Timeline for Individual Carriers

- All Individual QHP and Non-QHP binders must be submitted in SERFF no later than June 1st , 2022
- All form and rate filings for individual carriers due June 1st , 2022
- The NV DOI will provide final decision on August 25th , 2022



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2023 Filing Timeline for Small Group Carriers

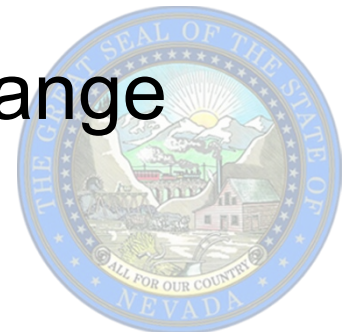
- All Small Group QHP and Non-QHP binders must be submitted in SERFF no later than July 13, 2022
- All form and rate filings for Small Group carriers due July 13, 2022
- The NV DOI will provide final decision on or before October 1st, 2022



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Risk Pool Filings

- All products from the same risk pool must be submitted within a single form 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 allowed off Exchange



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Binder Submissions

- Separate binders for individual and small group filings for each carrier
- Must include validated Plan Management templates
- Must include the completed MHPAEA Attestation Letter
- Must include the network adequacy supporting data and documentation
- Please follow the naming convention for templates



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MHPAEA Attestation Letter

- Supporting Documentation in binder.

**Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)
 Compliance Attestation**

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that generally prevents group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits.

Description	Reference	Carrier Comments	Attestation
Applicability of mental health parity	42 U.S.C. 18031(j)		The issuer has reviewed the Mental Health Parity and Addiction Equity Act of 2008, specifically those sections related to applicability, and is in compliance with the applicable requirements. <input type="checkbox"/> Act of 2008, specifically those sections related to applicability, and is in compliance with the applicable requirements.
Aggregate lifetime limits	42 U.S.C. 300gg-26 (a) (1), 45 CFR 146.136(b)		The issuer has reviewed the Mental Health Parity and Addiction Equity Act of 2008, specifically those sections related to the aggregate lifetime limits, and is in compliance with the applicable requirements. <input type="checkbox"/> Act of 2008, specifically those sections related to the aggregate lifetime limits, and is in compliance with the applicable requirements.
Annual limits	42 U.S.C. 300gg-26 (a) (2), 45 CFR 146.136(b)		The issuer has reviewed the Mental Health Parity and Addiction Equity Act of 2008, specifically those sections related to the annual limits, and is in compliance with the applicable requirements. <input type="checkbox"/> Act of 2008, specifically those sections related to the annual limits, and is in compliance with the applicable requirements.
Financial requirements and treatment limitations	42 U.S.C. 300gg-26(a) (3), 45 CFR 146.136(c), 45 CFR 146.136(d)(2)		The issuer has reviewed the Mental Health Parity and Addiction Equity Act of 2008, specifically those sections related to the financial requirements and treatment limitations, and is in compliance with the applicable requirements. <input type="checkbox"/> Act of 2008, specifically those sections related to the financial requirements and treatment limitations, and is in compliance with the applicable requirements.
Availability of plan information	42 U.S.C. 300gg-26(a)(4)		The issuer has reviewed the Mental Health Parity and Addiction Equity Act of 2008, specifically those sections related to the availability of plan information, and is in compliance with the applicable requirements. <input type="checkbox"/> Act of 2008, specifically those sections related to the availability of plan information, and is in compliance with the applicable requirements.
Internal claims and appeals and external review processes	45 CFR 147.136		The issuer has reviewed the Mental Health Parity and Addiction Equity Act of 2008, specifically those sections related to the internal claims and appeals and external review processes, and is in compliance with the applicable requirements. <input type="checkbox"/> Act of 2008, specifically those sections related to the internal claims and appeals and external review processes, and is in compliance with the applicable requirements.
Nonquantitative treatment limitations (NQTL)	42 U.S.C. 300gg-26(a) (3), 45 CFR 146.136 (c), 45 CFR 156.115(a)(3), ACA FAQs Part 34		The issuer has reviewed the Mental Health Parity and Addiction Equity Act of 2008, specifically those sections related to the NQTL, and is in compliance with the applicable requirements. <input type="checkbox"/> Act of 2008, specifically those sections related to the NQTL, and is in compliance with the applicable requirements.

Whether the mental health services are outsourced? _____

If the answer is "Yes", please provide more details _____

Name of Organization / Agency: _____
 Street _____
 City, State, Zip Code: _____
 Phone: _____
 Authorized Signature: _____
 Print Name: _____
 Title: _____
 Date: _____



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Template Naming Convention

- CarrierName_YYYYmkt_v#_Template.xml
 - CarrierName: Up to 6 Characters which identify the carrier
 - YYYY: 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 – Rating Business Rules Template
 - URRT - URR Template



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Health Form Filings

- Redlined versions of SOBs and EOCs for existing plans under Forms Schedule Tab
- Final objection will be to submit clean copies for each document.
- Clean copies emailed to the Division, once approved, for website posting (Only email the standard plans)
- AV calculator screen shots for each plan
- Upload completed checklist under the “Supporting Documentation” tab (should reflect redlined Pg. #'s)
 - http://doi.nv.gov/Insurers/Life_and_Health/ACA_Plans/Form_Filings_and_Plan_Certification/
- Please follow the naming convention for forms

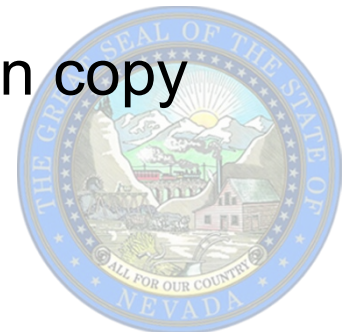


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Form Filing Name Convention

- PlanMarketingName_PlanID_Form_type_v#.pdf
 - PlanMarketingName: Please use acronyms and not the full name, and include descriptors such as HSA, ZCS, LCS, CSR73, etc
 - PlanID: Last 9 digits of HIOS Plan ID (use the product ID for documents that will be paired with multiple plans) including CSR variations (_00,_01,etc)
 - Form: Cert, EOC, Pol, Sch, App
 - Type: “r” for redline version and “c” for clean copy
 - v#: version number

* *example: MyBestSilverCSR87_0010001_05_Sch_c_v1.pdf*



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Removing Plans From a Product

- Carriers may remove plans from a product each year
- All affected policyholders must receive a notice of cancelation 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)



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2023 Nevada EHB Benchmark Plan

- HPN Solutions HMO Platinum 15/0/90% (no change from PY 2022)
- 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



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Documentation for \$ limit substitutions

- ABA benefit limit
 - A maximum benefit of not less than the actuarial equivalent of \$72K per year for ABA, justified by an actuary
 - Must specify the ABA benefit limits (or unlimited)
- Coverage for special food for PKU
 - Actuarial equivalent of \$2,500 minimum



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Presumptively Discriminatory Benefit Designs

- 2023 Payment Notice
- No age restrictions for autism spectrum disorder
- No age restrictions for infertility treatment



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Plan Service Area

- QHP service areas must equal one or more rating territories
- Nevada's rating territories for 2023 are unchanged
- Off-exchange plan service areas may use partial counties
 - May be 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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Prescription Drugs

- Issuers have the flexibility to determine whether to include or exclude coupon amounts from the annual limitation on cost sharing, regardless of whether a generic equivalent is available.



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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 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 at the same time that the rate and form filings finalized.



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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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MOOP and Deductible Guidance

- For 2023 individual and small group health benefit plans, the maximum out-of-pocket will be
 - \$9,100 single, \$18,200 family
- For 2023 HSA plans, the maximum out-of-pocket will be
 - \$7,500 single, \$15,000 family (*Pending IRS announcement*)
- For 2023 HSA plans, the minimum deductible will be
 - \$1,500 single, \$3,000 family (*Pending IRS announcement*)



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MOOP and Deductible Guidance

- For the 73 percent AV silver plan variations, the maximum out-of-pocket will be
 - \$7,250 single, \$14,500 family
- For the 87 percent and 94 percent AV silver plan variations, the maximum out-of-pocket will be
 - \$3,000 single, \$6,000 family



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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



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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
- 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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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



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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 schedule of benefits
- For pediatric dental, Type I dental services (preventive and diagnostic services) cannot be subject to the deductible



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- The Division will not post proposed 2023 rates
- Approved 2023 rates will be posted by October 1st
- The approved schedule of benefits and evidence of coverage for each individual plan will be posted by November 1st
- Website will generally use “Plan Marketing Name” from Plans & Benefits Template



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- Network Adequacy Requirements -



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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 Submission

- Carriers must submit network plan documentation within plan binders
 - Individual Health Plans – June 1, 2022
 - Small Group Health Plans – July 13, 2022
- Required Documentation
 - CMS ECP/Network Adequacy Template
 - 2023 Nevada Declaration Document
 - Autism Provider Template
 - Network Adequacy Year Over Year Exhibit
 - Network Adequacy Filing Checklist



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Network Adequacy Timeline

Individual Health Plans

- June 1st Deadline for carrier submissions
- August 30th DOI makes final determinations

Small Group Plans

- July 13th Deadline for carrier submissions
- September 30th DOI makes final determinations

Objections/Responses

- The DOI anticipates no more than a two-week turn around after a submission
- Under normal circumstances the carriers will have two weeks to respond to any objections



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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
	Psychiatrist	45	30	60	45	75	60	110	100
	Psychologist	45	30	60	45	75	60	110	100
	LCSW	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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Essential Community Provider Standards

A carrier must:

- Contract with at least **30%** 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
- 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



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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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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 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



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Network Adequacy Review Process

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

Templates submitted with urgent care facilities classified as hospitals will be objected to and be required to submit a corrected template

- Check data for error
 - Addresses with no city, state, or zip codes
 - Typographical errors in provider names or street addresses
 - Misclassification of a provider specialty or facility specialty



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Access for Individuals with High-Cost Illnesses

Identifying Market Outliers in Network Access for High-Cost Illness

- Using time or distance standards analysis
- The following illnesses will be studied
 - Cancer, diabetes mellitus, epilepsy, heart disease, HIV, multiple sclerosis, rheumatoid arthritis and severe mental illness
- Each disease has been paired to providers based on customary patterns of care
- Outliers will be investigated further to determine if discrimination for a particular disease exists due to network design
- Each carrier will submit a narrative including established patterns of care for treatment; highlighting the accessibility of the providers included in the treatment of these illnesses based on the health plan network used for each plan being offered.



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Access for Individuals with High-Cost Illness

Disease	Specialty
Cancer	021 Medical Oncology and Surgical Oncology
	022 Radiation Oncology
	047 Diagnostic Radiology
Diabetes Mellitus	012 Endocrinology
	015 General Surgery
	023 Ophthalmology
	028 Podiatry
Epilepsy	019 Neurology
	047 Diagnostic Radiology
Heart Disease	008 Cardiovascular Disease
	035 Cardiothoracic Surgery
	041 Cardiac Surgery Program
	042 Cardiac Catheterization Services

Disease	Specialty
Hepatitis C	014 Gastroenterology
	015 General Surgery
	017 Infectious Diseases
HIV	017 Infectious Diseases
Multiple Sclerosis	019 Neurology
	049 Physical Therapy
Rheumatoid Arthritis	015 General Surgery
	031 Rheumatology
	049 Physical Therapy
Severe Mental Illness	029 Psychiatry
	040 General Acute Care Hospital
	052 Inpatient Psychiatry
	103 Psychology

Division of Insurance

Last Year's Issues

- Triple check submissions before final approval.
- Don't reuse terminated HIOS plan ID's
- Rates exist for all service areas listed for the plan in the PBT.



Division of Insurance

Contact Us

- Rate, Form, and Binder Filings
 - Jeremy Christensen - jchristensen@doi.nv.gov
- Network Adequacy
 - Jeremey Gladstone jgladstone@doi.nv.gov



Division of Insurance

Questions

