State of Nevada

DEPARTMENT OF BUSINESS AND INDUSTRY

Division of Insurance

2025 Health Benefit Plan Filing Guidance

Webinar: 04/30/2024 08:00 am Pacific

Effective January 1, 2025

Scott J. Kipper, Commissioner of Insurance

Filing Submission Deadlines*

	Rates	Forms	Binders
All Individual Medical Plans	June 17th	June 3rd	June 3rd
All Small Group Medical Plans	July 15th	July 15th	July 15th
All exchange-certified Dental Plans	June 3rd	June 3rd	June 3rd

*These deadlines are applicable to Rate, Form, Binder Filings (including Network Adequacy)

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)

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 PY25 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 PY25 Rate Filings – Part II

- Actuarial Value (AV) Calculator for 2025
- 2025 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.
  - 2023 Risk Adjustment values will be updated once RATEE reports are sent to carriers, Approx 5/24.

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	06/17/2024	07/15/2024
First Objection to Carriers	Division	06/24/2024	07/22/2024
Response to First Objection	Carriers	07/01/2024	07/29/2024
Second Objection to Carrier	Division	07/08/2024	08/05/2024
Response to Second Objection	Carriers	07/15/2024	08/12/2024
Third Objection to Carrier	Division	07/22/2024	08/19/2024
Response to Third Objection	Carriers	07/29/2024	08/26/2024
Proposed Rate Changes posted on Division's website	Division	08/1/2024	08/1/2024
Rate Decisions to Carriers ("Final" if no modification required)	Division	08/09/2024	09/09/2024
Final Modification to Division	Carriers	08/19/2024	09/19/2024
Final Rate Decisions to Carriers	Division	08/26/2024	09/26/2024
Final Data Transfer to SSHIX	Division	09/03/2024	NA
Final Approved Rates posted on Division's website	Division	10/01/2024	10/01/2024

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 2025 rates will not be posted
- Proposed rate filing information (min, max, average rate changes) will be posted by August 1st
- Approved 2025 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 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

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

Submitting Templates and Support

- Use separate headers for each template under “Supporting Documentation” tab
- Please submit AV calculator screen shots as a single 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.
- The Network Adequacy Declaration Document has been reformatted and revised.

SERFF Submissions - I

- Rate/Rule Tab of SERFF (public access - nothing confidential!)
  - 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
  - 2025 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 2025 URR instructions

SERFF Submission - III

- Supporting Documents tab of SERFF
  - 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
  - Plan & benefits template
    - Both XLS and XML formats
  - Service area template
    - Both XLS and XML formats
  - 2025 Nevada rate filing template (version 4.2.2)
    - Both XLS and XML formats
  - AV Calculator screenshots and support for unique plan designs
  - AV Equiv. Documentation for $ limit substitutions
  - Completed rate filing checklist
  - Drug defrayal support (SB 439)

SB 439

- Carriers must cover FDA-approved drugs for testing, treating and preventing human immunodeficiency virus (HIV) and hepatitis C.
- Carriers must provide coverage for testing, treating and preventing hepatitis B.
- State mandated drugs covered by a carrier in excess of the EHB BMP cannot be counted as EHB; they must be defrayed.

PY2025 Drug Defrayal Process

- Price as normal using 2023 experience data with no adjustment factors for SB439 mandates
- Provide 2023 EDGE server data directly to consulting actuaries
- DOI consulting actuaries will use state-wide EDGE data to develop a PMPM defrayal amount
- Based on 2022 EDGE data, the current estimate is a $10 PMPM defrayal amount for Individual QHP's

Drug Defrayal Rating

- Per CMS guidance, the cost of drugs in addition to EHB must be excluded from QHP rates on both the URRT and Rates Table Template
- Carriers must not factor these state-required benefits into the calculation of "Benefits in Addition to EHB"
- Carriers must still indicate in the Benefits Information field on the Plans and Benefits template that it covers the state-required benefits
- Rates for individual plans that are not QHPs must be adjusted at the plan level to reflect the cost of drugs in addition to EHB

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.

New 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 2025 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 (v4.2.2) completed in accordance with instructions

New Enrollment Template

- The Division is in the process of evaluating the format and data provided in the Nevada Template (NVT) to reduce the overall burden on carriers in the rate filings.
- Throughout the transition process, there may be some added redundancy in the data provided to ensure that we are getting everything we need, but the end goal is to simplify and eliminate these redundancies.
- A new Enrollment Template is available on our website as a supplement and possible replacement to the NVT.
- The data requested is far more granular, but should be much easier for carriers to populate, and still allow the Division to extract the same information provided in the NVT.
- Please attach this new completed template under supporting documentation in addition to the NVT.

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

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

- 05/01/2024 RATEE file from carrier
  - CMS has delayed final report to 5/21
  - We will use this RATEE file for the PY2023 RA report

- Deadline: First Friday of May
  - To DOI by 5/23, report back to carriers 5/24
  - Imperative that we get these back timely

- Confidentiality

2025 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

2025 Exchange Fee

- Exchange Fee – 2.95% of premium for QHPs and SADPs
  - Decreased from 3.05%

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 same as PY24

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

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

2025 Filing Timeline for Individual Carriers

- All Individual QHP and Non-QHP binder and form filings must be submitted in SERFF no later than June 3, 2024

- The NV DOI will provide final decision by August 26, 2024

2025 Filing Timeline for Small Group Carriers

- All Small Group binder and form filings must be submitted in SERFF no later than July 15, 2024

- The NV DOI will provide final decision by September 26, 2024

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 only allowed off Exchange

Binder Submissions

- Separate binders for individual and small group filings for each carrier

- Must include the validated Plan Management templates and, under Supporting Documentation, in addition to previous required responses, the following new/revised items:
  - Binder Checklist and associated items (replaces "Network Adequacy Filing Checklist")
  - Results from Data Integrity Tool (DIT)
  - Revised network adequacy declaration document and support (YOY exhibit revisions)
  - Indian Health Care Provider letter documentation
  - Appropriately renamed CMS templates (.xls)
  - Documentation for URLs for Machine-readable files and cost estimator tool
  - **Org chart and narrative for outsourced operations (NEW)**

- Removed MHPAEA attestation letter, ECP Write-in worksheet and Autism Provider Templates from submission requirements

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 – Business Rating Rules Template
  - URRT – Unified Rate Review Template

Form Filings Instructions Part I

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

- Form Schedule Tab –
  - ✓ Submit redlined versions of SOBs and EOCs for existing plans (*see naming convention details on Form Filing Instructions Part II*)
    - The final objection will be to replace the redlines with clean copies.
    - Clean copies for **all** (Ind/SG) approved policy forms must be emailed to the Division for website posting.
      - ❖ For the Individual SOBs, send the "-00" variant version only
      - ❖ Confirm all links are working within policy forms.

Form Filings Instructions Part I (cont.)

- Supporting Documentation tab -
  - ✓ Add AV calculator screen shots for each plan
  - ✓ Add Actuarial Value Equivalent
    - 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
  - ✓ Upload completed 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 PY25 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

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)

PY25 Nevada EHB Benchmark Plan

- HPN Solutions HMO Platinum 15/0/90% (no change from PY 2024)
- 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

82nd Legislative Session Approved Bills

- AB 155: Biomarker
- AB 156: Opioid Use Disorder
- SB 132: Living Organ Donor
- SB 163: Gender Affirming Care
- SB 167: Psychiatric Step Therapy
- SB 194: Step Therapy
- SB 280: Hospital Contraception
- SB 330: Enhanced Breast Cancer Testing
- SB 439: Drug Coverage (details on next slide)

SB 439: Drug Coverage

Effective 1/1/2024, carriers must cover FDA-approved drugs for testing, treating and preventing human immunodeficiency virus and hepatitis C.

- Ensure the CMS Formulary Template includes **the FDA approved** drugs.
  - ✓ *The Division will confirm using the CMS Drug Count Review Tool <Category Class Detail Tab>. Example below:*

DRUG CLASS	
Anti-HIV Agents, Integrase Inhibitors (INSTI)	Anti-HIV Agents, Protease Inhibitors (PI)
Anti-HIV Agents, Non-nucleoside Reverse Transcriptase Inhibitors (NNRTI)	Anti-HIV Agents, Nucleoside and Nucleotide Reverse Transcriptase Inhibitors (NRTI)
Anti-HIV Agents, Other	

- Ensure policy forms include language to support SB 439.

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 Civil Action No. 22-2604 (JDB), HIV & Hepatitis Pol'y Inst. v. U.S. Dep't of Health & Hum. Servs., the Division is enforcing prior guidance to allow the exclusion of Rx coupons from cost-sharing limits **only in situations where a generic is available**.

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

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

Prescription Drugs (cont.)

- Issuers must provide a link to an exceptions process* that allows an individual access, without cost-sharing, to the specific contraceptive drug or drug-led device (that is a therapeutic equivalent to the product that is covered without cost sharing) that is determined to be medically necessary with respect to the individual, as determined by the individual's attending provider.

  NOTE: The link must take the consumer directly to this process.

*https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-64.pdf

Plans and Benefits Template re: Benefits Explanation Field

The language displayed on the SSHIX, derived from the PBT Benefits Explanation field, should be consumer friendly. Carriers are being asked to review their responses before submitting the PBT and, where necessary, to modify existing language. To assist in this review, the Division is providing a few examples of previously approved language and suggested replacement language on the next two slides.

Benefits Explanation Field Examples (cont.)

Benefit	Benefit Explanation - Current	Benefit Explanation - Proposed
Hearing Aids	1 Item(s) Per Hearing-Impaired Ear. Repairs and replacement limited to once every 3 years.	Your Hearing Aids Services benefit includes the purchase of one item per hearing-impaired ear as well as repairs and replacements.
Generic Drugs	30 day supply	This is your lowest cost-share option. Generic drugs must have the same active ingredient as the brand name drug as well as the same dosage, strength, safety, conditions of use and route of administration. Consult with your medical professional to see if a generic drug is right for you.
Preferred Brand Drugs	30 day supply	Often two brand-name drugs are useful for the same problem. <Carrier> may be able to get one less expensively than the other, while providing the same positive outcomes, and that drug becomes a preferred drug.
Non-Preferred Brand Drugs	30 day supply	If, on the advice of your medical professional, you are unable to tolerate the Preferred Brand Drug, <Carrier> provides coverage for an equivalent Non-Preferred Brand Drug.

Benefits Explanation Field Examples (cont.)

Benefit	Benefit Explanation - Current	Benefit Explanation - Proposed
Bariatric Surgery	Bariatric Surgery/Gastric Bypass is limited to one surgery every five years.	Trying to improve your health but struggling with weight management issues? You may be eligible for Bariatric/Gastric Surgery if you meet <Carrier's> medical requirements. Please refer to <Carrier's> Certificate of Coverage for the requirements.
Home Health Care Services	Benefits provided for medical social service consultation per course of treatment; nutrition consultation by a certified registered dietitian; and health aide services are furnished only when receiving nursing services or therapy.	Your Home Health Care Services includes several benefits throughout the course of treatment: social service consultation, nutritional consultation and health aide services. Please refer to <Carriers> Certificate of Coverage for additional details.
Emergency Room Services	Copayment is waived if admitted	If you are admitted to an inpatient hospital facility through an emergency room and you are enrolled in a plan with an Emergency Room copayment, <Carrier> will waive your Emergency Room copayment.
Infertility Treatment	Covered services include office visit evaluation and limited: 1. Laboratory studies; 2. Diagnostic procedures; and 3. Artificial insemination services, up to six (6) cycles per Member per lifetime.	Trying to have a baby? <Carrier> provides Infertility Treatment Services that includes office visit evaluations, limited laboratory studies and diagnostic procedures, including artificial insemination services.
Private-Duty Nursing	Covered when provided by "a Hospital, Ambulatory Surgical Facility, Skilled Nursing Facility or Hospice Care Facility", subject to the benefit limitation for such facility services.	You have benefits for Private-Duty Nursing services through a Hospital, Ambulatory Surgical, Skilled Nursing or Hospice Care Facility. Please refer to <Carriers> Certificate of Coverage for the specific benefit limitations.
Habilitation Services	Limit is combined across all settings. Limit is combined for habilitative physical therapy, occupational therapy and speech therapy.	You have benefits for Habilitation Services for Physical, Occupational and Speech Therapy. There is a combined benefit maximum that applies to all habililation services.
Outpatient Rehabilitation Services	Limit is combined across all settings. Limit is combined for rehabilitative physical therapy, occupational therapy and speech therapy.	You have benefits for Outpatient Rehabilitation Services for Physical, Occupational and Speech Therapy. There is a combined benefit maximum that applies to all rehabilitation services.

CMS Guidance regarding Medicare

On May 23, 2023, the Centers for Medicare & Medicaid Services (CMS) issued a clarification that the Affordable Care Act requirements of D7 in the 2016 updates to Frequently Asked Questions Regarding Medicare and the Marketplace[1] apply in the same manner to non-grandfathered individual health insurance coverage. In that clarification CMS makes clear that health plans can't limit or exclude coverage based on the theoretical possibility of an individual's enrollment in other primary health care coverage. In addition, a health plan can't modify benefit coverage or non-renew coverage based on Medicare eligibility. While this recent clarification by CMS applies only to a small number of health plans it's an important statement about the inapplicability of theoretical coverage to the payment of health care benefits.

[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.

Presumptively Discriminatory Benefit Designs

- 2022 Payment Notice
  - No discriminatory benefit design regardless of inclusion of discriminatory language in statute or benchmark plan, e.g.,
    - Age restrictions for autism spectrum disorder
    - Age restrictions for infertility treatment

Plan Service Areas

- QHP service areas must equal one or more rating territories
- Nevada's rating territories for 2025 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 2025 individual and small group health benefit plans, the maximum out-of-pocket will be
  - $9,200 single, $18,400 family
- For 2025 HSA plans, the maximum out-of-pocket will be
  - $8,050 single, $16,100 family (Pending IRS announcement)
- For 2025 HSA plans, the minimum deductible will be
  - $1,600 single, $3,200 family (Pending IRS announcement)

MOOP and Deductible Guidance (cont.)

- For the 73 percent AV silver plan variation, the maximum out-of-pocket will be
  - $7,350 single, $14,700 family
- For the 87 percent and 94 percent AV silver plan variations, the maximum out-of-pocket will be
  - $3,050 single, $6,100 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”

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 Division will not post proposed 2025 rates
- **Approved** 2025 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

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

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 Regulation

- Applies to 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

DIVISION OF INSURANCE

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Network Adequacy Standards

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

Nevada County Designations

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				

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

Network Adequacy Review Process (cont.)

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

  An objection will be submitted if a carrier submits templates that classify "urgent care facilities" as "hospitals"; a corrected template will be required.

- Check data for common errors
  - Addresses with no city, state, or zip codes
  - Typographical errors in provider names or street addresses
  - Misclassification of a provider specialty or facility specialty
  - Missing/incorrect provider code (NPI)

Network Adequacy Submission

- Carriers must submit network adequacy documentation within plan binders
  - Individual Health Plans: June 03, 2024
  - Small Group Health Plans: July 15, 2024

- Network ID Template: do not include data on the NT that are not included on the PBT.

- Required Documentation
  1. Validated CMS ECP/Network Adequacy Template
  2. Supplemental Outpatient Dialysis/Oral Surgeon Workbook[1]
  3. Nevada Network Adequacy Declaration Document
  4. Network Adequacy YOY Summary Results Exhibit

[1]A supplemental network adequacy file is required for outpatient dialysis and oral surgery providers (use designation of "044 Outpatient Dialysis" for medical plans and "Oral Surgeon" for dental plans) . This file **must** match the format of the Network Adequacy Provider tab of the CMS ECP/Network Adequacy Template. An objection will be submitted if this direction is not followed.

Network Adequacy Submission (cont.)

- Network Adequacy Year Over Year Exhibit (summary table only)

Network ID:	NVN001 -Sample

COUNTY Y -Sample						
Provider/Facility	Code	PY 2024 Providers/ Facilities	Dropped Providers/ Facilities	New Providers/ Facilities	PY 2025 Providers/ Facilities	YOY Change
Primary Care		**1005**	**0**	**119**	**1124**	12%
General Practice	001	10	2	0	8	-20%
Family Medicine	002	200	0	18	218	9%
Internal Medicine	003	200	0	64	264	32%
Physician Assistant	005	350	0	65	415	19%
Nurse Practitioner	006	125	26	0	99	-21%
Endrocrinology	012	30	3	0	27	-10%
Infectious Diseases	017	20	0	8	28	40%
Psychiatry	029	175	0	72	247	41%
Licensed Clinical Social Workers	102	300	0	181	481	60%
Psychology	103	36	0	21	57	58%
Oncology - Medical/Surgery	021	65	5	0	60	-8%
Oncology - Radiation Oncology	022	20	0	0	20	0%
Pediatrics	101	200	19	0	181	-10%
Rheumatology	031	6	2	0	4	-33%
General Acute Care Hospital	040	38	11	0	27	-29%
Critical Services - ICU	043	0	0	0	0	
Outpatient Dialysis	044	0	0	0	0	

Network Adequacy Timeline

Individual Health Plans

- June 3rd — Deadline for carrier submissions
- August 12th — DOI makes final determinations

Small Group Plans

- July 15th — Deadline for carrier submissions
- September 26th — 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

Essential Community Provider Standards

A carrier must:

- Contract with at least **35%** of available Essential Community Providers (ECP) in each plan's **service area.** Additional ECPs requirements:
  - 35% of Family Planning Providers and
  - 35% of Federally Qualified Health Centers
- 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

PY24 Binder and Form Issues

- Carriers were missing the required Zero Cost Share drug tier in the Formulary template.
- Carriers must utilize the "Associate Schedule Items" function in the Binder.
- Carriers included service areas and/or network IDs that were not included in the PBT.
- Carriers provided indirect links within documents; a link must take the enrollee **directly** to the informational site referenced in the policy form; the enrollee should not have to "hunt" for the information.
- There were requested revisions after **final** Division approval. Carriers should thoroughly check submissions before final Division approval.
  - Individual Plans: After 8/26, requires both SSHIX & DOI approval
  - Limited Data Correction Window: 10/7 – 10/11
  - Absolutely no changes after 10/31 - **Division will favor the consumer in decisions**.

Contact Us

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QUESTIONS?