



State of Nevada DEPARTMENT OF BUSINESS AND INDUSTRY

Division of Insurance 2027 Health Benefit Plan Filing Guidance

Webinar: May 6, 2026
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.

Ned Gaines, Commissioner of Insurance

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Basis for PY27 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.

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Basis for PY27 Rate Filings – Part II

- Actuarial Value (AV) Calculator for 2027
- 2027 Unified Rate Review Template (URRT) and instructions
- Updated Nevada rate filing template (NVT) and instructions
 - 5.0 as posted on the Division's website.
 - 2025 Risk Adjustment values will be updated once RATEE reports are received from issuers.

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Nevada Rate Review Process

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

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Filing Submission Deadlines*

	Rates	Forms	Binders
All Individual Medical Plans	June 1 st	June 1 st	June 1 st
All Small Group Medical Plans	July 13 th	July 13 th	July 13 th
All Dental Plans	June 1 st	June 1 st	June 1 st

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

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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.

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Detailed Rate Review Timeline

Description	Responsibility	Individual Plans	Small Group Plans
Rate Filing Due	Issuer	06/01/2026	07/13/2026
First Objection to issuers	Division	06/08/2026	07/20/2026
Response to First Objection	Issuers	06/15/2026	07/27/2026
Second Objection to issuer	Division	06/22/2026	08/03/2026
Response to Second Objection	Issuer	06/29/2026	08/10/2026
Third Objection to issuer	Division	07/06/2026	08/17/2026
Response to Third Objection	Issuer	07/13/2026	08/24/2026
Proposed Rate Changes posted on Division's website	Division	08/01/2026	08/1/2026
Rate Decisions to issuers ("Final" if no modification required)	Division	07/27/2026	09/08/2026
Final Modification to Division	Issuer	08/07/2026	09/18/2026
Final Rate Decisions to issuers	Division	08/18/2026	09/29/2026
Final Data Transfer to SSHIX	Division	08/28/26	NA
Final Approved Rates posted on Division's website	Division	10/01/2026	10/01/2026

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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 the issuer:
 - 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 2027 rates will not be posted
- Proposed rate filing information (min, max, average rate changes) will be posted by August 1st
- Approved 2027 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

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CONTACTS IN SERFF

The Division may have to contact the issuer, therefore, please confirm that the contact information in the SERFF Rate/Form/Binder filing is

- **the person submitting the filing;**
- **current and accurate; and**
- **inclusive of the telephone number and email address.**

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Battle Born State Plans (BBSP)

For issuers approved to sell BBSPs for PY27, an issuer 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.

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BBSP (Continued)

If an issuer is planning to “crosswalk” membership from an existing plan to a BBSP

- a. the issuer 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 using “Discontinuing product; enrollment into a different product” as the reason for the crosswalk. For a complete list of plan crosswalk rules, please see 45 CFR 155.335(j).

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BBSP (Continued) **Counterfactual Scenarios**

- **Scenario 1: No Waiver Scenario / Rates** – These are the rates assuming there is no waiver (neither BBSP plans nor reinsurance exist).
- **Scenario 2: BBSP Only Scenario / Rates** – These rates assume that BBSP plans are introduced to the market, but there is no reinsurance program in place. For BBSP carriers, this would include rates for their BBSP plans with the contractually required rating adjustments. For carriers not offering BBSP plans, the general expectation is that these rates will reflect adjustments made to No Waiver rates to remain competitive with BBSP rates.

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BBSP (Continued) - Counterfactual Scenarios

- **Scenario 3: Full Waiver Scenario / Rates** – these rates are the actual rates that include both the BBSPs and the reinsurance program. For all carriers, these reflect the reinsurance percent reduction in plan liability (paid claims) relative to Scenario 2 above. For BBSPs, these rates also reflect the BBSP-required % reduction noted above. These are the final, approved rates.

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BBSP (Continued) - Counterfactual Scenarios

- All carriers must submit all three scenarios.
- For BBSP Carriers, BBSP plans should be submitted under all scenarios (i.e. do not omit BBSP plans under the 'no-waiver' scenario). In the case of scenario 1, these plans would be priced as they normally would (at current provider rates and admin loads). In Scenario 2 they would have any additional provider discounts, admin changes to comply with BBSP pricing. In Scenario 3, reinsurance is layered in.
- For scenarios 1 and 2 (i.e. non-actual) only the following need to be submitted: (1) Rate Templates (2) URRTs (3) A memo clearly and specifically detailing what is changed in the scenario vs. actual.

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Plan Level Administrative Expense

- Provide detail, in the Actuarial Memorandum, on commission levels contributing to the plan-level administrative expense factor, including how the commission component was derived. Include information on commission structures and any variation by plan.

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Silver Loading

- Apply a single silver load to all Silver plans offered on the Exchange
- Use issuer specific CSR distribution if credible
- Use statewide CSR distribution if issuer specific data is non-credible
- Provide Excel exhibit supporting silver load development
- Additional requirements indicated in the Final 2027 NBPP

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Nevada Enrollment Template (Current Period Covered Lives and Member Months)

- Totals should match to the URRT
- Covered lives should be a snapshot as of a date, typically 3/31
- Member months should be totals for the current year through a date, typically 3/31 (i.e. sum member months for January – March)

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Rate Submission Requirements

- Add Form/Binder Filing 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

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Rate Submission Requirements (Continued)

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 issuers 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 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.

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Standardized Naming Convention

- IssuerName_MMDD_YYYYQ#mkt_v#_Template.xml
 - IssuerName: Up to 6 Characters which identify the issuer
 - 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 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 consolidated file and use the following naming convention: *AVC_ScreenShots_v1*. (NOTE: must be the same iteration in each filing where the document is found; e.g., if the rate filing has *AVC_ScreenShots_v2*, that same document with that same number must be in every other filing where it appears)
- 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.

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SERFF Submissions - I

- Rate/Rule Tab of SERFF
 - Rate Data Template (XLS and XML formats)
 - Consumer Disclosure – URRT Part II
 - Required for **all** submissions
 - Actuarial Memorandum – URRT Part III (**redacted**)
 - Public - 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)
 - Issuers 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.
 - Issuers 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 Submission - II

- URRT Tab¹
 - 2027 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 2027 URR instructions

¹Issuer direction for naming convention for PY27

- ✓ Name the URRT Part I (*Rate Review Template*): "URRT"
- ✓ Name the URRT Part II: "Consumer Disclosure"
- ✓ Name the URRT Part III: "Actuarial Memorandum"*

* "Include "Redacted" as appropriate

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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. 2027 Nevada rate filing template (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

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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”

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Defrayal of State Mandated Benefits Above EHB

Per CMS URRT Instructions, carriers shall make an adjustment to rate development to exclude costs associated with the following state-mandated benefits above EHB (applicable to QHP-certified plans only):

- **SB 439, 82nd Session (2023):**
 - Requires coverage of all FDA-approved drugs for the prevention or treatment of HIV and hepatitis C.
 - Issuers should calculate claims costs by sorting drugs within a category-class from most to least utilized as measured by cost on a PMPM basis. The most utilized drugs, up to, and including, the EHB benchmark drug count, are considered EHB. The least utilized drugs beyond this count are not EHB and subject to defrayal.
- **AB 428, 83rd Session (2025):**
 - Requires coverage for certain procedures or services for the preservation of fertility of insureds who have been diagnosed with breast or ovarian cancer.

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Defrayal of State Mandated Benefits Above EHB (Continued)

- **SB 163, 82nd Session (2023):**

- Requires coverage of medically necessary treatment for gender dysphoria and gender incongruence. CMS's 2025 Marketplace Integrity and Affordability Rule provides that specified sex-trait modification procedures may no longer be considered as essential health benefits. This provision of the rule is currently under litigation, and there is a possibility that issuers may be required to adjust their filings depending on the outcome.

All adjustments for benefits subject to defrayal must include a detailed accounting or supporting exhibits showing how the adjustment was developed.

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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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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 issuer'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 issuers have provided this information in the annual filings, some issuers are omitting components, embedding the information within memorandum verbiage or referring the reviewer to other documents.

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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

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Formula for Timely Approvals - I

- Follow 2027 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

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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 Division

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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
- control between filings
 - Templates that appear across multiple filings must be the same iteration in each filing. For example, if the rate filing has RT_v2, that same document with that same version number, must be in every other filing where that template appears. Refer to Slides 50 and 58.

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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

- 05/01/2026 RATEE file from issuer
- Deadline: First Monday of May (05/04/2026)
- Confidentiality

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2027 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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2027 Exchange Fee

- Exchange Fee – 3.00% of premium for QHPs and SADPs

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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:
 - 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

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AV Calculator De Minimus Ranges (pending final NBPP)

- Expanded Bronze: Change to +5% / -2%
- Silver CSR Variations: Change to +1% / 0%
- All Others: +2% / -2%

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Small Group Topics

- Tobacco rating: applied separately, on a per-member basis
- Issuers 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 Q3 update

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Form and Binder Requirements

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2027 Filing Timeline for Individual issuers

- All Individual QHP and Non-QHP binder and form filings must be submitted in SERFF no later than **June 1, 2026**
- The NV DOI will provide final decision by **August 18, 2026**

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2027 Filing Timeline for Small Group Issuers

- All Small Group binder and form filings must be submitted in SERFF no later than **July 13, 2026**
- The NV DOI will provide final decision by **September 29, 2026**

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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, allowed in off Exchange filings only

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Social Security #s and Off-Exchange Individual Plans

Reminder:

Issuers 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 issuer. The Division will expect the issuer 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.

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Cost Sharing Provisions: REMINDER

Per NAC 695C.215

Cost sharing.

([NRS 679B.130](#), [695C.275](#))

An organization may establish schedules for cost sharing between an enrollee and the organization. For a benefit provided pursuant to a health care plan by a provider who is under contract with the organization to provide services on a preferred basis, commonly referred to as a “preferred” or “in-network” benefit, cost sharing may be not more than 50 percent of the usual and customary charges for providing any single service or supplying an item to an enrollee, but in no case more than 50 percent of the maximum benefits provided by the evidence of coverage for such service or item, after any applicable deductible has been met.

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Binder Submissions

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

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Template Naming Convention

IssuerName_MMDD_YYYYmkt_v#_Template.xml

- IssuerName: Up to 6 Characters which identify the issuer
- MMDD_YYYY: month, day and four-digit plan year
- mkt: "i" for individual "s" for small group filings
- v#: v followed by the 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
 - TOC – Transparency in Coverage Template is not required for SBEs

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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 issuer.**
- “Fees”: N/A
- “Templates”: Added by the issuer 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 issuer, dispositions and certifications, etc.

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Binder - Associate Schedule Items Function

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“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 – Consumer Disclosure
- ✓ URRT III - Actuarial Memorandum (redacted)

Rate Filing URRT tab:

- ✓ URRT Part I - URRT
- ✓ URRT III - 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.

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“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) CMS templates (PBT, DT, NT, SAT, ECP, BRT) to address control. *List the templates separately in the Rate filing.**
- ✓ Unique Plan Design support

*If there is a file limitation error for any of the Binder templates, please send a “Note to Reviewer” in the Binder as follows : “In the <Issuer> Rate filing, only the zip file containing the .xlm files has been uploaded as the .xlsm file exceeds the file size limit”.

Please rename the .xlsm file in the Binder Template tab to match the zip file added to the Rate filing, to ensure control, and upload it back to the Binder. The Division will download the renamed .xlsm from the Binder.

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“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** s of the Evidence of Coverage (EOC) in the Form Filing/Form Schedule tab, i.e., an issuer has more than one EOC.

After the EOC(s) is/are associated, the issuer 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

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“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

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Binder Submissions – *Quality 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 number and
- it is also added to the Rate filing. NOTE: the *Associate Schedule Items* function should reflect this change.

DO NOT ADD ANY TEMPLATE TO THE RATE FILING WITHOUT VALIDATING IT IN THE BINDER UNDER THE *TEMPLATES* TAB.

EXAMPLE: PBT Revision for Individual Filing:

1. An objection in the Rate Filing requires a revised PBT, i.e., a new .
2. The revised PBT (with change noted in the .xml file name) is uploaded to the *Templates* tab in the **Binder and validated in SERFF under the *Templates* tab.**
3. The .xlsm of the PBT is renamed, ex.: ABCIns_MMDD_2027Q1i_v2_PBT.xlsm.
4. The new s (.xml/.xlsm) of the PBT are added under *Supporting Documentation* tab in the Rate filing.

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Binder Submissions – *Quality Control* (Continued)

When an issuer voluntarily makes a revision to a CMS template, the issuer 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.

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Binder Checklist

PY27 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	
Non-Discrimination Treatment Protocol Calculator - Supporting Documentation and Justification	Medical – as needed	
NV Network Adequacy Declaration Document (includes Telehealth Exhibit)	Medical	
Combined Prescription Drug Supporting Documentation and Justification	Medical – as needed	
YOY Deficiency Response	Medical	Due to the 2027 NBPP Time and Distance revision, a deficiency response will not be required.
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	
Supplemental Provider Listing for Outpatient Dialysis, Hospitals and Oral Surgeon (for medical plans with embedded pediatric dental)	Medical	Carriers are required to utilize the Excel workbook found on the Division website.
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	
Supplemental Provider Listing (Oral Surgeon)	Dental	Carriers are to utilize the Excel workbook found on the Division website.
Actuarial Memorandum (and redacted version if necessary)	Dental	
License	As needed – New carrier	

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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
Non- Discrimination Treatment Protocol Calculator - 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
Binder Checklist	Plan ID Crosswalk Template
ECP UI Data (N/A for SBE)	Org chart and narrative for outsourced operations (include subcontractors)
Indian Healthcare Provider letter documentation	Justification for Network Adequacy/Essential Community Provider (ECP) Objections(s)
URLs for machine readable-files and cost estimator tool	Actuarial Memorandum (and redacted if necessary)
Data Integrity Tools (DIT) and completed Review Tools results	License

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Binder Submissions – Supporting Documentation II

Each issuer **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 \(cms.gov\)](https://www.cms.gov). The issuer 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.

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Form Filings Instructions Part I

- *General Information* tab-
 - ✓ Add Rate Filing/Binder SERFF #s to “Corresponding Filing Tracking Number”
- *Form Schedule* Tab –
 - ✓ Redline s of existing SOBs (all plan variants) and EOCs
 - ✓ If applicable, clean copies of new SOBs (all plan variants) and EOC.

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Form Filings Instructions Part I (Continued)

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). Checklists are found at:
 - [http://doi.nv.gov/Insurers/Life and Health/ACA Plans/Form Filings and Plan Certification/](http://doi.nv.gov/Insurers/Life_and_Health/ACA_Plans/Form_Filings_and_Plan_Certification/)

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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 issuer documents to the Nevada DOI website for PY27 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. **type**
 - i. Redline (r)
 - ii. Clean copy (c)
5. **number**
 - i. v1, v2, v3, etc.

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Naming Convention (Continued)

Examples for Issuer 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**HighOptioncsr_99999NV0010017_00_SCH_r_v1

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

- Use **this**: 99999NV0010017_00_S_HSA_SCH_CERT_r_v1
- Not **this**: MyCompanyfullmarketingname**Silver**HighOptioncsr_99999NV0010017_00_SCH_r_v1

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Form Filings Instructions Part III

The final objection for **both** 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 issuer is to **email** clean copies of the approved forms, see below:

- 1. Provide** clean copies of the Individual and Small Group approved policy forms. They must be **emailed** to the Division for website posting.
 - ✓ Use the clean copy forms from the filing. *NOTE: there is a 50-character file name limit for display purposes.*
 - ✓ For the SOBs, send the off exchange ("**-00**") variant only.
 - Naming Convention must include the HIOS ID, e.g., 99999NV0010017_00_S_HSA_SCH_r_v1

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Form Filings Instructions Part III (Continued)

2. **Confirm** all links are working within policy forms.
3. **Include** a PDF of the Provider and Formulary URLs. Please refer to the Division website for the template.

NOTE: the Division website is limited to posting one sample of each type of document (EOC, SOB and URLs) for every HIOS ID. Issuers should provide consolidated forms as appropriate when benefits (RX, vision, dental, etc.) are outlined in separate documents but are included in the rates.

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Removing Plans from a Product

- Issuers 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)

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PY27 Nevada EHB Benchmark Plan

- HPN Solutions HMO Platinum 15/0/90% (no change from PY 2026)
- 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

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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
- Non state mandated drugs in excess of a state's EHB benchmark plan are considered EHB and the cost share rules must apply.

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Prescription Drugs (Continued)

- Issuers **must** include a separate tier (Tier 1) for Zero Cost Share Preventive tier in the Prescription Drug Template per NRS¹.
- Per prior guidance² an issuer is not allowed to exclude Rx coupons from cost-sharing limits except in situations where a **generic is available**.

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

²Plan Year 2020 NBPP final rule

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CMS Guidance regarding Medicare

Specific to non-grandfathered individual health insurance coverage, an issuer 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.

¹https://www.cms.gov/Medicare/Eligibility-and-Enrollment/Medicare-and-the-Marketplace/Downloads/Medicare-Marketplace_Master_FAQ_4-28-16_v2.pdf

²This 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.

³Non-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.

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Plan Service Areas

- QHP service areas must equal one or more rating territories
- Nevada's rating territories for 2027 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

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Formulary Modifications

- An issuer 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.

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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

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MOOP and Deductible Guidance

- For 2027 individual and small group health benefit plans, the maximum out-of-pocket will be
 - \$12,000 single, \$24,000 family
- For 2027* HSA plans, the maximum out-of-pocket will be
 - \$8,500 single, \$17,000 family
- For 2027* HSA plans, the minimum deductible will be
 - \$1,700 single, \$3,400 family

*Waiting on IRS, will update and post when finalized

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MOOP and Deductible Guidance (Continued)

- For the 73 percent AV silver plan variation, the maximum out-of-pocket will be
 - \$9,600 single, \$19,200 family
- For the 87 percent and 94 percent AV silver plan variations, the maximum out-of-pocket will be
 - \$4,000 single, \$8,000 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 any 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
- 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.

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Benefit Waiting Periods for Pediatric Dental

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

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Division of Insurance Website

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

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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: issuers submitting a BBSP in a QHP filing must include an identifier in the naming convention of each plan, e.g., "Battle Born State Plan <Silver Plan Name>", "Battle Born State Plan <Bronze Plan Name>", etc.

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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

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Cost-Sharing (Continued)

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

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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

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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

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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

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- Network Adequacy Requirements -

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Network Adequacy Submission and Timelines

Individual Health Plans

- 06/01/26 Deadline for issuer submissions in Plan Binders
- 08/18/26 DOI makes final determinations

Small Group Health Plans

- 07/13/26 Deadline for issuer submissions in Plan Binders
- 09/29/26 DOI makes final determinations

Objections/Responses

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

Required Documentation

1. Validated CMS ECP/Network Adequacy Template **(Include only providers that can be accessed by Nevada enrollees)**
2. Nevada Network Adequacy Declaration Document
3. Supplemental Outpatient Dialysis/Oral Surgeon/Hospital Workbook

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Network Adequacy

NAC 687B.768

- Applies to QHP/non-QHP individual and small group health benefit plans
- Exemption for a non-QHP issuer 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 – 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 issuer submitted CMS templates and Division supplied supplemental templates.
 - NOTE: Quest has a character limit on queries, please ensure the <Specialty Types> column does not exceed **255 characters**.

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Network Adequacy Standards PY27

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

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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				

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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 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

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ACUTE INPATIENT HOSPITALS PY27

- Please refer to the Network Adequacy General Acute Care Hospital (NA GACH) list on the following page; the list is also available at <https://www.qhpcertification.cms.gov/s/Network%20Adequacy>. If the issuer contracts with more hospitals than those listed, update and submit the Supplemental Provider Template, located at the Division website ([Nevada Division of Insurance](#)), with the Binder filing.
- **Do not** include Urgent Care Centers as Acute Care Hospitals.
- **Do not** include VA Hospitals.

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Network Adequacy Supplemental Provider Template

The Supplemental Provider Template is required for the following provider types:

- outpatient dialysis (non-QHPs),
- oral surgery providers
- acute care hospitals **not found** on the NA GACH List

A separate template **is not** required for each provider type; issuers may combine all three provider types into one file. The template is included on the Division website at [Nevada Division of Insurance](#). NOTE: the template found on the Division website is the only acceptable document to be used for the **supplemental** providers, any deviation will result in an objection and, subsequently, a delay in review.

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NA GACH PY27 List

FACILITY	STREET ADDRESS	FACILITY	STREET ADDRESS
RENOWN REGIONAL MEDICAL CENTER	1155 Mill St	SPRING VALLEY HOSPITAL MEDICAL CENTER	5400 S Rainbow Blvd
SUNRISE HOSPITAL AND MEDICAL CENTER	3186 S Maryland Pkwy	SOUTHERN HILLS HOSPITAL AND MEDICAL CENTER	9300 W Sunset Rd
NORTH VISTA HOSPITAL	1409 E Lake Mead Blvd	RENOWN SOUTH MEADOWS MEDICAL CENTER	10101 Double R Blvd
UNIVERSITY MEDICAL CENTER	1800 W Charleston Blvd	DIGNITY HEALTH - ST. ROSE DOMINICAN HOSPITAL, SAN MARTIN CAMPUS - LAS VEGAS, NV	8280 W Warm Springs Rd
NORTHEASTERN NEVADA REGIONAL HOSPITAL	2001 Errecart Blvd	CENTENNIAL HILLS HOSPITAL	6900 N Durango Dr
SAINT MARY'S REGIONAL MEDICAL CENTER	235 W 6th St	HENDERSON HOSPITAL	1050 W Galleria Dr
DIGNITY HEALTH - ST. ROSE DOMINICAN HOSPITAL, ROSE DE LIMA CAMPUS - HENDERSON, NV	102 E Lake Mead Pkwy	DIGNITY HEALTH - ST. ROSE DOMINICAN HOSPITAL, NORTH LAS VEGAS, NV CAMPUS	1550 W Craig Rd
CARSON TAHOE REGIONAL MEDICAL CENTER	1600 Medical Pkwy	DIGNITY HEALTH - ST. ROSE DOMINICAN HOSPITAL, BLUE DIAMOND - LAS VEGAS, NV	4855 Blue Diamond Rd
VALLEY HOSPITAL MEDICAL CENTER	620 Shadow Ln	DIGNITY HEALTH - ST. ROSE DOMINICAN HOSPITAL, SAHARA CAMPUS - LAS VEGAS, NV	4980 W Sahara Ave
NORTHERN NEVADA MEDICAL CENTER	2375 E Prater Way	DIGNITY HEALTH - ST. ROSE DOMINICAN HOSPITAL, WEST FLAMINGO - LAS VEGAS, NV	9880 W Flamingo Rd
MOUNTAINVIEW HOSPITAL	3100 N Tenaya Way	SIERRA MEDICAL CENTER	6500 Longley Ln
SUMMERLIN HOSPITAL MEDICAL CENTER	657 N Town Center Dr	WEST HENDERSON HOSPITAL	1155 Raiders Way
DIGNITY HEALTH - ST. ROSE DOMINICAN HOSPITAL, SIENA CAMPUS - HENDERSON, NV	3001 Saint Rose Pkwy		

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Essential Community Provider Standards

An issuer 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

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PY26 Binder and Form Issues

- There were requested revisions after **final** Division approval. issuers should thoroughly check submissions before final Division approval.
 - Individual Plans: After 8/28, requires both SSHIX & DOI approval
 - Limited Data Correction Window: 10/5 – 10/09
 - Absolutely no changes after 10/31 - **Division will favor the consumer in decisions.**
- Versioning control between filing types was not verified
- Revised templates in the rate filings were not validated in the Binder filings
- The “Associate Schedule Items” function in the Binder to attach the required forms was not consistently utilized
- Incorrect supplemental provider templates
- Plans and Benefits templates data completion issues, examples to follow

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Plans and Benefits Template

There were data completion issues for the PY26 submissions. The Division is utilizing the PBTs as a source of truth for reporting needs and is requiring all issuers to follow the data input instructions per the following five slides:

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Binder Submissions – *Plans and Benefits Template (PBT)*

Gender Affirming Care –

Issuers who include “Gender Affirming Care” as an additional benefit are directed to select the value of “Other Law/Regulation” in the EHB Variance Reason column.

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Plans and Benefits Template CYD Display HMO/EPO Sample

Combined Medical and Drug EHB Deductible										
In Network			In Network (Tier 2)			Out of Network			Combined In/Out Network	
Individual	Family	Default Coinsurance	Individual	Family	Default Coinsurance	Individual	Family	Individual	Family	
\$5,000	\$5000 per person \$10000 per group	20.00%				Not Applicable	per person not applicable per group not ap	\$5,000	\$5000 per person \$10000 per group	

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Plans and Benefits Template CYD Display PPO Sample

BK	BS	BT	BU	BV	BW	BX	BY	BZ	CA		
<i>Combined Medical and Drug EHB Deductible</i>											
In Network			In Network (Tier 2)			Out of Network		Combined In/Out Network			
<i>Individual</i>	<i>Family</i>	<i>Default Coinsurance</i>	<i>Individual</i>	<i>Family</i>	<i>Default Coinsurance</i>	<i>Individual</i>	<i>Family</i>	<i>Individual</i>	<i>Family</i>		
\$5,000	\$5000 per person \$10000 per group					\$10,000	\$10000 per person \$20000 per group		\$15,000	\$15000 per person \$30000 per group	

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Plans and Benefits Template Display HMO/EPO Benefit Value Sample

Specialist Visit					
Copay			Coinsurance		
In Network (Tier 1)	In Network (Tier 2)	Out of Network	In Network (Tier 1)	In Network (Tier 2)	Out of Network
\$25.00		Not Applicable	Not Applicable		100.00%

DP	DQ	DK	DS	DT	DU
Specialist Visit					
Copay			Coinsurance		
In Network (Tier 1)	In Network (Tier 2)	Out of Network	In Network (Tier 1)	In Network (Tier 2)	Out of Network
Not Applicable		Not Applicable	20.00%		100.00%

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Plans and Benefits Template Display PPO Benefit Value Sample

DJ	DK	DL	DM	DN	DO
Primary Care Visit to Treat an Injury or Illness					
Copay			Coinsurance		
<i>In Network (Tier 1)</i>	<i>In Network (Tier 2)</i>	<i>Out of Network</i>	<i>In Network (Tier 1)</i>	<i>In Network (Tier 2)</i>	<i>Out of Network</i>
\$50.00		Not Applicable	Not Applicable		50.00% Coinsurance after deductible
DJ	DK	DL	DM	DN	DO
Primary Care Visit to Treat an Injury or Illness					
Copay			Coinsurance		
<i>In Network (Tier 1)</i>	<i>In Network (Tier 2)</i>	<i>Out of Network</i>	<i>In Network (Tier 1)</i>	<i>In Network (Tier 2)</i>	<i>Out of Network</i>
Not Applicable		Not Applicable	20.00% Coinsurance after deductible		50.00% Coinsurance after deductible

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QUESTIONS?