



# State of Nevada DEPARTMENT OF BUSINESS AND INDUSTRY

## Division of Insurance

# 2025 Health Benefit Plan Filing Guidance

Webinar: 04/30/2024 10:00 am Pacific

**Effective January 1, 2025**

Scott J. Kipper, Commissioner of Insurance

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## Filing Submission Deadlines\*

	Rates	Forms	Binders
All Individual Medical Plans	June 3 <sup>rd</sup>	June 3 <sup>rd</sup>	June 3 <sup>rd</sup>
All Small Group Medical Plans	July 15 <sup>th</sup>	July 15 <sup>th</sup>	July 15 <sup>th</sup>
All exchange-certified Dental Plans	June 3 <sup>rd</sup>	June 3 <sup>rd</sup>	June 3 <sup>rd</sup>

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

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## **Rate Filing Requirements**

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## 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)

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## Silver Loading

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

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## **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.

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## Basis for PY25 Rate Filings – Part II

- Actuarial Value (AV) Calculator for 2024
- 2024 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 5/6.

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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	Carriers	06/03/2024	07/15/2024
First Objection to Carriers	Division	06/10/2024	07/22/2024
Response to First Objection	Carriers	06/17/2024	07/29/2024
Second Objection to Carrier	Division	06/24/2024	08/05/2024
Response to Second Objection	Carriers	07/01/2024	08/12/2024
Third Objection to Carrier	Division	07/08/2024	08/19/2024
Response to Third Objection	Carriers	07/15/2024	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	07/29/2024	09/09/2024
Final Modification to Division	Carriers	08/05/2024	09/19/2024
Final Rate Decisions to Carriers	Division	08/12/2024	09/26/2024
Final Data Transfer to SSHIX	Division	08/28/2024	NA
Final Approved Rates posted on Division's website	Division	10/01/2024	10/01/2024

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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 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.).

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## 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 1<sup>st</sup>
- Approved 2025 individual and small group rates will be posted by October 1<sup>st</sup>
- 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

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## 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

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## Standardized Naming Convention

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

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## Submitting Templates and Support

- Use separate headers for each template
- Please submit AV calculator screen shots as a single file
- Service Area Templates (SAT) and Network ID Templates (NID) 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 NID.
- The Network Adequacy Declaration Document has been reformatted and revised.

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## 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

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## Redacted Actuarial Memorandum

- Federal guideline: [https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Instructions for the Redacted Actuarial Memorandum 20150416.pdf](https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Instructions%20for%20the%20Redacted%20Actuarial%20Memorandum%2020150416.pdf)
  - Carriers can redact any information that is a trade secret or confidential commercial or financial information as defined in HHS's Freedom of Information Act (FOIA) regulations at 45 CFR § 5.65.
  - Carriers must not redact information unless its release would likely result in specific, reasonably foreseeable, and substantial competitive harm.
    - Be prepared to explain how each redacted item meets the federal criteria for redaction.



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## SERFF 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

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## 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

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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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## New Actuarial Memorandum Exhibit

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

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## 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

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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

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## Example: Calculating the Threshold Rate Increase

Plan	Current Annual Premium	Annual Premium Based on Proposed Rates	Rate Change
<b>A</b>	\$10,000,000	\$11,000,000	10.00%
<b>B</b>	\$20,000,000	\$19,000,000	-5.00%
<b>C</b>	\$15,000,000	\$18,000,000	20.00%
<b>D</b>	\$ 5,000,000	\$ 5,000,000	0.00%
<b>Total</b>	\$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

- 05/01/2024 RATEE file from carrier
- Deadline: First Friday of May (05/03/2024)
- Confidentiality

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## 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

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## 2025 Exchange Fee

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

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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 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%

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## Small Group Issues

- Tobacco rating: applied separately, on a per-member basis
- Carriers cannot impose contribution or participation rules for small employers that apply for coverage between 11/15 and 12/15 of each year.
- Quarterly rate updates are allowed for **Q3 only**:
  - Standardized rate effective dates (January 1, April 1, July 1, October 1). Monthly trend adjustments are not allowed.
  - Q3 updates due March 15<sup>th</sup>
  - Plans **may not** be added with the 7/1 update

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## **Form and Binder Requirements**



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## 2025 Filing Timeline for Individual Carriers

- All Individual QHP and Non-QHP binder, rate and form filings must be submitted in SERFF no later than June 3, 2024
- The NV DOI will provide final decision by August 12, 2024

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## 2025 Filing Timeline for Small Group Carriers

- All Small Group binder, rate 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**

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## Risk Pool Filings

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

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## Binder Submissions

- Separate binders for individual and small group filings for each carrier
- Must include the validated Plan Management templates and, under Supporting Documentation, in addition to previous required responses, the following new/updated 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

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## Template Naming Convention

CarrierName\_YYYYmkt\_v#\_Template.xml

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

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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 –
  - ✓ 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.

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## 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 (should correspond to redlined Pg. #'s)
    - [http://doi.nv.gov/Insurers/Life and Health/ACA Plans/Form Filings and Plan Certification/](http://doi.nv.gov/Insurers/Life%20and%20Health/ACA%20Plans/Form%20Filings%20and%20Plan%20Certification/)

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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 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.



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## 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**: NV0010017\_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**: NV0010017\_00\_S\_HSA\_SCH\_CERT\_r\_v1
- Not **this**: MyCompanyfullmarketingname**Silver**HighOptioncsrversion\_99999NV0010017\_00\_SCH\_r\_v1

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## Removing Plans from a Product

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

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## 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

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## 82<sup>nd</sup> Legislative Session Approved Bills

- AB 155: Biomarker
- 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)

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## SB 439: Drug Coverage

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

- Ensure the CMS Formulary Template includes the appropriate drugs.
  - ✓ *The Division will confirm using the CMS Drug Count Review Tool <Category Class Detail Tab>.*
- Ensure policy forms include language to support SB 439.

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## 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<sup>1</sup> 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.

<sup>1</sup>[https://www.cms.gov/Medicare/Eligibility-and-Enrollment/Medicare-and-the-Marketplace/Downloads/Medicare-Marketplace\\_Master\\_FAQ\\_4-28-16\\_v2.pdf](https://www.cms.gov/Medicare/Eligibility-and-Enrollment/Medicare-and-the-Marketplace/Downloads/Medicare-Marketplace_Master_FAQ_4-28-16_v2.pdf)

<sup>2</sup>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.

<sup>3</sup>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.

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## Presumptively Discriminatory Benefit Designs

- 2022 Payment Notice
  - No discriminatory benefit design regardless of inclusion in statute or benchmark plan
    - Benefit exclusions that are not clinically based, examples include:
      - Age restrictions for autism spectrum disorder
      - Age restrictions for infertility treatment

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## 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



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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
- Nevada's benchmark plan is Solutions HMO Platinum 15/0/90%

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## Prescription Drugs (cont.)

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

<sup>1</sup>NRS 689A.0418(9), NRS 689B.0378(10), NRS 689C.1676(9)

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## Prescription Drugs (cont.)

- Issuers must provide a link to an exceptions process\* that allows an individual to access, without cost-sharing, 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.
  - ❖ 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>

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## Formulary Modifications

- A carrier shall neither remove a drug nor increase the cost share for a drug from an approved formulary for an individual or small group health benefit plan unless:
  - The drug is not approved by the FDA;
  - The FDA issues a notice, guidance or warning concerning the safety of the drug; or
  - The drug is approved by the FDA for use without a prescription.
- Individual and small group formularies will be approved and locked down 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 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)

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## 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

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## Subrogation or Reduction in Benefits

- NRS 689A.230 (2) prohibits “other valid coverage” from including automobile medical and 3<sup>rd</sup> party liability coverage, and subrogation in individual health plans
- NRS 689B.063 (2) and NAC 689B.195 prohibits reducing benefits based on other health coverage through a franchise plan or first-party auto insurance



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## Pediatric Dental

- Pediatric dental is not required to be embedded in a medical plan if the issuer is reasonably assured certified stand-alone coverage has been obtained
- 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”

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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 Division will not post proposed 2025 rates
- **Approved** 2025 rates will be posted by October 1<sup>st</sup>
- The approved schedule of benefits and evidence of coverage for each individual plan will be posted by November 1<sup>st</sup>
- Website will generally use “Plan Marketing Name” from Plans & 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.

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## Non-Integrated Deductible

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

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

## Cost-Sharing

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

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

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## 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

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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 Regulation

- Applies to individual and small group health benefit plans
- Exemption for a carrier with fewer than 1,000 covered lives in the preceding calendar year or 1,250 lives anticipated in the next year
- Exemption for grandfathered plans

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## Network Adequacy 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

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## Nevada County Designations

County	Designation	Rating Area	County	Designation	Rating Area
<b>Clark</b>	Metro	<b>1</b>	<b>Esmeralda</b>	CEAC	<b>4</b>
<b>Nye</b>	CEAC		<b>Eureka</b>	CEAC	
<b>Washoe</b>	Metro	<b>2</b>	<b>Humboldt</b>	CEAC	
<b>Carson City</b>	Metro	<b>3</b>	<b>Lander</b>	CEAC	
<b>Douglas</b>	Micro		<b>Lincoln</b>	CEAC	
<b>Lyon</b>	Micro		<b>Mineral</b>	CEAC	
<b>Storey</b>	Rural		<b>Pershing</b>	CEAC	
<b>Churchill</b>	CEAC	<b>4</b>	<b>White Pine</b>	CEAC	
<b>Elko</b>	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 types for at least 90 percent of the population sample in the service area.
- Justification should describe any established patterns of care and the availability of providers in the specialty type related to the deficiency within the applicable geographic service area
- Access plan should be based upon established patterns of care

## 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)



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## 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 NID templates that are not included on the PBT.
- Required Documentation
  1. Validated CMS ECP/Network Adequacy Template
  2. Supplemental Outpatient Dialysis/Oral Surgeon Workbook<sup>1</sup>
  3. Nevada Declaration Document
  4. Network Adequacy YOY Summary Results Exhibit

<sup>1</sup>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.

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## Network Adequacy Submission (cont.)

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

Network ID:		NVN001 -Sample				
COUNTY Y -Sample						
Provider/Facility	Code	PY 2023 Providers/ Facilities	Dropped Providers/ Facilities	New Providers/ Facilities	PY 2024 Providers/ Facilities	YOY Change
<b>Primary Care</b>		<b>1005</b>	<b>0</b>	<b>119</b>	<b>1124</b>	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%
<b>Endocrinology</b>	012	30	3	0	27	-10%
<b>Infectious Diseases</b>	017	20	0	8	28	40%
<b>Psychiatry</b>	029	175	0	72	247	41%
<b>Licensed Clinical Social Workers</b>	102	300	0	181	481	60%
<b>Psychology</b>	103	36	0	21	57	58%
<b>Oncology - Medical/Surgery</b>	021	65	5	0	60	-8%
<b>Oncology - Radiation Oncology</b>	022	20	0	0	20	0%
<b>Pediatrics</b>	101	200	19	0	181	-10%
<b>Rheumatology</b>	031	6	2	0	4	-33%
<b>General Acute Care Hospital</b>	040	38	11	0	27	-29%
<b>Critical Services - ICU</b>	043	0	0	0	0	
<b>Outpatient Dialysis</b>	044	0	0	0	0	

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## Network Adequacy Timeline

### Individual Health Plans

- June 3<sup>rd</sup> Deadline for carrier submissions
- August 30<sup>th</sup> DOI makes final determinations

### Small Group Plans

- July 15<sup>th</sup> Deadline for carrier submissions
- September 30<sup>th</sup> DOI makes final determinations

### Objections/Responses

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

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## 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

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## 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 triple check submissions before final Division approval.
  - Individual Plans: After 8/21, 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.**

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**QUESTIONS?**