Final 2019 Filing Guidance

Filing Timeline for Exchange Carriers

- All QHP and on-Exchange SADP binders must be submitted in SERFF no later than June 8th
- Rate filings due June 8th
- Form filings due July 13th

Filing Timeline for Individual Market Off-Exchange Carriers

- Rate filings due June 8th
- Form filings due July 13th
- All non-QHP and off-Exchange SADP binders must be submitted in SERFF no later than July 13th
  - All plans should be included within this binder
  - Network adequacy application for non-QHP networks must be included within this binder

Filing Timeline for Small Group Carriers

- Form filings due July 13th
- Rate filings due July 13th
- All non-QHP and off-Exchange SADP binders must be submitted in SERFF no later than July 13th
  - All plans should be included within this binder
  - Network adequacy application for non-QHP networks must be included within this binder

Review Timeline for Forms

- July 13th — Form filings due
- July 25th — DOI sends first objection letter
- August 6th — Carrier response due in SERFF
- August 20th — DOI sends second objection letter
- September 3rd — Carrier response due in SERFF
- September 17th — DOI sends third objection letter
- October 1st — Carrier response due in SERFF
- October 11th — DOI makes final determinations

Risk Pool Filings

- All risk pool plans must be submitted within a single form filing
- Plans within a product vary by cost sharing structure, network, formulary or service area
- 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

Off-Exchange Binder Submissions

- Separate binder for each market segment (individual and small group) from each carrier
- The following templates must be validated:
  - Prescription Drug
  - ECP/Network Adequacy
  - Rate Data
- The following templates must be included but may be submitted within supporting documentation:
  - Plans & Benefits (Plan Identifiers section is required)
  - Network ID
  - Service Area

Health Form Filings

- Redlined versions of SOBs and EOCs for existing plans
- Clean copies of the individual market SOBs and EOCs due October 19th for display on DOI website
- Formulary and Provider URLs for individual market due October 19th

2017 Nevada Enrolled Legislation

- AB227 – Expands relationships recognized as valid domestic partnerships
- AB304 - New definition for “autism spectrum disorder”
- AB381 - A small group carrier shall only move a prescription drug from lower cost tier to a higher cost tier on January 1st and July 1st

2017 Nevada Enrolled Legislation

- SB262 – Payment for treatment relating solely to mental health or the abuse of alcohol or drugs must be made directly to the provider of health care that provides the treatment if the provider
  - Is an out-of-network provider; and
  - Has delivered a written assignment of benefits to the carrier

- SB286 - New definitions for “registered behavior technician” and “state certified behavior interventionist”
  - “autism behavior interventionist” definition has been repealed

- SB539 – Individual carriers required to identify essential diabetes drugs removed from a formulary for an upcoming year

AB249 and SB233

- It is no longer sufficient to only reference USPSTF and HRSA within forms for women's preventive health benefits
  - AB249 and SB233 mandates may be broader than USPSTF and HRSA
  - The DOI has developed a webpage which includes all relevant links, including to AB249 and SB233
- Each Evidence of Coverage should include all benefits specified within NRS

Removing Plans From a Product

- Individual carriers may remove plans from a product each year
- If a product is not being discontinued, all policyholders within the remaining service area of this product must receive a notice of renewal with altered terms pursuant to NRS 687B.420
  - Policyholders must be mapped to a plan within this product at the same metallic level (or nearest metallic level if no plan at the same level will be available)

2019 Nevada EHB Benchmark Plan

- HPN Solutions HMO Platinum 15/0/90% (no change from PY 2018)
- Plan includes embedded pediatric dental and vision consistent with NV CHIP and FEDVIP, respectively

Plans & Benefits EHB Add-In

- Auto populates benefit explanation field based upon the 2014 HPN Solutions HMO Platinum 15/0/90% plan
- A carrier will need to correct this field for QHPs to describe its own medical management requirements or other limitations

Telehealth

- A policy of health or dental insurance must include coverage for services through telehealth to the same extent as though provided in person or by other means
- A carrier shall not:
  - Require an insured to establish a relationship in person
  - Refuse to provide coverage because of the distant site from which a provider delivers services through telehealth
  - Refuse to provide coverage because of the originating site at which an insured receives services through telehealth
- A policy of health or dental insurance must not require an insured to obtain prior authorization for any service provided through telehealth that is not required for the service when provided in person

Plan Service Area

- QHP and SADP service areas must equal one or more rating territories
- Nevada's rating territories for 2019 are unchanged
- Off-exchange plan service areas may use partial counties
- The Service Area Template does support service areas defined by a collection of Zip Codes

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 is Solutions HMO Platinum 15/0/90%

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 employer 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.
- Final individual and small employer drug lists must be submitted by October 12th
- Individual and small group market formularies will be approved and locked down on October 26th

Formulary Template

- Issuers should complete cost-sharing fields in the Prescription Drug Template for the most typical or most utilized benefit cost-share design
- Issuers can describe any cost-sharing features that do not directly fit into the Prescription Drug Template in the Benefit Explanation field of the Plans & Benefits Template
- Issuers should place preventive drugs in a separate Zero Cost Share Preventive tier in the Prescription Drug Template

Division of Insurance Website

- The Division will not post proposed 2019 rates
- Approved 2019 rates will be posted on October 2nd
- Small group quarterly rates will not be posted after 2018
- Clean copies of the SOB and EOC for each approved individual market plan must be submitted for display on the DOI website no later than October 19th
- The approved schedule of benefits and evidence of coverage for each individual market plan will be posted by October 26th
- Website will generally use “Plan Marketing Name” from Plans & Benefits Template

MOOP and Deductible Guidance

- For 2019 individual and small group health benefit plans, the maximum out-of-pocket will be
  - $7,900 single, $15,800 family
- For 2019 HSA plans, the maximum out-of-pocket will be
  - $ single, $ family
- For 2019 HSA plans, the minimum deductible will be
  - $ single, $ family

MOOP and Deductible Guidance

- For the 73 percent AV silver plan variations, the maximum out-of-pocket will be
  - $6,300 single, $ 12,600 family
- For the 87 percent and 94 percent AV silver plan variations, the maximum out-of-pocket will be
  - $2,600 single, $5,200 family

Pediatric Dental

- Pediatric dental is not required to be embedded in a medical plan outside the Exchange if the issuer is reasonably assured certified stand-alone coverage has been obtained
- Nevada will consider self-attestation by an applicant to be “reasonable assurance”
- The issuer must obtain “reasonable assurance” that the consumer has certified stand-alone coverage every year at renewal

SOB: Embedded Pediatric Dental

- The calendar year deductible applicable to pediatric dental services must be prominently displayed on page 1 of the benefit schedule
- For pediatric dental, Type I dental services (preventive and diagnostic services) cannot be subject to the deductible

Stand-Alone Dental Plans

- 2019 SADPs are allowed an out-of-pocket maximum of $350 for one covered child and $700 for two or more covered children
- Type I dental services (preventive and diagnostic services) should not be subject to a deductible
- Binders are required for all SADPs seeking certification for sale on or off the exchange
- Individual SADP expense ratio limited to 25%

Dental Form Filings

- Redlined versions of all forms for existing plans must be submitted
- Explanations of Type I, Type II, Type III, and Type IV dental services must be included within each schedule of benefits
  - Every service does not need to be listed in the Schedule of Benefits; however, important services of each category should be listed
- A detailed list of pediatric dental services must be included in the Evidence of Coverage

AV for Stand-Alone Dental

SADPs will no longer be subject to AV requirements in 2019