Silver State Health Insurance Exchange

Plan Year 2020
Plan Certification

May 6, 2019

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Nevada State Based Exchange Notes

- QHP/SADP binder submission are done through SERFF
- QHP/SADP Approval/Certification for on exchange plans will be completed by the Exchange
- QHP/SAPD display on NevadaHealthLink.com
- QHP/APTC/CSR eligibility is determined by the Federal guidelines
- Medicaid/CHIP eligibility determined by State of Nevada DWSS
- Carrier invoicing will be performed by SSHIX

Calendar Year 2020 Carrier Fees

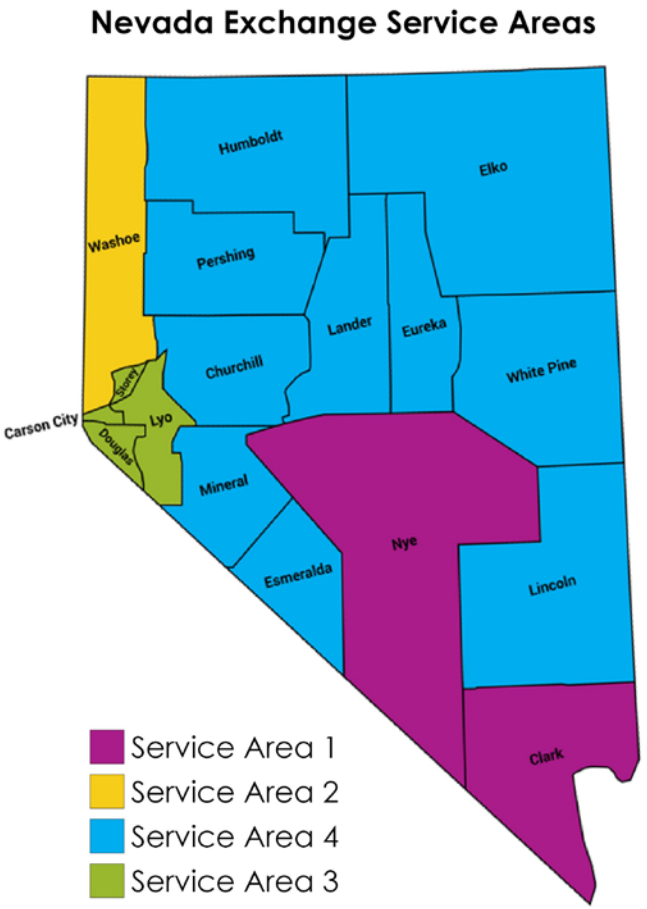
Fees will remain the same (3.15%) as the 2019 carrier fees.

Plan Type	Percent of Premium
Qualified Health Plan	3.15%
Standalone Dental Plan	3.15%

https://www.nevadahealthlink.com/partner-resources/carriers/

Exchange Service Areas

- Nevada's rating territories are aligned with Nevada's on Exchange Service Areas
- Nevada's Service Areas for 2020 are unchanged
- QHP and SADP service areas must equal one or more rating territories
- On Exchange plans are not permitted to offer partial county coverage



Plan Year 2020 QHP/SADP Timeline

Activity	Deadline
Carriers submit “Issuer Submission Form”	5/20/2019
All binder filings due in SERFF	6/3/2019
SSHIX initial review of binder data submitted in SERFF	6/3-7/15/2019
SSHIX sends first correction notice to carriers. Carriers have 5 business days to respond	6/17/2019
First data transfer from SERFF to Nevada Health Link SBE Platform	7/15/2019
SSHIX initial certification review on Nevada Health Link SBE Platform	7/15-8/2/2019
Proposed rate change posted on the DOI website	8/1/2019
Carrier plan preview on Nevada Health Link SBE Platform	8/5-8/22/19
Letters of Good Standing and Network Adequacy submitted to SSHIX from DOI	8/20/2019
Final Deadline for Carriers to change QHP application without state authorization	8/22/2019
Final data transfer from SERFF to Nevada Health Link SBE Platform	8/23/2019

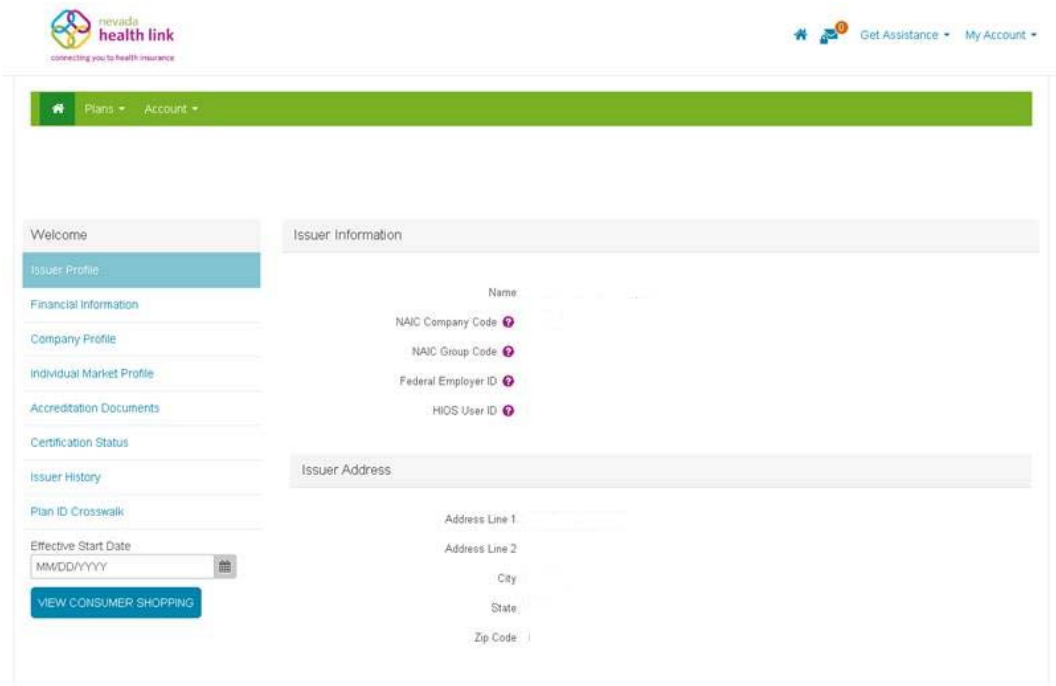
Plan Year 2020 QHP/SADP Timeline (cont.)

Activity	Deadline
Attestations and Billing Agreements sent to carriers with final plan confirmation list	9/2/2019
Issuers send signed agreements, and confirm final plan listings	9/16-9/20/2019
Limited data correction window (not applicable to utilize for service area changes or rate data). Must obtain State Authorization prior to use of window.	9/18-9/20/2019
SSHIX to send final plan confirmation list and countersigned attestations and billing agreements to carriers	9/25/2019
Plans Certified	9/25/2019
Approved rate changes posted on the DOI website	10/1/2019
Consumer window shopping begins	10/1/2019
Open enrollment begins	11/1/2019

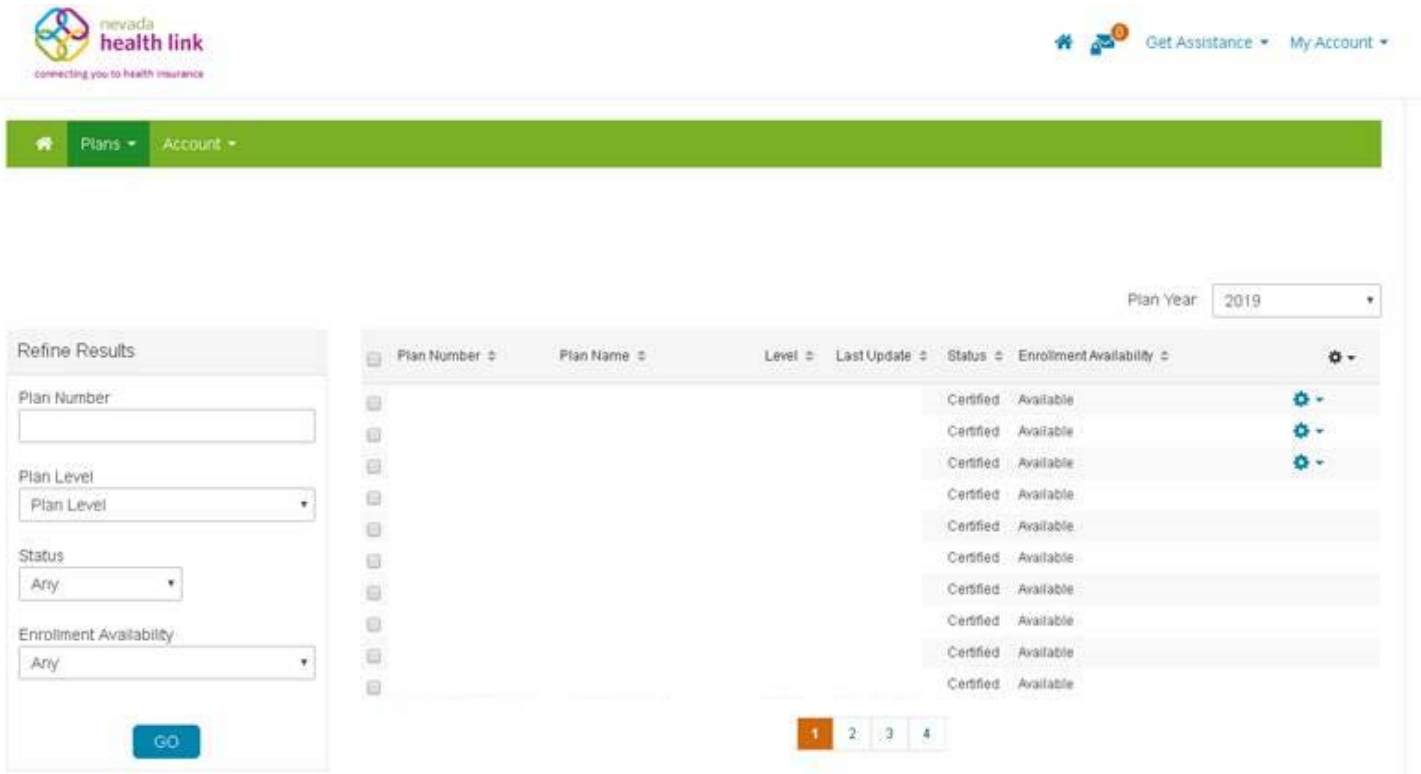
Issuer Representative

The Issuer Representative will be the issuers primary point of contact for non-technical QHP and SADP issuers related to the Exchange.

This assigned person will have access to verify plan data, add other designated staff with the Issuer Representative role access, and update issuer information such as: Issuer logo, URL's, and phone numbers.



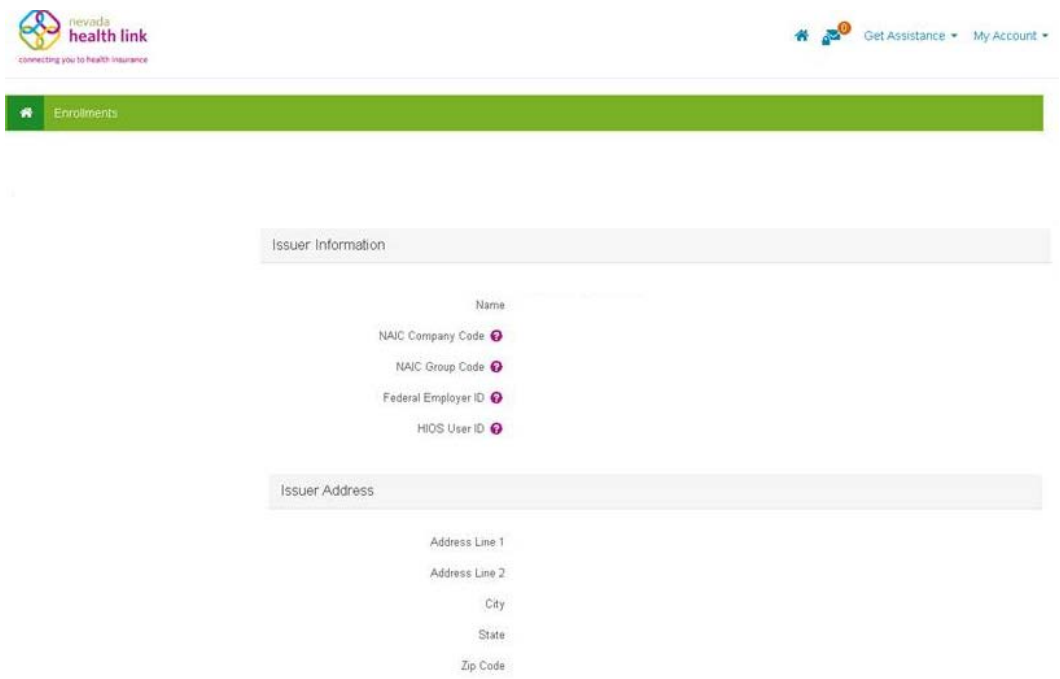
Issuer Representative



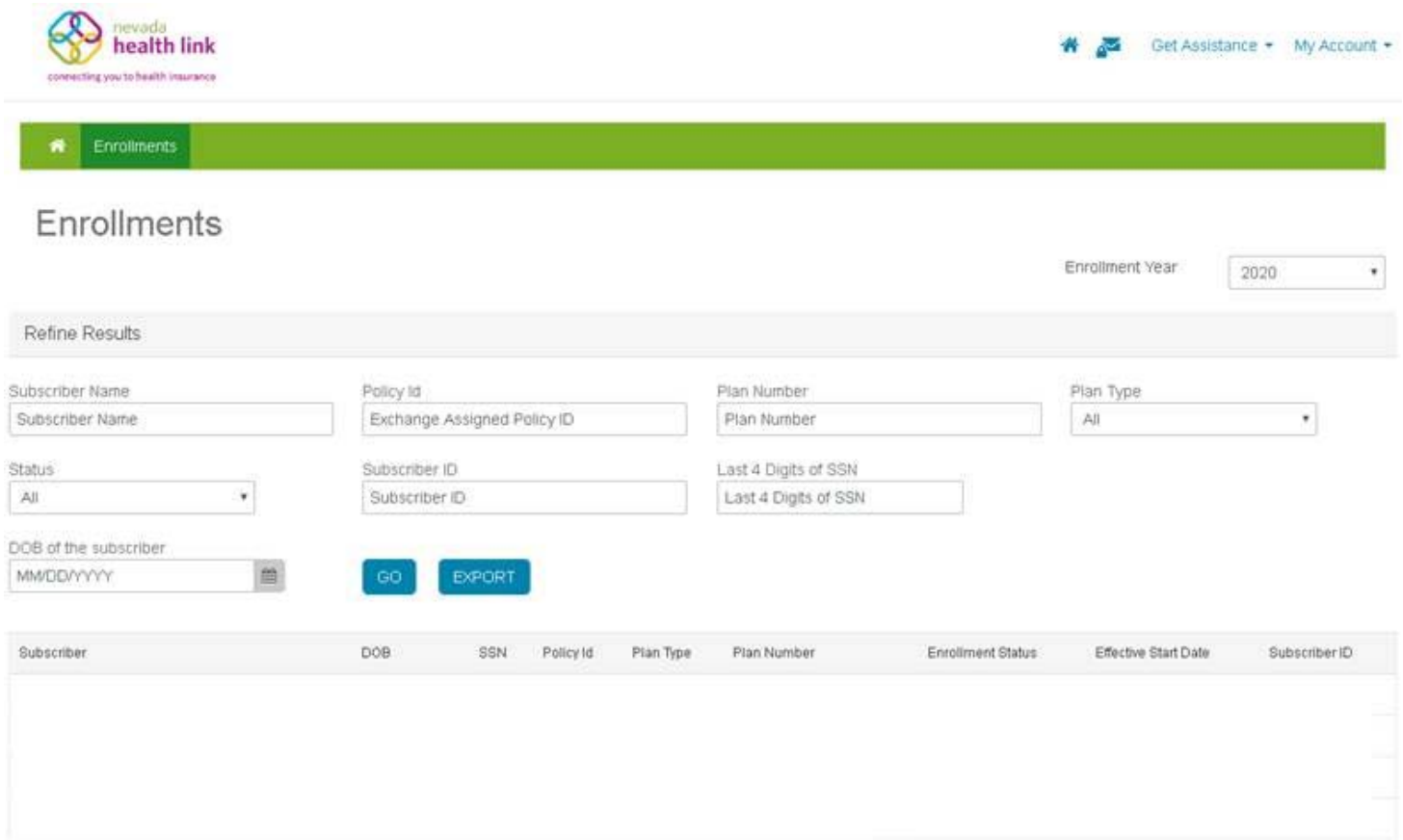
Enrollment Representative

The Enrollment Representative will be the issuers primary point of contact for enrollment related functions on the Exchange.

The assigned person will have access to view enrollment data.



Enrollment Representative



Application Review Tools

- Carriers will still use all the applicable tools provided by CMS to identify and resolve data errors prior to each submission
- Carriers with data errors post-data lockdown that could have been identified and fixed through use of CMS tools incur the risk of not being certified

Download the toolkit at:

https://www.qhpcertification.cms.gov/s/Review%20Tools

List of tools

- ✓ **Data Integrity Tool**
- ✓ **Plan ID Crosswalk Tool**
- ✓ **Master Review Tool**
- ✓ **Essential Community Provider Tool**
- ✓ **SADP Essential Community Providers Tool**
- ✓ **Meaningful Difference Tool**
- ✓ **Non-discrimination**
- ✓ **Cost Sharing Tool**
- ✓ **Category & Class Drug Count Tool**
- ✓ **Non-discrimination Formulary Outlier**
- ✓ **Non-discrimination Clinical Appropriateness**

Required Templates – QHP Carriers

- ECP/Network Adequacy Template (XML uploaded in .zip file)
- Plans and Benefits Template (and Add-in file)
- Prescription Drug Formulary Template
- Network Template
- Service Area Template
- Rates Table Template
- Business Rules Template
- Crosswalk Template in .xlsm format is required on the supporting documents tab

Templates available for download: https://www.qhpcertification.cms.gov/s/QHP

Note: All templates must be validated and submitted within a SERFF binder. Carriers **MUST** run CMS tools prior to template submission.

Application Tips and Hints

Plans and Benefits Template

- Each product should be its own benefit package in the template.
- QHP/Non-QHP – must select both because of guaranteed availability.
- For specialties, if there is a “yes” in “specialist requiring a referral,” the next field should also be populated, most of the time with “ALL.”
- Individual plan’s expiration date: Should always be 12/31/20XX. (Not applicable to SHOP)
- Live URL for payment information must be working by 10/01
    - SSHIX will test this URL and notify carriers if the link is not active

Application Tips and Hints (cont.)

Plans and Benefits Template (cont.)

- On the cost sharing tab of the template, verify the following do not apply for silver plans:
  - ✓Deductible does not increase as actuarial values increase.
  - ✓MOOP does not increase as the actuarial values increase.
  - ✓Cost sharing for all benefits does not increase as the actuarial values increase.
- On the cost sharing tab of the template, verify the following do not apply for any cost sharing plan variations:
  - ✓You have listed a non-zero cost sharing for an essential health benefit.
  - ✓The zero cost sharing plan has values of zero for deductible and MOOP.

Application Tips and Hints (cont.)

Plan ID Crosswalk Template

All carriers who offered 2019 coverage must submit a Plan ID Crosswalk template.

- Include all plans that were offered on the Marketplace in 2019, including those that were suppressed following open enrollment if they received enrollees. Don't include plans that were withdrawn prior to certification.
- File name for automatically created XML file must **not** be changed.
- When entering the Reason for Crosswalk, only select the "Discontinuing Product" reason if you are not offering any plans in that product in any counties for the 2020 plan year.
- Submit as "Supporting Documentation" within binder

***Please add both the XLSM and XML versions of the crosswalk to the SERFF binder as well**

Application Tips and Hints (cont.)

Business Rules Template:

- Requires minimum relations between primary and dependent:

  Spouse-no, Adopted Child-no, Foster Child-no, Ward-no, Stepson or Stepdaughter-no, Self-yes, Child-no, ***Other Relationship-no****

  **Other Relationship* is required when offering SHOP plans, and if also selling individual plans it must be added because the relationships have to be identical*

Note: On Child-only plans to allow sibling relationships to be listed on the same plan sibling relationships must be selected

Standardized Plans

- Standardized plan designs (now called *Simple Choice Plans*) are ***optional,*** and ***not required*** for PY2020
- The 2018 Payment Notice Final Rule finalized standardized options for bronze, silver (and CSR levels), and gold metal levels
- Issuers have the ***option*** to offer standardized plans at one metal level of coverage and not the others, unless it is silver then must have standardized silver cost-sharing levels.
- “Set 1” would be utilized for Nevada
- Standardized plans will not be given differential display on the Nevada Health Link SBE Platform

Accreditation

Accreditation

- All issuers applying for 2nd or later year of certification must be accredited by one of the HHS recognized accrediting entities (NCQA, URAC, AAAHC)
- Verify that all products on Accreditation Template do not expire before November 1, 2020.
- **Accreditation Template is optional.**

  *SSHIX will request a copy of accreditation certificate

Indian Health Care Providers Addendum

- Issuers are required to offer contracts in good faith to Indian Health Care Providers.
- There are some provisions pertaining to Indian Health Care Providers that are not applicable to regular QHP/Network Provider agreements.
- These provisions are addressed in the document called “Model QHP Addendum for Indian Health Care Providers.”
- Issuers who do contract with Indian Health Care Providers must sign the Addendum. The Indian Health Care Provider must also sign.
- The terms in the Addendum will supersede terms in regular QHP/Network Provider contracts.
- SSHIX will require carriers to provide a statement that good faith contracts have been offered to all applicable Indian Health Care Providers.

Quality Improvement Strategy (QIS)

- QHP issuers who offered coverage in a marketplace for at least two consecutive years (2018 and 2019 or more), and who had a minimum enrollment of 500 enrollees must submit a QIS for implementation for plan coverage year 2020
- Issuers applying for QHP certification for the 2020 Plan Year that meet the QIS participation criteria are required to submit a QIS Implementation Plan and Progress Report to either: (a) implement a new QIS beginning January 2020; OR (b) provide a progress update on an existing QIS
- QHPs that are compatible with health savings accounts (HSAs) and issuers are required to include such plans in their QIS.

https://www.qhpcertification.cms.gov/s/Quality%20Improvement

Note: SADPs and child-only plans are not subject to QIS reporting.

Quality Improvement Strategy (cont.)

Issuer's Initial QHP Certification Application Year	Two Consecutive Years of Providing Coverage	Calendar Year of Initial QIS Implementation Plan Submission	Initial QIS Implementation Plan Coverage Year
2016	2017 and 2018	2019	2020
2017	2018 and 2019	2020	2021
2018	2019 and 2020	2021	2022
2019	2020 and 2021	2022	2023
2020	2021 and 2022	2023	2024

2020 SADP
Certification Standards

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SADPs On Exchange

On Exchange Standards:

- SADPs are no longer subject to AV requirements per the 2019 Notice and Benefit of Payment Parameters
- HIOS Plan IDs can remain the same as plan year 2019, even with changes in cost-share
- Renewal with altered terms requires 60 day notice to policyholders
- Plan Year 2020 SADP plans will be eligible for purchase on Exchange without the purchase of a QHP plan

Certification Standards that DO NOT apply to on Exchange SADPs

The following are certification standards that **DO NOT** apply to SADP on Exchange:

- Accreditation
- Cost-sharing Reduction Plan Variations
- Unified Rate Review Template
- Patient Safety
- Quality Reporting
- Prescription Drugs

Required SADP Templates

- ECP/Network Adequacy Template (XML uploaded in .zip file)
- Plans and Benefits Template (and Add-in file)
- Network Template
- Service Area Template
- Rates Table Template
- Business Rules Template
- Crosswalk Template in .xlsm format is required on the supporting documents tab

Templates available for download: https://www.qhpcertification.cms.gov/s/QHP

Note: All templates must be validated and submitted within a SERFF binder. Carriers **MUST** run CMS tools prior to template submission.

On Exchange SADP Network Adequacy

- SADP counties must have at least:
  - One general dentist
  - One periodontist
  - One oral surgeon
  - One orthodontist
- All providers must be within the specific travel standards established for each geographic area
- An access plan is required that demonstrates that the SADP carrier has standards and procedures in place to maintain an adequate network consistent with NAIC's Health Benefit Plan Network Access and Adequacy Model Act (NAIC Model ACT)

  http://www.naic.org/store/free/MDL-74.pdf

On Exchange SADP Network Adequacy Distance and Time Standards

Geographic Areas by County	Maximum Travel Distance or Time
Urban Counties	
Carson City Clark Washoe	45 miles or 45 minutes
Rural Counties	
Douglas Lyon Storey	60 miles or 1 hour
Frontier Counties	
Churchill Elko Esmeralda Eureka Humboldt Lander Lincoln Mineral Nye Pershing White Pine	100 miles or 2 hours

SADP Standards Tips and Hints

Annual Limits on Cost Sharing:

- Stand-alone dental plans must have a maximum out-of-pocket limit applicable to pediatric essential health benefits that is no greater than $350 for one child or $700 for two or more children

Pediatric Dental EHBs

- Only pediatric dental essential health benefits are subject to EHB rules.
- All pediatric dental benefits within Nevada Check-Up as of March 31, 2012 must be covered
- Benefits cannot have limitations which are more restrictive
- Nevada Check-Up guidelines can be found at:
  http://doi.nv.gov/uploadedFiles/doinvgov/_public-documents/Healthcare-Reform/NV_CheckUp_Dental.pdf

Non-discrimination

- SADPs may not employ market practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs.
- **Type I services can not be subject to a deductible.**

Application Tips and Hints

Plans and Benefits Template

- The P&B template has a Dental Macro that can be activated by selecting “yes” in the Dental Only Plan Field
- The template will grey out all benefits except:
  - Basic Dental Care – Adult
  - Basic Dental Care – Child
  - Dental Check-Up for Children
  - Major Dental Care – Adult
  - Major Dental Care – Child
  - Orthodontia – Adult
  - Orthodontia – Child
  - Accidental Dental
  - Routine Dental Services (Adult)
- SADP issuers may offer the pediatric dental EHB at any AV and are not required to enter the high or low level of coverage in the template
  - If the high or low level of coverage is entered, then it must fall within the AV range of high or low.
  - The AV for the pediatric dental EHB must be entered on the AV supporting document

Application Tips and Hints (cont.)

Plans and Benefits Template (cont.)

- Pursuant to the provision of EHB at 45 CFR 156.115(a)(6), SADPs must cover pediatric dental benefits for individuals until at least the end of the month in which the enrollee turns 19 years of age
- Accidental Dental is included on the template but does not have to be covered
- Quantitative Limit on Service, Limit Quantity, Limit Unit, and Minimum Stay should be filled out according to the most typical/highest utilized benefit in each "Covered" benefit category
- All other limits or details of the services provided should be described in the Benefit Explanation field

Note: Consumers should be able to easily access this detail when viewing Plan Brochures

Application Tips and Hints (cont.)

Plans and Benefits Template (cont.)

- The Plan Brochure URL is provided in the Plans & Benefits Template but is not required
- The Provider Directory URL is provided in the Network ID Template and **is** required
- Live URL for payment information must be working by 10/01
  - SSHIX will test this URL and notify carriers if the link is not active
- Portion of premium (dollar amount) that applies towards EHB
  - Statewide average should be represented in template
  - Cannot exceed premium for child-only plan
  - Description of EHB Allocation form required to be signed by an actuary

Application Tips and Hints (cont.)

Plans and Benefits Template (cont.)

Guaranteed vs. Estimated Rate

- Guaranteed – Carrier must charge consumers the exact rates entered in the Rates Table Template
- Estimated – Carrier must make adjustments to the rates charged to the consumer beyond what it entered in the Rates Table Template
  - This will be indicated on Plan Compare
  - Allows carriers to rate 19 and 20 year olds differently
- SHOP rates must be “Guaranteed”

Business Rules Template:

- Requires minimum relations between primary and dependent:

  *Spouse-no, Adopted Child-no, Foster Child-no, Ward-no, Stepson or Stepdaughter-no, Self-yes, Child-no, Life Partner-no, Other Relationship-no**

  **Other Relationship* is required for SHOP plans, and if also selling individual plans it must be added because the relationships have to be identical*

Prohibition of Waiting Periods

- Waiting periods are not allowed for any EHB's, including pediatric orthodontia EHB.
- Imposing a waiting period on an EHB could mean the issuer is not offering coverage that provides EHB as required by 45 CFR 156.115

https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Waiting-period-FAQ-05262016-Final-.pdf

SHOP – Small Business Health Options Program

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SHOP Standards

- SHOP binder submissions mimic the process of submitting individual binders.
- Nevada Health Link's Small Business Health Options Program (SHOP) is open to small businesses in Nevada with up to 50 employees. Employees are defined as working on average 30 or more hours per week.
- A small business employer will navigate the SHOP page on NevadaHealthLink.com and enroll directly through the insurer offering SHOP coverage.

  https://www.nevadahealthlink.com/start-here/about-the-aca/rates-and-carriers/

Contacting the Exchange

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