State of Nevada

Silver State Health Insurance Exchange
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Nevada Health Link State Based Exchange Platform

Plan Year 2021 Draft Letter to Issuers

January 6th, 2020

Date: January 6, 2020

From: The Silver State Health Insurance Exchange (The Exchange or SSHIX)

Title: 2021 Draft Letter to Issuers

The Silver State Health Insurance Exchange is releasing this plan year 2021 Draft Letter to Issuers. This letter provides updates on operational and technical guidance for the 2021 plan year for issuers seeking to offer qualified health plans (QHPs), including qualified dental plans (QDPs) on Exchange. This letter contains guidance provided by Centers for Medicare and Medicaid (CMS), the Nevada Administrative Code, the Code of Federal Regulations (CFRs), the Nevada Revised Statutes (NRS),the Office of the Law Revision Counsel, United States Code (OLRC, U.S.C.), as well as the Nevada Division of Insurance (DOI). Issuers should refer to these updates to help them successfully participate on Exchange in 2021.

The Silver State Health Insurance Exchange welcomes comments on this proposed guidance. To the extent that this guidance summarizes policies proposed through other rulemaking processes that have not yet been finalized, such as the rulemaking process for the 2021 Payment Notice Proposed Rule, stakeholders should comment on those underlying policies through the ongoing rulemaking processes, and not through the comment process for this Letter. Please send comments on other aspects of this Letter to pmanagement@exchange.nv.gov by January 31, 2020. Comments will be most helpful if organized by subsections of this Letter.

CHAPTER 1: CERTIFICATION PROCESS FOR QUALIFIED HEALTH PLANS

The Patient Protection and Affordable Care Act (PPACA) and applicable regulations provide that health plans, including QDPs, must meet a number of standards in order to be certified as QHPs. Several of these are market-wide standards that apply to plans offered in the individual and small group markets both inside and outside of the Exchange. The remaining standards are specific to health plans seeking QHP certification from the Exchange.

This chapter provides an overview of the QHP certification process. Additional information and instructions about the process for issuers to complete a QHP application can be found at https://www.nevadahealthlink.com/partner-resources/carriers/

Section 1. QHP Certification Process and Timeline

As in prior years, issuers will submit an Intent to Sell Form, linked here: Intent to Sell Form, as well as a complete QHP application for all plan year 2021 plans they intend to have certified by SSHIX. Through an iterative process as shown below in Table 1.1., SSHIX will review QHP applications for current and new issuers applying for QHP certification and send issuers notices summarizing any need for corrections after each round of review.

Finally, issuers intending to offer QHPs, including QDPs, will sign and submit to SSHIX the Plan Year 2021 Issuer Agreements that will be provided to the issuers by SSHIX as outlined in the timeline below.

SSHIX will countersign the Issuer Agreements and return to issuers along with a final list of certified QHPs, completing the certification process for the upcoming plan year. An issuer must submit a plan withdrawal form to SSHIX in order to withdraw a plan from QHP certification consideration, or to change an on-Exchange QDP under certification consideration to an off-Exchange QDP for certification consideration.

Please note: All QHP binders must be certified through the Nevada Health Link SBE Platform as well as SERFF in order for plans to be visible for purchase to consumers. Once binders are received, no plans may be added. Also, certification in the Nevada Health Link SBE Platform can only occur once the plans Review of Rates and Network Adequacy have received approval from the DOI. See Section 9. Review of Rates and Section 3. Network Adequacy for more information. Any changes needed to a QHP binder after 8/22/2020 would need a State Authorization form to be submitted through SSHIX.

Table 1.1 Draft Plan Year 2021 QHP Certification Timeline**

Activity	Deadline
Issuers submit Intent to EDI Test Form with SSHIX - **Required**	1/31/2020
EDI discussions and precreation	3/1-5/31/2020
Issuers submit Intent to Sell Form with SSHIX – **Required**	4/15/2020
Binder submission due in SERFF	6/3/2020
SSHIX initial review of binder data submitted in SERFF	6/3-7/13/2020
EDI testing must be successfully completed	6/1/-7/31/2020
First data transfer from SERFF to Nevada Health Link SBE Platform	7/13/2020
Proposed rate change posted on the DOI website	7/31/2020
Issuer plan preview on Nevada Health Link SBE Platform	7/13-8/19/2020
Letters of Good Standing and Network Adequacy submitted to the Exchange from DOI	8/20/2020
Final deadline for Issuers to change QHP application without State Authorization (not applicable to rates)*	8/22/2020
Final data transfer from SERFF to Nevada Health Link SBE Platform if applicable	8/24/2020
Plan Year 2021 Issuer Agreements sent to issuers with final plan confirmation list	9/2/2020
Issuers send signed agreements and confirm final plan listings	9/2-9/16/2020
SSHIX to send final plan confirmation list and countersigned Issuer Agreements to issuers	9/25/2020
Plans Certified in SERFF	9/25/2020
Approved rate changes posted on the DOI website	10/1/2020
Consumer window shopping begins	10/1/2020
Limited data correction window (not applicable to utilize for service area changes, plan offerings, or rate data). Must obtain State Authorization prior to use of window.	10/5-10/8/2020
Open enrollment begins	11/1/2020

* Does not apply to Rate changes

**All dates are subject to change with notice to carriers

Section 2. Electronic Data Interchange (EDI) Requirements

Any issuer intending to sell plans in Nevada for PY2021 must complete requirements with EDI testing prior to certification. Issuers will be required to notify SSHIX no later than January 31, 2020 if they intend to offer plans in Nevada for PY2021. Issuers will then be required to work collaboratively with SSHIX's vendor GetInsured (GI) for EDI related matters. Please see link provided for Intent to EDI test form: Intent to EDI Test PY2021

Fees may apply for EDI related processes and issuer onboarding. For a schedule of fees, please contact the Exchange at: pmanagement@exchange.nv.gov.

Failure to successfully test by the required timeframes indicated in Table 1.1 Draft Plan Year 2021 QHP Certification Timeline and Table 1.2 below may result in additional fees and/or not being certified to offer plans on the Exchange for PY2021.

Table 1.2 Key Dates for Electronic Data Interchange (EDI) Requirements

Activity	Deadline
Issuers submit Intent to EDI test with SSHIX - **Required**	1/31/2020
EDI discussions and precreation	3/1-5/31/2020
EDI testing must be successfully completed	6/1/-7/31/2020

Section 3. QHP Application Data Submission

The Exchange and DOI expect issuers to adhere to the QHP certification timeline. The Exchange requires issuers, including QDP issuers, to submit complete QHP applications by the initial binder submission deadline on 6/3/2020 and to make necessary updates to the QHP application prior to the last deadline for issuer submission on 8/22/2020.

All issuers must obtain Health Insurance Oversight System (HIOS) product and plan IDs using HIOS. New for plan year 2020, all issuers will receive access to the Nevada Health Link SBE Platform issuer portal for plan preview, and verifying accuracy of plan data.
Issuers applying for QHP certification will use the National Association of Insurance Commissioners' System for Electronic Rate and Form Filing (SERFF) to collect plan data, which may include copies of the QHP templates, and any data submitted by issuers applying for QHP certification.

All issuers applying for QHP certification will be able to view plan data in the Plan Preview environment in order to identify and correct data submission errors before the final QHP application data submission deadline. Issuers will be able to view their plan data after SSHIX transfers the QHP data from SERFF to Nevada Health Link SBE Platform. Issuers should utilize the Plan Preview environment to verify that their plan display reflects their approved filings.

Discrepancies between an issuer's QHP application and approved filings may result in a plan not being certified or a compliance action if SSHIX has already certified a plan as a QHP. All issuers must complete quality assurance activities to ensure the completeness and accuracy of QHP application data, including reviewing plan data in the Plan Preview environment, and run all necessary review tools provided by CMS. Tools can be found at the following link: https://www.qhpcertification.cms.gov/s/Review%20Tools

Section 4. QHP Data Changes

During the certification process for plan year 2021, SSHIX will allow issuers to make changes to their QHP application based on the guidelines below. These changes are in addition to any corrections that SSHIX identified during its review of QHP applications. There will be occasional windows used for data corrections as needed. Those dates will be defined at a later date and issuers will be notified by SSHIX of the data correction windows.

Table 1.3 Key Dates for QHP Data Changes

Activity	Deadline
QHP/QDP certification review. Changes permitted without State Authorization	6/4-8/22/2020
Limited data correction window. Data corrections must have State Authorization	10/5-10/8/2020

Issuers may make changes to their QHP submissions without State Authorization with the exception of rate information until the deadline listed in Table 1.1 QHP Certification Timeline. After the close of the initial QHP application submission window, issuers may not add new plans to a QHP application or change an off-Exchange plan to both on and off-Exchange. Issuers also may not change plan type(s) and may not change QHPs, excluding QDPs, from a child-only plan to a non-child-only plan. Issuers may only change their service area after SSHIX approves the change. For all other changes, issuers will be able to upload revised QHP data templates and make other necessary changes to QHP applications in response to State feedback until the deadline for issuer changes.

To withdraw a plan from QHP certification consideration, an issuer must submit to SSHIX a plan withdrawal form. After submission of an initial QHP application, an issuer should not remove plan data from the application templates, even if the issuer withdraws a plan. In addition, issuers seeking to change an on-Exchange QDP under certification consideration to an off-Exchange QDP for certification consideration must submit a plan withdrawal request.

After the final deadline for issuer changes to QHP applications, issuers will only make corrections directed by SSHIX. Issuers whose applications are not accurate after the deadline for issuer submission of changes to the QHP application, which is 8/22/2020, and are then required to enter the limited data correction window, may be subject to compliance action by the Exchange and DOI. Issuer changes made in the limited data correction window not approved by

SSHIX may result in compliance action by the Exchange and DOI, which could include decertification and suppression of the issuer's plans on https://www.nevadahealthlink.com/.

After completion of the QHP certification process, SSHIX may offer additional data correction windows. SSHIX will only consider approving changes that do not alter the QHP's certification status or require re-review of data previously approved by the Exchange or DOI. A request for a data change after 8/22/2020, excluding administrative changes, may be made due to inaccuracies in or the incompleteness of a QHP application, and may result in compliance action. Discrepancies between the issuer's QHP application and approved State filings may result in a plan not being certified or a compliance action if SSHIX has already certified a plan as a QHP. Issuers that request to make changes that affect consumers may have their plans suppressed from display on Nevadahealthlink.com until the data is corrected and refreshed for consumer display.

Section 5. QHP Review Coordination with SSHIX

SSHIX will define the relevant submission window for reviews as well as dates and processes for corrections and resubmissions.

SSHIX will perform QHP certification reviews, and may exercise reasonable flexibility in their application of QHP certification standards, provided that the application of each standard is consistent with state and federal regulations and guidance. Issuers seeking QHP certification in Nevada should continue to refer to State direction in addition to this guidance.

The Exchange and DOI will establish the timeline, communication process, and resubmission window for any reviews conducted under State authority. As noted previously, issuers should comply with any State-specific guidelines for review and resubmission related to State review standards. Issuers must meet all applicable obligations under State law and Federal law to be certified for sale on https://www.nevadahealthlink.com/.

SSHIX will make final QHP certification decisions, and load certified QHP plans on Nevada Health Link SBE Platform for consumer purchase.

SSHIX will provide all of their recommendations and relevant information to issuers in a timely manner and no later than the final plan recommendation deadline noted in Table 1.1.

Section 6. Plan ID Crosswalk

In pursuant to 45 CFR 155.335(j), the Division of Insurance is responsible to conduct Plan ID Crosswalk for plan year 2021. Plan ID Crosswalk changes must be uploaded to SERFF. DOI will provide SSHIX with a letter of approval for all Plan ID Crosswalk Templates.

Section 7. Issuer Participation for the Full Plan Year

Issuers seeking QHP certification must adhere to 45 CFR 156.272 in offering a QHP through the full plan year. The full plan year for plan year 2021 is defined as 1/1/2021-12/31/2021.

CHAPTER 2: QUALIFIED HEALTH PLAN AND QUALIFIED DENTAL PLAN CERTIFICATION STANDARDS

This Chapter provides an overview of key QHP certification standards for both QHPs and QDPs on Exchange how SSHIX will evaluate and conduct reviews of 2021 QHPs and QDPs for compliance.

Section 1. Licensure and Good Standing

The Division of Insurance determines whether each applicant is licensed and in good standing pursuant to 45 CFR 156.200(b)(4).

Section 2. Service Area

SSHIX has defined service areas for on-Exchange plans. The Service Area Policy is linked for reference:
https://d1q4hslcl8rmbx.cloudfront.net/assets/uploads/2019/05/08_-_Service_Areas.pdf

Section 3. Network Adequacy

This section describes how SSHIX will address network adequacy standards and certification review. Exchange will rely on the Division of Insurance to conduct its network adequacy review for plan year 2021 QHP certification of all plans with the exception of dental plans which will be reviewed by the Exchange. NRS 687B.490 requires that "a carrier that offers coverage in the small employer group or individual market must, before making any network plan available for sale in this State, demonstrate the capacity to deliver services adequately by applying to the Commissioner for the issuance of a network plan and submitting a description of the procedures and programs to be implemented to meet the requirements."

As was done during the 2019 and 2020 certification processes, for 2021 plan year certification, the Division of Insurance will assess provider networks using the standards outlined in the Adequacy of Networks section of NAC 687B.

This section provides clarity on the criteria that the Division of Insurance has previously used and will use as part of the certification process to review network provider data to determine network adequacy. For 2021, the Division of Insurance will review provider data with a focus on the following specialties: Hospitals, Endocrinology, Infectious Disease, Psychiatrist, Psychologist, Licensed Clinical Social Works, Pediatrics, Oncology, Outpatient Dialysis, Primary Care, and Rheumatology.

Specifically, in order to determine whether plans provide reasonable access for these specialties, we will review the provider data using the maximum time and distance standards detailed in the table below.

Table 2.1. Specialties and Standards for Plan Year 2021 Network Adequacy Certification[1]

Specialty Area	Maximum Time or Distance Standards (Minutes/Miles)			
	Metro	Micro	Rural	Counties with Extreme Access Considerations (CEAC)
Primary Care	15/10	30/20	40/30	70/60
Endocrinology	60/40	100/75	110/90	145/130
Infectious Diseases	60/40	100/75	110/90	145/130
Oncology - Medical/Surgical	45/30	60/45	75/60	110/100
Oncology - Radiation/Radiology	60/40	100/75	110/90	145/130
Psychiatrist	45/30	60/45	75/60	110/100
Psychologist	45/30	60/45	75/60	110/100
Licensed Clinical Social Works (LCSW)	45/30	60/45	75/60	110/100
Pediatrics	25/15	30/20	40/30	105/90
Rheumatology	60/40	100/75	110/90	145/130
Hospitals	45/30	80/60	75/60	110/100
Outpatient Dialysis	45/30	80/60	90/75	125/110

For each specialty and standard listed in the table, we will review the issuer-submitted data to make sure that the plan provides access to at least one provider in each of the above-listed provider types for at least 90 percent of enrollees. For example, for Primary Care in a Metro county type, at least 90 percent of enrollees must have at least one provider within 15 miles or 30 minutes.

[1] The full definitions for each of the county types listed can be found on page 6 of the temporary regulation T005-18.

As in past years, in addition to permitting issuers to add additional providers, we will use a justification process when the Division of Insurance determines that an issuer's network is inadequate under the review standard. The justification process requires that QHP issuers detail patterns of care and other relevant information that explain how the issuer provides reasonable access to enrollees in the identified area(s). The justification must specifically address how issuers meet the reasonable access standard, despite not meeting the time and distance standards.

Section 4. Essential Community Providers

The Exchange will rely on the Division of Insurance as the State regulatory agency to conduct reviews of the ECP standard for QHP and QDP certification for plan year 2021. The approach for reviews of the ECP standard remains unchanged from that used in 2020, with the exceptions noted below. Please refer to NAC 687B.768[2] for more information.

Each network plan must contract with at least 30 percent of the essential community providers in the service area of the network plan that are available to participate in the provider network of the network plan, as calculated using the same methodology utilized in Federally facilitated Exchanges. Contracts must be offered in good faith to all available Indian health care providers in the service area of the network plan, including, without limitation, the Indian Health Service, Indian Tribes, tribal organizations and urban Indian organizations, as defined in 25 U.S.C. § 1603, which apply the special terms and conditions necessitated by federal statutes and regulations as referenced in the *Model Qualified Health Plan Addendum for Indian Health Care Providers* and which offers 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.

Section 5. Accreditation

The QHP issuer must meet a minimum level of accreditation by an accrediting entity recognized by HHS. SSHIX will verify an issuer's accreditation status for certification or recertification. SSHIX utilizes the same timeline requirements defined in 45 CFR 155.1045(b) that are used in Federally Facilitated Exchanges. In addition, SSHIX requires a QHP issuer to comply with regulations set forth in 45 CFR 156.275.
Issuers entering their initial year of QHP certification for plan years beginning in 2020 must meet the requirement in 45 CFR 155.1045(b)(1), but may submit accreditation information for display if they have existing accreditation. If an issuer is entering its initial year of QHP certification, it must schedule (or plan to schedule) a review with a recognized accrediting entity (i.e., AAAHC, NCQA or URAC). A QHP issuer in their second or later year of certification must achieve AAAHC, NCQA, or URAC accreditation.

[2] https://www.leg.state.nv.us/NAC/NAC-687B.html#NAC687BSec768

SSHIX will request a copy of any accreditation review scheduled for the upcoming plan year, or the accreditation certificate. The issuer shall notify SSHIX within five business days if there is a change in accreditation status or if there is a failure to maintain up-to-date accreditation. SSHIX reserves the right to decertify a QHP if accreditation is terminated or not achieved by the relevant deadline.

SSHIX will certify a health plan as accredited if one of the following statuses is held by the QHP issuer:

- NCQA: excellent, commendable, accredited, provisional, or interim (interim status requires a second review within 18 months)
    - SSHIX will not recognize NCQA status: denied
- URAC: full, provisional, or conditional (conditional status requires a second review within three to six months)
    - SSHIX will not recognize URAC status: denial
- AAAHC: Certificate of Accreditation
    - SSHIX will not recognize AAAHC status: denial

SSHIX may certify a QHP prior to that health plan becoming exchange-accredited as described below. During a new issuer's initial and next two certification processes, SSHIX may certify a health plan as a QHP that is unaccredited if the issuer satisfies the following:

- When submitting a health plan for certification, an issuer must attest that it will schedule the "exchange accreditation" (in accordance with 45 CFR §§156.275 and 156.1045) in the product types (HMO, EPO, MCO, POS, or PPO) used in offering its QHPs.

Section 6. Patient Safety Standards for QHP Issuers

The approach for QHP patient safety annual certification standards is outlined in 45 CFR 156.1110. SSHIX utilizes the same requirements defined in 45 CFR 156.1110 that are used in Federally Facilitated Exchanges. Please refer to the regulation for details regarding guidance for QHP issuers who contract with a hospital with more than 50 beds.

Section 7. Quality Reporting Strategy

To satisfy this criteria, QHP issuers are required to participate in Quality Rating System (QRS) provided under ACA Section 1311(c)(3), including the disclosure and reporting of information on health care quality and outcomes described in ACA Sections 1311(c)(1)(H) and 1311(c)(1)(I), and the implementation of appropriate enrollee satisfaction surveys consistent with ACA Section 1311(c)(4) (and 45 CFR §156.200(b)(5)). Issuers must also comply with additional federal guidance regarding the QRS and enrollee satisfaction surveys, including requirements described in the Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 20120 and the 2020 Quality Rating System Measure Technical Specification, published by CMS, and any subsequent updates to that guidance.

QHP issuers should refer to the Marketplace Quality Initiatives website for more detailed information on issuer data collection and reporting requirements for the 2020 calendar year. CMS will issue technical guidance for the QRS and QHP Enrollee Experience Survey.

All qualifying issuers offering a QHP of any metal level through SSHIX must comply with QRS requirements and report on all quality measures defined by CMS. For data reporting to CMS during 2020, a qualifying issuer is an issuer that offers a product type on SSHIX that meets the minimum enrollment threshold (more than 500 enrollees in that product type as of both July 1, 2019 and January 1, 2020). An issuer that meets the minimum enrollment threshold but is offering a different product type for 2020 coverage will have the option of displaying their QRS rating for plans of the different product type.

CMS will work with issuers to collect data and calculate the quality performance ratings for QHPs offered through SSHIX during the open enrollment period for the 2021 plan year. During 2021 qualifying issuers will report data from the 2019 plan year to CMS, and that data will be analyzed by CMS and be the basis for the quality performance.

For the 2021 plan year, the Nevada Health Link SBE Platform will display plan rating data on the nevadahealthlink.com Transparency page, linked here: https://www.nevadahealthlink.com/transparency/

In addition to the requirements described above, a QHP issuer will also be required to participate in any other quality reporting requirements that may be authorized by federal regulation or specified by SSHIX.

SSHIX will notify any issuer who is eligible for 2020 QRS based on the 2020 QRS participation requirements. Participation requirements can be found in the CMS Technical Guidance for 2020.

Section 8. Quality Improvement Strategy

Any eligible QHP issuer participating in SSHIX for three or more consecutive years must implement, and report on, a quality improvement strategy (QIS), in accordance with ACA § 1311(g), 45 CFR 156.1130, other applicable law, and Exchange guidance. A QIS is required to incentivize quality by tying payments to (1) performance measures when providers meet specific quality indicators, or (2) measures related to incentivizing enrollees to make certain choices or exhibit behaviors associated with improved health.

An eligible issuer for the 2021 plan year is any QHP issuer that:

- Offered coverage through SSHIX in 2018, 2019, and 2020,

- Provides family and/or adult-only medical coverage, and
- Meets the QIS minimum enrollment threshold (more than 500 enrollees within a product type as of July 1, 2019).

The QIS requirements apply to all issuers offering QHPs, including QHPs compatible with health savings accounts (HSAs). For plan year 2021, QIS requirements will not apply to child-only plans or qualified dental plans.

All eligible issuers must comply with the following QIS requirements for the 2021 plan year:

- Implement a QIS, which is a payment structure that provides increased reimbursement or other market-based incentives for improving health outcomes of plan enrollees.
- Implement a QIS that includes at least one of the following:
    - Activities for improving health outcomes;
    - Activities to prevent hospital readmissions;
    - Activities to improve patient safety and reduce medical errors;
    - Activities for wellness and health promotion; and
    - Activities to reduce health and health care disparities.
- Adhere to federal guidelines, including the QIS Technical Guidance and User Guide for the 2021 Coverage Year.
- Report on progress implementing the QIS to SSHIX in accordance with guidelines established by SSHIX.

Issuers may implement one QIS that applies to all eligible QHPs in SSHIX, or may implement more than one QIS, tailored to the needs of different QHPs. A QIS does not have to address the needs of all enrollees in a given QHP but may address needs of specified sub-populations.

Eligible issuers for the 2021 plan year must submit the following documents to SSHIX along with their binder filing in SERFF in order to meet this certification criterion:

- A QIS applicable to any QHP to be offered by SSHIX in the form and manner specified by SSHIX, which for the 2021 plan year will require use of the QIS Implementation Plan and Progress Report Form provided by SSHIX.

SSHIX utilizes the forms that CMS relates for the Implementation Plan and Progress Report Form.

Issuers are required to submit QIS information using the CMS QIS Implementation Plan and Progress Report form, which will be formatted and provided to issuers by SSHIX. Issuers should also submit a summary of each QIS applicable to a QHP offered by SSHIX.

Eligible issuers who submitted a QIS for the 2020 plan year will need to indicate that they are submitting a new QIS for 2021 if any of the following changes are made to their 2020 QIS:

- QIS market-based incentive type or sub-type change;
- Change or addition of QIS topic area;
- One or more of the QIS performance targets are reached or changed; or
- The QIS results in negative outcomes or unintended consequences.

If an issuer with a 2020 QIS does not make any of the above changes, it should indicate that it is submitting a continuing QIS, with or without modifications, as appropriate.

Issuers with a 2020 QIS are required to complete a Progress Report as part of their 2021 QIS submission. This Progress Report is Section F of the QIS Implementation Plan Form, and should include data about the 2019 QIS implemented to comply with these QIS requirements for the 2020 plan year.

Issuers are required to submit their QIS summary in both PDF and Word formats and include the issuer's logo.

Section 9. Review of Rates

This section pertains to QHP rate filings. Additional information is available in 45 CFR Part 154.

As required by 45 CFR 156.210(c) and 155.1020, a QHP issuer must submit a rate filing justification for each plan in the single risk pool. A rate filing justification includes:

(1) Part I: Uniform Rate Review Template (URRT), required for all single risk pool products, including new and discontinuing plans and products;

(2) Part II: Written description justifying the rate increase (also known as a consumer justification narrative), required for each single risk pool product that includes a plan with a rate increase;

(3) Part III: Actuarial memorandum, required for each single risk pool product.

Please contact the DOI if you have any questions relating to the content of these documents and any other state-specific requirements.

Section 10. Discriminatory Benefit Design

The approach to discriminatory benefit design remains unchanged from that used in 2020. The Exchange will collaboratively work with the Division of Insurance to conduct and review the Discriminatory Benefit Design review for plan year 2021 QHP Certification of all plans, including discriminatory benefit design, QHP discriminatory benefit design, and the treatment protocol calculator.

Pursuant to 45 CFR 156.125, an issuer does not provide EHB if its benefit design, or the

implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.

Pursuant to 45 CFR 156.200(e), a QHP issuer must not, with respect to its QHP, discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.

Pursuant to 45 CFR 156.225, a QHP issuer must not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in QHPs.

Section 11. Prescription Drugs

The approach for reviewing issuers' prescription drug benefit offerings remains unchanged from that used in 2020. The Division of Insurance as the State regulatory agency will conduct a review of the QHP issuer's prescription drug benefit offerings in plan year 2021.

Pursuant to 45 CFR 156.122(a)(1), referred to as the EHB prescription drug count standard, establishes that, generally, a health plan does not provide EHB unless is covers at least the greater of: 1) one drug in every United States Pharmacopeia (USP) category and class; or 2) the same number of prescription drugs in each category and class as the EHB-benchmark plan.

Section 12. Third Party Payment of Premiums and Cost Sharing

45 CFR 156.1250, governs requirements related to QHP and QDP issuers' acceptance of third party payments of premiums and cost sharing on behalf of QHP enrollees. Issuers offering individual market QHPs, including QDPs, and their downstream entities, must accept premium and cost-sharing payments on behalf of QHP enrollees from the following third-party entities (in the case of a downstream entity, to the extent the entity routinely collects premiums or cost sharing):

- Ryan White HIV/AIDS Program under title XXVI of the PHS;
- An Indian tribe, tribal organization, or urban Indian organization; and
- A local, State, or Federal government program, including a grantee directed by a government program to make payments on its behalf.

Section 13. Cost-sharing Reduction Plan Variations

QHP issuers are required under 45 CFR 156.420 to submit three plan variations with reduced cost sharing for each silver level QHP an issuer offers through SSHIX, as well as zero and limited cost-sharing plan variations for all metal-level QHPs an issuer offers through SSHIX, for individuals who are eligible for cost-sharing reductions, as outlined in 45 CFR 155.305. This section does not apply to QDPs, as cost-sharing reductions (CSRs) do not apply to QDPs. Eligible consumers can enroll in these plan variations for the 2021 plan year and will continue to receive cost-sharing reductions provided by the issuers. However, cost-sharing reduction

payments to issuers are subject to appropriation.

45 CFR 156.420(a) specifies for individuals eligible for cost-sharing reductions, the variations of the standard silver plan with an annual limitation on cost sharing specified in the annual HHS notice of benefit and payment parameters for such individuals, and other cost-sharing reductions such that the AV of the silver plan variations are at 94 percent, 87 percent and 73 percent, plus or minus the de minimis variation for each silver plan variation.

45 CFR 156.420(b) specifies for the submission of zero and limited cost sharing plan variations for individuals who are eligible as outlined in 45 CFR 155.350, the variation of the health plan with all cost sharing eliminated, or a variation of the health plan with no cost sharing on any item or service that is an EHB furnished by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (each as defined in 25 U.S.C. 1603) or through referral under contract health services. Please refer to Chapter 5: Tribal Relations and Support for more information in that regard.

Additionally, the benefit and network equivalence in the standard silver plan and each silver plan variation thereof must cover the same benefits and providers. The benefit and network equivalence in the zero and limited cost sharing plans thereof must cover the same benefits and providers. The out-of-pocket spending required of enrollees in the zero cost sharing plan variation of a QHP for a benefit that is not an essential health benefit from a provider (including a provider outside the plan's network) may not exceed the corresponding out-of-pocket spending required in the limited cost sharing plan variation of the QHP and the corresponding out-of-pocket spending required in the silver plan variation of the QHP for individuals eligible for cost sharing reductions under 45 CFR 155.305(g)(2)(i), in the case of a silver QHP. The out-of-pocket spending required of enrollees in the limited cost sharing plan variation of the QHP for a benefit that is not an essential health benefit from a provider (including a provider outside the plan's network) may not exceed the corresponding out-of-pocket spending required in the QHP with no cost-sharing reductions. A limited cost sharing plan variation must have the same cost sharing for essential health benefits as the QHP with no-cost sharing reductions. Each zero cost sharing plan variation or limited cost sharing plan variation is subject to all requirements applicable to the QHP.

Note that in reviewing for compliance with 45 CFR 156.420, SSHIX will ensure that silver plan variations have an annual limitation on cost sharing that does not exceed the permissible threshold for the specified plan variation as finalized in the 2019 Payment Notice final rule.[3]

Section 14. Data Integrity Review

The Exchange and DOI will conduct data integrity reviews as needed and will supply issuers with any discrepancies found. Issuers should submit binders in accordance with ensuring data integrity tools have been ran.

[3] https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-07355.pdf

CHAPTER 3: QUALIFIED DENTAL PLANS: 2021 APPROACH

The approach for submitting applications for certification of QDPs remains unchanged from that used in 2020

Table 3.1 Draft Plan Year 2021 QDP Certification Timeline**

Activity	Deadline
Issuers submit Intent to EDI test with SSHIX - **Required**	1/31/2020
EDI discussions and precreation	3/1-5/31/2020
Issuers submit Intent to Sell Form with SSHIX - **Required**	4/15/2020
Binder submission due in SERFF	6/3/2020
SSHIX initial review of binder data submitted in SERFF	6/3-7/13/2020
EDI must be successfully completed	6/1-7/31/2020
First data transfer from SERFF to Nevada Health Link SBE Platform	7/13/2020
Issuer plan preview on Nevada Health Link SBE Platform	7/13-8/19/2020
Letters of Good Standing and Network Adequacy submitted to Exchange from DOI	8/20/2020
Final Deadline for Issuers to change QDP application without State Authorization (not applicable to rates)*	8/22/2020
Final data transfer from SERFF to Nevada Health Link SBE Platform	8/24/2020
Plan Year 2021 Issuer Agreements sent to issuers with final plan confirmation list	9/2/2020
Final deadline for Issuers to have all plans to be approved by DOI and the Exchange (including Rate and Network approval)	9/7/2020
Issuers send signed agreements, and confirm final plan listings	9/2-9/16/2020
SSHIX to send final plan confirmation list and countersigned attestations and billing agreements to issuers	9/25/2020
Plans Certified in SERFF	9/25/2020
Consumer window shopping begins	10/1/2020
Limited data correction window (not applicable to utilize for service area changes or rate data). Must obtain State Authorization prior to use of window.	10/5-10/8/2020
Open enrollment begins	11/1/2020

* Does not apply to Rate changes

**All dates are subject to change with notice to carriers

Section 1. Electronic Data Interchange (EDI) Requirements

Any issuer intending to sell plans in Nevada for PY2021 must complete requirements with EDI testing prior to certification. Issuers will be required to notify SSHIX no later than January 31, 2020 if they intend to offer plans in Nevada for PY2021. Issuers will then be required to work collaboratively with SSHIX's vendor GetInsured (GI) for EDI related matters. Please see the provided link for Intent to EDI Test form: Intent to EDI Test form

Fees may apply for EDI testing and issuer onboarding. Please contact the Exchange at: pmanagement@exchange.nv.gov for a fee schedule.

Failure to successfully test by the required timeframes indicated in Table 1.1 Draft Plan Year 2021 QHP Certification Timeline and Table 1.2 below may result in additional fees and/or not being certified to offer plans on the Exchange for PY2021.

Table 3.2 Key Dates for Electronic Data Interchange (EDI) Requirements

Activity	Deadline
Issuers submit Intent to EDI test with SSHIX - **Required**	1/31/2020
EDI discussions and precreation	3/1-5/31/2020
EDI testing must be successfully completed	6/1/-7/31/2020

Section 2. QDP Annual Limitation on Cost Sharing

The applicable percentage increase (2.1 percent from 2017 to 2018) in the Consumer Price Index (CPI) for dental services would increase the annual limitation on cost-sharing for QDPs by $7.48. Because this amount is less than $25, and the regulation at 45 CFR 156.150(d) requires incremental increases to be rounded down to the next lowest multiple of $25, the annual limitation on cost sharing for QDPs for plan year 2020 will remain $350 for one child and $700 for two or more children. For more information on how this limitation is determined, please refer to the regulation.

Section 3. Network Adequacy Standards

For the Network Adequacy Standards of QDP's, as well as Essential Community Providers on Exchange, please refer to the link provided below, located on the Carrier Resource page of Nevada Health Link:

https://d1q4hslcl8rmbx.cloudfront.net/assets/uploads/2018/12/Network-Adequacy-for-Stand-Alone-Dental-Plans-on-Exchange.pdf

Section 4. QDP Actuarial Value Requirements

QDP issuers can offer pediatric dental essential health benefit (EHB) without selecting or calculating an AV level of that coverage.

CHAPTER 4: CONSUMER SUPPORT AND RELATED ISSUES

Section 1. Consumer Case Tracking and Coverage Appeals

SSHIX requires QHP and QDP issuers to thoroughly investigate and resolve consumer complaints received directly from the members, or forwarded to the QHP or QDP issuer by the Exchange or the DOI.

For complaints that are sent to the issuer from SSHIX, the issuer will be required to monitor the complaint via case management through the Carrier Connector. Cases received in any form will be input into the GI issuer portal for issuers to meet a resolution.

Section 2. Meaningful Access

45 CFR 155.205(c) specifies access standards for certain entities, including QHP issuers and web-brokers, and includes language access standards with respect to oral interpretation, written translation, the use of taglines indicating the availability of language services, and website translation.

As a reminder, QHP issuers that are also subject to the notice and tagline requirements in the regulations implementing section 1557 of the PPACA (45 CFR 92.8), will be deemed to be in compliance with §155.205(c)(2)(iii)(A) if they are in compliance with §92.8.

Additionally, we note that QHP issuers are not required to make available a printed copy of written translations of a formulary drug list pursuant to §155.205(c), unless doing so is necessary for providing meaningful access to an individual with a disability or an individual with limited English proficiency. Under §155.205(c) (cross-referenced at §156.250), QHP issuers must make information that is critical for obtaining health insurance coverage or access to health care services through the QHP, including the formulary drug list, accessible to individuals with disabilities and individuals with limited English proficiency. We consider a QHP issuer to be in compliance with the written translation requirements under §155.205(c) if the issuer's general practice is to make required written translations of the formulary drug list available on its website, as long as the issuer provides printed copies of the document to consumers who need a printed copy in order to access it.

Section 3. Summary of Benefits and Coverage

The content of this section applies to all QHP issuers and summarizes the completion of the Summary of Benefits of Coverage.

SSHIX utilizes the requirements defined in 45 CFR 147.200

QHP issuers are required to provide the SBC in a manner compliant with the standards set forth in 45 CFR 147.200, which implements section 2715 of the PHS Act, as added by the ACA. Specifically, issuers must fully comply with the requirements of 45 CFR 147.200(a)(3), which requires issuers to "provide an SBC in the form, and in accordance with the instructions for completing the SBC, that are specified by the Secretary in guidance. The SBC must be presented in a uniform format, use terminology understandable by the average plan enrollee (or, in the case of individual market coverage, the average individual covered under a health insurance policy), not exceed four double-sided pages in length, and not include print smaller than 12-point font. A health insurance issuer offering individual health insurance coverage must provide the SBC as a stand-alone document."

The 2017 SBC instructions for both individual and group market health plans require plans and issuers to disclose whether the plan for which they are preparing an SBC provides minimum value by indicating "Yes" or "No" in the minimum value disclosure line. HHS noted in the preamble to the 2015 Summary of Benefits and Coverage and Uniform Glossary Final Rule that the concept of minimum value is not relevant with respect to individual market coverage and we would therefore not take enforcement action against an individual market issuer for omitting such a statement until the new template and associated documents were finalized and applicable. While materials for the 2017 SBC were finalized in 2016, and are applicable for open enrollment periods or plan or policy years beginning on or after April 1, 2017, HHS will maintain this position of not enforcing against an individual market issuer for omitting the minimum value disclosure. Options for these plans include using "Not Applicable" or "N/A" for this section.

Finally, as a reminder, guidance on the SBC applies to all QHP issuers and not to QDPs. Additionally, QHP issuers were required to begin using the 2017 SBC on or before the 2017 open enrollment period for the 2018 plan year, and should continue using the 2017 SBC template and associated documents for future open enrollment periods.

CHAPTER 5: DECERTIFICATION

Pursuant to 45 CFR 155.1080, SSHIX can terminate the certification status and offering of a QHP if at any time the QHP issuer is no longer in compliance with the general certification criteria as outlined in 45 CFR 155.1000(c). More information on the process of decertification can be found in the SSHIX Plan Certification Guide.

CHAPTER 6: TRIBAL RELATIONS AND SUPPORT

The Federal Government, and therefore CMS, has a historic and unique relationship with Federally-recognized tribes, and the health programs operated by the IHS, Tribes and Tribal organizations and Urban Indian organizations. These are collectively known as Indian health care providers. Adhering to QHP certification standards, CMS reminds QHP issuers to contract with Indian health care providers, through which a significant number of American Indians and Alaska Natives (AI/AN) access health care. To promote contracting between issuers and Indian health care providers, CMS is continuing to require QHPs to offer contracts in good faith to all available Indian health care providers in the QHP's service area, applying the special terms and conditions necessitated by Federal law and regulations as referenced in the Model QHP Addendum (Addendum).

CMS developed the Addendum to facilitate the inclusion of Indian health care providers in QHP provider networks. The Addendum is a model standardized document for QHP issuers to use in contracting with Indian health care providers. To make it easier for QHPs to find Indian health care providers, a list of eligible providers and their address and contact information may be found on the HHS ECP list available on the CCIIO website. We strongly encourage issuers to ensure each offer is sent to the correct address and contacts. Similarly, we encourage all Indian health care providers to ensure their contact information correctly appears on the HHS ECP list and review all offers and respond timely to issuers. For further details, please refer to Chapter 2, Section 4, Essential Community Providers" in this document.

Section 206 of the Indian Health Care Improvement Act (IHCIA) (25 USC 1621e) provides for a right of recovery from an insurance company and other third party entities, including QHP issuers, for reasonable charges billed by an Indian health care provider when providing services, or, if higher, the highest amount the third party would pay for services furnished by other providers. This right of recovery applies whether the Indian health care provider is in a plan network or not. Further details can be found at https://www.ihs.gov/ihcia/.

Even though Indian health care providers have a right of recovery under section 206 of the IHCIA, CMS encourages issuers and Indian health care providers to develop mutually beneficial business relationships that promote effective care for medically underserved and vulnerable populations.

For more information on Indian Health Care Providers and the Model QHP Addendum, please see the Carrier Resources page of our website linked below:
https://d1q4hslcl8rmbx.cloudfront.net/assets/uploads/2015/07/ITU_Model_QHP_Addendum_04_04_13.pdf