Brian Sandoval
Governor

Barbara Smith Campbell
Chairwoman

Jon M. Hager
Executive Director

Silver State Health Insurance Exchange
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Silver State Health Insurance Exchange (SSHIX)
Board Meeting
Minutes
Thursday, May 9, 2013

Meeting Location:
Silver State Health Insurance Exchange
2310 South Carson Street, Suite 3A
Carson City, NV 89701

Videoconference Location:
College of Southern Nevada
3200 East Cheyenne Ave.
Cheyenne Campus Bldg. B, Room 2647
North Las Vegas, NV 89030

Members Present
CC: Barbara Smith Campbell
Marie Martin Kerr, Esq.
Scott Kipper (Non-voting Ex-Officio)

LV: Lynn Etkins, Esq.
Leslie Johnstone
E. Lavonne Lewis
Ronald M. Kline, MD

Members Absent
Judith P. Ford, MD
Mike Willden (Non-voting Ex-Officio)
Jeff Mohlenkamp (Non-voting Ex-Officio)

Staff Members Assisting
Jon M. Hager, SSHIX
Shawna DeRousse, SSHIX
C.J. Bawden, SSHIX
Damon Haycock, SSHIX
Athena Cox, SSHIX
Keith Marcher, Chief DAG

I. Call to Order, Welcome, Roll Call, Announcements

Chair Barbara Smith Campbell called the meeting to order at approximately 1:35 p.m., welcoming all. Roll call was taken by Executive Director Hager, who stated that a quorum was present. Instructions were given to public phone participants to mute their phones so that we don't get any background feed. Mr. Hager announced that agenda item VII has been postponed until Thursday, the 16th, at 4:00 p.m., and that due to the Exchange Summit on June 13th and 14th, the next Board meeting will be on Wednesday,

June 12th. He gave some information regarding the length of the paper single streamlined application.

II. Public Comment

There was no public comment at this time.

III. Approval of the minutes of the April 11, 2013 and April 24, 2013 Board meetings

MOTION **To approve the minutes of the April 11, 2013 and April 24, 2013 Board meetings.**
BY: **Ms. Kerr**
SECOND: **Ms. Etkins**
PASS: **Unanimously**

IV. Executive Director's Report regarding the following matters of the Exchange:

A. 2013 Legislative Session
B. Status of Exchange implementation
C. Advisory committees
D. Board calendar

Mr. Hager presented the report on each of the listed items, There was a question by a Board member and input by Commissioner Kipper.

V. Discussion and possible action regarding Legislative Bills that may impact the Silver State Health Insurance Exchange, including the following:

A. Assembly Bills - 65, 251, 425, 489
B. Senate Bills - 266, 318, 352, 359, 454

Mr. Hager stated that there are really no changes since the last Board meeting, that some of the bills have moved past the first house and are into the second house, and some have had a hearing at the finance committees. There were no Board questions or comments. No action was taken.

VI. Discussion and possible action regarding the adoption of network adequacy standards for standalone dental plans

Mr. Haycock presented the Standalone Dental Plan Network Adequacy report, noting that on page 3 "Aopt" should be "Adopt." He then went through the 11 sections in the attached Network Adequacy Standards for Standalone Dental Plans in the Silver State Health Insurance Exchange, noting that there are two changes to this document from this morning's Plan Certification and Management Advisory Committee meeting, as follows:

In Section X, the last two bullets on this document have been combined into one bullet, to ensure we have parity across both types of networks, HMO and PPO, to read as follows: "Compliance with the distance standards will be achieved if 80 percent of the population

of the geographic service area or existing membership is within the distance standards of the providers with whom the carrier contracts."

In Section XI, the final bullet will read as follows: "A provider directory must be available for publication online and to potential enrollees in hard copy upon request. A provider directory must identify general dentists that are not accepting new patients."

There were Board questions and comments. At the suggestion of Ms. Campbell and the request of Mr. Hager, Dennis Spain of Nevada Dental Benefits provided input and answered questions. The following action was taken:

MOTION	**To adopt the network adequacy standards for standalone plans attached to the report, with the amendment of replacing the words in Section IX of the document "one (1) general dentist and one (1) dental specialist/facility" with the words "one (1) pediatric dentist, one (1) oral surgeon, and one (1) orthodontist."**
BY:	**Dr. Kline**
SECOND:	**Ms. Lewis**
PASS:	**Unanimously**

VII. Discussion and possible action regarding amending Plan Certification and Management Advisory Committee Recommendation 11(3), approved by the Board on March 14, 2013, in which the Exchange required all Qualified Health Plans (QHPs) that provide the pediatric dental essential health benefit separate the pricing out from the remainder of the health plan by submitting the dental benefit as a rider for that product. Due to guaranteed issue rules, any dental product certified as a standalone dental product must be available to all individuals. Therefore, dental riders cannot be certified as standalone dental plans. This agenda item allows the Exchange to:

- **a. Decide whether it should allow dental benefits to be embedded in QHPs or if it should prohibit dental benefits from being embedded in QHPs.**
- **b. Decide whether the purchase of standalone dental should be required on the Exchange when an individual purchases a QHP that does not include dental benefits.**

Mr. Hager announced at the beginning of the meeting that this item will not be heard today and is being postponed to Thursday, the 16th, at 4:00 p.m.

VIII. Discussion and possible action regarding amending Plan Certification and Management Advisory Committee Recommendation 10, approved by the Board on February 14, 2013, in which the Exchange:

- **A. Aligned the service areas for Qualified Health Plans with the rating areas developed by the Division of Insurance and approved by the Center for Consumer Information and Insurance Oversight (CCIIO).**
- **B. Indicated it will review the services areas once they are approved by CCIIO.**

The service areas approved by CCIIO changed the Clark County rating area to include Nye County.

Mr. Hager presented the report, with input by Commissioner Kipper, indicating that because the recommendation was to align the service areas, and they are still aligned, that no action is necessary. No action was taken.

IX. Discussion and possible action regarding the process to submit comments to the Federal Government regarding preliminary regulations

Ms. Campbell recapped this item and the underlying issue of the timing back to the federal government for comments on regulations, that Mr. Hager doesn't have the opportunity of putting those comments out to the full Board at a Board meeting; and she provided recommendations and thoughts. Mr. Marcher provided input regarding the open meeting law. There were Board questions, comments and discussion. The following action was taken:

MOTION	**That they're all sent out to the Board; the Board's given two days, three days, five days to send comments back to Mr. Hager; if there are no comments, then the comments get sent to the federal government; if there are any comments, then the Chair, the Vice-Chair and Executive Director can get together and discuss and try and come up with a solution that the three of them are happy with; and if not, then the result is that on that particular issue that there is a conflict on, we just don't comment. There will be a deadline of two days to a week for us to get comments back.**
BY:	**Ms. Etkins**
SECOND:	**Dr. Kline**
PASS:	**Unanimously**

X. Discussion and possible action regarding the Silver State Health Insurance Exchange Bylaws and an agreement between the Board and the Executive Director

FIRST MOTION	**To approve the recommended changes to the bylaws.**
BY:	**Ms. Johnstone**
SECOND:	**Ms. Lewis**
PASS:	**Unanimously**

SECOND MOTION	**To accept, with the deletion of 6.d. and replacing item number 9 with the language that we just approved in agenda item number IX.**
BY:	**Ms. Etkins**
SECOND:	**Ms. Johnstone**
PASS:	**Unanimous**

XI. Discussion and possible action regarding dates, times, and agenda items for future meetings

Mr. Hager mentioned that the next meeting will be a week from today, May 16th, at 4:00 p.m. over the phone, to discuss the embedded versus nonembedded dental and whether it should be mandatory or not, that we need to make sure that the carriers get that decision as soon as possible. He mentioned the May 29th legislative update meeting. And he mentioned the June 12th meeting also will have a legislative update, along with that we will provide the winning navigators enrollment assister grantees to the Board, will have the fiscal and operational report, a review of the market segment taking survey and the Nevada Health Link web portal demo

XII. Public Comment

Barry Gold, AARP Nevada

XIII. Adjournment

Ms. Campbell thanked everyone for their time and preparation. The meeting adjourned. No action was taken.

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DRAFT **NETWORK ADEQUACY STANDARDS** **DRAFT**

FOR

STANDALONE DENTAL PLANS

IN THE

SILVER STATE HEALTH INSURANCE EXCHANGE

TO BE REVIEWED MAY 9, 2013

PURPOSE

This document is intended to provide network adequacy standards for standalone dental plans offered through the Silver State Health Insurance Exchange.

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SECTION I – GENERAL REQUIREMENTS

A dental carrier that is participating in the Silver State Health Insurance Exchange (Exchange) by offering a network plan shall use best efforts to maintain each product provider network in a manner that is sufficient in numbers and types of oral health care providers to assure that all oral health care services to covered persons will be accessible without unreasonable delay. Each

covered person shall have adequate choice of oral health care providers. Provider directories shall be updated on-line no less than every 90 days and filed with the Division of Insurance in SERFF.

SECTION II – SUBMISSION AND UPDATED PROCESSES

Each carrier shall complete the "Network Access Plan Cover Sheet Template" in SERFF and include it in the Binder submission. Additionally, each carrier shall attest that its network(s) will meet these requirements by January 1, 2014, and at all times thereafter. An attestation form of compliance with network adequacy standards will be required to be signed by an officer of the company and submitted to the Exchange via SERFF on or before January 1st of each subsequent year. *An attestation form can be obtained on the Division of Insurance website.* A carrier shall use best efforts to provide notice of any significant change in the network to the Exchange within 60 days of the change taking affect. If the significant change results in a deficiency in the network, the notification must include a corrective action plan by the carrier to resolve the deficiency. Failure to provide such notification may lead to the suspension or termination of participation in the Exchange. The carrier shall have the right to appeal the decision and submit a corrective action plan to the Exchange for consideration.

SECTION III – REFERRALS AND REIMBURSEMENT

In any case where the carrier has an absence of or an insufficient number or type of participating providers or facilities to provide a covered oral health care service, the carrier shall use best efforts to ensure through referral by the primary care provider or otherwise that the covered person obtains the covered service from a provider or facility within reasonable proximity of the covered person at no greater cost to the covered person than if the service were obtained from network providers and facilities, or shall make other arrangements acceptable to the Exchange.

SECTION IV – REASONABLE EFFORT AND RELATIVE AVAILABILITY

Each carrier shall use best efforts to establish and maintain adequate arrangements to ensure reasonable proximity of network providers and facilities to the business or personal residence of covered persons. Carriers shall make reasonable efforts to include providers and facilities in networks in a manner that limits the amount of travel required to obtain covered benefits. In determining whether a carrier has complied with this provision, the Exchange will give due consideration to the relative availability of health care providers or facilities in each geographic area using standards that are realistic for the community, the delivery system and clinical safety. Relative availability includes the willingness of providers or facilities in the geographic area to contract with the carrier under reasonable terms and conditions.

SECTION V – DISCLOSURE OF NETWORK LIMITATIONS

The carrier shall disclose to all covered persons that limitations or restrictions to access of participating providers and facilities may arise from the oral health care service referral and authorization practices of participating providers and facilities. The carrier shall provide

instructions to covered persons as to how they can receive details about such practices from their primary care provider or through other formally established processes.

SECTION VI – COVERAGE OF FACILITIES WITHIN THE INDIAN HEALTH CARE SYSTEM

A carrier that is participating in the Exchange shall use best efforts to maintain arrangements that ensure that American Indians and Native Alaskans who are covered persons have access to Indian health care services and facilities that are part of the Indian Health Care System (IHS). Carriers shall ensure that such covered persons may obtain covered services from the Indian health care system at no greater cost to the covered person than if the service were obtained from network providers and facilities. Carriers are not responsible for credentialing providers and facilities that are part of the Indian health care system. Nothing in this subsection prohibits a carrier from limiting coverage to those health care services that meet the standards for medical necessity, care management, and claims administration, or from limiting payment to that amount payable if the oral health care service were obtained from a network provider or facility.

SECTION VII – ESSENTIAL COMMUNITY PROVIDERS

A carrier that is participating in the Exchange shall use best efforts to have a sufficient number and geographic distribution of Essential Community Providers (ECPs), where available, to ensure reasonable and timely access to such providers for low-income, medically underserved individuals in the geographic area. Sufficient number and geographic distribution is defined as "at least 20 percent of available ECPs in the plan's geographic area participating in the applicant's provider network; or at least 10 percent of available ECPs in the plan's geographic area participating in the applicant's provider network(s)". A narrative justification must be included as part of the Qualified Health Plan application. You can find a list of ECPs for Nevada at: https://data.cms.gov/dataset/Non-Exhaustive-List-of-Essential-Community-Provide/ibqy-mswq

SECTION VIII – ESTABLISHMENT OF REASONABLE CRITERIA

Adequacy of choice may be established by the carrier with reference to any reasonable criteria used by the carrier, including but not limited to: provider-to-covered-person ratios by specialty, primary-care-provider-to-covered-person ratios, geographic accessibility, waiting times for appointments with participating providers, hours of operation, and the volume of specialty services available to serve the needs of covered persons requiring specialty care. Any exceptions or deviations from the standards identified below (ratios and geographic accessibility) must be approved by Exchange.

SECTION IX – PARTICIPATING PROVIDER AVAILABILITY AND ACCESSIBILITY STANDARDS

Accessibility standards have been developed to address the fact that population density in the carrier's geographic area varies from one defined market region to another. One set of standards for each type of geographic area (urban, rural, or frontier) will be addressed separately for general dentist and dental specialty. Each carrier must demonstrate that its network meets the

established time and distance requirements. Carriers will be held accountable for meeting the standards described below.

The standalone dental network must have one (1) **general dentist** and one (1) **dental specialist/facility** within the travel standards established below[1].

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

SECTION X – PROVIDER NETWORK ADEQUACY GOALS

- To offer an adequate number and type of contracted or participating providers to meet the oral health care needs of the covered persons.
- To offer a network of participating providers that is geographically accessible to covered persons.
- The number of network providers of different specialties will vary from one geographic area/county to another. The Carrier will contract with sufficient providers of all types necessary to provide a full range of covered services using standards that are realistic for the community, the delivery system and clinical safety.

[1] Availability of certain provider types may be limited within each county. Additionally, the availability of certain provider types may also be limited within certain cities/communities within a specific county. Every consideration, including established community patterns of care, will be given by the Exchange to the relative availability of oral health care providers or facilities in the geographic area when determining if a carrier meets the above established network adequacy travel standards as measured in distance or time as outlined above.

- Compliance with the distance standards will be achieved if 95 percent of the population of the geographic service area or existing HMO membership is within the distance standards of the providers with whom the Carrier contracts.
- The minimum distance standards for PPO insureds will be achieved if 50 percent of the population of the geographic service area or the Carrier's enrolled membership is within the distance standards of the providers with whom the Carrier contracts.

SECTION XI – PROVIDER NETWORK REQUIREMENTS

- Be adequate in numbers and types of providers to meet the full range of health care service needs of the enrolled population.
- Comply with the Essential Community Provider requirement.
- A provider directory must be available for publication online and to potential enrollees in hard copy upon request. An HMO/POS provider directory must identify primary care providers that are not accepting new patients.