State of Nevada

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Nevada Health Link State Based Exchange Platform

Plan Year 2024 DRAFT Plan Certification Letter to Issuers

February 22, 2023

Date: February 22, 2023

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

Title: Plan Year 2024 DRAFT Plan Certification Letter to Issuers

The Silver State Health Insurance Exchange (SSHIX or Exchange), also known as Nevada Health Link, in collaboration with the Division of Insurance (DOI), is releasing this 2024 draft Letter to Issuers participating in Nevada's State-Based Exchange (SBE) for Plan Year (PY) 2024. This letter is issued alongside and incorporates guidance from the Centers for Medicare & Medicaid Services (CMS) 2024 Letter to Issuers in the Federally-Facilitated Exchanges. See *CMS PY24 Draft Letter to Issuers* for more information.

This letter provides updates on operational and technical guidance for PY 2024 for issuers seeking to offer qualified health plans (QHPs), including qualified dental plans (QDPs), on the Exchange ("Nevada Health Link platform"). It contains guidance provided by CMS and DOI to ensure compliance with CMS, the Nevada Administrative Code (NAC), the Code of Federal Regulations (CFRs), the Nevada Revised Statutes (NRS), and the Office of the Law Revision Counsel, United States Code (OLRC, U.S.C.).

This guidance summarizes policies proposed through other rulemaking processes that may not have yet been finalized, such as proposals included in the Notice of Benefit and Payment Parameters for 2024 not included in the final rule. Stakeholders should refer to further rulemaking for finalized policies.

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 on the Carrier Resources webpage on NevadaHealthLink.com or CMS QHP Certification.

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 a QHP application for all PY 2024 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.

The Exchange will send Draft Plan Year 2024 Issuer Agreements for issuers to review prior to finalizing the agreements. Once finalized, SSHIX will send the Final Plan Year 2024 Issuer Agreements to QHP and QDP issuers to sign and submit to SSHIX outlined in Table 1.1. Proposed QHP Data Submission and Certification Timeline for Plan Year 2024.

The Exchange 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 QHP under certification consideration to an off-Exchange QHP for certification consideration.

Please note: All QHP binders must be certified through the Nevada Health Link SBE Platform as well as the System for Electronic Rates and Form Filings (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 QDP or QHP binder after 8/24/2023 would need a State Authorization form to be submitted through SSHIX.

New for Plan Year 2024, the QHP Data Submission and Certification Timeline includes additional dates associated with the CMS QHP Quality Rating and QHP Enrollee Survey activities. These activities already take place, and no new requirements are reflected here, but certain deadlines related to those activities are also included in this timeline. The timeline has also been updated with additional dates for plan verification and URL requirements as related to plan preview and window shopping.

Issuers may have their QHP application denied if they fail to meet the deadlines in the plan year 2024 QHP Data Submission Timeline, or if their applications are not accurate or complete after the deadline for issuer submission of changes to the QHP application.

Table 1.1 Final QHP Data Submission and Certification Timeline for Plan Year 2024**

Activity	Deadline
Issuers submit Intent to EDI Test Form with SSHIX – Required (Only new carriers)	4/3/2023
Issuers submit Intent to Sell Form with SSHIX – Required	4/3/2023
All form filings subject to ACA and CAA Compliance due in SERFF	5/15/2023
CMS QHP Enrollee Survey data submission deadline[1]	5/19/2023
HHS-approved QHP Enrollee Survey vendor securely submits the QHP Enrollee Survey response data to CMS on behalf of the QHP issuer[2]	5/24/2023
Binder submission due in SERFF	5/31/2023
SSHIX initial review of binder data submitted in SERFF	6/1-7/13/2023
QHP issuer submits the validated QRS clinical measure data, with attestation, to CMS via NCQA's Interactive Data Submission System (IDSS)[3]	6/15/2023
Initial objection letter sent	6/16/2023
First data transfer from SERFF to Nevada Health Link SBE Platform	7/13/2023
Issuer plan preview on Nevada Health Link SBE Platform	7/13-8/19/2023
QHP issuers, Exchange administrators, and CMS preview the 2022 QHP quality rating information	8/1-9/30/2023
Proposed rate change posted on the DOI website	7/31/2023
Supplemental URL Templates due in SERFF	8/3/2023
Draft Plan Year 2024 Issuer Agreements sent to issuers for review (Including attachments and Policy Memo)	8/16/2023
Plan Preview ends, deadline for all plans to be	8/18/2023

[1] Regulations at 45 CFR 155.1000 provide Exchanges with broad discretion to certify QHPs that otherwise meet the QHP certification standards specified in Subpart C of Part 156, and afford Exchanges the discretion to deny certification of QHPs that meet minimum QHP certification standards, but are not ultimately in the "interest" of qualified individuals and qualified employers.

[2] QRS and QHP Enrollee Survey Technical Guidance for 2023, available at: https://www.cms.gov/files/document/qhp-ess-tech-specs.pdf

[3] Each QHP issuer must submit and plan-lock its QRS clinical measure data by June 1 to allow the HEDIS® Compliance Auditor sufficient time to review, approve, and audit-lock all submissions by the June 15 deadline. There are no fees for QHP issuers associated with accessing and using the IDSS.

verified	
Letters of Good Standing and Network Adequacy submitted to the Exchange from DOI	8/18/2023
Final deadline for issuers to change QHP application without State Authorization (not applicable to rates)	8/24/2023
Rate filings approved by DOI	8/25/2023
Final data transfer from SERFF to Nevada Health Link SBE Platform if applicable	8/28/2023
Plans re verified for rates – rates must be approved by DOI	8/30/2023
Final Plan Year 2024 Issuer Agreements sent to issuers with final plan confirmation list	9/4/2023
Issuers send signed agreements and confirm final plan listings	9/4-9/13/2023
SSHIX to send final plan confirmation list and countersigned Issuer Agreements to issuers	9/13/2023
Plans Certified in SERFF	9/13/2023
Approved rate changes posted on the DOI website	10/1/2023
Consumer window shopping begins	10/1/2023
URL links need to be live for window shopping	10/1/2023
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.	10/5-10/9—/2023
Anticipated public display of QHP quality rating information[4]	11/1/2023
Open enrollment begins	11/1/2023

**All dates are subject to change with notice to carrier.

Section 2. Electronic Data Interchange (EDI) Requirements

Issuers will be required to notify SSHIX no later than April 3, 2023, if they intend to offer plans in Nevada for Plan Year 2024. New issuers are required to work collaboratively with SSHIX's technology vendor, GetInsured (GI), for EDI-related matters[5]. PLEASE NOTE: returning issuers offering plans through Nevada Health Link for Plan Year 2023 are not required to complete EDI testing for Plan Year 2024. Please see link provided for Intent to EDI test form: Intent to EDI Test PY 2024. In addition, please refer to the 834 companion guide for EDI requirements.

[4] QHP Quality Rating information will be available on the Nevada Health Link Website at: https://www.nevadahealthlink.com/transparency/

[5] For questions regarding EDI matters, please email the Recon Support team at: reconsupport@exchange.nv.gov.

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 5/31/2023 and to make necessary updates to the QHP application prior to the last deadline for issuer submission on 8/24/2023.

All issuers must obtain Health Insurance Oversight System (HIOS) product and plan IDs using HIOS. HIOS plan ID's cannot be recycled. Only new plan ID's can be used. When reusing a Plan ID from one benefit year to the next, the metal level, market, and plan type (e.g., HMO, PPO) must be the same to ensure the integrity of the Risk Adjustment program and adherence to uniform modification requirements established in 45 CFR Sections 144.103 (definition of "plan") and 147.106. If the plan's actuarial value changes, resulting in a metal level change, you must establish a new Plan ID for the following year. In past years, CMS has been able to accommodate some of these issues, but system changes implemented preclude CMS from changing the metal level for a Plan ID. These changes were made to ensure the integrity and accuracy of EDGE server data for all issuers.

Issuers applying for QHP/QDP certification will use the National Association of Insurance Commissioners' System for Electronic Rate and Form Filing (SERFF) to submit plan data, which may include copies of the QHP/QDP templates, and any data submitted by issuers applying for QHP certification. Plan data from SERFF will then be electronically transferred to the Nevada Health Link SBE Platform (enroll.nevadahealthlink.com), where it will be collaboratively reviewed to verify the accuracy and completeness of plan data. Issuer personnel wishing to gain access to the SBE Platform for plan certification functions must submit a System Access Request form requesting the "Plan Representative (SBE Platform)" role.

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. All plans must be verified in the Nevada Health Link SBE Platform by 8/30/2023, as reflected in Table 1.1, Proposed QHP Data Submission and Certification Timeline for Plan Year 2024.

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 2024, 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	6/4-8/24/2023
Limited data correction window. Data corrections must have State Authorization	10/5-10/9/2023

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 Proposed QHP Data Submission and Certification Timeline for Plan Year 2024. 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 a plan withdrawal form to the Exchange. 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 QHP under certification consideration to an off-Exchange QHP 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 8/24/2023, 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 require state authorization. If not approved by SSHIX and/or the DOI may result in compliance action by the Exchange and/or the DOI, which could include decertification and suppression of the issuer's plans on https://www.nevadahealthlink.com/[6].

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 8/24/2023, excluding administrative changes, may be made due to inaccuracies

[6] The SSHIX Plan Certification Guide provides a detailed overview of the annual Plan Certification process for the Nevada Health Link State Based Exchange (SBE) Platform, defining the coordinated roles and responsibilities of the Silver State Health Insurance Exchange (SSHIX), the Nevada Division of Insurance (DOI) and Nevada's On-Exchange Insurance Carriers (Issuers). SSHIC Plan Certification Guide can be found at https://www.nevadahealthlink.com/

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 Nevada Health Link SBE Platform 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

Pursuant to 45 CFR 155.335(j), the Division of Insurance is responsible to conduct Plan ID Crosswalk for plan year 2024. Issuers will need to submit their Plan ID Crosswalk template along with their binder submission in SERFF on May 31, 2023. Plan ID Crosswalk changes must be uploaded to SERFF. DOI will provide SSHIX with a letter of approval for all Plan ID Crosswalk Templates.

In the proposed 2024 Payment Notice, CMS proposes to allow Exchanges, beginning in plan year 2024, to modify the automatic re-enrollment hierarchy such that enrollees who are eligible for CSR in accordance with 45 CFR 155.305(g) and who would otherwise be automatically reenrolled in a bronze-level QHP would instead be automatically re-enrolled in a silver-level QHP in the same product with a lower or equivalent net premium, provided that certain conditions are met. Furthermore, we propose to amend the Exchange re-enrollment hierarchy to allow Exchanges to ensure enrollees are re-enrolled into plans with the most similar network to the plan they had in the previous year, provided that certain conditions are met. If this proposal were finalized, the Exchange would adopt the newly permitted approach. Under this approach, issuers

would continue to identify the reenrollment plan in service areas where the issuer continues to offer plans, except that the Exchanges would identify the silver reenrollment plan for bronze enrollees if those enrollees were redetermined CSR eligible. If this proposal is finalized, the Exchange will describe this new process in further detail in updated QHP Certification guidance for plan year 2024.

If the proposed change to the re-enrollment hierarchy is finalized, CMS intends to modify the 2024 certification approach for alternate enrollments to align with the proposed changes to 45 CFR 155.335(j) outlined in the proposed 2024 Payment Notice for QHPs that are not SADPs.

QDPs, as plans that offer excepted benefits, are not subject to the guaranteed renewability standards specified at 45 CFR 147.106. However, CMS aims to apply the processes established for the 2023 Plan ID Crosswalk Template to QDPs in order to support automatic re-enrollment for QDPs offered during the 2024 plan year.

Section 7. Template Changes for Plan Year 2024

The Exchange will continue to use the CMS templates for Plan Year 2024. CMS has introduced various changes in templates. The changes to these templates has required SSHIX to utilize supplement changes to collect the data being removed from the CMS templates.

Supplemental templates can be found on the Carrier Resources webpage.

Issuers will need to submit their supplemental URL templates in SERFF by 5/31/2023, as reflected in Tables 1.1 and 3.1. The Enrollment Payment URL is manually updated. If any issuers have changes to their Enrollment Payment URL, please email Plan Management at pmanagment@exchange.nv.gov.

Section 8. 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 2024 is defined as 1/1/2024-12/31/2024.

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 and how SSHIX will evaluate and conduct reviews of 2024 QHPs and QDPs for compliance.

Section 1. Licensure and Good Standing

The Division of Insurance (DOI) 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: SSHIX Service Areas

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 2024 QHP certification of all plans. 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 2023 certification processes, for 2024 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 DOI has previously used and will use as part of the certification process to review network provider data to determine network adequacy. NAC 687B.768 currently has time and distance standards for the following specialties: Hospitals, Endocrinology, Infectious Disease, Psychiatrist, Psychologist, Licensed Clinical Social Works, Pediatrics, Oncology, Outpatient Dialysis, Primary Care, and Rheumatology.

Based on the current state standards which were in effect for plan year 2023, 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 2024 Network Adequacy Certification[7]

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, the Exchange 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

[7] Full definitions for each of the county designations listed can be found are available at https://www.cms.gov/Medicare/MedicareAdvantage/MedicareAdvantageApps/Downloads/MA_Network_Adequacy_Criteria_Guidance_Document_1-10-17.pdf.

30 minutes.

As in past years, in addition to permitting issuers to add additional providers, the Exchange will use a justification process when the DOI 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 (ECP)

The Exchange will rely on the DOI as the State regulatory agency to conduct reviews of the ECP standard for QHP and QDP certification for Plan Year 2024. The approach for reviews of the ECP standard remains unchanged from that used in 2023, with the exceptions noted below. Please refer to NAC 687B.768[8] for more information.

To comply with the Essential Community Provider requirements a network plan must provide evidence that the network plan:

Contract with at least 35 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.
Offer contracts 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.*

Offer contracts in good faith to all available ECPs in all Counties designated as Counties with Extreme Access Considerations (CEAC) included in the plan's service area.

Section 5. Accreditation

The approach for reviews of the accreditation standard remains largely unchanged from 2023. However, in consideration of the announcements by HHS-recognized accrediting entities making modifications to accreditation standards due to the COVID-19 public health emergency, CMS may provide flexibilities with regard to health plan accreditation reviews, as appropriate. HHS encourages issuers to provide their accrediting entity (AE) their Health Insurance Oversight System (HIOS) ID number associated with their organization as they begin to work with the AE(s) on 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

[8] NAC: CHAPTER 687B-Contracts of Insurance (state.nv.us)

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.

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: Certificate of Accreditation (The overall rating is the weighted average of a plan's HEDIS and CAHPS measure ratings, plus accreditation bonus points, rounded to the nearest half point displayed as stars)
    - 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 remains unchanged from 2023 and prior years, and 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

The approach for review of QHP issuer compliance with quality reporting standards related to the QRS and QHP Enrollee Survey remains unchanged from 2023. Please refer to the Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2023 for more detailed information on issuer data collection and reporting requirements for the 2023 calendar year.

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 2023 and the 2023 Quality Rating System Measure Technical Specification, published by CMS, and any subsequent updates to that guidance.

While reporting units that meet all eligibility criteria per CMS[9] will be required to collect and submit 2023 QRS clinical measure data and QHP Enrollee Survey response data, not all reporting units will be eligible for QRS scoring. Eligible reporting units will not receive QRS scores and ratings until their third consecutive year of operation in the Exchange. Therefore, a reporting unit that is eligible to be scored must meet the criteria for data submission and have been in operation for at least three consecutive years. Therefore, a reporting unit must be operational on the Exchange in 2021, 2022, and 2023 to receive QRS scores and ratings. 2023 Quality Rating System and QHP Enrollee Experience Survey is subject to final rule per CMS. This information and corresponding QRS and QHP Enrollee Survey activity dates are also included in Table 1.1

QHP issuers are required to collect and submit validated 2023 QRS clinical measure data and QHP Enrollee Survey response data to CMS for each reporting unit that meets all the criteria listed below:

- Offered through an Exchange in the prior year (i.e., 2022 calendar year);
- Offered through an Exchange in the ratings year (i.e., 2023 calendar year) as the exact same product type; and
- Meets the QRS and QHP Enrollee Survey minimum enrollment requirements:

- Included more than 500 enrollees as of July 1 in the prior year (i.e., July 1, 2022); and - Included more than 500 enrollees as of January 1 of the ratings year (i.e., January 1, 2023).

In other words, QHP issuers are required to collect and submit validated clinical measure data and QHP Enrollee Survey response data for each product type offered through an Exchange for two consecutive years (i.e., 2022 and 2023) that had more than 500 enrollees as of July 1, 2022 and more than 500 enrollees as of January 1, 2023.

Reporting units discontinued before June 15 of the ratings year (i.e., June 15, 2023) are exempt

[9] 2023 QRS and QHP Enrollee Experience Survey: Operational Instructions (cms.gov)

from the QRS and QHP Enrollee Survey requirements. QHP issuers with reporting units with more than 500 enrollees as of July 1, 2022 that are uncertain whether they will have more than 500 enrollees as of January 1, 2023 should proceed as if they are required to field the 2022 QHP Enrollee Survey by contracting with an HHS approved QHP Enrollee Survey vendor and preparing to generate the sample frame on or after January 7, 2023. If the eligibility status of a reporting unit changes, QHP issuer must notify CMS within three business days of discovery, but no later than January 6, 2023.

QHP issuers should refer to the Marketplace Quality Initiatives website for more detailed information on issuer data collection and reporting requirements for the 2023 calendar year. CMS will issue technical guidance for the QRS and QHP Enrollee Experience Survey.

CMS will work with issuers to collect data and calculate the quality performance ratings for QHPs offered through SSHIX that will display during the open enrollment period for the 2024 plan year. During 2024, qualifying issuers will report data from the 2023 plan year to CMS, and that data will be analyzed by CMS and be the basis for the quality performance. All qualifying issuers must submit QRS Reporting via SERFF with annual binder submission.

For Plan Year 2024, the Nevada Health Link SBE Platform will display plan rating data on the NevadaHealthLink.com Transparency page, linked below. The QRS ratings will be published during consumer shopping in accordance with CMS regulations: Nevada Health Link/Transparency webpage

In addition to the requirements described above, a QHP issuer may also be required to participate in any other quality reporting requirements that may be authorized by federal regulation or specified by SSHIX. There are no requirements for issuers on Exchange at this time to submit Transparency in Coverage to CMS.

SSHIX will notify any issuer who is eligible for 2023 QRS based on the 2023 QRS participation requirements. Participation requirements can be found in the CMS Technical Guidance for 2023.

Section 8. Quality Improvement Strategy

The approach for QHP certification reviews for quality improvement strategy (QIS) reporting remains unchanged from 2023. CMS intends to provide information on the applicable QIS requirements in the forthcoming QIS Technical Guidance and User Guide for the 2023 Plan Year.

SSHIX follows CMS guidance for QIS reporting. Any eligible QHP issuer participating in SSHIX for two 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.

QHP issuers should refer to the Marketplace Quality Initiatives website for more detailed information on Quality Improvement Strategy Requirements for the 2023 calendar year, as well as the forthcoming Plan Year 2024 QIS Technical Guidance and User Guide.
An eligible issuer for the 2024 plan year is any QHP issuer that:

- Offered coverage through SSHIX in 2020 and 2021 and submitted a QIS Implementation Plan or Progress Report for the 2022 Plan Year,
- 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, of the prior year).

The QIS requirements apply to all issuers offering QHPs, including QHPs compatible with health savings accounts (HSAs). For plan year 2024, 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 2024 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 forthcoming IS Technical Guidance and User Guide for the 2024 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 2024 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 2024 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.

Issuers are required to submit their QIS summary in both PDF and Word formats and include the issuer's logo. All qualifying issuers must submit QIS Reporting via SERFF with annual binder submission.

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 2023. The Exchange will collaboratively work with the Division of Insurance to conduct and review the Discriminatory Benefit Design review for plan year 2024 QHP Certification of all plans, including discriminatory benefit design, QHP discriminatory benefit design, and the treatment protocol calculator.

Under § 156.125(a), 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; and that a non-discriminatory benefit design that provides EHB is one that is clinically base. These presumptively discriminatory practice examples may point to a state's benchmark plan, state law, or an issuer's application of a state's benchmark plan or law as being the source of the discriminatory benefit design. A benefit design that is discriminatory and inconsistent with §156.125 must be cured regardless of how it originated. Thus, for example, if a state EHB benchmark plan has a discriminatory benefit design, that state may issue guidance to issuers in

the state explaining that to be compliant plans providing benefits that are substantially equal to the EHB-benchmark plan must not replicate this design. No discriminatory benefit design regardless of inclusion in statute or benchmark plan

a. Benefit exclusions that are not clinically based
    - No age restrictions for autism spectrum disorder
    - No age restrictions for infertility treatment

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 2023. 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 2024.

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

Requirements related to QHP and QDP issuers' acceptance of third-party payments of premiums and cost sharing on behalf of QHP enrollees remain unchanged from 2023. 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

The approach for issuers to provide cost-sharing reductions (CSRs) to consumers through CSR plan variations remains unchanged from 2023 and earlier years. 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 2024 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 2023 Payment Notice final rule[10].

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.

Section 15. Requirements for Plan Marketing Names

In the proposed 2024 Payment Notice, CMS proposes a requirement that QHP plan and plan variation marketing names include correct information, without omission of material fact, and do not include content that is misleading. As described in the proposed 2024 Payment Notice, starting in the 2024 plan year, CMS would review plan and plan variation marketing names for misleading information, inaccurate information, or omission of material fact during the annual QHP certification process.

Plan Marketing Name Guidance

All information included in plan and plan variation marketing names that relates to plan attributes should correspond to and match information that issuers submit for the plan in the Plans & Benefits Template, and in other materials submitted as part of the QHP certification process such as any content that is part of the Summary of Benefits and Coverage. If necessary, this information can be included in the "Benefit Explanation" field of the Plans & Benefits Template. Consumers applying for coverage should be able to understand references to benefit information in plan marketing names, and they should be able to confirm any information from a plan marketing name in the plan's publicly available benefit descriptions. Also, plan benefit or cost sharing information in a plan or plan variation marketing name should not conflict with plan information displayed on Nevada Health Link SBE Platform during the plan selection process in terms of dollar amount and, where applicable, terminology. In practice, CMS and stakeholders often use the term "plan variants" to refer to "plan variations." Per 45 CFR § 156.400, plan variation means a zero-cost sharing plan variation, a limited cost sharing plan variation, or a silver plan variation. Issuers may choose to vary plan marketing name by the plan variant – for example, use one plan marketing name for a silver plan that meets the actuarial value (AV) requirements at 45 CFR 156.140(b)(2), and a different name for that plan's equivalent that meets the AV requirements at 45 CFR 156.420(a)(1), (2), or (3). 18 Examples of information that should be validated to ensure accuracy and consistency across the plan or plan variation marketing name, Plans & Benefits Template, Nevada Health Link SBE Platform plan selection information, and other applicable QHP certification materials:

a. Deductible amounts
b. For tiered or network-specific benefits, which tier or network is referenced.
c. Maximum out of pocket (MOOP) amounts
d. Benefit copay or coinsurance
e. Initial free or discounted visits

[10] https://www.federalregister.gov/documents/2022/01/05/2021-28317/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2023

f. Ability of the plan to be paired with a health savings account (HSA)

Section 16. Interoperability

The Interoperability and Patient Access Final Rule was finalized on May 1, 2020. For the 2024 plan year, the policy remains unchanged from the 2022 plan year. To assess compliance with all interoperability requirements, the FFEs will require QHP issuers to attest that they are meeting the requirements at 45 CFR 156.221 or submit a justification as part of the QHP application. As noted in the final rule, the interoperability requirements specifically exclude QHP issuers on the FFEs offering only QDPs or issuers only offering QHPs in the FF-SHOPs.

As noted in the Notification of Enforcement Discretion released on December 10, 2021, CMS has opted to employ enforcement discretion for 45 CFR 156.221(f), known as the payer-to-payer data exchange provision, which instructs issuers to maintain a process for the electronic exchange of data classes and elements with other payers for current and prior enrollees. Enforcement of the payer-to-payer data exchange requirement is delayed and will not be incorporated in QHP certification for the 2024 plan year. QHP issuers are encouraged to review the Federal Register notice referenced above announcing enforcement discretion for information.

CHAPTER 3: QUALIFIED DENTAL PLANS: 2024 APPROACH

New for PY 2024, the Proposed QDP Certification Timeline for Plan Year 2024 includes the additional due dates of verification of plans and live URL links as they relate to plan preview and window shopping. As in prior years, issuers will submit an Intent to Sell Form, linked here: Intent to Sell Form

Table 3.1 Final QDP Certification Timeline for Plan Year 2024*

Activity	Deadline
Issuers submit Intent to EDI test with SSHIX - Required	4/3/2023
Issuers submit Intent to Sell Form with SSHIX – Required	4/3/2023
All form filings subject to ACA and CAA Compliance due in SERFF	5/15/2023
Binder submission due in SERFF	5/31//2023
SSHIX initial review of binder data submitted in SERFF	6/1-7/13/2023
Initial objection letter sent	6/16/2023
First data transfer from SERFF to Nevada Health Link SBE Platform	7/13/2023
Issuer plan preview on Nevada Health Link SBE Platform	7/13-8/19/2023
Supplemental URL Templates due in SERFF	8/3/2023
Draft Plan Year 2024 Issuer Agreements sent to issuers for review (Including attachments and Policy Memo)	8/16/2023
Plan Preview ends	8/18/20212
Letters of Good Standing and Network Adequacy submitted to Exchange from DOI	8/18/2023
Final Deadline for Issuers to change QDP application without State Authorization (not applicable to rates)	8/24/2023
Final data transfer from SERFF to Nevada Health Link SBE Platform	8/28/2023
Plans verified for plan accuracy and rates – rates must be approved by DOI	8/30/2023
Final Plan Year 2024 Issuer Agreements sent to issuers with final plan confirmation list	9/4/2023
Issuers send signed agreements, and confirm final plan listings	9/2-9/13/2023
SSHIX to send final plan confirmation list and countersigned attestations and billing agreements to issuers	9/13/2023
Plans Certified in SERFF	9/13/2023
Consumer window shopping begins	10/1/2023
URL links need to be live for window shopping	10/1/2023
Limited data correction window (not applicable to utilize for service area changes or rate data). Must obtain State Authorization prior to use of window.	10/5-10/9/2023
Open enrollment begins	11/1/2023

* All dates are subject to change with notice to carrier.

Section 1. Electronic Data Interchange (EDI) Requirements

Issuers will be required to notify SSHIX no later than April 1, 2023, if they intend to offer plans in Nevada for Plan Year 2024. New issuers will then be required to work collaboratively with SSHIX's vendor, GetInsured (GI), for EDI-related matters[11]. PLEASE NOTE: returning issuers offering plans through Nevada Health Link for Plan Year 2023 are not required to complete EDI testing for Plan Year 2024. Please see link provided for Intent to EDI test form: Intent to EDI Test PY20242. In addition to refer to the 834 companion guide for EDI requirements[12].

Section 2. QDP Annual Limitation on Cost Sharing

For Plan Year 2024, the SADP annual limitation on cost sharing for one covered child is $350 increased by the 15.336 percentage point increase of the Consumer Price Index (CPI) for dental services of 528.630 for 2022 over the CPI for dental services for 2016 of 458.330, increasing the annual limitation on cost sharing for QDPs by $53.68 to a total of $403.68. The regulation at 45 CFR 156.150(d) requires incremental increases to be rounded down to the next lowest multiple of $25, meaning the annual limitation on cost sharing for QDPs for plan year 2024 will be $400 for one child and $800 for two or more children. For more information on how this limitation is determined, please refer to § 156.150 and to the 2018 Letter to Issuers.

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: Network Adequacy for Qualified Dental Plans

Section 4. QDP Actuarial Value Requirements

The approach to actuarial value requirements and certification for QDP coverage of the pediatric EHB remains unchanged from 2023. For plan year 2024, QDP issuers may offer the pediatric dental EHB at any actuarial value. QDP issuers will be required to certify the actuarial value of each QDP's coverage of pediatric dental EHB. QDP issuers can offer pediatric dental essential health benefit (EHB) without selecting or calculating an AV level of that coverage.

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[11] For questions regarding EDI matters, please email the Recon Support team at: reconsupport@exchange.nv.gov.

[12] This section may be updated with additional information in future publications. GetInsured 834 Companion Guide can be found at the Nevada Health Link Website at: https://nevadahealthlink.com/834-companion-guide

Section 5. QDP Guaranteed Rates Requirement

In the proposed 2024 Payment Notice, CMS proposes at 45 CFR 156.210(d)(2) to require SADP issuers, as a condition of Exchange certification, to submit guaranteed rates beginning with Exchange certification for PY 2024. CMS proposes that this requirement apply to all Exchange certified QDPs, whether they are sold on- or off-Exchange. As stated in the proposed 2024 Payment Notice, this proposed change would help reduce the risk of incorrect advance premium tax credit (APTC) calculation for the pediatric dental EHB portion of premiums, thereby reducing the risk of consumer harm.

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 impacted members, or referred to SSHIX on behalf of these members. When SSHIX receives such a complaint a new case will be created in the Carrier Connector collaborative casework system. Each time a new case is created, an automated email notification describing the nature of the complaint and the deadline for resolution will be sent to system users.

Each case will be assigned a Priority Level of either Level 1 (72-hour resolution deadline, reserved for critical access-to-care issues) or Level 2 (14-day deadline, the default). These guidelines were established by CMS, and SSHIX bears a responsibility as an ACA Administering Entity to enforce the timely resolution of all Carrier Connector cases. Chronic untimeliness of case resolution will be referred to CMS and/or the Nevada DOI at SSHIX's discretion.

Each issuer will be required to maintain at least two active Carrier Connector user at all times (one primary and one backup), though QHP issuers can utilize up to 20 Carrier Connector licenses, and QDP issuers can utilize up to 10 licenses. Issuers are responsible for providing adequate staffing levels to ensure the timely resolution of all cases. Issuer personnel wishing to gain access to Carrier Connector must submit a System Access Request form requesting the "Case Management (Carrier Connector)" user role.

Section 2. Coverage Appeals

Occasionally the appeals process might require the retroactive reinstatement of APTC subsidies, even for policies that were eventually cancelled or terminated for non-payment by the issuer. In these cases, issuers are required to process the resultant financial change transactions on a retroactive basis and apply the appropriate credits to the impacted consumers' invoice histories.

Section 3. Resolution of Enrollment Data Discrepancies

Each month issuers are required to submit a Reconciliation Inbound (RCNI) file, representing a complete data dump of the issuer's On-Exchange enrollment records. The contents of this file are then compared against the Exchange's internal enrollment records, and any discrepancies are identified in a monthly Discrepancy Report. Issuers are responsible for ensuring the accuracy and completeness of enrollment data contained in the RCNI. For detailed information regarding this monthly reconciliation process please refer to the SSHIX Reconciliation Guide.

SSHIX requires issuers to thoroughly investigate and resolve all discrepancies indicated on the monthly Discrepancy Report within three months of discovery. For instance, if a given discrepancy first appears in the February Discrepancy Report, it must be resolved prior to the generation of the May Discrepancy Report. In this context a "discrepancy" is defined as a unique combination of Exchange Assigned Policy ID + Exchange Assigned Member ID + Discrepancy

Type. Issuers are further responsible for coordinating with their respective IT staff or contractors to resolve RCNI-related data discrepancies, such as those caused by data mapping errors or insufficient business rules, within the required timeframe. Chronic untimeliness of discrepancy resolution will be referred to CMS and/or the Nevada DOI at SSHIX's discretion.

Please note that some sort of corrective action is required from issuers for all categories of data discrepancies. For financial data points (e.g. Gross Premium, APTC Amount, Net Premium) and demographic data points (e.g. Name, DOB, Address, Broker Designation) the Exchange Platform is the sole source of truth. When discrepancies with these data points are identified issuers are required to update their systems to reflect the 'HIX Value' specified on the Discrepancy Report. The only data point for which issuers are considered the source of truth is consumer payment history. However, even for discrepancies that resulted from the issuer-initiated cancellation/termination of a policy for non-payment—and which might reflect the correct value in the 'Issuer Value' column—the required corrective action is for the issuer to send a valid EDI termination transaction to the Exchange Platform.

Issuers are responsible for providing adequate staffing levels to ensure the timely resolution of all discrepancies. In order to assist with the investigation and resolution of data discrepancies the Exchange Platform includes a portal (known as the "Enrollment Representative" portal) which provides read-only access to the Exchange's current enrollment records. Issuer personnel wishing to gain access to this portal must submit a System Access Request form requesting the "Enrollment Representative (SBE Platform)" user role. There is no limit to the number of Enrollment Representative accounts that can be requested by your personnel.

Section 4. Meaningful Access

45 CFR 155.205(c) and ACA Section 1557 specifies access standards for QHP issuers, and includes language access standards with respect to oral interpretation, written translation, and website translation.

HHS implemented a Final Rule of the ACA Section 1557 in June 2020 in which a portion of the final rule removes the previous mandate that required issuers to distribute non-discrimination notices and "taglines" translation notices in at least fifteen languages within all "significant communications" to patients and customers, eliminating costly and unnecessary regulatory burdens.

Additionally, the Exchange notes 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 5. 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."

On November 7, 2019, CMS released an updated SBC coverage examples Calculator, Guide and Narratives for coverage examples, SBC Template, and other associated resources (the 2021 SBC) for SBCs describing plans or policies effective on or after January 1, 2021. On February 3, 2020, the Departments of Health and Human Services, Labor, and the Treasury released updated versions of the 2021 SBC Template and related materials, following the identification of minor formatting issues, typographical errors, and inconsistencies across documents. These versions replace the versions released on November 7, 2019. These updates ensure consistency across 2021 SBC materials and do not impact SBC guidelines and instructions. The SBC Calculator is used by plans and issuers to generate cost-sharing estimates for coverage to treat three hypothetical medical scenarios (maternity care, type II diabetes, and a simple foot fracture) that are required to be included in the SBC. The Departments of Health and Human Services, Labor, and the Treasury updated the Calculator, Guide, and Narratives based on feedback from stakeholders in order to improve its functionality, flexibility, and accuracy. Use of the Calculator is not required. Plans and issuers may create their own calculator using the Guide and Narratives provided by HHS, or modify the logic of the Calculator to provide their own method of calculating estimated out-of-pocket-costs for the Coverage Examples, which may be more accurate based on their particular plan or policy design.

Issuers will be required to use the 2021 Summary of Benefits and Coverage (SBC) form, as well as the sample SBC's for American Indian/Alaska Native (AI/AN) zero and limited cost sharing plans13, authorized for use for plan years that begin on or after January 1, 2021.

[13] Other Resources | CMS

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

Guidance concerning Indian health care providers remains unchanged from 2023 and earlier years. For more information, please refer to the 2023 Letter to Issuers.

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:

Model QHP Addendum for Indian Health Care Providers