State of Nevada
Nevada Health Authority
Division of Consumer Health Services

NEVADA HEALTH AUTHORITY
DIVISION OF CONSUMER HEALTH SERVICES
SILVER STATE HEALTH INSURANCE EXCHANGE

Plan Year 2027 Plan Certification Letter to Issuers

Date: May 11, 2026

From: The Silver State Health Insurance Exchange

Title: Plan Year 2027 Plan Certification Letter to Issuers

The Silver State Health Insurance Exchange operates under the Division of Consumer Health Services within the Nevada Health Authority. The online health insurance marketplace, known as Nevada Health Link, serves as Nevada's marketplace for health insurance, connecting eligible individuals and families who are not covered by employer-sponsored insurance, Medicaid, or Medicare to qualified health and dental plans. Through Nevada Health Link, the Exchange facilitates access to Affordable Care Act–compliant and state-certified health plans. Eligible consumers may also receive financial assistance, including subsidies, to help reduce monthly premiums and out-of-pocket healthcare costs. The Exchange plays a critical role in expanding access to affordable health coverage and supporting the health and well-being of Nevadans statewide.

The Exchange in collaboration with the Nevada Division of Insurance (DOI), is releasing its Letter to Issuers participating in Nevada's State-Based Exchange (SBE) for Plan Year (PY) 2027. This letter is issued alongside and incorporates guidance from the Centers for Medicare & Medicaid Services (CMS) 2027 Letter to Issuers in the Federally Facilitated Exchanges. See CMS PY27 DRAFT Letter to Issuers.

This letter provides updates on operational and technical guidance for PY 2027 for issuers seeking to offer qualified health plans (QHPs), including qualified dental plans (QDPs), sold on the Nevada Health Link platform. It contains guidance provided by the CMS and the DOI to ensure compliance with federal regulations, 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.).

CHAPTER 1: CERTIFICATION PROCESS FOR QUALIFIED HEALTH PLANS

The Patient Protection and Affordable Care Act (ACA) and applicable regulations provide that health plans must meet a number of standards 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 complete a QHP application for all PY 2027 plans they intend to have certified by The Exchange through an iterative process as shown below in Table 1.1., The Exchange 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 2027 Issuer Agreements for issuers to review prior to finalizing the agreements. Once finalized, The Exchange will send the Final Plan Year 2027 Issuer Agreements to QHP and QDP issuers to sign and submit to the Exchange outlined in Table 1.1. QHP Data Submission and Certification Timeline for Plan Year 2027.

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 The Exchange 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) for plans to be visible for purchase to consumers. Once binders are received, no additional plans may be added. Certification of plans in the Nevada Health Link SBE Platform can only occur after 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 8/21/2026 would need a state authorization form to be submitted through The Exchange.

For Plan Year 2027, the QHP Data Submission and Certification Timeline includes additional dates associated with the CMS QHP Quality Rating and QHP Enrollee Survey activities. These activities are already taking 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 2027 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 2027**

Activity	Deadline
Issuers submit Intent to EDI Test Form with The Exchange – Required (Only new carriers)	4/1/2026
Issuers submit Intent to Sell Form with The Exchange – Required	4/1/2026
CMS QHP Enrollee Survey data submission deadline[1]	5/15/2026
HHS-approved QHP Enrollee Survey vendor securely submits the QHP Enrollee Survey response data to CMS on behalf of the QHP issuer[2]	5/21/26
Binders, forms, and rate submission due in SERFF	6/1/26
The Exchange initial review of binder data submitted in SERFF	6/1/26-7/10/26
QHP issuer submits the validated QRS clinical measure data, with attestation, to CMS via NCQA's Interactive Data Submission System (IDSS)[3]	6/12/26
Initial objection letter sent	6/17/26
First data transfer from SERFF	7/13/2026

[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 2026, available at: https://www.cms.gov/files/document/qrs-and-qhp-enrollee-experience-survey-technical-guidance-2026.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 12 deadline. There are no fees for QHP issuers associated with accessing and using the IDSS.

to Nevada Health Link SBE Platform	
Issuer plan preview on Nevada Health Link SBE Platform	7/31/26- 9/4/26
QHP issuers, Exchange administrators, and CMS preview the 2025 QHP quality rating information	7/31/26-9/29/26
Proposed rate change posted on the DOI website	8/1/26
Draft upcoming Plan Year Issuer Agreements sent to issuers for review (Including attachments and Policy Memo)	8/14/26
Plan Preview ends, deadline for all plans to be verified	9/4/26
Letters of Good Standing submitted to the Exchange from DOI	9/4/26
Final deadline for issuers to change QHP application without State Authorization (not applicable to rates)	8/21/26
Rate filings approved by DOI	8/28/26
Final data transfer from SERFF to Nevada Health Link SBE Platform if applicable	9/8/26
Plans re verified for rates – rates must be approved by DOI	8/28/26
Final upcoming Plan Year Issuer Agreements sent to issuers with final plan confirmation list	9/8/26
Issuers send signed agreements and confirm final plan listings	9/8/26-9/11/26
The Exchange to send final plan confirmation list and countersigned Issuer Agreements to issuers	9/14/26
Plans Certified in SERFF	9/14/26
Approved rate changes posted on the DOI website	10/1/26
Consumer window shopping begins	10/1/26

URL links need to be live for window shopping	10/1/26
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.	10/5/26-10/9/26
Anticipated public display of QHP quality rating information[4]	11/1/2026
Open enrollment begins	11/1/2026

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

Section 2. Electronic Data Interchange (EDI) Requirements

Issuers will be required to notify the Exchange no later than April 1, 2026, if they intend to offer plans in Nevada for Plan Year 2027. New issuers are required to work collaboratively with the Exchange's technology vendor, for EDI-related matters. [5]

PLEASE NOTE: returning issuers offering plans through Nevada Health Link for Plan Year 2026 are not required to complete EDI testing for Plan Year 2027. Please see link provided for Intent to EDI test form: Intent to EDI Test PY 2027. Please email reconsupport@nvha.nv.gov to request a copy of the 834 Companion guide for EDI requirements.

Section 3. QHP and QDP 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 6/1/2026 and to make necessary updates to the QHP application prior to the last deadline for issuer submission on 8/21/2026.

All issuers must obtain Health Insurance Oversight System (HIOS) product and plan IDs using HIOS. HIOS plan IDs 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

[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@nvha.nv.gov.

server data for all issuers.

For Plan Year 2027, the Exchange is limiting all carriers to a maximum of seven (7) unique HIOS plan ID's for each metal level tier per plan rating area. These limits do not include the plan variants -00, -01, …-06. Exceptions to the numerical limitation may be granted on a case-by-case basis. Exceptions are not guaranteed and will be granted at the Exchange's discretion. Examples of exceptions to the numerical limitation include, but are not limited to, products that have a unique design as determined by offering meaningful benefits above and beyond the benchmark plan requirements and products which meet a unique need in the market. Issuers wishing to exceed the numerical limitation will be required to provide information on how the products in question benefit Nevada consumers.

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, 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 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 the Exchange transfers the QHP data from SERFF to the 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 8/28/2026, as reflected in Table 1.1, QHP Data Submission and Certification Timeline for Plan Year 2027.

Discrepancies between an issuer's QHP application and approved filings may result in a plan not being certified. This may also result in decertification if the Exchange has already certified a plan as a QHP. All filings and document versions must correspond across the Binder filing and the Rate filings. All issuers are required to 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/QHP

Section 4. QHP Data Changes

During the certification process for Plan Year 2027, the Exchange will allow issuers to make changes to their QHP application based on the guidelines below. These changes are in addition to any corrections that the Exchange identified during its review of QHP applications. There will be occasional windows used for data corrections as needed. Those dates will be defined later, and issuers will be notified by the Exchange of the data correction windows.

Table 1.2 Key Dates for QHP Data Changes

Activity	Deadline
QHP/QDP certification review. Changes permitted without State Authorization	6/1/26-8/21/26
Limited data correction window. Data corrections must have State Authorization	10/5/26-10/9/26

Issuers may make changes to their QHP submissions without state authorization with the exception of rate information until the deadline listed in Table 1.2 *Proposed QHP Data Submission and Certification Timeline for Plan Year 2027*. After the closing 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. Additionally, issuers 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 the Exchange 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 the Exchange. Issuer changes made in the limited data correction window require state authorization. If the corrections are not approved by the Exchange and/or the DOI, this may result in compliance action by the Exchange and/or the DOI, which could include decertification and suppression of the issuer's plans on the Nevada Health Link platform.[6].

After completion of the QHP certification process, the Exchange may offer additional data correction windows. The Exchange 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 8/21/2026, excluding administrative changes, may be made due to inaccuracies in or the incompleteness of a QHP application, but 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 The Exchange has already certified a plan as a Q H P . Issuers that request changes that affect consumers may have their plans suppressed from display on the Nevada Health Link SBE Platform until the data is corrected

[6] The Exchange 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). The Exchange Plan Certification Guide can be found at https://www.nevadahealthlink.com/

and refreshed for consumer display.

Section 5. QHP Review Coordination with the Exchange

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

The Exchange 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/.

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

The Exchange will provide all their recommendations and relevant information to issuers in a timely manner and no later than the final plan recommendation deadline noted in Table 1.2.

Section 6. Plan ID Crosswalk

Pursuant to 45 CFR 155.335(j), the Division of Insurance is responsible for reviewing QHP and QDP Plan ID Crosswalks for plan year 2027. Issuers will need to submit their Plan ID Crosswalk template along with their binder submission in SERFF by June 1, 2026. The DOI will provide the Exchange with a letter of approval for all Plan ID Crosswalk Templates.

Issuers are required to submit plan ID crosswalk data for each QHP and SADP that were certified for the 2026 plan year. Please refer to the 2018 Letter to Issuers for more information regarding submission requirements pertinent to the Plan ID Crosswalk.

As outlined in § 155.335(j), the Exchange re-enrolls consumers who have catastrophic coverage as defined in section 1302(e) of the ACA, including those who lose eligibility for catastrophic coverage or whose current plan will no longer be available, into a new QHP for the coming plan year, to the extent permitted by applicable State law. Incorporating catastrophic plan enrollees into the rules at § 155.335(j) will help ensure continuity of coverage in cases where the issuer does not offer the catastrophic plan for the subsequent plan year, and these enrollees do not actively select a different QHP or terminate their coverage. Consistent with§ 155.335(j)(4), the Exchange may not newly auto re-enroll an enrollee into catastrophic coverage who is currently enrolled in coverage of a metal level (a non-catastrophic plan) as defined in section 1302(d) of the ACA, consistent with the practice of the Exchanges on the Federal platform. SADPs, as plans that offer excepted benefits, are not subject to the guaranteed renewability standards specified at

45 CFR 147.106.

Section 7. Template Changes for Plan Year 2027

The Exchange will continue to use the CMS templates for Plan Year 2027. CMS has introduced various changes in templates. The changes to these templates have required the Exchange 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 6/1/2026, 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@nvha.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 2027 is defined as 1/1/2027-12/31/2027.

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

This chapter provides an overview of key certification standards for both QHPs and QDPs on Exchange and how the Exchange will evaluate and conduct reviews of 2027 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

The Exchange has defined service areas for on-Exchange plans that align with Nevada's rating areas developed by the Nevada Division of Insurance and approved by the Center for Consumer Information and Insurance Oversight (CCIIO). The Exchange plan service areas are as follows:

- Service Area 1: Clark and Nye counties
- Service Area 2: Washoe County
- Service Area 3: Carson City, Lyon, Douglas, and Storey counties
- Service Area 4: All other counties

Section 3. Network Adequacy

This section describes how the Exchange will address network adequacy standards and certification review for qualified health plans. The Exchange will rely on the DOI to conduct its network adequacy review for plan year 2027 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."

Further guidance regarding network adequacy standards will be released in the annual plan filing guidance released by the DOI which is anticipated to be available in May 2026. Please visit the DOI's website for more information: https://doi.nv.gov/Insurers/Life_and_Health/ACA_Plans/

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 2027. The approach for reviews of the ECP standard remains unchanged from that used in 2024. Please refer to NAC 687B.768[7] for more information.

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

- Contracts with at least 35 percent of the ECP's in the service area of the network plan that are available to participate in the provider network of the network plan and networks must specifically contact with at least 35% of Family Planning Providers and 35% of the Federally Qualified Health Centers.
- 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 for Plan Year 2027. CMS encourages issuers to provide their accrediting entity (AE) with their Health Insurance Oversight System (HIOS) ID number associated with their organization as they begin to work with the AE(s) on accreditation.

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

The QHP issuer must meet a minimum level of accreditation by an accrediting entity recognized by HHS. The Exchange will verify an issuer's accreditation status for certification or recertification. The Exchange utilizes the same timeline requirements defined in 45 CFR 155.1045(b) that are used in Federally Facilitated Exchanges. In addition, the Exchange requires a QHP issuer to comply with regulations set forth in 45 CFR 156.275.

Issuers entering their initial year of QHP certification 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.

The Exchange will request a copy of any accreditation review scheduled for the upcoming plan year, or the accreditation certificate. The issuer shall notify the Exchange within five business days if there is a change in accreditation status or if there is a failure to maintain up-to-date accreditation.

The Exchange reserves the right to decertify a QHP if accreditation is terminated or not achieved by the relevant deadline.

The Exchange 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)
    - The Exchange will not recognize NCQA status: denied
- URAC: full, provisional, or conditional (conditional status requires a second review within three to six months)
    - The Exchange will not recognize URAC status: denial
- AAAHC: Certificate of Accreditation
    - The Exchange will not recognize AAAHC status: denial

The Exchange may certify a QHP prior to the health plan becoming Exchange-accredited as described below. During a new issuer's initial and next two certification processes, the Exchange 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 for 2027 and prior years. The Exchange 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 2026. Please refer to the Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2026 for more detailed information on issuer data collection and reporting requirements for the 2026 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 2026 and the 2026 Quality Rating System Measure Technical Specification, published by CMS, and any subsequent updates to that guidance.

While QHP issuers are required to submit QRS measure data for eligible reporting units beginning with the reporting unit's second year of operation, 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 must be in operation for at least three consecutive years. Therefore, a reporting unit must be operational on the Exchange in 2024, 2025, and 2026 to receive QRS scores and ratings. 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 2026 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., 2025 calendar year);
- Offered through an Exchange in the ratings year (i.e., 2026 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, 2025); and
    - Included more than 500 enrollees as of January 1 of the ratings year (i.e., January 1, 2026).

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., 2025 and 2026) that had more than 500 enrollees as of July 1, 2025

and more than 500 enrollees as of January 1, 2026.

Reporting units discontinued before June 15 of the ratings year (i.e., June 15, 2026) are exempt from these requirements. For an eligible reporting unit impacted by a QHP issuer change in ownership (e.g., merger, acquisition) effective as of January 1 of the ratings year, the QHP issuer that assumes the reporting unit is responsible for meeting these requirements. For an eligible reporting unit impacted by a transfer (e.g., all enrollees automatically transferred to a new reporting unit of the same product type) effective prior to June 15 of the ratings year, the QHP issuer is responsible for meeting these requirements for that reporting unit.

QHP issuers should refer to the Marketplace Quality Initiatives website for more detailed information on issuer data collection and reporting requirements for the 2026 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 the Exchange that will display during the open enrollment period for the 2027 plan year. During 2027, qualifying issuers will report data from the 2026 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 2027, the Nevada Health Link SBE Platform will display plan rating data on the Nevada Health Link/Transparency webpage. The QRS ratings will be published during consumer shopping in accordance with CMS regulations.:.

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 the Exchange.
The Exchange will notify any issuer who is eligible for 2026 QRS based on the 2026 QRS participation requirements. Participation requirements can be found in the CMS Technical Guidance for 2026.

Section 8. Quality Improvement Strategy

The approach for QHP certification reviews for quality improvement strategy (QIS) reporting remains unchanged for 2026. CMS intends to provide information on the applicable QIS requirements in the forthcoming QIS Technical Guidance and User Guide for the 2027 plan year. At this time, the QIS requirements do not apply to indemnity plans, SADPs or to child-only plans offered on Exchanges. The QIS requirements also do not apply to BHP plans.

The Exchange follows CMS guidance for QIS reporting. Any eligible QHP issuer participating in the Exchange 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 2026 calendar year, as well as the forthcoming Plan Year 2026 QIS Technical Guidance and User Guide.
An eligible issuer for the 2027 plan year is any QHP issuer that:

- Offered coverage through the Exchange in 2023 and 2024 and submitted a QIS Implementation Plan or Progress Report for the 2025 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).

All eligible issuers must comply with the following QIS requirements for the 2027 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 2027 Coverage Year.
- Report on progress implementing the QIS to the Exchange in accordance with guidelines established by the Exchange.

Issuers may implement one QIS that applies to all eligible QHPs in the Exchange, 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 each QHP but may address needs of specified sub-populations.

Eligible issuers for the 2027 plan year must submit the following documents to the Exchange along with their binder filing in SERFF to meet this certification criteria:

- A QIS applicable to any QHP to be offered by the Exchange in the form and manner specified by the Exchange, which for the 2026 plan year will require use of the QIS Implementation Plan and Progress Report Form provided by the Exchange.

The Exchange 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 the Exchange. Issuers should also submit a summary of each QIS applicable to a QHP offered by the Exchange.

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 and Marketing Practices

The approach to discriminatory benefit design remains unchanged from that used for plan year 2026. The Exchange will collaboratively work with the Division of Insurance to conduct and review the Discriminatory Benefit Design review for plan year 2027 QHP Certification of all plans, including discriminatory benefit design, QHP discriminatory benefit design, and the treatment protocol calculator.

Pursuant to 45 CFR 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. A non-discriminatory benefit design that provides EHB is one that is clinically based.

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. Broker Commissions

This section describes new requirements for QHP issuers offering plans through the Exchange for Plan Year 2027. Issuers that offer QHPs through the Exchange will be required to pay commissions to brokers for enrollments in any of their QHPs.

Agents and Brokers play a vital role in helping Nevadans get affordable coverage and enroll in QHPs on the Exchange through enrollment assistance, education, and expert advice and decision support. Adequate compensation to brokers for their services to consumers to determine the best QHP to meet their health care needs is essential for brokers to do their job, and for the successful maintenance and stability of the Exchange's enrollment and the broader individual market risk pool.

45 CFR 155.1000(c)(2) gives the Exchange authority to establish requirements that issuers must meet for plans offered on the Exchange. It provides that "[t]he Exchange may certify a health plan as a QHP if . . . the Exchange determines that making the health plan available is in the interest of qualified individuals and employers," subject to certain exceptions[8] which are not relevant to broker commissions. CMS has made clear that commissions are a marketing practice covered under 45 CFR 147.104(e) and 156.225(b) and that reducing or not offering commissions to steer certain customers away from certain plans can be considered a discriminatory practice.[9] A practice by an issuer of paying no commissions or lower commissions for enrollments in certain QHPs may provide a disincentive for brokers to offer or to enroll consumers in certain QHPs, and would be a discriminatory practice that is not in the best interest of Nevadans. It is the Exchange's policy that consumers should receive assistance to enroll in the plan that best meets their needs. As such:

1) *Compensation:* Issuers are required to contract with and reasonably compensate brokers for enrollment in their QHPs available through the Exchange.

2) *Broker/Agent Code of Conduct Compliance:* Issuers are required to implement policies and procedures to ensure that agents comply with the Broker/Agent Code of Conduct which requires licensed brokers to: "…act in the best interest of Nevada Health Link consumers. The best interest of the consumer includes but is not limited to assisting consumers to enroll in the most appropriate coverage for their medical needs, optimizing consumer savings and affordability,

[8] 45 CFR 155.1000 (c)(2) notes the following exceptions: (i) On the basis that such plan is a fee-for-service plan; (ii) Through the imposition of premium price controls; or (iii) On the basis that the health plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange determines are inappropriate or too costly.

[9] Federal rules prohibit marketing practices that have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage, both inside and outside of the Marketplaces. Issuers commonly use agents and brokers as an important part of their marketing and sales distribution channels, and the way an issuer structures its compensation to agents and brokers influences the enrollment and retention of consumers. Therefore, a commission arrangement or other agent/broker compensation that is structured to discourage agents and brokers from marketing to and enrolling consumers with significant health needs constitutes a discriminatory marketing practice prohibited under 45 CFR 147.104(e) and 156.225(b).2. CMS guidance available at: https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Agent-Broker-Compensation-and-Discriminatory-Marketing-Practices.pdf

providing the most transparent and relevant information, and providing meaningful consumer choice, while diligently working to inform consumers of reconciliation liability and avoiding reconciliation burden."

Section 12. Prescription Drugs

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 2027.

For the 2027 plan year, CMS will continue conducting an adverse tiering review as one of the prescription drug reviews. The adverse tiering review assesses whether submitted formularies associate higher cost sharing to all or a majority of drugs needed to treat certain chronic medical condition(s). The final 2023 Payment Notice established adverse tiering as a presumptively discriminatory practice when placing all drugs for particular high-cost chronic condition(s) on the highest formulary tier, even when those drugs are costly. For the 2025 plan year, the following medical conditions were included in the adverse tiering review: Hepatitis C virus, HIV, multiple sclerosis, and rheumatoid arthritis. Plans will be flagged for possible adverse tiering if all drugs for at least one of the four medical conditions are placed on the highest effective cost sharing tier. Drugs and drug classes in each condition under review are Food and Drug Administration (FDA)-approved drug therapies, as recommended by nationally recognized clinical guidelines.

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 it 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 13. 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 2024. 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 14. Cost-sharing Reduction Plan Variations

(This section does not apply to QDPs, as cost-sharing reductions (CSRs) do not apply to QDPs).

The approach for issuers to provide cost-sharing reductions (CSRs) to consumers through CSR

plan variations remains unchanged from 2026 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 the Exchange, as well as zero and limited cost-sharing plan variations for all metal-level QHPs an issuer offers through the Exchange, for individuals who are eligible for cost-sharing reductions, as outlined in 45 CFR 155.305. Eligible consumers can enroll in these plan variations for the 2027 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 6: 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, including 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, the Exchange 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 2027 Payment Notice final rule.

Section 15. 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 16. Requirements for Plan Marketing Names

Requirements related to QHP and QDP Plan Marketing Names remain unchanged from 2026 Plan Year. The Exchange and DOI will conduct reviews of QHP plan and plan variation marketing names to ensure they include correct information, without omission of material fact, and do not include content that is misleading. More information about this review is available in the 2026 Letter to Issuers, and in the Plan Marketing Name Fact Sheet.

Section 17. 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). 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
f. Ability of the plan to be paired with a health savings account (HSA)

Section 18. Interoperability

For the 2027 plan year, requirements for the interoperability QHP Certification review have not changed. More information on this review can be found in the 2024 Letter to Issuers. However, note that in February 2024 CMS published the Advancing Interoperability and Improving Prior

Authorization Processes Final Rule, which established additional requirements that will apply in future plan years. Issuers can refer to that Final Rule and related technical assistance materials to learn more about these requirements, several of which will take effect in plan year 2026 related to publicly reporting certain information from plan year 2025.

CHAPTER 4: QUALIFIED DENTAL PLANS: 2027 APPROACH

New for Plan Year 2027, the QDP Certification Timeline 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 2027*

Activity	Deadline
Issuers submit Intent to EDI test with the Exchange - Required	4/1/2026
Issuers submit Intent to Sell Form with the Exchange – Required	4/1/2026
Binders, forms and rate submission due in SERFF	6/1/2026
The Exchange initial review of binder data submitted in SERFF	6/1/2026-7/10/2026
Initial objection letter sent	6/17/2026
First data transfer from SERFF to Nevada Health Link SBE Platform	7/13/2026
Issuer plan preview on Nevada Health Link SBE Platform	7/31/2026- 9/04/2026
Draft Plan Year 2027Issuer Agreements sent to issuers for review (Including attachments and Policy Memo)	8/14/2026
Plan Preview ends	9/04/2026
Letters of Good Standing submitted to Exchange from DOI	9/04/2026
Final Deadline for Issuers to change QDP application without State Authorization (not applicable to rates)	8/21/2026
Final data transfer from SERFF to Nevada Health Link SBE Platform	9/08/2026
Plans verified for plan accuracy and rates – rates must be approved by DOI	8/28/2026
Final Plan Year 2026 Issuer Agreements sent to issuers with final plan confirmation list	9/8/2026
Issuers send signed agreements, and confirm final plan listings	9/11/2026
The Exchange to send final plan confirmation list and countersigned attestations and billing agreements to issuers	9/14/2026

Plans Certified in SERFF	9/14/2026
Consumer window shopping begins	10/1/2026
URL links need to be live for window shopping	10/1/2026
Limited data correction window (not applicable to utilize for service area changes or rate data). Must obtain State Authorization prior to use of window.	10/5/2026- 10/9/2026
Open enrollment begins	11/1/2026

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

Section 1. Electronic Data Interchange (EDI) Requirements

Issuers will be required to notify the Exchange no later than April 1, 2026, if they intend to offer plans in Nevada for Plan Year 2027. New issuers will then be required to work collaboratively with the Exchange's vendor, GetInsured (GI)/Vimo, for EDI-related matters[10]. PLEASE NOTE: returning issuers offering plans through Nevada Health Link for Plan Year 2026 are not required to complete EDI testing for Plan Year 2027. Please see link provided for Intent to EDI test form: Intent to EDI Test PY27 . Please email reconsupport@nvha.nv.gov to request a copy of the 834 Companion guide for EDI requirements.

Section 2. QDP Annual Limitation on Cost Sharing

For the 2027 plan year, the SADP annual limitation on cost sharing for one covered child is $350 increased by the 28.863 percentage point increase in the Consumer Price Index (CPI) for dental services of 590.616 for 2024 over the CPI for dental services for 2016 of 458.330, increasing the annual limitation on cost sharing for SADPs by $101.02 to a total of $451.02. 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 SADPs for the 2027 plan year will be $450 for one child and $900 for two or more children. For more information on how this limitation is determined, please refer to 45 CFR 156.150.

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 AV requirements and certification for SADP coverage of the pediatric EHB remains unchanged from 2021 and later years. Please refer to the 2021 Letter to Issuers for more

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

information. Starting with the 2024 plan year, SADP issuers may offer the pediatric dental EHB at any AV. SADP issuers are required to certify the AV of each SADP's coverage of pediatric dental EHB. Additionally, beginning with the 2024 plan year, SADP issuers applying for QHP certification are no longer required to submit a separate SADP attestation form and instead attest to compliance with applicable standards as part of the general program attestation. Please note the requirement in 45 CFR 156.150(b)(2) that an SADP must have the plan's AV of coverage for pediatric dental EHB certified by a member of the American Academy of Actuaries using generally accepted actuarial principles and reported to the Exchange is still applicable, and submitting the general program attestation includes attesting to compliance with this requirement.

Section 5. QDP Guaranteed Rates Requirement

Guidance on the requirement for SADP issuers to submit guaranteed rates remains unchanged from 2024. Please refer to the 2025 Letter to Issuers for more information.

CHAPTER 5: CONSUMER SUPPORT AND RELATED ISSUES

Section 1. Consumer Case Tracking and Coverage Appeals

The Exchange requires QHP and QDP issuers to thoroughly investigate and resolve consumer complaints received directly from impacted members or referred to the Exchange on behalf of these members. When the Exchange 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 the designated QHP and QDP carrier users who have access to the Carrier Connector system.

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 the Exchange 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 the Exchange's discretion.

Each issuer will be required to maintain at least two active Carrier Connector users 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 to the Exchange 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, which represents 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 Exchange Reconciliation Guide located at: https://www.nevadahealthlink.com/reconciliation-guide/

The Exchange 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 the Exchange's discretion.

Corrective action is required 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 system of record. 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. 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 outline the access standards for QHP issuers and

includes language access standards with respect to oral interpretation, written translation, and website translation.

The approach to meaningful access generally remains unchanged from 2023 and earlier years. As a reminder, in November 2023, Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (the Departments) issued updated guidance for plans and issuers subject to the culturally and linguistically appropriate standards set forth in the internal claims and appeals and external review processes under the rules implementing section 2719 of the PHS Act and in the summary of benefits and coverage (SBC) and uniform glossary rules implementing section 2715 of the PHS Act (2023 CLAS Guidance). The Departments also published an FAQ indicating that this guidance is applicable for plan years (in the individual market, policy years) beginning on or after January 1, 2025, and until the next version of this guidance is issued and effective. The Departments intend to update the following documents to reflect the updates in the 2023 CLAS Guidance:

- SBC template and sample completed SBCs in English (with updated taglines in applicable non-English languages);
- Additional translated versions of the SBC and Uniform Glossary; and
- Model notices for internal claims and appeals and external review (with updated taglines in applicable non-English languages).

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. The Exchange considers 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 (SBC).

The Exchange utilizes the requirements defined in 45 CFR 147.200, which requires QHP issuers to provide the SBC in a culturally and linguistically appropriate manner to consumers.

Qualified Health Plan (QHP) issuers are also responsible for complying with the standards set forth at 45 CFR 155.205(c) to provide information in a manner that is accessible to individuals living with disabilities and individuals with limited English proficiency, including with respect to oral interpretation, written translations, and website translations. The Exchange reminds QHP issuers of their obligations take reasonable steps to provide meaningful access to their programs or activities to individuals with limited English proficiency under applicable Federal civil rights laws, including Affordable Care Act section 1557 and Title VI of the Civil Rights Act of 1964,

and their implementing regulations.

The QHP issuers are required to follow the SBC Instruction Guide for Individual Health Insurance Coverage for limited and zero cost-sharing plans (IHCP) for American Indians and Alaska Natives (AI/AN), including instructions specific to those variations. This includes the requirement that for AI/AN limited cost-sharing plans, QHP issuers must include a box below the coverage examples with the following language: "Note: These numbers assume the patient received care from an IHCP provider or with IHCP referral at a non-IHCP. If you receive care from a non-IHCP provider without a referral from an IHCP your costs may be higher." Issuers may find it helpful to refer to the AI/AN limited cost sharing and AI/AN zero-cost sharing sample completed SBCs for examples of how to complete SBCs for those variations.

CHAPTER 6: DECERTIFICATION

Pursuant to 45 CFR 155.1080, the Exchange 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 7: TRIBAL RELATIONS AND SUPPORT

Guidance concerning Indian Health Care Providers remains unchanged from 2025 and earlier years. For more information, please refer to the 2025 Final 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. The Exchange strongly encourages issuers to ensure each offer is sent to the correct address and contacts. Similarly, it is advised that all Indian health care providers 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 Indian Health Care Improvement Act.

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

https://www.cms.gov/files/document/modelqhpaddendumexplanatorydocument040413pdf