Health Insurance Marketplace Plan Management
2015 QHP Application Process

March 18, 2014
9:00AM – 12:00PM

Location:
New Hampshire Insurance Department
Second Floor Conference Room
21 South Fruit Street
Concord, NH 03301

WebEx:
https://pcgus.webex.com/pcgus/j.php?MTID=m3cfefb3861566b982b9a64abab80e484
Password: nhid
Phone: 1-877-668-4493
Access code: 762 024 336

In order to receive any follow-up documents, please send a list of attendees and their email addresses to Marlene Sawicki at Marlene.Sawicki@ins.nh.gov
## Agenda (Contents)

<table>
<thead>
<tr>
<th>Part 1: Policy Discussion</th>
<th>Slide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timeline &amp; Introduction</td>
<td>3 – 4</td>
</tr>
<tr>
<td>Network Adequacy</td>
<td>5 – 12</td>
</tr>
<tr>
<td>Essential Community Providers</td>
<td>13</td>
</tr>
<tr>
<td>Meaningful Difference &amp; Cost Sharing</td>
<td>14 – 15</td>
</tr>
<tr>
<td>Rate Filing Requirements</td>
<td>16</td>
</tr>
<tr>
<td>Stand-Alone Dental</td>
<td>17</td>
</tr>
<tr>
<td>Small Business Health Options (SHOP)</td>
<td>18 – 19</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Part 2: SERFF and Filing Submittal</th>
<th>Slide</th>
</tr>
</thead>
<tbody>
<tr>
<td>SERFF Online Portal</td>
<td>21</td>
</tr>
<tr>
<td>Filings</td>
<td>22</td>
</tr>
<tr>
<td>Binders</td>
<td>23</td>
</tr>
<tr>
<td>Helpful Filing Tips</td>
<td>24</td>
</tr>
</tbody>
</table>
Part 1: Policy Discussion

QHP Review Timeline

<table>
<thead>
<tr>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deadline for submission of letters of intent</td>
<td>QHP Application Review &amp; Certification</td>
<td>QHP filing review</td>
<td>QHP application review &amp; certification (Medical &amp; Dental)</td>
<td>Filing reviews completed &amp; finalized</td>
<td></td>
</tr>
<tr>
<td>(3/18) Meeting with prospective QHP issuers</td>
<td>(5/1) Final date to accept Medical &amp; Dental QHP form submissions</td>
<td>(6/1) Final date to accept Medical &amp; Dental QHP Rate, Network, &amp; Template submissions</td>
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</tbody>
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Key Dates
- **May 1**: Final date to submit forms
- **May 27 - June 27**: QHP Apps due to CMS
- **June 1**: Final date to submit rates and templates
- **August 1**: NHID to have completed all QHP reviews
- **August 7**: Approved QHP applications transferred to FFM
- **November 15 - February 15**: Open enrollment period
The Department understands for many attendees this may be the first time going through the QHP Certification process. As such, the Department is working on guidance and tools to assist issuers during the QHP submission and review process.

Tools/Guidance include:

- 2015 NHID Issuer Bulletin;
  - Tentatively scheduled to be released prior to the end of the month
  - Subject to approval by Health Oversight Committee, likely meeting within the next two weeks
- Non-Exhaustive List of Applicable Federal/State Certification Standards;
- Network Adequacy Package;
- SERFF Filing Instructions;
- QHP Filing Checklists (Individual, Small Group Medical Plans & Individual/Small Group Stand-Alone Dental Plans)

Note: The Department will schedule more meetings with issuers on a one on one or group basis as we move through the certification process.
Network Adequacy

NHID will prospectively review adequacy of issuer networks for 2015 plan year based on distance measures from providers.

The State will determine network adequacy through receipt of a Network Adequacy Package, created with the goals of:

1. Providing, on a prospective basis, a measure of accessibility offered by issuer networks;
2. Increasing transparency of network data as it relates to service areas and key provider types; and
3. Maintaining consistency of provider network data.

This package is a State requirement, any remaining federal requirements put in place through new or existing guidance will be considered in addition to the State’s review.
Network Adequacy Package

Network Adequacy Package to include 3 documents

1. Network Adequacy Attestations
   - Network Attestations
   - Proposed service area (Counties)
   - List key provider types:
     - Hospitals
     - ECPs
     - Inpatient/Outpatient Mental Health

2. Network Data Template (Excel)
   - Standardized format for issuers to input current provider networks
   - Additional data fields requested in document:
     - Hospital Admitting Privileges
     - Accepting New Patients
     - Essential Community Provider (and Type)

3. Network Adequacy Cover Page
   - Provider distance measurement results summary
   - Allowable distance measures vary according to provider type

All documents to be made available on the NHID website after this meeting
Network Adequacy Package

1 Network Adequacy Attestations

Issuer attests that:

- Network is “sufficient in number and types of providers to assure that all services will be accessible without unreasonable delay” (based on federal attestation)

- Network data submitted represents signed contracts in place

- Identify the counties covered in the proposed service area

- Lists the key provider types—for each county, issuer lists:
  - Hospitals
  - ECPs
  - In/Outpatient Mental Health
Network Adequacy Package

2 Network Data Template

- Standardized excel-based template for listing issuer provider networks
- Key data fields
  - Hospital admitting privileges;
  - Admitting new patients;
  - Essential community providers

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<tr>
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<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
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<tbody>
<tr>
<td>1</td>
<td>Updated 3/12/2010 New Hampshire Insurance Department</td>
<td>New Hampshire Insurance Department</td>
<td>New Hampshire Network Data Template (Provider Network Data)</td>
<td>Instructions: Complete the fields below to detail the Provider Networks you are submitting for approval in this filing. If needed, use the instructions contained within the New Hampshire Network Adequacy Package as a guide on how to use this form.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>HICIS Issuer ID</td>
<td>Company Legal Name</td>
<td></td>
<td></td>
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<td>3</td>
<td>Service Area Name</td>
<td>Network ID</td>
<td>Network Provider ID Number (NPI)</td>
<td>Provider Name</td>
<td>Provider Type</td>
<td>Provider Subspecialty</td>
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<td>4</td>
<td>Required: Enter the Service Area Identification as delineated from the SERFF Service Area Template</td>
<td>Required: Enter the Network Identification as delineated from the SERFF Network Template</td>
<td>Enter the 10 digit NPI Number (if available) as found at <a href="http://www.ncbi.nlm.nih.gov/">http://www.ncbi.nlm.nih.gov/</a></td>
<td>Provider Name: Enter the last and first name (in that order) of each contracted physician provider. If the provider is not a physician, enter the name of the hospital, facility, pharmacy, etc.</td>
<td>Provider Type: Select the Provider Type from the given list. Required: Provider Subspecialty: Select the Provider Subspecialty from the given list, if applicable.</td>
<td>Required: Enter the office address of the provider</td>
<td></td>
</tr>
</tbody>
</table>
3 Network Adequacy Summary Page

- Issuer attests that the network meets geographic access standards
- Access standards based on distance from provider, reflective of standards found in INS 2701 Network Adequacy
- Issuers must provide an access summary page for each county included in the proposed service area
- Process for determining adequacy found in following slides

In addition to these statements of compliance, issuers must provide documentation of compliance with these standards.

Note 3/18/14: For issuers offering dental coverage (including stand-alone dental plans), access to coverage will be deemed adequate in cases where the issuer offers two open-panel general practice dental providers for each county within the proposed service area.
Network Adequacy Package - Summary Page Methodology

NHID will prospectively review adequacy of issuer networks for 2015 plan year based on distance measures from providers. Three scenarios exist for issuers proposing a network:

1. Issuer submits network and has existing QHP membership within the entire proposed service area. Issuer may use existing QHP enrollment data as population sample.

2. Issuer submits network and has existing QHP membership within the state, but not in the entire proposed service area. Issuer must use proxy population as enrollment data. Proxy population: Under 65 population by Zip code (data set to be hosted on NHID web site).

3. Issuer submits network without any existing QHP membership within proposed service areas.
Network Adequacy - Distance Measurement Process

Issuers will be responsible for performing time and distance measures and reporting results to the NHID through Network Adequacy Summary Page.

1. Provider location(s) mapped across the State

2. Radius drawn around provider location to cover applicable distance standard (e.g., 45 miles for general surgeons)

3. Under-65 population of all areas within radius meet are added to the county’s “covered” population

4. Covered population compared against the full under-65 population for the county

5. Network adequacy standard is met for that provider type if over 90 percent of the county population is covered
Network Adequacy - Distance Measurement Process Example

The summary page requires both a statement of compliance with these standards and documentation of this compliance.

<table>
<thead>
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<th>Zip</th>
<th>Pop.</th>
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<td>960</td>
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<tr>
<td>03220</td>
<td>7,430</td>
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<td>03225</td>
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Numerator = Under 65 Population of covered zip codes within county

61,891

Denominator = Total under 65 population of all zip codes within county

63,429

= 95.3%

If 90 percent or more of a county's under-65 population lies within the distance standards, the issuer meets network adequacy for that county and may market its plan.

If the covered population is less than 90 percent, the issuer must either expand its network or reduce the proposed service area to exclude counties in which the threshold is not met.
Essential Community Provider Standards

Final 2015 Letter to Issuers proposes rule changes for Network Adequacy with respect to Essential Community Providers (ECP)

In order to satisfy the requirements set out in 45 C.F.R 156.235, Issuers must:

- Contract with at least **30 percent** of ECPs available within each plan’s service area.¹
- Offer contracts in good faith² to:
  - All Indian health providers in the service area; and
  - At least one ECP in each ECP category in each county in the service area.

### ECP Categories

<table>
<thead>
<tr>
<th>Federally Qualified Health Centers</th>
<th>Family Planning Providers</th>
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<tbody>
<tr>
<td>Ryan White Providers</td>
<td>Indian Health Providers</td>
</tr>
<tr>
<td>Hospitals</td>
<td>Other ECP Providers</td>
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</table>

¹A non-exhaustive list which may be used to calculate the satisfaction of the 30 percent ECP standard can be found at [http://www.cms.gov/cciio/programs-and-initiatives/health-insurance-marketplaces/qhp.html](http://www.cms.gov/cciio/programs-and-initiatives/health-insurance-marketplaces/qhp.html)

Meaningful Difference

2014 Review Standards

- Deductible
  - Plan A: $50 Difference
  - Plan B:

- Out-of-Pocket Maximum
  - Plan A: $100 Difference
  - Plan B:

2015 Review Standards\(^1\)

A plan is considered meaningfully different from another plan in the same service area and metal tier (including catastrophic plans) if a reasonable consumer would be able to identify one or more material differences among the following characteristics between the plans:

- Cost Sharing
- Provider Network
- Covered Benefits
- Plan Type (HMO, PPO)
- HSA Eligibility
- Self/Non-Self/Family Offering

Cost Sharing

2014
Maximum Cost Sharing

Medical
- Individual: $2,000
- Family: $4,000

Dental
- Individual: $6,350
- Family: $12,700

2015
Maximum Cost Sharing

Medical
- Individual: $2,050
- Family: $4,100

Pedi Dental
- Individual: $6,600
- 1 Child: $13,200
- >1 Child: $700

Pharmacy cost sharing (OOPM) must be aggregated with medical cost sharing accumulations for plan year 2015.

Rate Filing Requirements

Rate Review Considerations for 2015 Plan Year

Changes in rates between plan years\(^1\):

- Issuers seeking rate increases greater than or equal to 10% must publicly disclose and provide justification for proposed increases;
- States will determine whether these increases are reasonable.

Same rates for On- and Off-Marketplace\(^2\):

- A QHP issuer must charge the same premium rate without regard to whether the plan is offered through an Exchange, or whether the plan is offered directly from the issuer or through an agent.

Additional Resource: Notice of Benefit and Payment Parameters Final Rule\(^3\)


\(^2\)http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=162e6716ea28bf56fdbd02636800d296&ty=HTML&h=L&r=PART&n=45y1.0.1.2.71#45:1.0.1.2.71.3.27.10

Stand-Alone Dental

All Stand-Alone Dental Plan (SADP) issuers are bound by the same timeline as QHP issuers, included on Slide 3

SADPs shall be filed using the SERFF system, and additional guidance regarding SADP filings can be found in the following documents:

- 2015 Letter to Issuers in the Federally-Facilitated Marketplace;
- NHID 2015 Issuer Bulletin; and
- SADP Small Group and Individual Filing Checklists

More information about the changes to SADP, including SHOP requirements and links to applicable regulations, are found in slide 19.
Small Business Health Options (SHOP) Marketplace

What is the latest information on the SHOP?

- Reference the Final 2015 Letter to Issuers in the Federally-Facilitated Marketplace, specifically Chapter 5, pgs. 37-42

- The following link organizes all SHOP regulations, including all recently filed proposed regulations relating to SHOP functions, and should serve as a resource to carriers
  http://www.ecfr.gov/cgi-bin/text-idx?SID=5ad9efecf3ee32555500a7adb3282420&node=45:1.0.1.2.70.8&rgn=div6

- Note 3/18/14: Additional resource for the SHOP released 3/17
Small Business Health Options (SHOP) Marketplace

- Timeline: All SHOP plans shall be filed in accordance with the 2015 QHP Review Period Timelines, included on Slide [3]

- Notable Changes for Plan Year 2015:
  - For plan years beginning on or after January 1, 2015, FF-SHOP employers will provide employees with the choice of all plans at a metal level or a single QHP.
  
  - Employers will also have the option of offering all Stand-Alone Dental Plans within a metal level, or one Stand-Alone Dental Plan to employees.
  
  - Relying on premium aggregation services, employers will receive and pay one bill; information for issuers on premium payment, reconciliation and the associated timelines are included in the 2015 Benefit & Payment Parameter regulation

Part 2: SERFF and Filing Submittal

QHP filings to be submitted through the NAIC System for Electronic Rate and Form Filing (SERFF)

Process from SERFF to plan visibility on the Marketplace:
QHP Filing Submission - SERFF

- QHP filings to be submitted through the System for Electronic Rate and Form Filing (SERFF)
- SERFF components include Filings and Binders

**Online Portal**

- With release of v6.0, SERFF Plan Management functionality has been introduced for Qualified Health Plan (QHP) submissions
- Issuers must have valid SERFF ID and adequate access to submit Form/Rate filings to NHID
- NHID has “retaliatory” fee requirements, meaning that issuer’s state of domicile determines whether the issuer submits a filing fee
Filing

- Filings are submitted through SERFF
- Filings must be submitted as a “Form/Rate” Filing type

Components of a Form/Rate Filing

Form Schedule Documents
- Policy
- Certificate
- ID Cards
- Schedule of Benefits
- Outline of Coverage
- Application Form (Off-FFE Only)
- Enrollment Form (Off-FFE Only)

Supporting Documentation
- Compliance Certification
- (Applicable) NHID Filing Checklist
- Certificate of Readability
- Consumer Disclosure Form (New)
- Online Formulary

Forms Due: May 1, 2014
Rates Due: June 1, 2014
Binder

- Binder contain specific QHP content and hyperlinks data from filings
- Instructions on binders: https://login.serff.com/Appendix%20II.pdf

Components of a QHP Binder

<table>
<thead>
<tr>
<th>Associate Schedule Items</th>
<th>QHP Templates*</th>
<th>Supporting Documentation</th>
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</thead>
<tbody>
<tr>
<td>Issuer links documents from form/rate filing</td>
<td>Administrative Data</td>
<td>Network Adequacy Package</td>
</tr>
<tr>
<td>Forms queried from filings by the SERFF tracking number</td>
<td>Plan and Benefits</td>
<td>Compliance Plan/Org Chart</td>
</tr>
<tr>
<td>Forms assigned to specific plans within the binder</td>
<td>Prescription Drug</td>
<td>Program Attestations</td>
</tr>
<tr>
<td></td>
<td>Network</td>
<td>Unified Rate Review Template</td>
</tr>
<tr>
<td></td>
<td>Service Area</td>
<td>Actuarial Memorandum</td>
</tr>
<tr>
<td></td>
<td>Essential Community Providers</td>
<td>Accreditation</td>
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<tr>
<td></td>
<td>Rate Data</td>
<td>Licensure</td>
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<tr>
<td></td>
<td>Rating Business Rules</td>
<td>Cert. of Good Standing</td>
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</tbody>
</table>

Templates Due: June 1, 2014
Binders Transferred to FFM: August 7, 2014

*Changes to templates are expected, additional updates expected mid-April
Helpful Filing Tips

State licensure:
- Issuer licenses are renewed on June 15 of each year—currently during the QHP review period. In order to receive a recommendation for certification, the issuer must re-apply for a license in the State for the next year and provide proof of this application to the Department.
- State license must be provided for the correct company for the filing (HMO product must have HMO license, etc.)

NHID Filing Check Lists
- SADP – Individual and SHOP
- Medical – Individual and SHOP
- Issuers must submit the applicable check list with filings, these check lists are currently under review, with updated versions expected to be posted by March 31 to http://www.nh.gov/insurance/iah/

SERFF, QHP Templates, Supporting Documentation
- In SERFF, select the applicable Type of Insurance (TOI) to the plans submitted (HMO, PPO, POS);
- When associating schedule items in SERFF, the Standard Component ID must be entered exactly as generated by HIOS;
- Both On- and Certified Off-Exchange plans must contain a binder and be submitted through SERFF;
- Plan and Benefits, Prescription Drug, Rates & Unified Rate Review templates/supporting documents must be submitted in .xls format.
- HMO Advertisements must be submitted for approval within its own SERFF filing (Filing Type: Advertisement)

Summaries of Benefits and Coverage
- Issuers offering group or individual health insurance coverage must compile and provide a Summary of Benefits and Coverage (SBC) that accurately describes the benefits and coverage under the applicable plan or coverage.
- While not required to submit separate SBCs to reflect cost-sharing variations for each plan variation, QHP issuers shall create an SBC that represents the base plan and issuers may not combine information about multiple plan variations in one SBC. Issuers are encouraged to create separate SBC’s for each plan variation.
<table>
<thead>
<tr>
<th>NHID Division</th>
<th>Contact</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Office</td>
<td>Roger Sevigny</td>
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<td>Market Conduct</td>
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</tr>
<tr>
<td>LAH Actuarial</td>
<td>David Sky</td>
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<td>Consumer Services</td>
<td>Keith Nyhan</td>
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<td>PCG</td>
<td>Charlie Punches</td>
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</table>
Additional Resources

The NHID will post this presentation and additional related documentation to its website under Federal Health Reform: http://www.nh.gov/insurance/consumers/fedhealthref.htm

We encourage interested parties to regularly to check the Department website for additional guidance and bulletins.