

State of New Hampshire Insurance Department

Issuer Questions & Answers #1

April 18, 2014

This Q&A document contains information from the New Hampshire Insurance Department relating to the processes and policies for applying to offer coverage on the State Health Insurance Marketplace during the 2015 plan year.

Any additional questions should be directed to Michael Wilkey, Director of Compliance and Consumer Services, at Michael.Wilkey@ins.nh.gov.

Q1. Distance for Network Adequacy

Is the Insurance Department using straight-line distance measurements (as-the-crow-flies) to determine distance from providers for its Network Adequacy review?

Answer: Yes, the Insurance Department will be measuring distance from providers using this standard to determine Network Adequacy. Please refer to INS Bulletin 014-10-AB <http://www.nh.gov/insurance/media/bulletins/2014/documents/14-010-ab.pdf>.

Q2. Meaningful Difference

Must issuers explicitly report the means by which plans meet the Meaningful Difference standards?

Answer: Yes, issuers provide the Department a narrative stating meaningful differences between plans. *Note: Please review the updated slides from the March 18 presentation. The Final Rule on Notice of Benefit and Payment Parameters made slight changes to the allowable categories for measuring meaningful difference.*

Q3. Pediatric Dental

In cases where a medical plan covers the pediatric dental benefit, can that plan include a separate out-of-pocket maximum for the pediatric dental benefit, or must the pediatric dental out-of-pocket costs be integrated into the maximum out of pocket for the whole plan?

Answer: A stand-alone dental plan is subject to the separate dental out-of-pocket maximums at the 2015 amounts. If the dental benefit is embedded within a medical plan, then the dental cost accruals are included along with the medical cost accruals in the calculation for the out-of-pocket maximums.

Q4. Stand-Alone Dental

Must stand-alone dental plan issuers file plans with both the high and low Actuarial Values, or can issuers file plans that meet just one of the two stand-alone dental Actuarial Values?

Answer: Issuers of stand-alone dental plans (SADP) are not required to offer plans at both the high and low actuarial values. SADP carriers can offer one or the other, or both the high and the low designs.

Q5. Embedded Dental

Must issuers offering plans with embedded pediatric dental benefits meet the high and low actuarial value standards for that embedded dental benefit?

Answer: The stand alone dental plan's actuarial value requirements do not apply to the embedded dental coverage. When dental benefits are embedded, the actuarial value is determined based on the entire plan design.

Q6. Dates for Filing

Can issuers submit Form and Rate filings at different times?

Answer: Form and Rate filings may be submitted at different times within the same filing, however the filing must be submitted as a Form/Rate filing type. When creating a filing, the issuer may submit the form and bypass the rates portion (if necessary) to be added to the filing at a later date.

Issuers, as well as stand-alone dental issuers wishing to offer plans in the Marketplace, should submit their initial applications, including all form filings, by May 1, 2014. Rate filings must be submitted (attached to the same filing as the forms) by June 1. In order to allow adequate time for review of QHP submissions, the Insurance Department also requires that all SERFF Binders containing Marketplace plans be submitted by June 1, 2014.

Q7. Availability of NH Insurance Department Documents

When will the documents & instructions on how to file be available?

Answer: The Insurance Department has included guidance on filing submission on its website at the following link: <http://www.nh.gov/insurance/iah/index.htm>.

Q8. Consumer Disclosure Form

When will the Consumer Disclosure Form be released?

Answer: Required federal templates and forms will be posted on the CMS zONE and SERFF portals.

Q9. Off-Exchange Plans

Must issuers file binder submissions for Off-Exchange plans?

Answer: Yes, federal requirements state that both On-Exchange and Off-Exchange plans must be filed within the same binder.

Q10. Stand Alone Dental Off-Exchange Binders

Do issuers need to file binder submissions for Off-Exchange stand-alone dental plans?

Answer: Yes, federal requirements state that both On-Exchange and Off-Exchange plans (including stand-alone dental plans) must be filed within the same binder.

Q11. Transfer of Binders to HHS

Which entity is responsible for the final transfer of binders to CMS and the FFM?

Answer: Issuers are required to load certain information electronically through SERFF. The Insurance Department then reviews all binders and transfers them to CMS as recommended for certification and offering on the Marketplace.

Q12. Identification Number

Can issuers use the same Issuer ID numbers as those used in the previous certification period?

Answer: Yes, issuer can use the same issuer ID numbers.

Q13. Unified Rate Review Template

Has the Unified Rate Review Template changed?

Answer: Some templates have undergone minor changes since previous years. Federal templates and supporting documents can be found on the CMS zONE and SERFF portals.

Q14. Timing for Examining Off-Exchange QHP Plans

Is the Insurance Department going to prioritize review of On-Exchange plans over reviewing Off-Exchange Plans?

Answer: Both On-Exchange and Off-Exchange plans must be submitted in the same binder. The Insurance Department will review the contents of an entire binder during its compliance review.

Q15. Templates

Do issuers send the templates to the Department through HIOS?

Answer: No, issuers send data templates to the Insurance Department via SERFF. The Department will transfer from SERFF to HIOS for CMS review.

Q16. Summary of Benefits and Coverage

Must issuers submit the summaries of benefits and coverage as part of the filing?

Answer: Summaries of benefits and coverage are federal forms and must be submitted as supporting documents to the filing. Accurate data reflective of the plan design data must be provided in the summaries; these summaries must be no longer than 8 pages.

Q17. Summary of Benefits and Coverage

Summaries of benefits and coverage were not required in the previous year for stand-alone dental plans, will they be required for dental plans this year?

Answer: No, summaries of benefits and coverage are not required for stand-alone dental plans.

Q18. Template File Format

Must templates be submitted to the Department in .xls/.xlsx format or in .xml format?

Answer: Templates must be saved in .xml format to be validated in SERFF, however the Department must also receive these templates in .xls/.xlsx format to perform their reviews of these templates. Issuers must submit templates in both formats through SERFF.

Q19. Type of Insurance

Must separate Types of Insurance (e.g. POS and HMO plans) be submitted in separate filings?

Answer: Yes separate Types of Insurance require separate Form and Rate filings with unique SERFF tracking numbers.

Q20. Summary of Benefits and Coverage Template

Is CMS making changes to the summary of benefits and coverage template that they did last year?

Answer: Some templates have undergone minor changes since previous years. Federal templates and supporting documents can be found on the CMS zONE and SERFF portals.

Q21. Grace Period

Is the Insurance Department giving guidance on advanced premium tax credit members and their three month grace period?

Answer: State law allows a 31 day grace period for medical plans. The Insurance Department will follow the federal guidance on the allowable grace period for advanced premium tax credit recipients.

Q22. Network Adequacy

Is the Insurance Department planning to make changes to its network adequacy rules (INS 2701)?

Answer: The Department is looking to further examine its Network Adequacy standards in 2014-2015. The Department will be reaching out to issuers, providing documents for discussion and beginning the process of looking at current standards in the coming months.

Q23. Binders for Off-SHOP Filings

Must Off-SHOP plans be submitted at the same time as On-SHOP plans?

Answer: Yes, federal requirements state that both On-Exchange and Off-Exchange plans (including small group plans) must be filed within the same binder.

Q24. Minimum Variability

Are issuers permitted to use minimal variability in their schedules of benefits?

Answer: No variability is allowed within these schedules. Each schedule of benefits can apply to only one metal level.

Q25. Separate On-Exchange and Off-Exchange Templates

Do issuers need to submit separate templates for plans on the Exchange and those off the Exchange?

Answer: Issuers must submit one template for all plans, both on and off the Exchange, except for grandfathered plans.

Q26. SHOP Stand-Alone Dental

Can employers offering stand-alone dental benefits to their employees pick a variety of plan offerings at a metal level, or must they offer every offering at the metal level?

Answer: Employers in the FF-SHOP may offer either a single stand-alone dental plan to employees or a single coverage level (high or low) with all plans within that level made available to employees. This policy was finalized on pages 13838-13839 in the 2015 Payment Notice available by clicking on this link: <http://www.gpo.gov/fdsys/pkg/FR-2014-03-11/pdf/2014-05052.pdf>

Q27. SHOP Waiver

Can only State-Based Marketplaces apply for the “SHOP waiver”, or is the waiver open to Partnership Marketplaces as well?

A: The [proposed] Summary of Exchange and Insurance Marketplace Standards for 2015 & Beyond states that CMS will “allow State departments of insurance to recommend that, in 2015, a SHOP not provide employers with the option of selecting a level of coverage as described in section 1302(d)(1) of the Affordable Care Act, and making all QHPs at that level of coverage available to their employees if making that option available would result in significant adverse selection in the State’s small group market resulting in market disruptions that could not be addressed by the premium stabilization programs or single risk pool, or if there would be insufficient issuers of qualified health plans or qualified stand-alone dental plans to allow for meaningful choice among plans.”

It is unclear at time, as this is a proposed regulation, what the process to recommend and what the standard will be to demonstrate “market disruption.” CMS at this time has indicated they “will be accepting comments from states and interested parties who wish to submit public comments during the comment period.

Q28. Benefit Design

Can plan designs establish a visit threshold after which a deductible applies?

Answer: Yes. Thresholds can be established based on a number of visits provided visits being counted are consistent between primary or specialty categories and do not discriminate based on types of service.