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BULLETIN
Docket No.: INS 13-007-AB

TO: All New Hampshire Licensed Health Carriers and Dental Insurers

FROM: Roger A. Sevigny
Insurance Commissioner

DATE: April 10, 2013

RE: Qualified Health Plan Certification Process in New Hampshire

New Hampshire Qualified Health Plan Certification Bulletin to Issuers – 2014 Plan Year

The purpose of this Bulletin is to detail the process issuers must follow in New Hampshire to have their non-grandfathered individual and small group health plans certified as Qualified Health Plans (QHPs) eligible to be offered in the New Hampshire Health Insurance Marketplace for October 1, 2013 open enrollment and January 1, 2014 effective date coverage.

New Hampshire has chosen to enter into a plan management partnership with the Federally Facilitated Exchange that will be established for New Hampshire, which will be known as the New Hampshire Health Insurance Marketplace, or New Hampshire Marketplace. To be certified as a QHP on the New Hampshire Marketplace, issuers and their health plans must meet all applicable federal and state statutory requirements and standards. Operating in partnership with the US Department of Health and Human Services (HHS), the New Hampshire Insurance Department (NHID) will review and recommend certification of QHPs to the HHS Center for Consumer Information and Insurance Oversight (CCIIO), which will have the opportunity to ratify the certification recommendation.

The New Hampshire Insurance Commissioner "is charged with the rights, powers, and duties pertaining to the enforcement and execution of the insurance laws" of New Hampshire. NH RSA 400-A:3. The Commissioner has general rulemaking and enforcement authority with respect to regulation of the business of insurance in New Hampshire. NH RSA 400-A:15 and 16. Under New Hampshire law, the Insurance Department regulates health insurance carrier licensing (NH RSA chapter 420-A and NH RSA chapter 420-B) and solvency (NH RSA 400-A:36-37), reviews health insurance policy forms, rates, and benefit design (NH RSA chapter 415, NH RSA chapter 420-G), monitors health insurance marketing practices, network adequacy and treatment of consumers (NH RSA chapter 420-J), and has authority to take enforcement action with respect to violations of health insurance regulatory standards (NH RSA 415:20, NH RSA 420-G:16, NH RSA 420-J:14) and unfair trade practices (NH RSA chapter 417).

The Department has adopted many administrative rules that are applicable to some or all health insurance plans and issuers. These include: N.H. Code of Administrative Rules Chapter Ins 200 (Practices and Procedures); Chapter Ins 400 (Filings for Life, Accident and Health Insurance); Part Ins 1001 (Claim Settlement for all Insurers, Except Property and Casualty); Chapter Ins 1900 (Accident and Health Insurance); Chapter Ins 2000 (Medical Utilization Review Entities); Chapter Ins 2200 (Health

Maintenance Organizations); Chapter Ins 2400 (Actuarial Opinion and Memorandum); Part Ins 2601 (Advertisements of Accident and Health Insurance); Chapter Ins 2700 (Managed Care, including Ins Part 2701, Network Adequacy, Ins Part 2702, Parity In Mental Health And Substance Use Disorder Benefits, and Ins Part 2703, External Review); Chapter Ins 3000 (Privacy of Consumer Financial and Health Information); Chapter Ins 3700 (Standards for Safeguarding Customer Information); Chapter Ins 4000 (Uniform Reporting System For Health Care Claims Data Sets); and Chapter Ins 4100 (Requirements For Accident And Health Insurance Rate Submissions).

In reviewing proposed QHPs, the NHID will apply all state regulatory standards except those that are inconsistent with and would prevent the application of federal law. The Affordable Care Act (ACA) establishes the legal authority for QHP certification as well as other operational standards for the Marketplace in the following sections: 1301-1304, 1311-1312, 1321-1322, 1324, 1334, 1401-1402, 1411, and 1412. Federal standards for QHP issuers are codified in 45 CFR 155 and 156. With respect to QHP-specific standards, the New Hampshire Insurance Commissioner has authority to adopt and apply standards consistent with the Affordable Care Act "for form and rate review of insurance products and any other regulatory oversight functions performed by the department." NH RSA 420-N:5, IV. Adoption and application of such standards requires prior approval of the Joint Health Care Reform Oversight Committee under NH RSA 420-N:4, II. The Department received approval to use the standards in this bulletin on April 9, 2013, with the caveat that changes may be made to the bulletin if necessary to conform with the terms of a Memorandum of Understanding between the state and CCIIO.

Health insurance issuers wishing to offer plans in the New Hampshire Marketplace may submit their applications with included rate and form filings between April 10, 2013 and June 1, 2013. Stand alone dental issuers may begin submitting their applications under the same timeframe; however, data templates specific to stand alone dental plans will not be available in SERFF until May 15, 2013. Specific timelines for the QHP certification process are detailed below. Any plan that is not certified under this timeline will be ineligible to be offered in the New Hampshire Marketplace during plan year 2014.

Although New Hampshire has already requested that issuers notify the Department of their intent to participate in the certification process by March 28, 2013, issuers that have not yet made this declaration may still make an application according to the timelines laid out in this Bulletin. Plans will be reviewed in the order received, with priority given to plans submitted by carriers who filed letters of intent.

The timeline for the QHP certification process in New Hampshire will be as follows:

March 28, 2013: Carriers notify NHID of intent to participate in the Marketplace.

April 15, 2013: Health issuers and stand alone dental plans wishing to participate in the Marketplace may begin to submit QHP and company applications.

May 15, 2013: Data templates supporting stand-alone dental plan filings available in SERFF.

June 1, 2013: Final date for QHP submission, including stand-alone dental plans.

July 31, 2013: Final date for NHID to submit certification recommendations for QHP issuers and QHPs to CCIIO.

Spring – Fall 2013: Non-Marketplace health and dental plans may be filed. Please provide enough time for state review pending planned marketing for 2014 plan year.

Late August 2013: Plan Preview Period - CCIIO will give health and dental issuers applying for Marketplace certification an opportunity to address any data errors. However, CCIIO has noted that any changes made to plans during this time period may jeopardize certification.

Early September 2013: CMS will notify issuers of the QHP Certification decision and negotiate certification agreements with carriers.

October 1, 2013 – March 31, 2014: Marketplace is open for annual enrollment.

All filings must be made within the System for Electronic Rate and Form Filings (SERFF). Individual and small group filings must be submitted using different SERFF tracking numbers. Insurers may contact the Health Insurance Oversight System (HIOS) to receive their Marketplace Issuer and Plan Identification numbers. Additional training for HIOS may be offered. More information is available at http://www.regtap.info.

Starting in March, insurers may begin registering for training with SERFF to learn how to submit filings and utilize Qualified Health Plan(QHP) Templates. This training is expected to last through April, 2013. Information can be found at http://www.serff.com/hix.htm.

The following table provides citations of federal law and the Code of Federal Regulations (CFR) that establish the certification criteria for qualified health plans (QHPs) for specific substantive areas, followed by an explanation of the Department's planned approach to conducting review to determine whether applicable requirements are met.

General Requirements	
Federal Standard 45 CFR 155 and 156 45 CFR 156.20 42 USC §18021 42 USC §18022 42 USC §18031 CMS Guidance Rules ACA §1311 ACA §1002	A QHP issuer must— (1) Comply with all certification requirements on an ongoing basis; (2) Ensure that each QHP complies with benefit design standards; (3) Be licensed and in good standing to offer health insurance coverage in New Hampshire; (4) Implement and report on a quality improvement strategy or strategies consistent with the standards described within the ACA, disclose and report information on health care quality and outcomes as will be later defined by the Centers for Medicaid and Medicare Services (CMS), and implement appropriate enrollee satisfaction surveys as required by the ACA; (5) Agree to charge the same premium rate for each QHP of the issuer without regard to whether the plan is offered through the Marketplace or whether the plan is offered directly from the issuer or through an agent; (6) Pay any applicable user fees assessed; (7) Comply with the standards related to the risk adjustment program administered by CMS; (8) Notify customers of the effective date of coverage; (9) Participate in initial and annual open enrollment periods, as well as special open enrollment periods; (10) Collect enrollment information, transmit it to the Marketplace and reconcile enrollment files with the Marketplace enrollment files monthly; (11) Provide and maintain notices of termination of coverage. A standard policy must be established and include a grace period for certain enrollees that is applied uniformly. Notice of payment delinquency must be provided; (12) Segregate funds for services for which Federal funding is prohibited under section 1303 of the ACA, if the QHP covers such services; (13) Timely notify the Marketplace if it plans not to seek recertification, and in such

	event fulfill coverage obligations through the end of the plan/benefit year, fulfill data reporting obligations from the last plan/benefit year, provide notice to enrollees, and terminate coverage for enrollees, providing written notice; (14) In the event that the QHP becomes decertified, terminate coverage only after notification of enrollees and after enrollees have had an opportunity to enroll in other coverage; and (15) Meet all readability and accessibility standards.
New Hampshire Insurance Department Certification Procedure	NHID will review rates, forms and QHP application filings. For QHPs that meet applicable standards, NHID will recommend certification. At least one carrier has notified NHID of its intent to offer a stand-alone dental QHP on the Marketplace. Therefore, NHID will not require QHP issuers to include pediatric dental benefits in their non-grandfathered individual and small group plans.
Licensure and Solvency	
Federal Requirements 45 CFR 156.200	A QHP issuer must be licensed and in good standing with the State.
New Hampshire Insurance Department Certification Procedure	In order to be considered "in good standing" and to offer a QHP through the Marketplace, a QHP issuer must have unrestricted authority to write its authorized lines of business in New Hampshire. NHID is the sole source of a determination of whether an issuer is in good standing. An issuer will be allowed to apply for New Hampshire licensure and QHP issuer and plan certification simultaneously during the first QHP certification cycle; however, a QHP issuer may not be certified for participation in the Marketplace until state licensure has been established.
Network Adequacy	
Federal Standard 45 CFR 156.230 45 CFR 156.235 Public Health Services Act (PHS) §2702(c)	A QHP issuer must ensure that the provider network of each of its QHPs is available to all enrollees and: (1) (a) Includes essential community providers (ECP) in sufficient number and geographic distribution where available to ensure reasonable and timely access to a broad range of such providers for low income and medically underserved individuals in QHP service areas. This must be done by demonstrating one of the following during the first year of the Marketplace: • That the issuer achieved at least 20% ECP participation in network in the service area, agreed to offer contracts to at least 1 ECP of each type available by county; • That the issuer achieved at least 10% ECP participation in the network service area and submits a satisfactory narrative justification as part of its issuer application; or • That the issuer failed to achieve either standard but submitted a satisfactory narrative justification as part of its issuer application.

	OR (b) If an issuer provides a majority of covered services through employed physicians or a single contracted medical group complying with the alternate ECP standard identified within federal regulations, the issuer must verify one of the following: • That the issuer has at least the same number of providers located in designated low income areas as the equivalent of at least 20% of available ECPs in the service area; • That the issuer has at least the same number of providers located in designated low income areas as the equivalent of at least 10% of available ECPs in the service area, and submits a satisfactory narrative justification as part of its issuer application; or • That the issuer failed to achieve either standard but submitted a satisfactory narrative justification as part of its issuer application. (2) Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder treatment services, to assure that all services will be accessible without unreasonable delay; and (3) Makes its provider directory for a QHP available to the Marketplace for publication online in accordance with guidance from the Marketplace and to potential enrollees in hard copy upon request noting which providers are not accepting new patients.
New Hampshire Insurance Department Certification Procedure	Issuers of medical QHPs must comply with New Hampshire Code of Administrative Rules Part INS 2701 (Network Adequacy). The Department's specific approach to this review will be as follows: 1. An adequacy report must be made, or on file, pursuant to Part INS 2701. The Department will accept and review changes to previously filed adequacy reports. 2. The issuer must submit an attestation that the network is in compliance with the essential community provider requirements. 3. Issuers shall make their provider directory available for online publication and in print as requested. 4. Mental Health network adequacy is also required. Issuers of stand-alone dental plans must submit an adequacy report demonstrating that their network has sufficient numbers and types of providers to assure that all services will be accessible without unreasonable delay.
Accreditation	
Federal Standard 45 CFR 156.275 45 CFR 155.1045	QHP issuers must maintain accreditation on the basis of local performance in the following categories by an accrediting entity recognized by HHS: Clinical quality measures, such as the HEDIS; Patient experience ratings on a standardized CAHPS survey; Consumer access; Utilization management; Quality assurance; Provider credentialing; Complaints and appeals; Network adequacy and access; and Patient information programs. Existing commercial or Marketplace health plan accreditation from HHS-recognized

	accrediting entities will be accepted. For the purposes of QHP issuer certification in 2013, these are the National Committee for Quality Assurance (NCQA) and URAC. QHP issuers without existing commercial or Marketplace health plan accreditation from HHS-recognized accrediting entities must schedule an accreditation review during their first year of certification and receive accreditation on QHP issuer policies and procedures prior to their second year of QHP issuer certification. Prior to the QHP issuer's fourth year of QHP issuer certification and annually thereafter, a QHP issuer must be accredited in accordance with 45 CFR 156.275 QHP issuers will be required to authorize the release of their accreditation survey data and any official correspondence related to accreditation status to NHID.
New Hampshire Insurance Department Certification Procedure	NHID will follow federal requirements related to accreditation and will require an authorization from the issuer for the release of all accreditation data upon request from NHID. Additionally, NHID will require an attestation by QHP issuers not already accredited that those QHP issuers will schedule, become accredited on policies and procedures in the plan types used, and provide proof of such accreditation on policies and procedures prior to submission of any application for recertification. The QHP issuer must also indicate that it will receive and provide proof of receipt of full Marketplace accreditation prior to its third recertification application.
Service Area	
Federal Standard 45 CFR 155.30 & 155.70	Service area is the geographic area in which an individual must reside or be employed in order to enroll in a QHP. A QHP issuer must specify what service areas it will be utilizing. The service area must be established without regard to racial, ethnic, language or health status related factors or other factors that exclude specific high utilization, high cost or medically underserved populations.
New Hampshire Insurance Department Certification Procedure	NHID will allow the QHP issuers to choose their service area(s), except that requested service areas may not be smaller than a county.
Rating Area	
Federal Standard 45 CFR §156.255	As it applies to QHPs, the ACA defines a "Rating Area" as a geographic area established by a state that provides boundaries by which issuers can adjust premiums. The ACA requires that each state establish one (1) or more rating areas within that State for purposes of applying the requirement of this title.
New Hampshire Insurance Department Certification Procedure	Present New Hampshire law prohibits geographic rating in the individual and small group markets. In addition, HB 668, which is now pending in the New Hampshire legislature, would establish a single rating area for QHP certification for 2014. Prospective QHP issuers should proceed under the assumption that they will not be able to vary premiums by regions within the state in 2014.
Quality Improvement Standards	
Federal Standard 45 CFR 156.20 ACA §1311 ACA §2717	A QHP issuer must implement and report on a quality improvement strategy or strategies consistent with standards of the ACA to disclose and report information on healthcare quality and outcomes and implement appropriate enrollee satisfaction surveys which include but are not limited to the implementation of: • A payment structure for health care providers that provides incentives for

	improving health outcomes through the implementation of activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage; • Activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and cost discharge reinforcement by an appropriate health care professional; • Activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage; • Wellness and health promotion activities; and • Activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings.
New Hampshire Insurance Department Certification Procedure	NHID will require all QHP issuers to report on the implementation of their quality improvement standards. The carrier shall submit an attestation of intent to comply with all regulatory guidelines issued by HHS relating to quality improvement standards.
General Offering Requirements	
Federal Standard 45 CFR 155 and 156 45 USC §18022 45 C.F.R. § 156.130(a) 45 CFR §147.126 45 CFR §147.120 45 CFR §147.138 CMS Guidance Rules	A QHP issuer must offer at least one QHP at the silver coverage level and at least one QHP at the gold coverage level, along with and a child-only plan at the same level of coverage as any QHP offered through either the individual Marketplace or SHOP to individuals who, as of the beginning of the plan year, have not attained the age of 21. Additionally, a catastrophic plan may be filed to be sold on the Marketplace in addition to the tiered metal levels. All offerings by a QHP issuer, excluding stand-alone dental issuers, on a single metal tier must show a meaningful difference between the plans and comply with standards in the best interest of the consumer. Moreover, the QHP, excluding stand-alone dental, must provide coverage for dependents up to age 26 if the Plan offers dependent coverage. Pediatric dental and vision services must be covered for dependents up to age 19. Additionally, the QHP must cover emergency services with no prior authorization, no limitation to participating or in-network providers. Emergency services must be covered at the in-network cost-sharing level. QHP issuers will be required to meet all annual limitation and cost sharing requirements without affecting the actuarial value of the plans within each of the tiers. The QHP issuer must demonstrate in an Exhibit filed with the plan that annual out of pocket cost sharing under the plan does not exceed the limits established by federal and state laws and regulations. Moreover, the QHP must contain no lifetime limits on the dollar value of any Essential Health Benefits (EHB), including the specific benefits and services covered under the EHB-Benchmark Plan.

	Catastrophic plans can be sold to individuals who have not attained the age of 30 before the beginning of the plan year, or to an individual who has a certification in effect for any plan year that the individual is exempt from the Shared Responsibility Payment by reason of lack of affordable coverage or hardship. If offered, catastrophic plans are offered only in the individual Marketplace and **not** in the SHOP. A QHP issuer must comply with all federal and state laws related to rating rules, factors and tables used to determine rates. Such rates must be based upon the analysis of the plan rating assumptions and rate increase justifications in coordination with NHID.
New Hampshire Insurance Department Certification Procedure	Issuers must comply with all federal and state laws related to rating rules, factors and tables used to determine rates. The Department will post a revised checklist on its website integrating state and federal rate and form filing requirements.
Essential Health Benefit Standards	
Federal Standards 45 CFR 156.115 42 U.S.C. § 18022 45 CFR §147.130 45 CFR §148.170 45 CFR §155.170 45 CFR §156.110 45 CFR §156.125	The QHP issuer must offer coverage that is substantially equal to the coverage offered by the state's base benchmark plan. This may be done by substituting benefits within EHB categories only if the QHP issuer demonstrates actuarial value of the substituted benefits. Services for which federal funding is prohibited under section 1303 of the ACA are subject to financial segregation requirements; the QHP issuer must provide notice through its summary of benefits if such coverage is being made available. The QHP must cover preventive services without cost sharing requirements including deductibles, co-payments, and co-insurance. Covered preventive services include evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF); certain immunizations, screenings provided for in HRSA guidelines for infants, children, adolescents, and women (including compliance with standards related to benefits for and current recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention). Additionally, coverage for the medical treatment of mental illness and substance use disorder must be provided under the same terms and conditions as that coverage provided for other illnesses and diseases.
New Hampshire Insurance Department Certification Procedure	New Hampshire has adopted the Matthew Thornton Blue Plan as the Base Benchmark Plan to set the essential health benefits for New Hampshire. The U.S. DHHS has supplemented the Matthew Thornton Blue Plan with the Federal Employee Dental and Vision Insurance Plan (FEDVIP) for pediatric dental and vision benefits, and has determined that habilitative services are already included in New Hampshire's base benchmark plan. Carriers must comply with the Mental Health Parity and Addiction Equity Act (MHPAEA) requirements.
Essential Health Benefit Formulary Review	
Federal Standards 45 CFR 156.120 45 CFR §156.295	The QHP must cover at least the greater of one drug in every U.S. Pharmacopeial Convention (USP) category and class or the same number of drugs in each category and class as the base benchmark plan. Issuers must report data such as the following to U.S. DHHS on prescription drug distribution and costs (paid by Pharmacy Benefit Management (PBM) or issuer): Percentage of all prescriptions that were provided through retail pharmacies compared

	to mail order pharmacies; percentage of prescriptions for which a generic drug was available and dispensed compared to all drugs dispensed, broken down by pharmacy type; Aggregate amount and type of rebates, discounts or price concessions that the issuer or its contracted PBM negotiates that are attributable to patient utilization and passed through to the issuer; Total number of prescriptions that were dispensed; Aggregate amount of the difference between the amount the issuer pays its contracted PBM and the amounts that the PBM pays retail pharmacies, and mail order pharmacies.
New Hampshire Insurance Department Certification Procedure	NHID will require an attestation of compliance with EHB Formulary Standards.
Non-Discrimination Standards in Marketing and Benefit Design	
Federal Standard 45 CFR 156.125 45 CFR 156.200 45 CFR 156.225 45 FR 155.1045 42 U.S.C. § 300gg-3 45 CFR §148.180	(1) A QHP issuer must: • Be able to pass a review and an outlier analysis or other automated test to identify possible discriminatory benefits; and • Refrain from: o Adjusting premiums based on genetic information; o Discriminating with respect to its QHP on the basis of race, color, national origin, disability, age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, sex, gender identity, sexual orientation or other health conditions; o Utilizing any preexisting condition exclusions; o Requesting/requiring genetic testing; or o Collecting genetic information from an individual prior to, or in connection with enrollment in a plan, or at any time for underwriting purposes. (2) A QHP issuer may not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs.
New Hampshire Insurance Department Certification Procedure	QHP issuers and QHPs must comply with state laws and regulations regarding marketing by health insurance issuers. QHP issuers may inform consumers in QHP marketing materials that the QHP is certified by the Marketplace. The QHP issuer may not inform consumers that the certification of a QHP implies any form of further endorsement or support of the QHP. NHID will require prior approval of QHP marketing material and an attestation that the QHP issuer meets all marketing standards. If NHID determines through its regulatory efforts that unfair or discriminatory marketing is occurring, NHID will enforce through use of state remedies and will recommend the QHP for decertification.
Actuarial Value Standards	

Federal Standards 45 CFR 156.135	Plans being offered at the various metal tiers within the Marketplace must meet the specified levels of actuarial value (or fall within the allowable variation): Bronze plan: 60% (58 to 62%) Silver plan: 70% (68 to 72%) Gold plan: 80% (78 to 82%) Platinum plan: 90% (88% to 92%) Stand-alone dental plans must offer plans at either a 70% or 85% actuarial value level (also within the allowable ± 2% variations). Percent of actuarial value means the share of total plan costs that would, on average across the entire benefit, be paid by the plan and not the member.
New Hampshire Insurance Department Certification Procedure	NHID will require issuers to submit the completed actuarial value calculator provided by CCIIO to verify compliance with AV standards. NHID will also require issuers to submit an actuarial certification. The actuary shall certify that either the AV calculator accommodated the plan design or specify the methodology used to accommodate the plan for calculation purposes. In the event accommodation was necessary, the actuary shall certify that such accommodations were in accordance with generally accepted actuarial principles and practices. See Federal Register, Vol. 78, Number 37, February 25, 2013, p. 12844 for further detail.
Quality Rating Standards	
Federal Standard 45 CFR §156.265 (b)(2) 45 CFR §156.265 (f); 45 CFR §156.400 (d) 45 CFR §156.285 (c) PHSA 2794	HHS intends to propose a phased approach to new quality reporting and display requirements for all Marketplaces with reporting requirements related to all QHP issuers expected to start in 2016. HHS intends to support the calculation of the QHP-specific quality rating for all QHP issuers in all Marketplaces. The results of such surveys and rating will be available to consumers. HHS intends to issue future rulemaking on quality reporting and disclosure requirements. The carrier shall submit with its application an attestation to comply with all regulatory guidelines issued by HHS by the date of certification. QHP issuers must also provide plain language information/data on claims payment policies and practices, periodic financial disclosures, data on enrollment and disenrollment, number of denied claims, rating practices, cost-sharing and payments for out-of-network coverage, and enrollee rights must be submitted to the Marketplace, HHS, and the state insurance commissioner.
New Hampshire Insurance Department Certification Procedure	NHID will address the issue of Quality Rating Standards after the federal guidance has been issued.
Rate Filing	
Federal Standard	Under the ACA, premiums may be varied by geographic rating area, but premium rates must be the same inside and outside the Marketplace. • Rating will be allowed on a per member basis. • ACA: premium rate may vary only by individual/family, rating area, age (3:1), and tobacco use (1.5:1) • All rates filed for individual QHPs will be set for an entire benefit/plan year. States have authority to further limit the variables by which issuers may vary premium

	rates, so long as the state does not add additional rating factors or exceed the ratios set by federal law.
New Hampshire Insurance Department Certification Procedure	NHID will continue to effectuate its rate review program, inclusive of federal rating standards and state specific standards, and will review all rate filings for prior approval. Final rating rules are currently being deliberated by New Hampshire's General Court via HB 668. For more info on the status of this bill, visit http://www.gencourt.state.nh.us/legislation/2013/HB0668.html NHID will accept any rate filing that complies with the bill's current text. Carriers shall monitor this bill and amend their rates, if necessary, to accommodate statutory changes. Rate filing information must be submitted to NHID prior to the implementation of said rates.
Plan Variations for Individuals Eligible for Cost Sharing	
Federal Standard 45 CFR §155.1030 45 CFR §156.420	Each QHP issuer must offer three silver plan variations for each silver QHP, and one zero cost sharing plan variation and one limited cost sharing plan variation for each metal level QHP. Silver plan variations must have a reduced annual limitation on cost sharing, cost sharing requirements and AVs that meet the required levels within a de minimis range. Benefits, networks, non-EHB cost sharing, and premiums cannot change. All cost sharing must be eliminated for the zero cost sharing plan variation. Cost sharing for certain services must be eliminated for the limited cost sharing plan variation. This will be completed via rate and benefit templates.
New Hampshire Insurance Department Certification Procedure	NHID will require an attestation of compliance with Plan Variation Standards.

For questions regarding this bulletin, contact Michael Wilkey or Sonja Barker at 603-271-2261 or email at michael.wilkey@ins.nh.gov or sonja.barker@ins.nh.gov.