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BULLETIN
Docket No.: 20-018-AB

TO: All New Hampshire Licensed Health and Dental Insurers
FROM: Insurance Commissioner C.R.N
DATE: April 3, 2020
RE: 2021 Plan Year Issuer Guidance

I. Introduction

The purpose of this Bulletin is to detail the process which issuers must follow in New Hampshire to have their non-grandfathered individual and small group health plans certified as Qualified Health Plans (QHPs) to be offered on the federally-operated New Hampshire Health Insurance Marketplace (Marketplace) for calendar year/Plan Year 2021 as well as the standards that apply to QHPs and individual and small group plans offered on and off the Marketplace. Issuers should note that the Bulletin reflects the guidance set forth in the proposed Notice of Benefit and Payment Parameters for 2021 (NBPP) and the draft 2021 Letter to Issuers in the FFM (Letter) but is subject to revision for further state and federal guidance.

In April 2013, New Hampshire was approved by the US Department of Health and Human Services (HHS) to perform plan management functions with respect to the federally-operated Marketplace. To be certified as QHPs on the Marketplace, issuers and their health plans must meet all applicable federal and state statutory requirements and standards. The New Hampshire Insurance Department (NHID or the Department) will review and recommend certification of QHPs to the HHS Center for Consumer Information and Insurance Oversight (CCIIO), which will have the sole authority to ratify the certification recommendations.

If an issuer is planning to introduce a new product or network in Plan Year 2021, they are strongly urged to contact the Department as soon as possible, but no later than the initial filing deadline in May. Issuers should provide notice to Jason Dexter at the New Hampshire Insurance Department, Jason.G.Dexter@ins.nh.gov or by phone at (603) 271-3041.

Individual and small group plans to be offered off the Marketplace must also meet certain QHP standards for benefit and rate approval and are subject to filing deadlines set forth in this Bulletin and in accordance with CMS key dates for certification. Large group plans should familiarize themselves with the guidance set forth in this Bulletin to ensure compliance with applicable policies and provisions included herein.

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II. Legal Authority

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 under NH RSA chapter 400-A:3. The Commissioner has general rulemaking and enforcement authority with respect to regulation of the business of insurance in New Hampshire under NH RSA 400-A:15 and 16. Under New Hampshire law, the Insurance Department regulates health insurance carrier licensing (NH RSA 400-A; NH RSA chapter 402; NH RSA 420-A and NH RSA 420-B) and solvency (NH RSA 400-A:36-37), reviews health insurance policy forms and benefit design (NH RSA chapter 415, NH RSA 420-G), exercises prior approval authority over rates (NH RSA 415:1), monitors health insurance marketing practices, network adequacy and treatment of consumers (NH RSA 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 federal Affordable Care Act (ACA) establishes the legal authority for QHP certification as well as other operational standards, codified in 45 CFR 155 and 156. To ensure full compliance with the ACA, issuers shall consult and comply with all applicable federal regulations, including, but not limited to 45 CFR Subtitle A, Subchapter B, and the NBPP and the Letter. Federal regulatory and guidance materials are available here.

The Department has issued several bulletins addressing legal requirements that are applicable to individual and small group coverage in New Hampshire and interpreting the interplay between state law and ACA requirements. Issuers are responsible for reviewing and complying with all standards laid out in Department bulletins.

These bulletins include, but are not limited to, the following:

- Registration of all Pharmacy Benefit Managers
- SB 11- Coverage and Reimbursement for Emergency Room Boarding
- HB 1809-New Hampshire Balance Billing and Network Adequacy Laws
- 2020 Plan Year Issuer Guidance
- Short Term Limited-Duration Insurance
- 2019 Plan Year Issuer Guidance
- Off-cycle Filing of Small Group Plans and Products
- Guidance on Annual Notice of Consumer Rights and Access to Out of Network Services
- Product Discontinuance v. Market Withdrawal
- Guidance on Newborn Coverage
- Coverage of Preventive Health Services under the Patient Protection and Affordable Care Act
- Large and Small Group Coverage for 2016
- Guidance on Federal Group Size Amendment, Including REVISED Guidance on Application of Extended Transition to Individual and Group Policies and Employee Counting
- Guidance on Administration of Autism Benefits
- Transparency in Provider Network Directory and Formulary

- Auto Enrollment for Pediatric Dental
- Market Rules Guidance
- Network Based Hospital Services

III. Procedures and Timelines

Health insurance issuers, as well as stand-alone dental issuers requesting certification from CMS, must submit their initial applications (including all state-required templates, submissions, and form filings) with initial rate filings and binder submissions no later than May 10, 2020. Issuers are permitted to file a rate template as a placeholder on or by the initial filing date (5/10) and will be allowed to update the template prior to the initial rate filing deadline. Initial rate submissions must be finalized by July 1, 2020 and final rate submissions are due by July 15, 2020. Off-exchange only form and rate filings are due by July 1, 2020.

The NHID will link to the CMS website where proposed rate increases subject to state review will be posted on or around August 19, 2020 based on CMS preparedness. The NHID will complete all reviews and make recommendations for certification by August. Specific timelines for the QHP certification process are attached hereto as Appendices I and II. Any plan that is not certified under this timeline will be ineligible to be offered in the Marketplace during Plan Year 2021. Petition to the Centers for Medicare & Medicaid Services (CMS) is required for changes to service area after initial submission. For more information, please see INS-18-006-AB Off-cycle Filing of Small Group Plans and Products. Individual products not certified during the QHP process cannot be offered in Plan Year 2021.

A. SERFF Filing Procedures

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. Issuers should also contact the Health Insurance Oversight System (HIOS), operated by CCIIO, to receive their Marketplace Issuer and Plan Identification numbers. More information about HIOS, including training opportunities, is available at https://www.regtap.info. Each issuer should submit no more than one binder per market product - one individual binder and one Small Business Health Options Program (SHOP) binder, inclusive of both on and off Marketplace plans. It is important for issuers to be aware that additional plans **cannot** be added to a QHP binder after it is submitted in SERFF. Additional plans, including cost-sharing reduction plan variations, would require a withdrawal and a complete resubmission of the QHP binder. A complete set of associated documents needs to be submitted for each plan under the "Associate Schedule Items" tab contained in the SERFF Plan Management functionality. In no event may a plan be added after the initial CMS transfer date of June 17, 2020.

For Plan Year 2021, the NHID will require an attestation from issuers that all CMS QHP tools have been run and errors resolved prior to submission of data templates and **each time** an issuer makes a subsequent change that results in a change to the plan and benefit template or would result in the Department having to re-run the compliance tools. NHID will require the state-generated attestation form at the time of filing, and submissions will not be reviewed

until such time as attestations are received noting satisfactory results. If issuers receive an "unmet" when running a tool but believe they are still compliant, they must submit the Excel tool's results tab and add an "explanations" column for their justification. Both the attestation form and Excel spreadsheet must be uploaded to the Supporting Documents tab in the binder.

Issuers are urged to follow the guidelines and requirements in the applicable NHID filing checklists prior to submitting forms for review. Updated checklists (individual major medical/small group major medical) for 2021 can be found here.

Issuers are urged to consult Bulletin INS-17-048-AB for guidance related to the Annual Notice of Consumer Rights and Access to Out-of-Network Services ("annual notice"). For 2021, the annual notice must be filed under Supporting Documents in the QHP submission for all QHPs and SADPs. This annual notice must be sent to policyholders in the individual, small, and large group at the time of issuance of a new policy or at the renewal of a policy. More generally, issuers should consult the NHID Medical Issuer Master List to ensure all required materials are filed correctly in the filing and/or binders in SERFF.

B. Rate Filing Procedures

Issuers are urged to consult the Plan Year 2018 Rate Filing Guidance issued by the Department on April 1, 2017 for the full details of rate filing requirements, but, as in past years, issuers shall price their products incorporating their own assessment regarding cost sharing reduction (CSR) funding or the lack thereof.

New Hampshire has submitted a Section 1332 State Relief and Empowerment Waiver application, seeking a waiver and pass-through funding to allow the state to implement a reinsurance program ("Program") in the individual market. For Plan Year 2021, individual market issuers will be required to file two sets of rates and include explanation of such rate assumptions in the 2021 actuarial memorandum for all plans eligible for participation in the Program.[1] Issuers should submit the following: a "with waiver" rate template that factors in the estimated impact of Program payments on rates and a "without waiver" rate template (into the Supporting Documentation tab) that shows the anticipated rates if there were no Program or Program payments. For PY 2021, the *with waiver* rates must be reflective of the insurer's estimated actuarial impact that the Program will have on the insurer's plan(s) for the upcoming benefit year. It is anticipated that federal approval of the NH Section 1332 Waiver application will occur prior to final certification of 2021 plans, allowing time any for rate revision necessary to comply with the final federally approved reinsurance program. Individual market issuers will be required to file two sets of rates for the duration of the NH Section 1332 Waiver program for federal pass through funding calculation purposes.

[1] All single risk pool individual market plans that comply with program requirements will be eligible for payments.

C. Recertification/Guaranteed Renewability of 2020 QHPs

QHPs currently offered on the New Hampshire Marketplace that are applying for renewal must be recertified, i.e., they are not to be withdrawn and filed as new plans so long as any plan modifications fall within regulatory parameters for uniform modifications of coverage. To be eligible for recertification, a QHP or Stand-Alone Dental Plan (SADP) certified by a federally-facilitated Marketplace (FFM) must be the same "plan," as defined in 45 CFR 144.103, as the plan that was certified for plan years beginning in 2020. Such plans are also guaranteed renewable.

A change in the plan marketing name itself does not constitute a new plan. Issuers should consult the Exchange and Insurance Market Standards for 2015 and Beyond, as well as the guidance on updated definitions issued in 2018, which outlines the standards for determining whether a plan has undergone a uniform modification and would be found guaranteed renewable.[2]

As a reminder, in the 2018 NBPP CMS clarified and 2019 NBPP reiterated that[3]:

A product is a discrete package of health insurance coverage benefits that are offered using a particular product network type (HMO, PPO, POS) within a service area.

In the case of a product that has been modified, transferred, or replaced, the resulting new product will be considered to be the same as the modified, transferred, or replaced product if the changes to the modified, transferred, or replaced product meet the standards relating to uniform modification of coverage,[3] as applicable. Additionally, any set of plans that share a network type and benefits is a product. A plan is the pairing of the health insurance coverage benefits under a product and a particular cost-sharing structure, provider network, and service area.

Allowed changes are summarized below:

Changes made solely pursuant to applicable federal or state requirements; or
all of the following:

- Changes in cost sharing are solely related to changes in cost and utilization of medical care, or to maintain the same metal tier level of coverage.
- The plan provides the same covered benefits, except for changes in benefits that cumulatively impact the A/V by no more than 2 percent;
- The plan covers a majority of the same counties in its service area; and
- The plan covers a majority of the same provider network.

Allowed changes also include certain mid-year formulary changes that meet the requirements of uniform modification as outlined in *Section G* regarding Prescription Drugs.

As outlined in the Department's Bulletin INS-15-051-AB issued on August 25, 2015, the Department will require that issuers alert consumers to the addition or removal of a benefit from a plan, even if the plan is within the above-outlined parameters for renewal and falls within the

[1] [2] http://www.ecfr.gov/cgi-bin/text-idx?node=se45.1.147_1106&rgn=div8

[2] [3] Updated definitions of product/plan were included in the Final Notice of Benefit and Payment Parameters for 2018; additionally, see 45 CFR 144.103.

regulatory parameters for uniform modification. This information must be provided in a consumer notice to be issued on the first allowable date, but no less than 60 days, prior to open enrollment for 2020 and is in addition to all federally-required notice language outlined in 45 CFR 146.152, 147.106, and 148.122. The disclosure must appear on the first page in bold type and include sufficient information for the average consumer to understand the nature of the change and make an informed plan selection decision for 2020. Pursuant to state and federal law, issuers must provide notice of formulary changes, as outlined in *Section G* regarding Prescription Drugs.

The recertification process for QHPs and SADPs will continue to mirror the certification process of a new plan. Issuers must submit all of the same information for recertification of plans that are on the Marketplace in 2020 and will be continued for 2021.

QHPs and SADPs being recertified for Plan Year 2021 must use the same HIOS plan identification number as used for Plan Year 2020.

D. Plan Terminations and Mapping

If an issuer chooses to not recertify a plan in the Marketplace, it is subject to the standards outlined in 45 CFR 156.290.[4]

The definition of the same "plan" from 45 CFR 144.103 will also apply to reenrollment. Issuers offering plans on the individual market FFM and SHOP in plan year 2019 should submit Plan ID Crosswalk data for their QHPs and SADPs to CMS via email.

The hierarchy set forth at 45 CFR 155.335(j) will apply to both QHPs and SADPs. CMS only requires the Plan ID Crosswalk for the individual market. For purposes of identifying to CMS significant rate increases, new plans that map 2020 members from terminating plans will be considered the same "plan." Issuers are urged to consult guidance released by the Department in 2017 as a result of issues with terminations and mapping enrollees including the Product Discontinuance v. Market Withdrawal Bulletin. Any termination and auto-enrollment notifications being sent to enrollees should be sent to the Department with enough time for the Department to conduct a review and provide necessary edits prior to dissemination. Notices shall be submitted through SERFF as a change to the binder to the attention of Jason Dexter, Administrator of Life and Health Forms Examination, at the New Hampshire Insurance Department at Jason.G.Dexter @ins.nh.gov.

IV. Guidance to Issuers on Select QHP Requirements

As the certification and open enrollment process proceeded in past years, certain areas were flagged as needing additional clarity in order to ensure that all plan offerings are compliant. In subsequent pages, issuers will find guidance regarding those issues the NHID seeks to clarify for the Plan Year 2021 certification process.

[4] 45 CFR 146.152(f), 147.106(e), or 148.122(g)

In order to ensure adequate and timely review under both state and federal standards, **we ask that issuers explicitly highlight any deviations** from these standards.

A. Network Adequacy

Issuers are responsible for complying with N.H. Code of Admin. R. PART Ins 2701, HEALTH AND DENTAL BENEFIT PLAN NETWORK ADEQUACY. Ins 2700. To demonstrate compliance, carriers must submit the NHID Network Adequacy Template. The Network Adequacy Template is designed to assist carriers with submitting provider networks and ensuring that networks are reviewed as efficiently and fairly as possible. As is specified in the template, the submission must include complete and accurate information in the fields of Issuer Name, Network ID, Network Name, National Provider Identifier (NPI), Provider Name, and Provider Street Address, City, State and Zip Code. Issuers must adhere to Template Guidelines and requirements to ensure an accurate and timely review of network adequacy submissions. Carriers should submit separate networks using separate templates, even when the networks are very similar. If multiple product networks are identical, only one network filing is necessary.

Network adequacy filings must reflect signed contracts with providers as of the time of filing. If an issuer network changes after submission that impacts compliance with network adequacy standards or results in the loss of a major inpatient/outpatient facility or large provider group, **that change must be immediately reported to the Department and issuers must also update all applicable state and federal templates via SERFF.** Please note changes to issuer networks after certification remain subject to the reporting requirements detailed by Ins. 2700.11.

B. Essential Community Provider Requirements

The Department will review the plan's compliance with 2020 Essential Community Provider (ECP) Standards, set forth by CMS and outlined in the Plan Year 2021 NBPP and Letter. QHP issuers must ensure that the provider network of each of its QHPs includes ECPs in sufficient number and geographic distribution to ensure reasonable and timely access to a broad range of such providers for low-income and medically underserved individuals in QHP service areas.

ECP compliance requires the issuer to demonstrate that it has:

- Achieved at least 20% ECP participation in network in the service area.
- Offered contracts in good faith to all available Indian health providers in the service area, to include the Indian Health Service, Indian Tribes, Tribal organizations, and urban Indian organizations; and
- Offered contracts in good faith to at least one ECP in each ECP category in each county in the service area, where an ECP in that category is available.

If an issuer's application does not satisfy the requirements above, the issuer must include as part of its application a narrative justification describing how the issuer's provider network, as currently designed, provides an adequate level of service for low-income and medically-underserved enrollees and how the issuer plans to increase ECP participation in the issuer's provider network in future years, as necessary. The justification is subject to approval by the Department and is due at the time of filing.

At a minimum, such narrative justification would include the following:

- Number of contracts offered to ECPs for the 2021 benefit year.
- Number of additional contracts issuer expects to offer for the 2021 benefit year and the timeframe of those planned negotiations.
- Evidence of efforts of contracting including, but not limited to emails; date/time of contract attempts made and to whom those communications were made to in an effort to contract; or other evidence as requested by the Department if needed.
- Names of the ECP hospitals, Federally Qualified Health Centers (FQHCs), Ryan White providers, family planning providers, and providers in the other ECP categories to which the issuer has offered contracts, but with which an agreement has not yet been reached.
- Contingency plans for how the issuer's provider network, as currently designed, will provide adequate care to enrollees who might otherwise be cared for by relevant ECPs. For example, if available FQHCs, Indian health care providers, Ryan White HIV/AIDS Program providers, or family planning providers are missing from the network(s), the issuer must explain how its target populations will be served.

To assist issuers in identifying these providers, CMS has published a non-exhaustive list of available ECPs based on data maintained by CMS and other federal agencies, which issuers may use to assess their satisfaction of the ECP standard. Issuers can also write in ECP providers, as long as those providers submit an ECP petition to CMS no later than the final date to make changes to the issuer's QHP application. This non-exhaustive list is updated annually near the beginning of the calendar year and is available at: https://www.qhpcertification.cms.gov/s/ECP%20and%20Network%20Adequacy.

The Department reiterates the importance of issuers complying with 45 CFR. 156.235(e), which requires that QHP issuers pay an amount to FQHCs that is not less than the amount that would have been paid to the center under section 1902(bb) of the Social Security Act for such item or service, as specified in section 1302(g) of the ACA.[4]

Issuers of individual market QHPs, including SADPs, are required under 45 CFR. 156.1250 to accept third-party premium and cost-sharing payments made on behalf of enrollees by the Ryan White HIV/AIDS Programs; Indian tribes, tribal organizations, or urban Indian organizations; and state or federal government programs, as well as applicable downstream entities.[5] This rule clarifies HHS's position on Ryan White HIV/AIDS programs, stating that QHPs must accept third-party premium payments from Ryan White HIV/AIDS programs.

C. Contraceptive Coverage

Public Health Service Act section 2713 and federal regulations require non-grandfathered group health plans and health insurance coverage offered in the individual or group market to provide benefits for and prohibit the imposition of cost-sharing requirements, with respect to women, for evidence-informed preventive care and screening provided for in

comprehensive guidelines supported by the Health Resources and Services Administration (HRSA), to the extent not already included in certain recommendations of the US Preventative Services Task Force.[6]

As stated in Affordable Care Act Implementation FAQs - Set 12, under the HRSA Guidelines, intrauterine devices and implant contraceptive methods are required to be covered without cost sharing if approved by the FDA and prescribed for a woman by her health care provider, subject to reasonable medical management.

RSA 415:6-w (Individual) and RSA 415:18-i (Group) require all insurance plans, regardless of whether or not in grandfathered status under the ACA to provide for the required contraceptive coverage.

The NHID will only recommend for certification those plan offerings that comply with the above stated federal requirements and that include the following language in an issuer's Summary of Benefits and Coverage:

"*Prescribed FDA approved contraceptives are not subject to cost-shares."*

D. Mental Health Parity and Addiction Equity

The federal Mental Health Parity and Addiction Equity Act (MHPAEA) requires that treatment limitations for mental health and substance use disorder (SUD) benefits be no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.[7] The law specifically expands parity requirements to include substance use disorder benefits. As a result, all parity requirements that apply to coverage of services for mental health conditions also apply to coverage of services for substance use disorders. Under the MHPAEA, plans must define mental health conditions and substance use disorders in accordance with applicable federal and state law and consistent with generally recognized independent standards of current medical practice (including the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), most current version of the International Classification of Diseases (ICD), or state guidelines).

The requirements and limitations are evaluated within six different categories, with an additional subcategory for specialists. For example, requirements and limitations for inpatient (in-network) Mental Health and SUD services may be no more restrictive than requirements and limitations for inpatient (in-network) medical and surgical benefits.

The MHPAEA refers to annual and lifetime aggregate limits, quantitative treatment limitations and financial requirements, such as cost sharing, in establishing parity between mental health and substance use disorder services and medical/surgical services. As noted above, these requirements and limitations must be offered at parity with medical and surgical services in each of the six classifications. Non-quantitative treatment limitations (NQTLs) are also regulated under the MHPAEA and must be offered at parity with medical and surgical services. NQTL requirements include geographic limits, facility-type limits, and network

adequacy. As such, issuers will need to demonstrate that members will have the necessary access to mental health and substance use disorder providers. Issuers must submit to the Department their attestations to CMS that their plans filed for offering on the Marketplace comply with the requirements of 45 CFR 146.136, including in regards to the coverage of prescription drugs used for Medication-Assisted Treatment of opioid use disorders as outlined in *Section G* regarding Prescription Drug Coverage[5].

In addition to MHPAEA compliance, issuers must comply with state requirements with respect to pervasive development disorders/autism treatment service as set forth in NH RSA 417-E, NH RSA 415:6-n and NH RSA 415:18-s and the NHID bulletin regarding Guidance on Administration of Autism Benefits (INS-15-046-AB) which clarifies that, in New Hampshire, pervasive development disorders and autism are defined as biologically-based mental illnesses. New Hampshire also requires compliance with specific requirements with respect to treatment for substance use disorders, including use of the ASAM criteria to determine medical necessity, as set forth in RSA 420-J:15-18.

The Department issued a bulletin (included above in II. Legal Authority) in 2019 in response to the passage of SB 11 which amended RSA 417-F, Coverage for Emergency Services, by inserting a new section 417-F:4, Reimbursement for Emergency Room Boarding. The NHID bulletin sets forth guidance on the reimbursement for emergency room boarding and details the requirements of SB 11, including that issuers must following the completion of an involuntary admission certificate "pay the acute care hospital a per diem day rate required to board and care for the patient, to be contracted between the insurer and acute care hospital." Issuers are directed to consult the full bulletin in order to ensure compliance for Plan Year 2021.

E. Benefit Design

Essential Health Benefit

The Essential Health Benefit (EHB) benchmark plan for Plan Year 2021 is the same as previous years - Matthew Thornton Blue; plan materials can be found here. Pediatric dental is supplemented by the FEDVIP dental plan.

Clarity in Describing Benefit Design

As in previous years, the Department will be enforcing a prohibition on deceptive or misleading language in forms filed by those issuers seeking to sell plans on the New Hampshire Marketplace. Issuers should strive to describe benefit design in terms that will be clear even to consumers who may have little experience purchasing and using insurance.

Issuers must make benefit coverage and cost-sharing limitations clear in their Plan and Benefit Template submissions by utilizing the exclusions and benefit explanations section of the template. If, for example, there is a copay for the first three visits and then a coinsurance after deductible for the subsequent visits, issuers must put in the benefit explanations that the copay is only for the first three visits. Issuers must strictly follow the QHP Application Instructions which give explicit instruction for the templates and supporting documentation

[5] 7 42 U.S.C. 300gg-26; 78 FR 68240.

and can be found here.

Please remember to update form filings if changes are made to Plan and Benefit Templates and vice versa. After initial certification, and during our process of assembling our "plan compare" document over the course of previous certification, the NHID consistently finds significant discrepancies between the benefit and cost-sharing wording on forms and the way plans were input into the Plan and Benefit Templates. Issuers must input data into the Plan and Benefits Template accurately and that data must match the policy forms. The discrepancies found in previous plan years caused both the state and CMS serious concern. Issuers must ensure both the filings and templates are accurate.

Cost Sharing

As CMS does annually, it has updated the maximum annual limits on cost sharing in the Draft NBPP for 2020 as follows. Issuers are expected to comply with the final cost sharing and maximum annual limits when released by CMS.

	2020		**2021*** **Proposed**	
	Self-Only	**Other than Self-Only**	**Self-Only**	**Other than Self-Only**
Maximum Annual Limit on Cost Sharing	$8,150	$16,300	$8,550	$17,100
Reduced Annual Limit on Cost Sharing for Individuals between 100% and 150% of the Federal Poverty Level (FPL)	$2,700	$5,400	$2,850	$5,700
Reduced Annual Limit on Cost Sharing for Individuals between 150% and 200% of the FPL	$2,700	$5,400	$2,850	$5,700
Reduced Annual Limit on Cost Sharing for Individuals between 200% and 250% of the FPL	$6,500	$13,000	$6,800	$13,600

F. Provider Directory

Issuers are expected to comply with state and federal guidance related to provider directory requirements. Under N.H. Code of Admin. R. PART Ins 2701.12, health carriers are required to electronically post and maintain a current, accurate, and searchable provider directory that includes plain language descriptions of the criteria used to build and tier provider networks and that is updated for each network plan at least monthly. Carriers must also include a customer service email address and telephone number or electronic link that covered persons or the general public may use to obtain further information or notify the carrier of

inaccuracies in the directory.

In addition, in order to avoid CMS correction notifications, the Department recommends strict compliance with 45 CFR 156.230(b), which requires, among other things, that a QHP issuer publish an up-to-date, accurate, and complete provider directory, including information on which providers are accepting new patients, the provider's location, contact information, specialty, medical group, and any institutional affiliations, in a manner that is easily accessible to plan enrollees, prospective enrollees, the state, the FFM, and CMS. The general public should be able to easily discern which providers participate in which plans and provider networks. Further, if the health plan issuer maintains multiple provider networks, the plan(s) and provider network(s) associated with each provider, including the tier in which the provider is included, should be clearly identified on the website and in the provider directory.

CMS also requires QHP issuers in the FFMs, including issuers of SADPs, to make this provider directory information publicly available on their websites in a machine-readable file and format specified by CMS, to allow the creation of user-friendly aggregated information sources.

Upon enrollee request, issuers must send a printed copy of the provider network directory. Issuers are prohibited from using the same printed provider directory for all plans. Each printed directory must also include a designation for providers that are not accepting new patients.

Additionally, please read and ensure compliance with the New Hampshire Insurance Department September 25, 2014 Bulletin INS-14-025-AB.

The Department will be checking for compliance with provider directory standards. If non-compliant, the Department will refer the issuer to its Market Conduct Division for action as needed.

G. Prescription Drugs

Coverage Requirements/Formulary Reviews

Issuers are reminded that non-discrimination provisions apply to issuer formularies and will be reviewed by the Department. As in previous years, reviews will be done to help ensure that QHPs follow applicable regulations on prescription drugs.

CMS will conduct the following prescription drug reviews:

Formulary Category/Class Count: Issuers do not meet the EHB standards unless they cover the greater of one drug in every USP category and class or the same number of drugs in each category and class as the EHB benchmark plan. All issuers will be reviewed to ensure compliance with this provision, and we note that there is only one drug (Naloxone) in the Anti-Addiction/Substance Abuse Treatment Agents (Opioid Reversal Agent) class. Therefore, Naloxone must be covered to be compliant with this rule. More guidance on the coverage of drugs used for substance abuse disorder is outlined below and in *Section D* regarding Mental Health Parity and Addiction Equity.

Formulary Outlier Review: All formularies will be compared, and formularies with an unusually high number of drugs that are subject to prior authorization or step therapy requirements in a particular USP category and class will be flagged and identified as outliers. The PY 2021 tool will review 28 USP classes. The outlier calculation includes both state and national level outlier threshold values. Because this calculation will be performed by the NHID based on market-wide data, carriers will not know at the time of filing whether or not they are an outlier.

Clinical Guideline-Based Review of Prescription Drug Coverage: The availability of drugs recommended by nationally recognized clinical guidelines will be analyzed. In some cases, the review will also evaluate whether certain first-line therapies are available without step therapy or prior authorization. Drugs included in this review are not limited to those included on the EHB- Rx Crosswalk. The ten medical conditions included in the review for 2021 include: opioid use disorder, bipolar disorder, breast cancer, diabetes, hepatitis C, HIV, multiple sclerosis, prostate cancer, rheumatoid arthritis, and schizophrenia.

2021 New Hampshire Formulary File Submission

Beginning in 2019, issuers must submit to the Department a complete 2021 Formulary file with initial plan filings. The 2021 New Hampshire Formulary form may be found on the Department website. The form should be filed in SERFF under the Supporting Documents tab, with a complete and final list of the drugs included in the plan for 2021 uploaded prior to the close of the certification period. The 2021 Formulary excel file must include the eleven-digit National Drug Code (NDC) without the hyphens, in character format (to avoid dropping leading zeros or other technical issues). NDC codes may be found here.

Coverage of Medication-Assisted Treatment (MAT)

The NHID reiterates the suggestion in the preamble of the 2020 NBPP that issuers include all MAT drugs on their QHP formularies.[6] We also remind carriers that excluding coverage of drugs when used for MAT while covering the same drugs for other medically necessary purposes may be a violation of 45 CFR 156.125, which states that a QHP does not meet the Essential Health Benefit requirements if its benefit design or the implementation of its benefit design is discriminatory, including based on health conditions. Exclusions of MAT drugs for the treatment of opioid use disorder while covering the same drugs for other medically necessary purposes is only permitted if doing so can be justified as reasonable medical management based on clinical guidelines and medical evidence. Such variations of coverage may also be a prohibited non-quantitative treatment limitation in violation of MHPAEA.

RSA 420-J:18 prohibits a heath carrier that has authorized or otherwise approved MAT from requiring a renewal of such authorization more frequently than once every 12 months.

Formulary Access

Issuers are expected to comply with the following federal guidance related to formulary requirements. In order to avoid CMS correction notifications, strict compliance is recommended

[6] The four drugs currently used in MAT are buprenorphine; naltrexone; buprenorphine in combination with naloxone; and methadone.

by the Department.

The formulary drug list must be published in a manner that is easily accessible to plan enrollees, prospective enrollees, the State, the Marketplace, CMS and the general public. A formulary drug list is easily accessible when it can be viewed on the plan's public website through a clearly identifiable link or tab without requiring an individual to create or access an account or enter a policy number, and if an issuer offers more than one plan, when an individual can easily discern which formulary drug list applies to which plan.

Under CFR 156.122(d)(2), CMS requires QHP issuers in the FFMs, including SHOP issuers but excluding SADP issuers, to make this formulary drug list information publicly available on their websites in a machine-readable file and format specified by CMS, to allow the creation of user-friendly aggregated information sources.

Mid-Year Formulary Changes

The Department believes that formulary stability is extremely important so that enrollees maintain access to the benefits of the plan they chose during enrollment as represented to them by issuers. However, it is understood that prescription drug therapies are constantly evolving and that new drug availability, medical knowledge and opportunities for improving safety and quality in prescription drug use at a low cost will inevitably occur over the course of the year and that these new developments may necessitate formulary changes during the plan year. State law does not prohibit issuers from making mid-year formulary changes, but does prohibit changes in plan design to the extent they are detrimental to a consumer.[7] The Department is committed to ensuring non-discrimination in the formularies offered to consumers and will consider any mid-year formulary changes in the analysis for non-discrimination in formulary development.

Pursuant to state and federal law, issuers must provide notice of certain formulary changes at the time they are made. There is some – but not complete – overlap between the following federal and state notice requirements. Issuers should ensure they comply with the most stringent requirements applicable to the given situation.

<u>Notices of Changes to Brand Drug Coverage when a Generic Alternative becomes Newly Available</u>

45 CFR 146.152, 147.106, and 148.122 require issuers to notify all plan enrollees of the change in writing at least 60 days prior to a deletion or tier change of a brand prescription drug when a generic drug alternative becomes newly available and is added to the formulary. The notice must include the name of the brand drug subject to the change, the change being made, the name of the generic that will be newly available, the date the change will be effective, and the process for requesting an exception to gain access to the removed drug.

[7] In addition, Federal law now specifically permits formulary changes to add a generic drug that becomes newly available to the formulary and to either remove the brand equivalent from the formulary or move the brand drug to a higher cost-sharing tier on the formulary, pursuant to 45 CFR 146.152, 147.106 and 148.122.

Issuers must also notify CMS of any changes made in the prior year on an annual basis subject to the requirements outlined in 45 CFR 146.152, 147.106, and 148.122.

State-Required Notices of Other Formulary Changes

RSA 420-J:7-b requires issuers to provide 45 days' notice prior to removing any prescription drug from the formulary to enrollees for whom the plan provided coverage of the prescription drug in question during the 12-month period immediately prior to the deletion. Issuers should be aware that the Department considers moving a drug to a higher cost tier to be a drug deletion. The issuer must also provide an explanation of the exception process that can be used to access non-formulary, medically necessary prescription drugs and provide a toll-free phone number for accessing additional information. In addition, RSA 420-J:7-b requires issuers to provide notice of deletions from and additions to formularies to all enrollees at least annually. Compliance with these notice requirements are subject to Market Conduct review.

Cost Sharing for Brand Drugs

When a generic alternative to a brand prescription drug becomes newly available, the issuer may make a mid-year change to the formulary in order to add the generic drug to the formulary and to remove or change the tier of the brand drug, as outlined above. However, for consumers for whom the brand drug is medically necessary, the cost sharing for the brand drug must be no less favorable to the consumer mid-year than it was at the beginning of the policy regardless of any tier change made generally.

Appeals

45 CFR 156.122(c) requires health plans to have a process to allow an enrollee to request and gain access to clinically appropriate drugs not otherwise covered by the health plan. The process must include:

- An internal review (federal regulations require the issuer to make a determination and notify the enrollee no later than 72 hours following receipt of the request, however, RSA 420-J:7-b requires that the process not exceed 48 hours);
- An external review;] and
- The ability to expedite the reviews (must make determination and notify the enrollee no later than 24 hours following receipt of the request).
- In the event that an exception request is granted, the excepted drug(s) are treated as an EHB including counting any cost sharing towards the plan's annual limitation on cost sharing.

Uniform Prior Authorization Form

In 2017, NHID moved to a Uniform Prior Authorization form. Issuers are not allowed to edit or require more information than included in the standard form but may have a version with the issuer's contact information prefilled on their websites.

For plan year 2021, all issuers must accept and use the NH Standard Prior Authorization RX form: https://www.nh.gov/insurance/legal/documents/nhstandard-rx-pa-form.pdf

H. Prohibition on Mid-Year Withdrawals

Issuers are reminded that QHPs must be made available for enrollment through the Marketplace for the full plan year for which the plan was certified, unless a basis for suppression under 45 CFR 156.815 applies.

I. Summary of Benefits and Coverage

Issuers are reminded that CMS released the Summary of Benefits and Coverage and Uniform Glossary final rule on June 16, 2015 and it includes the following provisions:

- Summaries of Benefits and Coverage (SBCs) must include a web address that links directly to a copy of the individual coverage policy or group certificate of coverage.
- All URL links included on the SBC must link directly to the referenced information, such as the specific formulary for that SBC benefit package. URL links must be active prior to the date of final submission to CMS, August 21, 2020.
- QHP SBCs must disclose whether or not the QHP pays for abortions for which federal funding is not available.
- QHP insurers are required to make SBCs available that accurately reflect each cost-sharing plan variation and must include a separate URL linking to the SBC created for each plan variation as part of the QHP data submission.

CMS SBC instructions and templates can be found here.

J. Advertisements

Advertising materials for all plans, including indemnity licensed products, must conform with applicable requirements under both state and federal law. This Bulletin specifies which advertising materials and attestations must be submitted to the Department during the QHP review process; however, QHP certification should not be construed as approval of all submitted advertising materials. The Department reserves the right to review all advertisements, whether submitted or not, in order to protect consumers in the event such advertising is determined to be misleading or inaccurate.

The ACA and subsequent regulations grant the Department authority to review marketing materials, including advertisements, and ensure that materials are not false, misleading or discriminatory. This authority is in addition to existing authority under state law, discussed further below. Marketing practices or benefit designs may not have the effect of discouraging the enrollment of individuals with significant health needs in QHPs. Advertising must also comply with N.H. Code of Admin. R. PART Ins 2600.

For 2021 QHP certification purposes, the NHID requires issuers to file advertisements "prior to use," in accordance with RSA 420-B:8, VI. In 2015 QHP Certification: Guidance on the Filing of Advertising Materials (INS-14-015), NHID interpreted "review and approval prior to use" in RSA 420-B:8 Forms of Evidence of Coverage to mean:

Before an HMO uses any materials meeting the definition of advertising in RSA 420-B:1 I, the HMO shall file materials with the Department for review. Issuers must submit all such advertisements in SERFF in the filing mode of "information only" with the filing type

marked as "Advertising." Per N.H. Code of Admin. R. PART Ins 401.04(a), all forms, including webpages, must have a form number in the lower left-hand corner.

Issuers shall submit an attestation in the supporting documentation tab in the SERFF binder for each market stating that all advertising materials are in compliance with applicable state and federal regulations, including the standards set forth in RSA 420-B:12, I. Attestations are not required for subsequent form and advertising filings.

The Department reserves the right to disapprove any and all filed advertisements, to the extent that they do not conform with the substantive requirements under RSA 420-B:12, or other applicable laws. All issuers should be prepared to participate in a full review of all filed materials and are reminded that advertisements are subject to a market conduct review if issues arise after use, even if a form was approved. Issuers are urged to consult INS-14-015 for additional information.

In the event there is information presented that would lead a reasonable consumer to believe that a policy confers a greater benefit than stated in the approved policy or certificate, the issuer will be held accountable, as set forth in INS-14-015. As a reminder, insurance issuers are responsible for the advertisements utilized by their appointed producers.

K. Segregation of Funds under ACA Section 1303

Each QHP issuer offering Marketplace coverage must submit to the Department its annual attestation to CMS that it will adhere to the requirements related to segregation of funds and offering of plans consistent with 45 CFR 156.280 and all applicable guidance.

L. Stand-Alone Dental/Pediatric Dental Disclosure

All stand-alone dental plans offered on the Marketplace must be filed with the NHID and are subject to review in accordance with all applicable state and federal regulations prior to any recommendation for certification to CMS. Both health plans and stand-alone dental plans are bound by the same filing deadlines, set forth in Appendices I and II. Stand-alone dental plan issuers are urged to reference the 2021 Letter to Issuers in the FFM for any additional guidance. As a reference for stand-alone dental plan issuers, we have included as Appendix II to this Bulletin the chart put forth by CMS detailing which standards and tools apply to stand-alone dental coverage and which do not.

The NHID strongly encourages issuers of stand-alone dental plans seeking certification to thoroughly check all federal guidance and Department bulletins prior to submission.

All issuers are reminded that if no issuer offers a stand-alone pediatric plan for Plan Year 2021, then all issuers must embed the benefit. The Department will make all issuers aware if a filing revision is required soon after the initial intake procedure is completed, so that issuers may revise and embed pediatric dental if necessary. All issuers offering individual or small group health insurance plans for purchase on the Marketplace must disclose, at the time of solicitation, whether the plan covers pediatric dental services, and shall include the following

language on policy documents and enrollment forms if the plan does not include pediatric dental services:

"This policy does not include pediatric dental services. Pediatric dental coverage is included in some health plans but can also be purchased as a standalone product. Please contact your insurance carrier or producer, or seek assistance through Healthcare.gov, if you wish to purchase pediatric dental coverage or a stand-alone dental services product."

M. Out-of-Network Services and Balance Billing

Pursuant to 45 CFR 156.230(e), issuers are required to count cost sharing paid for an essential health benefit provided by an out-of-network, ancillary provider at an in-network setting towards the in-network annual cost-sharing limitation unless the issuer provides written notice meeting the requirements set forth at 45 CFR 156.230(e) to the enrollee by the longer of: when the issuer would typically respond to a prior authorization request; or 48 hours prior to the provision of the benefit. Each issuer must provide a statement to the Department outlining how it is complying with this requirement.

Issuers also must comply with state law regarding balance billing. RSA 420-J:8 requires health insurance issuers to include in their contracts with participating providers a provision stating that the provider shall not "bill, charge, collect a deposit from, seek payment or reimbursement from, or have recourse against a covered person or a person acting on behalf of the covered person (other than the health issuer or intermediary) for services provided pursuant to this agreement" including, but limited to, in the event of nonpayment by the issuer, issuer insolvency, or breach of agreement. Issuers are expected to include this provision in all provider agreements.

In addition, RSA 329:31-b, prohibits providers of anesthesiology, radiology, emergency medicine, or pathology services from billing consumers covered by a managed care plan for fees or amounts other than copayments, deductibles, or coinsurance, if the service is performed in a hospital or ambulatory surgical center that is in-network under the patient's health insurance plan. This prohibition applies whether or not the health care provider is contracted with the patient's insurance carrier. Fees for such services charged to issuers must be commercially reasonable and based on payments for similar services from New Hampshire issuers to New Hampshire health care providers. If an issuer cannot come to agreement with a provider on the reasonable value of a service being billed in such a situation, the issuer or provider may petition the Insurance Commissioner for a hearing under RSA 400-A:17. Issuers and providers are instructed to make best efforts to resolve the dispute prior to applying for a hearing and may be required to engage in mediation prior to the Commissioner issuing a decision.

In addition, issuers that offer HMO products for the 2021 plan year are reminded they are subject to requirements under RSA chapter 420-B, which are explained further in a bulletin issued by the Department in 2006, entitled Network Based Hospital Services.

N. SHOP Guidance

Group Size and Employee Counting

Pursuant to the PACE Act,[10] which was signed into law on October 7, 2015 and as communicated in the Department's Bulletin INS-15-065-AB issued on October 27, 2015, issuers should offer and write small group coverage only to groups of 1-50. Any group of 51 or more may be offered and written only as large group coverage.

As outlined in NHID Bulletin INS-15-014-AB issued on April 20, 2015, federal counting rules for determining whether a purchaser falls into the definition of a small group or a large group are different from the method traditionally used in New Hampshire and should be used in all cases. Issuers should consult 45 CFR 155.20 for a detailed explanation of the counting methodology to be followed.

Small Business Health Options Program (SHOP)

As of open enrollment for 2018, the functions of the federally facilitated SHOP have been streamlined. The New Hampshire SHOP no longer facilitates enrollment or premium payment. However, SHOP plans will still be certified, must conduct enrollment in compliance with all applicable SHOP rules and policies and must comply with certain SHOP rules, including those related to plan design, special enrollment periods, and employer eligibility, in order to be displayed on the SHOP and for enrollments to qualify for small business tax credits. Issuers are responsible for complying with FF-SHOP rules that remain applicable and should consult the final NBPP for 2021 and 2021 Letter to ensure compliance.

In a bulletin released on February 12, 2018, the Department announced that it will now accept form and rate filings for new small group products and plans with effective dates on the calendar quarter. The current requirement of no more than one binder per market remains in effect.

Issuers wishing to file new small group plans should submit a request to the Department to reopen the binder for issuer submission of revised templates for plan identification codes, benefit designs, formulary templates, rate templates and, where appropriate, new network templates. The single risk pool requirement remains in effect and rate submissions must be made in accordance with Department and CMS guidance. For the full announcement related to this change, please review the Bulletin INS-18-006-AB Off-cycle Filing of Small Group Plans and Products.

Filings for small group products offered by issuers with no plans offered on the exchange can delay the filing of their forms, rates and binders until July 1. 2020.

Employee Choice

Though enrollment is no longer being facilitated through the New Hampshire SHOP, qualified employers will continue to have the option of offering their employees choice among multiple QHPs and SADPs on the FF-SHOP. In New Hampshire, employers may offer employees a single QHP/SADP or, in the alternative, may provide qualified employees a choice of: (1) all QHPs at a single level of coverage; or (2) all plans across all metal levels

from a single insurer.[8] Employers will need to submit enrollments and payments directly to each health insurance carrier.

O. Transition Coverage

On January 31, 2020, CMS issued guidance providing that it will not take enforcement action against certain non-grandfathered coverage in the individual and small group insurance markets that is out of compliance with certain specified market reforms (transitional coverage). The CMS guidance allows the renewal of transition coverage through October 1, 2021, but also stipulates that no such policy shall extend past December 31, 2021. As in previous years, the NHID has adopted the CMS transitional guidance and will allow the renewal of transition coverage; however, because of the 12-month rate guarantee period under RSA 420-G:4, I (a), New Hampshire will not allow renewals for less than a 12- month period. See INS-18-018-AB.

P. Transparency in Coverage Data Collection

For Plan Year 2021, issuer should include transparency in coverage data collection into the QHP certification data submission process, such that issuers will submit the transparency template in the same manner and using the same timeline as other QHP certification templates.

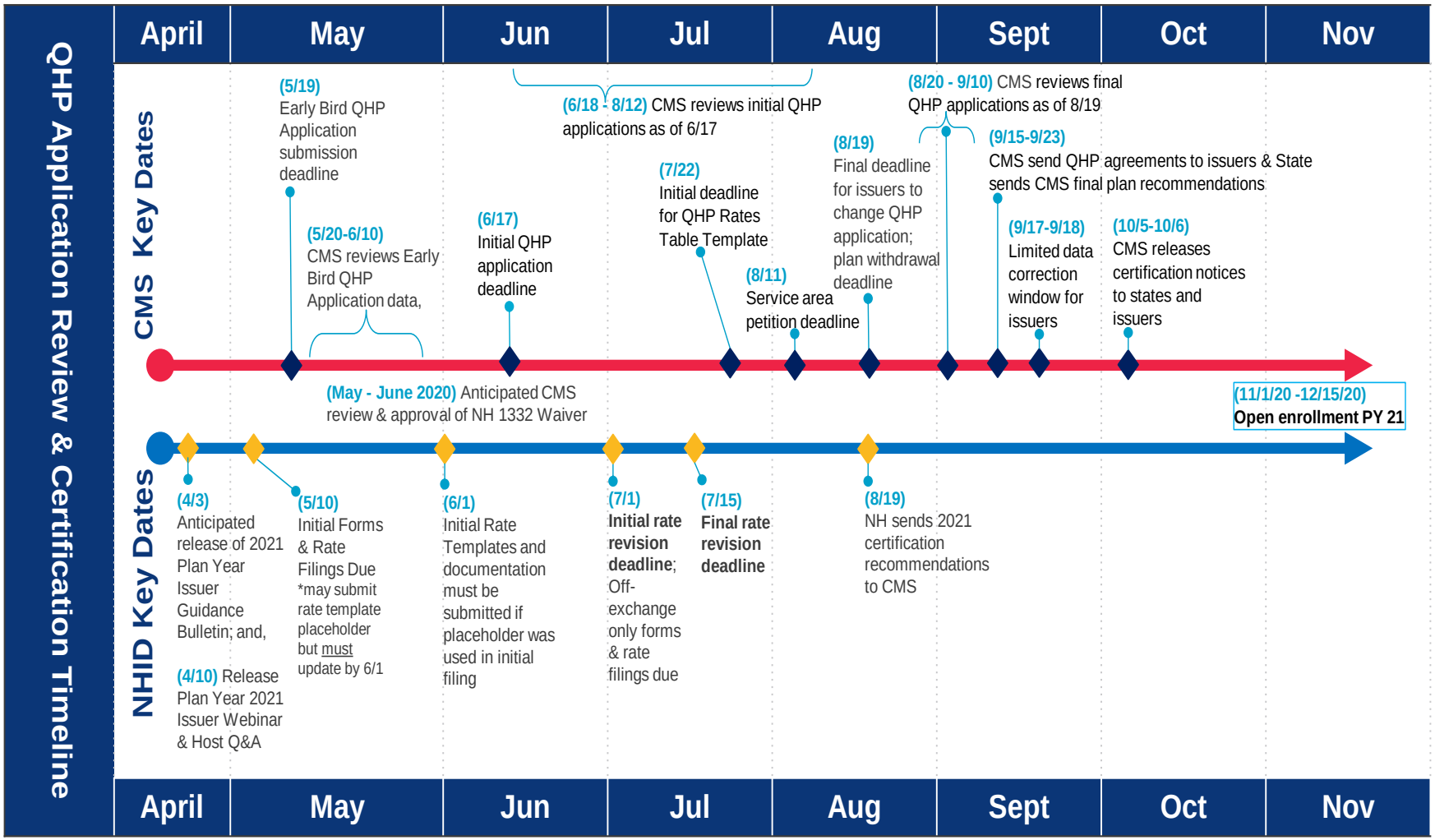
Contact Information

Please direct questions related to this Bulletin to Jason Dexter at the New Hampshire Insurance Department, at Jason.G.Dexter@ins.nh.gov or by phone at (603) 271-3041.

8 RSA 420-G:2, XVI

Appendix I: NHID Draft QHP Review Timeline

DRAFT NHID QHP Timeline Plan Year 2021



Appendix II: Standards and Tools Applicable to SADPs

Standard or Tool Applies (* denotes modified standard)	
Essential Health Benefits*	Actuarial Value*
Annual Limits on Cost Sharing*	Licensure
Network Adequacy	Inclusion of ECPs
Non-discrimination	Service Area
Acceptance of Third-Party Premium and Cost-sharing Payments	Data Integrity Tool
Rates submission*	Machine Readable* (SADPs must comply with provider directory standards but not drug formulary standards)
Transparency in Coverage Reporting	

Standard or Tool Does Not Apply	
Accreditation	Patient Safety
Quality Reporting and Quality Improvement Strategy	Standardized Options
Prescription Drugs	Out-of-Pocket Cost Comparison Tool
Cost Sharing Reductions	